Client experiences of videocall therapy during COVID-19 restrictions in Aotearoa New Zealand.

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Attestation of authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Dated: 11/11/2022

Candidate contributions to co-authored works

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Abstract

Intermittent restrictions on personal movement were introduced in Aotearoa New Zealand from March 2020, in response to the COVID-19 global pandemic. Phone or online delivery of psychotherapy, psychology and counselling services (telepsychology) became the norm, often facilitated by videocall technology. Whilst there is literature exploring therapists' experiences of videocall therapy, there are relatively few international studies on clients' experiences. This research aims to describe six clients' experience of videocall therapy during COVID-19 restrictions in Aotearoa New Zealand. Recruited via social media advertisements, participants shared their experiences in semi-structured interviews. Reflexive thematic analysis of the interviews identified that videocall therapy is commonly thought of as a conceptual 'space' defined by safety and containment. It is created by manipulating a client's external environment, as well as practices from therapists and clients that acknowledge that videocall therapy is a fundamentally different experience to in-person therapy. Findings from the analysis contribute to the knowledge base in this area, suggesting that perceptions of therapeutic efficacy in videocall therapy may be influenced by practices before, during, and after therapy sessions. Though limited by a small sample size, these findings are the first in Aotearoa New Zealand to describe client experiences of videocall therapy during the period in which COVID-19 restricted therapy in-person.

Introduction

Therapists' traditional belief that in-person therapy is the "gold standard" (Agosta, 2019) was challenged when health considerations about COVID-19 and associated restrictions to personal movement stimulated world-wide use of distance communication technologies for psychological service delivery. Videocall technology became regularly used for therapy, and is likely to continue in the future.

Issue and context

COVID-19 is a highly-infectious disease that causes respiratory illness, spread by coughing and sneezing, breathing, singing and speaking (World Health Organisation, 2022). After the COVID-19 outbreak was declared a global pandemic by the World Health Organisation in March 2020 (*Timeline - Coronavirus*, 2022), the New Zealand government joined many others in implementing a range of unprecedented restrictions to personal movement in an effort to slow community spread of the disease. An Alert Level framework based on continuous assessment of public health risk was developed by the New Zealand government to communicate the range of restrictions in place at any one time (Department of the Prime Minister and Cabinet, 2020). In the framework, Level 1 corresponded to the least risk and restrictions and Level 4 the highest risk and strictest restrictions.

Restrictions preventing people who did not share a residence from interacting were present in Alert Levels 4 and 3, colloquially referred to as 'lockdown'. The first nation-wide lockdown at Alert Level 4 lasted from mid-March 2020 until mid-May 2020 (*Timeline - Coronavirus*, 2022), requiring people to refrain from leaving their residences except under strict exceptions. At Alert Level 3, appropriate leave from a residence included travel for a wider range of activities. However, Alert Level 3 restrictions also functioned as a lockdown for most people as most businesses were unable to operate because they delivered services involving close physical contact (Department of Prime Minister and Cabinet, 2020). Over the following two years, lockdowns were implemented intermittently for periods of a few days to several months, with variances depending on geographical location. Notably, those residing in Tāmaki Makaurau Auckland and Waikato regions experienced a lockdown from August to November 2021 that featured easing and tightening of personal movement restrictions that were not implemented for most of the country (*Timeline - Coronavirus*, 2022).

According to Tindle and Moustafa's (2021) analysis of country-specific reporting, already concerning levels of psychological distress in the general population were exacerbated globally by the COVID-19 pandemic (McGinty et al., 2020). Restrictions on personal movement, by their very nature, increased social isolation and limited people's

access to social support networks (generally seen to be a protective factor for psychological wellbeing). Brooks et al.'s (2020) systematic review of 24 articles evaluating the impact of quarantine (implemented in response to SARS, COVID-19, MERS and Ebola pandemics) on psychological wellbeing showed that the longer the duration of quarantine, the higher risk posed developing poorer psychological health. Adjustment disorder, acute stress, depression, and anxiety exemplify a number of psychological wellbeing concerns predicted to increase over time (Ahmed et al., 2020; Torales et al., 2020), compounded by predictions of delayed psychological wellbeing effects from experiences of the pandemic (Mukhtar, 2020).

Developments in global psychological health and wellbeing suggest that the stresses associated with experiencing pandemic health concerns and personal movement restrictions are likely to also have ongoing psychological impact for people in Aotearoa New Zealand. Increased prevalence in psychological distress for New Zealanders, moving from 7.4% in 2019/2020 to 9.3% in 2020/21 was recorded in New Zealand Health Survey (*Annual Data Explorer*, 2022). This can be considered an early indicator, as COVID-19 restrictions of some form were still in place at the time of the survey, and the pandemic continues to have wide-ranging impacts on people's everyday lives. Structural disruption as a result of the pandemic saw a rise globally in unemployment, financial instability, domestic violence, and diagnosis of mental health disorders (Ahmed et al., 2020; Bradbury-Jones and Isham, 2020; Galea, Merchant and Lurie, 2020; Mukhtar, 2020; Torales et al., 2020). Of special significance to Aotearoa New Zealand is the consistent overrepresentation of Māori (estimated to be 17.9% of the population) in physical and mental health statistics (Stats NZ, 2022), influenced by existing access and structural disadvantages. Reverberations from the COVID-19 pandemic and associated personal movement restrictions are likely to have a disproportionate impact on the wellbeing of Māori in Aotearoa New Zealand.

On advice from the New Zealand Ministry of Health, from March 2020 the relevant health-related professional bodies in Aotearoa New Zealand directed psychologists, psychotherapists and counsellors to use distance communication technologies to communicate with clients at Alert Levels 4 and 3 (New Zealand Association of Counsellors, 2022; New Zealand Association of Psychotherapists, 2020; New Zealand Psychological Society, New Zealand Psychologists Board, New Zealand Psychologists Board, 2021). The use of distance communication technologies such telephone, email, chat, and videocall for psychological service delivery is considered telepsychology (New Zealand Psychologists Board, 2012). Globally, therapists were unlikely to have had experience using distance communication technologies for therapy before being compelled to do so by the unprecedented events of the COVID-19 pandemic. Majority results from a 2019 survey of

1791 American psychologists with an average of 26 years' experience indicated no experience of telepsychology (Pierce, Perrin and McDonald, 2020). In general, telepsychology was regarded primarily as a supplement to in-person therapy (Rosen, Glassman &and Moreland, 2020). Geller (2020) connects therapists' negative views about telepsychology to limited literature and training about effective practicing in telepsychology, and concerns around therapeutic efficacy due to perceived difficulties establishing a successful working relationship (Jerome and Zaylor, 2000; Rees and Stone, 2005; Simpson and Reid, 2014). These factors may have both influenced and sustained low use of telepsychology globally prior to the pandemic.

Rosen, Glassman, and Morland (2020) note that the COVID-19 pandemic created conditions for trauma and stress which differ from any previous provision of telepsychology. Effectively overnight, telepsychology became the primary mode of therapy engagement in many parts of the world including Aotearoa New Zealand. Downing et al. (2021) described how in response to the implementation of similar personal movement restrictions in Australia, 5521 solo-practicing psychologists engaged in rapid uptake of videocall technology to deliver psychological services following the provision of publicly-funded telepsychology for all Australians (previously this had only been available for a small percentage of people living remotely). Videocall technology that facilitates real-time synchronous audio and visual communication is most analogous to in-person interactions between client/s and mental health practitioner (Smith et al., 2021). For the purposes of this study, the term videocall therapy refers to real-time therapy sessions facilitated by digital platforms with videoconferencing abilities such as Zoom, BetterHelp and doxy.me.

Literature review

This section provides an overview of relevant literature on attitudes towards and experiences of telepsychology from therapist and client perspectives, supplemented by discussions of literature on associated aspects of psychological service delivery in therapy by videocall.

Pre-pandemic views on telepsychology

Over the past two decades, the efficacy of telepsychology compared with in-person therapy has been well-researched. Research into videocall therapy prior to the pandemic indicated that it results in equivalent therapeutic outcomes when compared with in-person therapy (Acierno et al., 2017; Fletcher et al., 2018; Norwood, 2018). Irvine et al.'s 2020 systematic review of 15 studies comparing telephone to in-person therapy consistently found no difference discerned in disclosure, empathy, attentiveness, participation or working alliance. Working alliance (variously referred to as therapeutic alliance or therapeutic relationship) is widely regarded as fundamental to therapeutic satisfaction and success (Flückiger et al., 2018). Moreover, a number of studies showed use of technology to be effective in the treatment of a variety of presentations involving psychological distress including mood and eating disorders, Post-Traumatic Stress Disorder, Obsessive Compulsive Disorder and chronic pain (Beinter et al., 2011; Loucas et al., 2011; Sloan et al., 2011; Pozza et al., 2014; Varker et al., 2019).

As noted in the earlier section, a range of factors related to therapist discomfort and unfamiliarity with use of the videocall medium (Jerome and Zaylor, 2000; Rees and Stone, 2005; Simpson and Reid, 2014) are likely to have influenced poor engagement with telepsychology in general. However, pre-pandemic research indicated a trend towards the particular practice of talk-based therapeutic modality cognitive behavioural therapy (CBT) for telepsychology. In a 2016 systematic review of eight studies delivering telepsychology, Chipps et al. (2022) identified that all studies practiced forms CBT. Eschewing the need for in-person interactions, having highly prescriptive approaches for working with certain presentations, and the ability for brief interventions were identified as some of the factors contributing to CBT's suitability for telepsychology. There is limited evidence evaluating the practice, let alone efficacy, of other therapeutic modalities (Smith et al., 2021).

Despite the body of evidence indicating therapeutic efficacy and no detrimental effect on working alliance, telepsychology had been under-utilised prior to the necessary uptake

created by COVID-19 restrictions. In general, qualitative studies on the experience of telepsychology concentrated on mental health professionals' concerns about its use. Most studies sought to understand mental health professionals' experiences across the United Kingdom, Northern Europe and the United States, cataloguing therapists' practical, ethical and relational concerns about engaging in videocall therapy. Practical difficulties highlighted by therapists included the inability to assess non-verbal cues and to undertake some tasks integral to their modality (Gershkovich et al., 2016; Irvine et al., 2020). Studies show therapists were also concerned about barriers to managing crisis or risk with clients, as well as managing the occurrence of technical disruptions (Carper et al., 2011; Gershkovich et al., 2016). Therapists feeling less confident and experiencing more self-doubt from working in this way (Aafjes-van Doorn et al., 2020) is likely to have contributed to the prevalence of in-person therapy over videocall therapy when conditions did not necessitate it. There is suggestion that videocall therapy and other telepsychology mediums may be beneficial for people with avoidant coping strategies, as research shows it can be experienced or perceived as promoting less stress, anxiety, and commitment than in-person therapy (Day and Schneider, 2002; Dunn, 2012)

Conversely, limited pre-pandemic research documenting clients' experiences of telepsychology indicated clients reported similar levels of satisfaction compared with in-person therapy (Norwood et al., 2018; Simpson et al., 2005). For example, Simpson et al.'s 2005 study of 23 Scottish clients engaging in therapy for eating disorder recovery reported a general sense of satisfaction with videocall therapy. Participants cited convenience as a factor, and felt less pressured and intimidated (Simpson et al., 2005). Often these studies were for specific client populations, therefore posing issues with generalisability. Studies mostly focused on client populations that experienced challenges attending in-person therapy such as clients living remotely or with problems accessing appropriately qualified therapists (Scogin et al., 2018; Zheng and Gray, 2018), and clients with social anxiety (Yuen et al., 2013) and medical conditions limiting contact (Lleras de Frutos et al., 2020). Babbage et al. (2020) explored attitudes on the role of technology in healthcare in two rural communities in Aotearoa New Zealand, including one with a high representation of residents identifying as Māori. Thematic findings indicated overall positivity towards incorporating technology into health-based activities, with concerns raised about access to devices due to cost barriers (Babbage et al., 2020).

Emerging post-pandemic views on telepsychology

There is little consensus yet within international studies on how increased use of videocall therapy may have shifted pre-pandemic findings. A 2022 meta-analysis of 11

studies showed a mean reduction in anxiety and depression levels for clients engaging in videocall therapy using CBT as the modality (Zamiri-Miandoab et al., 2022). Uysal et al.'s 2021 study using a pre-test-post-test design to examine the effectiveness of four-session videocall therapy using CBT on a Turkish adolescent population showed a reduction in reported anxiety and depression symptoms, in line with previous research on the use of CBT (Brown et al., 2019; Olsson et al., 2021; Sclare et al., 2015; Wignall, 2006).

There is a limited body of research examining experiences of clients engaging in therapy by videocall during the COVID-19 pandemic, and to the researcher's knowledge no published studies of client experiences in Aotearoa New Zealand during COVID-19 restrictions. Emerging research on client experiences indicate that the removal of time and cost considerations due to travel was viewed as beneficial for engaging in videocall therapy (Brothwood et al., 2021; Vuillier et al., 2021). Zubala and Hackett's 2020 survey of 96 therapists practicing the action-based therapeutic modality of art therapy suggests that therapists opting to deliver art therapy by videocall felt client characteristics were important to consider when engaging in this way. Most survey participants felt only some of their clients were suitable to working in this way. Cooner et al. (2022) surveyed 73 Australian and New Zealand teams concerning perceived barriers and identified solutions to delivering dialectical behaviour therapy (DBT) by videocall during periods of COVID-19 restrictions. Themes generated from this qualitative study show concerns about access to resources (physical and digital tools, and technical expertise) and about process (therapeutic connection, management of risk and dysregulated behaviour, and lack of confidence in the medium). Solutions for process concerns identified by 56 teams who engaged in videocall therapy mainly centred around education and skills training for therapists. Some studies report that despite positive experiences with videocall therapy, in-person therapy was generally preferred (Barker and Barker, 2022; Bleyel et al., 2020; Brothwood et al., 2021).

Therapist concerns continue to shape emerging post-pandemic research on experiences of videocall therapy. Békés & Aafjes-van Doorn (2020) report that many therapists continued to prefer in-person therapy for a perceived greater level of emotional connection, flow, engagement, ability to access empathetic feelings and the diminished ability for fatigue and boredom experiences (Békés et al., 2020; Messina and Löffler-Stastka, 2021; Smith and Gillon, 2021). Technical barriers and disruptions were noted as contributing factors (Aafjes-van Doorn et al., 2021; Békés and Aafjes-van Doorn, 2020; Smith and Gillon, 2021). However, therapists' own enjoyment of the videocall therapy experience was associated with their perception of client's having a positive experience, often influenced by therapists feeling confident and experienced with using videocall therapy as a medium (Békés and Aafjes-van Doorn, 2020). Psychodynamic and psychoanalytic therapists

experienced a shift towards feeling more connection and authenticity two months into delivering videocall therapy, as opposed to experiences in the initial weeks engaging in it (Aafjes-van Doorn et al., 2021).

In pre- and post-pandemic research, videocall therapy experiences for therapists and clients are often framed in terms of the therapeutic relationship – components of which include working alliance, affective environment, embodied relating and therapeutic presence.

Working alliance

The term working alliance generally refers to a working relationship between the client and therapist built on mutual trust. It is considered crucial for safe and successful therapy. For Rogers (1951), the active components of mutual trust (which is essential to a working alliance) are empathy, congruence, and unconditional positive regard. Bordin's (1979) seminal formulation of the working alliance can be described as when client and therapist share a common belief with regard to the goals of therapy and have a common understanding of the efficacy and relevancy of the methods used to achieve these goals. Thus, the working alliance is defined by agreement on therapeutic goals, agreement on tasks, and the creation and maintenance of a personal bond of reciprocated positive feelings.

Several studies suggest therapists may report diminished experiences of working alliance in videocall therapy when compared with in-person therapy, whereas clients generally do not perceive impacts made based on the use of videocall as a medium (Rees and Stone, 2005; Berger, 2017; Norwood et al., 2018). Therapists express concerns about the potential for disruption to what is perceived to be the core mechanism for therapeutic change and also the most reliable predictor for outcome and attrition (Flückiger et al., 2018; Simpson et al., 2021)

Research shows that clients perceive a stronger working alliance from earlier on in the relationship when engaging in videocall therapy, compared with in-person therapy (Simpson et al., 2021). Jenkin-Guarnieri et al.'s review (2015) of 15 studies examining client perceptions of telepsychology found generally little difference in perceptions of working alliance or satisfaction with therapy. While working alliance was found to be lower on average in a meta-analysis of randomised controlled trials comparing remote and in-person cognitive behavioural therapy, this was not shown to result in any difference in therapeutic outcomes (Norwood et al., 2018). Stefan et al. (2021) surveyed Austrian psychotherapists about their experiences with this transition between March 2020 – November 2020, during which time Austria was experiencing intermittent lockdowns. The aim was to examine longitudinal effects of the involuntary provision of videocall therapy. The study found no

overall decline in working alliance as reported by psychotherapists, which is in line with more recent research (Simpson et al., 2021; Stefan et al., 2021).

Irvine et al. (2020) have suggested that in therapy via telephone, an alternative working alliance may be created. While it may be qualitatively different to that which is created in conventional in-person therapy, it could be as effective (Irvine et al., 2020). A small number of studies have concluded similarly for telepsychology in general and including videocall therapy (Kocsis and Yellowlees, 2017; Langley-Pottie and McGrath, 2007; Turner, 2018).

Affective environment

Being located remotely from one another in videocall therapy, the ability to read, understand and reciprocate body language and non-verbal cues is diminished for both the client and the therapist (Kysely et al., 2022). Research indicates that the shared virtual environment in which client and therapist engage in therapy has an influence on the experience of videocall therapy (Kysely et al., 2022). Rather than conceiving of the physical and virtual as binaries, Pink et al. (2016) argues that it is more appropriate to understand the digital and material as "entangled elements of the same processes, activities and intentionalities". Digital communication technologies are embedded into into everyday life for a vast range of activities. Drawing on Pink et al.'s (2016) to frame engagement with videocall therapy helps to situate space as relational as well as tangible.

Winnicott (1953) described the primary role of the therapist as providing a safe 'holding environment' for the client in which to engage in the therapeutic project. Within the contained relational 'space' of the holding environment, the client's affect is able to be influenced. Competing ideas of how affect is influenced by the 'holding environment' exist (Massumi, 1995; Tomkins, 1966; Thrift, 2007). Downing et al. (2021) note that affect can triggered or created through the complex interplay of relational and material interactions (Downing et al., 2021). Fernandez et al. (2021) note that in telepsychology, therapists have a reduced ability to express their attunement and presence through full-body movement, requiring new processes and communication to build an affective environment for engaging in therapy.

Embodied relating and therapeutic presence

In videocall therapy, the 'holding space' is no longer one that is informed by the therapist's embodied relating to the client. Geller (2017) suggests that the sense of safety in their physical environment and in the working alliance helps clients become open to

engaging in the necessary therapeutic work ahead of them. For clients with trauma experiences, the safety of this holding space supports their emotion regulation and ability to be vulnerable (Geller, 2018; Geller and Porges, 2014; Simpson et al., 2021). In videocall therapy, therapists are unable to express their attunement and presence using embodied relating.

Co-regulation through embodied relating draws on Porges' (2011) polyvagal theory to explain the neurophysiological mechanisms that come into play during interpersonal interactions. Polyvagal theory acknowledges the mechanisms of affective change that being in the presence of the therapist might deliver (Porges, 2011). In this theory, one's nervous systems is constantly in bidirectional communication with other peoples' nervous systems (Geller, 2017, 2018; Geller and Porges, 2014; Porges, 1998, 2011, 2018; Thompson, 2018). The therapist's attunement with their client and full attention to the present moment sends calming neurophysiological message to client, and they both experience feelings of safety. In-person, this may be communicated through synchronised and reciprocal body movements and rhythms, mutual eye gaze, and mirroring of gestures and expressions (Geller, 2017; Marci et al., 2007; Marci and Orr, 2006; Ramseyer and Tschacher, 2014). Ultimately, this is said to strengthen the traditional working alliance (Geller, 2017, 2018; Geller and Porges, 2014). Payne et al. (2020) notes that socially anxious or narcissistic clients and therapists may be more inclined to pay more attention to their own behaviour in videocall therapy.

Geller (2017) describes therapeutic presence as a way of 'being' with a client that therapists can adopt that optimises the 'work' that each engages in together during a therapy session. Therapeutic presence is a skill present across a range of person-centred psychological approaches, most notably in modern psychodynamic approaches (Geller, 2020). Siegel (2010) posits that therapeutic presence acts an invitation for clients to "feel felt" and creates conditions for a sense of safety and co-regulation that allows clients to engage in the work of the therapeutic project (Geller, 2017; 2018). Some emerging research indicates an online calming hypothesis (Reynolds et al., 2013; Simpson et al., 2021) that may help build an adapted or alternative working alliance. Adaptation of therapeutic presence for videocall therapy may help to address complications to the working alliance found when therapy occurs when therapist and client are not sharing the same physical space. Geller (2020) notes that client trust in the therapist can be delayed and more fragile in videocall and telephone therapy. Indicative of an entangled digital and material space, technical disruption during videocall sessions can complicate the building of reciprocal trust.

In summary, existing literature on telepsychology mainly shows there is little change in therapeutic efficacy compared with in-person therapy. Despite this, research has focused on therapist concerns and limited experiences of videocall therapy, and there is little known about client experiences. Emerging research on client experiences of videocall therapy indicate that the working alliance is not adversely affected by using videocall as a medium. The limitations of videocall therapy call attention to aspects of communicating a working alliance such as embodied relating and therapeutic presence, and the affective environment.

Gaps in Literature

Client perspectives on experiences and efficacy of telepsychology is underrepresented in global literature, both pre- and post- COVID-19 pandemic. There is a significant gap in the literature for client experiences of videocall therapy during the COVID-19 global pandemic, in particular with respect to personal movement restrictions that impacted therapist and client abilities to choose in-person therapy were it a preference. Further, little research to understand therapist and client experiences in an Aotearoa New Zealand context has been undertaken. To the primary researcher's knowledge, there is no published research on client experiences of videocall therapy in Aotearoa New Zealand during the COVID-19 pandemic to date. Some research is being undertaken to document provider experiences in Aotearoa New Zealand.

Rationale

The purpose of this study was to explore the experiences of clients who engaged in videocall therapy during COVID-19 restrictions in Aotearoa New Zealand. Health service research indicates that engaging with client perspectives on quality of care include improvements in satisfaction, sustained uptake of services, and better health outcomes (Bertrand et al., 1995; Kols and Sherman, 1988). With significant gaps in the literature on client experiences of videocall therapy, contributions of knowledge to this area will be meaningful. Rosen, Glassman, and Morland (2020) note that the COVID-19 pandemic created conditions for trauma and stress which differ to any previous provision of videocall therapy. This study presented a valuable first opportunity to collect and explore client experiences of videocall during COVID-19 restrictions in Aotearoa New Zealand. As uptake of videocall therapy grows, findings from this study may contribute to the development of clinical practice guidance for the remote delivery of therapeutic services.

Methodology

The section steps through the underlying philosophical and methodological approaches for this study, and describes the recruitment, data collection and analysis methods. The aim of the study was to describe a contextualised analysis of client experiences, with potential for findings to inform future research into the nature of videocall therapy. This study asked a broad research question:

- What are the experiences of clients who engaged in videocall therapy during COVID-19 restrictions in Aotearoa New Zealand?

Methodological Framework

The context for this study was a critical realist qualitative research project that used semi-structured interviews to collect data on clients' experiences of videocall therapy during the period of COVID-19 restrictions in Aotearoa New Zealand. Broadly considered to bridge competing ontological and epistemological beliefs about the nature of reality, the critical realist paradigm best reflects the researcher's own beliefs. It combines ontological realism – that a single tangible reality exists – with an interpretivist epistemological position that people's understanding of reality does not result from direct or objective perception but is mediated by our own construction of it (Archer et al., 2013; Braun and Clarke, 2013).

Critical realism was well-suited to frame qualitative research into experiences (as in this study) because it is concerned with understanding and explaining the mechanisms underpinning empirical experiences and actual events. Flick (2013) characterises qualitative research by its theoretical allegiance to the social construction of realities, interest in participant perspectives and everyday practices, and use of textual material. Critical realist and qualitative paradigms take a phenomenological perspective in which peoples' experiences of reality are processed through language, culture, ideologies, and sensory mediators (Wiltshire and Ronkainen, 2021).

A qualitative approach using semi-structured interviews was selected for its potential to elicit rich accounts of participants' experiences. Ethical approval was granted by the Auckland University of Technology Ethics Committee (AUTEC) on the 16th of June 2022, reference number 22/127. Participants' accounts were treated both as reports of their experience of videocall therapy, and as understandings processed through the senses, language, culture, ideologies, and shaped by socially available meanings related to therapy in Aotearoa New Zealand (Adams, Mccreanor and Braun, 2013; Wiltshire and Ronkainen, 2021). Using a fluid and flexible conversational style (Braun and Clarke, 2022) for semi-

structured interviews allowed for deductive and inductive approaches to data collection and analysis. Reflexive thematic analysis was selected for its compatibility with the research question, critical realist and qualitative paradigm/s, and interview methodology.

As a cluster of methods for identifying patterns of meaning across data, thematic analysis is generally considered to have theoretical and design flexibility (Braun and Clarke, 2022). Situated at the “Big Q” end of Kidder and Fine’s (1987) qualitative research spectrum, reflexive thematic analysis adopts the postpositivist position that the researcher is an active agent in the generation of research outcomes (Braun and Clarke, 2022). Coding reliability or codebook thematic analyses would not have been suitable for this study as they incorporate “small q” positivist quantitative research values and practices that deny or disestablish researcher subjectivity (Kidder and Fine, 1987; Braun and Clarke, 2022; Kidder and Fine, 1987). The concept of researcher bias is deemed irrelevant in reflexive thematic analysis because knowledge generation is “inherently subjective and situated” (Braun and Clarke, 2022). Instead, researcher subjectivity and positionality are considered a “resource for research” (Gough and Madill, 2012) rather than a source of bias to be managed.

Reflexivity and positionality

The aim of using reflexivity in this study was to explicitly account for and integrate the researcher’s own personal contributions to the research process and outputs (Finlay, 2002). In reflexive thematic analysis, the researcher’s interactions with research design and data are understood to be informed by their ideologies, culture and socio-economic position, and scholarly knowledge (Braun et al., 2018). This is known as researcher positionality. The following summary delineates my position with regards to the research area:

I am a Masters student studying health science, with an interest in psychological growth, telepsychology, and the interplay between spatial environments and psychological wellbeing. Because of an occupational background in spatial design research and workplace strategy I am familiar with using coding reliability and codebook thematic analysis methods in industrial research. Reflexivity is a core skill I am learning as part of my training to be a counselling psychologist. I attended a two-day workshop to prepare for my first experience of using reflexive thematic analysis for this Practice Research Project. Two years’ experience as a provider of brief intervention telepsychology and a small number of sessions of videocall therapy as a client gave me some foundational knowledge for the context of the research. I was present in Aotearoa New Zealand for the time period that was the focus of this study, and experienced the same COVID-19 restrictions. During data collection this was beneficial for rapport, but also presented the opportunity for role clarity challenges. I became

increasingly aware of my own positionality over the course of the research, and how it guided my decision-making and eventual research outputs.

Researcher positionality is but one component of reflexivity. As an active agent in the research process, researchers need to reflect on and negotiate the complexity of their positionality (Hill and Dao, 2020). In particular, I engaged in intersubjective reflection (reflecting on the role of the researcher in relation to the participant), notably during interviews where I encouraged the participants for their own contributions that were not guided by my research questions and engaging in conversation that conveyed empathetic understanding of their experience (Finlay, 2002; Trainor and Bundon, 2021). Further, I engaged in introspection reflexivity (self-understanding for interpersonal insight, interpretation and connecting knowledge) most notably during the analysis phase and attempted limited mutual collaboration (engaging the participant in reflexive dialogue about the research) by giving participants the opportunity to review and amend their transcripts. The function of reflexivity in this study was to contextualise the research and use reflexivity as a resource to interpret meaning from the data.

Participant Recruitment

Braun and Clarke's (2013) "rule of thumb" sample size of six to ten participants for a small-scale exploratory study designed to encourage future research was deemed practical, given constraints around researcher availability and funding for participant recruitment. Seven potential participants were recruited over a four-week period via Facebook and Instagram advertisements. Advertisements were oriented to people in Aotearoa New Zealand over the age of 18 years. Potential participants responded to the advertisement by clicking a link to the information sheet detailing the study and inclusion criteria, hosted on an AUT Qualtrics site. Potential participants entered their email address, and subsequently received an email invitation to participate, with a consent form for completion. Once the researcher received the completed consent form, the date and time for the interview was determined through email correspondence.

Inclusion criteria for participation was not being a client of the researcher, experience of videocall therapy from March 2020 and no longer presently engaged. The inclusion criteria recognised the onset of COVID-19 restrictions in Aotearoa New Zealand and provided the study with defined environmental conditions within which to understand and interpret participant experiences – from March 2020 until July 2022. One potential participant was excluded for not meeting the criteria.

Data Collection

Information sheets with inclusion criteria were provided to all potential participants for review upon clicking through the advertisement, and consent forms collected by email. Participants also completed oral interview consent before commencing the interview. Semi-structured interviews were recorded using an audio device, and transcribed at a later date. Existing literature helped structure the interview agenda (finalised in consultation with the primary and secondary supervisors), while scope for eliciting organic responses was made possible by adopting a fluid and flexible conversational style (Braun and Clarke, 2022). The interview agenda asked for demographic and contextual information, and explored participants experiences of videocall therapy. The researcher videocalled participants using Zoom and Microsoft Teams for interviews. The decision to situate interviews in the natural setting of the research (videocall) has merit in qualitative research methods (Flick, 2018), and created conditions to elicit spontaneous reflections about the experience of videocall therapy. Additionally, videocall was identified as a low-cost option that accommodated participant and researcher schedules. The duration of the interviews varied between approximately thirty to fifty minutes. Data analysis began on completion of interview transcription. Transcripts were circulated to participants for their review, with opportunity to provide further comments or clarification. No responses from participants were received.

Reflexive Thematic Analysis

In Braun and Clarke's (2013) conception of reflexive thematic analysis, the researcher is an active participant in a non-linear six-phase process. The first phase involved familiarising myself with the collected data through deep engagement with interview recordings in audio and transcribed form and reflexive note-taking. After an 'active listen' of each interview, I made informal observations about participants' nonverbal cues and tone of voice and general affect. Reflecting intersubjectively, I considered the range of interview 'journeys' generated as a result of shifting power dynamics and spontaneous questioning during each the interview. Microsoft Word's audio-to-text transcribe function delivered word-for-word transcription as a starting point. Then with multiple listens of each interview, I manually edited the transcripts to better reflect the participant's delivery. I read transcripts multiple times and took casual notes on the participant's key areas of focus in relation to the research question.

I entered the second phase by closely reading hardcopies of the transcripts, for succinct and systematic identification of meaning across the data (Braun et al., 2018). When identifying codes (labels assigned to blocks of text with similar focus), no prioritisation of semantic or latent codes was made. This reflects the critical realist foundations of the analysis which recognise that semantic information capturing the explicit meaning conveyed by the participant is equally as valuable as the latent conceptual interpretations made by the researcher. After a period away from the data to allow time for insight and reflection (Braun and Clarke, 2022), I input the codes into tables organised according to individual transcript. In a separate document, codes were assessed for repetition and collapsed together where relevant.

In the third phase, I was concerned with clustering codes to generate early themes. A number of early themes were developed deductively – capturing responses to interview questions informed by the existing body of research on videocall therapy experiences, as well as scholarship on concepts related to development of the therapeutic relationship. Some early themes were developed inductively through familiarisation with the experiences conveyed by the six participants in this study. In practice, I used a whiteboard to identify themes with overlapping or contradictory codes – moving from early themes to candidate themes. Reflexive thematic analysis is concerned with identifying meaning-based patterns, not features of the data (Braun et al., 2018). Accordingly, I isolated some early themes from further analysis, to be reported as demographic and contextual information.

For the fourth phase, I reviewed transcripts for illustrative quotes and wrote short summaries of each candidate theme. The primary supervisor and I discussed the short summaries. This gave me the opportunity to review candidate themes in relation to the research question and further develop them to convey a convincing narrative of the collected information (Braun et al., 2018). I noticed that I drew on acquired knowledge about the interplay between spatial design and human behaviour to compose candidate themes. This helped me to frame behaviours or practices described by participants in relation to the underlying meanings ascribed to them. It also prompted additional reading for relevant research on the experience of intersecting digital and physical environments.

Braun and Clarke (2022) note that the purpose and methodology informing analysis guide the researcher's decision-making when developing themes. The fifth phase involved taking relatively 'settled' themes, naming them and articulating the scope and focus of each theme. In practice, I mapped a coherent overall narrative of the data, using a loose structure of pre-, during, and post-session to organise themes. Themes were detailed in-depth showing the flow of information within the theme, as well as how they flowed into other

themes. An early iteration was shared with the primary and secondary supervisors, and they gave feedback on information flow. With this in mind, the scope of themes was refined and transcripts re-visited to identify quotes from the data to better “convey the ‘essence’ of each theme” (Braun and Clarke, 2022).

The final phase consisted of revisiting all analytic phases – development of the research question, data familiarisation and coding, theme generation and refinement – while writing a compelling narrative for the data. In practice, this meant reviewing transcripts, notes, and summaries written throughout the analytic process and engaging with relevant research. These are important actions to align final themes with the research question and “remain close” to the data (Braun et al., 2018). I identified appropriate subthemes, contextualised themes within existing research findings, honed boundaries between themes, and re-organised the flow of the themes to better reflect the narrative.

Analysis

This section begins by summarising participant demographic and contextual information that shaped participants' description of their experiences of videocall therapy. This section is rounded out by reporting of five themes generated by the researcher in the course of a reflexive thematic analysis process.

Participant Demographics

All participants were women (three identified as cisgender), ranging from 27 to 50 years of age. Three out of five participants who disclosed their ages were in their thirties. One participant identified as a disabled person, living with multiple chronic illnesses and neurodivergence. Four participants described themselves as New Zealand European. One participant described herself as a migrant who was born in England and grew up in Italy. Another participant located herself as half-Chinese, whose parent immigrated as a refugee. Five participants described having a husband or a partner, with one of these participants identifying as bisexual in a heterosexual relationship.

Participant Contexts

In line with reflexive thematic analysis, emphasis was placed on understanding participants' contexts (Willig, 2017; Braun and Clarke, 2022). Four out of six participants were living in Tāmaki Makaurau Auckland during the period they were engaging in videocall therapy, which means they experienced greater and longer periods of lockdowns than the participants living in Ōtautahi Christchurch and rural Taranaki. All participants described having secure accommodation during the period of COVID-19 restrictions, and four participants disclosed that they owned their own home. Four participants indicated they shared a residence with their partner, and one participant described living with her parents. Three participants had at least one cat or dog, and two participants were parents to multiple children also living at their residence. Four participants described being in paid employment while they were engaging in videocall therapy.

Over the period that was the focus of this study – March 2020 to July 2022 – half of the participant group exclusively used videoconferencing technology to engage in therapy. Conversely, half of participants also attended in-person sessions, generally at the therapist's place of work. One participant attended some in-person sessions held outdoors. Four participants used videoconferencing platform Zoom and two participants used specialist

telehealth applications - one participant used BetterHelp and one participant used doxy.me. BetterHelp is subscription-based platform that facilitates worldwide telepsychology (*Terms and conditions*, 2022). Doxy.me is a videoconferencing platform designed specifically for use by telehealth providers.

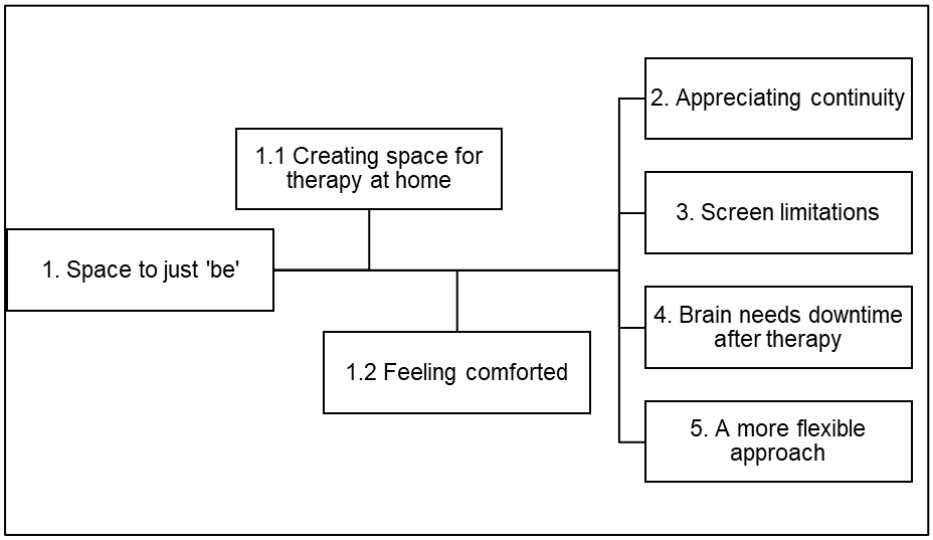
The majority of participants worked with more than one therapist over the two-year period that was the focus of this study. Of the four participants who engaged with more than one therapist, three participants saw two therapists in total, and one participant engaged with four therapists. Three of these participants elected to end services with one therapist and start with another over this time. One participant was referred to another therapist for four sessions by videocall while their primary therapist took a leave of absence.

For three participants, ending their engagement with a therapist was dictated by external factors. In one case, the funding allocation from insurance was exhausted. Two other participants were discharged from publicly funded services. Five participants engaged with therapists working privately. One participant received both public and private services, and one participant received public services exclusively. Of the two participants who engaged with therapists based in different cities or countries to them, one participant has maintained connection with the therapist via their professional social media.

Two out of four participants who worked with a psychologist did not recall the psychologist's scope of practice. One therapist practiced under the clinical psychology scope. Another participant engaged with a therapist dually trained in clinical psychology and psychotherapy, and one psychotherapist. One participant engaged with a psychotherapist and three psychologists of unknown scope. Two participants worked exclusively with counsellors.

Figure 1

Themes and sub-themes.



Five themes were identified in the reflexive thematic analysis. The first theme concerned participants' experience of therapy by videocall as a conceptual therapeutic 'space'. This theme was supported by two subthemes: participant ownership exercised over their physical environment and the incorporation of material comforts into the practice of videocall therapy. The next themes were participant appreciation for therapists demonstrating thought and care about the client experience, the inability to observe and respond to body language, and the need for transitory practices to come out of the therapeutic 'space'. The final theme was videocall facilitating a more flexible approach to incorporating therapy into their lives.

Theme 1. Space to just 'be'

Participants thought of therapy sessions by videocall as a conceptual 'space'. Elements of the physical and digital environments helped participants create a therapeutic 'space' defined by safety and containment away from everyday life. Participants had a range of previous in-person therapy experiences, from one-off sessions to longstanding and/or ongoing relationships. They all brought some pre-existing idea about the elements needed for a therapeutic 'space' to their experiences of videocall therapy.

> *"I still think physically going somewhere and doing a thing, then leaving – it's that mental space where you've got that clear boundary. When I'm pottering around and doing a Zoom call and you go back to whatever you're doing it's not the same as actually physically being in a different space and physically doing the work that you need to do." (Participant 06)*

The experience of doing therapy from home, with videocall as the mode of delivery, was considered fundamentally different to the in-person experience of therapy. The above

extract shows how participants considered the transition into and out of the therapeutic 'space' as part of "the work" of therapy. This participant indicated that experiencing therapy in a separate physical environment communicated the "clear boundary" necessary to evoke the "mental space". The distinction suggests that the tangible actions of a) traveling to a location, b) being physically as well as intellectually and emotionally present while engaging with a therapist, and c) physically and mentally transition out of the therapeutic 'space' are fundamental elements of the therapy experience.

> *"Not being able to remove myself from my environment because I like the experience of going somewhere. It's somewhere safe and it's somewhere that I'm also not distracted and worried about everything else that's going on around me." (Participant 01)*

This participant described the discomfort and frustration felt when she was unable to access an affective atmosphere cued by "the experience of going somewhere" that was not associated with everyday concerns. Across the interview data, the value of a physical environment which supported the client to be fully present was recognised – a therapeutic 'space' defined by feeling safe and contained away from everyday life.

> *"There were a few challenges when you've got all the kids home and you've got to find a space that you can just kind of 'be'…There were no interruptions and nobody who was likely to walk in and go "hey, mum?". I think being in a space that's out of the ordinary the kids were less likely to come and go "Oh, mum where are the biscuits?" or something." (Participant 06)*

> *"I haven't thought about it much, but just in reflection I think it was also nice that [doxy.me] was a separate tool. It wasn't my usual tool, it was her tool. I didn't use it for any other purpose except for that. So, there was something nice in that - almost like there won't be a blurring of accounts." (Participant 04)*

It was important for participants to 'contain' therapy away from the roles and responsibilities in their everyday lives in order to create the conditions for the therapeutic 'space'. In the first extract, the participant has separated the idea of "just 'be'[ing]" from their identity as a parent. The second extract shows that participant's appreciation for the therapist's selection of a videocall platform did not contain the opportunity for "blurring" into their other activities or identities online. This illustrates that digital and physical environments are interdependent elements of a person's identity and everyday experience.

Theme 1.1 Creating space for therapy at home

Participants engaged in minimal but targeted preparatory practices to facilitate the therapeutic 'space' within their physical environment. For some, this manifested as talking a walk before the therapy videocall session to emulate the act of travelling to a destination. Mostly, participants were intentional when selecting the location at their residence to videocall from, taking actions to ensure acoustic and visual privacy.

> *"The odd occasion where I had to find a small room in the house to Zoom when I knew there was other people here, that was a little bit uncomfortable. It just made home feel less like a therapy environment probably." (Participant 02)*

The importance of privacy to a therapeutic 'space' is illustrated by this participant's perception that their physical environment felt "less like a therapy environment" when privacy was compromised. Out of necessity, most participants selected a room within their residence that had a different primary function to videocall from. This included their bedroom, children's bedrooms, a home office, and the dining area. On occasion, a participant engaged in sessions from a car parked in the driveway.

> *"But other times it was because there were people in the house and I was like as much as I love them there, this is my time and I don't want to cry in front of them. They can have me afterwards. This is my space, and my time and so sometimes that's why I did that." (Participant 02)*

> *"One thing I did do to prepare was make sure that my dog had something to entertain herself so she wouldn't be too distracting." (Participant 01)*

Both extracts illustrate a claim of ownership over the experience of videocall therapy, where interactions with others in the immediate vicinity would be considered "interruptions" or "distractions" from the therapeutic project. Some actions taken in order to facilitate a therapeutic 'space' were placing a 'Zoom meeting in progress' sign outside the door, telling other people in their residence that they needed privacy to engage in videocall therapy, and dedicating a room in their residence for work, study and videocall therapy purposes only. These actions illustrate client willingness to create the conditions in their physical environment to support a 'space' in which they can be better attuned to their own emotions and present experience.

Theme 1.2 Feeling comforted

Material items available in the home environment provided haptic comfort during videocall therapy sessions. For example, participants reported videocalling from bed, wearing their pyjamas, and bringing a blanket, something to hold, and a cup of tea to therapy sessions.

> *"You've got to feel comfortable in the space to get the most out of whatever it is you're doing." (Participant 06)*

> *"I did some of my sessions from bed, which from a therapist perspective was very interesting for her. She's like, you're in bed you're not doing well. It meant I could be really vulnerable and I felt very safe here. Being in a therapist office and crying your eyes out in an unfamiliar place where you then have to get yourself together and go out to reception and drive home, it's unfamiliar and it's uncomfortable. Whereas being at home I just cried and cried and then my partner was here afterwards straight away" (Participant 02)*

The association between feeling comfortable and the ability to achieve therapeutic goals was a sentiment shared across the interview data. The second extract helps to bring this into sharper focus. The primary meaning participant ascribed to her decision to videocall from her bed was a sense of safety which allowed her “be really vulnerable”. For this participant, the ability to incorporate supports available in the surrounding environment that both signified and supplied comfort stood in contrast to “unfamiliar” and “uncomfortable” experiences of being vulnerable during in-person therapy sessions. Participants described a need for comfort and soothing when present in their therapeutic ‘space’. Material items that signified and provided comfort played were important for helping participants access and ‘stay with’ their emotions during a therapy session by videocall. Lack of control over when pets could be integrated into the therapy session meant that participants with pets regarded them primarily as a distraction.

Theme 2. Appreciation for continuity

A common theme was appreciation for continuity in the quality of the working alliance. Participants usually expressed this when describing demonstrations from therapists that showed consideration for the client’s experience of videocall therapy.

“I mean, it ended up being not so different from when I did it in-person. Even with the one I was seeing for the first time via videocall, it was fine. I've noticed in my experience, it's either a good relationship or it's not.” (Participant 03)

Participants largely felt that the quality of the working alliance was not associated with the circumstances in which therapy occurred. Most participants who had existing relationships with therapists prior to engaging in therapy videocall indicated that they did not perceive a change in the quality or nature of the working alliance. A few participants lamented having the final session by videocall, as it did not provide adequate closure for the relationship.

> *“If the therapist had a high level of creativity online like bringing up some kind of interactive whiteboard or something that could replicate the creative elements of the action-based methods, that possibly would have maintained some continuity. Whereas the more talking, psychoanalytic, profound navel gazing methods work fine online. They work really well.” (Participant 04)*

Most participants characterised the content of their therapy sessions as conversations or indicated that they were working with a therapist using talk-based modalities (not requiring the addition or radical adaptation of processes), such as cognitive behavioural therapy, psychoanalysis, relational psychotherapy, and metacognitive therapy. In the above extract, the participant described actions a therapist practicing psychodrama

(an action-based modality) could have taken to create a beneficial experience for the client. She acknowledged that adapting this modality to videocall therapy required specific personal attributes and technical ability – a "high level of creativity online" – that the therapist did not possess. This participant subsequently sought a therapist who practiced talk-based modalities with whom she experienced a successful working alliance.

> *"She did little things like checking I could always hear her okay, and if we did have a slightly dodgy connection she would check in and check she'd caught what I'd said and repeat things if needed. Which is I suppose is just good practice, but I guess not everyone would naturally do that either...I think it probably boils down to, the therapy was always for me and everything she did was to make sure that I was comfortable and I understood and I got the most out of it, even though it wasn't face-to-face. It always felt like she cared most for me and that was the key." (Participant 04)*

Demonstrations from therapists that they were actively expanding or integrating new ways of communicating with clients were appreciated for the continuity it achieved within a videocall therapy session and for the therapeutic process as a whole. The extract above illustrates a sentiment present across interview data, appreciation for the therapist's focus on clear verbal communication, deliberately asking for repetition or checking they had correctly heard before moving on. As this participant notes, "it always felt like she cared most for me". Participants also expressed appreciation for emails sent prior to the first session outlining the process of working together by videocall and the option to use a messaging function in the days between weekly sessions. The BetterHelp application also has a range of pre-recorded seminars available to users, and an option of completing worksheets between sessions.

> *"It didn't feel like someone sitting at their desk on Zoom with headphones on. It was actually like a real therapeutic room. It was a really lovely little couch and plant, that I could see she had clearly thought about her presentation on Zoom…It wasn't like Zoom was an add-on to her practice, she's thought about this, and this is a nice environment. As much as you can make an online environment feel safe and nice and personalised and all of that." (Participant 02)*

> *"I found that people would start the Zoom meeting and then start getting ready. It makes me straight away pull back and start to shut down and be less open…I do find that those first few minutes are really important. If I have the tendency to shut down, then the clinician is all unorganised and I've already shut down then it's not going to be good for the rest of the time." (Participant 01)*

The first extract describes actions the participant's therapist took that contributed to a successful work alliance. The participant expressed appreciation for the therapist's composition of what could be seen on screen because it communicated care and attentiveness towards the client experience. It gave the participant confidence that videocall therapy was a legitimate and worthy way of engaging in therapy, not an "add-on". By contrast, the second extract illustrates how the immediacy of the therapeutic 'space' created in part by 'up-close' audio-visual connection meant that "those first few minutes" became crucial for a successful working alliance. Participants expected that their level of

engagement would be reciprocated by the therapist and were looking for demonstrations of this.

Theme 3. Screen limitations

Awareness that body language and nonverbal cues helped therapists in their work was present across the interview data. As was acknowledgement of that lessened ability to observe and respond to nonverbal cues posed difficulties for therapists engaging in videocall therapy.

> *"I can only see what's on a tiny screen and they can only see me on a tiny screen." (Participant 01)*

> *"I think the psychologist preference was in-person, for obvious reasons, because I'm the sort of person that can mask really easily, so unless you can see some of the other body language and stuff, it's going to be really difficult to get a gauge of where I'm at just by me talking to somebody…From her perspective, Zoom meetings are a lot harder because those observational tools are somewhat limited…From my perspective, it was neither here or there. But I do know it is a lot harder to gauge where I'm at or what I'm thinking if you can't see and observe some of the other more subtle cues that you would be picking up on in-person more so than over a screen." (Participant 06)*

Despite actions taken to create a therapeutic 'space', the artificiality of the "tiny screen" and restrictions on what can "only" be seen were clearly articulated across the interview data. By reducing sources of information for both parties that create intimacy, videocall therapy introduced distance into the client-therapist relationship. In the second extract, the participant remained ambivalent about returning to in-person therapy despite recognising and agreeing with her therapist that because the participant can "mask really easily" in-person therapy would have more therapeutic value for the client. Most discussions about preference for in-person therapy or videocall therapy indicated ambivalence, but participants indicated that avoidant tendencies had some influence in this.

> *"It's like wow, good luck to you because I'm pre-wired not to actually do that thing because culturally Chinese people don't talk about feelings. Trauma is like stuff it down and get on with it - even looking at intergenerational trauma - because my dad came over as a refugee with the Japanese invasion and how parenting and stuff has happened." (Participant 06)*

> *"That capacity to be with yourself more and not feel the other people's stuff, which I think you become quite attuned to as a trauma survivor. You're feeling a lot of what's going on that then actually you're not quite sure is this mine or is this yours? There's something quite useful being with another person, but because they're online you're not feeling them. Like you're not getting all of that sensory information…Actually, how could it be used usefully and purposefully for those who really struggle in that interpersonal space and it's too intense and too much? This could actually be a really useful tool" (Participant 04)*

Videocall therapy provided a less intimate sensory experience in which clients can feel 'protected' from the relational aspect of therapy. Potential for videocall therapy to amplify or reinforce existing avoidant tendencies was noticed, generating some experiences of being more self-referential than relational. Cultural considerations around the use of videocall for therapy are highlighted in the first extract. In the second extract, the therapeutic utility of videocall therapy for this client's "work" is floated, by helping the participant become better attuned to her own emotions when "not getting all of that sensory information".

Theme 4. Brains need downtime after therapy

Participants expressed a need to engage in solo, sensory practices to transition out of the therapeutic 'space' and into their everyday lives.

> *"I did notice that I couldn't go straight back to work after a session. Whereas when I was going a person, I would have the bus ride home to decompress. I noticed that that I needed to go on social media or exercise or something like that, because my brain wasn't ready to be on work right afterwards. Even if I wasn't upset after a session, it's just because you're doing so much with your brain during a session." (Participant 03)*

Discussions of practices immediately after videocall therapy sessions were commonly accompanied by recognition of therapy as a draining experience cognitively as well as emotionally. The phrases "mental drain", "tiring" and "draining" were used across the interview data to describe how participants felt following a videocall therapy session. As shown in the extract above, participants were aware that when therapy occurs at a separate physical location it allows for organic processing of the therapy session. The need to select new ways to "decompress" post-session was shared across the interview data. There was general agreement that it was necessary to engage in some kind of practice before attempting to engage in work activities.

> *"Because [in-person therapy] was when the kids were at school I could go home, sit down, have a cup of tea or something and not have to worry about "Where's the biscuits, where's my socks?" Having to just jump straight back into brain stuff was probably more the challenge - going from quite a mental drain anyway to quick, back into parent mode. Whereas being at the office, you get that downtime." (Participant 06)*

Similar to the earlier extract, the participant described solitary practices for transitioning out of the therapeutic 'space' that involve engaging the senses – making and having a cup of tea in a physical environment empty of other people. The majority of participants engaged in solitary and sensory transition practices including talking a walk, washing clothes, sleeping, social media use, exercise, tea-drinking and doing an activity that did not involve a screen. For participants who were parents, this was sometimes not possible

to achieve. The difficulty of having to “jump straight back into brain stuff” is illustrated by this participant.

Theme 5. A more flexible approach

A common theme was increased flexibility facilitated by videocall, making it easier to ‘fit in’ or continue therapy despite competing priorities for time and energy. Most participants already possessed some familiarity with videoconferencing technology, but COVID-19 restrictions accelerated and expanded participant use especially for work, education and socialising.

> *“I changed jobs five weeks before the first lockdown…to a job where they were like…here's your laptop and your headphones. I mean five weeks before I was moving into that space of oh, you can do things online and it is valuable. So I think I probably had that bias towards like, I'm playing someone $150 an hour I don't feel like a video chat is good value. But then it's funny because that's completely flipped on its head for me because it's like of course it's good value - I don't have to leave the house. It saves me rushing somewhere.” (Participant 05)*

A sentiment expressed across the interview data was that participants had come to accept and expect that digital technologies would play an increased functional role in their everyday lives. This extract exemplified how sustained exposure to a variety of activities facilitated by videocall helped open participants up to the potential value of videocall therapy. For this participant, value was expressed through financial, time and energy commitments.

> *“Some of it is just logistics. Especially because I have to drop the small boy at school and then backwards and forwards, because for some reason the office is on the exact opposite end of town where we are and it's like a good 20 minutes / half an hour depending on the traffic. So, some of that is a mental barrier.” (Participant 06)*

In the extract above, the participant described their reluctance to attend in-person therapy sessions when this became an option again. Not having to travel to attend an in-person therapy session was considered to be a positive aspect of engaging in videocall therapy. Consideration of timing travel by public and private transport to attend an in-person therapy sessions generally featured in all discussions on the merits of engaging in videocall therapy. Some participants appreciated that they were able to schedule a therapy session for the optimal time within their planned day, around work and other commitments. This circumvented the “mental barrier” mentioned above that suggests difficulties incorporating therapy into a client’s routine can impact on a willingness to engage in therapy in general.

> *“We were doing online and offline according to lockdowns, but then if I needed to travel for work, I could carry on my therapy. There was just this more acceptance of we've done online so much before, we can we see it works. So if you're away for work, we don't have to cancel your appointment, which was really nice actually in terms of continuity. And similar, my therapist had just gone away on holiday. She was travelling overseas so the week and a half before travelling she put herself in self*

isolation and was seeing all her clients online. It's given a more flexible approach to the work in many ways." (Participant 04)

Satisfaction with videocall therapy when it was the only choice available gave most participants the confidence to engage in videocall therapy after COVID-19 restrictions had eased, for both parties' travel, work and health considerations. The "flexible approach to the work" illustrated by the above extract facilitated continuity and strengthened the client-therapist commitment to a shared therapeutic project.

In summary, the reflexive thematic analysis of interview data from participants has indicated that participants experience of videocall therapy is made up of interactions with physical, digital and affective environments. In response to the research question exploring the experience of clients who engaged in videocall therapy during COVID-19 restrictions in Aotearoa New Zealand, themes were generated describing participants experienced videocall therapy as a conceptual therapeutic 'space' defined by safety and containment from everyday life. Participants took actions to enter into this 'space' by changing or adapting their physical environment, and actions to transition out of the 'space' were solitary and involving the senses. Other themes described participants appreciation for continuity communicated by therapist demonstrations that they were attending to the client experience of videocall therapy, and observations of 'lack' with regard to diminished access to body language and nonverbal cues.

Discussion

The aim of this study was to describe a contextualised analysis of client experiences of videocall therapy during COVID-19 restrictions, with potential for findings to inform future research into the nature of videocall therapy. This section discusses findings from the study in relation to existing research and considers clinical implications for therapists engaging in videocall therapy, limitations and suggestions for future research.

Themes generated in this study indicate that participants experienced videocall therapy as a therapeutic 'space' entered into by manipulating their external environment and transitioned out of by practicing solitary activities that invoke the senses. Common characteristics of the therapeutic 'space' were safety and containment away from everyday roles and responsibilities. Participants demonstrated commitment and creative action in order to generate an affective atmosphere in which they could be present. In turn, they appreciated the sense of continuity created when therapists demonstrated thought and care with regard to their experience of videocall therapy. Observations of the inability to note and respond to nonverbal cues saturated the data. Overall, the loss of in-person intimacy in

videocall therapy did not result in clients' perceptions of change to the working alliance, although there was strong recognition of the difficulties this presented for therapists.

Participants described videocall therapy sessions as a therapeutic 'space' influenced by conditions in their external environment but primarily as a mindset or mental space they felt they needed to induce in order to achieve their therapeutic goals. This description of therapy aligns with established theory on the therapeutic 'holding space' (Winnicott, 1953). However, the responsibility of creating such a 'space' has typically been allocated to the therapist rather than the client. The ubiquity of this theme suggests that the act of engaging with a therapist through videocall may establish a new balance within the client-therapist relationship.

This is consistent with literature that posits the creation of an alternative working alliance created through connection mediated by digital communication technologies (Irvine, 2020; Kocsis and Yellowlees, 2017; Lingley-Pottie and McGrath, 2007; Turner et al., 2018). Cooperation between therapist and client due to unreliability of audio synchronisation and technical challenges can place the therapist and client in symmetrical roles. Typically, in in-person therapy, the therapist is in a privileged position – with control and ownership of their environment. Further, the roles taken by client and therapist within the shared therapeutic project are both equally valuable but distinct from one another. By equalising the power dynamics between therapist and client, videocall therapy creates a new way of relating to the shared therapeutic project.

Further, participant expressions of appreciation for continuity to the therapeutic relationship and the therapy process establishes consistency with literature indicating that clients generally do not perceive a negative impact on working alliance from videocall therapy when compared with in-person therapy (Jenkin-Guaranieri et al., 2015; Simpson et al., 2021). Participant's consistent awareness of not being able to communicate through body language and nonverbal cues may provide some context for studies in which therapists consistently indicate a decline in working alliance or therapeutic relationship (Berger, 2017; Norwood et al., 2018; Rees and Stone, 2005). Thus, it counters Geller's (2020) thesis that lack of training and experience with using digital communication technology shape negative views of videocall therapy. Instead, the generation of this theme tentatively endorses the view that adaptation within practices and processes are more likely to result in positive client experiences of videocall therapy.

This study has the potential to provide beneficial insight into these new practices and processes, for health professionals to consider in their ongoing practice of videocall therapy.

In-person therapy may no longer be considered the “gold standard” (Agosta, 2019) as expressed by participants appreciation for the flexibility that videocall therapy allowed for them in their everyday routines. Like other research on client experiences of videocall therapy (Brothwood et al., 2021; Vuillier et al., 2021), participants appreciated not having to engage in travel to a location and associated planning. Thus, it would be pertinent for therapists to consider ways in which to adapt their current therapeutic practice or adopt new communication and engagement processes to meet client expectations for videocall therapy.

Participants described the kind of therapeutic work they were engaging in for videocall therapy as conversations or involving talk-based modalities which aligns with most research pre- and post-pandemic primarily examining CBT (Brown et al., 2019; Olsson et al., 2021; Sclare et al., 2015; Uysal, 2021; Wignall, 2006; Zamiri-Miandoab et al., 2022). While this study did not seek to measure therapeutic efficacy, most participants evaluated little change within the therapeutic relationship. A strong working alliance within the therapeutic relationship is widely regarded to be fundamental for therapeutic satisfaction and success (Flückiger et al., 2018). Therefore, participants evaluation of that videocall therapy had little to no impact on the quality or nature of the therapeutic relationship indicates support for research that consistently shows the therapeutic efficacy of videocall therapy compared with in-person therapy (Jerome and Zaylor, 2000; Rees and Stone, 2005; Simpson and Reid, 2014) This is particularly significant for Aotearoa New Zealand where videocall therapy continues to be popular mode of delivery due to intermittent restrictions around in-person healthcare possible when COVID-19 is in the community. Further, some populations face more barriers to access adequate in-person therapy than others in Aotearoa New Zealand. Populations that may benefit from videocall therapy as a first order approach due to access barriers include people living rurally and Māori (who are consistently overrepresented in mental health statistics) (Babbage, 2020; Stats NZ, 2022).

Limitations and future research

There are several important limitations to this study to note. As a qualitative study with a small and relatively homogenous sample size, the findings from this research are unlikely to be representative of larger client groups. Further, the study captured experiences of videocall therapy in environmental conditions specific to Aotearoa New Zealand. The social and cultural specificities of predominantly New Zealand European woman clients, with secure accommodation during the period of COVID-19 restrictions in Aotearoa New Zealand are noted. Future research with more diverse and larger samples is encouraged to contribute to developing knowledge in this area. That being said, the themes developed in

this research provide much-needed insight into the client experience of videocall therapy and will be relevant to a range of health professionals as well as therapists and clients.

Further, the recruitment method used in this study was limiting. The participants who took part are likely to be of high socio-economic status and more familiar with use of digital technologies. Accordingly, the sample was self-selecting in that participants who took part were likely to have had experiences with videocall therapy they were willing to share. Future research using a mixed methods research design using a combination of offline and online recruitment methods may be valuable to build a broader picture of videocall therapy experiences in Aotearoa New Zealand. Themes generated in this study can provide the basis for future in-depth exploration of this research area.

Thematic findings from the broad research question used in this study gave rise to further research questions. These include: what was the experience of men / Māori who engaged in therapy by videocall? How did the experience of videocall therapy influence attitudes toward therapy in general? What effect did engaging in videocall therapy have on client's experience of lockdown and/or the COVID-19 pandemic?

Conclusion

In conclusion, themes generated from accounts of client experiences of videocall therapy in Aotearoa New Zealand during COVID-19 restrictions indicate that the experience of videocall therapy involves an interaction between the conditions of the client's physical environment, the audiovisual connection provided by videocall as a medium, and the quality of the relationship between the therapist and client.

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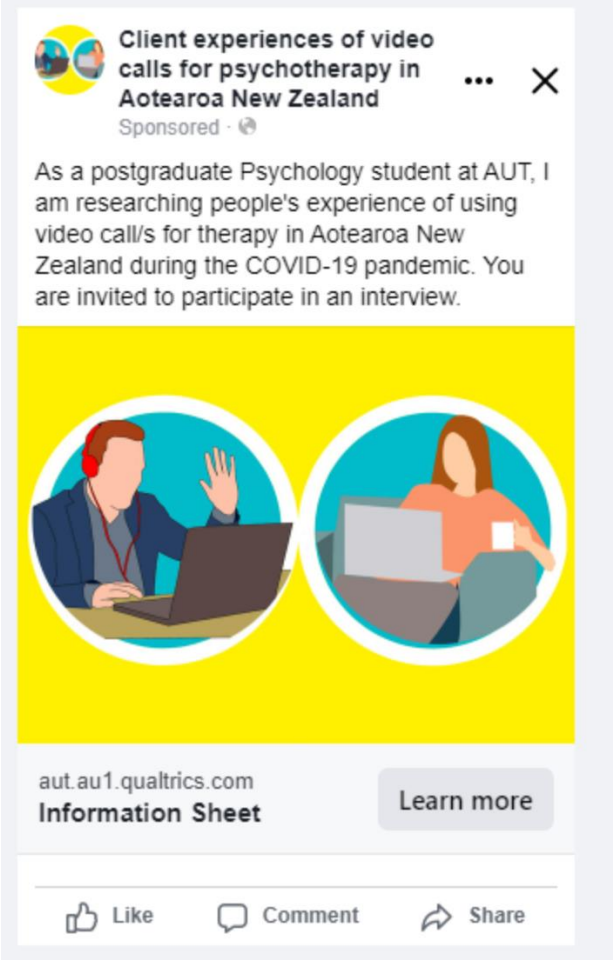
Appendices


Client experiences of video calls for psychotherapy in Aotearoa New Zealand
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As a postgraduate Psychology student at AUT, I am researching people's experience of using video call/s for therapy in Aotearoa New Zealand during the COVID-19 pandemic. You are invited to participate in an interview.
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Date Information Sheet Produced:

19th June 2022.

Project Title

Client experiences of video calls for psychotherapy in Aotearoa New Zealand during the COVID-19 pandemic.

An Invitation

I am Amelia Jones, a postgraduate Psychology student at AUT (Auckland University of Technology) based in Auckland, New Zealand. You are invited to participate in an interview over Zoom or Teams. This research forms part of my Master of Health Science qualification in Psychology and my role as the researcher will be to interview participants about their experience of video call/s for therapy. Your contribution would be very valuable.

What is the purpose of this research?

From March 2020, most therapy in Aotearoa New Zealand moved to online delivery like Zoom or Teams (videocall technology), following the introduction of lockdowns and other public health measures in response to COVID-19. The purpose of this research is to explore people's experience of using video call/s for therapy in Aotearoa New Zealand. The focus is on the experience of using the technology, not the therapy itself. Overseas research from before and during the pandemic has shown the experience of people providing the therapy rather than the experiences of clients.

This research can help health professionals to consider how they deliver therapy by videocall. The findings of this research may be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

Participants are recruited by responding to social media advertisements. You can be included if you have experienced therapy using videocall from March 2020 and are no longer presently engaged in therapy, and have not been a client of the researcher.

How do I agree to participate in this research?

At the end of this page, you can provide your email address or other preferred contact details. I will email you a consent form to read, understand and sign and send back. Interviews over Zoom or Teams at a suitable time and date will take place from 17 July to 31 August 2022.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the research at any time. If you choose to withdraw from the research, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

Interviews will take between 45 – 60 minutes. In the one-off interview you will be asked questions relating to your demographics (age, ethnicity, gender) and experiences of therapy using videocall technology. Your responses will be transcribed and given back to you for review and approval at a later date and will only be used for research purposes.

What are the discomforts and risks?

You may find talking about your experiences using videocall technology for therapy during the COVID-19 pandemic creates discomfort or brings up memories of hardship during this time.

In this case, AUT Student Counselling and Mental Health is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues

that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9998.
- let the receptionist know that you are a research participant and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

What are the benefits?

This research is unlikely to have any direct benefits for participants, other than sharing experiences that may help health professionals deliver better services using videocall technology. This research will benefit the researcher by contributing to the completion of a qualification.

How will my privacy be protected?

This is a voluntary research project, and no personally identifiable information will be included in research findings. All information provided is bound by AUT's guidelines for confidentiality. All identifying information will be removed from the interview write-up. You will have the opportunity to review the interview write-up and make further changes if required.

What are the costs of participating in this research?

This research is likely to take up to 90 minutes of the participant's time, including the interview and subsequent review of transcript. No other costs should be incurred.

What opportunity do I have to consider this invitation?

Recruitment for this research runs for four weeks, from 19 June – 17 July 2022.

Will I receive feedback on the results of this research?

On completion of the research, participants can be provided a summary of research findings at their request.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Kirsten van Kessel, Kvankess@aut.ac.nz, 09 219 999 ext. 7691.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* , (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Amelia Jones, gbz9882@autuni.ac.nz

Project Supervisor Contact Details:

Dr Kirsten van Kessel, Kvankess@aut.ac.nz, 09 219 999 ext. 7691.

Approved by the Auckland University of Technology Ethics Committee on *16 June 2022*, AUTEC Reference number *22/127*.

Consent Form

Project title: ***Client experiences of therapy by videocall in Aotearoa New Zealand during the COVID-19 pandemic***

Project Supervisor: ***Dr Kirsten van Kessel***

Researcher: ***Amelia Jones***

- O I have read and understood the information provided about this research project in the Information Sheet dated 5th May 2022.
- O I have had an opportunity to ask questions and to have them answered.
- O I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- O I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- O I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- O I agree to take part in this research.
- O I wish to receive a summary of the research findings (please tick one): YesO NoO

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

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.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* ***AUTEC Reference number*** *type the AUTEC reference number*

Note: The Participant should retain a copy of this form.

Indicative Question Set

Welcome.

1. Self-description (Age, ethnicity, gender and other ways you identify)
2. What kind of therapy did you receive by videocall?
3. How was the video call therapy facilitated / organised?
4. How and when did you do it? Where? (e.g., at home, in vehicle)
5. How many sessions did you have?
6. What was a typical session like?
7. How did you prepare for a session?
8. How did you start and end a session?

09. What were your prior experiences of therapy like (if any)?
10. If applicable, can you describe the shift from in-person to therapy by videocall?
11. What reasons did you have for doing therapy by videocall?
12. What were your initial thoughts about it?
13. How did you feel about the experience after the first session?
14. How did you feel about the experience after the last session?
15. What factors might have influenced this?
16. What helped the experience?
17. What hindered the experience?
18. Overall, how satisfied were you with the experience?
19. What was the relationship like with your therapist?