‘In my own comfort zone’: client experiences of relational aspects of Skype therapy for alcohol problems

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Abstract

Background: therapists and counsellors are increasingly using Skype or equivalent video-based applications to offer treatment in place of face-to-face delivery of talking therapies. In the alcohol treatment sector, this offers a range of potential benefits including value for money, accessibility, reduced stigma and increased privacy for service users. However, the impact on the therapeutic relationship remains unclear and under-researched, particularly from a service user or client perspective.

Aims: to explore how alcohol treatment clients make sense of the relational aspects of their Skype therapy, and to examine how Skype might disrupt existing ideas around the therapeutic relationship between client and therapist.

Methodology: qualitative design using thematic analysis, with 15 participant interviews, conducted via Skype and telephone, with male and female adult service users from a single treatment provider. All participants undertook a minimum of four Skype treatment sessions, and had completed their therapy in the six months prior to interview.

Findings: the themes that were identified highlighted the significance of the participant's own home as the site of therapy, with emphasis on the comfort of the home, and the presence of family members and pets in the therapeutic environment. Participants stressed the importance of viewing the face of the therapist, the establishment of a therapeutic bond, and specific therapist

qualities that were viewed positively. Participants also reflected on their relationship with alcohol, issues around denial and avoidance, and their decision to undertake therapy for alcohol problems ‘remotely’ via Skype.

Discussion: There are nuanced and potentially unforeseen consequences of undertaking therapy for alcohol problems via Skype, relating to the significance of the therapy environment and relationship between client and therapist. It is important for treatment providers and individual practitioners to be aware of these issues in light of rapid and radical changes in the way that therapy is increasingly delivered via new video-based technologies.

Chapter 1

Introduction and review of literature

The study examines alcohol treatment clients' experiences of the relational aspects of therapy delivered by Skype. This includes a review of relevant literature and existing debates on the impact of online communication technologies on interpersonal relationships, examining the evidence base relating to counselling via Skype and video, and the impact that Skype or video-based therapy has on alcohol treatment clients in particular. This encompasses debates on the therapeutic relationship and on the specific relational needs of alcohol treatment clients, as well as themes of power, disinhibition, avoidance and stigma. This review also draws on communication theories, as well as debates from counselling and psychotherapy around embodiment and attunement.

Innovations in online technologies continue to have a significant impact on interpersonal communication, from telephone use to more recent email, text and video messaging. Increased use and reliance on such technologies has profoundly altered the tools used in communication with others, as well as leading to more subtle changes in the manner and meaning of interpersonal communication (Hennigan & Goss, 2016). Social distancing requirements associated with the coronavirus pandemic during 2020 have accelerated the

use of video calling, with widespread use of software applications such as Skype, Microsoft Teams and Zoom among many others, in both occupational and social settings, as well as their widespread use in therapeutic practice. In this context of rapid technological change, it makes sense to further an understanding of the subtle changes and adaptations which are occurring in human communication and relatedness.

In a study which highlights the disruptive or transformative effect that Skype can have on how we relate to others, King-O'Riain's (2015) ethnographic study of transnational families describes ways in which Skype allows families which are separated geographically to create spaces of *transconnectivity*, which help them to maintain emotional connection. These transnational families engaged in what King-O'Riain calls 'emotional streaming', through continuous and ongoing emotional interaction over distance. Skype was not used simply as a voice call with an additional visual aspect; instead, continuous webcam use was used as a window into everyday life, for hours at a time. King-O'Riain suggests that this enabled participants to 'de-intensify emotional interaction'. This provides an example of one way that Skype can offer new opportunities for human relationship and communication, as well as disrupting existing patterns of relational and communicative behaviour.

The use of online technologies in the delivery of mental health and counselling services has been evident since the 1990s, and has expanded and diversified with the increasing use and availability of the internet (Mallen, Jenkins, Vogel & Day, 2011). Alongside this, researchers have been questioning the potential for

internet technology to impact on the effective delivery of therapy (Hunt, 2002; Wentzel, et al., 2016). Naslund et al. (2015) note that internet technologies can offer benefits in the delivery of mental health services, overcoming barriers relating to distance and access, and offering increased anonymity, as well as potential benefits around supporting psychoeducation, health promotion, symptom monitoring, self-management and relapse prevention (Bambling, King, Reid, & Wegner, 2008). Other authors have expressed a range of concerns about the potential for online therapies to result in diminished engagement from clients and higher rates of drop out, particularly in the substance misuse field (Ekström & Johansson, 2019). Researchers have suggested that Skype and other online therapies risk disrupting communication between therapist and client, with technical issues, lack of eye contact and ethical dilemmas being listed as potential causes of difficulties (Dunn, 2012). There is, therefore, no broad consensus around the impacts of the shift away from physical interaction and proximity in therapeutic services, and it remains a complex and contested issue.

For the purpose of this study, and in light of the multiplicity of labels and terms in use to describe a range of approaches, the term ‘therapy’ will be used to encompass psychological interventions, psychotherapy, counselling, talking therapies and other therapeutic modalities under a single title which supposes a therapeutic intervention between two people, within boundaries of confidentiality, where a therapeutic relationship is developed over time. For clarity, the terms ‘therapist’ and ‘client’ will be used in place of a range of alternative terms including service user, patient, psychologist, psychotherapist,

psychoanalyst, or counsellor, to denote the respective roles of those offering and receiving therapy.

Online technology and alcohol treatment

In the United Kingdom, alcohol treatment service providers have embraced the use of technology (Salleh et al., 2015; Elison, Davies & Ward, 2015; Elison et al., 2017), and the growth in online support for individuals with alcohol problems includes self-guided health apps, email support or live chat options (Kendzor & Hébert, 2017). Self-help interventions may be offered prior to introducing more resource intensive, personalised treatment for higher risk drinkers (Brendryen, et al., 2014). Online counselling via Skype or similar video software is increasingly available as an option for alcohol clients as an alternative to face-to-face counselling in a shared physical location (Holmes & Jones, 2016).

In 2017, the UK drug and alcohol treatment provider, Turning Point, began to offer treatment and recovery support via Breaking Free Online, and another large treatment provider, We Are With You (formerly known as Addaction), has developed its webchat facility, similarly making use of an online platform for delivery of psychosocial treatment. Individual therapists in private practice also regularly offer online treatment for alcohol problems. In February 2019, an online search on the BACP Therapist Register (www.bacp.org.uk), using the search term ‘alcohol’, identified 219 therapists who specialised in treatment for alcohol problems among other things, and of these, 94 therapists offered online treatment (42%). Just 18 months later, in September 2020, a search revealed

that 72% of therapists who specialised in alcohol treatment offered online treatments.

For treatment providers and for increasing numbers of private therapists, such technologies offer multiple benefits in relation to geographical accessibility, reduced waiting times and value for money (Tarp, Bojesen, Mejldal, & Nielsen, 2017), as well as convenience and security (Dowling & Rickwood, 2013). Further, there is a growing amount of research which suggests that service users are interested in accessing online services and keen to be offered the option to use technology to address their needs (Hanley, 2012; Trudeau, Ainscough, & Charity, 2012). However, others suggest that online techniques may be inherently risky for service users with alcohol problems, advocating instead for online treatments to be restricted to less 'serious' issues (Haberstroh et al., 2008; Rummell & Joyce, 2010). In a survey of counsellor views, Finn and Barak (2010) found that views differed considerably on whether online counselling was suitable for issues that are considered a higher risk to a client's personal safety or wellbeing, including suicidal thoughts, domestic violence, substance abuse, child abuse, and sexual assault. While psychological interventions are recognised as a key element of treatment for alcohol-use disorders in the United Kingdom (NICE, 2011), there is little consensus around the suitability of video-based therapy in particular for alcohol clients.

Evidence on effectiveness

In this rapidly changing context, a small number of studies have started to broaden the evidence base on the effectiveness of Skype or other video interventions for alcohol treatment clients. A number of studies have focused on the use of technology in preventative services for alcohol misuse, including Champion, Newton, and Teesson's (2016) systematic review of universal prevention programmes delivered by computers and the Internet. They concluded that evidence to support the efficacy of computer and Internet-based prevention programs for alcohol and other drug use and related harms among adolescents is rapidly emerging.

However, as Dugdale, Elison, Davies, and Ward (2016) argue, the evidence base on online treatments for substance-misusing clients, while growing, remains limited. Much research that has been carried out to date has reviewed outcomes of online treatments, based on quantitative indicators of successful completion and recovery (Elison, Davies & Ward, 2015; Byaruhanga et al., 2020), or measures around client characteristics and attendance (Frings et al., 2018), among others. While such studies provide some valuable data regarding treatment effectiveness, quantitative constructs of effectiveness may obscure some nuanced aspects of treatment. Quantitative data offers little insight into the experience of undergoing Skype therapy for alcohol problems, or any feedback provided by clients themselves.

One study which does focus on service user views of online alcohol treatment explores reasons for selecting video conferencing over face to face therapy (Tarp & Nielsen, 2017); this includes issues which were seen as positives, such

as flexibility and security, and those that were seen as negatives, such as when greater intimacy was desired, or when there were difficulties with technology. However, there has been virtually no research on the relational aspects of Skype or video therapy for alcohol treatment. In particular, there is an absence of studies on the impact of technology on the therapeutic relationship from the client perspective, or on the experiential, relational aspects of the therapeutic encounter in a Skype or video counselling session.

Technology and the therapeutic relationship

The United Kingdom's Department of Health and Social Care's (2017) clinical guidelines on drug use and dependence emphasise the therapeutic relationship as one of the 'core elements underpinning effective psychosocial interventions' (p. 47). Evidence suggests that the therapeutic relationship has a predictive effect on treatment outcomes for clients with alcohol problems (Meier, Barrowclough, & Donmall, 2005). The therapeutic relationship may be particularly significant in alcohol treatment because of the difficulty in engaging and retaining clients in treatment (Gossop, Marsden, Stewart, & Rolfe, 1999), and because of the suggestion that a strong therapeutic relationship may help to foster improved engagement and retention of this client group (Joe, Simpson, Dansereau, & Rowan-Szal, 2001). In particular, the therapeutic relationship is thought to be an important element at the commencement of online therapies, relating to ongoing motivation to engage with treatment (Elison, et al., 2014).

The quality of the therapeutic relationship has been found to be a significant predictor of treatment outcomes in clients presenting with a variety of difficulties

across different treatment modalities (Martin, Garske & Davis, 2000), and a positive therapeutic relationship is seen as an essential ingredient of therapeutic change in counselling (Horvath & Luborsky, 1993). The term ‘therapeutic relationship’ refers to various interpersonal processes in psychological treatment, and can be traced back to Freud's (1912) description of transference and counter-transference as key aspects of process and change in psychoanalysis. Carl Rogers (1965) went on to define the ‘core characteristics’ of a therapeutic relationship in humanistic psychotherapy, highlighting the significance of the patient's experience of therapist empathy, and the therapist’s ‘unconditional positive regard’. The notion of the therapeutic relationship has been operationalised and subjected to empirical testing; Orlinsky and Howard (1975) proposed three aspects of significance: working alliance, empathic resonance, and mutual affirmation. While there are many other ways of conceptualising the therapeutic relationship, it is widely accepted as a crucial element of therapeutic work, and is therefore worthy of examination in the context of Skype and video-based treatment.

Simpson and Reid’s (2014) literature review of research studies that measure the therapeutic relationship in videoconferencing psychotherapy, found support for the notion that the therapeutic relationship can be developed by videoconference, with clients rating bond and presence at least equally as strongly as in face-to-face settings across a range of diagnostic groups. However, the impact of these findings is limited by the fact that only 23 articles met the inclusion criteria for the review, and the review only included studies which formally measured self-reported therapeutic alliance, rather than any other observational or qualitative recording of therapeutic relationship.

This is significant, because while there is broad evidence in support of the idea that therapeutic relationship constitutes a major variable in relation to treatment outcomes, there is less agreement on how to conceptualise and measure 'relationship'. A number of quantitative measures focus on therapist or client self-reported features such as bond, empathic resonance and mutual affirmation, including the Working Alliance Inventory (Horvath & Greenberg, 1989), and the Kim Alliance Scale (Kim, Boren, & Solem, 2001), among others. However, it has been suggested that methodological problems limit the usefulness of such measures, including third factor confounds, and the effect of therapist variables (Elvins & Green, 2008), and it is evident that no unifying model of the therapeutic relationship or consensus on measurement has emerged.

Therefore, considering these methodological limitations, qualitative methods of examining the therapeutic alliance offer a valuable, alternative focus, emphasising the significance of client descriptions of their perceptual worlds, and enabling the full complexity and contextual relatedness of significant events to be taken into account (Reyre, et al., 2017). Data obtained via qualitative methods can offer a rich resource of information, as well as overcoming some of the limitations of quantitative constructs around therapeutic relationship.

Alcohol treatment clients and relational needs

It has been suggested that alcohol treatment clients may be characterised as having complex relational difficulties, with notable attachment issues, or with complex needs associated with historic trauma (Kreis, Gillings, Svanberg, &

Schwannauer, 2016). A study by Davidson and Ireland (2009), comparing attachment styles of problematic drug users with non-drug users found a significant relationship between avoidant attachment style and drug use, leading them to suggest that insecure or avoidant attachment styles may lead to inadequate and inflexible methods of coping in stressful situations, such as drug or alcohol use. This raises the question of whether alcohol treatment service users may have specific needs in relation to the therapeutic relationship, and specific responses to a therapeutic encounter conducted in a Skype or video environment. There is however, an absence of research which examines the question of whether Skype or video counselling is suitable to respond to the complex needs and attachment issues of this client group.

It has also been argued that a strong therapeutic relationship may serve as a model for improved social relationships outside of therapy (Greenson, 1965; Molenaar et al., 2011; Mullin & Hilsenroth, 2014), which in turn may improve treatment outcomes. This is relevant, because many alcohol treatment clients report unsatisfactory social relationships, and poor social and family relationships have been implicated in the aetiology of alcohol use (Marsden et al., 2000; Carrà et al., 2016). Furthermore, the presence of valuable social networks, connections and relationships, during and after treatment has been linked to sustained improvements in alcohol use after treatment (Laudet & White, 2008; Field, 2014). The question arises therefore as to whether the online therapeutic relationship acts as a model for improved social functioning for alcohol treatment clients in the same way as the face-to-face therapeutic relationship is said to.

It has been suggested that clients with substance misuse histories, including both alcohol and drugs, may have specific needs in terms of establishing and maintaining the therapeutic relationship. Thorberg and Lyvers (2006) suggest that clients in substance misuse treatment have greater levels of insecure attachment, greater fear of intimacy, higher emotional reactivity, and aloofness than control groups. Kothari, Hardy and Rowse (2010) argue that establishing a new and different relationship with drug and alcohol clients is particularly important. The notion of a 'secure base' (Bowlby, 1988) applied to this client group suggests that alcohol treatment clients are more likely to move forward in treatment when in the context of a reliable holding relationship (Ball & Legow, 1996). A question arises, therefore, about whether service users will experience the therapeutic relationship as containing and secure when it is established and maintained via Skype, or whether this aspect of therapy is compromised by the absence of physical proximity between therapist and client.

It is thought that empathy facilitates the development of the therapeutic relationship (Horvath & Bedi, 2002), and that it is through the empathic response that the therapist will attend to and satisfy the needs expressed by the client during the session. Thus, it is the therapist's empathic response perceived by the client that is critical for the process of change (Coutinho, Ribeiro, Hill, & Safran, 2011). There is a broad and established theoretical framework on empathy in the therapeutic encounter, including Carl Rogers's influential, experiential model of empathy (1962), which emphasises a transitory engagement with a client in order to understand the inner experience of that person, resonating in a bodily felt response to a client's functioning (Clark,

2006). Cognitive and behavioural therapies also emphasise the importance of empathy as constitutive of the therapeutic relationship, described by Beck, Rush, Shaw and Emery (1979) as, “how well the therapist can step into the patient’s world and see and experience life the way the patient does” (p.47). By conveying empathy to the client, it is argued that the therapist is able to facilitate further disclosure of feelings and cognitions, and develop enhanced therapeutic collaboration. It is therefore likely to be important to understand how the use of Skype or video influences clients’ perceptions of therapist’s empathic responses, and whether there is any disruption or enhancement of this process associated with such technology.

Alcohol and stigma

It has been suggested that seeking treatment for alcohol problems via Skype may be associated with fear of stigma, and that this may be a barrier to accessing traditional alcohol treatment services in a dedicated physical location (Vogel, Wade, & Hackler, 2007). There is a large body of research around the relationship between alcohol use and stigma (Kulesza, Ramsey, Brown & Larimer, 2014; Stringer & Baker, 2018), including, for example, an epidemiologic survey of 34,653 adults in the United States, which found that individuals with an alcohol use disorder diagnosis were less likely to access alcohol treatment if they perceived higher stigma toward individuals with alcohol disorders (Keyes, et al., 2010). It is suggested that people who experience problems with alcohol who perceive high levels of alcohol stigma may avoid entering treatment because it confirms their membership of a stigmatised group.

By avoiding the need to attend sessions at a local service, which may include co-located drug treatment provision - another highly stigmatised issue - Skype or video therapy offers clients a more private and secure option, reducing the fear of exposure. In an evaluation of an e-therapy programme for problem drinkers in the Netherlands, which used cognitive behavioural therapy and motivational interviewing, with asynchronous communication between therapist and client, Postel, De Haan, & De Jong (2010) found that client satisfaction with the programme was high and treatment outcomes were positive. Importantly the programme was able to attract clients who would otherwise not seek treatment.

There is also some evidence to suggest that online therapy using video may be associated with a 'disinhibition' effect, whereby the reduced social stigma and anxiety that some clients experience when meeting a therapist via video is thought to encourage clients to address core issues more quickly than in face-to-face therapy (Richards & Viganó, 2013; Salleh et al., 2015; Zamani, Nasir & Yusooff, 2010). Much of the growing body of research into the disinhibition effect focuses on negative aspects afforded by anonymity, such as 'trolling' or 'cyberbullying' (Kurek, Jose & Stuart, 2019; Wachs, Wright, & Vazsonyi, 2019). However, there is also evidence which points to benign effects associated with online disinhibition, such as self-disclosure and pro-social behaviour (Lapidot-Lefler & Barak, 2015). In the online therapy context, research by Cook and Doyle (2002) has shown that, during email counselling, clients reported experiencing disinhibition, which helped them relate to the therapist more openly and honestly. Therefore, it is particularly relevant to explore alcohol

client's experiences of disinhibition in a Skype therapy context, due to the acknowledged link between alcohol and stigma, secrecy and shame.

Skype therapy and power

Another relevant aspect of Skype therapy relates to the role and relationship of power between client and therapist, with some evidence that online treatments may offer empowerment to clients. Holmes and Jones' (2016) study into the use of online tools to treat alcohol misuse found that, "service users felt the power balance in the therapeutic relationship was shifted; the option to exit the conversation at the push of a button meant they felt in control of the relationship" (p.13). In a study into online therapeutic relationships in a young people's counselling service, Hanley (2012) describes a shift in the power dynamic compared to face-to-face therapies, whereby clients may feel, "more confident to openly challenge decisions made by the counsellor…or to choose not to return to the website" (p.41). Similarly, in a study of client and therapist views of Skype-based physiotherapeutic treatment following knee surgery, Hinman, Nelligan, Bennell and Delany (2017) found that the delivery model was empowering for patients, and that a strong therapeutic relationship was formed. Patients appreciated the undivided attention they received from their physiotherapist, with patient descriptions suggesting a subtle shift in the power balance in the relationship, such that the patient was the focus of the consultation, rather than the therapist. The concept of an altered power dynamic within online therapeutic relationships is one which requires further exploration. If clients experience empowerment via Skype therapy, it is worth considering what this shift might mean for the therapeutic relationship.

Interpersonal communication via Skype

One concern expressed by those concerned about the use of Skype in therapeutic work is around the loss of non-verbal information, including posture, breathing and gestures (Mallen & Vogel, 2005). While it can be argued that Skype allows the therapist and client to view facial movement and expressiveness, the tendency to focus the camera on a head and shoulders presentation means that the full range of postural, gestural, and expressive movement that the body conveys, as well as the intentionality that is carried and expressed in that movement, can be lost. Bayles (2012), for example, argues that this information is lost not only during the session itself, but also in the act of communication that is greeting the patient, watching them enter the therapy room, find their seat, and then seeing them as they leave the room.

Research by communication theorists suggests that individuals use body language in different ways, depending on whether they are aware of being ‘seen’ by a listener. This is relevant to Skype therapy, because it suggests that clients may have a repertoire of communication behaviours which can be adapted depending on the medium of communication. In a Dutch study by Mol, Krahmer, Maes and Swerts (2011), representational gestures were produced more frequently when speakers knew their addressee could see them. This was true both when speakers saw the addressee and when not. It is also argued that speakers produce fewer and different co-speech gestures when interlocutors cannot see each other, such as on the phone (Bavelas, Gerwing,

Sutton, & Prevost, 2008). Thus, speakers seem to take into account what their addressee cannot see and thus cannot know about.

Social information processing theory (Walther, 1992) suggests that users may be able to adjust their communicative efforts to a medium such as Skype, such that communication does not necessarily fall short of face-to-face interaction when it comes to experienced presence. Isaacs and Tang (1994) observed interactions that took place over the phone, through video-conferencing, or face-to-face. They found that participants used visual signals in videoconferencing much as they did in face-to-face communication, to express understanding or agreement, forecast responses, enhance verbal descriptions, give purely nonverbal information, express attitudes through posture and facial expression, and manage extended pauses. However, Isaacs and Tang also listed some differences between videoconferencing and face-to-face communication, including managing turn-taking.

One other difference between video and face-to-face interaction is the availability and interpretability of information from gaze (Mol, Krahmer, Maes & Swerts, 2011). For example, when client and therapist are not in a shared physical space, the direction of each other's gaze may be more difficult to interpret. If the image on the screen and the camera are not in almost exactly the same location, looking at the camera means not looking at the other person. Yet when someone looks into the camera, their image misleadingly appears as though they are looking at the person watching the image. This is significant because gaze and mutual gaze serve a variety of functions in the therapeutic

encounter. Perez-Garcia (2015) recommends that the camera should be as close as possible to the screen so that the ‘gaze angle’ is minimised, suggesting that gaze angles of five to seven degrees are not noticed by most people.

Embodiment and attunement

Counselling psychology has traditionally theorised the embodied experience of the therapeutic encounter in a shared physical space; with client and therapist physically positioned in a room together. This has drawn on ideas around the ‘felt sense’ (Gendlin, 1969), on findings from cognitive neuroscience and neurobiology around the influence of ‘mirror neurons’ (Coutinho, Silva, & Decety, 2014), on ideas about attunement and affect regulation (Dales & Jerry, 2008), limbic resonance (Lewis, Amini, & Lannon, 2000), and on the range of physical and emotional responses associated with empathic responses (Damasio, 2000).

These ideas build on evidence from neuroscience, suggesting as they do that the limbic system may play a role in the mediation of non-conscious, affect based communication (Carr, et al., 2003). It is suggested that ‘mutual synchrony’ (Lyons-Ruth, 2000) typically operates outside of focal attention and conscious experience and arises from nonverbal components of communication such as tone of voice, gestures, postures, and facial expressions (Schachner, Shaver, & Mikulincer, 2005). It is proposed that these nonverbal aspects of attachment are critical to the therapeutic alliance.

Findings around mirror neurons provide a neurological explanation for some nonverbal aspects of communication, suggesting as they do that the intentions behind the actions of others can be recognised by the motor system using a mirror mechanism. Iacoboni et al. (2005) suggest that, “mirror neurons are thought to recognize the actions of others, by matching the observed action onto its motor counterpart coded by the same neurons” (p. 533). However, some are critical of the empirical foundation of mirror neuron research, such as Alford (2016), who argues that complex human interactions cannot be explained by images on a brain scan or the electrical flow between neurons. Indeed, Alford argues that in order to understand interaction between therapist and client, “one requires narrative and metaphor more richly populated with human characters than stories about neural mechanisms can supply” (p.20).

A psychoanalytic theoretical framework draws on these ideas around the ‘embodied’ setting, in considering the patient’s experience of sharing a physical space and the analyst’s physical presence (Lemma, 2014). This emphasis on the sensory qualities of the setting, including the analyst’s physical appearance and the way the analyst sits in the chair, breathes, moves in the room, and speaks, are said to constitute core sensory features of the setting that contribute to the containment provided by the analyst.

Spinoza’s (1876) writings around ethics of knowing suggest that body and mind are two attributes of the same substance and that increasing the capacity of the body to both be affected and to affect others is the means by which the knowing subject progresses (Nadler, 2006). Drawing on Spinoza’s writings, Brown et al.

(2011) argue for a post-cognitive understanding of emotion, building an argument that effective therapists must be sensitively attuned to this realm of meaning. This is outlined by Shotter (1998) as a form of felt, practical, sensuous knowledge, known to the therapist in the lived moment, as a subtle, embodied sense of how the interaction is going, an embodied feeling of how things are.

There is a body of literature in psychoanalytic research that addresses the use of the analyst's body by the patient and the 'reciprocal observation' of it by both patient and analyst (de Toffoli, 2011; Zanardi, 1995). This includes a focus on 'somatic countertransference' responses in the analyst; a range of sensory and motor experiences such as the analyst feeling discomfort in the body, alterations in breathing, feeling sleepy, restless or nauseous and so on (Bronstein, 2013). Stern, et al. (1985) called this process 'affect attunement', consisting of both, (a) 'observable' synchrony, similar verbal and nonverbal behaviours, encompassing similar bodily responses that occur in a coordinated manner within a particular moment, and (b) non-observable elements such as feelings, impressions or anticipations of how things are in a relationship. Cromby (2012) argues that the complex and multidimensional nature of these embodied aspects of relating means that research on this subject calls for advanced designs and for approaches using mixed methods.

A range of research methods have been applied to measure embodied attunement. For example, Ramseyer and Tschacher (2011) found that synchronisation of body movements may increase the experience of a good working alliance. Studies have also been conducted which focus on the facial

expression of emotions during psychotherapy interactions (Darwiche et al., 2008). Marci et al. (2007) found that client-perceived therapist empathy was connected to good mutual concordance in skin conductance between the participants. Other studies emphasise the importance of the individual meanings and interpretations that participants give to relational interactions and experiences (Kykyri et al., 2017).

In a study on the use of Skype in psychoanalysis, Bayles (2012) asks whether seeing the physical presence of the patient/analyst is different from being in their physical presence. She questions whether we can articulate whether something is lost in the Skype context, and what is it that we lose or how it is lost. Bayles goes on to describe her own experience of selecting Skype in preference to telephone sessions, "*I wanted to feel my analyst's presence and have him feel mine. … Thinking now about my wish to use Skype I realize that my motivation also stemmed from my desire to see my analyst seeing me… I felt that my analyst needed to see me, and that he didn't have all the information he needed unless he could see me*." (p.577). This highlights Bayles' own struggle to understand the significance of physical presence in the therapeutic encounter, and the sense of the importance to the client of being 'seen' in therapy.

Summary of research aims

The alcohol treatment sector in the United Kingdom has seen a significant growth in the use of technology in treatment provision over recent years (Salleh

et al., 2015; Elison et al., 2015; Elison et al., 2017), and online treatments, including Skype therapy, are increasingly offered to service users as an alternative to face-to-face treatment in a shared physical location (Holmes & Jones, 2016). In this context, it is important to understand the implications of these new types of treatments for service users. The study therefore aims to identify specific issues arising for clients with alcohol problems when using Skype therapy.

The study also aims to examine whether the existing theoretical framework around the therapeutic relationship remains adequate to explain its nuanced and specific features within this innovative context of Skype-based treatment. This includes, for example, an examination of the relevance of concepts such as the ‘felt sense’ and the embodied aspects of empathy within Skype-based therapy for alcohol clients. It also aims to reflect on the implications of the creation of therapeutic space outside of the therapy room, and on power dynamics between therapist and client in the context of Skype therapy.

Chapter 2

Method

This chapter outlines the method adopted for data collection and rationale for the use of thematic analysis in this study. This includes an explanation of the significance of focusing on service user perspectives, a description of the recruitment of participants, an outline of relevant participant demographic information, and the procedure followed for participant interviews. Further, sections below reflect on ethical issues and on the process followed for analysis of interview data.

It is worth noting that data collection took place prior to February 2020, and was therefore completed before social distancing restrictions associated with the coronavirus (COVID-19) epidemic came into place. All participants in this study had actively selected Skype therapy as a choice, rather than as a necessity. Fifteen service users were recruited and interviewed from a single alcohol treatment service, a large, national treatment provider. All participants had completed a minimum of four treatment sessions via Skype, of between 45-60 minutes each, within the past six months. Interviews explored implications of the absence of physical proximity between therapist and client, and the impact of

video technology on the therapeutic encounter. Interview questions (Appendix 1) involved a focus on the relationship between client and therapist, including the reasons clients chose to undertake Skype therapy rather than face-to-face therapy in the first place, how clients communicate with therapists, client's sense of the openness and availability of the therapist, the ending of their relationship, and their perceptions of what has been helpful or unhelpful in therapy. This included discussion of the establishment of a therapeutic bond at the commencement of treatment, and on the maintenance and strength of the relationship as treatment progressed.

Qualitative research and service user voice

By focusing on client experience, the study aimed to provide access to the views of an under-represented group. Among groups of service users, alcohol treatment clients are particularly likely to be under-represented in research, and arguably represent a 'hard to reach' group (Postel, De Haan & De Jong, 2010). This may be attributed to lifestyle factors, stigma and shame associated with alcohol misuse, economic issues, or other factors. A key aim of this research was therefore to ensure that the experiences of this group were able to contribute to establishing the broad evidence base around Skype treatment. Further, the study aimed to explore those relational issues arising for clients with alcohol problems in particular, in order to better understand their specific issues and needs relating to the use of Skype or video technology.

A qualitative approach to data collection and analysis offered the benefit of being able to offer access to the 'hidden' population of service users (Fountain, 2009). This approach expanded upon the existing quantitative and statistical knowledge base in the substance misuse research field (Sanders, Lankenau, & Jackson-Bloom, 2010), and offered a means by which to reveal detailed and in-depth insights into the nuances contained within, but not necessarily revealed by, quantitative constructs (Damschroder & Hagedorn, 2011).

Dugdale, Elison, Davies and Ward (2016) argue that there is an overemphasis on quantitative research in the addictions field, and that more qualitative research is needed to determine, "the effectiveness of the various 'active ingredients' of complex interventions" (p.1049). Mearns and Dryden (2014) explain the absence of research into the client's experience of counselling or psychotherapy as a result of an institutional bias in favour of positivist, empiricist scientific methods, which renders the subjective feelings, states of mind or beliefs of clients as outside of any legitimate topics of interest. This emphasis on quantitative approaches may have meant that specific subjective processes which impact on the therapeutic relationship have been overlooked. One way to access more information about these subjective processes and 'active ingredients' is to collect evidence directly from service users themselves.

Rationale for the use of thematic analysis

This study was designed to enable an exploration of individual experiences of relational aspects of Skype therapy, reflecting on participants' own language as

they presented themselves, using thematic analysis to interpret interview data. Clarke and Braun (2018) position thematic analysis as ‘fully’ qualitative, meaning that qualitative techniques are underpinned by a distinctly qualitative research philosophy that emphasises researcher subjectivity, reflexivity and the situated and contextual nature of meaning. Meaning was derived from the experiences described by participants regarding their relationship with the therapist, and their descriptions of how Skype influenced their therapy. The research aimed to elicit and record the participants' own interpretation of their experience (Higginson & Mansell, 2008), and allowed for an examination of the subtle nature of the experiences involved in the therapeutic encounter.

Thematic analysis allowed the researcher to acknowledge the inherent validity of interrelated, subjective and sometimes oppositional descriptions and interpretations (Gelo, Braakmann, & Benetka, 2008; Smith, 2015); this approach recognises that reality is differentiated and stratified. In moving away from the rhetoric of neutrality and objectivity associated with positivism, thematic analysis allows for an exploratory engagement with detailed and varied participant descriptions, events and meanings, without denying the inherent reality of those events (Pilgrim, 2000).

This research philosophy is derived from a critical realist approach, allowing for the direct reporting of experiences, meanings and reality as articulated by participants. According to this approach, it is assumed that language reflects and enables us to articulate meaning and experience. However, critical realism also accepts an element of contextualism (Willig, 2013), in acknowledging the

ways that the broader social, economic and environmental contexts impinge on those experiences and meanings, while retaining a focus on the material and other limits of 'reality' (Braun & Clarke, 2006). This approach moved away from essentialist assumptions about uncovering an objective, empirically valid, universal reality, and instead aimed to offer meaningful observations from which understanding can be developed. Through the use of critical realism this research therefore integrates realist ontology – a belief in the value of observing a 'real' world - with an interpretivist epistemology which accepts the inevitability of subjectivity.

It is important in exploring this subjectivity to identify and acknowledge the researcher's role in the construction and interpretation of data (Charmaz, 2014) and the active construction of meaning (Treloar, Fraser & Valentine, 2007); it is acknowledged that the researcher's biases and preconceptions around therapy and online technologies are likely to play a role in the research process and data analysis. The researcher's interest in this subject was based on her curiosity around whether we relate differently to others in the online environment compared to face to face. Further, the author was a trainee counselling psychologist at the time of undertaking the research, and was therefore critically engaged with the language and discourse of that academic discipline and profession. In addition, the researcher has a professional background in drug and alcohol policy, hence her interest in the evidence base around treatment in these policy fields. The researcher attempted to maintain a reflexive process throughout, including paying attention to the prompting process during interviews.

Treatment model

The 15 participants who took part in the study were recruited via a national drug and alcohol treatment service provider. The provider offers a range of recovery services supporting drug and alcohol service users, families and carers, and provides community treatment, employment and educational support, aftercare, community-based social enterprises and family services. The dedicated Skype-based service for alcohol problems offered by this provider included approximately six sessions of online therapy via Skype with an alcohol treatment specialist; all specialists hold a counselling-related qualification. Sessions could be booked privately, although the majority of the participants in this study had undertaken their sessions free of charge as the service had been commissioned by local authorities and offered free to residents in those areas. The sessions offered an online form of extended brief intervention based on motivational interviewing techniques, as used elsewhere in standard face-to-face alcohol treatment.

Motivational interviewing has been described as a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence (Miller & Rollnick, 1991). Extended brief interventions are defined by the National Institute for Health and Care Excellence (2010), as intended, “to motivate people to change their behaviour by exploring with them why they behave the way they do and identifying positive reasons for making change” (p.46). In practice, this includes an emphasis on the individual's present interests and problems. It involves the therapist selectively responding to the client's speech in a way that resolves ambivalence and motivates the

person to change, focusing on intrinsic motivation for change. Within this approach, change occurs because of its relevance to the person's own values (Miller & Rollnick, 2002). Miller and Rollnick (1991) name five key techniques of motivational interviewing: expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy.

Motivational interviewing is understood to be an appropriate intervention for specific populations of individuals with alcohol problems: the first includes individuals who drink above guidelines for safe drinking but who would not be considered ‘alcoholic’. The second includes problem drinkers with low or moderate levels of dependence. The final category includes people with high levels of dependence who may face barriers to accessing mainstream treatment services (Heather, 1995).

Between January 2019 and February 2020, 15 research interviews were completed. Recruiting all participants from a single service meant that there was consistency in the type of therapy received and in the method of recruitment and interviewing, and in the presenting problem. While the original research proposal included treatment for drug users within its scope, it was not possible in January 2019 to identify a suitable UK-based drug treatment provider which offers at least four Skype or video counselling sessions with a single therapist. Of the nine drug treatment providers contacted, most did, however, offer some form of online treatment, including self-guided self-help, or ‘blended’ treatments supported by a designated support worker which included online chats, group forums and motivational text based support. This meant that recruitment of

participants was focused on a single alcohol treatment provider, and that individuals seeking support for alcohol or drugs at other services were excluded from the study.

Participants

Clients who had completed their sessions at the service were provided with information about the study (Appendix 2), and the contact details of those who were interested in taking part were passed on to the researcher by the service manager. Participants were required to be aged over 18, and to have completed a minimum of four one-to-one sessions with the same therapist via Skype, in order that they could reflect on the therapeutic relationship at various stages of treatment, from commencement to completion.

In recognition that thematic analysis supports a very wide range of sample sizes (Braun & Clarke, 2016), and that sample size in thematic analysis cannot be predicted by formulae (Malterud, Siersma & Guassora, 2016), a 'small/moderate' sample size was used (Braun & Clarke, 2013). Data collection ended when the researcher had a sense that further interviews would be unlikely to produce new data or themes than that already collected.

Demographic information

The average age of participant was 50 years, with ages ranging from 32 to 71 years old, including nine women and six men (see Table 1). All currently lived in

the United Kingdom. In the demographic questionnaire, 14 indicated that they were White, and one indicated that they were Mixed ethnicity. 10 of the participants said that they had previously had face to face counselling, and the remaining five had not had any previous counselling. Only one participant paid for the Skype counselling sessions; the other 14 received treatment free of charge via local authority commissioning arrangements. The average number of Skype alcohol treatment sessions completed by the participants was six; the minimum was four and the maximum was seven. The average gap between final therapy session and participant interview was less than three weeks.

Pseudonym	**Age (Years)**	**Gender**	**Ethnicity**	**Number of Skype therapy sessions completed**	**Time between final therapy session and interview (months)**	**Duration of research interview (minutes)**
Participant A	35	Female	Mixed	4	0.5	29
Participant B	45	Female	White	7	0.5	25
Participant C	32	Female	White	7	0	28
Participant F	61	Male	White	6	1	42
Participant G	40	Male	White Irish	6	0	40
Participant H	58	Female	White	6	3	51
Participant J	51	Male	White British	4	0	55
Participant K	51	Female	White	5	1	35
Participant M	71	Female	White	5	2	30
Participant N	66	Male	White British	6	0	19
Participant P	60	Female	White British	5	0.5	35
Participant S	51	Male	White British	7	1	51
Participant T	43	Female	White British	6	0.5	28
Participant W	45	Male	White	4	0	37
Participant X	48	Female	White	6	0.5	39
Average	50			5.6		36.3

Table 1: Participant information

Interview Procedure

Interview questions (Appendix 1) were developed on the basis of existing research findings on Skype use (Holmes & Jones, 2016) and on client experience of therapy (Salleh, et al., 2015). Interviews were 'exploratory' in nature (James & Busher, 2009), and were participant-led rather than fully structured (Wengraf, 2001). The questioning stance was adapted according to the narrative of the participant (Miller, 2012). Open ended questioning was used at the start of the interview, with more detailed and specific questioning used as the participants continued, enabling flexibility in response to participant style and narrative. Questions were not addressed in a pre-determined order, but all question areas are covered in each interview. The initial interview was treated as a pilot, and the list was subsequently amended in response to data collected. The amended list included an additional specific question focusing on the home environment and therapeutic space.

Participants were encouraged to choose between telephone or Skype video interview for data collection purposes. Nine chose Skype video, and the remaining six chose to be interviewed over the telephone, with no video connection. Average length of interviews was 36 minutes; the shortest interview being 19 minutes, and the longest being 55 minutes.

Interviewing via Skype or telephone was adopted as a pragmatic alternative to face-to-face interviewing due to the dispersed geographical location of participants. There is mixed research on the issue of telephone and video

interviewing; one benefit is that it enables researchers to include participants from virtually any geographic region, and no one is required to travel for the interview (Janghorban, Roudsari, & Taghipour, 2014). This provided an economical way to capture the experiences of non-local participants (Hill et al., 2005; Lowes & Gill, 2006). Musselwhite, Cuff, McGregor, and King (2006) also describe several advantages of this means of data collection, including the possibility of reduced response bias in the absence of facial expressions, and the possibility that the anonymity afforded by the phone may enable participants to be more open in their responses. This may be particularly relevant to alcohol treatment clients, a number of whom mentioned stigma and the avoidance of shame as a reason why they chose to undertake Skype rather than face to face treatment in the first place.

Relatedly, Brannen (1988) argued that interviewees are likely to have less fear and will be more forthcoming if they believe that they will never meet the interviewer after completing the interview, with the detachment fostering anonymity and thus greater disclosure. Shuy (2003) also addressed the advantages of phone interviews, stating that they reduce interviewer effects, allow better interviewer uniformity in delivery and greater standardisation of questions, enhance researcher safety and cost-efficiency, and facilitate faster results.

These views are countered by proponents of face-to-face interviewing techniques, who argue that when in the same room, participant and interviewer have access to facial expressions, gestures, and other paraverbal

communications that may enrich the meaning of the spoken words (Carr & Worth, 2001). Overall, while there are arguable advantages and disadvantages of each technique, a pragmatic approach which reflected the fact that participants had pre-existing familiarity with video technology, meant that Skype or telephone interviewing was selected as the most suitable technique for data collection.

Prior to interviews taking place, researcher information was provided (Appendix 2), and consent forms were signed and returned via email to the researcher (Appendix 3). Demographic information was also collected via an emailed questionnaire, including gender, age and self-reported ethnicity (Appendix 4). Interviews were all conducted individually by the researcher, and were audio recorded using standard Olympus digital voice recording equipment. Interview recordings were transcribed verbatim using basic orthographic conventions, allowing for inclusion of some paralinguistic information, such as the use of intonation for emphasis, laughter, pauses and the use of non-words (Jenks, 2011). All recording files and documents were stored appropriately on university secure systems.

Data Analysis

Thematic analysis of interview transcripts has enabled the identification and reporting of themes or patterns within data collected. Braun and Clarke (2006) proposed the following six-phase guidelines which describe the manner in which data from the transcribed interviews was organised into themed

meanings: becoming familiar with the data set; generating initial codes; identifying themes; reviewing the themes; defining and naming themes; and reporting the analysis.

Phase one involved becoming familiar with the data, both by repeatedly listening to the audio-recordings of the interviews and by creating and reading the verbatim transcripts (Jefferson, 2004). This phase began during data collection stage, and continued until after the final participant interview. The data was viewed with an analytical and critical lens, and items of interest were highlighted; this included text which was particularly relevant to the research aims or was otherwise of significant emphasis or interest (see Appendix 5 for an example). In the second phase there was a move towards a more systematic response to the data through the creation of codes. Each data block was saved onto an Excel spreadsheet, and labelled in a way that categorised that segment of data in relation to the research question (see Appendix 6 for an example of inductive data coding). It was at this stage that similarities and patterns were starting to be observed across the data, and these became the foundations for later stages of analysis. Revisiting and modifying codes was a part of the iterative process at this stage, and these codes varied in whether they captured a semantic meaning or more latent or conceptual ideas.

In the third phase of analysis, any patterns which were apparent within the data set were a focus for attention, with a progression towards the formation of broader themes. At this point the themes were flexible, and not fixed, but were developed by a clustering of codes that shared a common feature onto four

separate spreadsheet tabs representing the four main themes. Sub themes were clustered under each main theme. The fourth phase involved checking the robustness of the analysis, achieved by examining the coded extracts against themes and subthemes for fit. In a few cases where non-matches or duplication occurred codes were discarded or moved, or the themes were amended. At this point, a list of codes was produced to identify both patterning and diversity of relevant meaning within the dataset. The final stages of the analysis involved selecting suitable extracts from transcripts which exemplified each theme, and explaining the analysis around this, as set out below. This involved an interpretation of the data and drew on relevant literature and theory.

In order to ensure that the analysis process was rigorous and robust, Braun and Clarke's 15-point checklist for thematic analysis was applied at various stages (2006, p. 96) during the process. This included checking that data was transcribed to an appropriate level of detail, that coding was thorough, inclusive and comprehensive, and that themes were internally coherent, consistent, and distinctive. These phases were iterative and recursive, and the researcher moved back and forward between the different stages, defining and refining patterns, codes and themes at each stage, before developing the entire analysis and producing a written account. There was a detailed engagement with the participant data, following on from the assumption that data quality is improved through immersion in, or repeated engagement with, the data. The themes that were developed in this way were the outcome of the analytic process, rather than having been imagined or anticipated early on, and they did not drive analytic direction. In this sense, the analysis was created by the

researcher, at the intersection of the participant data, the researcher's theoretical frameworks, disciplinary background, and research skills and experience.

Ethics

As a reflection on the use of human participants, University of the West of England ethics approval was sought, and was granted in June 2018 by the Faculty of Health and Applied Sciences Research Ethics Committee. Participants were recruited from a national treatment service provider, with some services commissioned by local authorities. All participants were aged over 18. It was anticipated that participants may have had vulnerabilities associated with substance misuse, and some participants may still have been using alcohol or other substances. The impact of this was assessed by the researcher with support from the service manager prior to research interviews taking place. However, the content to be discussed in qualitative interviews focused on the therapeutic process and on the experience of undergoing therapy, rather than any significantly distressing content.

Those who expressed an interest in participating had information made available to them which explained the aims of the study and what participation might mean for them. Specifically, participants received information explaining the research procedure, confidentiality, their ability to withdraw at any point and contact details of support should they require it. This information was made available to them in the participant information sheet (Appendix 2). Participants were required to sign a consent form prior to interviews, confirming that they

had given their consent to taking part (Appendix 3). They also provided specific consent for the interviews to be audio-recorded and for their data to be used. Participants were also asked to confirm that they understood that they were able to withdraw their consent at any time up to the point of thesis submission. Data was stored in accordance with the Data Protection Act (2018). Excerpts have been anonymised by giving participants random identifying signifiers (eg. Participant F) and by removing any potentially identifying information from transcripts and quotes.

Chapter 3

Analysis

Thematic analysis of the data led to the identification of four main themes, and a number of further sub-themes, as outlined in Figure 1 below. The first theme, *the client in their own home*, draws together participant reflections on the significance of their sense of being comfortable while taking part in therapy sessions, including being able to control their home environment to suit their needs. This clearly articulated sense of the importance of physical and environmental comfort was often contrasted by participants with the relative discomfort of attending therapy sessions in other settings. With client's homes as the therapeutic environment, the presence of family members and pets in the therapy session is often reflected upon, as they become active observers, witnesses or otherwise involved in therapy. Further, participants reflect on the significance of undertaking therapy for alcohol problems in the home environment which is the site of alcohol consumption for many, reflecting on both the pros and cons of this proximity to alcohol.

The second theme, *virtual relationships*, brings together ideas around the therapeutic relationship in an online environment, starting with the client's experiences of seeing the therapist's face on a screen, and their sense of the therapist's presence. Participants describe how quickly they were able to build a

therapeutic rapport with the therapist, despite the physical distance. In describing the development of the therapeutic relationship over time, participants list a wide range of positive qualities which enabled them to develop rapport with the therapist, these qualities matching closely those ‘core conditions’ of therapeutic attributes that are familiar, for example from traditional face to face counselling.

In the third theme*, empowerment and choice*, ideas about therapy as a consumable service are explored, with the client as the empowered customer in a transaction, able to select a therapist from a range of options and times to suit their needs. Linked to this is the sense of the client being able to leave a session at the touch of a button, of having the ability to choose whether, how, when to start and finish the therapy, enabling a sense of power and control over the sessions.

The final theme relates to *stigma and dependency* associated specifically with alcohol. Participants repeatedly explored their own relationship with alcohol in comparison to others’, often minimising the seriousness of their drinking habits, or feeling the need to provide justification for their alcohol consumption. This links to participants’ descriptions of the perceived barriers to accessing treatment associated with being ‘seen’, including secrecy, shame and stigma. A relationship with dependency, and a fear of dependency, are also explored in ideas around endings with the therapist, and participants’ senses of attachment and loss.

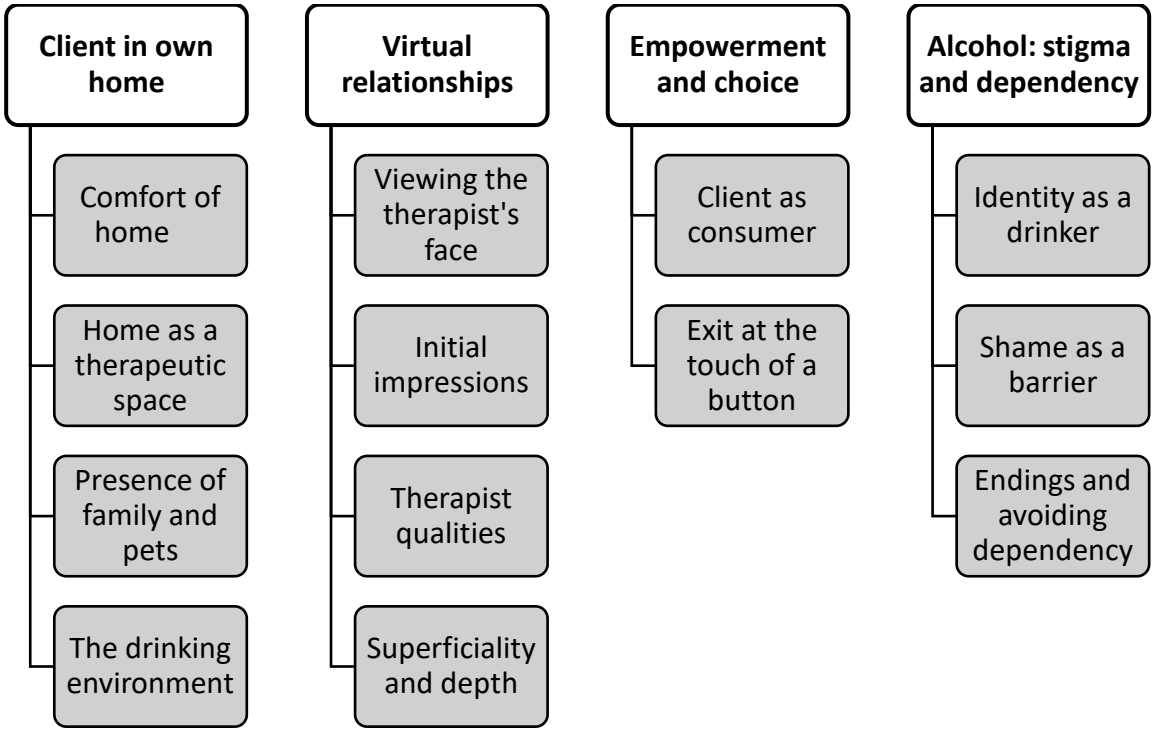

Figure 1: themes and sub-themes

T**heme 1: The client in their own home**

All of the participants interviewed had undertaken their therapy sessions within their own homes. They took part in the Skype sessions with their therapists via laptop, tablet, mobile phone or PC, and screens were of varying size and image quality. Some participants reported remaining in a fixed location each week, such as a study or bedroom, while others moved to different areas of their house for each session depending on presence of family members or other contextual factors. The significance and impact of being within their own home was commented on by all participants, and was frequently contrasted to the experience of travelling to and undertaking therapy within, a therapist's own office. There were a number of specific sub-themes which emerged in relation to this theme, as shown below.

a) Subtheme: Comfort of own home

Strikingly, all participants referred in some way to being in the 'comfort' of their own homes while participating in therapy sessions. This links to a sense that by undertaking therapy via Skype, the participants may have been able to derive some level of self-regulation from being in a familiar environment over which they had a degree of control, and that they viewed this as beneficial:

> *Just being physically comfortable, you know, being in my room, being in my bed...erm…being able to wear whatever I want. I'm talking to you right now, I'm still in my pyjamas...I feel a bit more anxious in the room with someone. Yeah. I...I feel more comfortable with Skype. I don't know*

why, but, erm...yeah. It could just be the environment, I don't know. (Participant A)

I'm in the kitchen but I shut both doors and I'm private, it's lovely. (Participant M)

You can make yourself really comfortable, whereas when you go to somebody's office or their house, you are kind of, you know...or especially when it's a counsellor's house, you're going into their...their home, even if it's, you know, a special room that they use, or whatever. So, you know, you're never going to be quite as comfortable, are you? (Participant K)

This idea of 'comfort', and the positive sense of being comfortable while undertaking therapy appears to go beyond a sense of physical comfort to encompass a sense of emotional comfort, a sense of ease associated with being within one's own home.

Some participants talked about an increased ability to 'be oneself' when in one's own home, with an increased ability to speak freely, as well as reflecting on an increased sense of control.

When you are in your home you feel like you are more able to be yourself as well. I feel like, I couldn't...if I sat in a GP's surgery, or, you know...it's more difficult to be yourself. (Participant S)

You're in your own environment, you're in your own comfort zone, so to speak, erm, and so from that point of view I felt I was able to be more open and honest with her, erm, than if I was in a group of people. (Participant N)

I'm surrounded by my own things. I'm in my, my comfy place, and I've...I don't feel that there's anything I can't say. (Participant H)

These comments suggest that a sense of comfort within the home environment enabled the participants have a sense that they were able to be authentic in terms of how they presented themselves to the therapist, talking with less constraint than they would elsewhere.

The proximity to familiar possessions, and to a sense of warmth associated with hot drinks, or sitting by a fireside, was also of importance to participants.

I am comfortable because I am in my own home. I can have a cup of tea here, or, you know...I've got everything I want here. (Participant F)

I do think the fact that I can be, you know, sitting on my sofa, I can have the TV on, or I can have a cup of tea, or whatever, you know, then the phone goes…. then when it's finished I'm on my sofa again. (Participant W)

If I wanted to, I could be just sat in front of the fire with my slippers on, and with the pets, and it's fine, isn't it, it's not a problem. (Participant K)

Yeah, and I've got a kettle. I can make my own coffee (laughs), don't have to drink out of a plastic cup. (Participant H)

The noticeable repetition of words relating to ‘comfort’ links to ideas around attachment, suggesting that the client is able to derive comfort from their own environment and household possessions in a way that may be in contrast to face-to-face therapy whereby the therapist provides the therapeutic space for the client, and the ‘holding environment’ is established by the therapist on the client’s behalf. Traditionally, therapy may be held in a therapist’s ‘comfort zone’, where it may be the therapist rather than the client who is surrounded by familiar objects, albeit those designed to create a sense of ease for the therapist’s clients.

b) Subtheme: Therapeutic space

The idea of the client’s home environment being transformed into a therapeutic space, and one into which the therapist enters at the invitation of the client, represents a shift away from traditional models of therapy. In the Skype context, the client is able to arrange, create and modify his or her own therapeutic space, rather than this being pre-determined by the therapist. In this study, a number of participants gave a clear sense of the therapist having been invited into their own homes, including a sense of familiarity with the client’s room, family members and pets.

> *I'd always sit in my bed in my room so I could shut the door, and she'd say, 'Oh, I like your wallpaper', or whatever (laughs). And, erm...you know, the kids would come in and...she'd be, 'Oh, that's alright. Oh, bless them', you know.* (Participant A)

I was decorating at the time, and I'd moved out of my normal office into one of the bedrooms. There was all this stuff around, and so it looked quite cramped, so I said, 'apologies...', like, 'it's a little bit messy'. She said, 'yeah, it looks like there is a lot of stuff in there' (laughs).
(Participant J)

In this way, the therapist may be experienced as a guest in the client's home, offering comments on decoration and aspects of the client's domestic situation, but with limited access which is firmly controlled by the client themselves.

c) Subtheme: presence of family and pets

The client's ability to control their own therapeutic space is connected to their ability to control the involvement or exclusion of family members or other people in their household from their therapy. Some participants talked about their concerns about being overheard,

I was worried that my husband was in the background listening through the keyhole, sort of thing, because there were things that I've definitely said to [the therapist] that, you know, I'll say to you, which...I wouldn't have said to him. I was concerned about him hearing in the background.
(Participant T)

You're having essentially a personal conversation, aren't you, so you don't necessarily want other people hearing how you are expressing things, how you are explaining things. (Participant P)

Erm...well yes. I live here with my wife, and my wife works full time, er…and I don't. There's nobody else here, so the house is quite quiet. (Participant N)

These participants suggest that it is important for them to be able to speak freely without being overheard by family members, and imply that the proximity of family members may have been an inhibiting factor in their therapy sessions.

Other participants suggested that they were comfortable with the presence of a family member in the room with them while they were having therapy sessions:

Yeah, so...erm, my husband is in the house when I've had the sessions. Erm...like he's sitting on the sofa over there at the moment ...erm, so yeah, I think the first one, he...he was out in the kitchen, erm...making the dinner or something, but since the first one, I haven't worried whether anybody could overhear or not.....Everything that I discussed with [the therapist], I'd already...my husband and I had already talked about it, so I didn't have to worry about that side of it either. (Participant K)

Other participants described the methods they had adopted in order to manage their concerns about being overheard or interrupted by family members:

I usually am always just in my room when I talk to [the therapist], because, erm...I've got two children, and...I just kind of want to have my own space, so I just shut my door….Because there's been a few times when I've been talking to [the therapist] and my girls, you know, burst through the door (laughs). (Participant A)

Although they couldn't hear what she was saying, I would go and put the radio on as a background, to stop them from being able to hear what I was saying to her...so that I could be open and honest. (Participant T)

You have to put some parameters in place. You're going to need to be totally comfortable knowing that you're not going to have any interruptions. You need to be in a quiet place. You need to be on your own, so that you can relax and concentrate on whatever is going on, and get the same environment that you would have if you went to somebody's office or treatment room. (Participant F)

The presence of family members suggests an element to therapy which is outside of the therapist's control to some extent, and which may impact on the content of a therapeutic session in ways that the therapist is not fully aware of. Family members may enter or leave rooms without the therapist knowing. It is possible for clients to derive a sense of comfort from having family members in the therapeutic environment, or alternatively to feel a sense of constraint around being overheard by family members. Participants outlined the various strategies they adopted in order to manage this uncertainty and negotiate the boundaries of their therapeutic environment with members of their households.

A number of participants referenced their pets in interviews, either referring to the noise of barking made during sessions, or to the comfort of having a pet with them during the therapeutic encounter. The regularity with which pets were mentioned in interviews suggested that they play a significant role in the

environment of the therapy. Apologies were made to the interviewer about potential interruptions by animals, giving a very real sense of their presence:

> *Sorry, my dog is making a strange noise.* (Participant F)

> *Apologies if you hear noises...Sorry, you might be able to see my dog in the background, he's currently standing...barking...he wants me to take him for a walk.* (Participant P)

As well as potentially disrupting the therapeutic work, pets are presented as silent witnesses to the therapeutic sessions, providing comfort, warmth and reassurance to participants:

> *I think sometimes I was sat at my dining table like I am now, but most times I think I was actually sat on the sofa with...with my chihuahua and my cat.* (Participant K)

At other times, an implied relationship between the therapist and the pets was given as evidence of the depth of the therapeutic alliance, with a sense of closeness and familiarity built up over Skype sessions:

> *I mean, [the therapist] has already met the dogs and everything (laughs).* (Participant M)

> *I've just taken over care of a dog, and we were just talking about that, and various other bits and pieces, you know, personal stuff.* (Participant N)

In this way, it is suggested that the therapist has in some ways become integrated into the client's home environment, establishing a relationship with others, beyond the client themselves, with a sense of implied acceptance.

Further, the involvement of animals in therapy is well documented, with evidence to suggest the therapeutic benefits offered by the presence of pets. It may be that the ability to sit quietly with a calm animal during therapy sessions offered participants a method of self-soothing and an ability to maintain calm.

d) Subtheme: the drinking environment

One further aspect of the client's own home as the therapeutic environment was the idea of the home as the site of alcohol consumption. A number of participants reflected on the fact that home was where they tended to drink alcohol, and that this impacted on the therapy they did in the home. There was a sense of the therapy taking place in proximity to their real lives:

> *I think it was useful to be in the location where…where most of it happened. … I am getting that out talking about it in the environment that I usually drink. So, yeah, I think it actually makes it a bit more impactful. Brings it home. It makes it a bit more real, because, you know, the fridge is over there, and that's where the drink is.* (Participant W)

> *That's....that's a good thing because this is real life. I'm sitting in my real life, and...so it is the right place to have the discussion.* (Participant F)

> *Actually, it's quite helpful that I am here at home because, you know, as soon as you put the phone down, I went and got the diary and wrote a few things down.* (Participant W)

These participants suggest that being in their homes meant that they could put their good intentions into action immediately; there is a suggestion that this immediacy was helpful and enabled them to feel supported in the environment where their alcohol problems were most manifest.

In reflecting on their own home as a site of alcohol consumption, one participant joked that he could have been drinking during the sessions, presumably outside the therapist's awareness:

> *I am comfortable because I am in my own home. I can have a cup of tea here, or, you know...I could have had a quadruple whisky...(laughs).* (Participant F)

This playful statement about the ability to continue drinking before, during or after a session shows the participant's sense of the potential advantages and disadvantages of having therapy at home, and also raises issues of secrecy and control, and the potential offered by Skype for clients to withhold relevant information from the therapist regarding their alcohol consumption.

All of these elements suggest that there are therapeutic pros and cons of the client being in their own homes. Overall, perhaps the most striking aspect is the shift in power and control over the therapeutic environment, away from a space managed by the therapist, towards a therapeutic space controlled and managed by the client, over which the therapist can only have limited knowledge and influence.

Theme 2: Virtual relationships

There were varied aspects of the way that participants described their relationship with the therapists having developed over time, and how their sense of the therapist was impacted on by the use of Skype technology. This theme therefore encompasses the different ways that the therapeutic relationship was described and understood by participants.

a) Subtheme: Viewing the therapist's face

Participants reflected on the value of seeing the therapist's face on screen, noting at times the difference between video calls and telephone calls and expanding on their sense of the significance of viewing the image of the other. While literature reflects on the significance of the size of the screen, quality of the image, framing or unavailability of wider visual clues, such as hand or body movements, as well as eye movement or direction, participants appeared to have little interest in the detail of the image they viewed. Rather, they reflected on their sense of the therapist's presence with them, and their perception of the therapist as a real person.

> *Yeah, you still make that connection with someone, you know, erm, with video. It's still real, you are both still human beings.* (Participant J)

> *I think it's quite nice to be able to see someone, and...just know, you know, what they look like. Because, you know, we all form ideas about how old somebody is, or what they look like or something, don't we? If you actually see them, it sort of takes all that away, doesn't it really.* (Participant K)

The fact that I could have an almost face to face conversation with her was better than just doing a dry conversation over the phone, so yes, it did...it did add something to the process. (Participant N)

I think it's just because you can see somebody, so, you know, you can kind of like...you can build up more of a relationship because you can actually see them rather than just, sort of...the whole facial expression thing and all the rest of it. (Participant X)

I think seeing somebody's face and seeing their body language and how they react non-verbally, erm, is…yeah, reacts with you. (Participant T)

Participants are making clear in these quotes their sense of the therapist as real, and are distinguishing from voice only phone calls which leave the other's physical appearance to the imagination.

One participant reflected on the fact that by seeing her face on the screen, the therapist could gain important information about her state of mind that would have been unavailable to the therapist in a telephone session:

With the phone you can control your voice to a certain extent, whereas...I certainly can't, I've never been able to do anything about my face. Whatever I'm feeling is just written all over it, so...(laughs)...so I think she could kind of like pick up on stuff that I wasn't comfortable about. (Participant M)

In this way, the participant acknowledges the importance of the face in signalling emotional content during the Skype sessions.

b) Subtheme: Initial impressions

When discussing their relationship with the therapist, a number of participants reflected on how quickly they had been able to establish a positive relationship with their therapist, from their initial impressions of the other individual in the first session onwards. This accords with mainstream understanding around how therapeutic rapport is established, and the importance of early sessions in the development of the relationship, particularly in the context of substance misuse (Kothari, Hardy & Rowse, 2010). Participants seemed to suggest that the relationship that they had with therapists could be developed very rapidly, despite the absence of physical proximity.

> *We made an instant connection, it just felt right from the start, it just flowed. I felt at ease with her straight away because she was very, er, you know it was just like chatting to a friend almost. You know, I know it is not supposed to be that sort of relationship, but, she made you feel really comfortable straight away.* (Participant K)

> *Straight away I felt comfortable with her, yeah…* And, s*ometimes you can tell at a glance whether you are going to get on with someone or not, you know.* (Participant M)

> *She just appeared on my screen and we got on.* (Participant F)

> *On my first session...I was a little bit nervous actually. But she put me at complete ease. Er...it was like talking to a friend really. Someone who, kind of like, not sympathise at all...er…or relate necessarily, but someone who I kind of felt was on my level. So it was very comforting and reassuring. And she wasn't there to judge.* (Participant C)

It is also notable that a number of participants reflected on the development of the therapeutic relationship over time, describing how a sense of trust build up over the course of a number of sessions. Again, this matches existing understanding of how rapport is developed in face to face settings.

> *I have to say, for the first two or three sessions, erm...I sort of...yeah, I didn't, I wasn't completely honest with her...erm...which I recognise now. At the time I didn't. But I recognise that it took a while to build up that relationship, to build up that sort of, erm...that confidence in her. I guess the more time I spent talking with her, er, the less self...self-conscious I felt. Perhaps the...I was more aware that, yes, I wasn't going to bump into her in Tesco's. There wasn't going to be anybody else involved, so those sort of barriers dropped, and I was able to be more honest.* (Participant T)

> *When you've spoken to someone for four times about something that is quite...can be quite emotional to talk about and very personal, then yeah, you do...you do, sort of, start to build a relationship, so yeah...it's gone from more practical to more emotional.* (Participant W)

c) Subtheme: Therapist qualities

Participants were able to provide a range of explanations for their positive relationships with their therapists, listing a wide range of therapist qualities which they felt had strengthened the rapport between them. These included

aspects which are familiar in terms of ‘core’ therapeutic skills, such as empathy, listening, understanding, non-judgement, and openness (Elvins & Green, 2008).

> *She remembers you, she remembers, you know, what you discussed, she remembers what you'd said...er…even if it's been a couple of weeks, or...you know, I was on holiday or she was on holiday or whatever...you know, if there was a gap between, but yeah, it felt like she cared and there was a relationship there, er…..and I trusted her and respected what she said, and her knowledge and experience.* (Participant W)

> *I don't know...there was something about her you could just trust.* (Participant X)

> *He was very good, and the relationship was good…I didn't want to let him down or let myself, or...you know?* (Participant S)

> *You know, she is very… she listens, but she also, she challenges you about things. But she just comes across in a really, really pleasant way.* (Participant K)

> *She was very friendly, and she was non-judgemental, and she just let me talk.* (Participant H)

> *She was very...er...accommodating, and positive, and understanding and perceptive.* (Participant F)

> *She came across as very supportive.* (Participant C)

These descriptions reflect positively on the skills and qualities of the therapists involved, and at the same time encompass the kinds of core features of traditional face to face counselling. This suggests that these same qualities of

supportive, warmth, non-judgemental, empathy, listening, positivity can be identified by clients in online work, and can impact positively on their sense of relatedness with the therapist.

d) Subtheme: Superficiality and depth

The limited number of therapy sessions (the average number of sessions for all participants interviewed was six), combined with the use of 'remote' technology, could lead to a suspicion that therapy would tend to remain at a superficial level, or that more in-depth emotional work would be more difficult to achieve. A small number of participants made comments which confirmed their sense of this:

> *It didn't get personal, which was probably what I didn't need it to be.* (Participant P)

> *You couldn't go deep into...you couldn't have a proper conversation about...you know...impacts, or, you know. It was quite a...I can't explain it, but it was kind of not like a deeper emotional level, it was more like, 'what are the issues', you know?...I don't think we really got to the bottom of it. I kind of feel like I'm still struggling with depression.* (Participant S)

> *I think if you really started to, you know, if you really...from a psychological point of view, if I was really trying to dig deep into what's going on in my psyche, my emotions, then I think being comfortable with someone in the same room would probably be better*. (Participant W)

However, others felt that their connection with the therapist had allowed them to cover more in-depth material:

> *It was private, and I wasn't being guarded about what I could say.* (Participant H)

> *Yeah, I think you still share, you know, quite personal stuff, you know, with someone, I guess because you can see them, you know...I think so, yeah, yeah...you know, yeah, it was quite comfortable, you know, talking to her. I didn't feel...like anything was awkward doing it over the video, you know.* (Participant J)

Some participants suggested that it was the distance afforded by the use of video which enabled them to address more distressing issues:

> *I was able to talk. I was able to be, you know, full disclosure, open, er...warts and all, erm...I think one of the things that helps that is the screen. Everything the other side of it is...er...almost artificial. It doesn't matter.* (Participant F)

One participant compared her previous face to face counselling experiences with the recent Skype therapy, suggesting that the detachment that she experience via Skype had enabled her to express her distress more easily than in the room with a therapist:

> *Because with the face to face I felt more, sort of, guarded. Like I couldn't let another human being see me lose it. Although [the therapist] was*

seeing me, I was still slightly detached, because there wasn't that...we weren't actually sitting right next to each other, so I felt more comfortable, erm...to lose it over Skype. (Participant A)

These participants appear to have felt that the artificiality of the connection and the detached aspect of the relationship enabled them to feel less shame about expressing their emotions than they would in a face to face context.

Overall, the range of participant responses regarding the depth and emotional content of the work that was addressed during sessions reflected the fact that some participants felt more inhibited by the Skype context than they thought they would in a face to face situation, while others felt that the remote access afforded by Skype allowed them to feel less inhibited than they would if meeting in person. This reflects the broadly accepted idea that the depth and quality of therapeutic work inevitably varies depending on the quality of the therapeutic relationship. These findings suggest that this appears to be the case whether therapy is conducted in a face to face environment, or via Skype or video.

Theme 3: Empowerment and choice

This theme draws on ideas around power in the therapeutic relationship, and on the subtle shifts in power dynamics between therapist and client in the online environment. In particular, this theme explores the ways that the power dynamic is altered by the influence of a consumer choice narrative; selection of therapist, choice of session times and dates, client control of the therapeutic space, and the ability to start and end sessions at the touch of a button, all impacting on power within the therapeutic relationship. Arguably, the client as consumer is empowered in comparison to the client in traditional, face-to-face therapy; clients reported feeling able to direct the content of their own sessions, rather than having therapy 'done' to them. This also raises questions around whether consumer clients experience a reduced sense of obligation and commitment in relation to therapy, and whether this means that they engage with it in a less committed way.

a) Subtheme: Client as consumer

This sense of the client having choice over selection of therapist, timings and content of sessions, and a therapist who will work with them in the way that they want, implies a shift in the power dynamic towards the client as the empowered consumer of therapy. A number of participants described their choice to undertake therapy, and particular their selection of an individual therapist, in terms of a wellbeing choice, a positive step, rather than a necessity.

You could choose. You could like...there's a whole long list of them, and the dates they had available, so you just went with whichever one you fancied, type thing. (Participant X)

This emphasises the sense of choice, of selecting a therapist from a range of options depending on personal preference and suitability. Further, participants expressed their sense of power in the process of initiating and engaging with the therapist.

I wouldn't say I looked forward to our session, because...er...every time it was me offloading, me in a weaker position, but...but I felt in control… I would definitely choose a Skype-type counselling over being in somebody's office, being in their space, erm...feeling intimidated, feeling embarrassed. (Participant T)

I kind of was in control doing it this way. When I had physio, you go along, you sit in a waiting room and they call you in. It's them calling the shots, you know...whereas, when you're at home and you're talking, you arrange the appointment, you start to speak to them straight away, and you feel like you are in control, whereas they are in control when you are in their...in their space. (Participant S)

I just think in this day and age everything is a lot more accessible, but I think, when it comes to therapy, because there's always been a bit of a taboo centered around it, I think, yeah…I suppose you could say it's similar to dating apps, if you think about the possibilities for people just to...don't even have to meet, or to be knocked down by people face to face, you can just do it. (Participant C)

A number of participants reflected on the fact that they had been able to remain in control of what was discussed in the therapy, and felt that the therapist had adapted the approach to fit with the client's own needs and demands. This suggests that the participants felt empowered to direct their own therapy, and that the therapist was seen as a support or enabler. Theirs was not a vision of therapy where something would be 'done' to them, but rather a vision with a more active role for the client.

> *I developed my own little programme of what I wanted to do, and she was just really positive about it.* (Participant K)

> *And the good thing about her...and this delivery system of Skype was that, first of all, she was fully on for that, er, and so she was...she wasn't even mentoring me, it was more like me driving the whole thing.*
> (Participant F)

> *Yeah, it was at my speed, it was how, how I wanted it to be. It wasn't like, you know, I'm a counsellor and you've only got so much time.*
> (Participant H)

b) Subtheme: Exit at the touch of a button

Participants discussed commitment in relation to Skype therapy, with the idea repeatedly expressed that this presented less of a commitment than face to face therapy would have. Participants recognised that they had the ability to end the session at the touch of a button, avoiding open conflict or therapeutic rupture, and more than this, that the technology enabled them to manage their

feelings of shame associated with accessing support and with disclosure of sensitive information:

> *You know, if it was really going wrong, well you can just turn it off (laughs). …I suppose it is an escape route. If you're really worried about it, it's much easier to have someone on a screen, when you're at home, and you can think, 'I really can't take this', turn it off. Whereas, when you're in a room with someone, there's...there's sort of social expectancies of...of, you can't just stand up and walk out, you know?* (Participant W)

> *I don't like admitting my weaknesses, and yeah...it gave me that extra level of control. I would always feel that I could just press a button and go, and I would never see her again, I would never hear from her again, whereas the person who I went to see where I live...I could bump into her in Tesco.* (Participant T)

This sense of having an escape route, of being able to end a session with the touch of a button or key, was cited by participants as a positive aspect of their own sense of control over the therapy. It is worth considering the impact of this element in terms of the therapeutic dynamic, and especially in relation to the therapist's ability to 'challenge' the client, to manage rupture and conflict, and to deal with difficult and distressing issues which the client may prefer to avoid. Interestingly, none of the participants reported having actually used this ability to 'switch off' in reality, but both client and therapist are likely to be aware of it as a possibility in the therapeutic work.

Theme 4: Alcohol – stigma and dependency

This theme explores the meaning of participant's attempts to articulate their identities in relation to alcohol, drawing on ideas around denial to examine the ways that participants understand and describe their own situations. This involves an exploration of stigma and shame associated with alcohol misuse, and the link between avoidance of shame and a preference to undertake therapy at a distance. Ideas around dependency are also explored, as are notions of attachment and relationship more generally, in an examination of endings in the therapeutic relationship.

a) Subtheme: Identity and understanding of self

It was striking that although participants were not asked to describe their drinking habits or patterns in any way, all participants did attempt to explain their relationship with alcohol to some extent. Most participants distinguished themselves from 'alcoholics' or 'other' drinkers, often in ways that often appeared to seek to minimise the extent of their drinking or the seriousness of their alcohol consumption.

> *I'm not a sort of...alcoholic whose life is falling apart.* (Participant W)

> *I'm not like an alcoholic, but...I do, when I do tend to go to social events or whatever, erm…I have a tendency to, like, binge drink.* (Participant A)

I don't want to go to AA because...I didn't think it was that...erm...that much of an issue…I didn't see myself as, sort of, alcoholic...that gets up in the morning and needs a drink in the morning, you know? (Participant S)

I don't think that I have an addiction, but I wanted to explore it. I don't want to do...one drink less tonight, two drinks less in three nights time...because that didn't...that's basically saying, 'well, I am an addict', ...and I didn't think I was. (Participant F)

You don't want to go straight into the, 'Hello doctor, I think I'm an alcoholic' type thing. That just seems a bit extreme. (Participant K)

It's not like I was drinking gallons of beer every day, but, I was drinking way more than what, er, yeah, you should be, really. (Participant J)

I'm sure it is just a social thing. Because, I said to [the therapist], I don't wake up thinking about it, I'm not…I don't drink at lunchtimes, even if I go out I don't always bother to have a glass of wine. …I mean, don't get me wrong, I'm not on the spirits, drinking bottles of vodka every day or anything like that… ...I mean, I'm not going down the alcoholic route or anything like that. (Participant M)

There was some evidence that participants recognised that online counselling did not feel as 'serious' as seeing a therapist in person or attending alcohol treatment services, and that this reflected their reluctance to see their own difficulties with alcohol as 'serious'.

When you go in to, like, a therapist's room, you sit down, you're all kind of like...little bit awkward...it feels a bigger deal than it is, and I actually feel that online Skype is a lot more relaxing. I don't know whether [face to face therapy] might even have been more successful, I might have even gone dry for like the last three months if I'd gone to...I don't know, it's weird. I think, had this not been an online session, I honestly don't think I would have done it...Maybe it's a form of denial. I don't know...I'd be like, 'But I don't drink that much, why do I need to actually go…go see somebody?'. Whereas this feels like, just, an extension of having one of my work calls…so it felt like it wasn't impacting too much on my life. (Participant C)

b) Subtheme: Shame as a barrier

This apparent distancing of the self from the identity of an alcoholic can be associated with the sense of shame and stigma that a number of participants expressed in relation to accessing support for alcohol problems:

It's that...bumping into them in Tesco later on, like...'Hi, yes it's me, it's the one that, you know, was talking to you about all my very shameful issues'. (Participant T)

I didn't really want anybody...I was ashamed. I...I just didn't want anybody else to, sort of, know about it until I could deal with it. (Participant H)

I think the privacy of it, erm...I mean I...me doing the whole group thing, I mean, that's...I would never do a group thing, but that's just me. I'm not a,

'let's have a whole group experience'...that would be my worst nightmare. (Participant X)

A number of people talked about their reluctance to risk being 'seen' attending alcohol treatment services in person, as well as a sense that peer support services, such as Alcoholic Anonymous, were not suitable for them.

I mean I'd rather do it that way than...than...I mean face to face for me would be very difficult. I'm not attracted to the idea about going into a room full of other alcoholics and baring my soul to them. (Participant N)

The group session that I used to go to, you know, it was in a drug and alcohol rehab centre...er...in the middle of town. You have to walk through the front door and you think, 'Shit, what if one of my colleagues...or what if, er...a friend...or what if my neighbour sees me walking in there, they're going to know that I've got a drug or alcohol problem' (laughs). So you know, there's that stigma to it, whereas with this, you know, I am in my own home. (Participant W)

Yeah, it's obviously very private...erm...nobody sees you walk in to Alcoholics Anonymous, and thinks, 'Oh...ahh'. (Participant F)

Walking in to places like the local AA groups, erm...you know, will I be bumping into people that know me? Will they go....will they be saying, 'you know K's got a drink problem?'. Although they are not supposed to. (Participant H)

c) Subtheme: Endings

Some of the shame and stigma around alcoholism appeared to be associated with the idea of dependency, and the participants' wishes to avoid being dependent on alcohol. This links to sense of self, and a keenness to be self-sufficient. There appeared to be parallels with the sense of attachment to the therapist, and a number of people talked about not wanting to be dependent on their therapist, or about their fears of becoming too dependent on their therapist over time.

Interestingly, some participants reflected on the fact that having therapy via Skype had enabled them to maintain an emotional distance and sense of control, avoiding this sense of reliance on the therapist. This was particularly apparent when participants discussed the 'ending' of therapy, reflecting on their final session with expressions of finality and inevitability, with an absence of any emotional reflection on the separation from their therapist.

> *When it ended, I was sort of 'Oh...that's it'. ...: I think...because we discussed the conclusions, and er….she was very happy with the conclusions, I was very happy with the conclusions. As an arm's length exercise, it had reached its finale. Well, there was no finale, but it reached its end. So, you know, we wished each other the best and that was it.....I don't want to be someone who is dependent on anything, actually. Er...red meat, cheese, anything consumable, any particular one individual. You know, I don't want to be dependent, on anything.*
>
> (Participant F)

> *I don't feel the need to continue the sessions particularly, because I think we've identified the goals and targets and where we want to be in the*

next two or three weeks, erm, and I feel that I'm moving down that pathway. (Participant N)

I think we had reached a conclusion really, so, I didn't feel that...I don't feel that I need more sessions with her necessarily. (Participant N)

While the quotes above express a sense of finality about the ending, and a fairly emotionless sense of conclusion, others expressed their feelings of concern around ending their sessions, and their fears around ongoing difficulties with alcohol.

Yeah, and on the last one, I was like, 'Oh my God, what if...what if after this session I just decide to go and have a drink?'. And I got a bit panicky about that. (Participant H)

I suppose if later on you started, you know, sinking back into old habits, and so on, you know....I suppose you could always pick things up with her. I guess I could always email her and say, you know, can we have a session?... So it's not like she has gone for ever. (Participant J)

I know, I'm quite sad actually (laughs). I feel the need to create another concern that I need to talk to her about. Yeah. (Participant C)

These participants acknowledged some sense of wanting to prolong their relationship with the therapist, as well as a fear of not being able to maintain their reduced alcohol consumption without the therapist's ongoing assistance. Overall, the sense is of a varied engagement with the therapist, with some participants remaining a distinct sense of separateness and emotional

autonomy, while others express more emotional attachment and distress around separation.

Chapter 4

Discussion

The following chapter considers the issues that emerged from interview data and explores the implications of these, involving a critical re-examination of pre-existing theory and research. Implications for practice and areas for further research are also considered, as are the limitations of the research methods used. In setting out to explore the experiences of clients with alcohol problems in Skype therapy, this study draws attention to the perspectives of those whose views may otherwise be obscured by quantitative constructs around treatment outcomes, or who are otherwise undervalued or silenced by stigma associated with alcohol misuse. The findings highlight issues around the therapeutic relationship, in particular the ways in which the relationship between therapist and client is formed and maintained over time. This chapter examines the novel context of therapy when it takes place outside of the therapist's room, including the significance of the home environment. This represents a deviation from the 'therapeutic frame' (Langs, 1984; Novak, 2016), defined as the relatively stable context in which therapy takes place, generally understood to be characterised by a regularly scheduled time, cost, and shared physical location. Service users are able to provide an important perspective on questions around whether Skype allows the therapist to deploy the therapeutic frame in a flexible enough way to ensure that a therapeutic space is established which protects and

promotes therapeutic change, and enables the therapist to demonstrate the core qualities of empathy, honest, openness and presence.

Also discussed below is a reflection on the potential of Skype therapy to alter the power dynamics between therapist and client, potentially offering empowerment to the client as a consumer, and within a more equitable context whereby client and therapist co-create the therapeutic space. Also considered are ideas that emerge from the data around the specific needs and relational requirements of clients with alcohol problems, including issues associated with stigma and inhibition.

Comfort: pets, people and space

Participants repeatedly attached significance and value to a having sense of 'comfort' during therapy sessions, derived from their home environment, and provided via proximity to pets, hot drinks, comfortable furnishings, privacy and familiarity with surroundings. Participants felt that being comfortable meant that they were more able to be 'themselves', with some suggesting that they could talk more openly with the therapist as a result.

It is worth considering the significance of 'comfort' as an aspect of therapy, particularly the role that comfort plays in relation to therapeutic change, and, more generally, the interaction between environmental features and clients' thoughts and feelings. Research into client preferences in relation to counselling room space and design has found that the desire for physical and emotional

comfort is important for clients (Sanders & Lehmann, 2018), including the creation of a welcoming, relaxed and homely environment that promotes a sense of safety (Larsen & Topor, 2017). Surroundings are likely to have positive or negative influences on clients' thoughts, feelings and behaviours (Pearson & Wilson, 2012). Other research suggests that the design of built environments also affects the 'hidden dimensions' that impact on human behaviour such as frame of mind, interactions with others and physiological state (Wapner & Derwick, 2002). Ulrich's (1991) theory of supportive design relates primarily to medical settings, but its underlying premise of creating environments that promote stress reduction, buffering, and coping (Ulrich, 2000) appear relevant to therapeutic environments. Ulrich's model demonstrates how such themes amplify a sense of comfort, this being determined by the regulation of negative feelings or increasing positive feelings. Literature on the therapeutic environment encourages therapists to consider their clinical or therapeutic spaces carefully, with the intention of creating a sense of comfort for clients.

The idea of comfort can be linked to the significance of 'containment' in therapy. Bion (1962) wrote about the therapeutic space as a container; linked to this are Winnicott's (1971) ideas around attachment and the creation of a holding environment, which recognises the significance of the therapeutic environment as a space to play and to share thoughts. The containment referred to by Bion is derived from the therapeutic relationship, when the therapist is able to hold the client within appropriate boundaries and receive and understand the emotional communication of another without being overwhelmed by it, processes it and then communicate understanding and recognition back to the

other person (Douglas, 2007). This experience of containment is thought to enable the development of thinking to manage experiences and emotion.

In a Skype therapy context, conceptual and physical boundaries are not all held by the therapist, but are established jointly by the client and the therapist in their own separate spaces. Environmental boundaries relating to the physical space in which the client sits are outside of the therapist's control. The key aspect of containment which is provided by the therapist lies not in physical proximity, but in the therapist's 'presence', the sense of connectedness to the other in the here-and-now (Krug, 2009). If this aspect can be communicated effectively via Skype, then the physical therapeutic environment arguably becomes relatively less significant.

While comfort was repeatedly discussed as a positive feature by participants in this study, this raises a question around the role of 'discomfort' in therapy. In particular, there may be concerns that heightened sense of comfort may be associated with greater avoidance; questions could be raised about whether a client is likely to want to 'go' to difficult and troubling places from within the comfort of their own homes. Further, it may also be important to consider whether clients are likely to be able to overcome inevitable ruptures in the therapeutic relationship if they are not being physically contained within the therapist's own 'holding environment' of the therapy room.

In therapy, the supportive relationship which offers comfort should ideally be balanced by constructive challenge from the therapist, occurring through sensitive feedback. The sense is that comfort alone is not enough to bring about change, but requires the co-existence of tensions, between comfort and challenge. Casement (1985) suggested that in personal therapy there seems to be a search for the right space with appropriate boundaries. In Skype therapy, it appears that the responsibility for defining these appropriate boundaries has been removed to some extent from the therapist and lies jointly with the client and therapist. This may suggest that Skype therapy offers the potential for an increased sense of collaboration and mutuality in the very means of establishing a shared physical and mental space.

Laws (2009), reflecting on therapy which occurs outside of counselling rooms, describes it as taking place in a 'non-technical space', which lacks a physical setup and removes the therapist from the conceptual centre. Laws argues that in standard counselling settings the, "carefully angled chairs, tactful box of tissues, tranquil painting on wall become like a tick-list with which to engineer a perfect therapy room" (p.1832), and that this creates a pre-determined power dynamic placing the therapist in the position of power over the client. In a non-technical space, such as outdoors or in the client's own home, however, it follows that there can be a more equal sense of relatedness. In contrast to the therapy room, where the therapist is responsible for creating and maintaining the boundaries of the physical space in which therapy takes place, in Skype therapy the client is empowered to establish their own boundaries relating to confidentiality, lack of interruption or distraction, privacy, and comfort.

Several participants did express concerns around confidentiality, or around being overheard by others, with some reflecting on the actions that they took to manage the boundaries of the physical space to avoid being overheard: "*I would go and put the radio on as a background, to stop them from being able to hear what I was saying*" (Participant T). The provision of confidentiality is given a good deal of emphasis in therapeutic settings, and can be conceptualised in terms of boundaries designed to place clear limits on the circulation of information about clients' identities and disclosures. These boundaries define a context within which clients' disclosures are held, beyond which disclosures cannot be transferred without the client's explicit permission (Jones et al., 2000). Boundaries of confidentiality are a vital part of the invitation to clients to share matters felt to be private or shameful, and serve to create a space safe for the issues the client brings to be spoken about and addressed, with a view to gaining new perspectives on their meaning and significance.

In Skype therapy, confidentiality cannot be managed entirely by the therapist; instead the client is required to determine how to establish appropriate boundaries within their own homes, allowing themselves sufficient privacy to enable them to engage with the therapy without feeling constrained or otherwise inhibited. This may be less of a radical departure from traditional methods than at first appears. While it is possible to conceptualise boundaries of confidentiality as coinciding with the walls of the therapy room, it can be argued that these boundaries are partly illusory anyway. As Bondi and Fewell (2003) point out, counselling does not seek to replace one form of secrecy, such as

secrecy within the family, with another. Instead, the illusion of confidentiality in face-to-face therapy is counter-balanced by an explicit acknowledgement that third parties may, under certain circumstances be notified of particular information. In this way, therapeutic spaces have always operated with boundaries that are simultaneously very concrete and specific, and necessarily flexible and fluid.

Taken together these features demonstrate that confidentiality is not just between client and therapist, or within the walls of the therapy room. The idea that client and practitioner work within a straightforward and impermeable boundary can undoubtedly serve an important purpose in fostering a sense of containment and safety. However, containment and safety can also be enhanced by more complicated and flexible boundaries, such as those created during Skype therapy sessions. In other words, Skype appears to allow for the co-construction of boundaries around confidentiality, while also allowing for the fluidity and blurring of such boundaries. Therapy can be thought of as a practice committed to redrawing boundaries. It seeks to offer a form of care, within which clients' most private thoughts can be shared, and it does so by traversing normative boundaries of relationship. The aim for therapists working via Skype is therefore to enable the co-creation of therapeutic spaces that are sufficiently flexible and safe to enable them to enter into relationships with clients within which relative positions can be problematised.

Another way that the boundaries of traditional therapeutic methods are challenged by Skype therapy is the presence of others in the therapeutic

setting: specifically, family members or pets. Participants in this study often referred to the proximity of pets in the home environment, in this case cats and dogs. In some cases, pets were present throughout therapy sessions, or the therapist had interacted with their pets via Skype. The presence of pets during therapy sessions appears to have contributed to the sense of comfort articulated by participants. In attachment terms pets are thought to serve as attachment figures, facilitating distress reduction and exploration (Zilcha-Mano Mikulincer, & Shaver, 2011). Studies suggest that pet owners feel emotionally close to their pets to the extent that pets are turned to for support in times of emotional distress (Kurdek, 2009), and that pets constitute a source of support, comfort, and relief in times of need (McConnell et al., 2011).

While also potentially acting as a distraction to clients by interrupting sessions or making a noise in the background, *"sorry, my dog is making a strange noise"* (Participant F), it appears that the pets described by participants in this study did provide their owners with a sense of comfort. By enabling the presence of family pets, Skype therapy therefore offers to clients an element which is not typically available in a therapy room in the physical presence of the therapist.

As well as the involvement of pets, participants also reported on the presence of family members in Skype therapy sessions. Family members sometimes appeared on screen, were in the background, brought drinks to clients, burst into the room, or otherwise became known to the therapist. This suggests that some participants felt able to explain their therapy session to family members, or even to speak to the therapist in front of partners, "*he's sitting on the sofa*

over there at the moment" (Participant K). In some ways this is a radical departure from traditional therapeutic methods whereby the therapist would not typically enter into the client's own home, become familiar with pets and household decorations or meet family members. It can be seen as part of a broad change in the way that individuals use technology to relate to each other. Maheu et al. (2012) suggest that there has been a fundamental shift in the way that individuals use communication tools, and that it is not unusual for a client to,

> "move smoothly from a supportive conversation on the telephone with a family member; to an in-person therapy session with a therapist; to a crystallizing insight sent via text messaging to a friend; to tracking with a smartphone based, self-help "app" entry later that same day" (p.615).

The traditional containment offered by therapists is inevitably impacted on by the array of communications sources, psycho-education, and other information available to clients, and the role of the therapist is therefore evolving. This evolution is likely to encompass a role in skilfully guiding clients in using the most appropriate resources, and possibly helping clients tailor technology to their specific needs, at the same time as maintaining opportunities for genuine connectedness and meaningful interactions.

The therapeutic relationship: Seeing and being seen

Participants clearly articulated the significance for them of viewing the face of the therapist, rather than having a "*dry conversation over the phone"* (Participant N). Participants suggested that seeing the therapist's face gave

them a sense of the other person as a human being who was present with them. The significance to clients of 'putting a face to a name' has emerged elsewhere in research into Skype therapy (Ashwick, Turgoose, & Murphy, 2019), and reflects wider research around neurobiological responses to viewing another's facial expressions and responses.

The use of Skype or other similar video communication applications leads to a focus on a head and shoulders presentation of the other person. It has been argued that this means a loss of significant information from postural, gestural and expressive movement and intent that is conveyed by the rest of the body (Bayles, 2012). However, the absence of a view of the rest of the therapist's body may also have emphasised or sharpened the focus on the face and upper shoulders. Participants suggested that by focusing carefully on their voice and facial expression, the therapist was able to remain attuned to subtle shifts in mood and emotion; "*I've never been able to control what my face does….so I think she could kind of like pick up on stuff*" (Participant M). This suggests that the limitations associated with a loss of some non-verbal cues such as hand gestures and leg movements may be compensated for by a deliberate and focused attention on facial movement and expression.

Linked to this, Seitz (2015) argues that the therapist can use their own facial expressions to convey understanding and emotion. Participant T commented, "*if I was talking about something emotional and she...you know, she would be sympathetic. To see that on her face was exactly the same as if she'd been sat on the other side of the table".* It is clear that clients were able to intensify their

focus on the therapist's facial expressions in order to obtain an understanding of the therapist's empathic responses.

Watching someone's face is linked with shifts in subjectivity and with intensification or inhibition of emotional experience; it may be simultaneously communicative and self-regulatory. Beebe (2004) suggests that, "faces enjoy a special status in the brain" (p.3), because neural activity in the temporal lobes surges twice as much when adults watch faces versus other objects; it may be that facial communication operates at a largely unconscious level. It has been suggested that matching of facial expressions can be an important way in which the emotional state of the individual can be transmitted to the partner (Winton, 1986). Research also shows that the perception of emotion in the partner creates a resonant emotional state in the perceiver (Davidson & Fox, 1982), and work around 'mirror neurons' suggests that neurobiological mechanisms can explain aspects of intersubjectivity, such as empathy, affect attunement or resonance. Neuroscientific evidence suggests that mirror neurons sit adjacent to motor neurons, and are activated in an observer who is watching another person behave (Stern, 2007). According to this model, visual information received when watching another person gets mapped on to the observer's equivalent motor representation in their own brain by the activity of these mirror neurons. This enables individuals to directly participate in another's actions, without having to imitate them. This 'participation' in another's mental life is thought to create a sense of shared understanding with them.

It is thought that positive or negative emotional matching reactions can be evoked out of awareness, so that important aspects of face to face communication occur on a non-conscious level, or occur too rapidly for simultaneous verbal transaction or conscious reflection. Schore (2003) suggests that in a therapeutic context, the empathic therapist is:

> "consciously, explicitly attending to the patient's verbalizations…But she is also listening and interacting at another level, an experience-near subjective level, one that implicitly processes moment-to-moment socioemotional information at levels beneath awareness" (p. 52).

This suggests that the client conveys information that is not symbolised in words, and that it is possible to recognise changes in emotional states of others based on perception of subtle shifts in their facial expression, and for the therapist to recognise changes in their own states based on somatic experience (Bucci, 2002). The role of the face in signalling affect and emotion therefore remains significant in Skype counselling, and may be understood as a significant aspect of the interaction when only the head and shoulders of both client and therapist are visible to the other.

In psychoanalytic practice, the face is significant for seeing and being seen. By locating his own chair behind and out of sight of the client, Freud is said to have believed he could limit undesired psychological transference and enable therapeutic regression (Arehart-Treichel, 2004, Freud, 1913). This spatial configuration is based on the idea that removing visual communication may help the client engage in subjective experiences without continuously trying to decode the psychoanalyst's non-verbal forms of communication. Even in this

context, the face is still important in interchanges around arrival and departure. Seeing and being seen carries much significance, including the view that being seen and being responded to by the other is constitutive of the self (Winnicott, 1974; Bion, 1977), and person-centred counselling's ideas around fostering the 'core conditions'. In person-centred approaches, client and therapist sit facing each other, in chairs of equal size in order to foster the 'core conditions' of acceptance, empathy and genuineness that Rogers posited were both necessary and sufficient for therapeutic change (Kahn, 1999). As Rogers (1961) wrote, "the therapist is genuine, hiding behind no defensive façade but meeting the client with the feelings which organically he is experiencing… no inner barriers keep the therapist from sensing what if feels like to be the client" (p.185). Departure from the psychoanalytic couch was therefore more than a means of establishing distance from psychoanalytic method, but by allowing the clients to see his face, Rogers intended to create the core conditions and create the therapeutic relationship (Laws, 2009).

The question arises, therefore, about this more recent shift from the therapy room to the online space in Skype therapy, and about the space that is created during the therapy. Davidson and Harrison (2019) suggest that in a telephone counselling setting, therapists appear to embody space during their connection with the client by constructing a mental place in their own minds that is separate from the physical environment. They argue that this mental space provides containment and shelter in the otherwise vast perceived metaphysical space between therapist and client. In this way, it can be said that therapists and clients, in response to the lack of physical proximity, mutually create a shared

therapeutic space and that this shared space fosters closeness and therapeutic relationship. This idea echoes Vanolo's (2014) ideas about therapeutic space not as fixed and fully knowable, but rather as dynamic and relational, always in the process of becoming. Space is assumed to be brought into being through performativity, or constituted through the interactions of people, and is always under construction. By focusing on the relational and dynamic aspects of space, therapy in an online setting can be understood as more than just the interaction between human bodies, but also as a mutual and progressive construction of ideas, discourses, emotions and objects.

For participants in this study, there was widespread acceptance of the importance of a positive therapeutic relationship, and that this was the key factor in their experience of therapy. A number of participants reported that they had experienced a strong sense of rapport very quickly after meeting their therapist, during the first session: *"right from the start I just had complete trust in her"* (Participant K). This suggests that the use of Skype does not interfere in the phenomenon remarked on elsewhere, whereby the therapeutic relationship can be established successfully online. Cipolletta's (2018) conversational analysis study on therapy via videoconference suggests that there are a number of specific features during early online sessions which contribute to the establishment of strong therapeutic relationships, including early definition of the problem online, motivation to use a communication technology, establishing the online therapeutic rules, and inter-session availability.

Participants in this study reported specific factors which enabled them to feel rapport with the therapist from early sessions onward; "*she was very friendly, and she was non-judgemental, and she just let me talk"* (Participant H) and "s*he was very...er...accommodating, and positive, and understanding and perceptive*" (Participant F). In particular, participants reported that they valued the therapist's qualities of non-judgement and kindness. This is reflected in other studies which have found that these particular qualities are deemed helpful to disclosure of alcohol related problems, as they are thought to counteract reported feelings of guilt and shame associated with the stigma of alcohol problems (Coste, et al.,2020).

The narrative of consumption

Participants described being able to select the therapist they wanted to see from a webpage listing potential options, with names accompanied by a photo of each therapist's face. Participants chose the therapist they liked the look of, or who had availability at times that suited them. Participant X reported that, *"You could choose...there's a whole long list of them, and the dates they had available, so you just went with whichever one you fancied"*. This ability to select from a range of available options suggests a process similar to online shopping, where the preferred option can be selected at the click of a button. Arguably, this strengthens a sense of the client as a customer, or a consumer of therapy. With increasing commodification of therapeutic services, therapy is positioned as one option in an emerging online wellness industry.

This positioning of therapist and client into roles aligned to supplier and customer means that the client has choice in selecting the therapist, choosing the time to suit them, able to have control over when to enter and leave, how to structure the content of the therapy, and which type of therapy is preferable for them. Shackak (2017) refers to the “commodification of psychotherapy”, to describe the gradual infusion of market and consumer logic into the production, dissemination and consumption of therapeutic knowledge and techniques. Shackak argues that in this context the therapeutic relationship becomes a contractual relationship which offers effective delivery of predefined emotional commodities. This individualised, interpretive framework for understanding and the self, one’s emotions and social relationships promotes a mode of attending, monitoring and consulting emotions and a set of practices one performs on oneself in order to regulate and control one’s emotions and experiences. Illouz (2008) argues that such techniques can produce ‘emotional capital’, commodities that overlap with economic repertoires and practices of cost-benefit calculation, personal choice and maximization of emotional reward.

This can be understood as a move away from a psychopathological view of external help from a therapist deriving from mental illness or distress, a viewpoint which could be said to assume a passive or ‘sick’ client. Instead, therapy is posited as a positive life choice, with an emphasis on wellbeing, rather than sickness. The focus is on development of life skills, rather than responding to a crisis, reflecting a wider trend in the ‘positive psychology’ movement focusing on ways to move towards self-actualisation (Woolfe, 2016).

This should also be understood in the context of the specific demographics of the participants included in this study. As has been outlined above, the average participant age was 50, with the youngest participant being 32 and the oldest being 71. Most participants in this study reported being employed, and many undertook their therapy sessions during the working day, or fitting sessions into their free time around work. It could be argued that the specific socio-economic features of this cohort of participants meant that they were particularly familiar with a discourse of consumption and were open to the idea of therapy as a kind of transaction. Participants were largely economically active and relatively prosperous, with enhanced experience of and familiarity with their role as consumer and their power as purchasers.

The implications of this are significant for therapists, who may find themselves in a new role as suppliers of therapy. A successful 'supplier' of therapy may well prefer to focus on client strengths and assets within an overall framework of promoting well-being, rather than more challenging therapeutic options which address client 'deficiencies and undermining characteristics' (Slade, 2010); this would represent a significant shift in focus. Another concern is that the increased focus on the individual as the agent of change may lead to a consequent downplaying of environmental, economic or social aspects which impact on the client. Such a focus would negatively impact on those clients most economically and socially disadvantaged, by implying that solutions to their difficulties could be found from within, rather than acknowledging the inequalities which hold them back. Smail (2011), for example, argues that, "'choice' and 'will power' are epiphenomena of material advantage, rather than

the innate moral potentialities" (p.235), arguing that an analysis of personal distress should focus less on diagnosing individuals and the idea self-transformation, but rather should examine the social and economic environments that surround them.

One aspect associated with the idea of the client as consumer are ideas around choice and self-direction. Participants reported that they appreciated feeling empowered to direct the course of their own therapy, rather than having therapy done to them. This accords with existing research which suggests that clients with high levels of shame may require greater levels of control in therapy (Simpson, Bell, Knox, & Mitchell, 2005). A number of participants made positive statements about the therapist's willingness to adapt the therapy to their needs. Although the therapist clearly maintained a clear focus on alcohol issues, participants appeared to feel empowered when they were able to adapt the therapy, particularly in relation to goal-setting and planning changes to lifestyle. *"I felt in control*" (Participant T), *"It was more like me driving the whole thing*" (Participant F), and *"I developed my own little programme of what I wanted to do, and she was just really positive about it*" (Participant K). This sense of empowerment described by participants suggests that participants may have been reluctant to engage with therapists who had a more directive style. These participants valued support and guidance rather than direction, homework, agenda setting or prohibition.

A further aspect of this sense of being in control described by participants was the potential to end a session at the touch of a button, effectively hanging up on

the therapist: "*I could just press a button and go, and I would never see her again*" (Participant T), and "*If it was really going wrong, well you can just turn it off … being online gives you that option of an escape route*" (Participant W). While none reported having used this option, this ability to control the ending, to escape suddenly, or to avoid any continuation of discomfort within therapy, gave participants a sense of security which they valued. This also gives a sense of the tenuous nature of the link between therapist and client in video-based therapy; for the therapist, it may be that there is a new role in terms of 'holding on' to the client, preventing them from leaving the session, keeping them engaged, with a permanent threat of them leaving if they feel uncomfortable. For the client, by reducing the ending of a session to the click of a button, therapy may seem more like what Tao (2015) has described as a 'magic game' than a real, genuine connection. It is also worth considering whether this impacts on the client's sense of commitment to the therapy. With the option to switch off and continue on with 'real' life, it may be easier for clients to view therapy as carrying less significance than they would if attending required greater commitment and effort.

Identity and the construct of denial

Participants in the study attempted to define their own sense of identity in relation to alcohol. With alcohol consumption as an accepted and normative aspect of culture in the United Kingdom, in a context where excess is somewhat normalised and participation expected (Szmigin, Bengry-Howell, & Griffin, 2011), the image of a social drinker is acceptable, in sharp comparison to the identity of an alcoholic. Despite an absence of interview questions focusing on

drinking habits and behaviours, all participants attempted to explain the context of their drinking, and noticeably attempted to minimise the seriousness of their drinking. Often this identification was made by differentiation from others with worse drinking problems in a process of 'othering' (Rogers et al., 2019): "*I didn't see myself as, sort of, alcoholic...that gets up in the morning and needs a drink in the morning, you know? Or drinks cans of Special Brew*" (Participant S). Others described their drinking as a social habit which they wanted to manage more effectively: "*I'm sure it's just a social thing*" (Participant M).

One of the most frequently used explanations for the failure of many individuals to recognise or address their alcohol-related problems is denial (Clark, 1998). The idea of denial was prominent in early psychoanalytic formulations (Freud, 1936), and is embodied in the formal language of mutual self-help and 12-step models of treatment, including Alcoholics Anonymous (AA; Alcoholics Anonymous World Services, 2016). Denial is envisaged as a powerful defence mechanism which enables those with alcohol problems to maintain a façade of normality and social acceptability (Howard et al., 2002).

However, the concept of denial is not unproblematic or uncontested. Stoddard Dare and Derigne (2010), for example, call for a reappraisal of the concept of denial due to the theoretical complexity of the construct – whether based on psychodynamic or phenomenological theory, or models of moral deficit, mental impairment or stages of change, and point to the wide variety of clinical responses to denial depending on the theoretical perspective. It is possible to argue that participants are not actually demonstrating denial at all, but are

instead reflecting the fact that addiction is actually “uncannily normal” (Lewis, 2015). From this perspective, alcohol difficulties are not a disease or pathology requiring medical treatment, and nor are they a matter of choice requiring shameful self-assessment, but rather a problematic product of ordinary development and social interaction which can be overcome through further learning and development, in the form of personal growth and self-understanding.

Evidence suggests that the extent to which individuals deny needing alcohol treatment may impact on the type of treatment received as well as overall treatment success (Quinn, 2020). For example, individuals who positively perceive a problem and the need for treatment may be more likely to engage in treatment and experience successful outcomes (Choi et al., 2014), while individuals who deny treatment need may attend treatment, but minimally benefit from the interventions (Gaume, Bertholet, & Daeppen, 2016; Rogers et al., 2019). This suggests that effective interventions for alcohol problems may need to address barriers to treatment, particularly an individual’s denial of treatment need (Emiliussen et al., 2017).

There is some indication that the tendency of participants to minimise or deny the significance of their difficulties with alcohol was associated with their choice to undertake therapy via Skype. One participant acknowledged that her sense that her alcohol problems were not very ‘serious’ was reflected in their choice of therapy: “*...maybe it's a form of denial. I don't know....I'd be like, 'But I don't drink that much, why do I need to actually go...go see somebody?'. Whereas*

this feels like, just, an extension of having one of my work calls" (Participant C). By avoiding having to attend therapy in person, participants are arguably avoiding having to 'face' the therapist and thereby accept the impact of their own difficulties. By having the option of ending sessions at the touch of a button, they are able to enter into therapy in a somewhat tentative way which allows for an increased sense of control and self-direction. Arguably, this arrangement allows for a potential maintenance of some aspects of denial; by maintaining secrecy, participants are at no point required to admit to family and friends the extent of their problems with alcohol, nor to accept that their problems are significant.

Privacy and dependency

Participants repeatedly referred to the privacy of undertaking therapy in their own homes, which allowed them to avoid the risk of being 'seen' by others when attending. A number of participants described group therapy as unavailable to them, "*I would never do a group thing*" (Participant X), and "*I'm not attracted to the idea about going into a room full of other alcoholics and baring my soul to them*" (Participant N). Although this represents a valid personal choice, it also reduces significantly the treatment options for these individuals, due to the prevalence of group-based therapeutic approaches within mainstream alcohol treatment systems, such as Alcoholics Anonymous or peer support groups. It also implies the existence of specific issues of secrecy and stigma around alcohol consumption that is perceived to be excessive and therefore non-normative. The risk of being seen by friends or colleagues when attending therapy in a physical location was provided as an explanation for

opting for Skype therapy by a number of participants *"it's that...bumping into them in Tesco later on*" (Participant T). This idea of 'bumping into' or accidentally meeting acquaintances outside of therapy and having their alcohol difficulties exposed was a very real fear for participants, and apparently led participants to prefer the privacy of Skype counselling within their own homes.

Barriers to treatment for alcohol problems associated with shame and stigma are well researched. Link and Phelan (2001) broadly conceptualise stigma as consisting of four interrelated components: labelling, stereotyping, separation, and discrimination. This framework accounts for the way that differences between persons with and without problematic alcohol use are distinguished and labelled. Negative stereotypes can then be applied to labelled persons, creating separation between groups, which then lead labelled individuals to experience negative social consequences like prejudice and discrimination. Individuals with alcohol problems are highly stigmatised and their behaviour often regarded as a personal choice where the blame is placed on the individual (Schomerus, et al., 2010). Such stigma may be a leading cause of why individuals with alcohol problems tend to hide their problems from others, or to use other means to avoid being labelled with a stigmatising title such as 'alcoholic'. Potentially, then, therapy via Skype offers individuals with alcohol problems a valuable means to overcome such barriers and to access treatment by avoiding the risk of shame and stigma associated with physical attendance at a treatment service. If treatment via Skype enables individuals, who may not otherwise access treatment, to seek help at an earlier stage in their difficulties

with alcohol, or to seek help without increasing their sense of marginalisation and shame, then this is clearly to be welcomed.

The reluctance of participants to become dependent on the therapist was summed up by Participant F, who said: "*I don't want to be someone who is dependent on anything, actually. Er...red meat, cheese, anything consumable, any particular one individual".* Fox and Wilson (2011) argue that there is little evidence that people who develop an alcohol dependency are necessarily likely to develop dependencies in other areas of their lives. The concept of the 'dependent personality' is widely discredited for lacking empirical evidence and for pathologizing individuals (Amodeo, 2015). Nevertheless, participants who have sought therapy for an alcohol problem will have done so because they felt unable to resolve it alone. They may therefore be likely to doubt their future ability to cope without support. Some participants suggested that they had concerns about ending their sessions with the therapist, and described their concerns about no longer having access to the support of the therapist: "*Will I just fall apart, you know? If there's not anybody there…*" (Participant H), and some suggested ways of continuing a relationship with the therapist, *"I feel the need to create another concern that I need to talk to her about*" (Participant C).

In contrast to this, other participants described the ending of their sessions in relatively functional terms, lacking in emotion: *"it reached its end"* (Participant F), *"we had reached a conclusion"* (Participant N), and, *"it's run its course"* (Participant J). It may be that the abrupt nature of ending each session via Skype influenced the way that some participants described their final session

with the therapist. Skype does not allow for the physical signifiers of departure and separation that are embodied by both client and therapist in face to face setting – standing, putting on a coat, moving towards a door, opening and closing a door; rather, in Skype sessions, the shared space is extinguished instantly when a participant leaves. Client and therapist are instantly separated and re-located into their own physical spaces, with no physical movement. This aspect of Skype counselling may have contributed to the sense of finality and lack of emotion described by some participants. There appears to be very little research specifically examining the psychological impact of separation and ending via Skype, and this may be an area where further research would be useful.

There may be other factors to explain why some participants described the ending of their relationship with the therapist in relatively functional and unemotional ways, beyond the relatively short number of sessions. Another factor could be associated with the dynamic and relational drivers behind the decision to undertake therapy via Skype. Rossi and Ferro (2020) suggest that fear of relationships could be one of the reasons why clients make this choice, rather than seeing a therapist in person. They argue that beyond the obvious explanations around convenience, flexibility and comfort may lie less obvious motivations, such as difficulties in being in relationship with another. It could be argued that Skype overcomes obstacles to accessing therapy around stigma and shame, as well as geography and time, but further, that it helps clients to overcome a fear of contact, enabling a type of intimacy and proximity that narrows the distance between two people. In other words, it offers a protected

means of being in a relationship. Arguably part of this protection lies in the means of ending a session, the control the client has over the ending, and the certainty of it.

Limitations

It should be noted that participants who had a poor relationship with their therapists may have been excluded from the study, particularly if they dropped out of treatment and therefore failed to meet the inclusion criteria of a minimum of four sessions. This study therefore may have failed to capture those therapist behaviours which were a barrier to therapeutic rapport, or to explore whether the online method of delivery itself represented a barrier in some ways for those service users.

The average age of participants in this study was 50, and the youngest participant was 32 years old. It is often assumed that young people are more familiar than older people with new technologies, but this study showed high levels of technical competence and familiarity among an older group of participants. The absence of younger participants means that the study does not allow us to draw any age-related comparisons in terms of familiarity with technology, and it would be interesting to know more about the ways that younger populations access support and therapy via technologies. Potentially, the absence of younger participants could be evidence of what Haig-Ferguson et al. (2019) call a ‘generational misunderstanding’ (p.49) that communicating virtually is a ‘young person’s thing’, when in reality, communicating via Skype may be more adequately understood as an extension of traditional ways of communicating.

Chapter 5

Conclusion

This study covers an under-researched issue, and there are no known prior publications on the specific issue of client experiences of relational aspects of Skype or video therapy in alcohol services, despite the increase in its prevalence. The study therefore hopes to influence an emerging and rapidly developing field within counselling, psychotherapy, psychology and beyond, around online treatments and Skype-based therapy. The findings may help to further an understanding about a range of new skills which counsellors and therapists may be required to acquire (Hanley, 2006), and should also broaden an understanding of how online therapies work in practice. Further, by exploring the limitations of the existing theoretical framework around the therapeutic relationship and relational aspects of the therapeutic encounter, when applied to the video-based setting, this study also seeks to engage in the process of ongoing reformulation of theory.

In highlighting the significance of the home environment as a site for therapeutic work, the findings of this study demonstrate the importance of the concept of comfort, as well as the implications of the involvement of family members and pets in the therapeutic dynamic. Participants reported positive therapeutic

relationships with their therapists, established and developed over time via Skype, appreciating the same core qualities that would be expected to be demonstrated by therapists in face to face therapy, such as empathy, non-judgement, openness, warmth and positivity. Participants had mixed views on whether Skype enabled greater disclosure; for some the Skype context meant that the work remained on a superficial level, while others felt empowered to express themselves more openly due to the distance afforded by Skype. The significance of viewing the face of the therapist was acknowledged as central to a sense of connectedness. The study also highlights ideas around the commodification of therapy, with the client positioned as consumer; this raises questions around client commitment to therapy and ability to withdraw at the touch of the button, as well as relative power dynamics between therapist and client. Finally, participant accounts of their own relationships with alcohol demonstrated the complexity of the concept of denial and allowed for an interrogation of ideas around shame and stigma, alongside an exploration of Skype's potential to reduce barriers to accessing treatment.

The findings of the study are likely to be of particular interest to alcohol treatment providers and local commissioners of treatment, as well as individual therapists and other practitioners providing treatment to clients with alcohol problems. By examining the potential benefits and limitations of Skype therapy for alcohol treatment clients, the study is able to present a rich account of relational issues which arise during Skype or video therapy. Further, the research enables a rare exploration of the voice of alcohol clients, providing an

insight into their individual experiences and the factors which influence their treatment and recovery.

More broadly, the findings contribute to a growing evidence base around our understanding of the psychology of online communication. This holds the potential to generalise more widely to counselling, psychology, psychotherapy and beyond; with increasing numbers of people conducting large parts of their professional and personal lives online, it is clearly important that there is an understanding of the subtle implications of technologies which remove the need for physical proximity. Future research in this area could helpfully build on the evidence base around client choice in Skype therapy, the notion of comfort versus discomfort, and around ideas of commitment to therapy when undertaking it via remote, online means such as Skype.

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Appendix 1: Interview questions

General questions:

1. What first attracted you to the idea of having alcohol treatment online, rather than face to face?
2. Have you ever had counselling or therapy before? Face to face or online?
3. Could you tell me about your experience of having therapy online?
4. How did you feel about the therapist, and did this change over time?
5. How did the therapist get to know you?
6. Were there any difficulties or problems for you in having therapy online?
7. What was the best thing about having therapy online?

More specific questions:

8. Did the therapist set out a 'contract' at the start of therapy, around things like appointment times, confidentiality and safety?
9. Can you remember what your thoughts and feelings about online therapy were before you started the first session?
10. What did the therapist do to encourage you to talk openly?
11. Where were you when you were having online therapy? Did you always stay in the same place? Were you able to find somewhere quiet to talk for each session?
12. Do you feel that you were close to your therapist? Why?
13. Did you feel emotional during your therapy sessions? How did the therapist respond to you when you were upset or distressed?
14. Did you have any strong emotional reactions to what you had discussed during a therapy session? How did you manage these immediately after the session?
15. How did you feel about finishing your sessions with the therapist? What was the final therapy session like for you?

Additional questions, arising from early interview(s):

16. During the therapy sessions, did you stay in one place?

17. During the therapy sessions, did you talk about your own environment with the therapist? Could they see where you were?

18. What did it mean for you that you were able to choose from a list of potential therapists?

Appendix 2: Participant information sheet

University of the West of England
BRISTOL

Service user perspectives on alcohol therapy delivered via Skype

Participant Information Sheet

What is the research about?

Thank you for your interest in this research into Skype therapy for alcohol-related issues; your views and experiences are really valuable, and I appreciate the time you have agreed to give in speaking to me.

What does participation involve?

You are invited to participate in an interview which should take approximately 30-40 minutes. You will be asked to answer questions in your own words. The questions will be about your experience of having therapy via Skype, including your impression of the therapist, your relationship with the therapist and your experience of communicating online. The interview will be audio recorded and I will transcribe / type-up the interview for the purpose of analysis.

Prior to the interview, I will ask you to read and complete a consent form, and return this to me via email. You will also be asked to complete a short demographic questionnaire. At the start of the interview you will be given an opportunity to ask any questions that you might have.

Who can participate?

Anyone over the age of 18 who is interested in taking part, and who has recently completed (no longer than six months ago) therapy for alcohol issues via Skype. Participants will need to have completed a minimum of four sessions of one-to-one

therapy with a trained therapist via Skype or similar online platform, in order that they can reflect on the various stages of treatment, from commencement to completion.

Confidentiality and data use

Your interview data will be treated confidentially and anonymised, and any information that could identify you will be removed. Extracts from your interview may be quoted in my thesis and in any publications and presentations arising from the research – details may be changed to preserve your anonymity, where required.

The demographic data for all participants will be compiled into a table and included in my thesis and in any publications or presentations arising from the research. The information you provide will be treated confidentially and personally identifiable details will be stored separately from the data.

The personal information collected in this research project (including the interview audio recording and transcript, and the demographic form) will be processed by the University in accordance with the terms and conditions of the 2018 Data Protection Act. We will hold your data securely and not make it available to any third party unless permitted or required to do so by law.

How do I withdraw from the research?

Participation in the research is entirely voluntary. If you decide you want to withdraw from the research please contact me via email [louise2.atkinson@live.uwe.ac.uk]. Please note that you have the right to withdraw from the study at any point up to the date of thesis submission, however, I strongly encourage you to contact me within two months of the interview if you wish to withdraw your data.

Are there any risks involved?

We do not anticipate any particular risks to you with participating in this research; however, there is always the potential for research participation to raise uncomfortable and distressing issues. For this reason I have provided information below about some of the resources which are available to you.

Drinkline - offers confidential advice and information to people affected by their own or someone else's drinking, including information about where to get support locally. Call 0300 123 1110 on Monday to Friday between 9am and 8pm, and at weekends between 11am and 4pm.

The Samaritans - Available 24 hours a day to provide confidential emotional support for people who are experiencing feelings of distress, despair or suicidal thoughts. Call free on 116 123.

If you have any concerns about this research please contact my research supervisor: Dr Toni DiCaccavo, Department of Health and Social Sciences, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY

Email: Toni.Dicaccavo@uwe.ac.uk

This research has been approved by the Health and Applied Sciences Faculty Research Ethics Committee (FREC)

Appendix 3: Consent form

University of the West of England
BRISTOL

Client perspectives on alcohol therapy delivered via Skype

Consent Form and Demographic questionnaire

Thank you for agreeing to take part in this research on Skype therapy for alcohol-related issues. My name is Louise Atkinson and I am a postgraduate in the Department of Health and Social Sciences, University of the West of England, Bristol. I am collecting this interview data for my Professional Doctorate in Counselling Psychology thesis.

I would like to emphasise that:

- your participation is entirely voluntary

- you are free to refuse to answer any question

- you are free to withdraw from the study at any point up to the date of dissertation submission, however, I strongly encourage you to contact me within two months of the interview if you wish to withdraw your data (see participant information sheet for info).

There are no right or wrong answers and I am interested in everything you have to say. I will be recording the interview so that I can transcribe and analyse it afterwards. Recordings will be held securely on an encrypted device, as outlined on the participant information sheet.

Please sign or type your name below to show that you have read the contents of this form and of the participant information sheet and you consent to participate in the research:

_____ (Signature/Name)

_____ (Date)

This research has been approved by the Health and Applied Sciences Faculty Research Ethics

Committee (FREC)

Appendix 4: Demographic questionnaire

Some questions about you

In order for us to learn about the range of people taking part in this research, we would be grateful if you could answer the following questions. All information provided is anonymous.

Please either write or type your answer in the space provided, or circle the answer, or answers, that best apply to you.

1	How old are you?			
2	I am:	Male	Female	Other
3	How would you describe your racial/ethnic background? (e.g., White; Black; White Jewish; Asian Muslim, etc,)			_____
4	How would you describe your relationship status?	Single Partnered Married/Civil Partnership Separated Divorced/Civil Partnership Dissolved Other: _____		
5	Substance that you have received treatment for?	Alcohol: Yes / No	Drugs: Yes / No Please specify:	
6	How many online counselling sessions have you had?			
7	When was your most recent online counselling session?			

Thank you!

Please return the form to me, louise2.atkinson@live.uwe.ac.uk

This research has been approved by the Health and Applied Sciences Faculty Research Ethics Committee (FREC)

Appendix 5: Example of initial, observational notes on transcript from participant interview

Transcript	Notes
I was starting to think that I wanted to get on top of the drinking, and cut down, and so it just came at the right time really. I registered for it...it's one of those things that you could go to your doctor, but then you feel like you're sort of sitting there going, **'Oh, my name is [participant's name] and I'm an alcoholic'**. You know, I didn't really want to do that, because you sort of thing that they are going to send you to rehab, or put me on some other drug or something. I didn't really want to go down that route, because you've got to start somewhere, and you don't want to go straight into the, 'Hello doctor, **I think I'm an alcoholic' type thing. That just seems a bit extreme.** I thought that this sounded quite good. I've used another thing through the NHS trust as well, that was around healthy eating. That was a couple of years ago. That was a six week course, and you...you went to a session every week, and it was all about portion sizes, and all that sort of stuff, with a bit of exercise thrown in. That was really good, so I thought, well, if it's anything like that, then it's going to be worthwhile. And I've had counselling before, in my life, so, erm...the thing about this that really appealed was when I saw that it was...you could do it over Skype. That was...erm...that was a bit bonus with it, because...erm...**when I had counselling before, I used to go to somebody's house, and it was actually a real pain. They lived in the middle of nowhere, you couldn't park, and it all was a bit**	Reluctance to identify as 'alcoholic'

of a hassle to be honest. It made it seem more difficult than it really was. Erm...so yeah, from that point of view...yeah, it was free, it was a way of getting started to see how it, you know...where it led me, erm, and **it was easy to, sort of, access it**. So I thought I might as well give it a go really. I: Yeah, well that's really interesting. And I suppose I'm really interested in that...the difference between face to face counselling and Skype counselling, and...and your experience of face to face counselling sounds like, erm, you know, there was a lot of hassle in terms of getting there, and the logistics of that. What was your experience of being in the room with somebody? How did that compare to talking to someone with Skype, like this? Did that feel different? A: Well, erm…I would...I think **before I did it, I would have expected it to be different, but actually, I don't think it really is. Er...I think maybe a lot of it is to do with the actual counsellor, because you know, the lady that I've been speaking to, she is very bubbly, and very sort of, er, very easy to talk to, and I felt as ease with her straight away because she was very, er, you know it was just like chatting to a friend almost. You know, I know it is not supposed to be that sort of relationship, but, she made you feel really comfortable straight away.** I: Hmm. So how did she do that? How did she...how did you know you liked her?	Negative aspects of F2F counselling Importance of therapeutic relationship

A: She was just, erm...she was just really bubbly, and sort of chatty, and you know, whatever...she was really, she is obviously very good at her job. You know, she is very… **she listens, but she also, she challenges you about things. But she just comes across in a really, really pleasant way**...erm...and, you know, if you book a session with her, you know, out of all the sessions....I can't remember if I had four or five now, **but I've never had to think about changing one of them because they are on Skype. They're after work...they're outside of work hours, so I get home and I have a Skype cal**l, whereas **when I went to counselling before, because I had to drive there and it was in the middle of nowhere, you know, if I got stuck at work late or something like that, erm...I didn't know if I was going to make it, it was very difficult to change it, because you had this contract with them, and if you don't go for whatever reason...you know, there could be like a nuclear bomb, and if you didn't go, then it's down to you, and you...you've lost that session, and it all feels a little bit, sort of, bit over the top from that point of view.** Whereas with Skype, you know, **[therapist name] always says to me, 'If you want to change it you can'**, but I've never needed to because it's very easy to stop doing other things, and...you sort of position it and make that commitment that it's going to be on a Wednesday...mine have always been on a Wednesday, erm, and it sort of worked out once a month. Because it, because it kind of went really well right from the start, I haven't needed to have the sessions closer together, I've kept them spaced out so that I can keep it going on longer to, sort of, police me, to make sure it keeps going, kind of thing.	Convenience of Skype Negative comparison with F2F which was perceived as 'inflexible'. Issues around power? Ability to schedule is more in client hands? Both in terms of timings, and frequency of sessions

Appendix 6

Example of inductive coding - section from coding spreadsheet

Comfort of own home	a	Erm...well just being physically comfortable, you know, being in my room, being in my bed...erm….being able to wear whatever I want. I'm talking to you right now, I'm still in my pyjamas.
	a	you're just physically comfortable, and environmentally comfortable, and you can just sort of be you.
	s	Yeah, definitely, that's a big advantage...when you are in your home you feel like you are more able to be yourself as well. I feel like, I couldn't...if I sat in a GP's surgery, or, you know...it's more difficult to be yourself.
	s	...you feel more like you can be yourself because it's your domain, and you're the king. You're the king of your own domain...you're the boss, whereas you're not the boss if you're sitting in someone's office. They're the boss. Bosses or doctors, you don't feel like you can be yourself as much. That's how I feel anyway.
	f	so I'm in the comfort of my own home. I have Skype connection...I am comfortable because I am in my own home. I can have a cup of tea here, or, you know..I've got everything I want here.
	p	...when you are in a situation where you are slightly unsure, you've got to put yourself at the most ease. And also, so it could be private, because I could shut the door to dining room, I could shut the door to the utility room, so that I felt I was in my own little bubble. Well, you could probably still hear me, but...do you know what I mean?
	n	You're in your own environment, you're in your own comfort zone, so to speak, erm, and so from that point of view I felt I was able to be more open and honest with her, erm, than if I was in a group of people.
	k	you know, you can make yourself really comfortable, whereas when you go to somebody's office or their house, you are kind of, you know...or especially when it's a counsellor's house, you're going into their...their home, even if it's, you know, a special room that they use, or whatever. So, you know, you're never going to be quite as comfortable, are you ?
	k	, I do actually thing that's probably another positive with the Skype, is...you know, if I wanted to I could be just sat in front of the fire with my slippers on, and with the pets, and it's fine, isn't it, it's not a problem.
	h	Because I'm surrounded by my own things. I'm in my, my comfy place, and I've...I don't feel that there's anything I can't say.

	h	Yeah, and I've got a kettle. I can make my own coffee (laughs), don't have to drink out of a plastic cup.
	j	...one thing I will say is that I've got good, quiet, peaceful space, you know, to work in. You haven't got things, sort of, falling on your head where you are...you know, where it is all messy and that....and so on....it's a professional environment, as if....well, to be honest, better than an office. I've got a better desk, you know. I've got a solid oak desk. You don't get them in an office. I've got a proper office chair...
	j	Yeah, my staff canteen is better (laughs). ...Yeah, sometimes I get deliveries from my other half, she comes up with a coffee or a...While I've been on the phone to you she has come up actually, and given me a pint of lime...lime cordial...so every now and then she will make an appearance with a drink or whatever, and then go back down. So yeah, that's quite good.
	m	I'm in the kitchen but I shut both doors and I'm private, it's lovely . Not a problem at all.

Article for Publication

‘In my own comfort zone’: client experiences of relational aspects of Skype therapy for alcohol problems

Abstract

Treatment providers are increasingly using Skype or similar video-based applications to deliver treatment in place of face-to-face talking therapy. However, the impact on the therapeutic relationship remains unclear and under-researched, particularly from a service user perspective. The study aimed to examine how Skype might disrupt existing ideas around the therapeutic relationship, and explore how alcohol treatment clients make sense of the relational aspects of their Skype therapy. Adopting a qualitative design using thematic analysis, 15 adult male and female participants from a single treatment provider were interviewed. The themes that were identified highlighted the significance of the participant’s own home as the site of therapy and the importance of viewing the face of the therapist. Participants also reflected on their relationship with alcohol, and their decision to undertake therapy for alcohol problems ‘remotely’ via Skype. There are nuanced and potentially unforeseen consequences of working with alcohol treatment clients via Skype, and it is important for treatment providers and individual practitioners to be aware of these.

Keywords: Skype, video, alcohol, therapy, therapeutic relationship, client perspective

Introduction

The study used thematic analysis to explore alcohol treatment client's experiences of the relational aspects of therapy delivered by Skype. Innovations in technology are having a significant impact on communication, from telephone use to more recent email, text and video messaging. Increased use and reliance on such technologies continues to profoundly alter the tools used in communication with others (Hennigan & Goss, 2016). Social distancing requirements associated with the coronavirus pandemic during 2020 have accelerated the use of video calling in both occupational and social settings, as well as their widespread use in therapeutic practice. Technologies such as Skype may have a transformative effect on how we relate to others, offering new opportunities for human relationship and communication, as well as disrupting existing patterns of relational and communicative behaviour.

The use of technology in the delivery of mental health and counselling services has been evident since the 1990s and has expanded and grown with the increasing use and availability of the internet (Hunt, 2002; Mallen, Jenkins, Vogel & Day, 2011; Wentzel, 2016). Naslund et al. (2015) note that the internet has become an important means of delivering mental health services, as it overcomes barriers relating to distance and access, and can offer increased anonymity, as well as potential benefits around supporting psychoeducation, health promotion, symptom monitoring, self-management and relapse prevention. At the same time, other authors have expressed a range of concerns about the potential for online therapies to result in diminished engagement from clients and higher rates of drop out, particularly in the

substance misuse field (Ekström & Johansson, 2019). Others argue that Skype and other online therapies risk disrupting communication between therapist and client, with technical issues, lack of eye contact and ethical dilemmas being listed as potential causes of difficulties (Dunn, 2012). There is, therefore, no broad consensus around the impacts of the shift away from physical interaction and proximity in therapeutic services, and it remains a complex and contested issue.

In this rapidly changing context, there is a clear need for evidence on the effectiveness of Skype or other video interventions for alcohol treatment clients. However, as Dugdale, Elison, Davies, and Ward (2016) argue, the evidence base on online treatments for substance-misusing clients, while growing, remains limited. Much research that has been carried out to date has focused on quantitative indicators (Elison, Davies & Ward, 2015; Byaruhanga et al., 2020). While such studies provide some valuable data regarding treatment effectiveness, quantitative constructs may obscure some nuanced aspects of treatment. Quantitative data can offer little insight into the experience of undergoing Skype therapy for alcohol problems, or any feedback provided by clients themselves. There has been virtually no research on the relational aspects of Skype or video therapy for alcohol treatment. In particular, there is an absence of studies on the impact of technology on the therapeutic relationship from the client perspective, or on the experiential, relational aspects of the therapeutic encounter in a Skype or video counselling session.

One concern expressed by counsellors and psychotherapists about the use of Skype in therapeutic work is around the loss of non-verbal information, including posture, breathing, gestures (Mallen & Vogel, 2005). While it can be argued that Skype allows the therapist and client to view facial movement and expressiveness, the tendency to focus the camera on a head and shoulders presentation means that the full range of postural, gestural, and expressive movement that the body conveys, as well as the intentionality that is carried and expressed in that movement, can be lost. Bayles (2012), for example, argues that this information is lost not only during the session itself, but also in the act of communication that is greeting the patient, watching them enter the therapy room, find their seat, and then seeing them as they leave the room.

Counselling psychology has traditionally theorised the embodied experience of the therapeutic encounter in a shared physical space; with client and therapist physically positioned in a room together. This has drawn on ideas around the 'felt sense' (Gendlin, 1969), on findings from cognitive neuroscience and neurobiology around the influence of 'mirror neurons' (Coutinho, Silva, & Decety, 2014), on ideas about attunement and affect regulation (Dales & Jerry, 2008), and on the range of physical and emotional responses associated with empathic responses (Damasio, 2000). It is proposed that these nonverbal aspects of attachment are critical to the therapeutic alliance; however, there has been little research on these aspects of attachment as observed in an online or video context.

This study therefore seeks to explore the implications of therapy being delivered via Skype, by identifying specific issues arising for clients with alcohol problems. This includes an examination of whether the existing theoretical framework around the therapeutic relationship remains adequate to explain its nuanced and specific features within this innovative context of Skype-based treatment.

Method

Data collection took place prior to February 2020, and was therefore completed before social distancing restrictions associated with covid-19 came into place. While physical proximity and travel was restricted from March 2020 onwards, all participants in this study had actively selected Skype therapy as a choice, rather than as a necessity associated with lockdown. Qualitative interviews explored implications of the absence of physical proximity between therapist and client, and the impact of video technology on the therapeutic encounter in alcohol treatment. Interview questions involved a focus on the relationship between client and therapist, including how clients communicated with therapists, client's sense of the openness and availability of the therapist, the ending of their relationship, and their perceptions of what was helpful or unhelpful in therapy.

By focusing on client experience, the study aimed to give voice to an under-represented group. Among groups of service users, alcohol treatment clients are particularly likely to be under-represented in research, and arguably represent a 'hard to reach' group (Postel, De Haan & De Jong, 2010). A key aim of this research was therefore to ensure that the views of this group were able to contribute to establishing the broad evidence base around Skype treatment.

Thematic analysis was used to identify, analyse and interpret the interview data. Clarke and Braun (2018) position thematic analysis as 'fully' qualitative, meaning that qualitative techniques are underpinned by a distinctly qualitative research philosophy that emphasises researcher subjectivity, reflexivity and the

situated and contextual nature of meaning. Analysis of interview transcripts enabled the researcher to draw meaning from the experiences described by participants regarding their relationship with the therapist, and their descriptions of how Skype influenced their therapy. The researcher attempted to elicit and record the participants' own interpretation of their experience (Higginson & Mansell, 2008), and encouraged an examination of the subtle nature of the experiences involved in the therapeutic encounter.

Interview data was scrutinised for meaning, using an approach that allowed themes to be formed from semantic patterns within the data (Braun & Clarke, 2013). The investigative stance was largely inductive, and allowed for an explicit recognition of the researcher's own role in the active construction of meaning (Treloar, Fraser & Valentine, 2007). The researcher attempted to maintain a reflexive process throughout, including paying attention to the prompting process during interviews.

Procedure

15 participants were recruited via a single national drug and alcohol treatment service provider, which offers six sessions of online therapy via Skype with an individual alcohol treatment specialist. All therapists working at the service held a counselling-related qualification, and different participants had worked with different therapists. The sessions were an online form of extended brief intervention based on motivational interviewing techniques, as used in standard face-to-face alcohol treatment.

Research interviews were conducted between January 2019 and February 2020. Recruiting all participants from a single service meant that there was some consistency in the therapy received and in the method of recruitment and interviewing. Participants were required to be aged over 18, and to have completed a minimum of four one-to-one sessions with the same therapist via Skype, in order that they could reflect on the therapeutic relationship at various stages of treatment, from commencement to completion.

In recognition that thematic analysis supports a very wide range of sample sizes, and that sample size in thematic analysis cannot be predicted by formulae (Malterud, Siersma & Guassora, 2016), a 'small/moderate' sample size was used (Braun & Clarke, 2013). Data collection ended when the researcher had a sense that further interviews would be unlikely to produce new data or themes than that already collected.

The average age of participant was 50 years, with ages ranging from 32 to 71 years old. There were nine women and six men. All currently lived in the United Kingdom. In the demographic questionnaire, 14 indicated that they were White, and one indicated that they were mixed ethnicity. 10 of the participants said that they had previously had face to face counselling, and the remaining five had not had any previous counselling. The average number of Skype alcohol treatment sessions completed by the participants was six; the minimum was four and the maximum was seven. The average time elapsed between final therapy session and participant interview was less than three weeks.

Interview questions were developed on the basis of existing research findings on Skype use (Holmes & Jones, 2016) and on client experience of therapy (Salleh, et al, 2015). Interviews were 'exploratory' in nature (James & Busher, 2009), and were participant-led rather than fully structured (Wengraf, 2001). The questioning stance was adapted according to the narrative of the participant (Miller, 2012). Open ended questioning was used at the start of the interview, with more detailed and specific questioning used as the participants continued, enabling flexibility in response to participant style and narrative.

Participants were encouraged to choose between telephone or Skype video interview for data collection purposes. Nine chose Skype video, and the remaining six chose to be interviewed over the telephone, with no video connection. Interviewing via Skype or telephone was adopted as a pragmatic alternative to face-to-face interviewing due to the dispersed geographical location of participants. There is mixed research on the issue of telephone and video interviewing; Musselwhite, Cuff, McGregor, and King (2006) describe several advantages of this means of data collection, including the possibility that the anonymity afforded by the phone may enable participants to be more open in their responses. This may be particularly relevant to alcohol treatment clients, a number of whom mentioned stigma and the avoidance of shame as a reason why they chose to undertake Skype rather than face to face treatment in the first place.

Interview recordings were transcribed verbatim using basic orthographic conventions, allowing for inclusion of some paralinguistic information, such as the use of intonation for emphasis, laughter, pauses and the use of non-words (Jenks, 2011). Thematic analysis of interview transcripts enabled the identification and reporting of themes or patterns within data collected. Braun and Clarke (2006) proposed the following six-phase guidelines which describe the manner in which data from the transcribed interviews was organised into themed meanings: becoming familiar with the data set; generating initial codes; identifying themes; reviewing the themes; defining and naming themes; and reporting the analysis.

Results

Thematic analysis of data led to the identification of four main themes. The first theme, *the client in their own home*, draws together participant reflections on the significance of their sense of being comfortable while taking part in therapy sessions, including being able to control their home environment to suit their needs. The second theme, *virtual relationships*, brings together ideas around the therapeutic relationship in an online environment, starting with the client's experiences of seeing the therapist's face on a screen, and their sense of the therapist's presence. In the third theme*, empowerment and choice*, ideas about therapy as a consumable service are explored, with the client as the empowered consumer of a transaction. Linked to this is the sense of the client being able to leave a session at the touch of a button, of having the ability to choose whether, how, when to start and finish the therapy, enabling a sense of power and control over the sessions. The final theme relates to *stigma and dependency* associated specifically with alcohol. This links to participants' descriptions of the perceived barriers to accessing treatment associated with being 'seen', including secrecy, shame and stigma.

Theme 1: The client in their own home

All participants referred in some way to being in the 'comfort' of their own homes while participating in therapy sessions. This links to a sense that by undertaking therapy via Skype, the participants may have been able to derive some level of self-regulation from being in a familiar environment:

> *I am comfortable because I am in my own home. I can have a cup of tea here, or, you know...I've got everything I want here.* (Participant F)
>
> *...well just being physically comfortable, you know, being in my room, being in my bed...erm…being able to wear whatever I want.* (Participant A)
>
> *You can make yourself really comfortable.* (Participant K)

Some participants talked about an increased ability to ‘be oneself’ when in one’s own home, with an increased ability to speak freely, as well as reflecting on an increased sense of control.

> *You're in your own environment, you're in your own comfort zone, so to speak, erm, and so from that point of view I felt I was able to be more open and honest with her, erm, than if I was in a group of people*. (Participant N)

> *I'm surrounded by my own things. I'm in my, my comfy place, and I've...I don't feel that there's anything I can't say..* (Participant H)

This suggests that a sense of comfort within the home environment enabled the participants have a sense that they were able to be authentic in terms of how they presented themselves to the therapist, talking with less constraint than they would elsewhere.

The proximity to familiar possessions, and to a sense of warmth associated with hot drinks, or sitting by a fireside, was also of importance to participants:

> *Yeah, I do think the fact that I can be, you know, sitting on my sofa, I can have the TV on, or I can have a cup of tea, or whatever, you know, then the phone goes…. then when it's finished I'm on my sofa again.* (Participant W)

> *...you know, if I wanted to I could be just sat in front of the fire with my slippers on, and with the pets, and it's fine, isn't it, it's not a problem.* (Participant K)

The noticeable repetition of words relating to ‘comfort’ links to ideas around attachment, suggesting that participants were able to derive comfort from their own environment in a way that may be in contrast to more traditional models whereby the therapist provides the therapeutic space for the client, and the ‘holding environment’ is established by the therapist on the client’s behalf. Traditionally, therapy may be held in a therapist’s ‘comfort zone’, where it may be the therapist rather than the client who is surrounded by familiar objects, albeit those designed to create a sense of ease for the therapist’s clients.

The idea of the client's home environment being transformed into a therapeutic space, and one into which the therapist enters at the invitation of the client, represents a shift away from traditional models of therapy:

> *I'd always sit in my bed in my room so I could shut the door, and she'd say, 'Oh, I like your wallpaper', or whatever (laughs). And, erm...you know, the kids would come in and...she'd be, 'Oh, that's alright. Oh, bless them', you know.* (Participant A)

In this way, the therapist may be experienced as a guest in the client's home, offering polite comment on decoration and aspects of the client's domestic situation, but with limited access which is firmly controlled by the client themselves.

The client's ability to control their own therapeutic space is connected to their ability to control the involvement or exclusion of family members or other people in their household from their therapy. Some participants talked about their concerns about being overheard,

> *I was worried that my husband was in the background listening through the keyhole, sort of thing, because there were things that I've definitely said to [the therapist] that, you know, I'll say to you, which...I wouldn't have said to him.* (Participant T)

> *You're having essentially a personal conversation, aren't you, so you don't necessarily want other people hearing how you are expressing things.* (Participant P)

These participants suggest that it is important for them to be able to speak freely without being overheard by family members, and imply that the proximity of family members may have been an inhibiting factor in their therapy sessions.

Other participants suggested that they were comfortable with the presence of a family member in the room with them while they were having therapy sessions:

I haven't worried whether anybody could overhear or not. Everything that I discussed with [the therapist], I'd already...my husband and I had already talked about it, so I didn't have to worry about that side of it either. (Participant K)

The presence of family members suggests an element to therapy which is outside of the therapist's control to some extent, and which may impact on the content of a therapeutic session in ways that the therapist is not fully aware of. Family members may enter or leave rooms without the therapist knowing about this change. It is possible for clients to derive a sense of comfort from having family members in the therapeutic environment, or alternatively to feel a sense of constraint around being overheard.

A number of participants referenced their pets in interviews, either referring to the noise of barking made during sessions, or to the comfort of having a pet with them during the therapeutic encounter. The regularity with which pets were mentioned in interviews suggested that they play a significant role in the environment of the therapy. Apologies were made to the interviewer about potential interruptions by animals, giving a very real sense of their presence:

Sorry, my dog is making a strange noise. (Participant F)

Apologies if you hear noises...Sorry, you might be able to see my dog in the background, he's currently standing...barking...he wants me to take him for a walk. (Participant P)

As well as potentially disrupting the therapeutic work, pets are presented as silent witnesses to the therapeutic sessions, providing comfort, warmth and reassurance to participants:

I think sometimes I was sat at my dining table like I am now, but most times I think I was actually sat on the sofa with...with my chihuahua and my cat. (Participant K)

At other times, an implied relationship between the therapist and the pets was given as evidence of the depth of the therapeutic alliance, with a sense of closeness and familiarity built up over Skype sessions:

> *I mean, she's already met the dogs and everything (laughs).* (Participant M)

> *I've just taken over care of a dog, and we were just talking about that, and various other bits and pieces, you know, personal stuff.* (Participant N)

In this way, it is suggested that the therapist has in some ways become integrated into the client's home environment, establishing a relationship with others, beyond the client themselves, with a sense of implied acceptance. Further, the involvement of animals in the therapy suggested that pets offered participants a benefit associated with comfort, relaxation and sense of security.

Theme 2: Virtual relationships

There were varied aspects of the way that participants described their relationship with the therapists having developed over time, and how their sense of the therapist was impacted on by the use of Skype technology. Participants reflected on the value of seeing the therapist's face on screen, noting at times the difference between video calls and telephone calls and expanding on their sense of the significance of viewing the image of the other.

> *The fact that I could have an almost face to face conversation with her was better than just doing a dry conversation over the phone, so yes, it did...it did add something to the process.* (Participant N)

> *I think seeing somebody's face and seeing their body language and how they react non-verbally, erm, is…yeah, reacts with you.* (Participant T)

Participants made clear their sense of the therapist as real, and distinguished from voice-only phone calls which leave the other's physical appearance to the imagination. One participant reflected on the fact that by seeing her face on the

screen, the therapist could gain important information about her state of mind that would have been unavailable to the therapist in a telephone session:

> *...like with the phone you can control your voice to a certain extent, whereas...I certainly can't, I've never been able to do anything about my face. Whatever I'm feeling is just written all over it, so...(laughs)...So I think she could kind of like pick up on stuff that I wasn't comfortable about.* (Participant M)

In this way, the participant acknowledges the importance of the face in signalling emotional content during the Skype sessions.

When discussing their relationship with the therapist, a number of participants reflected on how quickly they had been able to establish a positive relationship with their therapist.

> *Straight away I felt comfortable with her, yeah…* And, s*ometimes you can tell at a glance whether you are going to get on with someone or not, you know.* (Participant M)

> *She just appeared on my screen and we got on.* (Participant F)

Participants were able to provide a range of explanations for their positive relationships with their therapists, listing a wide range of therapist qualities which they felt had strengthened the rapport between them. These included aspects which are familiar in terms of 'core' therapeutic skills, such as empathy, listening, understanding, non-judgement, and openness (Elvins & Green, 2008).

> *It felt like she cared and there was a relationship there, er…..and I trusted her and respected what she said, and her knowledge and experience.* (Participant W)

> *He was very good and the relationship was good…I didn't want to let him down or let myself, or...you know?* (Participant S)

She was very friendly, and she was non-judgemental, and she just let me talk. (Participant H)

She was very...er...accommodating, and positive, and understanding and perceptive. (Participant F)

These descriptions reflect positively on the skills and qualities of the therapists involved, and at the same time encompass the kinds of core features of traditional face to face counselling. This suggests that these same qualities of supportive, warmth, non-judgemental, empathy, listening, positivity can be identified by clients in online work, and can impact positively on their sense of relatedness with the therapist.

The limited number of therapy sessions (the average number of sessions for all participants interviewed was six), combined with the use of 'remote' technology, could lead to a suspicion that therapy would remain at a superficial level, or that more in-depth emotional work would be more difficult to achieve. A small number of participants made comments which confirmed their sense of this:

It didn't get personal, which was probably what I didn't need it to be. (Participant P)

You couldn't go deep into...you couldn't have a proper conversation about...you know...impacts, or, you know. It was quite a...I can't explain it, but it was kind of not like a deeper emotional level, it was more like, 'what are the issues', you know? (Participant S)

However, others felt that their connection with the therapist had allowed them to cover more in-depth material:

It was private, and I wasn't being guarded about what I could say. (Participant H)

Some participants suggested that it was the distance afforded by the use of video which enabled them to address more distressing issues:

> *I was able to talk. I was able to be, you know, full disclosure, open, er...warts and all, erm...I think one of the things that helps that is the screen. Everything the other side of it is...er...almost artificial. It doesn't matter.* (Participant F)

This participant appears to have felt that the artificiality of the connection and the detached aspect of the relationship enabled them to feel less shame about expressing their emotions than they would in a face to face context.

Overall, the range of responses reflected the fact that some participants felt more inhibited by the Skype context than they thought they would in a face to face situation, while others felt that the remote access afforded by Skype allowed them to feel less inhibited than they would if meeting in person. This reflects the broadly accepted idea that the depth and quality of therapeutic work inevitably varies depending on the quality of the therapeutic relationship. These findings suggest that this appears to be the case whether therapy is conducted in a face to face environment, or via Skype or video.

Theme 3: Empowerment and choice

This theme draws on ideas around power in the therapeutic relationship, and on the subtle shifts in power dynamics between therapist and client in the online environment. In particular, this theme the influence of a consumer choice narrative. A number of participants described their choice to undertake therapy, and in particular the selection of an individual therapist, in terms of a wellbeing choice, a positive step, rather than a necessity:

> *You could choose. You could like...there's a whole long list of them, and the dates they had available, so you just went with whichever one you fancied, type thing.* (Participant X)

This emphasises the sense of choice, of selecting a therapist from a range of options depending on personal preference and suitability. Further, participants expressed their sense of power in the process of initiating and engaging with the therapist:

I felt in control… I would definitely choose a Skype-type counselling over being in somebody's office, being in their space, erm...feeling intimidated, feeling embarrassed. (Participant T)

When you're at home and you're talking, you arrange the appointment, you start to speak to them straight away, and you feel like you are in control, whereas they are in control when you are in their...in their space. (Participant S)

Participants discussed commitment in relation to Skype therapy, with the idea repeatedly expressed that this presented less of a commitment than face to face therapy would have. Participants recognised that they had the ability to end the session at the touch of a button, avoiding open conflict or therapeutic rupture, and more than this, that the technology enabled them to manage their feelings of shame associated with accessing support and with disclosure of sensitive information:

You know, if it was really going wrong, well you can just turn it off (laughs). …I suppose it is an escape route. If you're really worried about it, it's much easier to have someone on a screen, when you're at home, and you can think, 'I really can't take this', turn it off. Whereas, when you're in a room with someone, there's...there's sort of social expectancies of...of, you can't just stand up and walk out, you know? (Participant W)

I don't like admitting my weaknesses, and yeah...it gave me that extra level of control. I would always feel that I could just press a button and go, and I would never see her again, I would never hear from her again. (Participant T)

This sense of having an escape route was cited by participants as a positive aspect linked to their own sense of control over the therapy. It is worth considering the impact of this element in terms of the therapeutic dynamic, and especially in relation to the therapist's ability to challenge the client, to manage rupture and conflict, and to deal with difficult and distressing issues which the client may prefer to avoid.

Theme 4: Alcohol – stigma and dependency

Most participants distinguished themselves from ‘alcoholics’ or ‘other’ drinkers, often in ways that often appeared to seek to minimise the extent of their drinking:

> *I'm not a sort of...alcoholic whose life is falling apart.* (Participant W)

> *I'm not like an alcoholic, but...I do, when I do tend to go to social events or whatever, erm…I have a tendency to, like, binge drink.* (Participant A)

> *I don't want to go to AA because...I didn't think it was that...erm...that much of an issue…I didn't see myself as, sort of, alcoholic...that gets up in the morning and needs a drink in the morning, you know?* (Participant S)

There was some evidence that participants recognised that online counselling did not feel as ‘serious’ as seeing a therapist in person or attending alcohol treatment services, and that this reflected their reluctance to see their own difficulties with alcohol as ‘serious’.

> *When you go in to, like, a therapist's room, you sit down, you're all kind of like...little bit awkward...it feels a bigger deal than it is…Whereas this feels like, just, an extension of having one of my work calls…so it felt like it wasn't impacting too much on my life.* (Participant C)

This apparent distancing of the self from the identity of an alcoholic can be associated with the sense of shame and stigma that a number of participants expressed in relation to accessing support for alcohol problems:

> *It's that...bumping into them in Tesco's later on, like...'Hi, yes it's me, it's the one that, you know, was talking to you about all my very shameful issues'.* (Participant T)

I didn't really want anybody....I was ashamed. I...I just didn't want anybody else to, sort of, know about it until I could deal with it. (Participant H)

A number of people talked about their reluctance to risk being 'seen' attending alcohol treatment services in person:

Yeah, it's obviously very private...erm...nobody sees you walk in to Alcoholics Anonymous, and thinks, 'Oh...ahh'. (Participant F)

Some participants reflected on the fact that having therapy via Skype had enabled them to maintain an emotional distance, avoiding this sense of reliance on the therapist. This was particularly apparent when participants discussed the 'ending' of therapy, reflecting on their final session with expressions of finality and inevitability, with an absence of any emotional reflection on the separation from their therapist.

It reached its end. So, you know, we wished each other the best and that was it.....I don't want to be someone who is dependent on anything, actually. Er...red meat, cheese, anything consumable, any particular one individual. You know, I don't want to be dependent, on anything. (Participant F)

While the quotes above express a sense of finality about the ending, and a relatively emotionless sense of conclusion, others expressed their feelings of concern around ending their sessions, and their fears around ongoing difficulties with alcohol.

I know, I'm quite sad actually (laughs). I feel the need to create another concern that I need to talk to her about. Yeah. (Participant C)

Overall, the sense is of a varied engagement with the therapist, with some participants remaining a distinct sense of separateness and emotional

autonomy, while others express more emotional attachment and distress around separation.

Discussion

The findings highlight the novel context of therapy when it takes place outside of the therapist's room, including the significance of the home environment. This represents a deviation from the 'therapeutic frame' (Langs, 1984; Novak, 2016), defined as the relatively stable context in which therapy takes place, generally understood to be characterised by a regularly scheduled time, cost, and shared physical location. Service users were able to provide an important perspective on questions around whether Skype allows the therapist to deploy the therapeutic frame in a flexible enough way to ensure that a therapeutic space is established which protects and promotes therapeutic change, and enables the therapist to demonstrate the core qualities of empathy, honest, openness and presence.

Therapeutic space

It is worth considering the significance of 'comfort' as an aspect of therapy, particularly the role that comfort plays in relation to therapeutic change. Research into client preferences in relation to counselling room space and design has found that the desire for physical and emotional comfort is important for clients (Sanders & Lehmann, 2018), including the creation of a welcoming, relaxed and homely environment that promotes a sense of safety (Larsen & Topor, 2017). In a Skype therapy context, conceptual and physical boundaries are not all held by the therapist, but are established jointly by the client and the therapist in their own separate spaces. Environmental boundaries relating to the physical space in which the client sits are outside of the therapist's control. The key aspect of containment which is provided by the therapist lies not in physical proximity, but in the therapist's 'presence', the sense of connectedness to the other in the here-and-now (Krug, 2009). If this aspect can be communicated effectively via Skype, then the therapeutic environment arguably becomes relatively less significant.

While comfort was repeatedly discussed as a positive feature by participants in this study, this raises a question around the role of 'discomfort' in therapy. In

particular, there may be concerns that heightened sense of comfort may be associated with greater avoidance; questions could be raised about whether a client is likely to want to ‘go’ to difficult and troubling places from within the comfort of their own homes. Further, it may also be important to consider whether clients are likely to be able to overcome inevitable ruptures in the therapeutic relationship if they are not being physically contained within the therapist’s own ‘holding environment’ of the therapy room.

In therapy, the supportive relationship which offers comfort should ideally be balanced by constructive challenge from the therapist, occurring through sensitive feedback. The sense is that comfort alone is not enough to bring about change, but requires the co-existence of tensions, between comfort and challenge. This implies that the traditional containment offered by therapists is inevitably impacted on by the array of communications sources, psycho-education, and other information available to clients, and that the role of the therapist is therefore evolving. This evolution is likely to encompass a role in skilfully guiding clients in using the most appropriate resources, and possibly helping clients tailor technology to their specific needs, as well as maintaining opportunities for genuine connectedness and meaningful interactions.

Seeing and being seen

Participants suggested that seeing the therapist’s face gave them a sense of the other person as a human being who was present with them. The significance to clients of ‘putting a face to a name’ has emerged elsewhere in research into Skype therapy (Ashwick, Turgoose, & Murphy, 2019), and reflects wider research around neurobiological responses to viewing another’s facial expressions and responses.

The use of Skype leads to a focus on a head and shoulders presentation of the other person. It has been argued that this means a loss of significant information from postural, gestural and expressive movement and intent that is

conveyed by the rest of the body (Bayles, 2012). However, the absence of a view of the rest of the therapist's body may also have emphasised the focus on the face and upper shoulders. This suggests that the limitations associated with a loss of some non-verbal cues such as hand gestures and leg movements may be compensated for by a deliberate and focused attention on facial movement and expression.

For participants in this study, there was widespread acceptance of the importance of a positive therapeutic relationship, and that this was the key factor in their experience of therapy. This suggests that the use of Skype does not interfere in the phenomenon remarked on elsewhere, whereby the therapeutic relationship can be established successfully online. In particular, participants reported that they valued the therapist's qualities of non-judgement and kindness. This is reflected in other studies which have found that these particular qualities are deemed helpful to disclosure of alcohol related problems, as they are thought to counteract reported feelings of guilt and shame associated with the stigma of alcohol problems (Coste, et al.,2020).

The narrative of consumption

Participants described being able to select the therapist they wanted to see from a webpage listing potential options, with names accompanied by a photo of each therapist's face. Participants chose the therapist they liked the look of, or who had availability at times that suited them. Shackak (2017) refers to the "commodification of psychotherapy", to describe the gradual infusion of market and consumer logic into the production, dissemination and consumption of therapeutic knowledge and techniques. This can be understood as a move away from a psychopathological view of external help from a therapist deriving from mental illness or distress, a viewpoint which could be said to assume a passive or 'sick' client. Instead, therapy is posited as a positive life choice, with an emphasis on wellbeing, rather than sickness.

The implications of this are significant for therapists, who may find themselves increasingly framed as suppliers of therapy. A successful ‘supplier’ of therapy may well prefer to focus on client strengths and assets within an overall framework of promoting well-being, rather than more challenging therapeutic options which address client ‘deficiencies and undermining characteristics’ (Slade, 2010). Another concern is that the increased focus on the individual as the agent of change may lead to a consequent downplaying of environmental, economic or social aspects which impact on the client. Such a focus would negatively impact on those clients most economically and socially disadvantaged, by implying that solutions to their difficulties could be found from within, rather than acknowledging the inequalities which hold them back.

A further aspect was a sense of being in control described by participants, with the potential to end a session at the touch of a button. This ability to escape suddenly, or to avoid any continuation of discomfort within therapy, gave participants a sense of security which they valued. By reducing the ending of a session to the click of a button, therapy may seem more like what Tao (2015) has described as a ‘magic game’ than a real, genuine connection. It is also worth considering whether this impacts on the client’s sense of commitment to the therapy. With the option to switch off and continue on with ‘real’ life, it may be easier for clients to view therapy as carrying less significance than they would if attending required greater commitment and effort.

Identity and the construct of denial

Participants in the study attempted to define their own sense of identity in relation to alcohol. With alcohol consumption as an accepted and normative aspect of culture, in a context where excess is somewhat normalised and participation expected (Szmigin, Bengry-Howell, & Griffin, 2011), the image of a social drinker is acceptable, in sharp comparison to the identity of an alcoholic. Despite an absence of interview questions focusing on drinking habits and behaviours, all participants attempted to explain the context of their drinking, and noticeably attempted to minimise the seriousness of their drinking. One of

the most frequently used explanations for the failure of many individuals to recognise or address their alcohol-related problems is denial (Clark, 1998).

There is some indication that the tendency of participants to minimise or deny the significance of their difficulties with alcohol was associated with their choice to undertake therapy via Skype. By avoiding having to attend therapy in person, participants are arguably avoiding having to 'face' the therapist and thereby accept the impact of their own difficulties. Arguably, clients are able to enter into therapy in a somewhat tentative way which allows for an increased sense of control and self-direction. Arguably, this arrangement allows for a potential maintenance of some aspects of denial; by maintaining secrecy, participants are at no point required to admit to family and friends the extent of their problems with alcohol, nor to accept that their problems are significant.

Participants repeatedly referred to the privacy of undertaking therapy in their own homes, which allowed them to avoid the risk of being 'seen' by others when attending. Such stigma may be a leading cause of why individual with alcohol problems tend to hide their problems from others, or to use other means to avoid being labelled with a stigmatising title such as 'alcoholic'. Potentially, then, therapy via Skype offers individuals with alcohol problems a valuable means to overcome such barriers and to access treatment by avoiding the risk of shame and stigma associated with physical attendance at a treatment service.

Limitations

It should be noted that participants who had a poor relationship with their therapists may have been excluded from the study, particularly if they dropped out of treatment and therefore failed to meet the inclusion criteria of a minimum of four sessions. This study therefore may have failed to capture those therapist behaviours which were a barrier to therapeutic rapport, or to explore whether

the online method of delivery itself represented a barrier in some ways for those service users.

Conclusion

This study covers an under-researched issue, and therefore hopes to influence an emerging and rapidly developing field within counselling, psychotherapy, psychology and beyond, around online treatments and Skype-based therapy. The findings may help to further an understanding about how online therapies work in practice. Further, by exploring the limitations of the existing theoretical framework around the therapeutic relationship and relational aspects of the therapeutic encounter, when applied to the video-based setting, this study also seeks to engage in the process of ongoing reformulation of theory. The findings of the study are likely to be of particular interest to alcohol treatment providers and local commissioners, as well as individual therapists and other practitioners providing treatment to clients with alcohol problems. By examining the potential benefits and limitations of Skype therapy for alcohol treatment clients, the study presents an account of relational issues which can arise during Skype or video therapy. Further, the research enables a rare exploration of the voice of alcohol treatment clients, providing an insight into their individual experiences and the factors which influence their treatment and recovery.

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