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School of Psychology

PRACTITIONER EXPERIENCES OF ONLINE TREATMENT

by

Davina Wong

Thesis for the degree of Doctor of Clinical Psychology

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Abstract

It is increasingly popular to provide psychological assistance online. Existing literature summarises a variety of benefits associated with online treatments including remote access, or access to treatment where situational or environmental barriers may prevent clients from attending traditional face-to-face appointments.

The first part of this thesis is a qualitative systematic review synthesising the best available evidence exploring experiences and attitudes to online therapy and what role they play from the perspectives of practitioners. Relevant databases were searched focusing on qualitative empirical papers that fit the inclusion criteria. Thematic Synthesis was used to bring together findings. Ten studies were included and nine themes emerged from the data highlighting practitioner experiences and their contributions to their attitude toward online therapy. Themes included: Structure and safety of standardised manual approach; The power of the written word; Practical aspects – pros and cons; Communicating online – Fluidity and Structure; Social norms and genuineness; The Therapeutic Alliance; Responsibility; Therapist Skills; Efficacy, effectiveness and general professional issues. A need for more qualitative studies from practitioner perspectives may further research in online treatments.

The second part of this thesis is an empirical paper exploring practitioner experiences of facilitating family-focused online interventions via video conferencing. Important questions are whether therapeutic relationships can be developed via the internet and how therapeutic alliance is affected within family interventions. Semi structured interviews explored nine practitioner's experiences of facilitating family-focused online interventions. Interpretative Phenomenological Analysis enabled detailed investigation of practitioner's personal perspectives. Three master themes emerged: The therapeutic relationship: both the same and different; The positives outweigh the negatives;

Balancing the patients' need with the practitioners'. Practitioners highlighted benefits of access, providing a comfortable therapeutic environment for clients to disclose personal information. Strong relationships were built with clients despite disruptions and restricted visual information. Practitioner self-care, and their ability to minimise their needs against their view of the clients were emerging issues.

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Declaration Of Authorship

I, Davina Wong

declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

Practitioner Experiences of Online Treatment

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;

2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;

3. Where I have consulted the published work of others, this is always clearly attributed;

4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;

5. I have acknowledged all main sources of help;

6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;

7. Either none of this work has been published before submission, or parts of this work have been published as: [please list references below]:

Signed: ……

Date: ……

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1.0. Experiences and Attitudes to Online Therapy: A Qualitative Systematic Review of Practitioner Perspectives

1.1. Introduction

1.1.1. Psychological support online

It is increasingly popular to provide psychological assistance online (Chęć, Ligocka, Maciejewska, Samochowiec et al, 2016). Uses of computers within assessment, diagnostic and therapeutic work originate back to the 1980s, linked to the emergence of stimulation programs. The development of the foundation of the International Society for Mental Health On-Line (ISMHO) in 1997 indicated a milestone in the use of medical practice over the internet. The ISMHO brings professionals interested in providing psychological help together via the internet (Aouil, 2005; Rodzinski Rutkowski, Sobanski, Murzyn, Cyranka et al, 2015). As the practice of online counselling continues to grow, so does the demand for empirical evidence of both advantages and disadvantages of the form of treatment (Rochlen, Zack, & Speyer, 2004). Chec et al (2016) suggest that the decision whether to offer such service online may depend on the perception of specialist practitioners, on the form of psychological help.

Existing literature summarises a variety of benefits associated with online treatments. For example; remote access (Backhaus et al, 2012; Baker & Ray, 2011; Grubaugh, Cain Elhai, Patrick, & Frueh, 2008; Perle & Nierenberg, 2013; Simms, Gibson, & O'Donnell, 2011); access and care for individuals with limited mobility or physical disability (Austen & McGrath, 2006; Chester & Glass, 2006; Lange Rietdijk, Hudcovicova, et al 2003); or access to treatment when anxiety related to situational or environmental barriers (e.g. travelling by bus or attending hospital) may prevent clients from attending face-to-face, traditional appointments (Backhaus et al, 2012; Young, 2005). Additional but debated benefits include the case for anonymity when using online treatments, or the perception of anonymity; which may help with stigma and allow disinhibition (Abbott, Klein, & Ciechomski, 2008; Hollenbaugh & Everett, 2013; Lange et al, 2003; Suler, 2004; Young, 2005). Disinhibition refers to a phenomenon where by individuals appear less inhibited in expressing themselves through online means than face-to-face (Suler, 2004).

1.1.2. Defining online treatments

Barak, Klein, Proudfoot (2009) note that despite the growth of internet supported interventions, clarity and consistency is problematic. There has been a lack of standards leading to a variety of terminology, inconsistencies and incoherence. Tthis is reflected in the wide range of (often) interchangeable terminology e.g. cyberpsychology, telepsychology, online therapy, e-health, telehealth, web counselling, and online counselling (Barak et al, 2009; Beidoglu et al, 2015; Chester & Glass, 2006; Perle, Langsam & Nierenberg, 2011). Indeed throughout this review, a number of interchangeable terms may be used (e.g. internet supported treatments, online therapy/counselling/treatments). Some of the problem with unifying terminology with internet supported interventions is due to the wide availability of web-based programmes and the wide scope of online communication capabilities. Additionally to be able to identify the essential "defining" and "active" components is challenging. Barak et al (2009) attempted to clarify, and provide basic definitions to support and establish standards among professionals. Barak et al (2009) classify internet supported interventions into four main categories: 1. Web-based interventions; 2. Online counselling and therapy; 3. Internet-operated therapeutic software; and 4. Other online activities. This review concerns itself primarily with internet supported interventions with what Barak et al (2009) term to have an 'active' component. An 'active' component would include an intervention with a 'change' component, for example behavioural change content is regarded as 'active' as it provides enough specific detail/instruction on how to challenge thoughts whereas educative content is termed therapeutically 'inactive' as it aims to enhance knowledge and understanding but is not sufficient to implement change. This includes most subtypes within 1 and 2, thus categories 3 and 4 will not be described below. Interventions without an active component lack a therapeutic element. Additionally a therapist perspective would not be available to explore without an 'active' component.

1. Web-based Interventions are primarily self-guided intervention programmes that are implemented through a prescriptive online programme and operated via a website. The intervention attempts to create change and enhance knowledge, awareness and understanding through health-related material using interactive web-based components. Subtypes include Web-based education interventions; self-guided web-based therapeutic interventions and human-based therapeutic interventions.

- Web-based education interventions tend to have a primarily educative content and are generally seen to be therapeutically "inactive". Their aim, by nature is to enhance knowledge, awareness and understanding of health related information.
- Self-guided web-based therapeutic interventions can be both self-guided and human supported. They are designed to build positive change usually with cognitive, behavioural and emotional focus and with theoretical underpinnings such as Cognitive Behavioural Therapy (CBT). Thus, the behavioural change component is seen as "active", by which Barak et al (2009) mean that the programme provides patients with enough specific detailed instruction on how to challenge their thoughts.
- Human-supported therapeutic web-based interventions are similar to self- guided interventions in that they also provide a behaviour change component to encourage positive change. Support is often provided by a health care professional and considered a central component of the web-based programme. Support may take the form of email, instant messaging or videoconferencing via webcam.

2. Online Counselling and Therapy can be provided individually, in groups, synchronous or asynchronous, determining how individuals communicate and interact through online medium (Suler, 2000). Online therapy enables the client to contact a counsellor from any distance, at convenience of time and flexibility of location; replacing the traditional 'clinic' face-to-face appointment. The aim of counselling remains the same both online and face-to-face, thus "active" component towards positive change remains unchanged, only the mode of communication.

1.1.3. Attitude and Online Treatment

A few studies have explored the acceptability of internet supported treatment from the perspective of patients or public attitude. For example internet supported cCBT had been found to be an acceptable treatment which could overcome time constraints (Mohr, Siddique, Ho, Duffecy, Jin, et al, 2010; Wootton, Titov, Dear, Spence & Kemp et al, 2011). A recent study by Apolinário-Hagen, Vehreschild and Alkoudmani (2017) indicated ambivalent attitudes in the general population toward internet delivered therapies in a German speaking population. However, in addition to the potential uptake of internet delivered treatment by potential clients, is the need to explore the willingness and potential views of practitioners willing to provide internet delivered treatments.

Online counselling may be influenced by the attitudes and beliefs held toward it and its practice (Lazuras & Dokou, 2016; Simms, Gibson & O'Donnell, 2011). However, individual preference and views can be influenced by multiple factors which in turn may impact attitude (Centore & Milacci, 2008; Donovan, Poole, Boyes, Redgate, & March, 2015; Lazuras & Dokou, 2016; Teh, Acosta, Hechanova, Garabiles, & Alianan, 2014). A negative attitude has been found to be one of the most common barriers to adopting a new treatment (Cook, Biyanova & Coyne, 2009; Mora, Nevid, Chaplin, 2008).

Chęć, Ligocka, Maciejewska, Samochowiec, Łodygowska, & Samochowiec, (2016) explored the attitudes of psychologists, psychotherapists and psychology students towards online psychological support in Poland. This quantitative study used a self-designed research tool called the "Scale of Attitudes towards Psychological Support On-line" (SPWPPO and a socio-demographic survey to determine the attitudes of professionals and future professionals toward online psychological support. Chęć et al (2016) found that both professionals and future professionals had similar ambivalent attitudes toward online psychological support. However, participants who had experience providing assistance displayed a more positive attitude.

Cipolletta & Mocellin (2016) similarly designed a questionnaire specifically to investigate the attitude of Italian psychologists toward different aspects of online counselling (including email, chat, forums and videoconferencing). Cipolletta & Mocellin (2016) also found that participants with previous experience were more favourable toward online counselling; however there were also ethical concerns that required addressing.

A recent study by Tonn, Reuter, Kuchler, Reinke, Hinkelmann et al (2017) recognised the growing number of web-based interventions and their shown effectiveness, yet highlighted the minimal use in everyday therapeutic work. As a consequence, Tonn et al (2017) developed a questionnaire measure for examining attitude and expectation toward internet provided treatments. Attitude and experience is shown to be established as an important part of the growth of internet supported treatments and in the acceptance and take up of treatments from both patient and practitioner perspectives. Attitude is, however, a complex construct which requires an in-depth understanding.

As more internet supported treatment become available it might be useful to actually explore what is already known about how practitioners experience facilitating online treatments and what sort of role practitioner attitude has.

1.1.4. Importance of evaluating Qualitative studies

Quantitative forms of synthesising research tend to be favoured in systematic reviews, often omitting qualitative evidence (Dixon-Woods, Agarwal, Jones, Young & Sutton, 2005). However, a qualitative systematic review can also reveal new understandings, support the building of theory and illuminate questions such as 'why?' or 'what is it like?' (Seers, 2015). The nature of qualitative synthesis often provokes debate and strong criticism due to its potential for bias (Cooper, 1982). Where meta-analysis can offer quantitative synthesis of randomised controlled trials, with large enough samples, enabling bias to be effectively cancelled out; qualitative studies are more likely interpretive, drawn from smaller samples and not usually intended to be generalizable or without bias (Bearman & Dawson, 2013). Despite the controversies, it is of great importance to move past 'does it work' questions to gather what in depth interpretations can be collated through a range of methodological perspectives (Eva, 2008). Bearman and Dawson (2013) highlight the strengths of qualitative research, emphasising its ability to provide 'analytical depth' and focus on 'contextual detail' suggesting that different methodologies will yield different insights.

This systematic review focuses on the experience and attitudes of practitioners who may have influence on the utilisation of internet supported interventions and receptivity of clients (Cook et al, 2009; Wangberg, Gammon & Spitznogle, 2007). The aim of this review is to synthesise the best available evidence to explore experiences and attitudes to online therapy and what role they play from the perspectives of practitioners. The review aims to ask:

- What is known about how practitioners experience facilitating online treatment
- What is known about the role of practitioner attitudes to online treatment?

1.2. Method

1.2.1. Inclusion and Exclusion Criteria

The databases PsychInfo, Medline, CINAHL and Web of Science were searched using the PCO (Population, Context, Outcome) framework (as suggested by Butler, Hall & Copnell, 2016 for qualitative reviews) to identify keywords from the research question (see table 1).

Parameter	Inclusion Criteria	Exclusion Criteria
Population	Therapist	Patient
	Counsellor	Client
	Practitioner	Service User
Context	Internet	
	Online*	
	Web*	
	Treatment	
	Intervention	
	Therapy	
	Psychotherapy	
Outcomes	Attitude*	
	Experience*	
	Perspective*	
	Thought*	
	Feeling*	
	Belief*	
	Qualitative (used in Web of Science only)	

1.2.2. Table 1: Inclusion and Exclusion criteria using PCO

In the last decade, technology has advanced and developed rapidly, therefore this review focused on qualitative empirical papers and papers where the primary focus was inductive qualitative analysis, from 2007 – February 2018. The focus on qualitative empirical papers included any mixed methods studies where the focus was primarily on inductive qualitative analysis, thus papers predominantly focusing on quantitative components with only a small mention of qualitative analysis were not included. It was noted that there is less

focus on mental health in online interventions and within the literature, therefore it was decided that physical health papers would be excluded from the review to focus on what has been done in mental health. Physical health papers were filtered out in the last stage, as indicated in Figure 1 (under 'Inclusion/Exclusion Criteria Applied → Therapist Perspective and Mental Health'). Furthermore for the purpose of this review, 'online therapy' was defined as therapies provided primarily online with an 'active' change component. Therefore papers focusing on 'inactive' web-based interventions such as education interventions and social network based interventions were excluded (Table 2). The review focused on the Therapist perspective however, due to the paucity of research solely focusing on therapist perspective, articles were included which discussed both therapist and patient perspective. Therapist perspective was then focused on primarily during synthesis (see below).

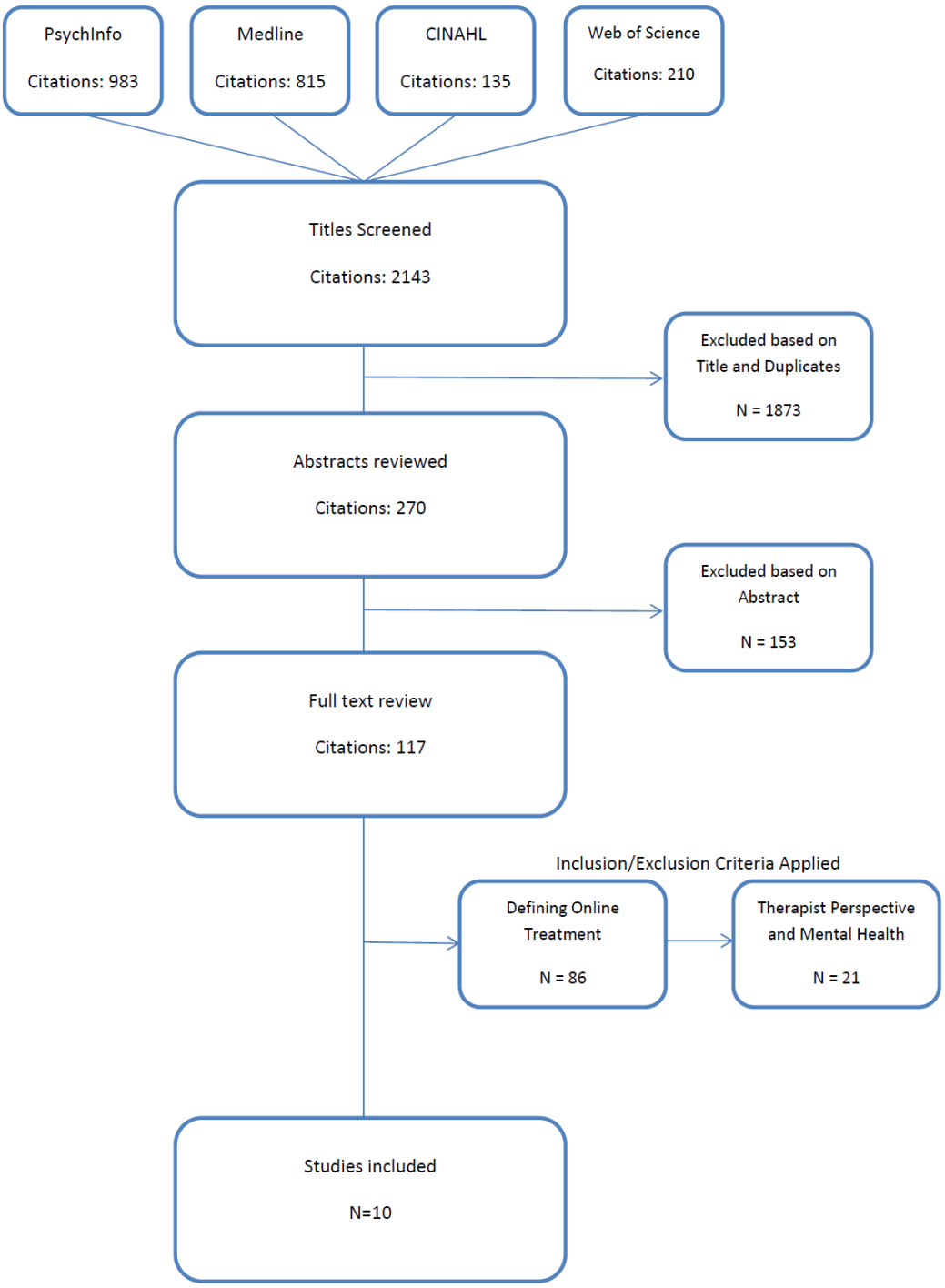
Inclusion	**Exclusion**
Self-guided web-based therapeutic interventions. • Content may be formulated in a modulated structure • Informed by theory e.g. CBT • Behavioural change content is considered *'active'* e.g. provides patients with specific and detailed instructions on how to challenge thoughts. • E.g. MoodGYM and Beating the Blues	**Therapeutically *'inactive'* Web based interventions.** • e.g. Education interventions which aim to improve/enhance knowledge, awareness and understanding only. • 'Relatively static websites' i.e. use one to two multimedia formats and very few online interactive activities, lacks online activities and supportive feedback.
Human-supported therapeutic web-based interventions. • Similar to self-guided, providing behaviour change content i.e. '*active*'. • Moderate to highly dynamic multimedia formats. • Human support by peers is generally	**Internet-Operated Therapeutic Software.** • e.g. robotic simulation of therapists providing dialog-based therapy, rule based expert systems, gaming, virtual environments **Personal online blogs and social media**

viewed as an adjunct to the interaction. • Support provided by HCP may be via email, instant message or webcam, does not tend to be automated feedback, human feedback is relatively tailored. • Amount/quantity, frequency and immediacy might vary. **Online Counselling and therapy.** • Can be individual, group, synchronous or asynchronous.	**Online social networks and posts on bulletin boards and chat room moderation, text only medium.** **Online intervention is used as an adjunct to face to face therapy** • Online is not primary intervention.

1.2.3. Table 2: Online treatment definitions (Barak, Klein & Proudfoot, 2009)

1.2.4. Search Strategy

Electronic databases were searched using each database's search box builder and filters for qualitative research articles. Early selections of articles were selected focusing on relevant title, then abstract. Full text papers were then retrieved to ensure the intervention was primarily online and the outcome produced findings related to the phenomenon under study (Stern, Jordan & McArthur, 2014). Full text articles were then appraised using the Critical Appraisal Skills Programme (CASP, 2017) qualitative assessment tool (See Figure 1 for PRISMA flowchart).



1.2.5. Figure 1: PRISMA Flowchart

1.2.6. Critical appraisal of qualitative research

Critical appraisal of qualitative studies is an essential step in reviewing evidence for a systematic review (Hannes, 2011). However, there continues to be considerable debate

around whether concepts such as validity and reliability apply to qualitative research and how it can be assessed. Consequently there are a range of critical appraisal instruments with variation in criteria and with them a variety of interpretations on use of appraisal instruments. Popay, Rogers & Williams (1998) and Spencer (2003) consider the use of appraisal tools a part of the exploration and interpretation process in qualitative research. Whereas Edwards, Elwyn, Hood & Rollnick (2002) suggest that balance can be sought between the methodological flaws of a study and significant insights and findings. Dixon-Woods, Shaw, Agarwal & Smith (2004), however, suggest the value of using critical appraisal tools in qualitative research can stifle creativity.

The variety of appraisal tools developed to support quality appraisal tend to share basic criteria for assessing qualitative research. This includes the ethical conduction of research, relevance informing clinical practice or policy and rigor in reporting of methods and findings (Cohen & Crabtree, 2008). Researcher bias relating to reliability, validity and objectivity is a contested area. Hannes (2011) specifies that as a scientific process, qualitative research is required to be both "rigorous" and "trustworthy" to be considered as a valuable component of a Cochrane systematic review and therefore criteria upon which to evaluate qualitative research is essential.

Dixon-Woods et al (2004) produced a checklist of 10 questions identified by commonalities of qualitative research: The Critical Appraisal Skills Programme (CASP, 2017). This assesses the clarity and appropriateness of the research question; description and appropriateness for sampling, data collection and data analysis; levels of support and evidence for claims; coherence between data, interpretation and conclusion, and finally level of contribution of the paper (Leung, 2015). CASP fosters these criteria and was the quality assessment tool used for this review. CASP does not suggest a scoring system and instead records "yes", "no" or "can't tell". For the purposes of this review, number of "Yes" were totalled to provide an overall score out of 10 (see Appendix A). All studies recorded at least 6 "Yes's" out of 10 criteria. Quality assessment was not carried out for the purposes of exclusion but to aid informing of the overall quality and information, therefore all studies were included. Criteria on the CASP which recorded most "No's" queried whether the relationship between the researcher and participant had been adequately considered (i.e. whether the researcher had critically examined their own role, potential for bias and influence). Only two studies had adequately reviewed and reflected upon their role and the

potential for bias (Dunn, 2012; Salleh, 2014). Therefore, whilst all 10 studies were included in synthesis, the lack of researcher reflexivity may impact on the any bias in findings of individual papers and emerging data from their study findings. Emerging results from this review should therefore also be considered with caution, taking into consideration both the unreported biases of the authors of the reviewed papers and of the current reviewers own influences.

1.2.7. Synthesis

Thomas and Harden (2008) present an approach to synthesis of findings of qualitative research, addressing questions around participant perspectives and experiences; Thematic Synthesis. Synthesising of qualitative research is required to bring findings together for a wider audience but at the same time respecting the essential context and complexity of individual qualitative studies. Thematic synthesis draws on techniques of thematic analysis to identify and develop themes. Thomas & Harden (2008) provide a detailed method for thematic synthesis which takes the form of three stages:

- free line-by-line coding of findings,
- organisation of 'free codes' into descriptive themes,
- development of analytical themes (and "going beyond the content of original studies" (Thomas, Jensen, Kearney et al, 2004; Dixon-Woods, Cavers, Agarwal et al, 2006).

Findings of each full text citation included in the review were thematically coded following the three steps suggested above, 10% of the included citations were thematically coded by two reviewers independently. Reviewers then discussed discrepancies and agreement was made between them. Final decisions were made by the primary reviewer and author.

1.2.8. Reflective note

The reviewer recognises that throughout the analysis process she cannot remain completely unbiased. Her experience prior to and during training as a Clinical Psychologist has meant that she has routinely provided face to face treatment. However, she has no experience of providing treatment over the medium of the internet. Coding and development of themes during the analytical process may have been influenced through the reviewers' personal experiences.

1.3. Findings

The search yielded 2143 citations. Following the search strategy and exclusion criteria, the reviewed studies comprised of 10 qualitative research papers (see table 3). The studies were carried out in six countries: UK (n=3), Australia (n=2), Sweden (n=1), Canada (n=2), Spain (n=1) and Malaysia (n=1). Half the reviewed studies included both practitioner and client views. A diverse range of practitioners views were recorded including psychotherapists (n= 1), school counsellors (n= 1), social workers and social work students (n=2), family physicians/GPs and nurses (n=2), online mental health clinicians (n=1), counsellors/university counsellors (n=2), BABCP[1] accredited counsellors (n=1). Papers included both individual (n=9) and group treatments (n=1). The favoured analytical approach was Thematic Analysis (n=4), with other papers specifying Grounded Theory (n=3); Interpretative Phenomenological Analysis (n=2); and Content Analysis (n=1). Three of the reviewed papers were 'pre-intervention' i.e. practitioners had not yet experienced providing online treatment but their current perspectives were explored. One paper specified the form of treatment as Internet Cognitive Behaviour Therapy (ICBT), with therapist contact via the manualised, web-based program. Other reviewed papers provided accounts of asynchronous email/email (n=3) or videoconferencing (n=1) or the choice of either videoconferencing or email (n=1). Interventions also targeted a range of ages including adults (n=5), children and young people (n=2), undergraduate students/university students (n=2) and carers (n=1).

[1] British Association for Counselling and Psychotherapy

First Author	Title	Journal	Year	Method of Analysis	Number of HCP participants	Country of origin	Diagnoses worked with	Form of treatment/Therapist contact	Perspective
1.Bengtsson	Therapists' experiences of conducting cognitive behavioural therapy online vis-à-vis face-to-face	Cognitive Behaviour Therapy	2015	Thematic analysis	11 (semi-structured interviews)	Sweden	Different forms of anxiety, depression, panic disorder, sleeping difficulties, IBS, OCD, pain, eating disorders and tinnitus	Text contact through manualised ICBT	Practitioner
2. Glasheen	School counsellors' and students' attitudes to online counselling: A qualitative study.	Journal of Relationships research	2015	Comparative thematic analysis	14 (2 focus groups of 6 and 8)	Australia	Children and young people. No specified diagnoses.	Participants had not experienced online therapy	Practitioner Client
3. Mishna	Cyber Counseling: Illuminating Benefits and Challenges	Clin Soc Work	2015	Grounded theory	24 (semi-structured interviews)	Canada	Undergraduate students. Anxiety, depression, family concerns, academic difficulties, disordered eating, relationship issues, and non-	asynchronous email	Practitioner Client

							specific, personal reasons		
4. Montero-Marin	Expectations Among Patients and Health Professionals Regarding Web-Based Interventions for Depression in Primary Care: A Qualitative Study	Journal of Medical Internet Research	2015	Thematic content analysis from grounded theory	23 (11 primary care physicians, 12 managers, interviews and focus groups)	Spain	Potential web-based intervention for depression	Participants had not experienced online therapy	Practitioner Client
5. Dowling	Experiences of counsellors providing online chat counselling to young people.	Australian Journal of Guidance and Counselling	2014	Thematic analysis	19 (focus group)	Australia	Young people. No specified diagnosis.	does not specify if this is videoconferencing or email	Practitioner
6. Dunn	A qualitative investigation into the online counselling relationship: To meet or not to meet, that is the question	Counselling and Psychotherapy Research	2012	IPA	6 (semi-structured interviews)	UK	University students. No specified diagnosis	asynchronous email	Practitioner Client
7. Fletcher-Tomenius	Trust in online therapeutic relationships: The therapist's	Counselling Psychology Review	2009	IPA	6 (semi-structured interviews)	UK	No specified diagnosis	Participants had not experienced online therapy	Practitioner

	experience.								
8. Damianakis	Social workers' experiences of virtual psychotherapeutic caregivers groups for Alzheimer's, Parkinson's, stroke, frontotemporal dementia, and traumatic brain injury.	Social Work with Groups: A Journal of Community and Clinical Practice	2008	Content analysis of a survey	9 (survey)	Canada	Caregivers for Alzheimer's, Parkinson's, Stroke, Frontotemporal Dementia nd Traumatic Brain Injury	Videoconferencing	Practitioner
9. Middlemass	Integrating online communities and social networks with computerised treatment for insomnia: a qualitative study	British Journal of General Practice	2012	Thematic analysis	23 (semi-structured interviews and focus groups)	UK	Potential manualised intervention for Insomnia	Participants had not experienced online therapy	Practitioner Client
10. Salleh	Online counseling using email: a qualitative study	Asia Pacific Educ. Rev	2014	Grounded Theory	6 (focus groups and individual interviews)	Malaysia	No specified diagnosis	Email	Practitioner

1.3.1. Table 3: Papers included in the review

Themes
Structure and safety of standardised manual approach
The power of the written word
Practical aspects – the pros and cons
Communicating online – Fluidity and Structure
Social Norms and Genuineness
The Therapeutic Alliance
Responsibility
Therapist Skills
Efficacy, effectiveness and general professional issues

1.3.2. Table 4: Emerging themes

Nine themes emerged from the data highlighting practitioner experiences and their contributions to their attitude toward online therapy. Themes are indicated in table 4. Themes related to the type of therapy, highlighting the use of structured manualised approaches (*Structure and safety of standardised manual approach*) and the impact of written forms of treatment as opposed to videoconferencing (*The power of the written word*). Practitioners also highlighted the practical aspects of the technology (*Practical aspects – pros and* cons) and its' impact on communication within an online context (*Communicating online – Fluidity and Structure*). There were concerns around genuineness and the impact of the therapeutic context when online on social norms (*Social norms and genuineness*) and the therapeutic alliance (*The Therapeutic Alliance*). They also reflected on their own feelings of responsibility (*Responsibility*) and skills (*Therapist Skills*). Finally, there was acknowledgement of the wider system and systemic issues, predominantly spoken about by participants who were GPs (*Efficacy, effectiveness and general professional issues*).

1.3.3. Structure and safety of standardised manual approach

Participants discussed having a manualised CBT treatment package as a clear and structured approach which supported practitioners to focus and fostered a feeling of 'safety'. In contrast, participants recognised that working with 'complete treatment packages' did not allow the ability to adapt to fit the clients' needs as well as a less structured and manualised approach:

When you work with complete treatment packages (in ICBT), then it becomes a little bit 'one size fits all'. Then it does not fit anyone really well. [1]

Bengtsson et al (2015) specifically demonstrates this, as it was the only paper where participants had provided manualised ICBT highlighting a contrast in participant opinion (see Appendix B). Two other papers; Montero-Marin et al (2015) and Middlemass et al (2012) explored the potential for introducing an ICBT package for specific disorders e.g. depression and insomnia). Montero-Marin et al (2015) also emphasises the importance of individualisation and flexibility within their online chat counselling whereas this concern does not emerge from the findings of Middlemass et al (2012) this is potentially due to a stronger focus on patent perspectives in the results.

Montero-Marn et al (2015) highlights the need for the form of treatment to be compatible through an online interface without losing the adaptability, flexibility and ability to individualise a clients' treatment. They suggest that the combination of a standardised programme with an individualised interaction would enhance the therapeutic experience for the client, and increase the necessary acceptance and positive attitudes toward online treatment.

…if the doctor could tailor the treatment a little and if it were based on a shared model of decision-making…[4]

The approach that the practitioner works within is also important for ICBT to be accepted. With several forms of internet treatment available, the therapeutic approach offered would need to equally fit the therapist style, for treatment to be accepted and be effective (Montero-Marin et al, 2015).

In our speciality, we refer to those of a cognitive behavioural model. Other more introspective or psychodynamic models revolve around the doctor-patient relationship, which cannot be applied using technology [4]

1.3.4. The Power of the 'written word'

Another way treatment was provided was through the *'written word*'. This refers to the treatment form being provided via email. At least three papers used a form of email, and the 'written word' to communicate throughout the therapeutic process. This form of communication was generally seen positively, providing both the practitioner and the client time to respond and reflect on the written word. The general perception was that writing

was powerful, opened up the therapeutic relationship and was highly valued as a "*unique benefit*" (Mishna, 2015):

the ability [of the client] to re-read what one has written and come back to it in the future in moments of upset or discontent [3]

1.3.5. Practical aspects of modality – the pros and cons

In Bengtsson (2015) the participant refers to the physical aspect of being in the room and being able to "*bury yourself in a case*" compared to internet therapy where the individualisation "*does not exist*" in the same way:

There is great room to individualise each treatment and that does not exist in internet therapy in the same way (…) Uh, so that you can really bury yourself in a case and think a little more and, uh, shape it after a specific patient. [1]

In some cases, such as Glasheen's participants indicate a fear of technology taking over at rapid pace, thus hesitance in embracing online therapy:

The world has gone technology mad in a short period of time (…) technology seems to be driving so much in our world and we (have) almost lost control of this technology demon [2]

Additionally several studies were aware of the lack of visual information, non-verbal communication and body language that helps to inform a response to a client. In contrast, technology and the internet were seen positively, as access to information and an additional mode of communicating and conveying information. Despite initial reservations, participants who had experienced facilitating online treatment developed skills to ease the online process, as highlighted in study Damianakis et al (2008); where participants recognised the "*formal and mechanical*" aspects due to the new focus and introduction of technological aspects of working.

1.3.6. Communicating online – Fluidity and Structure

This theme applied mostly to studies where participants had used videoconferencing i.e. Dowling & Rickwood (2014) and Damianakis et al (2008). Participants noticed a much slower pace of working was required in an online format (Dowling & Rickwood, 2014):

I think time wise as well, so you've got probably an hour to chat with someone and online what you do face to face in an hour you might do 15 minutes' worth online. It's really difficult to kind of get that flow sometimes [5]

Damianakis et al (2008) described the flow of therapy within a group setting through rules of "*taking turns*" online, limiting interruptions and going "*off topic*" however recognised that this approach may then lose the meaning behind the feedback from other participants as the delay caused the "*moment*" to pass. Although fluidity was less of an issue within sessions using email, delays between email contact may cause disruptions in the 'flow' of therapy. Salleh et al (2014) also discussed rules to structure responding of emails e.g. weekly replies ensuring timely responses.

1.3.7. Social Norms and Genuineness

Participants from Galsheen et al's (2015) study continued distrusting the online treatment process using email or chat based approaches. Participants voiced concerns that young clients would have opportunities to disguise themselves and practitioners' could not trust the online persona to be a true person. This is not an occurrence that would be as easily experienced in a face to face therapeutic situation. Additionally, Fletcher-Tomenius et al (2009) further discussed the social norms of the face to face therapeutic situation as opposed to online and the increased likelihood that a client would "*pull the plug*" mid-session in online treatment e.g. in chat based/asynchronous chat or email:

Online, it's easier for the client to withdraw from the relationship and they can do that literally by pulling the plug, leaving the session or, changing their email address [7]

Both studies expressed the differences in genuineness and the shift in social rules within an online environment and the ease in which clients can withdraw from treatment or fake a persona through hiding behind the medium of the technology.

1.3.8. Therapeutic Alliance

This was a major issue discussed by almost all studies. The one study that did not discuss elements of the therapeutic alliance was Montero-Marin et al (2015) which may have been because their main cohort of participants was primary care physicians and managers, whom may be less focused on relationship issues. Similarly Middlemass et al (2012) showed little mention of the therapeutic alliance for possibly similar reasons to Montero-Marin (2015) and Dowling (2014) although, did not explicitly discuss the therapeutic alliance, made reference to components and techniques, often related to alliance e.g. trust and validation. Several participants made reference to the lack of non-verbal information and the impact this had on being 'in-tune' or reading the clients emotions and genuineness e.g. Glasheen et al's (2015) referencing the "*truth*" and "*authenticity*" in clients' eyes; and the lack of "*shared connection*" (Mishna et al, 2015):

There may be some truth…in the maxum, the eyes, the window of the soul, [2]

Other studies discussed the need to trust the process and knowing that development of trust in the relationship will be indicated in the client's deepened disclosure of sensitive information. One participant went on to consider if the relationship could develop more easily online due to removing judgement of appearance or accent (Fletcher-Tomenius & Vossler, 2009):

It can be, sometimes easier than trust in a face to face scenario because of trusting yourself and trusting the other person. Whereas face to face, an unknown journey with an unknown other person. Whereas face to face, you have got different clues or cues rather from the physical appearance and the way someone talks and their accent and erm the words they choose etc. Whereas of course you haven't got that online [7]

The impact of how the online component added to therapy and influenced the therapeutic relationship was a contested subject. Particiants in Glasheen et al's (2015) study suggested that the protection of a screen and the internet also puts a barrier between the therapist and a young person conducting "*real communication*" and a method of avoidance:

I actually see this is just another nail that we're going to put in the coffin of the development of our young people and actually the skills needed to have real interpersonal relationships with their peers, with parents, with colleagues and with teachers [2]

Whereas Mishna et al (2015) suggested that particularly email contact can enhance the therapeutic relationship, this was supported by Fletcher-Tomenius & Vossler, (2009) who proposed that the action of writing helped to develop the relationship.

1.3.9. Responsibility

The sense of a shift in the responsibility and control within treatment toward the client was strongly discussed in a number of studies. This suggests the idea that in face to face treatment, the focus may be more on the therapist, whereas, particularly in manualised form, the responsibility of outcome may fall on the treatment itself.

The medium of online was also felt to increase client anonymity and this can heighten the level of control and disclosure for the client, enabling clients to open up more. Anonymity of being online might reduce the intensity and focus on the client that face to face therapies might produce (Dunn, 2012; Fletcher-Tomenius & Vossler, 2009). However,

with freer disclosure may also come heightened emotional dysregulation (Dowling et al, 2014) and risk.

…I think a lot of the time people are quite embarrassed by particular things and I think they feel kind of guilty for feeling that way, and sometimes when you sit there face to face with somebody..It's quite difficult. [7].

Participants' raised concerns over risk in an online context and the restrictions and access to information for the practitioner. Several participants felt that without the access to information, not being in the same room to support and manage clients during high risk situations, left practitioners feeling helpless yet still responsible.

Finally, one participant indicated concerns over the type of clinician who would only interact with clients through an online capacity, possibly raising "concerns regarding the accountability of online therapists" (Fletcher-Tomenius & Vossler, 2009):

I have some concerns over people who will only work in an online capacity, because I wonder if that is about them..kind of almost like hiding behind the computer..It's faceless. [7]

1.3.10. Therapist skills

The majority of the studies discussed skills brought to, required or lacking in online treatment. Where Glasheen et al's (2015) participants indicated hesitancy and fear toward online treatments; the opinions appeared to stem from participants' feeling a lack of skill. This was echoed in other studies (Montero-Marin et al, 2015), and recognising that confidence in the process needed to be developed (Dunn, 2012):

As I got more confident in working with the transference online, I've come to realise that such disturbances in the transference could just become part of the work [6]

Other studies highlighted adaptions that were made during the therapeutic process to compensate for the online element e.g. use of 'Netiquette' and 'Emoji's' (Fletcher-Tomenius & Vossler, 2009); use of clarification and meaning (Damianakis et al, 2008); and particular attention to content and writing style in email exchanges (Salleh et al, 2014):

This often required more clarification of the meaning of the words used in the context of the group discussion by members. [8]

1.3.11. Efficacy, Effectiveness and Professional Issues

Participants generally acknowledged the potential to increase access to a wider audience, particularly for people who are "*shut-ins, have time constraints, or live in remote*

areas" (Damianakis et al, 2008). However, GPs were particularly concerned about the evidence prior to implementation and how online treatment would change their "*routine practice*" or add to their workload (Montero-Marin et al, 2015):

The design is relatively simple to imagine, but it means a change to our routine practice. How long will it take to train us to use and implement this programme? Would we be released from our clinical practice for that time [4].

1.4. Discussion

This review incorporated the experiences and attitudes of online treatment from the perspectives of practitioners and explored the role of practitioner attitudes. A comprehensive search of recent published papers using predetermined criteria found 10 relevant studies. From the 10 studies reviewed, thematic synthesis identified nine themes highlighting practitioner experiences and their contributions to their attitude toward online therapy: '*Structure and safety of standardised manual approach*'; '*The power of the written word*'; '*Practical aspects – the pros and cons*'; '*Communicating online – Fluidity and Structure*'; '*Social Norms and Genuineness*'; '*The Therapeutic Alliance*'; '*Responsibility*'; '*Therapist Skills*'; '*Efficacy, effectiveness and general professional Issues*'.

1.4.1. The influences of attitude to online treatment

The type of therapy offered: Practitioners in primary studies highlighted differences in experience of the way therapy was provided e.g. whether the therapy was provided online via email or videoconferencing; whether or not the approach was manualised. Practitioners discussed how structured and manualised approaches provided a 'safe' method of working, however reduced the ability to individualise treatment. There is evidence that positive outcomes are associated with adherence to empirically supported, manual-based treatment for a range of disorders (Foley, O'Malley, Rounsaville, Prusoff, & Weissman, 1987; Frank, Kupfer, Wagner, McEachran, & Comes, 1991; Schulte, Kunzel, Pepping, & Schulte-Bahrenberg, 1992). Written forms of treatment may provide more opportunity to individualise, and were positively seen to enable reflection and time for both practitioner and client. Indeed, writing as a therapeutic process has a wealth of evidence indicating significant physical and mental health improvements (Pennebaker, 1997; Pennebaker & Chung, 2011; Reinhold, Bürkner, Holling, 2017). The practitioners' experience of the form of treatment and style, such as whether they found benefits in either providing 'safety and structure' or 'too restricted', is likely to play a role in how acceptable the internet supported treatment was viewed. Lazarus (1993), for example states that "'Relationships of choice' are no less important than 'techniques of choice' for effective psychotherapy". He also emphasises that a flexible collection of relationship styles and a range of techniques can enhance treatment outcomes. However, he additionally reflects on Hoch (1955) who indicates that "*if the approach employed, and the therapist's style differed markedly from the patient's ideas about the attitude and procedures… positive results are unlikely to ensue*". Reflecting on the studies reviewed; a wide range of practitioner backgrounds are included within qualitative studies with a number of social workers, registered mental health

workers, GP's, 'psychotherapists' / 'counsellors' / 'therapists' (registered and unregistered / with undefined background qualifications), however with a lack of knowledge of therapist 'style' of preferred approach to treatment. This may indicate an area that requires continued investigation.

The online format: There were factors that practitioners found were specifically influenced by treatment being provided in an online format, highlighting the uniqueness of working via the internet. These referred to practical aspects of online work for example, the differences practitioners felt with providing treatment when not physically being in the room and the impact this had on fluidity of conversation in videoconferencing formats. Bavelas and Gerwing (2011) suggest that face to face conversation provides a unique listening setting and identify the subtle and crucial behaviours that 'the listener' uses to join with the 'speaker' in such face to face dialogue. They discuss generic back channels (e.g. "m-hm" or nodding), specific facial movements in response to showing an understanding (e.g. opening eyes wide to show surprise) and suggest that responses are timed precisely to respond to speakers narrative. Thus a disruption in these subtle communications caused by the online aspect (e.g. the internet dropping, losing sound and/or visual) is likely to cause a breakdown in communication. Breakdowns in communication are also demonstrated in studies where sensory losses in older adults have led to psychosocial consequences (Heine & Browning, 2002), thus two way responding becomes problematic and a collaborative conversation requires additional effort. This is also interesting to reflect upon with other modes of treatment provision, such as telephone or text counselling, and what impact specific facial movements and bodily responses may impact these forms of treatment.

Additionally there was a sense from practitioner participants from certain primary studies that online work was not genuine (2. Glasheen et al, 2015) and as a consequence of the treatment being online, the social norms of therapy were changed (7. Fletcher-Tomineus et al, 2009). Although the review authors are not aware of research relating to social norms of online and face-to-face therapy, the impact of social media and the internet on self-effects is an emerging area of research. The concept of 'self-effects' is defined by "*how message creators/senders involuntarily influence their own cognitions, emotions, attitudes, or behaviour*" (Valkenburg, 2017). One of the theories under the umbrella term of 'self-effects'; 'theories of self-concept change'; have evolved from the role-playing paradigm (Valkenburg, 2017). Boyd (2011) argues that self-effects may be more potent online due to the 'scalability' i.e. the ability to articulate self-related messages to any size and nature of

audience, providing ample forms to send messages to imagined audiences. This in turn may enhance the public commitment aspects of self-effects and thus more likely to receive self-related feedback from expanded audiences. However, the research in self-effects relates mainly toward social media, whereas the circumstances within individual therapy are not to a 'mass audience' and thus likely to be very different. Nevertheless, the concerns highlighted by practitioners regarding 'genuineness' are valid and the ideas of the impact of social norms within therapy may be an interesting area to further explore. Disruptions due to poor connection and internet speed and lack of genuineness appear to highlight some of practitioners negative views of internet supported treatment.

*The therapeutic r*elationship: Almost all reviewed papers discussed the therapeutic relationship with practitioner participants debating the ability to form one through online treatment and the challenges. Therapeutic relationships in internet interventions have sparked much curiosity. Cook and Doyle's (2002) widely cited paper compared the "Working Alliance in Online Therapy as Compared to Face-to-Face Therapy", using measures such as the Working Alliance Inventory (WAI), suggesting that a working alliance can indeed be adequately established when therapy is delivered online. Following this, Sucala, Schnur, Constantino, Brackman & Montgomery (2012) systematically reviewed the therapeutic relationship in e-therapy for mental health. Sucala et al (2012) included 11 studies which included a range of assessment measures (the WAI; the Therapeutic Alliance Scale; the Agnew Relationship Measure-Short Form; an Internet-based patient-therapist alliance/assistance questionnaire; and patient satisfaction with the therapeutic relationship). Results from reviewed papers found two out of three studies showing no significant differences in therapeutic alliance. Studies reviewed indicated factors that may influence the therapeutic relationship such as baseline severity of symptoms i.e. patients who experienced severe anxiety symptoms at the start of treatment provided lower ratings for therapist and patient 'bond'. Additionally, consistently higher means of therapeutic alliance were found within 'chat' modes of communication as opposed to email, and participants who used several forms of communication (e.g. email and chat) reported higher ratings of therapeutic alliance than only one form of communication. The quality of the therapeutic alliance was also linked to treatment outcome in studies investigating this. This highlights how the online format can affect the therapeutic relationship. Additionally, the aspect of anonymity might affect the relationship in both positive and negative ways. For example, anonymity might increase disinhibition and disinhibition might make it harder for the therapist to manage high level of distress via the online format. Suler (2004) discusses "The

Online Disinhibition Effect" and six possible factors that interact creating an online disinhibition effect (dissociative anonymity, invisibility, asychronicity, solipsistic introjection, dissociative imagination, and minimisation of authority.

Most recently, Berger (2017) provided a narrative review of studies to distinguish different forms of internet interventions. The review does not restrict itself to specific internet-based treatment formats e.g. guided self-help, email or videoconferencing. Berger's review found that client-rated alliance scores were high and roughly equivalent to face-to-face alliance ratings, independent of communication modalities, diagnostic groups and the amount of contact between therapists and clients. However, mixed results were found regarding therapist-related alliance and the association between alliance and outcome. Caspar and Berger (2011) speculate that behaviours detrimental for the therapeutic alliance could be restricted in online interventions, however, alliance ruptures may be more likely to occur as there is less room to be quickly responsive to clients' needs (Svartvatten, Segerlund, Dennhag, Andersson, & Carlbring, 2015). Furthermore, suggested in some of the current studies reviewed (Dunn, 2012; 7. Fletcher-Tomenius et al, 2009), 'The Online Disinhibition Effect' (Suler, 2004) may play a role in the therapeutic relationship. Berger (2017) suggests that there may be a difference between client groups and that there is further need for studies measuring alliance frequently and continuously. Berger also called for more studies to include therapist ratings as only three studies in Berger's review focused on therapist-rated alliance and highlights a key aspect for future research is to develop a better understanding of specific characteristics in the online relationship; what qualitative differences there are between online and face-to-face relationships; and to develop a deeper understanding of specific variables that facilitate the relationship.

Opinion toward therapeutic alliance online was a significant factor discussed by most participants in studies reviewed. This systematic review similarly indicates a need for further understanding of the relationship in internet supported treatment. It further highlights how practitioner experience and views toward therapeutic relationships online (i.e. whether they can be built and to what extent) may have impact on future use of internet supported interventions.

Practitioner responsibility: Practitioners also discussed their sense of responsibility when working online; where control lies in the treatment process, and feeling skilled in adapting to different ways of working. Responsibility has been discussed in the literature with its association with burnout. Farber and Heifetz (1982) suggest that there are certain

inherent difficulties in all types of work with patients which include difficulties relating to the nature of the therapeutic role (e.g. the requirements of attentiveness, responsibility, detached concern) which can be a factor within burnout. Despite an intended shift in focus of responsibility of a clients' health being in the control of the client (e.g. with the increase in self-help type interventions), there were some practitioner participants whose concern around responsibility was still paramount. Concern was particularly heightened with the thought of potential risk, which in reality, and in all forms of treatment, the practitioner is responsible for informing and preventing client risk to self and others. This may indicate the need to further explore the role of responsibility within the therapeutic relationship and how this might change through online work. Responsibility, and practitioner's attitude toward 'who should be responsible/in control' during therapy may impact how internet supported treatments are used.

Practitioner skills: Regarding skills, Collie, Mitchell and Murphy (2000) suggest that success as an online counsellor might depend on acquiring specific online communication skills and discuss the work of Mitchell and Murphy's online counselling skills for text-only counselling. Lack of non-verbal information is often assumed to be a major disadvantage to online treatments (Colon, 1996). Specific skills such as "emotional bracketing"; "descriptive immediacy" and the use of similes, metaphors and stories can be used to contextualise and enhance meaning within the therapeutic process (Murphy & Mitchell, 1998) and support successful online work. How skilled and how practitioners use these skills are likely to impact practitioner confidence and feelings of contentment in working online.

Systemic issues: A final theme considered the influences of the wider system. These issues were primarily discussed by studies involving GP's who highlighted concerns around the evidence base and impact to 'routine practice'. Barak and Grohol (2011) attempted to summarise the research for online mental health interventions. They include a range of interventions from psychoeducational 'static' webpages, to interactive programmes based on CBT, videoconferencing, self-help programmes and groups to blogging. They found strong evidence to support the effective use of a variety of online mental health applications. However, the impact on routine practice and clinician workload may be an area in which future research is required.

1.4.2. Clinical Implications

There are a number of considerations which may relate to improvement in the area of internet delivered treatments. Writing as a therapeutic process has been supported by

the large evidence based in both physical and mental health (Pennebaker, 1997; Pennebaker & Chung, 2011). Online interventions such as videoconferencing only may consider this an opportunity to add supplemental written aspects (e.g. email contact) to forms of treatment where written contact is not currently available. This could also enable certain types of treatment to become more individualised to the client.

Service providers should also be encouraged to consider how best to tackle the shortcomings of technology. Is there for example the possibility of controlling the internet connection for both practitioner and client through the provision of 'local hubs', through which clients can access smoother internet connection? This may however compromise on the comforts of the 'home environment' aspect of online treatment. Practitioners who provide online treatments may also need to have a stronger awareness of how the 'rules of online therapy' may be different to seeing a client face to face and how best to manage this with minimal interruption to the therapeutic relationship.

Services that employ practitioners to provide online treatments may want to consider training in using the technology provided beforehand. Confidence in the technological medium may be an important skill to reduce distraction from focusing on the therapeutic relationship. Practitioners may also want to develop methods for sharing skills in adapting to working online, for example learning specific online communication skills (Collie, Mitchell and Murphy, 2000). A final factor for practitioners providing online treatments to consider is the role of control and responsibility, how this may shift in online treatments and how it is different from a face to face environment. Practitioners should develop awareness of this effect on both their style of working and the impact on the therapeutic relationship through reflective practice and supervision.

1.4.3. Strengths, limitations and future directions

The limited number of primary studies included highlights the paucity of research with a purely qualitative focus. Indeed from a potential of 270 abstracts of citations reviewed, only 10 citations were relevant for this review. A large number of excluded citations were studies of quantitative methodology and mixed methods; where the focus of research was not primarily qualitative data. The depth in which the included studies were analysed varied according to the method of analysis and the quality of the overall article. The reviewers attempted to assess the quality of the included citations through the CASP tool (as described in the methodology). Thus a major limitation indicated through quality assessment was the lack of reflexivity and acknowledgement of author bias throughout the

development of the study, collection of data, data analysis and in the authors drawn conclusions. Of course, varying methodologies place different emphasis on the need to acknowledge researcher influence and bias on the data. However, Morse (2015) suggests that the intimate relationship between the researchers and the process of obtaining data through verbal interaction and observation, the interpretative nature of analysis, and the subjective nature of data itself are considered the main threats to the validity of qualitative studies.

An additional consideration toward the variety of methodologies and forms of data analyses used within citations of this review should be taken into account. A wide range of analyses including Thematic Analysis, Grounded Theory, IPA and Content Analysis were used, which also reflects the range of in depth interpretation and meaning drawn from the data. Thus, the depth of analysis and interpreted meaning drawn from the studies may vary considerably. Indeed Pope, Mays and Popay (2007) emphasise that one of the strengths of qualitative research is its provision of analytical depth and contextual detail. They go on to express the difficulty that synthesis of qualitative data poses is then how appropriate it is to go on to combine the results of multiple studies containing contextually rich data (Bearman & Dawson, 2013). Thomas and Harden's (2008) Thematic synthesis, the method used within this review, shares an inductive approach similar to grounded theory and a constant comparison approach which develops analytical themes comparable to 'third order interpretations' (Barnett-Page & Thomas, 2009). This keeps an initial openness to 'new' themes which may emerge from each study included in this review, regardless of the initial analytical approach. As a qualitative systematic review, there is likely to always be an element of personal interpretation and therefore possible bias in interpreting and reporting of findings. What may be lost in specific contextual detail within individual studies may then be gained through analytical exploration and interpretation across individual studies to draw out further meaning across contexts. Not only does this review cover breadth in methodologies the review also notes the range and diversity of participant age, profession and experience of online treatments which has also made synthesis of the results harder due to the lack of homogeneity in the participants used in reviewed papers.

A further limitation relates to the lack of clarity and consistency in defining internet supported therapeutic interventions (Barak, Klein, Proudfoot, 2009). Despite a variety of terms used to label and describe therapeutic activities carried out over the internet. This review has attempted to clearly define and include studies which have been deemed by

Barak et al (2009) to have an 'active' component of treatment. Thus, attempting to limit confusion with terminology of activities conducted over the internet. However, the lack of consistency in terminology may mean that relevant studies may have been missed due to unclear definitions.

1.4.4. Conclusion

This systematic review aimed to synthesise the best available evidence exploring experiences and attitudes to online therapy and what role they play from the perspectives of practitioners. Experience and attitudes are difficult to measure quantitatively without standardised measures and will not necessarily be able to measure the quality of experience. Quality of experience may be explored better through means of qualitative research. This review not only highlighted the paucity of qualitative research and lack of studies with a practitioner focus, it found that attitude may be changeable and influenced by previous experience, practitioner preferred style of working, the form of treatment and the online modality. A need for further qualitative studies from practitioner perspectives may be helpful in further research in online treatments. Further understanding of clinician qualifications and their approaches or preferred styles when working in an online environment may provide deeper insight into online therapies; what forms of online treatment are acceptable, the therapeutic alliance and what combinations may be most successful when working with clients.

2.0. Exploring practitioner perspectives of facilitating an online intervention for individuals, families and carers of an individual with mental health problems.

2.1. Introduction

2.1.1. Provision of Interventions over the Internet

The provision of mental health services via the internet i.e. Online therapy, is a growing area, which continues to seek attention and empirical evidence for both advantages and disadvantages of its use as a medium for treatment (Rochlen, Zack & Speyer, 2004). The literature to date has shown efficacy in a variety of mental disorders via a number of randomised controlled trials (RCTs) which have indicated moderate to large effects at post-treatment (Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014; Andrews, Cuijpers, Craske, McEvoy, & Titov, 2010; Andersson & Cuijpers, 2009; Barak, Hen, Boniel-Nissim & Shapira, 2008; Cuijpers, van Straten & Andersson, 2008). Preliminary results are encouraging, finding traditional face-to-face therapy and online therapy with similar outcomes (Cohen and Kerr, 1999; Day and Schneider, 2000; Barak and Wander-Schwartz, 2000). Fenichel, Suler, Barak, Zelvin, Jones et al (2002) dispel several myths about online therapy suggesting that it is not only possible but, in their experience provides even more potential than they imagined for creative and therapeutic uses of internet-facilitated communication.

Several advantages have so far been highlighted including accessibility of treatment (Backhaus et al, 2012; Baker & Ray, 2011; Grubaugh, Cain Elhai, Patrick, & Frueh, 2008; Perle & Nierenberg, 2013; Simms, Gibson, & O'Donnell, 2011; Austen & McGrath, 2006; Chester & Glass, 2006; Lange et al, 2003), the ability to re-read, review and reflect on written forms of online treatment (Castelnuovo, Gaggioli, Mantovani & Riva, 2003) and the potential cost effectiveness of the approach (Hollinghurst, Peters, Kaur, Wiles, Lewis & Kessler, 2010). Anonymity of online contact is particularly appealing for individuals who present as more introverted, however the perception of anonymity may help with stigma and allow disinhibition (Abbott, Klein, & Ciechomski, 2008; Hollenbaugh & Everett, 2013; Lange et al, 2003; Suler, 2004; Young, 2005) but may lead to some debate as to whether anonymity is an advantage or a risk. Furthermore concerns have arisen around confidentiality, privacy and

reliability of technology (Rochlen, Zack & Speyer, 2004; Wells, Mitchell, Finkelhor & Becker-Blease, 2007).

Criticisms of treatments provided over the internet predominantly suggest that the medium may interfere with establishing a strong therapeutic alliance (Cook & Doyle, 2002; Rochlen et al, 2004). This may be due to the absence of non-verbal information which would be available in more traditional face to face approaches to treatment, and thought to be critical to the development of relationships and intimacy within a relationship (Altman & Taylor, 1973; Alleman, 2002).

Clinical evidence suggests that the therapeutic relationship is one of the most consistent and major factors to predict outcome in therapeutic counselling (Wampold, 2001; Messer, & Wampold, 2002; Wampold & Imel, 2015). This is identified in effect sizes of .25 to .35 in meta-analyses of the therapist-client relationship (Hovath, 1994; Horvath & Symonds, 1991). Only the allegiance to the therapeutic form (e.g. cognitive behavioural therapy) and competence of the providing therapist accounted for more variance in outcome than the therapist-client dyad (Wampold, 2001). Thus important questions to be explored are whether therapeutic relationships can be developed to a similar extent via the internet; and even, if the therapeutic alliance is *as important* via an online treatment format.

2.1.2. The online therapeutic relationship

The therapeutic alliance has been described in several different ways according to a range of theoretical orientations. The concept of therapeutic alliance tends to be defined by the established instrument which is used to measure the therapeutic alliance within the research piece. However, most definitions agree on three main occurring components: The affective bond or attachment between the client and therapist; the collaborative feature of the relationship; and the agreement on mutually acceptable therapeutic tasks and goals from both therapist and client (Simpson & Reid, 2014).

Through the availability of systems such as Skype, many clinicians are able to use video communication to provide treatment. However, research on this format is still scarce (Berger, 2017). Simpson and Reid (2014) carried out a systematic review focusing on the therapeutic alliance via videoconferencing psychotherapy, identifying seven RCTs, three case-controlled studies and seven uncontrolled single case studies. Their review excluded any qualitative methodologies, preferring to focus on research using alliance measures. The studies in the review overwhelmingly supported the idea that therapeutic alliance could be developed via videoconferencing. Patient-rated alliance via videoconferencing was

homogenously high, whereas therapists also rated high, but not quite as high as clients (Simpson & Reid, 2014). The review suggests an equivalent rating to face-to-face treatments. However, findings are still limited by the few studies available to be reviewed.

As a final thought on therapeutic alliance via internet treatment, Berger (2017) suggests that while there is extensive literature on the crucial role of therapeutic alliance in face-to-face psychotherapies, (i.e. with several meta-analyses indicating robust relations between alliance and outcome across a range of diagnoses and contexts (Horvath, Del Re, Flückiger & Symonds, 2011; Martin, Garske & Davis, 2000)) research on the therapeutic alliance in internet interventions remains scarce. Alliance-outcome correlations appear to be in a positive direction, however Berger (2017) notes that they are not often statistically significant, possibly due to a lack of statistical power. The range of therapist behaviour which may be significant for alliance development may also be restricted in internet interventions (Caspar & Berger, 2011). Berger therefore calls for more research to explore the relationship to a much greater extent.

2.1.3. Understanding the therapists perspective

Baldwin, Wampold and Imel (2007) look at therapist and patient variability in the alliance in more detail. They initially discuss Bordin's (1979) formulation of alliance in more detail explaining three important implications as suggested by Hatcher and Barends (2006):

1. "Technique is an activity, alliance is a way to characterise activity" (Hatcher & Barends, 2006). Thus by this suggestion, any aspect of intervention (including assessment, formulation and specific active techniques) that relate to the engagement within the work will contribute to the alliance.
2. Alliance is not equivalent to the therapeutic relationship; however, the relationship may also play a role in influencing the alliance.
3. The alliance cannot be reduced to just patients' experience; however, patient experience may also be a reasonable estimation of the alliance.

Exploring alliance is complex, involving transactions between the therapist and the patient; each brings their own characteristics and complexities in personality (Gelso & Carter, 1994). Thus variability in alliance is made up of patient factors (e.g. attachment style, social competencies, Mallinckrodt, 2000); therapist factors (e.g. effective therapist may be better at engaging patients in the therapeutic process to carry out the therapeutic work); and finally, the interaction between patient and therapist (e.g. some therapists may form strong alliances regardless of patient factors and vice versa).

Baldwin et al (2007) explore the importance of therapist and patient variability within the alliance. They used multilevel models to explore patient and therapist variability in alliance in relation to outcome among 331 patients seen by 80 therapists. Patients rated both alliance and outcome and all models were adjusted for baseline functioning. Their study indicated that therapist variability in the patient-rated alliance accounted for the correlation between alliance and outcome i.e. therapists who formed stronger bonds on average with their patients showed statistically significantly better outcomes than those who did not form strong alliances (Baldwin et al, 2007). The study suggests that patient variability in the alliance may overall be unimportant to outcome and emphasises the role of the therapist. Follow up studies have corroborated with this finding identifying therapist variability in the alliance to be more important, even when controlling for potential covariates of the relationship (Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012). This may suggest that the medium of treatment may not be important at all, however outcome may depend on how the practitioner adapts to treatment provided via the internet to create and maintain the therapeutic alliance.

In his review, Berger (2017) also suggests that more studies need to focus on the therapist ratings, particularly in internet interventions. And further argument from Blow, Sprenkle and Davis (2007) emphasises that the therapist is key in the change process in most successful therapies. Indeed, psychotherapy research is often focused on the application of clinical interventions, whilst regularly ignoring the psychotherapists who facilitate them; regularly treating interventions as pills, unaffected by the person administering them (Lebow, 2006). Thus this study attempts to include the therapist by interviewing therapist practitioners facilitating online interventions.

2.1.4. Involving the family and the therapeutic relationship

The therapeutic relationship has provided a backbone in systemic thinking and practice intertwined in systemic family therapy history and development. Early strategic and structural family theory laid emphasis on the application of the practitioners' use of techniques. Further development in systemic thinking moved toward a position of 'neutrality'; where the therapist maintained a curious and respectful engagement (Cecchin, 1987, 1992). Therapist reflexivity and understanding of their own prejudices and enactment of biases was encouraged (Cecchin, Lane & Ray, 1994) (see Roy-Chowdury, 2006). More current practice has returned to the ideas of the therapeutic relationship, considering psychoanalytic canon within systemic thinking (Roy-Chowdhury, 2006). Frosh (1997, 1999) and Pocock, (1997, 1999) share an academic and clinical interest in family therapy and

psychoanalysis (albeit through different therapeutic orientations); both emphasise the emotional connectedness and need to convey understanding and respect through privileging the therapeutic relationship above technique.

An added complication is how therapeutic alliance is affected within a family intervention itself. In individual therapy, we've already discussed how alliances can be predictive of outcome (Constantino, Castonguay, Schut, 2002). There is further evidence for different patterns of alliance development (Kivlighan and Shaughnessy, 2000) too. In family therapy, however, the 'open family system' (Jenkins and Asen, 1992) can cause alliances to either strengthen or break, for example when additional family member joins or leaves a sessions, or when powerful information is revealed within sessions. This 'expanded therapeutic alliance' is unique to conjoint therapy (Sprenkle and Blow, 2004). It can mean that family therapists are challenged to foster alliances with multiple individuals within the session. Additional complexities come with each person in the room being able to observe others interaction, relationships and alliances within the room (Friedlander Escudero & Heatherington, 2006). However, the 'safe' therapeutic environment also enables individuals to explore painful subjects and come to agreement about goals with each other (Friedlander et al., 2006).

There are a multiple of complexities to consider within the therapeutic environment and additional layers of complication to consider when the treatment is provided in a different format. The therapist practitioner in this context is a key individual in the process of providing the treatment and as a crucial agent of change. Qualitatively exploring therapist practitioner experiences and their perception of facilitating a unique family-focused online intervention is a useful way of attempting to understand the process involved in a novel approach to treatment. Several suggestions from Berger's (2017) narrative review emphasises the important of developing a better understanding, not only of the specific characteristics within the online relationship, but also what qualitative differences lie between online and face-to-face. Additionally Berger adds the need to move into process research to better understand the mechanisms of change. If for example, therapists are the main agents of change within the treatment process, how does that come about? Berger (2017) goes on to suggest that it may be "unlikely that more studies with conventional alliance measures will result in a better understanding and improved therapeutic procedures". Therefore this study takes the opportunity to explore practitioner experiences and perceptions of facilitating a unique online range of family-focused interventions.

This study aims to explore three main areas:

1. Practitioner's attitude and perceptions of facilitating an online intervention.
2. Practitioners' experience of developing a therapeutic alliance when facilitating an online intervention for individuals, families and carers of an individual with a mental health problem.
3. Practitioners' perception of working with multiple individuals in session via an online medium.

2.2. Methodology

2.2.1. Service Context

The company worked with in this research study provide a family intervention service built on components of behavioural family therapy, brief systemic family therapy and functional behavioural therapy. They use multimedia technology to provide access to trained clinicians who provide structured psychologically informed interventions (e.g. structured manualised CBT and structured manualised behavioural family therapy) through online video technology. The company provides projects addressing adult mental health (Psychosis, Dementia, Bipolar, Anxiety, Substance Misuse, Adjustment Disorder, Anxiety, Depression, PTSD and Eating Disorders; and Child Anxiety and Depression. For example, their Behavioural Family Therapy programme, based on the Meriden Family Programme (Falloon et al, 1996) is an evidence-based, psychoeducational approach and a recommended family intervention for individuals with schizophrenia (NICE, 2014); bipolar (NICE, 2006) and family and carer involvement is also suggested within guidance for depression, depression in long term conditions and eating disorders (NICE, 2016; NICE, 2009; NICE 2004).

Each of the company's programmes is structured around the needs of the family, following requirements set out by the National Institute of Health and Care Excellence (NICE). They look to provide services in more sustainable ways, transforming how care is delivered, by providing innovative solutions to challenges faced within the NHS. Their multimedia technology includes access to a secure online video platform which can be obtained at the convenience of the participants via computer, tablet or mobile phone, enabling individual members to join the sessions from multiple locations, keeping "the therapy system 'open' for relevant others to join at any time" (Jenkins and Asen, 1992). Interventions can be held either individually (one to one), or if interventions are to include wider family, participants can choose to 'join' therapy either as a 'group' (family together on one screen) or family members can join via multiple locations (this could be within the same house e.g. bedroom and lounge or different locations altogether). All treatments are intended to be carried out online, therapist and patients may use telephone to assist if there are technology difficulties. However, as therapists are often widespread and work remotely, from home environments, patients do not meet with therapists on a face to face basis. Additionally, staff are not employed by the company on a full-time basis and are mostly contracted for a few hours work a week.

2.2.2. Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) is concerned with the detailed examination of human lived experience (Smith, Flowers & Larkin, 2009). IPA commits importance in situating participants in their particular contexts through exploring their personal perspectives (Smith et al, 2009). This is particularly important for the current study which intends to explore practitioner experiences of facilitating a unique online range of family-focused interventions. In this case the context of the organisation and the services provided by practitioners is distinctive in its experience, thus IPA was deemed most appropriate for the current study.

2.2.3. Theoretical Underpinnings

IPA draws upon fundamental principles of phenomenology, hermeneutics and idiography (Pietkiewicz & Smith, 2012) with a primary goal of investigating how individuals make sense of their experience. IPA assumes that individuals are 'self-interpreting beings' (Taylor, 1985) i.e. they are actively engaged in the interpreting process of events and people within their lives.

Phenomenology: Phenomenology emphasises the importance of a focus on unique human experiences and development of meaning to develop a 'significant world' (Drummond, 2007; 61). Phenomenological studies attempt to focus on how people perceive and talk about events occurring as oppose to describing in accordance to a pre-determined system. Therefore, 'experience' invokes a 'lived process' and an 'unfurling of perspectives and meanings, unique to an individuals' context; engaging in a relationship with the world (Smith et al, 2009). With particular relevance to the current study, an attempt to understand that practitioner's relationships to the outer world are interpretative was made, focusing on attempts to make meanings out of their actions and activities within the context of online interventions.

Hermeneutics: Hermeneutics investigates whether it is possible to reveal the intentions and actual meaning of the original author, examining how language is shaped by the conventions and expectations of commonalities from which the author came but also the authors' individual style (Schleiermacher, 1998) accommodated into a wider context. Heidegger suggests that a lived engagement with the world requires access through interpretation. The analyst brings past experiences, assumptions and pre-conceptions to the encounter of the phenomenon and sheds new light onto any object/stimulus (Heidegger, 1962/1927). An understanding of own preconceptions, brings a better understanding of the

author. Finally, meaning is also influenced by the precise moment the interpretation is made.

The hermeneutic cycle: The hermeneutic cycle refers to the dynamic relationship between 'the part and the whole' i.e. interpretation is non-linear; the meaning of a word may only become clear within the context of the whole sentence. Simultaneously the meaning of a whole sentence may rest upon the combined meanings of the individual words.

Throughout analysis the researcher engaged in a sense making process of the participant who also attempted to make sense of the phenomenon. This highlighted the role of the researcher as both similar to, and dissimilar to the participant and engaged in a 'double hermeneutic' process (Smith & Osborn, 2003).

Idiography: IPA's idiographic approach is committed to a sense of detail and depth of analysis and focus on 'the particular'. Therefore a 'non-linear' way of thinking is balanced with a systematically thorough approach to analysis. IPA commits itself to understanding how a specific phenomenon is experienced by an individual within a particular context (e.g. how practitioners experience the therapeutic relationship in family orientated online treatments, within the specific context of the company described above). Harre (1980) suggests that IPA does not avoid generalisations but provides an alternative method for establishing generalisations, locating them in 'the particular', with more caution.

2.2.4. Recruitment

Sample: Participants were recruited specifically within a private company delivering online interventions. Participants were included if they were practitioners who provided online treatment within the varying service lines of intervention that were provided by the company. In this way, a purposive sample of practitioners providing online interventions was selected. Participants were targeted from the private company delivering the interventions to maintain homogeneity, particularly with the technology and the online context. Technology provided by the private company was both unique and specific for the purpose of family orientated treatments e.g. it was set up to increase accessibility and flexibility of working for users, simultaneously maintaining confidentiality via the online platform.

Permission was sought to contact practitioners through email or meetings. Recruitment involved a circular email to all practitioners providing online interventions. The

study was also promoted at the start of meetings and supervision meetings. Information sheets were attached to emails and provided to potential participants during meetings (see Appendix C). If practitioners voiced interest in being interviewed, they were contacted directly via email to arrange an interview date and forwarded consent forms (Appendix D). No participants were excluded. All participants completed written consent forms prior to being interviewed.

Nine participants were recruited and consented to be interviewed altogether. On top of the general challenges of conducting process research (Hill & Williams, 2000; Wampold, 2000), ambiguity and debate over exact definitions of online treatment can make research in this area particularly challenging. Technology can vary greatly in the form and medium of the intervention via the internet (Barak, Klein and Proudfoot, 2009). Therefore for this study, participants were recruited solely from one private company offering internet intervention as the technology being provided was unique to the organisation.

A primary concern of the use of IPA is with obtaining a detailed account of individual experience. The focus is the quality (not the quantity) of the complexity in human phenomena (Smith et al, 2009). Thus IPA studies are more often benefited from a smaller concentrate of cases. For the current study, nine participants may have been considered a large sample size with potential loss of depth due to the vast amount of data gathered. Smith et al (2009) suggest for a Professional Doctorate between four and ten interviews are sufficient to provide development of meaningful points of similarity and difference between participants. For an IPA research, too many participants may overwhelm and dilute the emphasis on 'the particular', which was a concern of having nine participants. With an aim to explore practitioner experiences of the therapeutic alliance, in depth exploration of 'the particular' is required to be able to investigate the online relationship to a greater extent as suggested by Berger (2017). Nine participants were included as several participants volunteered and wanted to take part in the study, it was felt that their perspectives were valid and would contribute to the data and that depth would also not be lost. Caution must also be exercised in generalising the results of research that has been conducted due to limitations of using participants from one company only. Demographics of the participants who were recruited and consented to be interviewed are detailed in table 1 below.

Participant	Gender	Age	Years of experience providing online treatment	Approx. years experience providing face to face treatment	Training and Theoretical orientation	Provision of which service?
1	F	57	3 years 6 months	20+ years	FI, Couples counselling	FI
2	F	43	4 years 6 months	0	FI	FI
3	F	58	3 years	20+	FI, Couples counselling, Life Coach	FI
4	F	40	1 year 4 months	7+	FI, Person Centred and Integrative Counselling, Solution Focused Therapy	FI
5	F	35	2 years	8+	Clinical Psychologist, CBT, Person Centred, Psychodynamic	CBT for CYP, ASD assessments
6	F	52	1 year 4 months	30+	Clinical Psychologist, Specialist CYP and Families	CBT for CYP

7	F	33	2 years 6 months	10+	Clinical Psychologist, Systemic and Narrative Therapy	ASD assessments
8	F	40	6 months	10+	Clinical Psychologist, CBT, Attachment, Systemic Behaviour Therapy	CYP for CYP
9	F	35	1 year 3 months	10+		ASD assessments

*FI = In house Family Intervention Training

*CBT = Cognitive Behaviour Therapy

*ASD = Autistic Spectrum Disorder

*CYP = Children and Young People

2.2.5. Table 5: Participant Demographics

2.2.6. Interview Process

Participants were requested to attend a semi-structured interview (see Appendix E) which initially asked general questions about their past experiences working as a practitioner, their previous experiences of developing a therapeutic relationship, more specific question to developing therapeutic relationships within an online context were then explored. The interview then explored participant experiences of working with more than one individual within session, i.e. participant's initial general experiences followed by experiences of working in an online context. Interviews were audio-recorded with the consent of the participant and transcribed verbatim. An interview schedule acted as a topic guide but the order and how topic areas were approached were not restrictive to the schedule. Participants were provided a debrief statement following participation in the study (Appendix F).

2.2.7. IPA data analysis

Transcribed data was read and recordings listened to initially to gain familiarity with the interview and become immersed into the data. Smith, et al (2009) propose a step by step guide for analysing IPA data for novice researchers, however state that there is no singular or prescribed method for working with the data. They emphasise the importance of IPA analysis lies in the analytic focus and particular attention towards participants' attempts to make meaning of their experiences. The process suggests moving from 'the particular' to the 'shared' experiences and additionally from the descriptive to an interpretative stance. The analysis process used therefore worked through a number of strategies including: initial responses; identifying emergent patterns (initially within a single case and moving more broadly across cases); further development of an interpretative account including the researchers' psychological knowledge; and a move toward a frame which indicated the relationship between themes. An example of coding from initial responses moving to emergent themes is demonstrated in Appendix G. Throughout the analytical process the researcher focused on organising the material whereby analysed data could be traced through the analytical process and made use of supervision to creatively think through possibilities and ideas.

2.2.8. Reflexivity

A final component included reflection of the researchers own perceptions and cognitive processes. The primary researchers' philosophical reflexive stance is of critical realism. Thus with a central focus on ontology, and an inquiry into the nature of things and the nature of the known as opposed to positivist questions of seeking 'how we know what

we know'. Although a critical realist perspective offers a critique of positivist approaches it is also opposed to a strong constructivist position and this is likely to influence the interpretative aspect of this study.

Reflections of the researcher were maintained through a record of thoughts, ideas and observations made throughout the data collection process and continuing throughout the analytical components. It was also interesting to note that seven out of nine practitioners were interviewed using the medium of the telephone. The researcher noticed how this impacted her thoughts and feelings of eliciting and interpreting information and what adaptations she made throughout the interview process to capture what was lost through the lack of visual information. This was reflected upon and considered how this might have impacted research and participant bias throughout data collection and the analysis process.

2.2.9. Reliability in the analytical process

Initial analyses using descriptive initial responses were carried out by the researcher and two research assistants. Codes from initial analysis were then compared to check similarities and differences to ensure the analysis process was closely related to the data at this point of analysis (see example in Appendix H).

2.2.10. Ethical Considerations

Ethical approval was granted by The University of Southampton. All participants were given information sheets and provided both verbal and written consent to be interviewed and to be audio-recorded. Following interview, participants were provided debrief information and during transcription process participant names and other identifiable data were anonymised or removed.

2.3. Findings

Analysis of the nine interviews demonstrated an interpretative process for both participant and researcher resulting in three master themes indicated in Table 2 alongside sub-themes:

Master Theme	Sub-Theme
The therapeutic relationship: both the same & different	• Building a therapeutic relationship online is similar and a natural process • What about that 'felt-sense'? • Interpreting what is seen • Divided by the screen
The positives outweigh the negatives	• Attitude can change with experience • My style of working • Positive stories
Balancing the patients' needs with the practitioners' needs	• Working with 'part', accessing the 'whole' • The patient is in control but I am still responsible • The emotional impact and support needs

2.3.1. Table 6: Master-themes and Sub-themes

Reflexive note: Semi-structured interviews demonstrated the hermeneutic cycle within the research process (see Appendix I). Where the researcher notes that prior to data collection and analysis, the researcher had preconceived ideas shaped by experiences of training as a Clinical Psychologist and years of working as a practitioner providing treatment to clients in both individual and family settings. The researcher also had some knowledge and understanding of the company that the research was carried out with and the provision of services they offered. Thus the researcher acknowledges that she starts from this position of her own understanding and knowledge and so attempts to 'bracket' these ideas to focus on the participant's story during the interview process. The participant follows this process by focusing on their own experience, informed by their pre-conceptions and understanding of facilitating treatment with the patient/clients, within the wider context of an online environment.

Indeed, the researchers' pre-conceived ideas came into play again when revisiting the transcribed material for analysis, with the added experience of her and the participants' joint account of the interview itself. Of note through the procedure of analysis it was observed that a number of participants appear to reassess and reflect on the treatment process and so come to re-consider their initial statements regarding provision of treatment over the internet. Thus for both researcher and participant the interview and analysis was an interpretative meaning making process that will be explored via the main themes highlighted in table 2 above and discussed in more depth below.

A number of quotations from transcripts are used, with significant quotes selected for narrative descriptions of the themes below. Appendix J indicates the frequency of related codes under each subtheme for each participant.

2.3.2. The therapeutic relationship: both the same and different

Participants within this theme discussed how the therapeutic relationship could be developed face to face and via treatment provided over the internet. All participants stated that they felt they were able to build a relationship with clients easily, both within face to face treatment and via online treatment. However, through the interview process, some participants began to re-consider the therapeutic process and whether the videoconferencing format provided by the technology platform could provide the same level of therapeutic relationship as initially thought. This is demonstrated by the four subthemes described below: 'Building a therapeutic relationship online is similar and a natural process'; 'What about that "felt-sense"?'; 'Interpreting what is seen'; 'Divided by the screen'.

Building a therapeutic relationship online is similar and a natural process: Several participants stated similarities in being able to build a therapeutic relationship through the videoconferencing technology, stating enthusiasm that it can work and that building a therapeutic relationship was fundamentally the same:

…developing a relationship is simply developing a relationship. It doesn't really matter how it is I'm doing it or what medium I'm having to use. (Participant 5; 319-320)

we're still fundamentally doing the same thing to develop relationships whether it's face to face or online. (Participant 8; 811-912)

Participant 2 suggests the medium has several similarities and an adequate environment to build a good therapeutic relationship. However throughout the interview, her thought process waivers between the similarities and the differences

suggesting some ambivalence. Below she suggests that the medium is a "strange way" of accessing the service, possibly suggesting dissimilarities. Her language hints toward underlying thoughts of working online which contradict initial enthusiasm that online working is just as effective:

I probably am but I'm not conscious of them…[…]…I'm just thinking. Sorry, I've got a stream of consciousness at you right now…[…]… I think I definitely have to compensate for the fact that I'm not meeting them in person so I definitely lather on the warmth and I try to make people feel really comfortable, so I do spend a bit more time, you know, if the technology's not quite working or they're getting a bit stressed out I tend to compensate for that by trying to be very calming and understanding until that frustrating bit's over with. So, yeah, I think the difference is that I really do need to be conscious of making that person feel as comfortable as possible so that they can get used to the strange way that they're accessing a service. (Participant 2; 246-255)

This quote suggests that building a relationship is so natural that she rarely stops to think about what she is doing. Thus within an online context, she considers that she must be doing something differently but this has yet to reach conscious thought due to it being such an automatic process. Participant 2 is not alone in her ambivalence; throughout the interview participant 8 questioned whether a relationship could be developed if you were not in the same room:

…how on earth am I going to develop a relationship when I'm not sat in a room with someone? I'm not going to be able to pick up on some of the non-verbal cues that you might get in a room or just the… I can't even describe what I mean but when you're in a room with someone that kind of… the feeling, the… I can't describe it but you can pick up on things, very subtle things that maybe you couldn't pick up on when you're not in the room. (Participant 8; 213-217)

Participant 8 routinely referred to the "genuine interaction" and "genuineness of being in the same room" which made the difference, suggesting that online was marginally more "superficial" and thus importantly notes that this more 'natural' way of being (in face to face treatment) meant that the relationship via this medium was the same, but it was also different:

I guess when I was saying better I was saying it wasn't as difficult as I thought it was going to be, it's definitely different to being in the room with someone and developing a

relationship and very, very marginally I guess it's a bit more superficial, (Participant 8; 402-404)

What about that "felt-sense"?: This leads us on to a second subtheme, where participants reconsider the relationship being 'the same' and reflect upon some of the differences. A distinctive theme for some participants (participants 1, 2, 4, 6, 8) was an 'indescribable quality' within the therapeutic relationship which some felt was achievable (Participants 1 & 4) via online treatment and others felt was missed. For example, participant 1 talks about a 'felt connection' which she considered for her to be achievable in both contexts:

.. you know you know what you feel about your connection to another person, and I would say that mine is no less online than it was face to face, in some ways I feel it's more pure more focused.. (Participant 1; 200-201)

Whereas others (particularly participants 6 & 8) felt strongly that something was 'missed' in the online context:

it's difficult to put into words, just being actually alongside someone, literally in the room where you are much more aware of the nuances of their communication, their non-verbal style, erm, the things they don't say, kinda where they put their eye gaze, you know, things that are really hard to quantify online (Participant 6; 82-84)

It's so hard to kind of put that into words but it's so much about that the interpersonal nature of therapy and when you're in the room with someone you could just pick up on things that you see, that you feel, you know, you could get a sense of how that person might be feeling or what might be going on or the kind of genuineness of what they're talking about in a different way than online. (Participant 8; 310-313)

Both participant 6 and 8 discuss a 'felt-sense', an element within face to face treatment which they found indescribable and hard to quantify but felt strongly that this element was significant and defined being physically in the same room as having a superior quality. They considered that this 'felt-sense' was limited online, possibly due to the lack of visible non-verbal cues, the impact of which is discussed in the next subtheme.

Interpreting what is seen: Non-verbal cues were discussed by almost all participants interviewed, either in the context of describing the similarities of videoconferencing or emphasising its restrictions. Sometimes restrictions to visual

information to aid understanding of a client and interpretations were disrupted by the technology:

I think, you know, with non-verbal communication you do, online or on the phone, you do miss, you know, you do miss certain communications or by the time you kind of catch it sometimes there's a bit of a delay. And also,…[…]…I think a lot of people have the camera quite close to their face, you kind of only see their face and you don't really kind of, you know, you can't notice things like body posture or gestures or kind of other non-verbal communication that I think in the room, you'd be able to pick up and, you know, just possibly incorporate into your understanding. But online, it's sometimes quite difficult and like I said, if there is – if there is any kind of delay or technological issue then it, you know, it can make it even harder. (Participant 7; 312-318)

For other participant's, the physical presence of being in the same room meant they could not access all the important information to interpret the situation. For practitioner's this posed difficulties in being able to assess what was truly going on for the client during the session. They were particularly aware of distractions in the clients' home environment and interpreting what a client might be doing. Participant 8 described a specific case she'd worked with where unseen non-verbal behaviour could have led to misinterpretations:

so I guess I needed to know what it was that was distracting her because it could have been that, you know, she was distracted by other things that were inappropriate like someone being in the room that I didn't know was in the room or, you know, it could have been anything else. You know, I might interpret it as she's hallucinating for example, you know, and that's why she's distracted and laughing and whatever or is it something about me as a therapist that had made her laugh (Participant 8; 368-372)

Divided by the screen: The screen emphasised a separation which either reflected participants awareness of their own actions and responding behaviours to the relationship (as seen via the computer screen), and/or their interpretation of themselves as a 'disembodied' voice.

Three participants (participants 1,2 &7) discussed note-taking as a limitation specific to the online technology, as the computer screen and camera showing themselves emphasised an awareness of their own physical actions and how it may be reflected to clients and affect the relationship:

So, if you're already behind a screen and you've got somebody who's sort of writing and nodding it doesn't really feel that they're really engaged in what you're saying even if they are. (Participant 2; 513-514)

In some situations, the lack of presence and the division of the screen meant that the practitioner could feel like an 'outsider'. This may be particularly relevant to family interventions and when working with multiple individuals in the room.

tricky when two people who are remote and together try to talk to each other because then, as the therapist, you do feel very outside very separate from that that conversation (Participant 6; 260-261)

Participant 1 humorously summarises how the relationship and connection can be lost because of being separated by the screen; demonstrating the impact of the separation between family and practitioner. Her use of the words "*disembodied voice"* indicating a disconnection not only with the family but also from her own physical presence:

*Again I think I think that biggest issue is that lack of physical presence in a room if things are quite active and mobile and potentially, potentially volatile. Because it's quite different, it's quite easy to sort of ignore the shouting computer screen in the corner, like 'will you please sit down!' [*laughter*], so yeah, it's like the telly blaring in the corner nobody takes any notice of it. Um, so I think it it's easier if things are going particularly difficult to lose that connection with the family because you are just just a disembodied voice in the corner of the room.* (Participant 1; 657-660)

2.3.3. The positives outweigh the negatives

Participants discussed how their past experiences informed their initial attitude, but how attitude was then influenced by a willingness to engage with the online medium and this experience further influencing attitude. The outcome of treatment meant that practitioners then gained positive feedback, either through their own experiences of using the programme or through clients they'd worked with, thus creating a cyclical influence of experience on behaviour and resulting attitude. Overall, participants found the online medium provided several benefits outweighing any difficulties. This theme consists of three subthemes: 'Attitude can change with experience'; 'My style of working'; and 'Positive stories'.

Attitude can change with experience: Majority of participants reported initial hesitance in the online approach to treatment, however, with an openness to working with

the medium and seeing what it was like. Hesitation was sometimes due to long term experience of being a practitioner, or uncertainty whether an online treatment could build the same level of therapeutic relationship with the client(s) (Participant 4, 6, 8 & 9). Two participants had previous experience of providing online treatment, however for one (Participant 7), past experiences made her hesitant and for the other (Participant 5) past experience made her strongly defensive of using videoconferencing as a medium for treatment. Participant 3 hesitated over the technology and having confidence to use it, whereas Participant 2 lacked experience of facilitating interventions and so attempted to keep an open mind to online treatment. Finally participant 1 held strong positive feelings towards online treatment but held initial concerns around efficacy. Following experience of using the online technology, hesitations tended to be disconfirmed and positive attitudes strengthened. Participant 9 demonstrated both hesitance but also held positive views around the use of technology:

Yes, I think before I first did it I was nervous, that it wouldn't feel right but actually almost immediately it was fine..[…]…but no I found it quite surprising how easy it was to still build that rapport and relationship with people. And I think yes I could think of a number of clients who felt like that relationship was so clearly developed, when it was online. So yes, it surprised me! (Participant 9; 97-100)

Although Participant 6 reported several benefits, she continued to have some reservations, but specified it was more to do with her own style of working.

I was aware that this was, you know, a very vibrant area of development for the offering of therapeutic interventions. And I had reservations about, from having long experiences of working face to face with people, how it might feel and whether it might be, whether it would feel as though you could make a proper therapeutic engagement with someone that you couldn't actually see, you weren't actually in the room with, that you were connected to, were actually able to see them but through the medium of the screen. Erm, and I thought it would be harder than it was really, so it was generally positive, some reservations because I think that it's not the same as being in the same room and there are things that are missed and the engagement is different, absolutely different but not unworkable and very acceptable to young people, (Participant 6; 72-78)

'My' Style of working: As suggested by Participant 6 above, the working style of the practitioner was an influencing element which could sway participants' potentially

continuing provision of treatment via the internet. A number of participants who identified themselves as trained Clinical Psychologists by profession were aware of their role and the limitations of what could be delivered via the online platform (Participants 5, 6, 8). A further two Clinical Psychologists (Participants 7 & 9) were contracted to provide assessment only interventions rather than longer term therapy and thus found their role clearer and less restricting of personal 'style'. Participants who talked about their style of working agreed that the structured form of treatment required adjusting to and was sometimes limiting:

At the beginning, I found it quite difficult to get used to that way of working because in my head, I was supposed to follow the slides as I went through and work to a very, very structured format that's very unlike what I would do. (Participant 5; 703-704)

And that was a particular tension for me because as a clinical psychologist I'm not just a CBT therapist and as much as I'm heavily influenced by CBT, I didn't particularly like delivering a manualised CBT intervention because I don't like having to stick to a manual because as clinical psychologists we're kind of very eclectic, integrative, we'll draw from all sorts of different things. And that was a tension for me in delivering online therapy (Participant 8; 995-999)

As suggested by Participant 8, the online approach tended to lend itself more to structured therapeutic treatment. This may have been in part to ensure standardisation of quality across practitioners' however it was felt that it restricted potential for wider approaches and individualisation for clients.

This view was not shared as much by practitioners providing the family intervention for carers, who welcomed a structured approach. Practitioner's providing the carer family intervention did not feel restricted by the structured approach online and instead some felt it enhanced their ability to focus better:

Yeah, because [the programme] is quite restricted in the areas that you cover, and I found it quite hard to stay on track if the client couldn't see the slides. So, you worked through different slides and psychoeducation, and if she couldn't see them, or if neither of us could see them, it would seem quite hard to keep the session focused, and it would then verge on a counselling session as opposed to working through the manual and psychoeducation. So, that definitely changed it. Whereas, if we could see the slides it would set an agenda at the beginning, and then we knew what we were working on that day. It kept us much more focused, and if neither of us could see them it was harder, even though I

had them in front of me and I would try and keep going back to them, with this particular client, it was tricky to get her to stay focused on the work that we were doing. (Participant 4; 375-382)

Another difference may be that practitioners providing the family intervention were not trained as Clinical Psychologists, which could possibly highlight how clinical psychologists might see themselves and their role within the delivery of different forms of treatment and the provision of them in an online context. This was also interesting to reflect upon from the researchers personal perspective as a 'Trainee Clinical Psychologist' as she also does not identify herself as working within a specific 'structured model' of work.

Positive Stories: Engagement with the online medium was encouraged by first hand experiences of the benefits to both practitioner and to clients, and from positive stories of clients. Participant 3 emphasised throughout her interview the benefits of *"time, accessibility and efficiency"* (442); and that despite online working requiring more effort and skill, the benefits outweighed the workload:

And, maybe it does take more out of me, but, for me, the benefits outweigh that. So, I don't mind (Participant 3; 355-356)

Participant 6 encapsulates how experiencing the online medium herself changed her attitude and how positive stories from clients supported a more optimistic outlook for online treatments:

well, think I came to it with some cynicism but I left being much more positive, as with online therapy as a medium being effective, just with my small amount of experience of it. Effective and acceptable and er, surprisingly flexible as a way of working and just, for young people, being a continuation of the normality of the way they live their lives which is accessing therapeutic support through the medium of their devices. So that felt good um. A comment from one mum, the mum of the young woman with Chronic fatigue, well I wasn't quite sure that [the] programme was quite right for her at all but with the adaptations that we made, mum had commented that she had engaged more with that as a therapeutic intervention than with anything that she had previously been offered…[…]… And I asked mum why that was and a lot of it was to do with the fact that it could be with her wherever she was…[…]…So it was a good illustration of how acceptable, how much more accessible it was to work online. (Participant 6; 285-296)

2.3.4. Balancing the Patients' needs with the practitioners' need

With the provision of online treatment practitioners were aware that alongside the benefits of wider access and flexibility of working, also came a shift in the 'rules' within the 'traditional' therapeutic context. Holding in mind the needs of the client(s) and reflecting on the practitioners' own necessities often required a frustrating compromise on behalf of the practitioner which developed through the reflective process of the interview. This theme comprised of three subthemes; 'Working with 'part', accessing the 'whole''; 'The patient is in control but I am still responsible'; 'The emotional impact and support needs'.

Working with 'part', accessing the 'whole': Some participants described face to face treatment as being too intense. This played to the strengths of working online, enabling the client to feel more comfortable and less under intense scrutiny:

Like I said, I think perhaps for some people who find it really difficult to talk about sort of emotional stuff having someone in the room with you might feel too confrontational, you might feel more vulnerable with someone in the room with you but I think for some reason someone being on a screen that just feels that they are, yeah, more anonymity I think. (Participant 2; 137-140)

This element of anonymity posed some advantages, clients may be more willing to disclose more and provide deeper insight without feeling confronted or scrutinised. Clients also have more choice to be both 'hidden and yet still heard':

And it's using the anonymity sometimes that the internet seems to present us with and using it to your advantage. Sometimes people will talk more or say more personal or more deeply upsetting things because they're behind a screen and you're not physically looking at them. (Participant 5; 289-291)

And you know this business about not being seen, another things that's really useful it's like rather than people hiding in cupboards they can just turn their camera off if they don't want to be seen, but they can still be part of the session, they can see other people. (Participant 1; 562-563)

However, alongside the advantages of the choice of being seen and maintaining anonymity for the clients, practitioners' often have to work harder; particularly when there is more than one individual attending the session as sessions can get quite *"crowded"* (Participant 7; 498):

…it's like the Brady Bunch when the heads pop up and I can see them, you know, talking to mum and dad, the daughter will be talking to mum and dad, the son will be talking, yeah, and they'll be all sort of having a little conversation with each other so you can see how they communicate with each other. I think the worst case scenario is when they won't appear on camera and you've just got the one person, you've just got two people talking… (Participant 2; 763-767)

It can be difficult to attend to all individuals when there are multiple clients in session and it can be additionally challenging when some clients within the family are not entirely present. Participant 2's description of individuals *"popping up"* is similarly reflected by Participant 7 emphasising the family member who is only partially present:

like, you know, just as an example, the mother of a child is answering and then she'll be like, 'Oh, you know, XXXX, what do you think? Does he do this?' And then, you know, the dad will turn up just momentarily and say something and then go off again and it kind of feels a lot less like a joint enterprise sometimes. (Participant 7; 559-562)

This can possibly only relate to the context of online treatment, as family members are less likely to be able to walk away from the treatment room in face to face, demonstrating a shift in the social rules of treatment. Even with the benefits of accessibility provided by the technology, the 'whole' picture' is often lacking; sometimes due to the chosen device used by the participant:

the majority of our face work even with families is where they crowd round one device. So you don't necessarily get such a full picture because I mean like for instance my session last night was just a couple, but because she decided to access it on her phone, you don't necessarily see them both side by side, I could see the corner of his face, and he's quite a quiet guy so I think he was quite happy for us to take the lead, but every so often she'd have to swing her phone round to pick him up and get close enough for me to actually hear what he was muttering. (Participant 1; 498-502)

One of the advantages of the technology is how accessible it is, ensuring involvement of multiple individuals from different locations. Practitioners acknowledged benefit for accessing 'the whole' family but also recognised its challenges. Most practitioners recognised challenges with working with the technology, however similarly to Participant 2 (below), emphasised the benefits over the added difficulties caused to themselves:

I also think what's quite good with the technology is that sometimes it's really hard to get people together. And the good thing about that is that actually people can access you from different locations, so there's the accessibility over… so which one? Accessibility and getting everybody there versus being really in a difficult situation where you're trying to make sure that everybody's getting what they need from the session and I think those are my two thoughts about online FI is that it's great for its accessibility, it's great because you may get family members in that may not have been able to contribute, which is brilliant and it is harder but it's valuable. (Participant 2; 804-809)

The patient is in control but I am still responsible: Accessibility also provided the client the choice of when and where treatment could occur. Flexible working and working from home proved to be both beneficial for both clients and practitioners, however, the choice of home treatment via the internet also highlighted for practitioners a loss of control over the environment and a shifting of personal boundaries. At times of risk and crisis this triggered an overwhelming sense of helpless responsibility.

The practitioner recognised that for the client, being able to access treatment from home was a more natural environment, which could enable clients to engage differently to treatment. Participant 5 highlights both the advantage to clients and hints to some of the difficulties of working within a clients' 'chaotic' environment that a practitioner had limited control over:

They're sitting on their sofa with their dogs and their cats and all the chaos around them and somehow, it's automatically making people talk to me differently and think differently about what I'm asking. (Participant 5; 175-177)

Participant 4 more explicitly highlights that practitioners' are "*not in control over* [clients] *environment*" (639):

…you know they can find a space that means they won't be distracted, and they won't have any interruptions. If they are not really feeling like the session that day, they could then put themselves in a different room where there could be distractions, or there could be interruptions… (Participant 4; 622-625)

Where control was most significant for practitioners was in relation to their experiences of feeling ultimately responsible and simultaneously helpless from a distance. This fit with situations of high risk and crisis (Participant 2, 4, 8, 9). In these cases, a good structure and policies were available to help guide clinicians facing risk. Practitioners were

all fully capable of following these structures; however this did not remove feelings of helplessness and responsibility:

I think [the risk policy has] been really fleshed out so we do have a whole process of that when something happens like that there are procedures to follow but, yeah, but I think on a personal level, sort of being at the other side of a screen you can feel quite helpless. I mean it'd be difficult if you were in the room with them but it's even worse I think if you're behind a screen. (Participant 2; 454-457)

I guess some of my worries were things that, you know, if you're working with a young person who's talking about risk issues, self-harm, you're not in the room with them which it just puts a whole different kind of spin on the information you're going to get and how you can judge what's going on, you know, if you can't see them (Participant 8; 226-228)

The online context also made some practitioners feel responsible for the technology working smoothly and the client's overall experience:

And it was really hard, especially when the sound went because you know that someone hasn't noticed and they are in the middle of this huge explanation. And you can't just say stop! You are almost trying to signal that it hasn't work, and I found that very difficult, especially in the earlier sessions, when you hadn't necessarily had that relationship built. Yes, I think it made you feel … I guess it made you feel incompetent, it was something you had done wrong and it wasn't the experience I wanted them to have. You are sitting there feeling quite helpless! (Participant 9; 459-463)

[regarding technology fails] *I can feel myself being drawn to becoming stressed out along with them so I resist that and I'm conscious of actually that's going to make them feel worse, I try and keep as calm as possible.* (Participant 2; 287-289)

The emotional impact and support needs: Participants more often than not discussed the advantages and the benefits for the client, continuously holding the client at the forefront of their minds. However, a few practitioners highlighted personal needs and the emotional impact of providing online treatment that may be somewhat neglected. For example, flexible and remote working also posed other challenges around personal boundaries, self-care and also knowing what might be best for the client:

Personally, I got worn out, I was drained, because potentially you come home, you have got an assessment then you might have another one, it gets booked in perhaps so you

leave an empty space in your diary and it gets booked in…[…]…being overly flexible is good for the patient but perhaps not good for the clinician…[…]…is there something good about having a boundary and a structure about when you involve yourself in these things as well? And that you aren't necessarily doing it an hour before you go to bed… (Participant 9; 350-365)

I thought 'I am not going to work too late into the evening' because, well, maybe it was just a couple of young people that I work with that, I just realised that beyond about 7'oclock, they didn't they didn't get the best from me and I really didn't feel that they could work because they had been, if they had been to school or college, then they were tired from their day [well yeah!] you know, and I felt that, and maybe this is me, just being, you know, generalising but I thought, fine an approach can be flexible and available to suit a family, to suit a young person but really, are you offering something that's really helpful if you are saying 'yeah, you can do this anytime during the evening' when actually what you might be better doing at that time is really relaxing, just recharging your batteries, not doing some quite hard psychological work. (Participant 6; 318-324)

Remote working also came with issues of isolation and the need for peer support and time for reflection. However also recognised that the distance and the 'screen' acted as a protective barrier:

I think if I hadn't have been working outside of it, and that was just my job, I would have found it incredibly isolating, yes. And I know some people work out of the office, but still they are in their little cubicle and I don't know, in my job you can come back to the office and if you have had a bad visit, just offload on someone. (Participant 9; 381-383)

Sometimes things are discussed that are really quite upsetting to hear and again I think that the little bit of distance can help, I think some of it sometimes still stays with you but I wonder if… I'm just wondering, I guess I was thinking it out loud, as to whether that helps and I think it does because I don't generally take too much of it, reflecting on it too much, sometimes it does. But I think if I was to meet them face to face, if we were in the room talking about some of this stuff I think it would have a greater effect. (Participant 2; 293-297)

Supervision and support in situations of risk and crisis were praised by practitioners. However there were times when isolated working left practitioners yearning for more immediate peer support:

Because it's nice to be able to sort of come out of that call and then seek support from, you know, my peers and say, 'Oh that was a really difficult call, that was really quite upsetting' and it's good to have them immediately afterwards you have that rather than if you were seeing someone you might have to go through a whole process before you could actually get that support and reflect on how the call went. (Participant 2; 305-308)

2.4. Discussion

This study focused on experiences and perceptions of practitioners who had facilitated a unique range of online family-focused interventions. Interviews with practitioners were interested in how development of a therapeutic relationship was formed, participant's attitude toward the online intervention and also practitioner perceptions of working with multiple individuals within session via the online medium.

Emerging themes highlighted: 'The therapeutic relationship: both the same and different' (Building a therapeutic relationship online is similar and a natural process; What about that 'felt-sense'?; Interpreting what is seen; Divided by the screen); 'The positives outweigh the negatives' (Attitude can change with experience; My style of working; Positive stories); 'Balancing the patients' needs with the practitioners' need' (Working with 'part', accessing the 'whole'; The patient is in control but I am still responsible; The emotional impact and support needs). Research questions are discussed within the context of the emerging themes below.

2.4.1. Development of a therapeutic relationship

Within the study, an emerging theme highlighted the developing therapeutic relationship via online treatment could be a natural process, similar to that found in direct face to face therapy. Although participants mostly all described an initial hesitation to the approach, many appeared pleasantly surprised. Similarly, Simpson and Reid (2014) in their systematic review also reported *"surprisingly homogenous"* self-reported therapeutic alliance ratings, which were roughly equivalent to face to face therapy. However, on deeper exploration of the language used, participant reflections of the process indicated a reconsideration and ambivalence appeared to emerge, emphasising this *"strange"* (Participant 2; 255) medium of working. Other participants emphasised an indescribable 'felt-sense' and recognition that one's interpretation was limited by the information being captured by the screen but also lacking a physical presence through a division of the screen. Simpson and Reid's (2014) review also suggests that therapists may not rate as highly as clients. This may reflect the studies included in Simpson and Reid's (2014) review and how therapeutic alliance is defined.

Traditionally an agreed definition of the concept of therapeutic alliance includes three main areas: affective bond/attachment between client and therapist; collaboration; and agreement on acceptable therapeutic tasks. However, participants in this study are describing factors that may not be quantifiable such as 'felt-sense', 'presence' and levels of interpretation – issues that are possibly associated and influence bond, collaboration and

agreed tasks. For example, participants still described an element of 'bond' in this study however lack of physical presence may influence effective collaboration and interpretation could affect agreement on acceptable tasks.

Rochlen et al (2004) recommend research investigates several critical phases, interventions, or processes of therapy which may be useful in exploring the therapeutic relationship further. Rochlen et al (2004) provide examples of areas to explore further such as therapist interpretation (Hoglend, 1996; Piper, Joyce, McCallum & Azim, 1993), self-disclosure (Edwards & Murdock, 1994; Knox, Hess, Petersen, & Hill, 1997), confrontation (Miller, Benefield, & Tonigan, 1993; Olson & Claiborn, 1990), compliance with homework assignments (Conoley, Padula, Payton, & Daniels, 1994; Mahrer, Gagnon, Fairweather, Boulet, & Herring, 1994), and countertransference and transference responses (Gelso, Hill, Mohr, Rochlen, & Zack, 1999). Research in these areas may help to break down an understanding of therapeutic alliance further. For example, exploring therapist interpretations and how they are different via online mediums such as videoconferencing may highlight similarities and differences, and the impact of patient self-disclosures and changes in therapist confrontation on the therapeutic relationship. Transference and countertransference may also link back to practitioners' feelings of 'something missing' and that felt-sense'.

Therapeutic 'Presence': Shepherd, Brown and Greaves (1972) further explore the role of being 'present' stating, to be fully present and fully human with another person is viewed as healing in itself. In psychotherapy the word 'presence' is suggested as essential for 'good' therapy and key in being an effective therapist (Bugental, 1987, Hycner, 1993; Hycner and Jacobs, 1985; May, 1958; Schneider and May, 1995; Shepherd *et al*., 1972; Webster, 1998). Hycner (1993) even suggests that even more important than the therapist's theoretical orientation is the availability and wholeness of the therapist's self. Rogers' person-centred approach (1957) asserts that the therapist's ability to be congruent, unconditionally positive, accepting and empathic was enough for psychotherapeutic change. However, in later writings he referred to a fourth condition (Rogers, 1980, p129 – This "*Characteristic"*) which can be referred to as 'presence' (Thorne, 1992).

It is interesting to consider how this issue of 'presence' is then affected within the online context. If 'presence' is key, it is likely linked with the development of the therapeutic relationship. Findings from this study highlight several areas where 'presence' may be lacking, for example, with lack of non-verbal information it is indeed difficult to interpret a situation entirely, anonymity and accessing part of the information rather than a whole

picture emphasises a lack of presence in online working for the client. Lack of presence is also emphasised through participant 1's description of a *"disembodied voice"* where the practitioner struggles to manage the room without physical presence and possibly how this may influence some practitioners' lack of 'felt-sense'.

Felt sense may arguably be a possible indicator of transference and countertransference. Jones (2004) defines transference as the 'unconscious transferring of experiences between one interpersonal situation to another'. As transference is also an individual subjective experience which is not necessarily equal in intensity and power across different practitioners, it can also be difficult to know the strength of the impact of physical presence with varying characteristics of practitioners and their matching clients. This is both difficult to measure, a possible additional qualitative component to what is quantitatively assessed through therapeutic alliance measures and so lacks research evidence. The online world therefore adds an additional factor of variability, which is hinted toward in the master theme 'The Therapeutic relationship: both the same and different; and particularly sub-themes such as 'felt-sense'.

2.4.2. Participant Attitude

Individual interviews brought about perspectives of online treatment that encompassed factors affecting attitude including areas relating to their past experience, openness in trying online treatment and the impact of positive experiences/hearing positive feedback from clients. Practitioners needed to initially be open to attempting to provide online treatment, even with some uncertainty. This fits with other research, similarly finding initial ambivalent attitudes amongst professionals toward online psychological support. However, professionals who had experienced online treatments displayed a more positive attitude (Chęć et al, 2016; Cipolletta & Mocellin, 2016). All practitioners recognised the benefits and all but one practitioner (participant 6) considered continuing to provide online treatment in the future. Participants were also more likely to be encouraged to continue providing treatment online, if the experience 'fit with their style' of working. Some participants, identifying themselves as Clinical Psychologists recognised a mismatch with their training and style of working.

Hill and Williams (2000) label client and therapist attitudes, demographics and expectations as 'Input Variables'. Past debate on the perceptions of online treatment (Barak, 1999; King & Moreggi, 1998; Murphy & Mitchell, 1998; Tait, 1999), indicate a need for researchers to initiate empirically based measures of general attitudes and perceptions related to online treatment. Research addressing attitudes toward online treatments can

provide pertinent information regarding the population traits of those utilizing this particular form of treatment. Further exploration of the implications of online treatments on the role of the Clinical Psychologist, other professions and experienced, but non-professions may be useful in the future. For example Rochlen, Zack and Speyer (2004) suggest further research efforts could address how online therapy is evaluated when conducted by therapists with different training levels and theoretical orientations. They propose it is possible that therapists who adhere to more structured theoretical orientations (e.g. solution-focused therapy, Rational Emotive Behavioural Therapy (REBT), etc.) conduct online therapy with greater ease; contrasted with therapists who adhere to models placing a greater emphasis on interpersonal dynamics of the face-to-face interaction (e.g., psychoanalytic approaches).

2.4.3. Working with multiple individuals within session via the online medium

Participants who had experienced working with more than one person in the room agreed that it was harder to carry out in an online environment. This is particularly demonstrated in the subtheme "Working with 'part', accessing the 'whole'", where participants attempted to gain access to the whole family however described an evolving set up where clients controlled whether or not they were seen or whether they decided to contribute. Fostering and maintaining alliances with each individual thus becomes an added challenge and it is easier for clients to disengage through their lack of presence.

It is debatable whether online treatments for families is able to create the same 'safe' environment as in face-to-face treatment to enable individuals to explore painful subjects (Friedlander et al, 2006). However, videoconferencing may provide opportunity to gain access to 'natural' family behaviour within the home environment, there is very little (if any) research exploring the therapeutic alliance in family treatments and no research focusing on the online context. There is definite scope in developing an understanding further in this area and exploring the role practitioners play in developing therapeutic relationships both in-person and via online treatment.

2.4.4. The Practitioners' internal conflict

A unique aspect of this study was the authors' journey with practitioners' internal exploration of their experiences throughout the interview process. The analyser was able to join with the participant as they voyaged through a 'to-ing and fro-ing' between the drawbacks and benefits of online treatment, initially moving from advantages to ambivalence; maintaining a 'patient centred' perspective and then realising the emotional needs of the self.

Benefits of online treatment were triggered by an altruistic and apparent professional responsibility and need to hold the client in mind. A final issue emerging from this study, was the maximising of benefit to client and minimising of practitioner's own needs. Prioritising client's own needs are common in the caring profession (Figley, 2002) however often less focused on but equally important are the self-care needs of the practitioner. Indeed Figley (2002) describes "*Psychotherapists who work with the chronic illness tend to disregard their own self-care needs when focusing on the needs of clients*"- stating this in the context of Compassion Fatigue (CF). This is most emphasised in the subtheme 'the positives outweigh the negatives' with quotes such as Participant 3's "*And, maybe it does take more out of me, but, for me, the benefits outweigh that. So, I don't mind"* (355-356) highlighting a disregard of her own self-care needs despite the medium potentially adding an extra layer of difficulty or challenge.

Negash and Sahin (2011) discuss some of the clinical implications of compassion fatigue, particularly in relation to working with families and the impact on the therapeutic relationship. They highlight areas affected such as: Emotional Exhaustion; Loss of Empathy; Depersonalisation; Loss of Respect; and Ethical, Clinical and Legal implications. Lack of awareness, adequate support and management of practitioner's self-care needs may exacerbate factors affected by CF e.g. affecting empathy and depersonalisation, areas which may already be additionally challenging in the online context due to lack of visual and non-verbal cues of some family members and only accessing 'part' of a person.

2.4.5. Strengths, Limitations and Future Research

This study emphasises the role of the practitioner, focusing in on 'the particular' in their experience facilitating online treatments. Participant numbers were small, thus generalisation of the results must be viewed with caution. However, a focus on the treatments provided by the investigated small company enabled in depth exploration and new thoughts on emerging data. Participants were also self-selecting and recruited from a company that only provided online treatments; therefore participants were more likely to be willing to provide online treatments which will also reflect their openness and attitude toward online therapies. Recruiting from one company meant that participant perspectives of online treatment were restricted to the specific technology used and context of the company they were recruited from. It also meant that participants may have been more aware of disclosing information during interviews as they may have been more anxious about confidentiality and anonymity. Some participants also continued to talk after the

audio recording had been stopped and information not recorded in transcripts may have had an influence on analysis and thoughts of the researcher.

Research in attitudes and behaviour toward online treatment still requires further research. Even within those who are willing to try online treatment, there is still hesitation when starting out. Additionally with more options available for a range of treatments for clients, health care services are still catching up, leaving mostly private companies to innovate online treatments and technology. The impact of the online environment on the therapeutic relationship has not yet been exhausted. Further in depth process research is required to explore the critical phases of therapy. For example exploring how the relationship is similar or different to face to face working and how practitioners can best work to enhance the relationship within the online context where lack of physical presence can be challenging. This study highlighted some concern around too much flexibility and raised issues concerning the boundaries of therapeutic sessions. It may be useful to explore how the shift in boundaries and control in the therapeutic environment affect success in treatment and how easily practitioners emotionally adapt to this shift, where the rules of treatment may be different.

Practitioners in this study also varied in experience and qualification, those qualified as Clinical Psychologists identified a limitation in their ability to freely work within their 'style', this may be due to the identified role of a Clinical Psychologist, however it may also highlight restrictions in the form of treatment or a mismatch with clinician working style. Further research exploring practitioner theoretical orientations, level of training and match with the online form of treatment may also be helpful to be able to select practitioners who will be best suited for this medium of work and optimise use of skills brought by specific professional roles.

Finally this study recognises the paucity of research exploring therapeutic relationships within family focused treatments but also recognises the potential role for online treatment to involve carers and family members within the system of the referred individual. Treatment is brought into the home environment through the medium of the internet and providing wide access to different localities. Family treatments can capitalise on this innovative way of working however, empirical evidenced research also needs to catch up.

2.4.6. Recommendations for Practitioners Providing Treatment via the Internet

From this study some recommendations can be made for practitioners and services continuing to provide treatment via the internet:

- Training needs: This study highlights both the need for household technology to improve to be able to access online treatment to full effect. They also emphasise the need for practitioners to be adequately trained to be able to manage the technology being used and to be confident in supporting clients to use the technology.
- Supervision: There is a need for regular specialist provision of supervision within all areas of working directly with clients. Supervision can help practitioners recognise and reflect on issues of responsibility (particularly within risk situations), transference and self-care needs.
- Reflection of the process: Following semi-structured interviews for this study, several participants reported that the process was interesting and helped them to think through more specifically about the process of providing treatment online. Time given specifically toward reflection of the process itself, enabled participants to consider the benefits of online treatment as well as enabling practitioners to consider personal needs and self-care aspects. A heightened awareness of own needs is more likely to help practitioners manage and prevent CF. For example, through the use of regular reflective practice and mindfulness skills (Raab, 2014; Pfifferling & Gilley, 2000).
- Peer support: This study also highlighted that isolated working can come alongside the flexibility of remote working. Local networks and knowledge of who may be working locally can provide opportunity for peer support/supervision groups where practitioners can meet up with others who provide online treatments.
- Risk: The company provided good guidelines and structure for managing crisis and risk situations however working in an online context might require additional support and training during and following risk situations. Although procedures are followed by practitioners, they continued to highlight feelings of helplessness and need for debrief with supervisors and peers immediately following the risky event. Home/remote working improves accessibility and convenience however is also likely to increase practitioners' feelings of isolated working, lack of support and helplessness. Local networks and peer support might also help with this and

companies providing online treatment can place structures to help manage these situations

- Boundaries: A number of practitioners highlighted the advantages that come with online treatments such as accessibility and flexibility. Practitioners also indicated how this may come with a cost, impacting the unspoken 'traditional rules' of face to face therapy and thus stretching personal boundaries of practitioners e.g. flexibility of working hours. One practitioner also noted the impact of modelling time management and daily routines with patients (particularly for children). This is a strong consideration for both the welfare of practitioners and patients with pushing the boundaries and rules of therapy for any provider of online treatment. Ground rules of online working may be useful to build into contracts for online work, which can be developed with patients, setting a standard for the online therapeutic context.

2.4.7. Conclusion

This study highlights the importance of input variables (Hill & Williams, 2000) such as attitude, experience and style of working. It focuses on the therapeutic alliance and critical phases/skills in the process of treatment such as therapist interpretation and the potential impact of presence on transference. The study also highlights the potential for family based treatments through online treatments. Practitioners interviewed for this study conveyed overall positive attitudes and experiences of providing treatment via the medium of the internet. All practitioners valued the benefits to the client and their families, with many additional advantages of remote and flexible working which can support both the needs of the client and the practitioner. Practitioners highlighted the benefits of access, and the ability to provide a comfortable therapeutic environment for clients to feel safe to disclose personal information. On further reflection throughout the interview process, practitioners also considered some of the difficulties, noting the challenges of engaging a full picture of the 'whole' family and at times even the client who was not willing to be 'seen'. Practitioners were able to develop strong relationships with clients despite sometimes limited or restricted visual information. However, there was sometimes the impression that something was missing. An aspect emerging from this study was practitioner self-care, and their ability to minimise their needs against their view of the clients need. With ongoing possibilities for the growth of online treatments, a more balanced and effective way to support clients in the longer term will be to consider the needs of the practitioner, therefore maximising the consequential care of the client. Developing services providing online

treatments have an opportunity to establish supportive environments and healthy practice for practitioners working with clients with complex mental health difficulties via the internet.

Appendices

Appendix A: Quality Assessment Review

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
Was there a clear statement of the aims of the research What was the goal of the research? Why it was thought important? it's relevance										
OUTCOME	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
Is a qualitative methodology appropriate? If the research seeks to interpret or illuminate the actions and/or subjective experience of research participants Is qualitative research the right methodology for addressing the research goal?										
OUTCOME	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
Was the research design appropriate to address the aims of the research? If the researcher has justified the research design e.g. discussed how they decided which method to use?	**MAYBE/ CAN'T TELL**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**NO**	**YES**	**YES**
OUTCOME	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**NO**	**YES**	**YES**
Was the recruitment strategy appropriate to the aims of the research? If the researcher has explained how the participants	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**NO**	**YES**	**YES**	**YES**

were selected										
If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
If there are any discussions around recruitment e.g. why some people chose not to take part	**NO**	**NO**	**NO**	**YES**	**NO**	**NO**	**NO**	**NO**	**NO**	**YES**
OUTCOME	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**MAYBE/ CAN'T TELL**	**YES**	**YES**	**YES**
Was the data collected in a way that addressed the research issue?										
If the setting for data collection was justified	**NO**	**NO**	**NO**	**YES**	**NO**	**YES**	**NO**	**NO**	**NO**	**YES**
If it is clear how data were collected e.g. focus group, semi-structured interview etc	**MAYBE/ CAN'T TELL**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
If the researcher has justified the methods chosen	**NO**	**YES**	**YES**	**YES**	**YES**	**YES**	**MAYBE/ CAN'T TELL**	**NO**	**YES**	**YES**
If the researcher has made the methods explicit e.g. for interview method, is there an indication of how interviews were conducted or did they use a topic guide?	**MAYBE/ CAN'T TELL**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
If methods were modified during the study, If so has the researcher explained how and why?	**MAYBE/ CAN'T TELL**	**NO**	**YES**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**

If the form of data is clear e.g. tape recordings, video material, notes etc	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
If the researcher has discussed saturation of data	**YES**	**NO**	**NO**	**YES**	**NO**	**NO**	**NO**	**NO**	**YES**	**YES**
OUTCOME	**MAYBE/ CAN'T TELL**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**MAYBE/ CAN'T TELL**	**YES**	**YES**
Has the relationship between researcher and participants been adequately considered?										
If the researcher critically examined their own role, potential bias and influence during:	**NO**	**NO**	**NO**	**NO**	**NO**	**YES**	**NO**	**NO**	**NO**	**YES**
formulation of research questions	**NO**	**NO**	**NO**	**NO**	**NO**	**YES**	**NO**	**NO**	**NO**	**YES**
data collection, including sample recruitment and choice of location	**NO**	**NO**	**NO**	**NO**	**NO**	**YES**	**NO**	**NO**	**NO**	**YES**
How the researcher responded to events during the study and whether they considered the implications of any changes in the research design	**NO**	**NO**	**YES**	**NO**	**NO**	**YES**	**NO**	**NO**	**NO**	**NO**
OUTCOME	**NO**	**NO**	**NO**	**NO**	**NO**	**YES**	**MAYBE/ CAN'T TELL**	**NO**	**NO**	**YES**
Have ethical issues been taken into consideration?										
Consider if there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained	**NO**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
If the researcher has discussed issues raised by the study e.g. issues around informed consent or	**NO**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**

confidentiality or how they have handled the effects of the study on participants during and after the study										
If approval has been sought from ethics committee	**NO**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
OUTCOME	**NO**	**YES**	**MAYBE/ CAN'T TELL**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
Was the data analysis sufficiently rigorous?										
Consider if there is an in-depth description of the analysis process	**YES**	**YES**	**YES**	**MAYBE/ CAN'T TELL**	**YES**	**YES**	**NO**	**MAYBE/ CAN'T TELL**	**YES**	**YES**
If thematic analysis is used, if so, is it clear how the categories/themes were derived from the data?	**YES**	**YES**	**NO**	**NO**	**YES**	**NO**	**NO**	**NO**	**NO**	**YES**
Whether the researcher explained how the data presented were selected from the original sample to demonstrate the analysis process	**YES**	**NO**	**YES**	**YES**	**YES**	**YES**	**NO**	**NO**	**YES**	**YES**
If sufficient data are presented to support the findings	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
To what extend contradictory data are taken into account	**MAYBE/ CAN'T TELL**	**MAYBE/ CAN'T TELL**	**MAYBE/ CAN'T TELL**	**MAYBE/ CAN'T TELL**	**MAYBE/ CAN'T TELL**	**MAYBE/ CAN'T TELL**	**YES**	**NO**	**MAYBE/ CAN'T TELL**	**MAYBE/ CAN'T TELL**
Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation	**NO**	**NO**	**NO**	**NO**	**NO**	**YES**	**NO**	**NO**	**NO**	**YES**
OUTCOME	**YES**	**MAYBE/ CAN'T TELL**	**MAYBE/ CAN'T TELL**	**MAYBE/ CAN'T TELL**	**YES**	**YES**	**YES**	**NO**	**MAYBE/ CAN'T TELL**	**YES**

Is there a clear statement of findings?										
Consider if the findings are explicit	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
If there is adequate discussion of the evidence both for and against the researchers arguments	**YES**	**YES**	**MAYBE/ CAN'T TELL**	**YES**	**MAYBE/ CAN'T TELL**	**YES**	**MAYBE/ CAN'T TELL**	**YES**	**YES**	**YES**
If the researcher has discussed the credibility of their findings e.g. triangulation, respondent validation, more than one analyst	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**NO**	**YES**	**YES**	**YES**
If the findings are discussed in relation to the original research question	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
OUTCOME	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**MAYBE/ CAN'T TELL**	**YES**	**YES**	**YES**
How valuable is the research?										
Consider if the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy? Or relevant research-based literature?	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
OUTCOME	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
OVERALL OUTCOME	**7/10**	**8/10**	**7/10**	**8/10**	**9/10**	**10/10**	**7/10**	**6/10**	**8/10**	**10/10**

Appendix B: Themes, Sub-themes and related Quotes

Themes and Subthemes	Quotations from participants in primary studies	Interpretations of findings offered by authors
	1. Type of therapy/Form of treatment	
	Definition:	
	- Whether the therapy is via email or videoconferencing	
	- Whether or not the approach is manualised.	
• Structure and safety of standardised manual approach	"The manual is clearer and easier to follow (…) You focus on what you really have agreed to focus on" *[1]*	"Having the treatment material and communication fixed in writing seemed to make it clearer and more available for both the therapist and the client. The manual was also seen as a safety measure for the therapists, and made them feel secure and believe in the treatment and that they provided evidence-based material that would yield results" *[1]*
	"When you work with complete treatment packages (in	"The manual also made the therapy difficult to adapt to the

	ICBT), then it becomes a little bit 'one size fits all'. Then it does not fit anyone really well." *[1]*	individual. However, some argued that they had the opportunity to adapt their answers and interventions to the client even via the Internet." *[1]*
• The Power of the written word	"the ability [of the client] to re-read what one has written and come back to it in the future in moments of upset or discontent" *[3]* "I have worked with clients who would not have been able to voice their issue face-to-face but can write it down when there is not someone looking at them." *[6]* "I generally look forward to reading a response in a different way to the anticipation I feel before a client arrives in my room. I think this is because I feel under less	"Many participants particularly valued the written communication and discussed its unique benefit" *[3]* "The image of the confessional is striking and suggests that shame and fear of judgement were mitigated (for this client) by the presence of the computer." *[6]* "The asynchronous delivery of email counselling emerged as a critical feature. Having 'time to think' was discussed widely and in detail. It helped clients to feel that they presented themselves

	pressure to respond in the moment" *[6]* "I read (the email) from beginning to end to get an overall picture of the client's issues. I will read twice or three times, and while reading, I will highlight important points" *[10]*	authentically" *[6]* "This extended reading was possible, according to most of the participants, because the nature of the email mode allows for the delayed response" *[10]*
	A **-** Interaction between Type of therapy/Form of treatment and Modality of treatment	
• Individualized online interaction with standardized programme	"…if the doctor could tailor the treatment a little and if it were based on a shared model of decision-making, with a certain proximity between the professional and the patient" *[4]*	"If these forms of individualised interaction, associated with the processes for standardisation of the program, created expectations of a therapeutic experience based on trust and on presence, the discourse would pave the way to hope, which could lead to positive attitudes once again linked to acceptance as a necessary condition for engagement with the therapeutic process." *[4]*

2. Modality of Treatment *Definition:* - Factors that are influenced by the form of treatment being online - Uniqueness of online treatment		
• Practical aspects of modality – the pros and cons	"There is great room to individualise each treatment (in face-to-face), and that does not exist in internet therapy in the same way (…) Uh, so that you can really bury yourself in a case and think a little more and, uh, shape it after a specific patient. And it does not have to be diagnose-specific either. It can be like…yes, compulsion or depression in a mix, like that" *[1]*	(in face-to-face) "They describe it as having more "tools" to work with meaning the direct feedback, the option to ask direct follow-up questions, body language, voice and tone as well as subconscious communication." *[1]*
	"The world has gone technology mad in a short period of time and as humans we often jump on band wagons…and so that concerns me that technology seems to be driving so much in our world and we (have) almost lost control of	"Participants were uncomfortable with the idea that technology could be an effective medium for online communication. The belief that the digital world was different from the 'real world' was evident.."

	this technology demon" *[2]*	*[2]*
	"…The computer is the tool that provides access to the most updated, complete, and verified information, depending on the platforms you consult. It's an important tool for both receiving and conveying information. " *[4]*	"The general acceptance of Web-based psychotherapy for depression depended on prior conditions, such as the inclination to use new technologies" *[4]*
	"If a client is upset…They may say something like I'm crying, but with body language and personal contact, you can see to what extent that crying is. When they say they are crying they could just have tears running down their face or they could be fully sobbing. So, that's difficult to evaluate, things like that." *[7]*	"A further sub-theme identified was how it would be harder to build trust online because of certain difficulties and limitations inherent to the online medium. The lack of cues and methods specific to a face-to face context was commented on by all interviewees. Many interviewees felt that this made understanding the client harder and that this in turn could impact on the development of trust." *[7]*
	"At first it felt very formal and mechanical because we	"Therapists described technological challenges in working online,

	were all so focused on the technical aspects of the group process. As time went on and everyone became more efficient with the system it became easier" *[8]*	in particular dealing with technological glitches (e.g. seeing the members but not hearing them, not seeing them at all)….dealing with technological glitches at any stage of group process was at times frustrating and required social workers' intervention" *[8]*
• Communicating online - Fluidity and Structure	"I think time wise as well, so you've got probably an hour to chat with someone and online what you do face to face in an hour you might do 15 minutes worth online. It's really difficult to kind of get that flow sometimes." *[5]*	"Time appeared as a significant issue for all participants, as working online via text was noted to be considerably slower than talking in person… This could leave participants feeling like the flow of their sessions was disjointed and the manner in which they collected information was "sporadic" *[5]*
	[online group working] "I found that taking turns in online group communication sessions kept an even flow with communication because speakers could not be interrupted, this also kept group members on topic, whereas in face-to-face groups there may be interruptions of people may get off topic"	The therapists surveyed also spoke of delays in communication sequence, reduced spontaneity, fewer body cues, and not being able to view all group members at the same time." *[8]*

	"The effect of the feedback might have been lost as one member had to wait their turn to offer the feedback; by the time feedback was offered the 'moment' might have past" *[8]*	
	[structuring email schedules] "I have already informed him/her within a week. If he/she didn't reply, he/she may not agree…[]…But, we have decided to respond within a week" *[10]*	"The interviewees discussed the following types of structuring: (i) structuring via the Web site and email, (ii) structuring the concept and services content, (iii) structuring the email counselling schedules, and (iv) structuring in situations of crisis. *[10]*
• Social Norms and Genuineness	"it's an opportunity for them to adopt another persona so they can become someone else" *[2]*	"…the concern that the process may be uncontrollable, some counsellors believed that students would be dishonest online" *[2]*
	"…In a face to face situation, if the client doesn't trust you or loses trust in you, then its still quite unlikely they would walk out. They would be more reserved, but, I	"Online therapist may feel reassured that there is a trusting relationship only by virtue of the fact that their clients remain online. This is related to their experience that it is obviously much

	don't think I have ever had a face to face client walk out. Online, it's easier for the client to withdraw from the relationship and they can do that literally by pulling the plug, leaving the session or, changing their email address." *[7]*	easier for online clients than for clients in a face-to-face context to express their mistrust or discomfort with the therapeutic relationship and to interrupt or terminate the therapeutic contact." *[7]*
	B -Interaction between Modality of treatment and Factors therapist brings	
• Modality and the impact on therapeutic relationship	"I actually see this is just another nail that we're going to put in the coffin of the development of our young people and actually the skills needed to have real interpersonal relationships with their peers, with parents, with colleagues and with teachers" *[2]*	"There was a fear that relying on the online interaction may make young people less able to conduct 'real' communication. One person saw the offering of online counselling as further evidence that it encouraged young people to avoid 'real relationships in the world' and hindered the development of essential interpersonal skills." *[2]*
	"I think it helped to enhance the therapeutic relationship	"Cyber counselling facilitated a positive relationship between the

	because in the email there are some things that are very personal that maybe would not have come up in face-to-face" *[3]*	intern and client" *[3]*
	"What I think may be happening though is that people engage more readily with these deep…feelings that perhaps in other circumstances they were very ashamed and they were avoiding talking about it in therapy. It's more difficult to avoid online because online is very focussed" *[7]*	Most interviewees commented how the action of typing had an effect on the relationship formed between counsellor and client. One aspect mentioned in this context was that through the process of typing, the typist was engaged with their thoughts and feelings in a way that was unique to the method of communication *[7]*
• Anonymity and Control	"A major strength of working online is just the anonymity of the medium which allows freer disclosure from young people, more honest type sharing, of course bringing the challenge of when they are more open as well with their aggression, their frustration."	"The focus group agreed that the sense of anonymity and control that clients attained through the online medium allowed them to act in a more disinhibited fashion. Participants from two groups noted that this extended to clients being more likely to act aggressively online – for example, by swearing at clinicians. Clients

	[5]	were perceived to have more control within the online compared to a face-to-face therapy environment, being able to sign in or leave and share or withhold information at their discretion. *[5]*
"I worked with one client online who I had initially worked with for a year face-to-face. She had experienced a terrible ordeal and was severely traumatised. Throughout the year we worked face-to-face she found it excruciatingly difficult to speak about what had happened to her but also felt a strong need to talk about it. When we began to offer online counselling I offered her the chance to use it and she leapt at the opportunity. She had another year of online counselling and was able to speak fully about what had happened and she made a lot of progress during that year." *[6]*		"For many, the perceived positions of counsellor and client at the start of the relationship, in terms of autonomy, power and locus of control, were crucial. This was linked to a fear of feeling disadvantaged or disempowered by a face-to-face relationship with a professional." *[6]*

	"…I think a lot of the time people are quite embarrassed by particular things and I think they feel kind of guilty for feeling that way, and sometimes when you sit there face to face with somebody..It's quite difficult. Whereas online, they are not seeing you, they are never likely to see you, they can just come out with anything" *[7]*	"The experience described here is aligned with observations from practitioners that clients are more direct and divulge problems very quickly in this medium. Stigmatised problems like depression, eating disorders and self-harming behaviour appear to be disclosed more frequently online than in face-to-face counselling. It is possible that for many clients online counselling and therapy is the place where they share an experienced trauma with others for the first time (Vossler & Hanley, 2008)" *[7]*
3. Therapist related factors - Elements brought by individual facilitating online treatment		
• Therapeutic Alliance	"It becomes another, yes, it becomes like another type of alliance, but at the same time it becomes a different alliance. It might be equally good, but it is not really the same" *[1]*	"opinions on whether the quality of the working alliance in both forms of therapy could be compared were diverse. Several stated that the two media were different in this respect. Some argued that the working alliance usually was "stronger" and "richer" in face-to-face therapy. However, most of them still maintained that

	this did not make the ICBT working alliance inferior" *[1]*
"There may be some truth…in the maxum, the eyes, the window of the soul, when you're looking at a person you begin to pick up the authenticity of the issues perhaps" *[2]*	"The online relationship was regarded as somehow not as genuine and therefore not suitable for a counselling intervention." *[2]*
"even if you talk about something funny in the email, you're not laughing together or you're not crying together. So you don't share that connection" *[3]*	"Some challenges in conveying emotion identified by the interns included not seeing or capturing clients' subtle nonverbal communications." *[3]*
"Trust and acceptance comes as they reveal more and more sensitive information about themselves" *[6]*	"Mutuality, collaboration and trust featured prominently in participant's descriptions of their experiences of online relationships." *[6]*
"It can be, sometimes easier than trust in a face to face scenario because of trusting yourself and trusting the other person. Whereas face to face, an unknown journey	"..linked with the phenomenon of 'immediacy' of trust is the therapists trust in self and the 'leap of faith' they described when working online."

	with an unknown other person. Whereas face to face, you have got different clues or cues rather from the physical appearance and the way someone talks and their accent and erm the words they choose etc. Whereas of course you haven't got that online" *[7]*	*[7]*
	"After the first 3-4 meetings I would judge my relationship and comfort level to be the same as in a face-to-face group setting " *[8]*	"Therapists frequently spoke about observations of group bonding despite the initial technology challenges" *[8]*
	"once we have chosen to become online counsellors, we need to devote time (to our clients) as they (the clients) had put their trust in us, and this became an opportunity for us to communicate with them (clients)." *[10]*	"The theme emerged as the participants spoke during the interviews and used phrases in their journals such as the feeling of being in a relationship, listening, acceptance, empathy, trust, intimacy, and other related terms.." *[10]*
• Responsibility	"There is more focus on me, that is also…uh, could	"Several therapists discussed how ICBT gives the clients more of

	actually be a disadvantage in live-therapy, that there is less focus on the therapy. Progress is also attributed more to me as therapist than to the therapy itself and what the patient does." *[1]*	the responsibilities for their own treatment. This seemed to coincide with a larger focus being brought onto the therapists' work in the face-to-face therapy. The increased focus on the therapist could make them feel "helpful" and better about their work." *[1]*
	"I mean imagine if you were counselling a child and they said that they were going to kill themselves; I mean that's the worst possible case scenario and you…did everything that you could do and then it happened anyway, you'd be screwed. You know what I mean? It's sort of scary isn't it?" *[2]*	"The counsellors cited the scenario of an online client who is at risk of harm and where there is no way to identify and support them. The fear of being the person responsible for not providing assistance to a student in danger was cited a number of times in the groups. *[2]*
	"It's a kind of tolerance that builds up to being able to say I cannot – you know, I can't control what's happening, I can't rescue you. I have to equip you as much – you know, you can try link people in but you can't even	"The participants appeared to be quite concerned about how to manage client risk, both in terms of providing support to the clients and coping with the feelings of helplessness engendered by the online environment."

	necessarily get permission to do that a lot of the time so you can get very stuck and you have kind of be able to sit in that a lot and just say I'm going to be okay if I can't put everything to bed at night and make sure everyone is safe." *[5]*	*[5]*
	"..I have some concerns over people who will only work in an online capacity, because I wonder if that is about them..kind of almost like hiding behind the computer..It's faceless. They can preserve their own anonymity and I guess they can't necessarily be judged. And I wonder if that is a good thing". *[7]*	"However, the anonymity of the therapist also has the potential to raise concerns regarding the accountability of online therapists, which refers to the theme of safety in an online environment." *[7]*
• Therapist skills	"There is a whole lot…that personally would overwhelm me." *[2]*	This criticism of technology resulted in the admission by some focus group participants that they lacked the necessary online counselling skills to conduct online school counselling. This lack of

		skills was the second major theme. *[2]*
	“Not all of us have the same technological know-how or motivation. Should all doctors use the tool or only the most qualified? Those of us who volunteer to participate could be released from our routine workload to devote ourselves more specifically to this matter”. *[4]*	“The physicians centred their interest on the professionals involved, with the concern of whether this type of intervention would improve the current delivery of healthcare, but at the cost of increasing their already excessive workload.” *[4]*
	“Validation of their emotions, and their circumstances, can be quite a significant contribution to their situation even if it doesn’t feel like you’ve given them a kind of therapeutic program” *[5]*	“The participants agreed that being able to engage a client and make them feel validated was a key skill for working online” *[5]*
	“As I got more confident in working with the transference online, I’ve come to realise that such disturbances in the transference could just become part of the work.”	“(participant), who had been working for less time online, shared these views but described a gradual shift as her experience grew” *[6]*

	[6]	
	"I like working with those, those facets of netiket (sic)…it makes the work a lot easier for me being in tune with the client at any given point. Whether they are sad, whether they can smile at something. Same for acronyms,…if they joke, put LOL (laugh out loud) then I can trust that they are laughing."	"Interviewees also described ways and techniques which could help to establish an effective and trusting therapeutic relationship even in the absence of cues and factors pertinent to the face-to-face environment. Acronyms and abbreviations for example were considered as alternative ways of conveying emotions"
	[7]	*[7]*
	"The main shifts related to the technical transitions, such as not getting to see all the group members' responses. This often required more clarification of the meaning of the words used in the context of the group discussion by members."	"Other therapists focused on the adjustment involved in group facilitation and the compensatory skill involved in online virtual communication that required additional clarification of meanings."
	[8]	*[8]*
	"paying attention to writing, content, language, writing style, repeated sentences, and the consistency of the	"The participants used various techniques in writing email texts to draw the attention of their clients to a specific issue of topic. The

	writing” *[10]*	techniques that they used included various language styles, the repetition of phrases, different text colours, and emoticons.” *[10]*
	C	
	- Interaction between Factors therapist brings and Type of therapy/Form of Treatment	
• Applicability of therapeutic style e.g. behavioural model vs doctor-patient relationship model	“In our speciality, we refer to those of a cognitive behavioural model. Other more introspective or psychodynamic models revolve around the doctor-patient relationship, which cannot be applied using technology” *[4]*	“The necessary processes for standardisation were associated with the idea of specific forms of interaction between participants and the program. This idea of interaction combined subtopics such as “feeling of security”, “program universality”, “possibilities for expression”, “supervision by a therapist”, and “individualised attention for patients”. *[4]*
	4. Systemic Issues	
	- Influences of the wider system	
• Efficacy, Effectiveness and Professional Issues	“The design is relatively simple to imagine, but it means a change to our routine practice. How long will it take to	“More specifically, the physicians centred their interest on the professionals involved, with the concern of whether this type of

	train us to use and implement this programme? Would we be released from our clinical practice for that time?" *[4]*	intervention could improve the current delivery of healthcare, but at the cost of increasing their already excessive workload" *[4]*
	"The members did not have to leave their spouse, the care recipients. All they had to do was turn-on their computers and log on. You could see the potential for people who are shut-ins, have time constraints, or live in remote areas" *[8]*	"several therapists appreciated the fact that through the use of technology they were able to provide accessible health care services to aging and/or isolated groups of caregivers. *[8]*
	"I think it's useful to have evidence that it does actually make a difference. Also that there's no evidence of harm or risk" *[9]*	"Most professionals were aware that CBT was recommended, widely promoted, and used for common mental health conditions but GPs wanted firm evidence of effectiveness of CCBT-I to have confidence to refer their patients" *[9]*

Appendix C: Participant Information Sheet

Participant Information Sheet

(Version: 1 ; date: 24/10/17)

Study title: Exploring practitioner perspectives of facilitating an online intervention for individuals, families and carers of an individual with mental health problems.

Researchers' names: Davina Wong

Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

The overall aim of the study is to explore therapist practitioner experiences of providing an online intervention with individuals, families and carers of individuals with mental health problems. The study was developed in collaboration with the University of Southampton and XXX. It will involve completing an interview which will take up to 90 minutes, during which, questions will be asked relating to your understanding and experiences of providing the intervention.

Why have I been chosen?

You have been chosen because you are a therapist practitioner within XXX and practitioner experiences within therapy are considered a key factor within the treatment process. It is therefore important to explore your experiences of delivering an online intervention with a range of types of client.

What will happen to me if I take part?

You will take part in a single interview (which can be held face to face or over the telephone) with a researcher about the topic described above. This interview will take up to 90 minutes. The interview will be audio-recorded and transcribed with all identifiable information anonymised at the transcription phase.

Are there any benefits in my taking part?

Taking part in this study may help to develop and support the evidence base for providing family/carer intervention online, whilst also highlighting the key role of the therapist practitioner. It may also help develop understanding around the mechanisms for change within the family receiving treatment.

Are there any risks involved?

There are no direct risks to taking part in the study. However, the interview may discuss some sensitive issues. If you feel that during the interview you become very upset and do not want to continue, you have the right to withdraw from the interview process at any point without explanation.

Will my participation be confidential?

The audio-recording of your interview will be transcribed and then deleted from the device as soon as possible. During transcription any identifiable information will be removed.

What happens if I change my mind?

You have the right to withdraw any information you have provided up until the 31st January 2018 and this will not have an impact on your continuing work/patient care. Following the 31st January 2018 it will not be possible to withdraw your data.

What happens if something goes wrong?

If you have any questions regarding the conduct of the study, you should contact either XXXXXXX or XXXXXX or the Chair of the Faculty of Social and Human Sciences Ethics Committee at Southampton University (fshs-rso@soton.ac.uk).

Appendix D: Consent Form

CONSENT FORM ((Version: 1 ; date: 24/10/17)

Study title: **Exploring practitioner perspectives of facilitating an online intervention for individuals, families and carers of an individual with mental health problems.**

Researchers' names: XXXX

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet (date 24/10/17/version 1) and have had the opportunity to ask questions about the study. ☐

I agree to take part in this research project and agree for my data to be used for the purpose of this study. ☐

I understand my participation is voluntary and I may withdraw at any time up until the 31st January 2018 this will not have an impact on my continuing work/patient care. Following the 31st January 2018 it will not be possible to withdraw your data. ☐

I agree that the interview will be audio-recorded and that the researcher can use anonymous quotes from my interview when reporting the study. ☐

Name of participant (print name)……

Signature of participant……..

Date……

Appendix E: Interview Schedule

Interview Schedule

(Version: 1 ; date: 24/10/17)

Exploring practitioner perspectives of facilitating an online intervention for individuals, families and carers of an individual with mental health problems.

Introduction: Thank you for consenting to take part in this study. The overall aim is to explore therapist practitioner experiences of providing an online intervention and its impact on developing therapeutic alliances with individuals, families and carers. The study was developed in collaboration with the University of Southampton and XXX.

This interview will take up to 90 minutes, during which questions will be asked relating to your understanding and experiences of providing an online intervention built on components of family therapy. Please try to answer questions as honestly and openly as possible. You are free to stop the interview at any point and/or withdraw from the study at any point during the interview. The interview will be audio recorded and once the interview has been completed, audio recordings from the interview will be transcribed and made anonymous in the process. You will have the right to withdraw any data you have provided until the 31st January 2018.

Please feel free to inform me if you require any breaks or have any questions.

Question	Notes from Interview
General questions 1. How long have you been working for XXX for? a. Which projects for XXX do you provide therapeutic interventions with? b. Have you worked as a therapist practitioner previously? i. What type of interventions did you provide previously	

(e.g. face to face, individual/family)	
2. How have you experienced developing a therapeutic relationship with your clients? (in general) a. What have been easy or difficult in the process of developing therapeutic relationships?	
3. More specific to facilitating an online intervention; what has been your experience of developing a therapeutic relationship with your clients when the intervention has been held over the internet using technology? a. What is your opinion/attitude toward the ability to develop a therapeutic relationship via online treatment? b. Are there any differences between face to face interventions? If so, what are these? c. Are there any similarities? d. Have you had to make any adjustments to your working style? e. What is easy or a challenge?	
4. If you have had experiences working with individuals and with more than one person in therapy (conjoint therapy); what differences have you found? a. Are there specific challenges that come with one or the other in developing a therapeutic relationship? b. How does the online/ technology	

aspect affect your work with individual vs conjoint sessions when developing therapeutic alliances? c. Have you had to make adjustments to your working style?	
5. Is there anything further you would like to add?	

Thank you for taking part in this research. Please feel free to contact XXXXX or XXXXX if you have any further questions following this interview

Appendix F: Debrief Statement

Debriefing Statement

(Version: 1; date: 24/10/17)

Study title: Exploring practitioner perspectives of facilitating an online intervention for individuals, families and carers of an individual with mental health problems.

Researchers' names: XXXX

The study was developed in collaboration with the University of Southampton and XXXX as part of a Doctorate in Clinical Psychology. Your participation helps develop a better understanding of intervention processes whilst delivering an online intervention for individuals, families and carers of individuals with mental health problems. This study attempts to investigate the impact of providing an intervention based on evidence-based family therapy components via an online platform and its impact on therapeutic alliance. The therapeutic relationship is seen as central to both the experiences of the therapist and the clients throughout the process of therapy; thus studies of client experience of treatment regularly stress the importance of the therapeutic relationship (Grunebaum, 1988). Blow, Sprenkle and Davis (2007) argue that the therapist is a key factor in the change process in most successful therapies. Psychotherapy research is often focused on the application of clinical interventions, whilst regularly ignoring the individuals who facilitate them; regularly treating interventions as pills, unaffected by the person administering them (Lebow, 2006). Thus your contribution to this research is extremely valuable in exploring the change process and role of therapeutic alliance within an intervention provided online.

Once again results of this study will not include identifiable information. Thank you for your participation in this research.

Researcher's Signature _____ Date _____

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact If you have any questions regarding the conduct of the study, you should contact either XXXXX (XXXXXX) or XXXXX (XXXXX) or the Chair of the Ethics Committee, Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: +44 (0)23 8059 4663, email fshs-rso@soton.ac.uk

If you feel distressed after undertaking this research, please seek support by contacting your GP and/or one of the following agencies:

For further information or support relative to Mental Health:

MIND – Info-line: 0300 123 3393 or text: 86463 or online: www.mind.org.uk

RETHINK – Advice and Information Team: 0300 5000 927 or online: www.rethink.org

Appendix G: Coding Example

Initial responses	Transcript Extract	Emergent Themes
Contributing and listening Trying to engage all people when you can't see them. Challenges with encouraging participation Straining to hear Accessible but not accessible Family member is uncomfortable 'way in' through technology Client might still not engage. Client's need Working harder for all involved to be 'present' not just visual Awareness of the whole family not just the one visible	P2: They were listening, contributing, but it's quite difficult to try and engage that and encourage that relationship when you're having to say, 'So, such and such, what do you think about what we just talked about?' and then trying to hear what they're saying and the father as well. So, it's quite difficult when you have, and it does happen, you have some people who are really uncomfortable although it's helpful that you're able to access, that's good because you've got the way in with the technology, they might not engage but if you came round in person that might be too much so trying to work with, well, physically seeing one person but being aware that there are two other people who are in that session as well trying to work with that.	Working harder for all involved to be 'present' not just part of the family

Transformation of theme over time:

1. Emergent theme: Working harder for all involved to be 'present' not just part of the family
2. Revised emergent theme: Working with part not the whole family
3. Initial Sub-theme: Working with part not the whole
4. Revised sub-theme: Working with 'part' accessing the 'whole'
5. Initial superordinate theme: Online increases access and difficulty for practitioner
6. Master theme: Balancing the patients' needs with the practitioners' need

Appendix H: Second Coder Reliability Check

Initial responses	Initial responses (second coder)	Transcript Extract	Emergent Themes
A natural process "Genuineness" A genuine interaction Language and body language Match in non-verbal and verbal Discrepancy may mean decreased therapeutic relationship Emphasis on previous comment/repeating Approach/therapy style and confidence Relationship and approach are separate How "I" appear to other – how patient is viewed Personality is a factor	Work process – automatic Relationship is a 2-way street Importance of body language Reflective Approach is less important Impact of level of self-confidence on perception of therapist Approach less important in rapport Relationship is separate to approach Personality is more important factor	No, it's just part of what I do. The genuineness of what's going on in the room, how honest and open someone is, how much it feels like it's kind of collaborative. I guess some of the stuff around non-verbal stuff, you know, if there's a discrepancy between what someone might be saying and their kind of non-verbal communication that might get in the way of developing a relationship. Hmm, I'm trying to think. Obviously it kind of goes back to what I was saying before as well to a degree about although not heavily influenced by what I might be using, the approach I might be using, i.e. the development, the ongoing development of the therapeutic relationship isn't massively dependent on the approach I'm using but the approach I'm using, how confident I feel, how competent I feel with that approach would probably influence how well kind of things go in a session and therefore how I come across to someone which is going to impact on that relationship that develops, yeah.	Therapeutic relationship is a natural and genuine interaction

Transformation of theme over time:

1. Emergent theme: Therapeutic relationship is a natural and genuine interaction
2. Initial Sub-theme: Building a therapeutic relationship online is similar and a natural process
3. Initial superordinate theme: Similarities and Differences in the therapeutic relationship
4. Master theme: The therapeutic relationship: both the same & different

Appendix I: Hermeneutic Cycle of the Research Process

Appendix J: Frequency of codes

Master themes and subthemes ↓	Participant number → 1	2	3	4	5	6	7	8	9
				The therapeutic relationship: both same & different					
Building a therapeutic relationship online is similar and a natural process	✓	✓	✓	✓	✓			✓	✓
What about that "felt-sense"?	✓	✓		✓		✓		✓	
Interpreting what is seen		✓	✓	✓	✓	✓	✓	✓	

Divided by the screen	✓	✓			✓	✓	✓		
The positives outweigh the negatives									
Attitude can change with experience	✓	✓	✓	✓	✓	✓	✓	✓	✓
'My' style of working	✓	✓		✓	✓	✓		✓	
Positive stories	✓	✓	✓	✓		✓	✓		✓
Balancing the patients' needs with the practitioners' need									
Working with 'part', accessing the 'whole'	✓	✓	✓	✓	✓	✓	✓		
The patient is in control but I am still responsible	✓	✓	✓	✓	✓	✓	✓	✓	✓

The emotional impact and support needs	✓	✓	✓	✓			✓

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