Received: 29 September 2022 | Revised: 14 January 2023 | Accepted: 15 January 2023

DOI: 10.1002/capr.12621

ORIGINAL ARTICLE

WILEY

"In my own comfort zone": Clients' experiences of relational aspects of online therapy for alcohol problems

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Abstract

Background: Therapists and counsellors increasingly use online video applications to offer treatment in place of face-to-face delivery. In the alcohol treatment sector, this offers a range of potential benefits for treatment providers. However, the impact of working remotely via video on the therapeutic relationship remains unclear and under-researched.

Aims: This study aimed to explore how alcohol treatment clients make sense of the relational aspects of therapy delivered remotely, and to examine how the use of remote therapy might disrupt existing ideas around the therapeutic relationship.

Methodology: This study utilised a qualitative design using thematic analysis, with 15 participant interviews with adult service users from a single treatment provider. All participants had previously undertaken at least four 1-h online therapy sessions.

Findings: The themes that were identified highlighted the significance of the participants' own homes as the site of therapy, with emphasis on the comfort of the home, and the presence of family members and pets. Participants stressed the importance of viewing the face of the therapist, the establishment of a therapeutic bond and specific therapist qualities. Participants also reflected on issues around denial and avoidance associated with self-image and identity.

Discussion: There are nuanced and potentially unforeseen consequences of undertaking therapy for alcohol problems via video, relating to the significance of the therapy environment and relationship between client and therapist. This may include issues of shame, denial and avoidance, which are of particular significance for clients experiencing difficulties associated with alcohol.

KEYWORDS
alcohol, client's perspective, Skype, therapeutic relationship, therapy, video

1 | INTRODUCTION

Innovations in technology have had a significant impact on communication, from telephone use to more recent email, text and video messaging. Increased reliance on such technologies continues to profoundly alter the tools used in communication with others (Hennigan & Goss, 2016). Social distancing requirements associated with the coronavirus pandemic during 2020 have accelerated the use of video calling in both occupational and social settings, as well as their widespread use in therapeutic practice. Such technological

changes may have a transformative effect on how we relate to others, offering new opportunities for human relationship and communication, as well as disrupting existing patterns of relational and communicative behaviour.

This study used thematic analysis to explore alcohol treatment clients' experiences of relational aspects of therapy delivered remotely by video. The use of Internet technology has become an important means of delivery for a range of mental health and counselling services (Simpson et al., 2021; Wentzel et al., 2016), as it offers opportunities to overcome barriers relating to distance and access, and can offer increased anonymity, as well as potential benefits around supporting psycho-education and health promotion.

At the same time, concerns have been expressed about the potential for online therapies to result in diminished engagement from clients and higher rates of dropout, particularly in the substance misuse field (Ekström & Johansson, 2019). It has been argued that online therapies risk disrupting communication between therapist and client, with technical issues, lack of eye contact and ethical dilemmas being listed as potential causes of difficulties (Dunn, 2012; Stoll et al., 2020). There is, therefore, no broad consensus around the impacts of the shift away from physical interaction and proximity in therapeutic services, and it remains a complex and contested issue.

In this rapidly changing context, there is a clear need for evidence on the effectiveness of online interventions for alcohol treatment clients. However, as Dugdale et al. (2016) argue, the evidence base, while growing, remains limited. Much research that has been carried out to date has focussed on quantitative indicators (Byaruhanga et al., 2020; Elison et al., 2015). There has been virtually no research on the relational aspects of video therapy for alcohol treatment. In particular, there is an absence of studies on the impact of technology on the therapeutic relationship from the client's perspective, or on the experiential, relational aspects of the therapeutic encounter in video counselling sessions.

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

Counselling and psychotherapy have traditionally theorised the embodied experience of the therapeutic encounter in a shared physical space, with client and therapist physically positioned in a room together. This has drawn on ideas around the "felt sense" (Gendlin, 1969), on findings from cognitive neuroscience and neurobiology around the influence of "mirror neurons" (Coutinho et al., 2014), on ideas about attunement and affect regulation (Dales & Jerry, 2008) and on the range of physical and emotional responses associated with empathic responses (Damasio, 2000). It is proposed that these non-verbal aspects of attachment are critical to the therapeutic alliance; however, there has been little research on these aspects of attachment as observed in an online or video context. This study therefore seeks to explore the implications of therapy being delivered via video, by identifying specific issues arising for clients with alcohol problems.

Implications for practice and policy

This study:

- highlights key issues to be considered by practitioners and clinicians regarding the novel context of therapy when it takes place outside of the therapist's room and without physical proximity between therapist and client;
- draws attention to the significance to clients of the home-as-therapeutic environment in online therapy, and examines the significance and implications of "comfort" as a factor in client choice to undertake online therapy remotely;
- suggests that online therapy via video can allow the therapist to deploy the therapeutic frame in a flexible enough way to ensure that a therapeutic space can be established, which promotes therapeutic change and enables the therapist to demonstrate the core qualities of empathy, honest, openness and presence;
- highlights specific issues to be considered by practitioners and clinicians when working with alcohol clients in an online context, particularly around engagement, denial and avoidance of shame.

2 | METHOD

Data collection took place prior to February 2020 and was therefore completed before social distancing restrictions associated with the coronavirus pandemic came into place. All participants in this study had actively selected video therapy as a choice, rather than as a necessity. Qualitative interviews explored implications of the absence of physical proximity between therapist and client, and the impact of video technology on the therapeutic encounter. Interview questions focussed on the relationship between client and therapist, including how clients communicated with therapists, clients' sense of the openness and availability of the therapist, the ending of their relationship and their perceptions of what was helpful or unhelpful in therapy.

By focusing on clients' experiences, the study aimed at giving voice to an under-represented group. Among groups of service users, alcohol treatment clients are particularly likely to be

under-represented in research and arguably represent a "hard to reach" group (Postel et al., 2010). A key aim of this research was therefore to ensure that the views of this group were able to contribute to establishing the broad evidence base around video-based therapy.

Thematic analysis was used to analyse and interpret the interview data. Clarke and Braun (2018) position thematic analysis as "fully" qualitative, meaning that qualitative techniques are underpinned by a distinctly qualitative research philosophy that emphasises researcher subjectivity, reflexivity and the situational and contextual nature of meaning. Analysis of interview transcripts enabled the researcher to draw meaning from the experiences described by participants regarding their relationship with the therapist, and their descriptions of how video technology influenced their therapy. The researcher attempted to elicit and record the participants' own interpretations of their experiences and encouraged an examination of the subtle nature of the experiences involved in the therapeutic encounter.

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

2.1 | Procedure

As a reflection on the use of human participants, ethics approval was sought and granted by the University of the West of England Faculty of Health and Applied Sciences Research Ethics Committee. Fifteen participants were recruited via a single national drug and alcohol treatment service provider, which offered six sessions of online therapy via Skype with an alcohol treatment specialist. All therapists working at the service held a counselling-related qualification, and different participants had worked with different therapists. The sessions were an online form of extended brief intervention based on motivational interviewing techniques, as used in standard face-to-face alcohol treatment.

Research interviews were conducted between January 2019 and February 2020. Recruiting all participants from a single service meant that there was some consistency in the therapy received and in the method of recruitment and interviewing. Participants were aged over 18 years and had completed a minimum of four one-to-one sessions with the same therapist via Skype. All participants completed consent forms, which were returned via email to the researcher.

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

The average age of the participants was 50 years (range 32–71). There were nine women and six men, all currently living in the UK. In the demographic questionnaire, 14 indicated that they were White, and one indicated that they were mixed ethnicity. Ten of the participants had previously had face-to-face counselling, whereas the remaining five had not had any previous counselling. The average number of treatment sessions completed by the participants was six, with the minimum and maximum being four and seven, respectively. The average time elapsed between the final therapy session and participant interview was less than three weeks.

Interview questions were developed on the basis of existing research findings on Skype use (Holmes & Jones, 2016) and on clients' experiences of therapy (Salleh et al., 2015). Interviews were "exploratory" in nature and were participant-led rather than fully structured (Wengraf, 2001). The questioning stance was adapted according to the narrative of the participant (Miller, 2012).

Participants were encouraged to choose either telephone or Skype video interview for data collection purposes. Nine chose Skype video, and the remaining six chose to be interviewed over the telephone. Interviewing via Skype or telephone was adopted as a pragmatic alternative to face-to-face interviewing due to the dispersed geographical location of participants. Musselwhite et al. (2006) describe several advantages of this means of data collection, including the possibility that the anonymity afforded by the phone may enable participants to be more open in their responses. The avoidance of stigma may be particularly relevant for alcohol treatment clients.

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

3 | RESULTS

Thematic analysis of data led to the identification of four main themes. The first theme, *the client in their own home*, draws together participants' reflections on the significance of their sense of being comfortable while taking part in therapy sessions, including being able to control their home environment to suit their needs. The second theme, *virtual relationships*, brings together ideas around the therapeutic relationship in an online environment, starting with the client's experiences of seeing the therapist's face on a screen, and

their sense of the therapist's presence. In the third theme, *empowerment and choice*, ideas about therapy as a consumable service are explored, with the client as the empowered consumer of a transaction. Linked to this is the sense of the client being able to leave a session at the touch of a button; of having the ability to choose whether, how and when to start and finish the therapy; and enabling a sense of power and control over the sessions. The final theme relates to *stigma and dependency* associated specifically with alcohol. This links to participants' descriptions of the perceived barriers to accessing treatment associated with being "seen," including secrecy, shame and stigma.

3.1 | Theme 1: The client in their own home

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

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

> …well just being physically comfortable, you know, being in my room, being in my bed…erm…being able to wear whatever I want.
>
> (Participant A)

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

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

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

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

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

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

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

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

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

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

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

The client's ability to control their own therapeutic space is especially highlighted by their ability to control the involvement or exclusion of other people in their household from their therapy. Some participants talked about their concerns about being overheard:

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

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

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

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

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

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

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

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

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

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

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

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

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

It might be inferred from this that the therapist has, in some ways, become integrated into the client's home environment, establishing a relationship with others, beyond the client themselves, with a sense of implied acceptance. Furthermore, the involvement of animals in the therapy suggests that pets offered participants a benefit associated with comfort, relaxation and a sense of security.

3.2 | Theme 2: Virtual relationships

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

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

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

Participants made clear their sense of the therapist as real, and distinguished from voice-only phone calls which leave the other's physical appearance to the imagination. One participant reflected on the fact that by seeing her face on the screen, the therapist could gain important information about her state of mind that would have been unavailable to the therapist in a telephone session:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.3 | Theme 3: Empowerment and choice

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

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

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

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

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

Participants discussed commitment in relation to online therapy, with the idea repeatedly expressed that this presented less of a commitment than face-to-face therapy would have. Participants recognised that they had the ability to end the session at the touch of a button, avoiding open conflict or therapeutic rupture:

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

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

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

3.4 | Theme 4: Alcohol—Stigma and dependency

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

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

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

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

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

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

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

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

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

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

> It reached its end. So, you know, we wished each other the best and that was it……I don't want to be someone who is dependent on anything, actually. Er…red meat, cheese, anything consumable, any

> particular one individual. You know, I don't want to be dependent, on anything.
>
> (Participant F)

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

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

Overall, the sense is of a varied engagement with the therapist, with some participants retaining a distinct sense of separateness and emotional autonomy, while others expressed more emotional attachment and distress around separation.

4 | DISCUSSION AND IMPLICATIONS

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

4.1 | Therapeutic space

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

While comfort was repeatedly discussed as a positive feature by participants in this study, this raises a question about the role of "discomfort" in therapy. In particular, there may be concerns that a heightened sense of comfort may be associated with greater avoidance; questions could be raised about whether a client is likely to want to "go" to difficult and troubling places from within the comfort of their own homes. Furthermore, it may also be important to consider whether clients are likely to be able to tolerate the "discomfort" of overcoming inevitable ruptures in the therapeutic relationship if comfort is a primary motivator for engagement with therapy.

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

4.2 | Seeing and being seen

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

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

4.3 | The narrative of consumption

Participants described being able to select the therapist they wanted to see from a webpage listing potential options, with names

accompanied by a photograph of each therapist's face. Participants chose the therapist they liked the look of, or who had availability at times that suited them. Shackak (2017) refers to the "commodification of psychotherapy" to describe the gradual infusion of market and consumer logic into the production, dissemination and consumption of therapeutic knowledge and techniques. In this view, therapy is posited as a positive life choice, with an emphasis on well-being.

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

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

4.4 | Identity and the construct of denial

Participants in the study attempted to define their own sense of identity in relation to alcohol. Despite an absence of interview questions seeking information on drinking habits and behaviours, all participants attempted to explain the context of their drinking to the researcher, and noticeably attempted to minimise the seriousness of their drinking.

It may be that the tendency of participants to minimise or deny the significance of their alcohol problems was associated with their choice to undertake therapy remotely via video. By avoiding having to attend therapy in person, participants are arguably avoiding having to "face" the therapist and thereby accept the significance of their own difficulties. Arguably, clients had been able to enter into therapy in a somewhat tentative way, which allowed for an increased sense of control and self-direction. This arrangement could have been said to allow for the maintenance of some aspects of denial.

Participants repeatedly referred to the privacy of undertaking therapy in their own homes, which allowed them to avoid the risk of being "seen" by others when attending. Potentially, then, therapy via video offers individuals with alcohol problems a valued means to overcome such barriers and to access treatment by avoiding the risk of shame and stigma associated with physical attendance at a treatment service. This benefit is balanced by the risk that by undertaking therapy online, rather than face to face, the problem may be experienced as less "serious" by the individual.

5 | CONCLUSION

This study covers an under-researched issue, and therefore hopes to influence an emerging and rapidly developing field within counselling, psychotherapy, psychology and beyond, around online treatments. The findings may help to further our understanding of how online therapies work in practice. The findings of the study are likely to be of particular interest to alcohol treatment providers and treatment commissioners, as well as individual therapists and other practitioners providing treatment to clients with alcohol problems. By examining the potential benefits and limitations of online therapy for alcohol treatment clients, the study presents an account of relational issues which can arise during video therapy. Furthermore, the research enables a rare exploration of the voice of alcohol treatment clients, providing an insight into their individual experiences and the factors which influence their treatment and recovery.

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How to cite this article: Atkinson, L. (2023). "In my own comfort zone": Clients' experiences of relational aspects of online therapy for alcohol problems. *Counselling and Psychotherapy Research*, *00*, 1–10. https://doi.org/10.1002/capr.12621