

**CHANGING TO REMOTE PSYCHOLOGICAL THERAPY DURING COVID-19:
PSYCHOLOGICAL THERAPISTS' EXPERIENCE OF THE WORKING ALLIANCE,
THERAPEUTIC BOUNDARIES, AND WORK INVOLVEMENT.**

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Portfolio Abstract

Background: Psychological therapy usually takes place face-to-face. The COVID-19 pandemic resulted in organisations recommending the ongoing provision of therapy remotely, via telephone or videoconferencing. Despite published guidelines for working remotely, specifically regarding some therapeutic processes such as the working alliance (WA) and therapeutic boundaries (TB), empirical support is limited. Existing literature indicates that therapists rate the WA differently in remote therapy, although how therapists experience the alliance remains unknown. Likewise, it is argued that remote therapy may present novel TB, yet this has not been explored. COVID-19 provided a natural opportunity to begin investigating if therapists' experiences and abilities differ when working remotely.

Aims: This thesis had three primary aims: (1) to investigate what impact changing to remote psychological therapy during the COVID-19 restrictions had on psychological therapists' perceived ability to form a WA and maintain TB, and their work involvement patterns (i.e., healing involvement (HI) and stressful involvement (SI)); (2) to examine how therapists' perceived abilities regarding the WA and TB relate to experiences of HI and SI; and (3) to explore how psychological therapists experience and manage TB when working remotely.

Method: A mixed-method sequential explanatory design was used. Phase one consisted of participants ($n = 161$) completing an online survey exploring therapists' perceived abilities regarding the WA and TB, and their work involvement patterns. Phase one analysis consisted of descriptive and inferential statistics. Phase two comprised of a semi-structured interview further exploring therapists' experience of TB when working remotely. Participants ($n = 12$) in this phase were selected using maximum variation sampling following analysis of phase one. Thematic analysis was used to analyse qualitative data.

Results: Phase one results indicated that therapists' perceived abilities regarding the WA and TB differed when working remotely, although how negatively or positively this was experienced varied. Therapists' work involvement patterns also differed compared to existing data for face-to-face therapy, indicated by increased rates of SI.

Furthermore, HI positively correlated with therapists' perceived abilities regarding the WA, $r(159) = .478$; $p < .01$; 95% CI [.327, .595] and TB, $r(159) = .369$; $p < .01$; 95% CI [.215, .498]. Conversely, SI negatively correlated with therapists' perceived abilities regarding the WA, $r(159) = -.356$; $p < .01$; 95% CI [-.493, -.218] and TB, $r(159) = -.370$; $p < .01$; 95% CI [-.493, -.218].

Regarding therapists' experience of TB, four overarching themes were identified in phase two: 'different boundaries in remote therapy', 'work home boundary', 'changes in the therapeutic safe space', and 'impact of boundaries when working remotely'.

Conclusions: Therapists' perceived abilities regarding the WA and TB differ when working remotely, which relates to their experience of therapy. This study provides insight into novel experiences of boundaries that present in remote therapy.

Considering that remote therapy may be used in the longer-term, these findings have clinical implications for increasing therapists' awareness of potential changes in their perceived abilities, therefore enabling them to address these changes where required. Future research, specifically into the impact of such differences on client outcomes, is recommended.

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Statement of Contribution

Thesis Research Project Design

Georgina James (supervised by Professor Thomas Schröder and Dr Danielle De Boos).

Application for University Ethical Approval

Georgina James (supervised by Professor Thomas Schröder and Dr Danielle De Boos).

Thesis Literature Review

Georgina James.

Thesis Participant Recruitment

Georgina James designed the recruitment process and recruited participants for the online survey (supervised by Professor Thomas Schröder and Dr Danielle De Boos). Georgina James recruited participants for the semi-structured interviews (supervised by Professor Thomas Schröder and Dr Danielle De Boos), although the sampling strategy was discussed with Dr Danielle De Boos.

Thesis Data Collection and Transcription

Georgina James.

Thesis Data Analysis

Georgina James with support from Professor Thomas Schröder for quantitative analysis and additional guidance sought from Dr Nima Moghaddam. Qualitative analysis was completed by Georgina James with support from Dr Danielle De Boos.

Thesis Write-up

Georgina James (supervised by Professor Thomas Schröder and Dr Danielle De Boos).

Systematic Literature Review

Georgina James with support from Dr Danielle De Boos and Professor Thomas Schröder. Amendments were made after being reviewed for publication by the Journal of Psychotherapy Integration.

Small Scale Research Project

Georgina James with support from Professor Thomas Schröder in designing the project and reviewing the write up. Dr Nima Moghaddam also supported with data analysis.

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SYSTEMATIC REVIEW¹

¹ This systematic review was submitted to and accepted by the Journal of Psychotherapy Integration for publication. This report is a pre-publication copy and not the version of record.

Therapists' Discovery: A Systematic Review of Therapists' Intersession Experiences.

Abstract

Therapists' and clients' unplanned, spontaneous experiences in the time between therapy sessions have been defined as 'intersession experiences' (ISE). This systematic literature review aims to inform clinical practice and future research by quality appraising and synthesising empirical evidence relating to therapists' ISE. Searches of electronic databases identified 1499 papers; six met the selection criteria, with a further six papers identified through citation and hand searching, resulting in 12 papers in total: six were qualitative, 4 quantitative, and 2 were mixed-method. To assess methodological quality, an adapted appraisal tool was used. Quantitative papers were synthesised using a narrative approach. Meta-Ethnography was used to synthesise qualitative papers. Reported frequency of ISE varied amongst therapists, which may be accounted for by factors that influence the onset of therapists' ISE, such as experiencing difficulty in therapy. Therapists from different theoretical orientations experience and use ISE differently. Qualitative synthesis identified ISE as a process of discovery for therapists, which they subsequently use to plan and prepare for therapy or discuss with others. Clinical implications include the identification of therapists' ISE as a common process of therapy, independent of theoretical orientation, that can potentially contribute to outcome. Future research should focus on strengthening the quality of research in this area, as well as exploring further aspects of ISE, particularly the possible interrelationship between therapist and client ISE.

Keywords:

intersession experiences, between session, therapy process, systematic review, therapist perspective.

Background

Psychotherapy process research, which considers the actions, events, and experiences that occur within psychotherapy, has mainly focused on in-session experiences (Orlinsky et al., 2015) or planned, deliberate events between sessions often referred to as 'homework' (Ronan & Kazantzis, 2006). More recently there has been a growing body of research into the unplanned, spontaneous experiences between sessions, defined as 'intersession experiences' (ISE).

ISE describe the experiences clients and therapists have about therapy between sessions, including thoughts, feelings, dreams, imagined interactions, and images. Empirical literature on ISE has mostly focused on clients' experiences (for a systematic review see Stewart & Schröder, 2015); however, there has been a growing body of empirical research into therapists' ISE and their impact on therapy process and outcome.

Different measures have been used in quantitative research of therapists' ISE; some are used as a repeated measure, such as the Therapist Intersession Experience Questionnaire (TIEQ; Lundy & Orlinsky, 1987), whereas others measure ISE at a single point in time, such as the Patient Representation Inventory (PRI; Geller et al., 2002), others. All measures use retrospective self-report. The TIEQ assesses the intensity, contexts, content, and emotional tone of therapists' representations of clients between sessions. Following qualitative exploration of therapists' experiences of ISE, Stewart et al. (2016) concluded that whilst the TIEQ may accurately reflect aspects of therapist ISE, some themes identified were not included in the existing measure. For example, the impact of planned versus spontaneously occurring ISE, with initial findings indicating that increases in spontaneous ISE associated negatively with ratings of the working alliance. Stewart et al. (2016) subsequently adapted the TIEQ to include items related to ISE as an intrusion, the spontaneity of ISE, the impact of ISE on therapist self-worth, self-conscious emotions, and therapist control (A-TIEQ). Schröder et al. (2009) used 5 items from the TIEQ, referred to as the Therapist Intersession Experience Scale (TIES). The PRI explores the form, frequency, duration, vividness, affect, and themes of therapists' representations of their clients. Recognising that the PRI was developed after the TIEQ, it is unclear how closely these instruments empirically measure the same concept.

The generic model of psychotherapy (Orlinsky & Howard, 1984), a transtheoretical framework developed to provide a coherent account of psychotherapy research, originally focused on in-session processes and their relationship to outcome. In-session processes were captured under five broad categories: therapeutic bond, therapeutic operations, therapeutic contract, participants' self-relatedness, and in-session impacts. However, following the inclusion of temporal process patterns as a sixth category (Orlinsky et al., 1994), considering the sequence of processes within and between therapy sessions, ISE are

now acknowledged as part of the therapeutic process (Orlinsky, 2009). Recognising that ISE may offer some insight into the relationship between therapeutic process and outcome, Hartmann et al. (2016) concluded that, for patients with anorexia nervosa, there are diverse relationships between different facets of the intersession processing of therapy and outcome, follow different trajectories over time. For example, patients who had better outcomes reported less application of therapeutic learning (e.g. doing something a therapist had suggested in a session) compared to patients who had not recovered. Furthermore, they identified that unpleasant emotions in the time between sessions were highest during the middle phase of treatment; thus, may be a way to track the process of therapy outcome. Acknowledging the therapist-client as a dyadic relationship, it could be that if ISE relate to outcome then therapists may experience ISE in a similar way to clients and therefore, potentially impact on therapy outcome.

Current Focus and Aims

Although there has been a recent systematic review of clients' ISE, no such review of therapists' ISE exists. Stewart and Schröder (2015) reported that clients experience a range of ISE, which significantly increase in frequency over time, and that the quantity of ISE positively correlated with ratings of the working alliance. Furthermore, ISE with a pleasant emotional tone were found to associate positively with a strong working alliance, whereas unpleasant emotional experiences showed an inverse relationship (Stewart & Schröder, 2015). Considering the empirical literature regarding clients' ISE it is possible that therapists' ISE may also influence aspects of the therapeutic process and client outcome. Were this to be the case, ISE might be used to better understand and strengthen the therapy process, including the therapeutic relationship, and to improve client outcome. Furthermore, acknowledging that therapy is an interpersonal relationship highlights the importance of understanding the process of therapy between sessions from both client's and therapist's perspectives.

The current systematic review aims to synthesise and appraise existing empirical literature on therapists' ISE by answering the following review questions:

1. What is the quality of the existing empirical literature on therapists' intersession experiences against pre-determined criteria?
2. What does the existing empirical evidence tell us about therapists' intersession experiences?

Method

Search Strategy

An initial scoping search was completed to check the feasibility of the review. Articles included were then identified by using three strategies to comprehensively search the

literature: 1) electronic database searching; 2) searching citations, and 3) hand searching reference lists.

Five databases (EMBASE, MEDLINE, PROQUEST, PsycINFO, and WEB OF SCIENCE) were searched up to 3rd April 2020. Unpublished dissertations and thesis projects were included due to these being subject to quality control by examiners, whilst other forms of grey literature were excluded. Search terms were identified and verified by a researcher established in the topic area, to improve search quality and inclusion. Concepts identified as being relevant to the review were: 'Therapists' and 'Intersession Experiences'. Synonyms for each concept were searched individually and then grouped together using Boolean operators (OR). Grouped searches for each concept were then combined (AND) to produce a final search strategy for each database (Appendix A). Where possible, subject headings were exploded to capture varied headings and terminology used on different databases. Following removal of duplications, titles and abstracts were screened against the inclusion and exclusion criteria. Remaining papers were then reviewed in full to check for eligibility. Subsequently, eligible papers were searched through Scopus for citations, and papers meeting the selection criteria included in the review, followed by hand searching of the reference lists, which identified papers focused on a specific type of ISE, namely dreams. Subsequently, the five databases were searched again, to check for additional, more recent publications in this area; for this search, a date restriction was applied from the date of the most recent paper identified in the search (2012) to present day (Appendix A).

Selection Criteria

Studies were included if they met the following criteria:

- Focused on therapists providing psychological therapy.
- Studies investigating therapists' ISE relating to clients or therapy sessions .
- Studies investigating both clients' and therapists' ISE, allowing the therapists' data being extracted for this review.
- Peer reviewed articles or unpublished dissertations and thesis projects.
- Any language.

Studies were excluded if they:

- Investigated clients' ISE only.
- Investigated only therapists' representations of themselves or significant others, e.g. a parental figure.
- Explored representations, events, and experiences that occurred in-session.

Data Extraction

After each paper was read and re-read, information was systematically extracted, including author, sample characteristics, methodology, research aims, and key findings, as summarised in Table 1. This approach was based on a similar review in the topic area including both quantitative and qualitative papers (Stewart & Schröder, 2015).

Quality Appraisal

Considering that this review synthesises data from quantitative, qualitative, and mixed-method papers, the Mixed Method Appraisal Tool (MMAT; Hong et al., 2018) was deemed the most appropriate tool to use; specifically, the criteria for descriptive quantitative, qualitative, and mixed-methods data. Although there is no unified method for appraising qualitative data (Finfgeld-Connett, 2008), the MMAT criteria appeared limited for appraising this type of data. To strengthen the systematic appraisal of qualitative papers, the appraisal tool was adapted to include items from the Critical Appraisal Skills Programme (CASP; 2018), including a general question on ethical considerations for all papers. Although not routinely used by the MMAT or CASP, due to papers included being assessed against different criteria, it seemed useful to provide an overall quality total to enable comparison across studies with percentage deemed the most appropriate method (Pluye et al., 2009). The primary author quality appraised all papers, with the second and third authors appraising six papers each. Discrepancies were discussed, reaching 98% consensus.

Quantitative Synthesis

Narrative synthesis is an alternative method for reviewing quantitative data where applying meta-analysis is inappropriate or where studies have a different focus (Cochrane Consumers & Communication, 2013). The limited number of quantitative papers identified in this review are largely descriptive and focus on different aspects of ISE, therefore narrative synthesis appeared the most appropriate review method using Cochrane guidelines for narrative synthesis (Cochrane Consumers & Communication, 2013).

Qualitative Synthesis

Qualitative synthesis followed the seven phases of meta-ethnography (Noblit & Hare, 1988). Involving induction and interpretation, meta-ethnography also emphasises the preservation of meaning (Britten et al., 2002). Meta-ethnography aims to identify reciprocal translations of directly comparable accounts, but also refutational translations standing in opposition to one another; both translations will be considered in this review. Meta-ethnography approaches distinguish between first, second, and third order constructs. First order constructs refer to direct quotes made by the research participants, whereas second order constructs refer to the authors' interpretations of first order constructs. Third order

constructs in meta-ethnography are developed from first and second order constructs to form a line of argument (Britten et al., 2002; Campbell et al., 2011).

Reflexivity

Interpretation of qualitative data is influenced and can differ according to the researcher's interests, theoretical framework, and epistemological position (Noblit & Hare, 1988; Willig, 2013). This review adopts the epistemological position of critical realism, which states that although reality exists, single truths cannot exist due to individuals having their own, independent interpretation of reality (Barker et al., 2002). The integration of realist ontology with a constructionist epistemology is considered a well suited position to approaching mixed-method research (Maxwell & Mittapalli, 2010) and was, therefore, an appropriate stance for reviewing papers with either quantitative, qualitative, or mixed methodologies. Furthermore, the primary author provides psychological therapy as part of their clinical practice, from which their interest of ISE developed. Thus, to reduce potential bias, the qualitative synthesis was reviewed by the third author, with comments provided and discussed.

Results

Search Results

Database searches retrieved 1553 papers. Following the removal of duplicates, the title and abstracts of 1043 papers were reviewed against the selection criteria. One unpublished thesis paper (Lehman, 1991) was excluded due being published under a different primary author (Geller et al., 2002). The full text of 39 papers were reviewed, resulting in six papers meeting the selection criteria, with two additional papers identified through searching Scopus. Reference list searching of these eight papers resulted in four additional papers. A post hoc search including 'dream*' yielded no additional relevant papers. Twelve papers were included in the review, as seen in Figure 1 using the PRISMA approach for reporting systematic reviews (Moher et al., 2009).

Study Characteristics

This synthesis incorporated the findings of 12 papers; four quantitative (Geller et al., 2002; Hartmann et al., 2015; Schröder et al., 2009; Zeeck et al., 2012), six qualitative (Arnd-Caddigan, 2012; Arnd-Caddigan, 2013; Bimont & Werbart, 2018; Knox et al., 2018; Kron & Avy, 2003; Spangler et al., 2009), and two mixed-method papers (Hill et al., 2013; Stewart, 2016). ISE were not the main focus for two quantitative papers (Hartmann et al., 2015; Zeeck et al., 2012) but were included with data related to ISE extracted for the purpose of this study. Papers included a wide variety of theoretical orientations. Qualitative papers used different methods of data collection, with some using written accounts of participant's

experience (Arnd-Caddigan, 2012; Arnd-Caddigan, 2013; Kron & Avy, 2003), and the remaining five papers using semi-structured interviews. Methods of data analysis across the qualitative papers varied. Characteristics of studies included in the review are outlined in

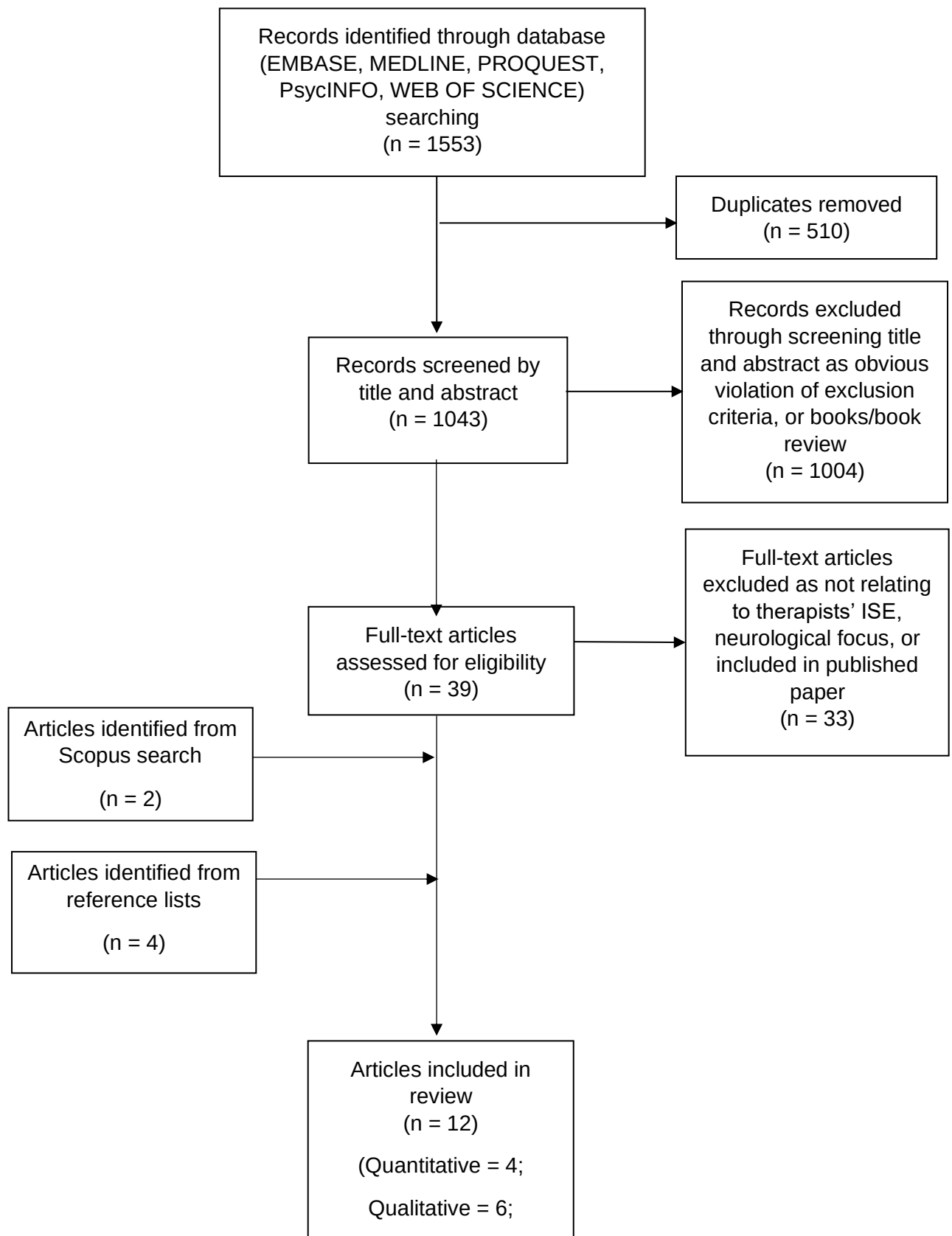


Figure 1. PRISMA diagram of the data selection process.

Table 1 *Characteristics of studies included in review.*

Authors	Sample Characteristics	Methodology	Aims/Focus	Key Findings
1. Arnd-Caddigan (2012)	<i>n</i> = 12 therapists, varied theoretical orientations	Qualitative; Constructivist Grounded Theory	Therapists' experiences of having intersession imagined conversations with clients outside of the therapeutic session.	• ICs helped therapists to uncover countertransferential feelings relative to the client and/or treatment process. • ICs helped them to understand their client better. • ICs tend to occur: 1) when a difficulty occurs, and 2) during the middle phase of treatment.
2. Arnd-Caddigan (2013)	<i>n</i> = 12 therapists, varied theoretical orientations	Qualitative; Constructivist Grounded Theory	Therapists' experiences of having intersession imagined conversations with clients outside of the therapeutic session.	• ICs help therapists to surface and process feelings that were previously outside of their awareness and the need to work through feelings showing up in ICs. • ICs help therapists avoid acting out feelings which may harm the therapy process. • ICs help therapist modulate their anxiety so that they can work with clients on sensitive and difficult material.
3. Bimont & Werbart (2018)	<i>n</i> = 5 relational therapists	Qualitative; Interpretative Phenomenological Analysis	Exploration of the therapists' experiences of thoughts and feelings about patients who disturb them between sessions more than usual, and who occupy their inner world. What can we learn from such a phenomenon about the therapy process in and between sessions?	• Therapists reported that patients appear in their thoughts and feelings outside of the therapy setting, with a 'traumatised woman' affecting them more than others. • A core theme identified was all that therapists described a sense of blurred or too permeable boundaries between themselves and the patient when having experiences about the patient in the time between sessions. • Fantasies about patients were common; dreams were not. • Contradictory feelings of anxiety, fear, and love. • The biggest effect on the therapy was an enhanced commitment to therapy, believing these benefited patients.

Table 1
(continued)

Authors	Sample Characteristics	Methodology	Aims/Focus	Key Findings
4. Geller et al. (2002)	<i>n</i> = 73 therapists, varied theoretical orientation and levels of experience	Quantitative; PRI	Explored the frequency, vividness and effects of therapists' representations of their patient at a single point in time. Also, focussed on theoretical orientation and therapist experience as putative correlates of therapist ISE.	• Therapists experience a number of ISE, typically relating to understanding past material or planning future sessions. • Less experienced and Cognitive Behavioural orientated therapists experience planning and problem-solving ISE. • More experienced therapists tend to evoke representations that include an experiential, bodily oriented qualities.
5. Hartmann et al. (2015)	<i>n</i> = 26 psychodynamic therapists of varying experience levels.	Quantitative; HAQ SEQ TWIS IEQ	Explored the divergence between therapists' and patients' perspectives on patients' alliance experience, and its relations to therapists' work involvement and intersession experiences.	• Although primarily focused on the perceptions of alliance, regarding therapists' ISE they reported that the divergence found amongst therapist and patient ratings of the therapeutic alliance was not significantly related to therapists' ISE.
6. Hill et al. (2013)	<i>n</i> = 13 doctoral student therapists with 63 clients in a community clinic, psychodynamic psychotherapy.	Mixed method. Quantitative; WAI-SR-C; WAI-SR-T; SES; IS; TS; IIP-32; OQ. Qualitative; Consensual Qualitative Research	To describe the frequency of therapists' dreams about their clients and clients dreams about their therapist. To determine how those who did dream about clients differed from those who did not, and to describe the content and consequences of the dreams.	• Nine (69%) therapists dreamed about their clients. • Therapists generally reported that they had these dreams because they were struggling with the clients represented in the dreams. • Therapists' dreams yielded insights about the therapist, clients, and therapy. • Therapists used insights in their work with the client. • Dreams typically had a negative affect.

Table 1
(continued)

Authors	Sample Characteristics	Methodology	Aims/Focus	Key Findings
7. Knox et al. (2018)	<i>n</i> = 14 therapists; 8 were integrative; 4 psychodynamic; 2 cognitive/cognitive-behavioural	Qualitative; Consensual Qualitative Research	To investigate therapists' experiences of being deeply touched or moved by clients and then carrying their clients' presence with them when not in session.	- Frequency of internal representations (IR) varied ('frequent while in PT [psychotherapy]', 'less frequent while in PT', and 'rarely post-termination'). - IRs were experienced about clients who presented with severe or challenging presentations. - IRs involved experiencing a feeling about the client, with participants reporting that they felt worried, pressured, responsible, sad, pained, a heavy heart, or a sense of urgency. - Therapists benefit from IRs through developed insight, learning, growth, or reflection in both their personal and professional experiences.
8. Kron & Avny, (2003)	<i>n</i> = 22 therapists; 31 dreams reported.	Qualitative; Narrative analysis, Jungian analysis.	What themes appear in the manifest content of therapists' dreams about their patients? What contributions are made by Jungian interpretation of therapists' dreams about their patients? To what extent are masochistic contents present in the manifest content of therapists' dreams about their patients?	- In 20 of the 31 dreams, therapists had a negative experience and was characterised as vulnerable. - Dreams about patients typically function as prognostic, diagnostic and compensatory for therapists. 18 of the 31 dreams met Beck's (1967) criteria for masochistic dreams - Therapist dreams about their patients can be valuable tool for deepening understanding of the therapeutic relationship and process.

Table 1
(continued)

Authors	Sample Characteristics	Methodology	Aims/Focus	Key Findings
9. Schröder et al. (2009)	<i>n</i> = 1040 therapists from US, Canada and New Zealand	Quantitative; DPCCQ (with TIES included)	Explore the frequency of therapist's ISE and the relationship of these to therapist's professional and demographic characteristics, difficulties experienced, coping strategies used in practice, and personal quality of life.	• Frequency was positively associated with therapists' level of difficulties in practice and use of constructive coping strategies. • Frequency of ISE varied amongst therapists depending on their professional characteristics, such as profession and theoretical approach, although were generally small differences. • Therapists from different theoretical orientations use ISE somewhat different. Dynamic had a stronger relationship with recalling and reflecting on feelings as a type of ISE.
10. Spangler et al. (2009)	<i>n</i> = 8 therapists; 4 psychologists and 4 master's level therapists.	Qualitative; Consensual Qualitative Research	What themes occur in therapists' dreams about clients? What methods do therapists use to explore and interpret dreams about their clients? What meanings do therapists make of dreams about their clients? How do therapists use their understanding of dreams about clients?	• Dreams were about difficulties with clients, intense personal concerns, and negative interpersonal interactions. • Dreams included a mixture of positive and negative feelings. • Therapists generally explored or processed the dreams to some extent, using a variety of methods. • Dream deepened therapists' awareness about their clinical decision-making with the client. • Therapists developed understanding of their countertransference with the client.

Table 1
(continued)

Authors	Sample Characteristics	Methodology	Aims/Focus	Key Findings
11. Zeeck et al. (2012)	<i>n</i> = 26 psychodynamic therapists of varying experience levels.	Quantitative; IEQ TWIS HAQ SEQ SCL-90-R IIP-C	To what extent can therapists' Stressful Involvement (SI) be predicted by (a) psychotherapeutic processes (ISE were included by considering how treatments was processed by therapists and patients in the time between session).	• ISE that include negatively experienced emotions strongly associated positively with a SI work involvement pattern. • Feeling 'discouraged' in the time between therapy sessions was the strongest predictor of SI.
12. Stewart (2016)	Phase 1: <i>n</i> = 7 therapists, varied theoretical orientations; Phase 2: <i>n</i> = 10 therapists, varied theoretical orientations; Phase 3: <i>n</i> = 3 participants from phase 2.	Mixed method; Single-case, time-series design. Quantitative; A-TIEQ. Qualitative; Thematic Analysis.	What are the types, function and impact of therapist ISE? To what extent are content, frequency of thoughts, and emotional tone of ISE associated across therapy? To what extent are aspects of therapist ISE associated with therapist ratings of alliance over therapy? How do therapists make sense of the patterns and associations between aspects of their intersession experience and ratings of alliance?	• All therapists reported ISE over the course of therapy. • Thoughts between sessions were associated with problem solving, re-experiencing aspects of therapy and internal reflection. • ISE may be planned or spontaneous, may affect in-session processes, and may impact on therapist wellbeing. • Positive emotional ISE preceded increases in alliance ratings. • ISE as an indicator of need for supervision, transference of patient difficulties and to help therapy progress.

Note. A-TIEQ = Adapted Therapist Intersession Experience Questionnaire (Stewart et al., 2016); DPCCQ = Development of Psychotherapists Common Core Questionnaire (Orlinsky & Rønnestad, 2005); TIEQ = Therapist Intersession Experience Questionnaire (Lundy & Orlinsky, 1987); TIES = Therapist Intersessions Experience Scale (5 items adapted from the TIEQ; Lundy & Orlinsky, 1987); HAQ = Helping Alliance Questionnaire (German version; Bassler et al., 1995); SEQ = Session Evaluation Questionnaire (Stiles et al., 1994); TWIS = Therapist Work

Involvement Scales (Orlinsky & Rønnestad, 2005); IEQ = Intersession Experience Questionnaire (Orlinsky & Geller, 1993); SCL-90-R = Symptom Check List-90 (German version; Franke, 1995); IIP-C = Inventory of Interpersonal Problems (German version; Horowitz et al., 2000); PRI = Patient Representation Inventory (Geller et al., 2002); WAI-SR-C = Working Alliance Inventory-Short Revised-Client (Hatcher & Gillaspay, 2006); WAI-SR-T = Working Alliance Inventory-Short Revised-Therapist (Hatcher & Gillaspay, 2006); SES = Session Evaluation Scale (Hill & Kellems, 2002); IS = Insight Scale (Gelso et al., 1991); TS = Transference Scale (Gelso et al., 1991); IIP-32 = Inventory of Interpersonal Problems-32 (Barkham et al., 1996); OQ = Outcome Questionnaire (Lambert et al., 1996).

Quality Appraisal Synthesis

Using the adapted quality criteria, the six qualitative papers were considered against eight criteria, the four quantitative ones were marked against six criteria, and the two mixed-method papers against eighteen criteria. Overall, the quality of studies varied, as can be seen in Table 2. Papers included in the quantitative analysis were of lower quality overall compared to papers included in the qualitative synthesis. Apart from one paper (Stewart, 2016), quantitative papers either failed to use a representative sample, and four papers (Hartmann et al., 2015; Hill et al., 2013; Schröder et al., 2009; Zeeck et al., 2012) failed to use an appropriate sampling strategy. Nonresponse bias was considered and reported by two papers (Hartmann et al., 2015; Zeeck et al., 2012), although it is worth noting that these papers used the same sample, further limiting the overall representativeness of the quantitative findings.

Quality appraisal of the qualitative papers highlighted that three studies (Hill et al., 2013; Knox et al., 2018; Kron & Avy, 2003) did not provide substantial data to support their interpretations. Furthermore, the same data appears to have also been used across two publications (Arnd-Caddigan, 2012; Arnd-Caddigan, 2013). Considering the transparency of the authors, two papers (Hill et al., 2013; Kron & Avy, 2003) did not report their epistemological position or a process of reflexivity, limiting the trustworthiness of the findings from these papers (Willig, 2013).

Quantitative Results

Narrative synthesis identified four key findings that have been summarised as themes: 1) *Frequency & type*; 2) *Emotional tone*; 3) *Therapists' characteristics*, and; 4) *Association with alliance*.

Table 2 *Studies' Methodological Quality*

Study	Qualitative								Quantitative					Mixed Method					Total (%)
	1*	2	3	4*	5	6	7*	8	9	10	11	12	13	14	15	16	17	18	
Geller et al. (2002)	U	-	-	-	-	-	-	-	Y	U	Y	U	Y	-	-	-	-	-	75%
Hartmann et al. (2015)	Y	-	-	-	-	-	-	-	U	U	Y	Y	Y	-	-	-	-	-	83%
Schröder et al. (2009)	U	-	-	-	-	-	-	-	U	U	U	U	U	-	-	-	-	-	50%
Zeeck et al. (2012)	Y	-	-	-	-	-	-	-	U	U	Y	Y	Y	-	-	-	-	-	83%
Arnd-Caddigan (2012)	Y	Y	U	Y	Y	Y	U	Y	-	-	-	-	-	-	-	-	-	-	88%
Arnd-Caddigan (2013)	Y	Y	U	Y	Y	Y	Y	Y	-	-	-	-	-	-	-	-	-	-	94%
Bimont & Werbart (2018)	U	Y	Y	Y	Y	Y	Y	Y	-	-	-	-	-	-	-	-	-	-	94%
Knox et al. (2018)	U	Y	Y	Y	Y	Y	Y	Y	-	-	-	-	-	-	-	-	-	-	94%
Kron & Avy (2003)	U	Y	U	U	Y	U	N	Y	-	-	-	-	-	-	-	-	-	-	63%
Spangler et al. (2009)	U	Y	Y	Y	Y	Y	N	Y	-	-	-	-	-	-	-	-	-	-	81%
Hill et al. (2014)	U	Y	Y	U	Y	Y	N	Y	U	N	Y	U	Y	U	Y	Y	N	U	67%
Stewart (2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	94%

Note. 1* = Ethical considerations; 2 = Appropriate qualitative approach; 3 = Appropriate data collection; 4* = Appropriate recruitment strategy; 5 = Findings derived from data; 6 = Interpretation substantiated by data; 7* = Researcher transparency; 8 = Overall coherence; 9 = Appropriate sampling strategy; 10 = Representative sample; 11 = Appropriate measurements; 12 = Low nonresponse bias; 13 = Appropriate statistical analysis; 14 = Adequate rationale; 15 = Integration of different components; 16 = Adequate interpretation of integration; 17 = Inconsistencies

adequately addressed; 18 = Adherence to the quality criteria of each tradition of the methods involved; Y = Yes (score = 2); U = Unclear/ Can't tell (score = 1); N = No (score = 0). Items marked with an asterisk (*) were adapted from the CASP, all other items were from the MMAT.

Frequency & type. Three papers discussed the frequency of therapists' ISE, with one specifically focused on dreaming about clients. Using a large sample of 1040 therapists, Schröder et al. (2009) reported that 61% endorsed the TIEQ item "thinking about how best to help resolve a patient's problems" recurrently, often, or very often, and 54% reported "remembering the feelings expressed by the patient" and "reflecting on your own feelings toward a patient". Forty-nine percent reported rarely or never "imagining a conversation with a patient". Forty-eight percent reported "experiencing something similar to what a patient experienced". Geller et al., (2002) reported means and standard deviations for frequency of representations rated on a 5-point scale (1 = 'never', 5 = 'very often') for psychodynamic ($M = 3.11$; $SD = 0.76$) and cognitive-behavioural ($M = 3.17$; $SD = 0.95$) therapists. Hill et al. (2013) reported in their small sample of 13 therapists, nine (69%) described having dreams about clients. These findings indicate the limited understanding of how frequently therapists experience ISE. Furthermore, these papers were of lowest quality comparative to other papers in the review and, therefore, findings on the frequency of therapists' ISE should be interpreted with caution.

Emotional tone. Few key findings were identified relating to the emotional tone of ISE. Across two of the three single cases studied, Stewart (2016) identified a relationship between experiencing negative emotional ISE and frequency of intersession thoughts one session later, however, these results differed in the direction of the association ($r = -.48$, $p = .03$; $r = +.63$, $p = .047$).

Schröder et al. (2009) explored the relationship between ISE and therapists' difficulties in practice, reporting a positive, moderate correlation ($r = .33$). Considering individual items on the Therapists' Difficulties in Practice Scale, "distressed by your own powerlessness to affect a patients tragic life situation" and "demoralized by your inability to find ways to help a patient" demonstrated the highest correlations with IES, although these were weak correlations of .29 and .28 respectively. However, due to the paper not providing a rationale for the measures used, including using only 5-items of the TIEQ, compromises the validity and reliability of these findings.

Investigating to what extent ISE predict therapists' level of stressful involvement² (SI), Zeeck et al. (2012) found "feeling discouraged" in the time between sessions to be

² 'Stressful involvement' (SI) and 'Healing involvement' (HI) are two independent second-level factor-analytic scales to describe therapists' work experiences (Orlinsky & Rønnestad, 2005). SI reflects therapists' experiences of frequent difficulties during sessions, unconstructive avoidant coping, and in-session feelings of boredom and anxiety. HI therapists are said to be accommodating, invested, and affirming, have deeply attentive interest or flow during sessions, and constructive coping when difficulties arise.

significantly related to SI. When multivariate modelling analysis was applied, therapists' increasing levels of discouragement were associated with increasing levels of SI.

Therapists' characteristics. Few papers considered the relationship between therapist characteristics and ISE. The main findings were related to theoretical orientation. Schröder et al. (2009) found small, positive correlations between therapists from a behavioural or cognitive orientation and ratings on the IEQ item "thinking about how best to help a patient". Contrastingly, psychodynamic therapists were more likely to recall a patient's feelings or reflect on their feelings about a patient in the time between therapy sessions; again, these were only small correlations but differed to other orientations. Similarly, Geller et al. (2002) investigated the degree to which therapists' level of experience and theoretical orientation (cognitive-behavioural or psychodynamic) were associated with therapists' mental representations of their clients. They found less experienced, cognitive-behavioural therapists, were more likely to use mental representations of their patients in treatment planning. No association was found between therapists' gender and ISE (Schröder et al., 2009), similarly to clients' ISE (Stewart & Schröder, 2015). However, both papers lack clarity regarding the representativeness of the sample used therefore, limiting the generalisability of the findings.

Association with alliance. Some findings specifically related to the association between ISE and therapeutic alliance. In three single cases, Stewart (2016) found that negative emotional ISE were negatively correlated with ratings of alliance across two cases ($r = -.53, p = .007$; $r = -.51, p = .018$). Hartmann et al. (2015) explored the divergence between therapist and client ratings of therapeutic alliance, reporting therapists' ISE were not significantly related to the divergence in alliance ratings.

Table 3 *Cross Comparison of Qualitative Themes*

Theme	Arnd-Caddigan (2012)	Arnd-Caddigan (2013)	Stewart (2016)	Bimont & Werbart (2018)	Knox et al. (2018)	Kron & Avy (2003)	Hill et al. (2013)	Spangler et al. (2009)
Frequency & form	*		*	*	*	*	*	
Triggers	*		*		*		*	*
Emotional impact			*	*	*	*	*	*
Therapists' discovery	*	*	*	*	*	*	*	*
Actions			*		*		*	*

Note. * indicates that the study was identified as contributing to the third-order construct developed during the meta-ethnographic synthesis.

Qualitative Results

The meta-ethnography synthesis identified five third-order constructs: 1) *Frequency and form*; 2) *Triggers*; 3) *Emotional impact*; 4) *Therapists' discovery*; and 5) *Actions*. For the third-order construct *Triggers*, three subthemes developed representing the distinctions made at the second-order level: 1) *At times of difficulty*; 2) *Chaos in the therapist's life*; and 3) *Connection with client*. Likewise, for the third-order construct *Actions*, yielded two subthemes: 1) *Planning and preparing*; and 2) *Discussing ISE*. The inclusion of studies in each construct can be seen in Table 3 for comparison. All papers with a qualitative methodology were of good quality, except for Hill et al. (2018) and Kron and Avy (2003) that were of low quality.

Frequency and form. Comparable findings were discussed in three papers regarding the variability in the *frequency* of ISE as a recurring theme across studies (Arnd-Caddigan, 2012; Knox et al., 2018; Stewart, 2016). Knox et al. (2018) noted therapists' internal representations of clients to occur 'frequently while in PT [psychotherapy] (multiple times during the week)'³, 'less frequent while in PT (a few time a month or less)', or 'rarely post-termination', with these reported equally across therapists' accounts. Similarly, Stewart (2016) reported this variability. As demonstrated in participant quotes, some reported ISE to occur frequently: "I suppose I would think about clients every day when I am not in the session with them"⁴ (p. 63). Conversely, others reported experiencing them less frequently: "I suppose I think about people once or twice a week outside of the sessions" (p. 63).

Considering the *form* of experiences that therapists have between sessions, few papers reported how therapists' ISE can be experienced in different ways (Arnd-Caddigan, 2012; Knox et al., 2018). For example, Arnd-Caddigan (2012) identified how ISE can involve 'visual, auditory and affective' aspects (p. 338). Knox et al. (2018) described how ISE can be experienced in the form of 'thoughts', 'feelings', 'behaviours', 'visual images', and a 'felt presence' (p. 359). Whilst these papers did not recognise the experience of dreams, some papers focused specifically on dreaming about clients (Hill et al., 2013; Kron & Avny, 2003; Spangler et al., 2009). Stewart (2016) also identified how therapists experienced 'dreams' (p. 70) as a form of ISE. However, Bimont and Werbart (2018) reported fantasies about clients to have been common amongst their participants, but dreams were not.

³ Inverted commas indicate direct quotes from the authors of the studies/ second-order constructs.

⁴ Speech marks indicate direct quotes of participants in original studies/ first-order constructs.

Triggers. Several papers referred to *triggers* for ISE, encompassing three subthemes: 1) experiencing ISE *at times of difficulty in therapy*; 2) experiencing ISE at times of *chaos in the therapist's life*; and 3) *quality of therapeutic relationship*.

“At times of difficulty” in therapy. A common theme was that ISE were triggered by a difficulty in therapy, including characteristics of the client that were challenging for the therapist (Arnd-Caddigan, 2012; Hill et al., 2013; Knox et al., 2018; Spangler et al., 2009; Stewart, 2016). For example, participants reported experiencing ISE “when I feel stuck with a case” (Arnd-Caddigan, 2012, p. 339) or “if I am struggling with them” (Stewart, 2016, p. 65).

Some papers reported how participants thought having difficulty in therapy triggered an ISE because experiencing the ISE was a helpful way to check how the therapy was progressing (Arnd-Caddigan, 2012; Stewart, 2016). On the other hand, some reported difficulties in therapy to trigger ISE because they did not feel prepared or able to help the client. For example, one participant reported dreaming about a client’s convictions because “I didn’t feel like I could have helped him with this issue” (Spangler et al., 2009, p. 88). Similarly, Knox et al. (2018) reported a participant to have thought they had an ISE about a client who they were having difficulty with as ‘she was trying to feel less guilty about the client not making progress’ (p. 363).

“Chaos” in the therapist’s life. Two studies (Hill et al., 2018; Spangler et al., 2009) identified ‘chaos’ occurring in the therapist’s life at the time, both personally and professionally, to have triggered ISE. It is worth noting that this theme emerged in papers focused specifically on dreams about clients. Hill et al. (2018) reported ‘therapists’ own issues seemingly elicited the dream’ (p. 350). For example, they described how ‘one therapist felt that the “chaos” of the dream paralleled the chaos of his waking life’ (p. 351). Likewise, Spangler et al. (2009) reported how therapists experienced dreams about clients because of how their ‘work environment was negatively affecting their well-being’ (p. 88).

Quality of the therapeutic relationship. Three papers discussed the therapeutic alliance as a potential trigger for ISE. Arnd-Caddigan (2012) and Knox et al. (2018) both identified having a “strong” therapeutic relationship with the client to have triggered ISE. However, this was not the case in all papers. Hill et al. (2013) reported that therapists experienced ISE because they ‘did not feel connected’ (p. 531) to the client, stating that ‘in one case, the therapist acknowledges that she would rather not be seeing her client’ (p. 531).

Emotional impact of ISE. Five papers identified ISE to have both a pleasant and/or unpleasant emotional impact on the therapist (Bimont & Werbart, 2018; Hill et al., 2013;

Knox et al., 2018; Spangler et al., 2009; Stewart, 2016). Spangler et al. (2009) discussed a range of emotions being present in the same ISE. For example, one participant described their emotional experience during a dream as an “emotional sequence that would go: sort of pleasant, relaxed, followed by curiosity and a little bit of a sense of foreboding, followed by panic and fear, followed by hopeful determination (p. 89).”

Most papers discussed an emotional element of ISE (Bimont & Werbart, 2018; Hill et al., 2013; Knox et al., 2018; Stewart, 2016). Bimont and Werbart (2018) reported therapists to have described a range of pleasant emotions, with ‘the strongest one being a feeling of love’ (p. 255), and that therapists experienced a sense of ‘joy and closeness’ (p. 255) about their patients. This sense of closeness was also discussed in other papers but considered regarding the therapeutic relationship. For example, one participant reported how her and her client “were really understanding each other, which was a positive experience” (Knox et al., 2018, p. 363). Similarly, Hill et al. (2013) discussed how some therapists were surprised by dreaming about a client but how, for one therapist, ‘dreaming of the client marked the first time she felt emotionally close to them’ (p. 531).

Many unpleasant emotions that were experienced as part of the ISE were reported including, fear, worry, embarrassment, guilt, shame, and sadness. One participant reported feeling concerned for the client:

“I worried about her when I was jogging, and I worried about her when I went on vacation because I knew she felt awful when I was away or I knew she felt bad when she was alone at home at night (Bimont & Werbart, 2018, p. 254).”

Others described how their experience of the client in the ISE was frightening and upsetting. For example, in an account of a dream about a patient one therapist reported:

“He was someone that was very aggressive in session... . He wouldn’t let me out of the room... I felt fine after I left and went home ... although when I got home, I rang up work in tears and I was so upset over this... I was thinking it through... . I couldn’t get him out of my mind of a long time and he still comes up from time to time now (Stewart, 2016, p. 70).”

One paper did not explicitly acknowledge the presence of pleasant emotions being a part of ISE, specifically dreams (Kron & Avny, 2003). Instead, it was reported that ‘in 20 of the 31 dreams, therapists experienced negative emotions and were described as being vulnerable’ (p. 325). Whilst this corroborates the findings above, it does not provide information of the of emotional impact experienced in the 11 dreams unaccounted for.

Therapists' discovery. Although referred to differently, a comparable theme emerged regarding ISE as a process of *therapists' discovery* about the therapy, client, or themselves. For example, ISE helping therapists to 'surface feelings that were previously outside of their awareness' (Arnd-Caddigan, 2013, p. 152), how ISE 'fostered insight' (Knox et al., 2018, p. 363), 'increased awareness' (Hill et al., 2013, p. 531), and how ISE developed a 'sense of too permeable, blurred self-boundaries' (Bimont & Werbart, 2018, p. 252).

Four papers identified this discovery as a second-order construct of 'insight' (Arnd-Caddigan, 2012; Hill et al., 2013; Knox et al., 2018; Spangler et al., 2009). This was discussed in relation to therapists developing or deepening their awareness and understanding of the client or therapy. For example, Arnd-Caddigan (2012) reported that the 'participants believe that the IC [imagined conversation] gives the therapist insight into how the client will experience possible intervention strategies' (p. 342). Similarly, Hill et al. (2013) stated that 'therapists reported that the dreams enhanced their understanding of the client's symptomology'. Two papers reported how the discovery was about the therapists themselves, their own feelings, and experiences of being a therapist (Hill et al., 2013; Knox et al., 2018). For example, 'one participant asserted that his IR [internal representation] helped him to understand himself as a clinician in a broader and deeper way' (Knox et al., 2018, p. 363). Hill et al. (2013) discussed one participant's experience of becoming aware of their internal conflict and how this made her feel restricted as a therapist: "I gained insight into how I cared about him and how restricted I felt in terms of not being able to be as reassuring as I wanted to be" (p. 531).

Three papers identified the sense of discovery as arising from previously unconscious feelings, describing this as 'countertransference' (Arnd-Caddigan, 2013; Kron & Avny, 2003; Spangler et al., 2009). Arnd-Caddigan (2013) reported several participants to have described how ISE help therapists to 'bring feelings of which the therapist had previously been unaware to the surface' (p. 152). Kron & Avy (2003) identified a second-order construct of 'diagnostic and prognostic dreams' (p. 326), stating that these indicate an unconscious resolution to an intrapsychic conflict. Spangler et al. (2009) also reported how therapists increased their awareness of countertransference reactions to a client, as explained in this first-order account:

"Okay, so my feelings of annoyance with him and anger toward him were normal and thus not countertransference, to an extent. But they were also countertransference in the sense that his stuff touched my stuff, my unresolved issues, and that's what brought out my inability to see what was happening (p. 90)."

Finally, the third-order construct of therapists' discovery was identified in three papers where boundaries were discussed (Bimont & Werbart, 2018; Spangler et al., 2009; Stewart, 2016). Bimont and Werbart (2018) identified this as a second-order construct of 'blurred or too permeable boundaries' (p. 252), which was represented in accounts from all participants. For one participant, they described being "pulled into something...so even though I could feel that it wasn't quite right that way, I still couldn't say no" (p. 253). Stewart (2016) identified a boundary between the new discovery being helpful and then beginning to dominate:

"I think it can be quite helpful just to spend a little time thinking things through planning and sort of reflecting...that's made me see things in a different light or I, or helped me see things from a different perspective or understand more...as long as it doesn't dominate (p. 67)."

Actions. Four papers referred to the *actions* therapists take and how they use ISE (Hill et al., 2013; Knox et al., 2018; Spangler et al., 2009; Stewart, 2016). Two subthemes emerged, representing the divergence at the second-order level: 1) *Planning and preparing*, and 2) *Discussing ISE*.

Planning and preparing. Three papers discussed how therapists use ISE to plan and prepare for therapy (Hill et al., 2013; Spangler et al., 2009; Stewart, 2016). Stewart (2016) reported therapists to have reported finding ISE helpful as a process of 'planning and preparation for future sessions' (p. 67). For example, one participant reported: "About planning in my head the next sessions that I am having with that person...I would be thinking about what has been said and the future session" (p. 67).

Spangler (2009) reported how therapists use their understanding from the ISE "therapeutically" (p. 89) to decide what action to take with the client. Similarly, Hill et al. (2013) reported how therapists used the dream in therapy, for example, one client 'used what he learned from the termination-related dream to prepare very carefully for the impending ending of therapy' (p. 532). Although most of the findings similarly described using ISE to plan and prepare helpful, one study reported this action to be unhelpful if therapists were unable to draw a conclusion (Stewart, 2016).

Discussing ISE. All four papers identified *discussing ISE* as an *action* therapists engage in following ISE. Although, whom therapists discussed ISE with varied, the most common theme was discussing ISE in supervision or with a colleague (Hill et al., 2013; Knox et al., 2018; Spangler et al., 2009; Stewart, 2016). For example, one participant reported: "So, after I'd had this dream, I sought consultation from somebody I had worked with before" (Spangler, et al., 2009, p. 89). Another participant reported: "So you would need to go and have a supervision session or talk this through with a colleague and look at why they are on

your mind” (Stewart, 2016, p. 66). Alternatively, instead of seeking supervision with another person, Stewart (2016) identified using the ISE as a form of ‘purposeful, self-directed sense making of therapy’ (p. 66) when access to supervision is limited or not enough. One paper reported therapists to discuss their ISE, specifically dreams about clients, with their family and friends (Knox et al., 2018). Another paper about dreaming, identified that some therapists disclose their ISE to the client.

Synthesis of Qualitative and Quantitative Findings

Although it is challenging to synthesise the findings of disparate research questions and foci, this review highlights areas of corroboration between the qualitative and quantitative findings, which may warrant further exploration.

Firstly, the consistent qualitative finding regarding variability in the frequency of therapists’ ISE (Arnd-Caddigan, 2012; Knox, et al., 2018; Stewart, 2016), is supported by quantitative findings (Hill et al., 2013; Schröder et al., 2009), although sampling issues in the quantitative papers compromise the generalisability of the findings. Therefore, it appears that therapists’ ISE are a prevalent phenomenon although the frequency of these experiences may vary widely. Secondly, the qualitative finding that chaos in therapists’ lives, both personally and professionally, can trigger ISE (Hill et al., 2013; Spangler et al., 2009) supports the weak positive correlation between ISE and current life stressors (Schröder et al., 2009). The positive, moderate correlation between ISE and therapists’ difficulties in practice identified by Schröder et al. (2009) is supported by the qualitative finding that therapists’ ISE are experienced at times of difficulty in therapy (Arnd-Caddigan, 2012; Hill et al., 2013; Knox et al., 2018; Spangler et al., 2009; Stewart, 2016). However, the paper by Schröder et al. (2009) lacks clarity regarding the measures and sample used and therefore indicates further possible exploration of the association between ISE and therapists’ difficulties in practice. Finally, although not investigated in detail, the indication that the emotional experience of therapists’ ISE may correlate with ratings of working alliance (Stewart, 2016) is supported by the qualitative finding of therapists’ ISE being related to the therapeutic relationship (Arnd-Caddigan, 2012; Hill et al., 2013; Knox et al., 2018).

Discussion

This review aimed to inform clinical practice and future research by quality appraising and synthesising the existing empirical literature on therapists’ ISE.

Firstly, the frequency of therapists’ ISE varied, which could be understood in the context of the qualitative findings. It is possible that the variability may be accounted for by factors that influence the onset of therapists’ ISE, such as experiencing difficulty in therapy. This raises clinical implications: if an increase in ISE indicates difficulties in practice these

might need to be explored in supervision, as proposed by Stewart (2016). Similarly, emotional experiences and triggers of ISE suggest that they can also be pleasant for therapists and can also be helpful in increasing therapists' awareness of the therapy or therapy process. Thus, intersession experiences triggered by pleasant or unpleasant experiences can be worthy of further exploration in supervision.

Findings relating ISE to difficulties in therapy are further corroborated by Zeeck et al (2012), who found feeling 'discouraged' in the time between sessions to most strongly associate with and predict therapists' level of stressful involvement. Therapists with low confidence and high levels of avoidant coping (considered aspects of SI) have been found to deliver poorer client outcomes (Heinonen, Lindfors, Laaksonen, & Knekt, 2012). This indicates the importance of supporting therapists in coping more constructively with difficulties in therapeutic practice, potentially through bringing ISE to the forefront in supervision. Furthermore, ISE appear to occur independent of theoretical orientation and, therefore, may provide a useful resource to all forms of therapy. Consequentially this could reduce levels of therapist 'burn out' (Rupert et al., 2015) and improve client outcomes by working through the difficulties.

All qualitative papers identified ISE as a key process of discovery for therapists. It is possible that the mere recognition of ISE contributes towards overcoming obstacles and increasing therapists' effectiveness. As identified by Stewart (2016), using ISE to plan and prepare for therapy can be helpful. Although therapists from different theoretical orientations are likely to focus on different aspects of ISE (Geller et al., 2002; Schröder et al., 2009), it raises the question of whether discussing ISE in supervision, and in what kind of supervision, increases the potential positive impact of these experiences by being supported to draw helpful conclusions, irrespective of theoretical orientation. The impact of explicitly discussing ISE in supervision is yet to be investigated but would be a promising area for future research.

Stewart's (2016) finding from a case series that negative emotional ISE had an inverse relationship with ratings of therapeutic alliance, is supported by qualitative findings (Hill et al., 2013). However, whether therapists' experience of ISE with pleasant emotions positively or negatively relates to the working alliance is not yet fully understood. In a systematic review of clients' ISE, Stewart and Schröder (2015) reported clients' ISE with pleasant emotions to be positively correlated with clients' ratings of working alliance. Bearing in mind the relational nature of ISE, and therapy per se, there may be an interaction between therapist and client ISE, which is yet to be investigated.

Limitations

Despite efforts to review therapists' ISE rigorously and systematically, including papers in languages other than English, there are some limitations. Firstly, data extraction and quantitative interpretation were completed by one author, increasing the risk of potential bias. However, quality appraisal and the qualitative synthesis were reviewed by a second author. Secondly, six of the final papers were not identified during the database search, with four of these studies focusing specifically on dreams. Whilst an ad hoc search was completed, this may indicate a possible limitation in the search terms used to identify papers. It is worth noting, however, that other, specific types of ISE (e.g. 'imagined interaction') were identified in the database searching, whereas dreams were not.

Future Directions

This review has highlighted that whilst therapists' ISE is a growing area of empirical interest, the existing literature is of varied quality, limiting confidence in the findings. Although papers with qualitative methodologies were of better quality, future studies could improve quality by focusing on researcher bias and data collection methods. Quantitative findings, however, were of more limited scope and overall quality. Although Schröder et al. (2009) used a large sample, other quantitative papers reviewed used relatively small samples with limited variation in therapists characteristics, such as theoretical orientation and level of experience. Future quantitative research should aim to improve quality by giving attention to the sampling strategy and representativeness of the sample, which would enable increased confidence in the literature and potentially further support ISE being considered a transtheoretical phenomenon.

In conclusion, this review has identified that therapists' experiences of their client or therapy in the time between sessions can potentially impact on therapists' wellbeing and effectiveness, therapy process, and outcome. Future research focusing on the following aspects of ISE, would deepen our understanding:

1. Investigate the relationship between ISE and preceding in-session process, as well as subsequent in-session process.
2. Study the impact of using ISE in supervision and its relation to therapy outcome.
3. Further explore the relationship between therapists' ISE and ratings of therapeutic alliance.
4. Explore the interaction between therapist and client ISE. This could be achieved through a single-case series.

5. Further differentiate between ISE resulting from difficulties in practice from those that occur as a result of achievements or successes in therapy, considering how these ISE relate to outcome.

Please note that data processed in this paper is already in the public domain in the identified published papers and, therefore, is not shared through the Centre for Open Science.

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JOURNAL PAPER

Abstract

This study aimed to investigate psychological therapists' perceived ability to form a working alliance and maintain therapeutic boundaries, and their work involvement patterns whilst working remotely via telephone or videoconferencing. Furthermore, the study aimed to explore therapists' experience of therapeutic boundaries when working remotely and how they managed these. A mixed-method sequential explanatory design was adopted. Descriptive and inferential statistics were used to analyse quantitative data, with thematic analysis used to analyse qualitative data. In total, 161 psychological therapists completed an online survey, and 12 participants were selected using maximum variation sampling to engage in a semi-structured interview. Although results between therapists varied, some perceived abilities regarding the working alliance and therapeutic boundaries differed when working remotely compared to face-to-face therapy. Therapists' work involvement patterns also differed compared to existing data for face-to-face therapy, indicated by increased rates of stressful involvement. Considering therapists' experience of therapeutic boundaries, four overarching themes were identified: 'different boundaries in remote therapy', 'work home boundary', 'changes in the therapeutic safe space', and 'impact of boundaries when working remotely'. Aspects of the working alliance and therapeutic boundaries are experienced differently by therapists working remotely, which relates to how they experience their work. The findings have clinical implications for increasing therapists' awareness of potential changes in their perceived abilities regarding the working alliance and therapeutic boundaries when working remotely, therefore enabling them to address these changes where required. Future research possibilities are considered.

Keywords: remote therapy, therapist, working alliance, therapeutic boundaries, therapist work involvement

Practitioner Points:

- Therapists' perceived abilities regarding the working alliance and therapeutic boundaries differed when working remotely during the COVID-19 restrictions.
- Remote therapy presents novel therapeutic boundary experiences and presents challenges for therapists' ability to manage boundaries.
- Therapists experience higher rates of stressful involvement when working remotely, which may be characterised by unpleasant emotional experiences and self-doubt.

Background

Psychological therapy usually takes place face-to-face. The COVID-19⁵ pandemic had major effects on the provision of therapy⁶ with organisations recommending therapy be provided via remote platforms, such as telephone or videoconferencing (British Psychological Society, 2020). Considering arguments for increasingly providing services remotely, such as it being more accessible and flexible with timings (Fleuty & Almond, 2020; Simpson & Reid, 2014), COVID-19 could catalyse a change in the way therapy is provided in the longer-term. Whilst guidelines and recommendations are available for conducting therapy remotely (e.g., British Psychological Society, 2020), empirical support appears limited.

Interventions without a direct interpersonal encounter, such as internet-based therapy and guided self-help⁷, are proposed to have benefits (Abbott et al., 2008) and can be an effective alternative to face-to-face therapy (Andersson, 2018). However, some argue that these interventions are distinguishable from therapy where there is a direct, synchronous interaction with a therapist via telephone or videoconferencing (Berger, 2016). Whilst terminology is debated, remote therapy is defined in this study as therapy that would usually be provided in person face-to-face, that is instead via telephone or videoconferencing.

Weinberg and Rolnick (2020) question whether remote therapy ‘is the same therapy or a different one?’ (p. 5), whilst others suggest that the interaction and intimacies experienced in remote therapy are real, although operate with new dynamics (Essig & Russel, 2017). This raises questions in terms of how psychological therapists experience remote therapy and the impact this has in their management of therapeutic processes, such as the working alliance (WA) and therapeutic boundaries (TB).

A pan-theoretical concept, Bordin (1979)⁸ defined the WA as comprising three aspects: 1) goal(s), 2) task(s), and 3) bond. Considered a common factor in therapy, the WA accounts for a significant proportion of therapeutic change (Horvath et al., 2011; Wampold, 2015). A positive association between WA and treatment outcome when using remote modes of therapy has been reported⁹, although this was based on

⁵ See extended paper section A.1. for further information on *COVID-19*.

⁶ See extended paper section A.2. for further information on *Mental Health Service Provision During COVID-19*.

⁷ See extended paper section A.3. for information about different *Methods of Online and Remote Psychological Therapy*.

⁸ See extended paper section A.6. for further information on the *Working Alliance and Bordin’s (1979) Theory*.

⁹ See extended paper section A.6.1 for further information on the *Working Alliance and Remote Therapy*.

'minimal therapist' interaction (Anderson et al., 2012) or text-based interventions (Cook & Doyle, 2002), whereas others have failed to establish this link (Knaevelsrud & Maercker, 2006). In their systematic review of videoconferencing psychotherapy, Norwood et al (2018) concluded that the WA was inferior in videoconferencing compared to face-to-face, although acknowledged that this may have been affected by therapists' lower ratings, which was not the case for clients. Furthermore, one study where therapists rated the WA lower in videoconferencing therapy involved therapists watching recorded sessions (Rees & Stone, 2005), thus lacking ecological validity. Nevertheless, these findings do not explain which aspects of the WA therapists' experienced differently when working remotely.

Furthermore, the WA is said to be governed by the boundaries¹⁰ of therapy, which differentiate it from a social or business relationship (Knapp & Slattery, 2004). Boundaries are said to guide the therapeutic relationship by regulating the therapist's and client's behaviour which, in turn, maximise outcome and minimise harm. Drum and Littleton (2014) propose that despite the increasing use of technology in mental health provision, little to no attention has been paid to TB in telepsychology relationships, arguing that therapists are likely to be presented with novel boundary issues when working remotely¹¹. Despite Drum and Littleton's (2014) recommendations for managing TB when working remotely, these are not empirically supported, and therapists' experience of boundaries remains unknown.

Finally, how therapists experience their work when working remotely has not previously been considered. Therapist work involvement patterns¹² were first described by Orlinsky and Rønnestad (2005) who, through factor analysis, identified two independent second-level scales to describe therapists' work experience: Stressful Involvement (SI) and Healing Involvement (HI). Stressful involvement reflects a therapist's experience of "frequent difficulties" during sessions, unconstructive "avoidant coping", and in-session feelings of "boredom" and "anxiety". Alternatively, therapists with high levels of HI are said to be "accommodating", "invested", and "affirming", have deeply attentive interest or "flow" during sessions, and "constructive coping" when difficulties arise. Work involvement patterns have been related to therapists' ongoing professional development and satisfaction (Orlinsky & Rønnestad 2005), engagement in intersession experiences (Zeeck et al., 2012), and the likelihood

¹⁰ See extended paper section A.7. for a discussion on *Therapeutic Boundaries*.

¹¹ See extended paper section A.7.1. for information on *Therapeutic Boundaries and Remote Therapy*.

¹² See extended paper section A.8. for further information on *Therapists' Work Involvement*.

that their clients will benefit from treatment (Orlinsky & Rønnestad 2005)¹³. However, such research has been based on conventional face-to-face therapy, which raises the question of whether therapists' work involvement patterns and experiences differ when working remotely.

Rationale for Current Study

Considering that therapy via telephone or videoconferencing may change the way therapy is provided in the longer-term, it raises the question of whether remote forms of therapy are the same or different (Weinberg & Rolnick, 2020), and if therapists' experiences and abilities differ when working remotely. The COVID-19 pandemic has provided a natural opportunity to begin investigating this. Therefore, this research aims to investigate the following research questions¹⁴:

- What impact has changing to remote psychological therapy during the COVID-19 restrictions had on psychological therapists' perceived ability to form a working alliance and maintain therapeutic boundaries, and their work involvement?
- How do therapists' perceived abilities regarding the working alliance and therapeutic boundaries relate to experiences of healing involvement and stressful involvement?
- How do psychological therapists experience and manage therapeutic boundaries when working remotely?

Method

Considering the paucity of research, a sequential explanatory mixed-method design¹⁵ was adopted. An online survey collected quantitative, self-report data about therapists' abilities regarding the WA and TB, and their work involvement patterns when working remotely (Phase One). Subsequently, semi-structured interviews explored therapists' experience of TB in remote therapy (Phase Two). Ethical¹⁶ approval was granted by the University of Nottingham Research Ethics Committee. Participation was voluntary with consent gained for both phases of the study.

Critical realism was the adopted epistemological¹⁷ position, which assumes that although data can tell us something about reality, it is not a direct reflection of what

¹³ See extended paper section A.8.1. for *Existing Evidence for Therapist Work Involvement Patterns*.

¹⁴ See extended paper section A.9. for the *Extended Research Questions*.

¹⁵ See extended paper section B.2. for more information on *Mixed-Method Designs*.

¹⁶ See extended paper section B.5. for information on *Ethical Considerations*.

¹⁷ See extended paper section B.1. for further information on *Epistemology* and section B.1.1. for further rationale for *Critical Realism*.

occurs in the real world (Willig, 2013). Critical realism provides a compatible and productive stance for mixed-method research (Maxwell & Mittapalli, 2010; Shannon-Baker, 2016).

Phase One¹⁸

Survey

Considering that this is a novel area of research, the research team created the online survey with new items based on existing definitions and theory. Questions to capture therapists' characteristics, including level of training and theoretical orientation, were included. Items relating to the WA were based on Bordin's (1979) conceptualisation. Items relating to TB were developed based on previous definitions of boundaries (Johnston & Farber, 1996; Smith & Fitzpatrick, 1995); see Table 5 for WA and TB items included. For the WA and TB items, participants were asked: '*Compared to face-to-face therapy session, providing remote therapy during the Covid-19 restrictions has affected...*'. To capture changes in therapists' perceived abilities, a bipolar response scale was used for the WA and TB items to indicate if changes were positive or negative (-5 to 5), including a neutral option to indicate no change. The WA and TB items demonstrated high internal consistency (see Results).

The Therapist Work Involvement Scale (TWIS; Orlinsky & Rønnestad 2005) was used to explore therapists' work involvement patterns based on the two independent dimensions of therapeutic work (HI & SI). Therapists' HI and SI scores were calculated using the equation by Orlinsky and Rønnestad (2005). Based on HI and SI scores, therapists could further be grouped into one of four work involvement patterns: Effective Practice, Challenging Practice, Disengaged Practice, and Distressing Practice. This scale has good internal consistency ($\alpha = .74$ for HI; $\alpha = .66$ for SI; Nissen-Lie et al., 2010) and was used to enable comparisons to existing data in face-to-face therapy. The survey was piloted with two Trainee Clinical Psychologists and amended accordingly.

Sample and Recruitment

Inclusion criteria required psychological therapists to:

- be either qualified or training in a professional therapy role (e.g., psychotherapists, counsellors, psychologists, CBT therapist, specified 'other').
- identify as having predominantly provided psychological therapy in a face-to-face setting prior to COVID-19.

¹⁸ See extended paper section B.3. for further details on the *Study Design: Phase One*.

- have changed from face-to-face psychotherapy to actively providing therapy via phone or videoconferencing to individual clients during COVID-19.
- be confident in reading and speaking the English language, as the survey and interview was in this language.

The survey was advertised on social networking sites¹⁹, including interest groups and pages to recruit therapists from different professional backgrounds and theoretical orientations. The survey was also advertised in the British Psychological Society Division of Counselling Psychology e-letter. To enable snowball sampling, permissions were set for the advert to be shared. The advert provided a link that took participants directly to the survey, where consent and eligibility questions preceded the main survey items. The survey was open from 23rd June 2020 to 14th September 2020. In line with the analysis described below, a power calculation was completed to establish what sample size was needed. To reach statistical power, 112 participants were required ($\alpha = 0.05$; $\beta = 0.9$; Effect size = 0.3).

Analysis

Descriptive statistics were used for therapists' responses to the WA and TB items and work involvement patterns. As this was a new survey, principal component analysis²⁰ (PCA) was completed on the WA and TB items to see if the two construct scales were statistically supported and to establish the internal consistency of the survey.

Pearson's product moment correlation with bootstrapping at 95%²¹ was used to analyse the association between therapists' abilities regarding the WA and TB and their work involvement patterns (HI and SI).

Phase Two²²

Interview Schedule

Consistent with a sequential explanatory design, the focus of phase two and interview schedule were created following analysis of phase one data, with consideration to existing literature. Whilst TB and the WA are related, it was beyond the scope of this project to qualitatively explore both factors. Considering claims that remote working may present novel TB (Drum & Littleton, 2014), phase one survey findings supported this inasmuch that some TB items were experienced differently in remote therapy. Thus, it was decided that phase two would explore therapists'

¹⁹ See extended paper section B.3.2. for further information on *Sample and Recruitment*.

²⁰ See extended paper section B.6.1.1. for further information on *Principal Component Analysis*.

²¹ See extended paper section B.6.1.2. for further information on *Inferential Analyses*.

²² See extended paper section B.4. for further details on the *Study Design: Phase Two*.

experience of TB whilst working remotely. Interview questions were developed, reviewed, and refined by all three researchers. As recommended by Braun and Clarke (2013), two researchers reviewed the first interview to ensure the interview schedule enabled sufficient data to be collected to answer the research question.

Participants and Recruitment

Participants consented in phase one to being contacted for interview. Potential participants were selected using maximum variation purposive sampling (Palinkas et al., 2013), based on the therapist's TB scale score (positive, negative, or neutral), age, and current state of wellbeing. Participants were then contacted and provided with a participant information sheet and consent form for this phase of the study.

Analysis

Thematic analysis²³ was used to analyse the semi-structured interviews, following Braun and Clarke's (2006) six phase approach. The lead researcher transcribed all interviews and subsequently read each transcript twice to increase familiarity with the data before coding. The data were then coded using a hybrid inductive-deductive approach. Data were first coded inductively to enable codes and themes to be identified that were not accounted for by the deductive framework that was subsequently applied, developed from existing literature on TB and data collected from phase one. It was hoped that this approach would generate a comprehensive thematic description of the data (Willig, 2013). A second researcher reviewed the initial coding to ensure the approach was working as intended. Codes were subsequently organised into themes, with initial themes reviewed and refined by two of the researchers.

Researcher's own experiences, beliefs, and values influence and shape the research process and findings. Reflexivity enables the researcher to consider the ways in which their own biases may operate and thus should be managed in the research and its findings (Willig, 2013). The primary researcher regularly recorded thoughts and experiences in a reflexive diary, which was referred to throughout the research process to maintain an awareness of their own potential biases.

Results

Sample Characteristics

Table 4 presents the personal characteristics of the 161 participants that completed the survey, whilst Table 5 reports the mean and standard deviation for

²³ See extended paper section B.6.2. for further information and rationale for thematic analysis in *Phase Two*.

theoretical orientations endorsed. Characteristics for the 12 participants who engaged in phase two is presented in Table 6.

Table 4 *Phase One Sample Characteristics*

Characteristic	Frequency (%)
Gender	
Female	86.9
Male	11.8
Non-binary	1.3
Age	
20-29	15.5
30-39	40.4
40-49	27.3
50-59	11.8
60+	5.0
Qualified/training	
Qualified	81.9
In training	18.2
Professional background	
Psychotherapist	17.4
Psychologist	57.8
Counsellor	14.3
CBT therapist	8.1
Other	2.5
Number of years practicing psychological therapy	
Less than 5 years	32.9
Between 5 and 15 years	46.6
More than 15 years	20.5
Present state of wellbeing	
Quite poor; I am barely managing to deal with things	1.2
Fairly poor; life is pretty tough for me at times	6.8
So-so; I manage to keep going with some effort	24.8
Fairly good; I have my ups and downs	35.4
Quite good; I have no major complaints	23.0
Very good; I get along much the way I would like to	8.7

Note. 'Other' professional backgrounds included: suicide prevention worker; psychological wellbeing practitioner; mentalization based treatment practitioner; and social worker.

Table 5 *Mean and Standard Deviation for Each Theoretical Orientation*

Theoretical Orientation	Mean	Standard Deviation
Psychodynamic	2.81	2.87
Behavioural	5.68	3.46
Cognitive	6.24	3.12
Humanistic	4.03	3.62
Interpersonal	3.87	3.29
Integrative	3.99	3.32
Systemic	6.30	3.79
Other	2.40	3.75

Note. Therapists reported how much their work was guided by each theoretical orientation on a 10-point scale (0 = 'not at all'; 10 = 'very greatly'). 'Other' theoretical orientations included: Acceptance and Commitment Therapy, Compassion Focused Therapy, Dialectical Behaviour Therapy, and Mindfulness Based Therapy.

Table 6 *Phase Two Sample Characteristics*

Participant	Profession	Gender	Age range	TB scale score	Wellbeing score
Derek	Psychotherapist, qualified	Male	60+	4.17	6
Victoria	Psychologist, qualified	Female	30-39	1.33	5
Susan	Psychotherapist, qualified	Female	30-39	0.33	5
Jayne	Psychotherapist, in training	Female	50-59	0.17	4
John	CBT Therapist, qualified	Male	60+	-0.33	4
Kimberley	Counsellor, qualified	Female	30-39	-0.33	5
Emily	Psychologist, in training	Female	20-29	-0.50	1
Danielle	Psychologist, qualified	Female	30-39	-1.33	4
Amy	Psychologist, in training	Female	20-29	-1.83	3
Katie	Psychologist, in training	Female	20-29	-1.83	5
Mandy	Psychotherapist, qualified	Female	40-49	-2.00	3
Julie	Psychologist, qualified	Female	40-49	-2.17	5

Note. Therapists were asked to rate their present state of emotional and psychological wellbeing. The criteria were: 1 = 'Quite poor; I am barely managing to deal with things'; 2 = 'Fairly poor; life is pretty tough for me at times'; 3 = 'So-so; I manage to keep going with some effort'; 4 = 'Fairly good; I have my ups and downs'; 5 = 'Quite good; I have no major complaints'; and, 6 = 'Very good; I get along much the way I would like to'.

Phase One Results

Remote Therapy and Therapist Work Involvement Patterns

Involvement patterns found in this study were compared to findings from traditional face-to-face therapy (Orlinsky & Rønnestad 2005), as seen in Table 7; percentages in a larger sample ($n = 12590$) are near identical (D. Orlinsky, personal communication, October 21, 2020). In this sample, the TWIS demonstrated good internal consistency ($\alpha = .78$).

Table 7 *Frequency of Work Involvement Patterns*

Healing Involvement	Stressful Involvement			
	Little (≤ 4.75)		More than a little (> 4.75)	
	Effective Practice		Challenging Practice	
Much (> 9.55)	Face-to-face	Remote	Face-to-face	Remote
	50%	37%	23%	62%
Not much (≤ 9.55)	Disengaged Practice		Distressing Practice	
	Face-to-face	Remote	Face-to-face	Remote
	17%	0%	10%	1%

Experiences of the Working Alliance and Therapeutic Boundaries

Responses to the WA and TB survey items are presented in Table 8.

Table 8 Mean and Standard Deviation for the Working Alliance and Therapeutic Boundary Survey Items

Survey item	Item topic	Mean	Standard deviation
My ability to effectively communicate nonverbally with my clients	WA*	-2.04	2.62
My ability to gauge my client's implicit communications	WA*	-1.47	2.40
My ability to gauge my client's emotions	WA*	-.92	2.29
My ability to only work during my working hours	TB**	-.86	2.51
My ability to stop thinking about my client's problems in the time between therapy sessions	TB**	-.78	2.36
The therapeutic boundary issues I experience as a therapist	TB**	-.46	1.95
My ability to attune with my clients	WA*	-.41	2.17
My ability to effectively manage my client's risk	TB	-.30	1.90
My ability to effectively manage ruptures in the therapeutic relationship	WA*	-.21	2.06
My ability to maintain concentration on the client and/or task	WA*	-.19	2.47
My ability to build a sense of trust with my clients	WA*	-.11	2.18
My ability to effectively communicate verbally with my clients	WA*	-.01	2.26
My ability to maintain therapeutic boundaries with my clients	TB**	.02	1.94
My ability to create risk management plans	TB	.04	1.67
My ability to maintain a consistent space where I engage in therapy	TB**	.12	2.37

Table 8 cont.*Mean and Standard Deviation for The Working Alliance and Therapeutic Boundary Survey Items*

Survey item	Item topic	Mean	Standard deviation
The amount that I self-disclose to clients	TB**	.18	1.64
My ability to establish a therapy contract with the client	TB**	.20	1.81
The way I contract with clients	TB**	.20	1.84
My ability to be empathic towards my clients	WA*	.27	2.03
My ability to work in collaboration with my clients to achieve their goals	WA*	.40	2.08
The length of agreed therapy sessions	TB	.53	2.10
The way I explain the limits of confidentiality	TB	.54	1.75
My ability to be compassionate towards my clients	WA*	.60	2.04
My ability to attend appointments on time	TB	1.32	2.15

Note. * items included in the 'WA scale' following PCA; ** items included in the 'TB scale' following PCA.

Principal Component Analysis

Principal component analysis²⁴ supported two separate components: 1) a 'working alliance' component scale including all eleven WA survey items ('WA scale'), and 2) a 'therapeutic boundary' scale with eight items ('TB scale'; see Table 5 for TB items included). Both the WA and TB scales demonstrated excellent reliability, with internal consistencies at .96 and .90, respectively²⁵.

Associations Between Therapists' Perceived Abilities and Work Involvement

Considering therapist work involvement patterns, HI positively correlated with therapists' perceived abilities regarding the WA, $r(159) = .478$; $p < .01$; 95% CI [.327, .595], whereas SI negatively correlated, $r(159) = -.356$; $p < .01$; 95% CI [-.493, -.218]. Similarly, HI positively correlated with therapists' perceived abilities regarding TB, $r(159) = .369$; $p < .01$; 95% CI [.215, .498], while SI negatively correlated, $r(159) = -.370$; $p < .01$; 95% CI [-.493, -.218].

Phase Two Findings

Four overarching themes were identified: (1) different boundaries in remote therapy, (2) work home boundary, (3) changes in the therapeutic safe space, and (4) impact of boundaries when working remotely. Data were organised into subthemes where there were clear distinctions between subthemes²⁶.

1) Different Boundaries in Remote Therapy

Therapists described changes to therapeutic boundaries, specifically relating to the type of boundaries experienced in remote therapy and their ability to engage with boundaries; hence, two subthemes were created: 'different boundaries' and 'ability to maintain boundaries'.

Different Boundaries. Whilst some boundaries remained unchanged from face-to-face therapy, others were experienced differently, such as what could be explored in therapy:

It's really really shrank the therapy to more of a check in... therapy in terms of how you would normally experience it or imagine it... So, like I said it's mostly checking in, how is she doing you know, we might do some mindfulness, short meditation, or something like that to support her. (Jayne)

As Jayne indicated, therapy was described by many therapists as being restricted to a "check-in", "stopgap", or a "chat" rather than what would usually be

²⁴ See extended paper section C.1.1. for results of the *Principal Component Analysis*.

²⁵ See extended paper section C.1.1.1. for results of *Reliability of The Component Scales*.

²⁶ See extended paper section C.2. for further discussion and quotes from the *Phase Two* findings.

explored, limiting the boundaries of what could be discussed and the content of therapy sessions. For some, the change was acknowledged at a service level, appearing to legitimise and perhaps relinquish therapist's individual responsibility for the changes in therapy: "the service I worked in, it was quite normalised that therapy felt like it was no longer therapy" (Katie).

Changes in the formality of the therapeutic encounter were also described: "it felt like I was being treated a bit like a FaceTime call, like if you were just chatting with your mate" (Danielle). Danielle described these changes in relation to the nature of the therapist-client relationship, with it feeling less like a formal, professional discussion that would typically happen between a therapist and client. Again, these changes appeared to reflect the content of sessions rather than what are typically considered structural (Smith & Fitzpatrick, 1995) or logistical (Johnston & Farber, 1996) boundaries, such as time or location. Furthermore, this change in formality was also described regarding how clients appeared to push the boundaries of therapy:

A client who is complaining that she's had a very hard day and, therefore, she's going to conduct the session sitting on the bed with a glass of wine...that for me is about remembering what it is that we are doing, that this is a formal psychotherapy session and not chatting. (John)

John described how changes in boundaries resulted in the opportunity for clients to present with novel behaviours that would not typically occur in the formal context of therapy. Changes also indicated a loss of boundaries, such as the use of resources as well as access to colleagues to help with managing boundaries. The most common reflection was about the loss of access to client's body language:

Not being able to monitor like people's body language and their reactions and responses to things... we get a sense in the room if you're pushing someone too far and how they're responding to it which is so much harder to gauge over the phone. (Katie)

As suggested by Katie, therapists appeared to use client's body language to guide their boundaries, with the loss of this resource presenting a potential barrier to establishing boundaries. Contrastingly, remote therapy provided new opportunities and was perceived as broadening the boundaries of therapy, specifically regarding location and physically accessing therapy. Remote therapy was considered more accessible for clients whom there may be physical or language barriers. For example, Kimberley reported being "Russian speaking... and more people could reach me online from my country of origin". Alternatively, some therapists described how remote therapy

provided “insight into how people live” (Danielle) or “a whole new avenue of exploration” (Susan), which would not typically be available in face-to-face.

Ability to Maintain Boundaries. Therapist’s ability to maintain boundaries varied with some finding “boundaries a lot harder to maintain” (Katie), whereas others noticed being “able to do that with ease” (Mandy). Whilst the type of boundaries varied in relation to therapist’s ability to maintain them, half of participants acknowledged an increased difficulty managing self-disclosure:

So, I’m having to work harder at that again because the natural tendency is to kind of start telling everyone much more about my life because I feel like they can see it and know a lot of it anyway. (Victoria)

Victoria acknowledges how the increased difficulty with self-disclosure may relate to the environment in which she provided therapy from. Contrastingly, the variability in being able to maintain boundaries was attributed to the mode of therapy used:

I feel more easily able to do that face-to-face on video, I feel like video is still not as good as face-to-face...when someone opts for just telephone, I have that sinking feeling of arghh... almost in my head I have this hierarchy of what’s better and what’s worse. (Amy)

Amy’s proposed hierarchy could be considered regarding the amount of access to client’s body language, with access gradually reducing from face-to-face, to videoconferencing, and then telephone.

Different strategies for managing boundaries were proposed, with the most common being contracting boundaries more explicitly with clients from the beginning of therapy and returning to this if needed. When boundaries were unable to be maintained, this resulted in the suspension or rescheduling of the therapy session or, on occasion when they were enforced, resulted in premature termination of therapy: “I think she was so offended that I cut her off mid-stream that she refused to come back again” (Derek).

When considering how they managed or maintained boundaries, several therapists described a period of adjustment to the different experiences. For example:

I think a lot of the initial transition things are now done. I am in this room and this is how it’s going to be, it’s not going to change unless, until we can go back to face-to-face. (Jayne)

Nevertheless, most therapists reported using supervision and reflection with others. These strategies provided a normalising experience for therapists but also

opportunities for learning how to manage therapeutic boundaries: “having a discussion about what it’s like working remotely, maybe share ideas about how to make things a bit easier, even if it’s just different things like practical things” (Susan).

2) *Work Home Boundary*

Therapists observed a blurring of the boundary between home and work, describing difficulty separating their home and work lives: “I think there’s been a lot more leakage for the want of a better word. It’s very hard to be professional Emily in home Emily’s setting” (Emily). This blurring was attributed to not having a commute or physical distance between home and work and resulted in therapists struggling to switch off from work: “and then you’re just appearing back into family life...I can’t quite deal with that yet because I’ve still got this stuff just, I’m still mulling over this in my head” (Julie).

Aspects of therapist’s personal lives, such as having to consider their family, were now also part of their work experience, adding to this blurring of work-home boundaries. Contrastingly, for Derek who usually provided face-to-face therapy from home, described remote therapy as feeling more “neutral” because clients were “not having to come into my space and be aware of my wife or see the kids”.

To cope with this blurring, several therapists described strategies to separate their experiences. Some replicated behaviours that they would do when working face-to-face, such as “I put my badge on when I’m at work even though I don’t technically need it” (Emily), or having to organise their personal lives so that there were fewer personal experiences in their work. Alternatively, several therapists created a physical space that they could work from to maintain a work-home transition:

I have got a loft, so I go up through, there’s like two doors closed when I go up into the loft...that’s something that I’ve had to really consider actually, where to do the therapy from... I think it’s just a decompression chamber I suppose, or a decompression space, you know, just to let that go and come back into me.
(Jayne)

Jayne describes how, as well as deciding where to do therapy from, having a physical separation and distance between her home and workspace enabled her to maintain this boundary.

3) *Changes in the Therapeutic Safe Space.*

Changes to the therapeutic space were observed regarding the physical space in which the therapy would take place as well as external disruptions and distractions that the therapist-client dyad encountered. Therefore, two subthemes were created: ‘therapeutic safe space’ and ‘disruptions and distractions’.

Therapeutic Safe Space. Therapists acknowledged the need for a safe space in therapy, with it being considered a “boundary issue” (Derek) when this was not possible. In face-to-face therapy, this was considered the therapist’s responsibility whereas remote therapy required a shift in responsibility from the therapist to the client, as Mandy described how “zoom invites there to be a request that the client be in control of that and for some clients that’s very easy but for other clients that’s not”. Mandy described how clients varied in their ability to manage this responsibility, potentially posing challenges for therapists in ensuring a safe space. Although not a view embraced by all, Katie proposed that this difficulty may have arisen from the therapist and client having different perceptions of what a safe space might be:

I guess you would ask at the beginning of the session like are you somewhere private and where you are able to talk but I guess they have no frame of reference of what it is that we might be talking about...as a therapist we have some kind of frame of reference that what sort of questions we might ask or what sort of things we might ask the client to be sharing.

Without being aware of what may be explored in therapy, Katie suggests that clients may not have that shared value in having a safe space in which to do therapy from.

Disruptions and Distractions. Therapists experienced the therapeutic safe space as also being affected by external distractions and disruptions that, whilst they happen in face-to-face therapy, are less predictable and controllable: “there’s a bit of being surprised by time to time by how the outside world bleeds into the therapeutic environment”. John described how such distractions may unexpectedly permeate therapy. Other disruptions related to technology issues:

If we know that the broadband is likely to be an issue the worst thing is if you’re mid-EMDR session, someone could be really quite uncontained, really quite distressed and you can’t then shut it down, you can’t contain it...if I don’t think that I can do that safely, I won’t start. (Danielle)

Danielle described how such technology disruptions may affect the safety of the therapeutic space and impact what therapy can be provided when technology stability cannot be assured. Some suggestions to manage this were proposed in terms of services being set up to safely address these challenges, as highlighted by Amy stating, “our team specifically has a certain bundle of money that is coming in to help people that don’t have access to technology or consistent technology”.

4) *Impact of Boundaries When Working Remotely.*

This theme highlights the noticeable effects that therapeutic boundaries when working remotely had on the therapists themselves, the clients, and the therapeutic process as captured in the following three subthemes: 'impact on therapists', 'impact on clients', and 'therapy process'.

Impact on Therapists. Most therapists noticed an increased awareness and effort in managing therapeutic boundaries. Nevertheless, despite an increased effort, most therapists spoke about being less present in the therapy because of all the additional considerations when working remotely:

I suppose it was that boundary for me as a therapist, you know, and as someone that is there fully, kind of investing fully kind of, you know, fully within the session... Whereas I was well aware that I'm saying to them, there might be noises in the background and there might be distractions and telling someone almost my attention at times is going to be pulled elsewhere. (Julie)

All therapists described the unpleasant emotional impact on themselves and on their wellbeing because of the different boundary experiences when working remotely, feeling "embarrassed", "frustrated", "uncomfortable", "angry", and "awkward". The intensity of this emotional impact varied depending on the boundary experience. John described being "slightly embarrassed" when there was a "friendly gardener outside whistling loudly". Whereas Danielle described a more intense experience because of the space in which she was providing therapy stating:

I felt like I needed to sort of almost say this is not my bedroom, you are not looking a place where I go to sleep every night... it's a very intimate, personal space and it, to be able to look at somebody's bed... I just felt really uncomfortable.

Furthermore, several therapists described a feeling of self-doubt in their ability to do therapy, as indicated by Susan saying, "it leaves me questioning myself as well, it leaves me questioning if there's anything I could have done differently".

To cope with the impact on themselves as therapists, most described an increased awareness to look after their own wellbeing. For some, this involved a period of rebalancing, particularly following a difficult therapy session:

If I'm face-to-face and driving, I have got so many minutes before I get home to kind of debrief and err re-group... so, getting back into my own body, feeling like in my own skin, if it's been particular difficult session what might I have that

is still lingering... I have learned that I need to do that, it's got to be part of a routine, I've got to spend time to decompress. (Jayne)

Impact on Clients. Changes to boundaries impacted clients' engagement: "I would say it's a huge impact because first they're distracted and, second, they're either silent or saying something not relevant at all" (Kimberley). The main inhibitory mechanism appeared to be clients' awareness of others being present in their therapeutic space, as Susan reported "the impact of other people being around is that they become more cautious about what they say, how they word it, and whether it's safe". However, Derek noticed that this varied between clients depending on how comfortable clients felt:

They look more comfortable and less self-conscious... it means that things can go deeper quicker... in this more informal atmosphere perhaps it speeds that process up. There's a trust involved. I guess in contrast to that, I think some people have remarked that, you know, it can be more difficult to work at depth.

Therapy Process. Altered boundary experiences had varying impacts on the therapy relationship and the perceived quality of work:

It felt very much like she was showing me that she understands what we've been working towards and she gets it... Silly example but a good one actually of I think a moment in the therapeutic relationship that probably would never have happened if we weren't doing video calls. (Danielle)

Danielle described an opportunity arising from the changed boundary, enabling a novel communication between her and her client. Alternatively, potential negative impacts are best demonstrated by Jayne:

I think it's reduced it, there's less, there's just that presence of having somebody in the room which is lost. I think it can be done virtually, and we are doing it virtually, it can be beneficial, can be therapeutic, it is working but I think we've lost something. (Jayne).

Her experience indicates a loss of intimacy by being bereft of her clients' physical presence, whilst still perceiving remote therapy as "working". Finally, therapists described changes in the focus and quality of the therapeutic process:

It makes your sessions, all the therapeutic process longer and longer and maybe has less results... It's about quality probably and about processes,

about the progress of the process because if you're distracted with the child or a dog or I don't know. (Kimberley)

Kimberley attributed such changes to the quality of work to the altered boundaries experienced in remote therapy, indicating a loss of intensity to the therapeutic process because of being less focused.

Synthesis of Phase One and Phase Two Findings

Phase one highlighted that therapists experience the WA and TB differently when working remotely, although this varied amongst therapists. Therapists' experience of their work also differed to face-to-face therapy, as indicated by the increased rates of SI. Phase two findings further explained and supported phase one TB findings, whilst also providing possible explanations for the work involvement patterns.

The varied TB experiences reported in the survey were supported by the interview inasmuch that whilst therapists experienced changes in what could be explored in therapy and the loss of some boundaries, remote therapy offered new opportunities and boundaries. Considering previous definitions of TB (Johnston & Farber, 1996; Smith & Fitzpatrick, 1995), changes described appeared to reflect content and conceptual changes rather than structural or logistical. Furthermore, whether the differences in phase one were experienced as positive or negative may also be explained by therapist's perceived ability to maintain boundaries, which varied depending on boundary type and mode of remote therapy used, as described in phase two.

The survey indicated that therapists experienced their ability 'to only work during my working hours' and 'to stop thinking about my client's problems in the time between therapy sessions' as being negatively impacted by working remotely. This was supported by the interviews where therapists described a blurring between their work and home boundary and their ability to 'switch off' from work.

Finally, the different frequencies of work involvement patterns in this study indicated an increase in SI experiences. This is supported by interview findings where therapists described unpleasant emotional experiences and self-doubt as an effect of the different therapeutic boundary experiences.

Discussion²⁷

Prior to Covid-19, the provision of healthcare services was moving toward the use of digital technologies (NHS, 2019; Roland et al., 2020; Topol Review, 2019).

²⁷ See extended paper section D.1. for further discussion on the *Study Findings in Relations to Existing Literature and Theory*.

These novel findings provide insight into aspects of remote therapy that therapists experience differently to conventional face-to-face settings and may need consideration within service design and delivery, particularly experiences perceived negatively that may impact therapists' work involvement.

The finding that therapists experience some facets of the WA differently compared to face-to-face therapy is consistent with previous research (Norwood et al., 2018; Rees & Stone, 2005). Nevertheless, considering Bordin's (1979) proposed three aspects of the WA, whilst previous studies have indicated that there is a difference in therapists' experiences, they have not explained what those differences might be for therapists. This study highlights that while therapists have difficulty using nonverbal communication and gauging client's implicit communications, their perceived ability to work with clients on their goals was not negatively affected. This may indicate changes in the WA being more focused on 'task' and 'goals' to counteract for possible changes in 'bond' due to the loss of nonverbal communication, which has also previously been considered with internet delivered therapies (Berger, 2016).

This study supported Drum and Littleton's (2014) argument that novel boundaries are present in remote therapy, whilst providing insight into what these boundaries are. Despite therapists indicating that they were able to focus on the therapeutic goal, qualitative findings highlighted therapists experienced a reduction in what could be explored in remote therapy due to difficulty gauging what was safe to explore and changes to the therapeutic safe space. Similarly, many people receiving mental health support remotely reported fearing being overheard by others, inhibiting what they would share with the therapist (Mind, 2021). Despite a loss of boundaries when working remotely, the findings supported previous claims that remote therapy provides new opportunities, particularly making therapy more accessible for clients (Simpson & Reid, 2014).

Furthermore, therapists described an increased awareness of their self-disclosure. Zur et al (2009) conceptualised 'unavoidable self-disclosure', referring to disclosures that are not deliberate or avoidable and how the presence of such self-disclosure may relate to the therapy setting. Qualitative findings in this study may be taken to indicate that therapists who typically worked from a clinic noticed an increased awareness of and effort in managing self-disclosure, whereas therapists who usually worked from home may have experienced a reduction in unavoidable self-disclosures.

A key finding related to the blurring of therapist's work-home boundary, a concern previously raised by therapists using an interactive platform (Richards et al., 2018). Therapists would find themselves thinking more about work during their non-working, 'home' time and an increased opportunity to work outside of their hours, which

has previously been considered a potential boundary crossing (Lustgarten & Elhai, 2018). Therapists described difficulty 'switching off' from their work by continuing to think about therapy or their clients in the time between therapy, a process previously conceptualised as 'intersession experiences'. Therapists' intersession experiences have been related to experiencing difficulties in practice (James et al, in press) which may result in a blurring of the work-home boundary for therapists. Nevertheless, in their systematic review, James et al (in press) suggest that using intersession experiences can lead to a process of discovery for therapists to overcome such difficulties, such as in supervision.

Furthermore, therapists described the unpleasant emotional impact and self-doubt they experienced when working remotely. Feeling 'discouraged' in the time between therapy sessions has positively associated with and found to predict levels of SI (Zeeck et al., 2012). This could potentially explain the higher SI rates in this study compared to therapists in face-to-face therapy, which is characterised as experiencing frequent difficulties in practice, feelings of anxiety and boredom, a sense of inadequacy regarding their skills, and engaging in avoidant styles of coping (Orlinsky & Rønnestad 2005;). Recognising the association between work involvement patterns and therapists' burnout (Steel et al., 2015; Zeeck et al., 2012) and the likelihood that clients will benefit from treatment (Orlinsky & Rønnestad, 2005), has implications for clinical practice when therapists work remotely.

Clinical Implications²⁸

Despite COVID-19 resulting in the provision of therapy moving to remote methods, therapists will inevitably be able to return to face-to-face settings. Acknowledging the reported differences in clients' and therapists' ratings of the WA in videoconferencing psychotherapy, clients' ratings are considered most important in relation to therapy outcome (Norwood, 2019), although in face-to-face therapy therapists who generally form better WA irrespective of client factors achieve better outcomes. Gaining client feedback has repeatedly been shown to effect outcome (Duncan, 2010). Therefore, when working remotely, systematically gaining client feedback on WA may be a helpful means to monitoring the relationship and potential outcome.

Furthermore, whilst we do not know the extent of the impact on therapists or therapeutic process and outcome, therapists should be aware of the potential impact of working remotely, including therapist burnout and to client outcomes. Supporting therapists with skill development in remote therapy and with their currently experienced

²⁸ See extended paper section D.2. for further discussion on *Clinical Implications*.

growth increases Healing Involvement (Duncan, 2010). The TWIS could be used as self-reflection tool, supporting therapists development in the realm of remote therapy. Therapists in this study also reported using supervision and peer discussions to normalise and validate their experiences. Similarly, supervision was also proposed by James et al (in press) to process emotionally unpleasant intersession experiences and aid the therapeutic process.

Regarding therapeutic boundaries, therapists described a change in the formality of therapy when working remotely indicating a possible shift in the nature of the therapist-client encounter. Recognising that boundaries help differentiate the therapeutic relationship from that of a business or social relationship (Knapp & Slattery, 2004), therapists described the importance of establishing a clear therapeutic contract from the outset that they could return to if boundaries were to slip; thus, potentially helping therapists avoid boundary crossings or violations.

Limitations²⁹

Although the phase one sample size is of adequate statistical power, more psychologists participated which possibly occurred from recruitment being via the authors' social networking, thus, impacting the representativeness of phase one findings. Nevertheless, steps were taken to overcome this as far as possible by sharing the advertisement on varied sites to attract therapists from different professional background. Furthermore, the cross-sectional nature of phase one does not enable conclusions to be drawn regarding the potentially dynamic nature of therapists' experiences and work involvement when working remotely.

Finally, COVID-19 has been considered to have a psychological impact on peoples' wellbeing which could be a contributory factor in the observed changes in therapists' work involvement patterns. Nevertheless, whilst the psychological impact of COVID-19 was not the focus of this study, therapists' wellbeing was comparable to a large sample of pre-pandemic data on therapists (T. Schröder, personal communication, October 9, 2020).

Conclusion and Future Research

This study provides novel, empirical insights into therapists' experience of the working alliance, therapeutic boundaries, and their work involvement when working remotely. The findings presented support previous claims that therapists experience remote therapy differently compared to face-to-face, raising the following questions for further inquiry³⁰:

²⁹ See extended paper section D.3. for further discussion on the study's *Strengths and Limitations*.

³⁰ See extended paper section D.4. for further *Recommendations for Future Research*.

- What impact do the observed therapeutic boundary and working alliance differences have on therapeutic outcomes when working remotely?
- Do therapists work involvement patterns change over time when working remotely?

Conflict of Interest

No conflicts of interest.

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EXTENDED PAPER

Chapter A: Extended Background

This section provides further background literature, theory, and rationale for the research project presented in the journal paper.

A.1. COVID-19

In December 2019, the first case of COVID-19 was reported in Wuhan, China. COVID-19 is a disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), resulting in symptoms of fever, cough, and loss of sense of smell. As the disease began spreading around the world, it was declared as a global pandemic by the World Health Organisation (WHO) on 11th March 2020. The disease has been understood to spread primarily by nose and mouth secretions produced by coughing, sneezing, and talking. People stood near to someone with the disease could inhale the virus, consequently becoming infected. Furthermore, people could become infected by touching a contaminated surface and then touching their face. To contain the virus globally, as well as specifically in the United Kingdom (UK), countries enforced travel restrictions, lockdowns, work-place requirements where people had to go into their workplace (e.g., wearing personal protective equipment), and the closure of non-essential services.

A.2. Mental Health Service Provision During COVID-19

As well as the impact on individuals' physical health, it has been suggested that the COVID-19 pandemic will cause a psychological health crisis (Salari et al., 2020; Xiang et al., 2020). Considering the social distancing restrictions enforced, the provision of psychological therapy in a face-to-face setting could no longer be provided. This challenged the provision of psychological services (British Psychological Society, 2020), with psychological therapists and mental health services more broadly having to adapt to new ways of working to continue providing care and treatment. The UK government advised that services needed to continue supporting individuals with mental health difficulties, albeit differently and with more flexibility, "particularly by telephone or other digital modes, including videoconferencing, written support, and digitally-enabled programmes" (p.1; NHSX, 2020).

Whilst therapy via telephone has been used for several decades, it has typically been perceived as an adjunct to in-person, face-to-face therapy and is not without its limitations (Mozer et al., 2008; Weinberg & Rolnick, 2020). The provision of therapy via videoconferencing is said to threaten to replace traditional face-to-face therapy (Weinberg & Rolnick, 2020). Furthermore, it is argued that the provision of psychological therapy remotely could be more clinically and economically cost-effective and improve access for individuals for whom attending in person presents a barrier

(Morriss et al., 2019; Mozer et al., 2008). Recognising that the empirical support for providing therapy remotely is limited, COVID-19 presents a natural opportunity to investigate this provision and various therapeutic factors that have widely been investigated in traditional face-to-face settings.

A.3. Methods of Online and Remote Psychological Therapy

It is worth acknowledging that there are several methods of providing therapy remotely using different technologies. Existing literature uses various terms, such as 'telepsychology' and 'telepsychotherapy'. These have been used as an umbrella term to describe psychological services being provided via modes such as email, telephone, text, videoconferencing, mobile applications, and web-based programs (America Psychiatric Association, 2013). Although focused on internet-based treatments, Berger (2016) distinguished between three categories of remote therapy largely depending on the level of therapist involvement: (1) unguided self-help, such as using the internet for information with no therapist contact during the intervention, (2) guided self-help, including the provision of a self-help program with minimal but regular therapist contact, and (3) remote therapy, such as email, chat, and videoconferencing, where the technology is used exclusively as a communication medium between the therapist and patient (conceptualised in this way, this would also include therapy via telephone). A further distinction is made between modes of psychological treatment that are synchronous (i.e., occurring in real-time) or not. For example, text and emails are modes of asynchronous communication, whereas audio or video-based communications provide a real-time interaction between therapist and client. Furthermore, Weinberg and Rolnick (2020) argue that despite the evidence for interventions without an interpersonal encounter between therapist and client, these offer a different form of intervention and have different qualities to those with a face-to-face (either in one room or via videoconferencing) or human-to-human, synchronous encounter. Empirical research into therapists' experience of remote psychological therapy where there is a real-time experience is lacking (Weinberg & Rolnick, 2020). Therefore, remote therapy in this study refers to the use of telephone or videoconferencing as an alternative to face-to-face, in person therapy sessions.

A.4. Remote Therapy and Theoretical Orientation

It has been proposed that remote therapy poses challenges for some therapists who practice from certain theoretical principles, specifically for treatments more focused on the therapeutic relationship (Weinberg & Rolnick, 2019). Recognising that therapeutic modalities use different interventions and processes, professional organisations have provided advice on adapting approaches to working remotely during COVID-19, including Cognitive Behaviour Therapy (CBT), Eye Movement

Desensitisation Reprocessing (EMDR), Systemic, and Psychodynamic (British Psychological Society, 2020). However, therapists' experience of working remotely from different theoretical orientations has not been considered empirically, and whether their experiences differ or not regarding therapeutic processes.

A.5. Therapeutic Outcomes, the Working Alliance, and Therapeutic Boundaries

The positive association between the working alliance (WA) and client outcomes has repeatedly been supported, with the overall aggregated relationship between the alliance and treatment outcome being $r = .275$ (Horvath et al., 2011); this is supported by a more recent meta-analysis reporting the overall alliance–outcome association as $r = .278$. (Flückiger et al., 2018). This contrasts with the one percent variability in treatment outcomes being due to treatment modality or therapy (Wampold & Imel, 2015). The establishment of the WA is said to be guided by therapeutic boundaries (TB), which is recognised across all therapeutic models (Brown & Stobart, 2018; Zur, 2007). Recognising the importance of rapport and warmth in relation to therapeutic outcomes, Zur (2004) argues that rigidity of boundaries is uncondusive to healing. Similarly, Audet (2011) found that clients experiences of self-disclosure, a recognised boundary dilemma, had a positive impact on the therapeutic relationship by reducing the inherent power differential. Therefore, whilst boundary violations are unethical and likely illegal, boundary crossings may enhance the WA and therefore therapeutic outcomes, when executed with the clients' interests in mind.

The relationship between the WA and TB with therapeutic outcomes has mostly been established within face-to-face therapy. Comparisons between face-to-face and videoconferencing therapy have been explored in relation to therapeutic outcomes, reporting no significant differences between conditions (Stubbings et al., 2013; Yuen et al., 2015). Whilst Yuen et al (2015) considered patient satisfaction, the impact of therapeutic processes, such as the WA or TB, were not explored. Stubbings et al. (2013) did explore potential differences between the WA and treatment conditions, reporting no significant differences, but did not explore the relationship between WA and therapeutic outcome in each condition. Furthermore, neither study considers the impact of therapist effects across both conditions, despite the magnitude of therapists' contribution to the alliance-outcome association being greater than patients' contribution (Wampold & Imel, 2015). Nevertheless, scepticism and concerns regarding the WA and TB in remote therapy have been discussed and explored in existing literature (which will be discussed below). This study aims to explore this scepticism by understanding therapists' perceptions of the WA and TB in remote therapy.

A.6. Working Alliance and Bordin's (1979) Theory

Freud (1913) originally considered the concept of 'alliance' in therapy, referring to the relationship between the therapist and client (Horvath & Greenberg, 1994). Within the psychodynamic tradition, a successful alliance was proposed to be the foundations for which transference, and therefore therapeutic change, could occur. It later became widely acknowledged that different therapies produced comparable outcomes despite their premises, assumptions, and techniques differing (Horvath et al., 2011). Within psychotherapy, this raised questions about which elements of therapy accounted for change, with the direction of research subsequently being focused on the relationship between client and therapist as a common factor to all forms of therapy (Wampold & Imel, 2015).

Bordin (1994; 1979) proposed a pan-theoretical conceptualisation of the working alliance (WA) that is widely accepted (Nissen-Lie et al., 2010). The theory proposes that the WA consists of three aspects: 1) an agreement about change *goals*, 2) the execution of *tasks* to move towards these goals, and 3) the establishment of *bond* to maintain the work. Bordin (1994) differentiated goals and tasks by conceptualising goals as a statement of what the client wants to change, whereas tasks refer to the specific activities used to instigate or facilitate change. Furthermore, collaborating with the patient to identify the change goal that most fully captured their difficulties is considered a key part of building a strong therapeutic alliance. Regarding bond, Bordin (1994) described how it is "likely to be expressed and felt in terms of liking, trusting, respect for each other, and a sense of common commitment and shared understanding in the activity" (p. 16). The WA is understood as a collaboration between the therapist and client, which integrates relational and technical aspects. Nevertheless, the alliance does not account for outcome in and of itself but is understood as an "interactive element that is synergetic with the therapeutic tasks used" (p.2 Horvath & Greenberg, 1994). Exploration of the different constructs of the WA in face-to-face therapy indicated that agreement on goals and task were predictive of outcome whereas bond was not (Webb et al., 2011).

There is now extensive evidence supporting the WA as a common factor in psychotherapy process and outcome research (Flückiger et al., 2018; Horvath et al., 2011; Wampold, 2015). As such, aspects of Bordin's theory can be identified in the generic model of psychotherapy (Orlinsky, 2009). Furthermore, there is evidence that the WA varies throughout treatment phases and the establishment of a positive alliance early in therapy is the best predictor of outcome (Ardito & Rabellino, 2011). However, considering the provision of therapy remotely as a relatively new construct, the evidence supporting the need for a good WA is predominantly based within face-to-

face therapy settings. There is a paucity of research for the WA in remote therapy settings, which will now be discussed.

A.6.1. Working Alliance and Remote Therapy

Similar to face-to-face therapy, most research into the WA in remote therapy has focused on client and therapist ratings of the WA for different therapies and presenting problems, although the evidence is still limited compared to face-to-face. In a randomised control trial, Watts et al. (2020) reported therapy via videoconferencing to have not interfered with the development of the WA compared to conventional face-to-face therapy. However, a recent meta-analysis reported inferiority of the WA in therapy via videoconferencing compared to face-to-face, which was established by combining therapist and client ratings (Norwood et al., 2018). Therapists have been found to rate the WA lower than clients in earlier sessions (Simpson & Reid, 2014) which, therefore, may skew these results. Nevertheless, this does not consider why therapists rate and experience the WA differently in earlier sessions. Comparable ratings of the WA have also been reported when face-to-face CBT was compared to a telephone CBT condition (Stiles-Shields et al., 2014), which was also supported by a systematic review exploring the 'interactional differences' between telephone and face-to-face therapy, including the WA (Irvine et al., 2020). However, most of these studies only focused on CBT.

Despite ratings of the WA being comparable, therapists have been reported to be sceptical about the quality of the relationship when working remotely, and to be less comfortable with remote therapy compared to clients (Watts et al., 2020). Considering psychologist's perceptions of the WA in therapy sessions via videoconferencing, Rees and Stone (2005) concluded that psychologists rated the therapeutic alliance in the videoconferencing condition lower than the face-to-face condition. However, in this study the psychologists watched recorded sessions which may question the ecological validity. Still, this does not explain what aspects of the WA therapists experience differently in remote therapy. Qualitatively, reservations have been reported about the absence of non-verbal cues and the impact this has on the alliance in telephone therapy, although this was found to not be a focus of concern by Bee et al. (2016) in their qualitative exploration of CBT therapists' narratives about telephone therapy.

Qualitative exploration of therapists' experience of the WA concluded that, despite initial scepticism, the development of the WA was possible via therapy delivered 'online', although it was thought to be easier developing the alliance in face-to-face therapy (Bengtsson et al., 2015). However, considering that the WA is considered a 'common factor' to all forms of therapy, this study only focused on

therapists providing internet-based CBT. This raises the question of therapists' experience of the WA, irrespective of theoretical modality.

Furthermore, current evidence of therapists' experience of working remotely following the COVID-19 pandemic indicated that whilst most therapists thought that remote therapy had been effective, it had changed the alliance (McBeath et al., 2020). This change was proposed to reflect a possible shift in the dynamics between therapist and client, due to the client being able to support the use of the technology. However, aspects and experiences of the WA whilst working remotely were not explored fully, nor were a key focus of this study.

A.7. Therapeutic Boundaries

Generally, a boundary refers to a border or line that imposes limits on a given area. Within therapy, therapeutic boundaries (TB) are understood as the implicit and explicit rules that manage the therapeutic relationship and differentiate it from a social or business meeting (Knapp & Slattery, 2004). Sometimes also defined as the therapeutic frame (Knox & Cooper, 2015), different types of boundaries present within therapy. Smith and Fitzpatrick (1995) distinguished between structural boundaries, such as time, place, and money, from content boundaries considering what happens and is discussed between the therapist and client. Similarly, Johnston and Farber (1996) defined two types of boundaries: (1) 'logistical' including times, payment, and scheduling, and (2) 'conceptual', such as self-disclosure, theoretical orientation, and availability between sessions. Despite these conceptualisations, it is argued that TB can be difficult to operationalise as they can vary depending on factors specific to the client and therapist, including diagnoses and theoretical orientation respectively (Johnston & Farber, 1996). Because of the flexibility in boundaries being dependent on the client, therapist, and context, this raises the possibility of boundary issues and challenges occurring (Drum & Littleton, 2014). Nevertheless, some argue for boundaries to be "regarded as flexible standards of good practice rather than lists of generically forbidden behaviour" (p. 409; Gutheil & Gabbard, 1998).

Therapeutic boundaries are considered important in psychotherapy as they protect both the client and therapist from harm. Furthermore, TB are proposed to support the therapeutic alliance as they "provide a foundation for this relationship by fostering a sense of safety and the belief that the clinician will always act in the clients best interest" (p. 500; Smith & Fitzpatrick, 1995). Boundaries also provide a sense of integrity of the relationship and opportunities for the therapist to model assertiveness skills to the client (Drum & Littleton, 2014). Despite these benefits, considering the variability and flexibility of TB, boundary issues and challenges have been known to arise. Gutheil and Gabbard (1998) distinguish between two types of boundary issues:

'boundary crossings' and 'boundary violations'. Boundary crossings are, at times, proposed to be constructive and lead to productive work in therapy. Whilst considering the importance of context, an example could be a patient stumbling and falling to the floor and the therapist helping them up. Alternatively, boundary violations are harmful and exploitative to the client, for example, engaging in sexual intercourse with a client.

Boundary crossings and violations have been described as on a continuum in which violations are often preceded by boundary crossings (Smith & Fitzpatrick, 1995). Building upon this and acknowledging the importance of the WA, Hamilton (2010) developed the boundary seesaw model for managing relational boundaries. This model was developed for clinicians working in forensic in-patient settings and, similarly, most of the existing literature on TB has been based on direct, face-to-face interactions between therapist and client. This raises the question of whether TB are the same or different in remote therapy provided via telephone or videoconferencing.

A.7.1. Therapeutic Boundaries and Remote Therapy

Advancements in the use of digital methods to provide therapy remotely is said to have moved the boundaries of professional work beyond the physical space in which therapy and wider mental health services are typically provided (Lustgarten & Elhai, 2018). Research regarding boundaries and the use of technology has mostly focused on the use of social media, internet searching, and email (Kolmes, 2012; Sabin & Harland, 2017). Lustgarten and Elhari (2018) discuss how technology provides possible increased access to therapists via calls, texts, and emails, although responding outside of working hours may indicate a 'boundary crossing'. As well as acknowledging the potential for increased flexibility in service delivery, Drum and Littleton (2014) highlight that there is an unfounded assumption that the physical distance inherent in remote therapy protects the therapeutic relationship from boundary transgressions and, instead, may result in more casual interactions and behaviours. Therefore, it is argued that there is a potentially increased likelihood of boundary crossings and violations occurring in remote therapy which, therefore, pose a threat to the therapeutic alliance (Drum & Littleton, 2014; Stoll et al., 2020).

Although not remote therapy provided via telephone or videoconferencing, Knapp and Slattery (2004) provided recommendations for psychologists delivering therapy in a client's home, acknowledging the potential for clients to challenge boundaries in a way that would not typically occur in clinic-based services. They proposed that boundary crossings are more likely to occur in this setting. Whilst therapists do not enter the client's home as such when providing therapy via telephone and video, it could be possible that by essence of the therapist and client being in different settings provides the therapist with access to information from the client's

home that would not be available in a face-to-face therapy, and vice versa. For example, the therapist may hear or see things in the client's home.

Where therapists' experience of using technology in therapy has been explored, this has investigated the use of software application as an interactive platform allowing therapists to connect with clients between face-to-face sessions (Richards et al., 2018). Despite this being an adjunct to face-to-face therapy sessions, therapists highlighted concerns about the impact on work-life boundaries and the potential for the boundary between therapist and client to become blurred. For example, the client contacting the therapist too frequently and concerns about crisis management. Despite the growing literature surrounding possible ethical and legal challenges when working remotely and respective guidance for managing such challenges, there is a paucity of empirical evidence into TB in remote therapy compared to face-to-face. Furthermore, it is proposed that therapy provided remotely may present novel therapeutic boundary issues and challenges that are worthy of further exploration (Drum & Littleton, 2014).

A.8. Therapists' Work Involvement

Therapist work involvement patterns originated from the Society for Psychotherapy Research Collaborative Research Network investigation into psychotherapists' work and professional development, in which therapists from different countries, professional backgrounds, and theoretical orientations were included. In 1991, the 392 item Development of Psychotherapists Common Core Questionnaire (DPCCQ) was developed, which has surveyed more than 10,000 psychotherapists to date (Orlinsky et al., 2019). Using several items of the DPCCQ, Orlinsky and Rønnestad (2005) developed the Therapist Work Involvement Scale (TWIS) reflecting overall dimensions of therapists' work experience. Through second-level factor analysis, two work experience dimensions emerged: Healing Involvement (HI) and Stressful Involvement (SI). Based upon therapist's HI and SI scores, their work experience can further be grouped into one of four work involvement patterns: (1) 'Effective Practice', referring to therapists with high levels of HI and low SI, (2) 'Challenging Practice' with high levels of both HI and SI, (3) 'Distressing Practice' with low HI and high SI and, (4) 'Disengaged Practice' with low levels of both HI and SI (Orlinsky & Rønnestad 2005). From a sample of 3629 therapists, Orlinsky and Rønnestad (2005) identified that 50% of therapists were in Effective Practice, 23% in Challenging Practice, 17% in Disengaged Practice, and 10% in Distressing Practice. It is worth noting, that the practice settings in which therapists and the sample worked did not include the provision of remote psychological therapy. It therefore raises the question of whether the distribution of practice patterns is similar or not for therapists working remotely.

A.8.1. Existing Evidence for Therapist Work Involvement Patterns

It is widely supported that therapists' factors and effectiveness relate to treatment outcome, accounting for about 5% of variance in outcome (Baldwin & Imel, 2013); equivalent to the level of variability in outcomes attributed to the WA (Horvath et al., 2011). Furthermore, therapist effectiveness can be understood as a global construct, irrespective of the type of patient difficulty (Nissen-Lie et al., 2016). Compared to therapists' technical skills which are only weakly correlated, global professional development and relational skills are reported to be stronger predictors of therapeutic outcome (Bennett-Levy, 2019). Therapist work involvement has been proposed as an indicator for professional development, as it includes several professional and relational aspects (Evers et al., 2019). Investigating therapists' current professional development, Orlinsky and Rønnestad (2005) identified two independent dimensions: (1) 'currently experienced growth', referring to therapists becoming more skilful, developing a deeper understanding of therapy, overcoming their limitations, progressive change, changing as a therapist, and experiencing a sense of enthusiasm and, (2) 'currently experienced depletion', referring to therapists performance becoming routine, losing capacity to respond publicly, becoming disillusioned by therapy, and experiencing a sense of current decline. Relating to therapist work involvement, HI strongly correlated with currently experienced growth ($r = .52$), whereas SI strongly correlated with currently experienced depletion ($r = .44$). This supports the use of work involvement patterns as an indicator to professional development and its relationship to therapeutic outcome.

Therapist burnout has been associated with poorer therapeutic outcomes (Delgadillo et al., 2018). Investigating variables that associate with SI, Zeeck et al. (2012) identified SI as a risk factor for therapist burnout and engaging in a non-productive therapeutic process. Furthermore, they identified that therapists with high levels of SI were more likely to experience negative feelings about the therapy and client in the time between sessions. These findings are supported by Steel et al. (2015) who found that SI predicted two out of the three proposed dimensions of burnout, namely emotional exhaustion and depersonalisation. Whilst these papers do not explicitly state that they were explored in face-to-face settings, data were collected from outpatient and day hospital settings (Zeeck et al., 2012), or from Improving Access to Psychological Therapy services (Steel et al., 2015). Considering therapists work involvement patterns in the context of professional development, burnout, and therapeutic outcomes, this highlights the importance of exploring therapists' work experience when working remotely as there may be potential implications for training and supervision.

A.9. Extended Research Questions

As well as the primary research questions reported in the journal paper, there were several secondary questions:

- What characteristics, if any, relate to therapists' perceived abilities regarding the WA or TB when working remotely during the COVID-19 restrictions?
- What work involvement patterns do psychological therapists experience when working remotely during the COVID-19 restrictions, and does this differ to therapists providing face-to-face therapy?
- Does the study support the development of two new therapeutic process scales (WA and TB) of therapists' perceived abilities while working remotely during COVID-19?

Chapter B: Extended Method

This chapter provides further background information on the method. Included, is further explanation and rationale for the epistemological position adopted and methodological decisions made.

B.1. Epistemology

Quantitative and qualitative research methods are underpinned by different philosophical positions, specifically in their ontological and epistemological assumptions (McEvoy & Richards, 2006). Ontology is concerned with the study of being and reality, whereas epistemology is the study of knowledge (Allmark & Machaczek, 2018). Paradigms each have their own ontological and epistemological assumptions (Scotland, 2012). Despite the increasing use of mixed-method designs, paradigmatic foundations have been identified as an issue for mixed-method research (Teddie & Tashakkori, 2003). Whilst the definition and utility of paradigms has been debated, specifically for mixed-method designs, it has been argued that they act as a guide for shaping the research question and the methods used to study them (Morgan, 2007; Shannon-Baker, 2016). Making clear the philosophical positions from which the research has been conducted helps the audience to understand the beliefs and potential influences underpinning the research (Shannon-Baker, 2016).

Quantitative data is often rooted in the positivist paradigm with the ontological and epistemological positions of realism and objectivism respectively (Scotland, 2012). This view holds that objects exist independent of the knower and that there is a true reality to be discovered via research, in which the researcher and the researched are independent entities. Methodology used is focused on explaining relationships and identifying causes which influence outcomes (Creswell, 2009). Methods producing quantitative data often include standardised tests and observation tools, and/or closed ended questionnaires.

Conversely, qualitative approaches are associated with the interpretivist paradigm (McEvoy & Richards, 2006), sometimes known as constructivism (Morgan, 2007). Qualitative approaches tend to examine personal meanings and subjective interpretations of an individual's reality (Barker, 2016). This reflects the ontological and epistemological positions that there can be multiple realities and knowledges. Compared to the positivist position of the detached observer, in the qualitative approach the researcher plays an active role in the research enquiry. Language also plays an important part, giving rise to different ways of interpreting the same phenomenon with neither way being perceived as wrong (Willig, 2013). Methods associated with the qualitative approach include focus groups, interviews, and textual analysis (McEvoy & Richards, 2006).

There has been a longstanding debate about whether quantitative and qualitative methods should be combined, with two competing positions being the methodological purist and the pragmatist (Taskakori & Teddlie, 1988). Methodological purists hold the view that quantitative and qualitative approaches are based on mutually exclusive assumptions and are, therefore, incommensurable (McEvoy & Richards, 2006). Whilst pragmatists accept the differences in the underlying assumptions, they argue that neither approach is sufficient alone and, therefore, whatever method needed to address the research inquiry should be used even if this involves mixing or switching between paradigms (McEvoy & Richards, 2006; Taskakori & Teddlie, 1988).

However, it has been argued that although research methods are not directly linked to epistemological or ontological positions, a pragmatist approach ignores the influence that philosophical assumptions have on research methods and the researcher's purpose and actions (Maxwell & Mittapalli, 2010). Instead, Maxwell and Mittapalli (2010) argue that as a philosophical perspective, critical realism "validates and supports key aspects of both qualitative and quantitative approaches while identifying some specific limitations of each" (p.2). Considering the current study, critical realism was the epistemological position adopted. Further explanation and rationale for this position will now be provided.

B.1.1. Critical Realism

Currently a prominent approach, critical realism offers an alternative to the polarising views of positivism and interpretivism (Maxwell & Mittapalli, 2010; Shannon-Baker, 2016). Critical realism is an integration of a realist ontology with a constructivist epistemology (Maxwell & Mittapalli, 2010), assuming that, although data can tell us something about reality, it is not a direct reflection of what occurs in the real world (Willig, 2013). Therefore, critical realism aims to develop deeper levels of explanation and understanding (McEvoy & Richards, 2016) by measuring and identifying underlying structures and mechanisms (Shannon-Baker, 2016).

Critical realism also takes account of the context in which the phenomenon of study occurs, recognising that the world operates in a multidimensional system, where the objects of study are the product of multiple components and forces (McEvoy & Richards, 2016; Sayer, 2000). Furthermore, this perspective argues that the world is characterised by development of new phenomena and, therefore, descriptions used in social sciences cannot remain stable or unproblematic across space and time. Hence, the emergence of new conceptualisations is expected (Sayer, 2000). Considering the abundance of literature into therapeutic processes in face-to-face settings, such as the working alliance and therapeutic boundaries, this framework is helpful for the current

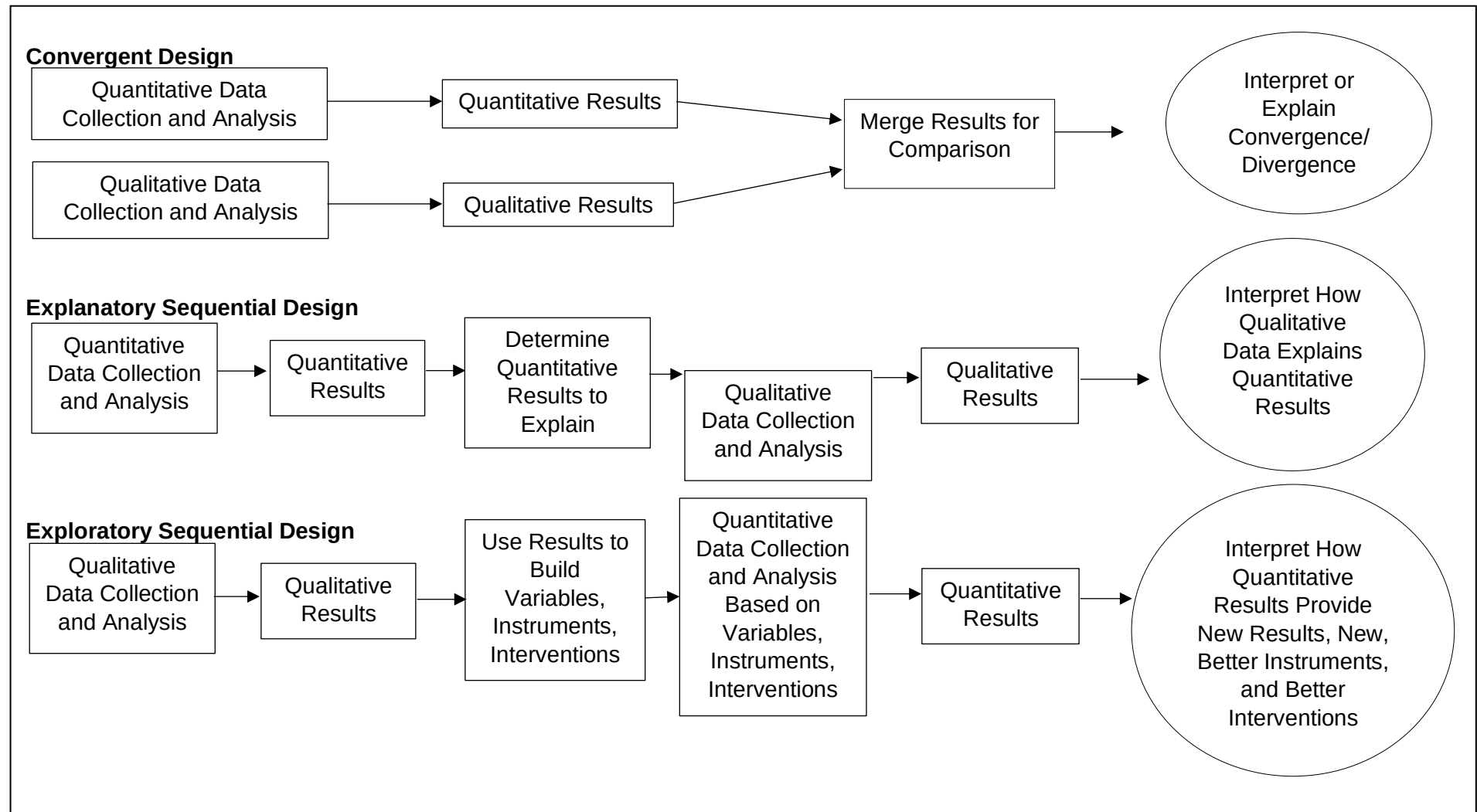
study by providing the opportunity for the emergence of new data and possible theory to best understand remote therapy.

Finally, critical realism is said to be compatible with both quantitative and qualitative research (Shannon-Baker, 2016), providing a productive stance for mixed-methods research by acknowledging the limitations of each approach (Maxwell & Mittapalli, 2010). The ability to use this epistemological position flexibly is helpful for the current study by exploring the frequency, context, and relationships between factors through quantitative methods, followed by further exploration of a given phenomenon, finally synthesising the findings to develop a deeper understanding.

B.2. Mixed-Method Design

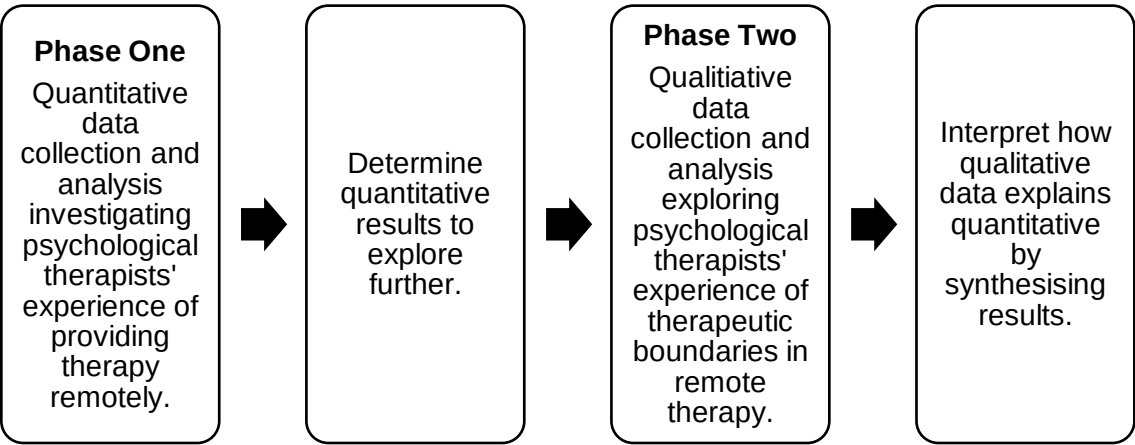
As mentioned, it is argued that quantitative and qualitative methods each have their own limitations and, when used in isolation, are not sufficient to capture and explain certain phenomenon. However, when both methods are used in combination, they are said to complement each other with the respective strengths and limitations of each method (Creswell & Guetterman, 2020; Ivankova et al., 2006). Whilst a definition has been debated for some time, mixed-method designs have recently been defined as a procedure for collecting, analysing, and integrating both quantitative and qualitative data to gain a better understanding of the research problem (Creswell & Guetterman, 2020). Quantitative data allows you to assess and describe the frequency and magnitude of a problem or experience for many people. Conversely, qualitative data provides detailed, potentially differing perspectives about a given phenomenon and enables further elaboration and explanation.

Figure 2 *Varieties of Mixed-method Designs Adapted from Creswell and Guetterman (2020)*



There are different mixed-method designs depending on the intent for combining quantitative and qualitative data, the sequence of data collection, and the priority or weight given to each type of data. Three of the most used designs are seen in Figure 2 (Creswell & Guetterman, 2020). An explanatory sequential design involves collecting quantitative data and subsequently gathering qualitative data to explain or elaborate on the quantitative findings (Creswell & Guetterman, 2020; Ivankova et al., 2006). Considering that little investigation into psychological therapists' experience of providing therapy remotely had occurred prior to the COVID-19 pandemic, using an explanatory sequential design allows for a general picture to be provided which can then be further explored in the second qualitative phase. This design seemed the most appropriate to address the research questions. Figure 3 depicts the process of data collection for this study.

Figure 3 *Sequential Explanatory Mixed-Method Design for Data Collection*



Further information on data collection methods, sample, recruitment, and analysis will now be discussed for each respective phase. Consistent with the sequential design and to represent how the research was conducted, information regarding the initial quantitative phase will be presented under the heading 'Phase One', whereas the qualitative phase will be referred to as 'Phase Two'. Ethical considerations will also be considered.

B.3. Study Design: Phase One

B.3.1. Online Survey

To collect a breadth of experiences representative of psychological therapists, an online survey was used (Appendix B). The use of an online survey enabled more geographically diverse responses to be collected, as well as recruiting therapists with

ease, whilst providing comparable psychometric properties to surveys not administered online (Hewson, 2014).

B.3.1.1. Development of the Survey. Considering that this is a novel area of research, no available survey exists to address the research questions. Therefore, the online survey was created by the researchers, with items based on existing definitions and theory. The survey was developed by the primary researcher and was reviewed in supervision with both supervisors (Appendix C), with subsequent amendments made. Once the final draft was developed, the survey was piloted on two Trainee Clinical Psychologists and subsequently amended following feedback, which focused on making the wording of study information clearer rather than changes to the survey items per se. For example, adding 'if you consent to taking part and complete the survey by clicking 'finish', you will be able to withdraw your responses up until the point of analysis by contacting the researcher with the unique identifier you provide'. Piloting surveys is helpful to ensure the content of the survey is adequate, clear, and comprehensive (Regmi et al., 2016).

The development of each respective area of the survey (i.e., demographics, WA, TB, and therapist work involvement) will be described below. In considering the construction of the response scale, whereas the work involvement items were adapted from an existing standardised measure, a bipolar response scale was chosen for the WA and TB items. Acknowledging that little is known about psychological therapists' experience of working remotely, using a bipolar scale enabled both positive and negative experiences to be captured. The response scale included five positive points, five negative points, and a neutral midpoint (-5 to 5). Five points either side of the midpoint were considered an optimal amount to capture differences in ratings, whilst acknowledging the potential of diminishing returns and difficulty discriminating responses with more scale points used (Barker, 2016). Although it can be argued that not having a neutral answer enables the data to be divided into those expressing a positive or negative opinion (Barker, 2016), a midpoint was included as this allows for a genuine alternative perspective that they do not experience remote therapy differently to face-to-face.

B.3.1.1.1. Screening, Demographic, and Contextual Items. The survey began with four screening questions to ensure respondents met the inclusion criteria. This also included a consent question whereby participants would be redirected to a 'screening out' page and could no longer continue with the survey if they did not consent.

Demographic items (i.e., gender, age, country, qualification, professional role, theoretical orientation, and number of years practising therapy) were considered helpful

in contextualising the data. Further contextual questions regarding therapist's prior and current experience of providing remote psychological therapy (i.e., prior, and current use of telephone or video, number of sessions provided by telephone and video, location, and prior training) were included. It was hypothesised that answers to these items may associate either positively or negatively with therapists' perceived abilities regarding the WA and TB. Finally, an item regarding the respondent's present state of emotional and psychological well-being was included, which was taken from the DPCCQ (Orlinsky & Rønnestad, 2005). It was thought that gaining a sense of participant's well-being was pertinent considering the potential impact that COVID-19 could have on individual's well-being.

B.3.1.1.2. Working Alliance Items. Developed, standardised, and psychometrically robust measures of the working alliance based on Bordin's (1979) conceptualisation and theory are available, such as the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986). Whilst this is completed by therapists, responses are based on their experience of the WA with a specific client in a therapy session. Furthermore, in accordance with Bordin's theory, the WAI was originally developed and used in traditional face-to-face therapy settings. Considering the purpose of this study being focused on psychological therapists' perceived ability regarding the WA generally when working remotely, the WAI was not appropriate to address the research question. Therefore, items on the survey about the WA were constructed by the researchers, whilst rooted theoretically in Bordin's widely accepted conceptualisation. Considering these newly developed items, psychometric properties were explored (see *Reliability of Component Scales*).

B.3.1.1.3. Therapeutic Boundary Items. There is no existing standardised questionnaire that could have been used to investigate therapists' perceived ability in maintaining TB whilst working remotely. Thus, these items were also constructed by the researchers. Existing definitions and examples of TB (Johnston & Farber, 1996; Smith & Fitzpatrick, 1995) were used to develop survey items. As such, some items were based on logistical/ structural boundaries, for example, '*the length of agreed therapy sessions*' and '*my ability to maintain a consistent space where I engage in therapy*'. Other items were based on content/ conceptual boundaries, for example, '*the amount that I self-disclose to clients*' and '*my ability to stop thinking about my client's problems in the time between therapy sessions*'. As these were newly developed items, psychometric properties were explored (see *Reliability of Component Scales*).

B.3.1.1.4. Therapist Work Involvement Scale. The Therapist Work Involvement Scale (TWIS; Orlinsky & Rønnestad, 2005) was used. The TWIS was developed from the larger DPCCQ survey, following factor analysis where 22

dimensions were identified in which therapists varied in their work experience. Subsequent second-level factor analysis proposed to penetrate “more deeply to the underlying structures of experience than is possible by conscious reflection alone” (p. 62; Orlinsky & Rønnestad, 2005) identified two broad factors: Healing Involvement (HI) and Stressful Involvement (SI). Therapists’ HI and SI scores were calculated using the equation by Orlinsky and Rønnestad (2005). Based on HI and SI scores, therapists could further be grouped into one of four work involvement patterns: Effective Practice (high HI, Low SI), Challenging Practice (high HI, high SI), Disengaged Practice (low HI, low SI), and Distressing Practice (low HI, high SI). The 52-item instrument has demonstrated good convergent and discriminant validity and yielded satisfactory internal consistencies ($\alpha = .74$ for HI; $\alpha = .66$ for SI; Nissen-Lie et al., 2010). More recently, Hartmann et al. (2011) reported higher internal consistencies for the TWIS ($\alpha = .82$ for HI; $\alpha = .93$ for SI).

It is worth noting that some items of the TWIS were adapted to direct the respondent to base their answers on their experiences when working remotely. For example, *‘when encountering difficulties in therapy, how often do you...?’* was changed to *‘when encountering difficulties in remote therapy, how often do you...?’*

B.3.2. Sample and Recruitment

B.3.2.1. Inclusion Criteria. The inclusion criteria are included in the journal paper, however, further rationale for these criteria will now be presented.

Some criteria were included to ensure that respondents had enough experience of providing therapy remotely to base their answers on, such as *‘psychological therapists for whom providing psychological therapy forms a large part of their job role’*. Considering that the research question aimed to explore therapists’ experience and abilities when working remotely, some criteria were included to ensure that therapists could compare their experience of providing remote therapy to therapy provided in-person, face-to-face with clients. For example, *‘psychological therapists will identify as having predominantly provided psychological therapy (i.e., more than 50% of their caseload) in a face-to-face setting prior to the COVID-19 restrictions’* and *‘psychological therapists will have changed from face-to-face psychotherapy to actively providing psychological therapy via phone or videoconferencing software during the COVID-19 restrictions’*.

Considering that little is known about therapists’ experience of providing remote therapy, therapists from different professional backgrounds, such as psychologists, psychotherapists, and counsellors, who were either qualified or in training were included. It was thought that this would provide a breadth of experiences, from which future research could focus on if differences were to emerge between professions.

Whilst it is acknowledged that professions vary in their level of training and not all are protected titles, it was thought that by including these criteria, participants will have engaged in some training in therapy. Finally, '*providing therapy remotely to individual clients*' was included as it was thought that providing therapy remotely to multiple people, such as intervention groups and family therapy, may present different dynamics or experiences for therapists.

B.3.2.2. Sample Size. As inferential statistics (i.e., correlations between therapists' perceived abilities regarding the working alliance and therapeutic boundaries with HI, SI, and therapists' characteristics) were going to be used, a statistical power analysis (Cohen, 1990) was completed prior to data collection. Power is the probability of rejecting the null hypothesis when it needs to be rejected. Thus, a high-power study will have a good chance of detecting an effect if there is one and, therefore, more confidence can be drawn from the conclusions made (Barker, 2016). A necessary sample size can be calculated by establishing an effect size and selecting appropriate alpha and beta levels; alpha and beta statistics reduce the risk of type I and type II errors, respectively. Considering effect size for correlational analyses, Cohen (1988, 1990) considered a correlation coefficient of .10 as a small effect, .30 as a medium effect, and .5 as a large effect. Psychology research is generally interested in medium effects (Barker, 2016). Thus, an effect size of .3 was used in the power calculation. A power calculation indicated that 112 participants were required ($\alpha = 0.05$; $\beta = 0.9$; Effect size = 0.3).

B.3.3.3. Recruitment.

A snowball sampling method was used as to enable participants to share the study advertisement with other potential participants, including potential participants from diverse locations. Participants were recruited via advertisements (Appendix D) posted on social networking sites and in the British Psychological Society Division of Counselling Psychology e-letter. Some social networking interest pages, such as the 'UK Based Clinical Psychology Facebook Group' and 'Counselling and Psychotherapy Networking', list rules that posts must abide by. Different interest pages were identified to try to recruit therapists from various professional backgrounds. Therefore, a private message was sent asking for permission to advertise the project prior to posting the advert. Table 9 indicates how many times the advertisement was posted on each social networking page and the e-letter. The advert stated that participants could share the advert to encourage snowball sampling to possible participants, with permission set to share the post where possible. Further professional bodies, such as the British Association for Counselling and Psychotherapy were considered possible recruitment

networks but were not pursued as enough participants had completed the survey, exceeding the number for statistical power.

Table 9 Number of Recruitment Adverts on Each Online Site

Advert	Number of times advertised
Instagram - Posted on the researcher's profile	5
Facebook - Posted on the researcher's profile	7
Facebook - UK Clinical Psychology page	4
Facebook - Counselling and psychotherapy page	2
Facebook – BPS psychotherapy section page	1
LinkedIn - Posted on the researcher's profile	1
Division of Counselling Psychology e-letter	1

B.4. Study Design: Phase Two

B.4.1. Semi-structured Interview

Semi-structured interviews were used to further explore and explain the data collected in phase one. This method is considered appropriate for research questions exploring participants experience and understanding of a phenomenon of interest particularly where the participant has a personal interest (Anne, 2013; Braun & Clarke, 2013). Where participants do not have a personal stake in the research topic, the focus group method which collects data from multiple participants at the same time is considered a better alternative (Braun & Clarke, 2013). Furthermore, whilst exploring a topic of interest, semi-structured interviews allow for participants to provide novel experiences and meanings (Anne, 2013). The opportunity for reciprocity between the researcher and participant enables the researcher to probe for further clarification, meaning, and reflection, which would not be as possible and other methods, such as written accounts provided by participants.

Semi-structured interviews conducted in a face-to-face setting have typically been considered 'gold standard' (Novick, 2008). Considering the social distancing restrictions because of COVID-19, interviews for this study had to be conducted remotely via videoconferencing or telephone. However, similarly to the provision of remote psychological therapy, these methods allow for synchronous interaction and have been considered a viable alternative to the traditional face-to-face interview (Lo

lacono et al., 2016). Braun and Clark (2013) report several advantages to conducting interviews remotely, particularly that they are more convenient, empowering, and accessible for participants. Participants who are geographically isolated or have physical difficulties may not be able to attend a face-to-face interview but could participate where a remote method of data collection is used. Furthermore, the use of video or telephone for interviewing broadens the geographical base in which the sample can be selected, thus increasing the variety of the sample (Lo lacono et al., 2016). Considering that participants practicing psychological therapy in different locations and countries were able to participate in phase one, the option of remote interviews enabled these participants to engage in phase two without being excluded on the grounds of accessibility, thus strengthening the integrity of the data collected.

It has been suggested that telephone interviews may allow participants to discuss sensitive information more freely, although lacks visual cues (Novick, 2008), which is considered an added benefit of videoconferencing interviews by enabling the researcher to use non-verbal communication, such as facial expressions (Holt, 2010). Compared to face-to-face interviews however, Lo lacono et al. (2016) acknowledge that whilst videoconferencing provides access to facial expressions, important cues are missing from the rest of the body and, therefore, the researcher must pay particular attention to the voice and face.

Considering the added benefit of videoconferencing, this was offered to participants in the first instance, with telephone planned to be used as a backup if needed. All interviews took place via MS Teams or Zoom videoconferencing platforms. The average length of interview was 52 minutes eight seconds (range 38.03 to 67.15). The interviews were all audio recorded and transcribed by the researcher.

B.3.1.1. Development of the Interview Schedule. Consistent with a sequential explanatory design, the research question for phase two and interview schedule were created following the analysis of phase one data. The initial review of existing literature indicated that there is a paucity of research into TB and remote psychological therapy, despite it being argued that remote therapy provides opportunities for novel boundaries to occur (Drum & Littleton, 2014). With that in mind, it was decided during early planning of the study that if this were supported by the survey findings, then the TB would be explored as a specific topic in phase two. As indicated by the survey findings, this claim was supported inasmuch that psychological therapists perceived some of their abilities differently regarding TB whilst working remotely. Therefore, this became the focus for phase two.

Dedicating time to developing a successful interview schedule is important as well-planned questions generate rich and detailed information, as well as supporting

the researcher to build a rapport with the participant (Braun & Clarke, 2013). Questions were developed, reviewed in supervision, and subsequently amended to ensure the questions were suitably created to answer the research question, and were structured in a way to aid rapport by moving from general to specific questions (Appendix E). As recommended by Braun and Clarke (2013), the first interview was reviewed in supervision to ensure the interview schedule was collecting sufficient data to answer the research question. No changes were made to the interview schedule, although time was spent reflecting on how to establish the researcher-participant relationship and how best to ask the questions. For example, gauging when to summarise what they have said or asking direct questions (Appendix F).

B.4.2. Sample and Recruitment

B.4.2.1. Sampling Method. Purposive sampling is used in qualitative research, with the aim of producing rich, detailed data by selecting participants relevant to the topic of interest. This differs to the aim of quantitative sampling methods which aim to generalise the data. Several different purposive sampling strategies are available (Braun & Clarke, 2013; Palinkas et al., 2013), which vary depending on if they aim to identify and look for common patterns across variations or differences (e.g., maximum variation or extreme cases) or by focusing on homogeneity by limiting the variation (e.g., typical case sampling or criterion sampling). Palinkas (2013) acknowledged that one challenge of purposive sampling is that the range of variation in a sample is not known at the beginning of the study. Thus, an iterative approach to sampling is recommended.

Considering that little is known about psychological therapists' experience of TB generally, it seemed appropriate to use a heterogeneous sampling strategy, instead of focusing on a specific type of therapist. Both maximum variation and extreme case sampling strategies were considered (see Table 10). After reviewing the sample of participants who had consented to being contacted for phase two, different ways of sampling were explored. Maximum variation sampling based on the therapist's score on the TB scale (positive, negative, or neutral), age category, and current state of well-being score was used to stratify the sample. These variables were used as they were identified during phase one analysis to associate with therapists' TB experiences. Where possible, participants from different countries were also included. Whilst both allow for variation in the sample, maximum variation was chosen as there was an increased scope for re-sampling if the initial participants identified no longer wanted to participate. Furthermore, considering the research question also focused on how therapists manage TB when working remotely, it was thought that maximum variation

would better yield this information from participants who typically scored neutral on the TB experiences, whereas extreme sampling would not capture this.

Table 10 *Purposeful Sampling Strategies Considered*

Strategy	Objective	Example	Considerations
Maximum variation	Important shared patterns that cut and arrived their significance from having emerged out of heterogeneity.	Sampling mental health services programs in urban and rural areas in different parts of the state (North, Central, South) to capture maximum variation in location (Bachman et al., 2009).	Can be used to document unique or diverse variations that have emerged in adapting to different conditions (Patton 2002).
Extreme or deviant case	To illuminate both the unusual and the typical.	Selecting clinicians from state agencies or mental health with best and worst performance records or implementation outcomes.	Extreme successes or failures may be discredited as being too extreme or too unusual to yield useful information, leading one to select cases that manifest sufficient intensity to illuminate the nature of success or failure, but not in the extreme.

Adapted from Palinkas (2013)

B.4.2.2. Sample. The number of participants required for qualitative datasets is debated (Trotter, 2012). Braun and Clarke (2013) argue that a sample size between 15 and 20 individuals is typically used for qualitative research, whilst others argue that there are no rules to the number of participants required (Patton, 2002). A minimum of 12 participants were aimed to be recruited. Seventy-two individuals consented in phase one to being contacted for phase two. In total, 44 participants were emailed based on the sampling method, of which 12 consented to participate.

B.5. Ethical Considerations

The study was granted ethical approval by the University of Nottingham Division of Psychiatry and Applied Psychology Research Ethics Committee (Appendix G). A subsequent amendment was approved following the development of the phase two interview schedule (Appendix H).

B.5.1. Informed Consent

For phase one, the survey was developed so that participants read the participant information sheet (Appendix I) and subsequently were asked screening questions to ensure they met the inclusion criteria and consented to the study. Where participants did not consent, they were directed to a screening out page explaining that they could no longer participate, thanking them for their time.

Similarly, participants who consented to being contacted and were selected for participation in phase two, were provided with a participant information sheet (Appendix J) and a consent form which was completed before participation began (Appendix K).

Both participant information sheets explained the purpose of the study, that participation was completely voluntary, and that all data would be treated anonymously. Contact information for the researchers was provided, with the opportunity to ask questions.

B.5.2. Right to Withdraw

Information regarding participants right to withdraw for each respective phase was included in the participant information sheet. For phase one, participants provided a unique identifier to enable their responses to be identified if they chose to withdraw, up until the point of data analysis. For phase two, participants were advised to contact the researcher within one week of the interview being completed. Outside of these timeframes, participants were informed that their data may still be used anonymously towards the analysis. No participants withdrew from the study.

B.5.3. Confidentiality

Identifiable information (e.g., email addresses) was treated confidentially and anonymously. Only members of the research team had access to the password protected files with identifiable information. For phase two, pseudonyms were used in the final write-up where participant accounts were provided.

B.5.4. Risks to Participants

No risks were identified to participants. Were risk or undue harm to occur because of participating in the study, participants were advised to contact the research team; no adverse events were reported.

B.5.5. Storage of Information

Participant information collected electronically was stored on a secure university one drive account, with files being password protected. Only members of the research team had access to the data.

B.6. Analysis

B.6.1. Phase One

B.6.1.1. Principal Component Analysis (PCA). A technique for identifying groups or clusters of variables, PCA aims to: (1) extract the most important information from the data, (2) reduce the size of the data set whilst keeping important data, simplify the description of the data set, and (3) analyse the structure of the variables (Abdi & Williams, 2010). Principal component analysis has been considered a statistically sound technique (Field, 2018). As survey items were designed to represent two theoretical constructs (i.e., the WA and TB), PCA was used to establish the optimum number of components needed to explain the variance amongst the items. Using PCA in this study enabled us to examine whether the WA and TB items were measuring such constructs as intended and, therefore, have more confidence in the findings. Where variables were related, this allowed for reliability analyses to be completed for the overall scales.

As variables can usually contribute highly to one component and have low contributions to others, the rotation method can be used to discriminate variables between components. Two rotational methods can be used: (1) orthogonal, when it can be assumed that the components are unrelated and the rotation ensures the components remain independent, and (2) oblique rotation which allows components to correlate. Field (2018) recommends that if there is a sound reason for components to be related, then oblique rotation should be used. To decide between methods, Tabachnick and Fidell (2019) recommend running an oblique rotation initially to see the component structure is related. They suggest that if the correlation between components exceeds .32, indicating more than 10% variance among components, then there is enough variance to warrant oblique rotation. Therefore, oblique rotation was applied initially (see *Extended Results*).

B.6.1.2. Inferential Analyses. Following parametric assumption testing (see *Assumption Testing*), bivariate Pearson's product moment correlation was used to analyse linear associations between two continuous variables. The point-biserial correlation was used for associations where one variable was dichotomous and discrete, such as gender. It is worth noting that therapists' overall HI and SI scores were used in the analysis to see if they associated with WA and TB experiences; individual items on the TWIS were not analysed as this was not the focus of the study. As stated above, correlation coefficient effect sizes of .3 are considered a medium

effect and are considered of interest in psychological research. Thus, a medium effect found in this study was considered of importance.

B.6.2. Phase Two

Interview data were analysed using thematic analysis, a flexible approach for identifying, organising, and reporting patterns within qualitative data (Braun & Clarke, 2006). Alternative qualitative methods considered are reported below, followed by a rationale and explanation for thematic analysis.

B.6.2.1. Interpretative Phenomenological Analysis (IPA). Rooted in a phenomenological epistemology, IPA aims to capture and explore the meaning of individual's experiences of a phenomenon (Smith, et al., 2009). This approach recognises that experience is never directly accessible to the researcher and, as such, the researcher engages in a 'double hermeneutic' interpreting the participants interpretation of the phenomena (Willig, 2013). Interpretative phenomenological analysis recognises that the researcher cannot bracket presuppositions and assumptions but rather there is an interaction between the researcher and the data. Nevertheless, concerned with individual experiences, IPA adopts an inductive approach to analysis through engaging with the raw data to identify themes and subsequently clusters of themes (Willig, 2013). Whilst interested in further exploring the therapists' experiences of TB whilst working remotely, phase two aimed to explore how therapists managed these experiences which would not be appropriate for an IPA approach. Additionally, following analysis of phase one data, it would arguably be difficult to adopt an entirely inductive stance to analysis.

B.6.2.2. Grounded Theory. Originally developed by Barney Glaser and Anselm Strauss, grounded theory aims to develop a theory grounded in the data by identifying, refining, and integrating categories (Willig, 2013). Different versions of grounded theory have evolved, with differences between approaches observed in the epistemological position they adopt, ranging from being influenced by positivism (e.g., Glaser & Strauss, 1967) to social constructionist versions of grounded theory (e.g., Charmaz, 2014). Grounded theory has been considered a promising approach to be used in mixed-method research (Howell Smith et al., 2019); although in an exploratory design where a theory is developed from qualitative data and subsequently tested quantitatively by the construction of an instrument based on the theory. As the primary aim of phase two was to further explain findings from phase one and not necessarily develop a theory, grounded theory was not considered an appropriate methodology for the study.

B.6.2.3. Thematic Analysis. Braun and Clarke (2006) suggest that whilst thematic analysis is poorly demarcated, it is a widely used method that is accessible

and theoretically flexible. Furthermore, an advantage of thematic analysis is that it allows for different perspectives to be examined, highlighting similarities and differences amongst participants (Nowell et al., 2017). Comparable to IPA and grounded theory, thematic analysis aims to identify themes and patterns in the data, although is not theoretically bound and can be used within different theoretical frameworks depending on the research question, including critical realism. Whilst considered a strength, the theoretical flexibility afforded by thematic analysis has been argued to potentially lead to inconsistency and incoherence when developing themes (Holloway & Todres, 2003; Nowell et al., 2017). The researcher must choose and be explicit about the epistemological and theoretical positions adopted and how this informs the interpretation of the data (Willig, 2013). As clarified above, the epistemological position for the study is critical realism.

As well as being transparent about the epistemological position, Braun and Clark (2006) propose that a number of decisions in thematic analysis are made that should also be made explicit. These decisions focus on how the data will be approached and themes identified, and the 'level' at which themes are identified. These decisions will now be explored further.

Researchers using thematic analysis must decide between an inductive or deductive approach to identifying themes or patterns. Working from the bottom up, in an inductive approach, themes identified are strongly linked to the data and do not reflect the researchers theoretical commitments (Braun & Clarke, 2006; Willig, 2013). Alternatively, a deductive analysis is driven by the researchers theoretical interests, using a specific framework or template based on existing literature to code the data and identify themes. A hybrid inductive-deductive approach to coding and identifying themes has been used by some researchers (e.g. Fereday & Muir-Cochrane, 2006), in which a priori and inductively identified codes are subsequently integrated to generate a comprehensive thematic description of the data (Willig, 2013). A hybrid approach was used to analyse the interview data by initially identifying themes inductively and then deductively using a coding frame developed from existing literature on therapeutic boundaries and data collected from phase one (Appendix L).

In the identification of themes, thematic analysis can focus on different 'levels' of meaning. At the semantic level, themes are identified at the surface level, where the researcher is not looking beyond what has been said. The process of semantic analysis moves from description of the semantic content to interpretation of its significance, meanings, and implications, often rooted within existing literature (Braun & Clarke, 2006). In contrast, analysis at the latent level moves beyond the semantic level by examining the underlying ideas, assumptions, and conceptualisations that may be

informing or shaping the semantic content (Braun & Clarke, 2013). A semantic approach to analysis was adopted as we were interested in what participants said across the whole data set, instead of what was unspoken. Furthermore, a semantic approach was considered appropriate for the epistemological position adopted as we did not aim to theorise underlying ideologies or sociocultural contexts of the data, which would be the focus of a constructionist epistemology and latent level analysis.

B.6.2.3.1. Phases of Thematic Analysis. Braun and Clarke (2006) provide a six-phase guide to conducting thematic analysis which was used to analyse the interview transcripts (Table 11). The phases of analysis are not considered a linear process but rather recursive, moving back-and-forth as appropriate.

Table 11 *Phases of Thematic Analysis*

Phase	Description of the process
1. Familiarising yourself with the data	Transcribing data, reading and re-reading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire dataset, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire dataset (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Adapted from Braun and Clarke (2006)

B.6.2.3.1.1. Familiarising yourself with the data. By the researcher conducting the interviews, began the process of familiarisation with the data. Whilst time consuming, recognising that transcribing data yourself provides an 'excellent way to start familiarising yourself with the data' (p. 87; Braun & Clarke, 2006); thus, all interviews were transcribed by the lead researcher. Finally, the lead researcher further immersed themselves in the data by reading each transcript twice before coding began. Following each interview and during the reading of each transcript, the researcher's initial thoughts and ideas were recorded in a reflexive diary (Appendix M).

B.6.2.3.1.2. Generating initial codes. Transcripts were coded systematically by the lead researcher inductively, adopting a line-by-line approach to coding whilst also considering codes for complete sentences. Following inductive coding, each transcript was then coded deductively using the developed framework. An example extract of coding can be found in Appendix N. To enhance trustworthiness of coding, the initial coded transcript was reviewed in supervision (Appendix O).

B.6.2.3.1.3. Searching for themes. To begin identifying themes, similar codes were clustered to capture the key concepts across all transcripts (Appendix P). A mind-map was developed for each potential theme, which captured the clustered codes that related to each theme or subtheme (Appendix Q).

B.6.2.3.1.4. Reviewing themes. A mind-map was created to organise the initial overarching themes and subthemes to visualise how each theme related to the overall research question (Appendix R). At this stage, all data under each theme and subtheme was collated and reviewed to check the credibility of each theme. Where overlap between themes emerged, themes were refined and combined. Summaries for each theme and subtheme were drafted with supporting quotes, which was then reviewed and discussed in supervision (Appendix S). Subsequently, themes were further refined, resulting in the final four overarching themes (Appendix T).

B.6.2.3.1.5. Defining and naming themes. Defining and naming themes was a recursive process which occurred during the last three phases. Discussing each theme name in relation to the data and story in supervision was also helpful in ensuring the title captured the essence of the theme, whilst ensuring the names gave the reader a sense of what the theme is about. Where this was not clear, themes were re-named. For example, 'different boundaries' was expanded to 'different boundaries in remote therapy'.

B.6.2.3.1.6. Producing the report. Once final themes were developed, the writing process began. Themes must be provided by example extracts of raw data, which has been considered an essential component of the write up and increases trustworthiness by supporting the points made (Nowell et al., 2017). Furthermore, each quote was accompanied with the respective pseudonym for each participant to demonstrate variation amongst responses. Finally, whilst member checking is considered helpful in increasing trustworthiness (Nowell et al., 2017), this was not possible due to time constraints.

B.7. Quality Assurance

Research quality and the use of quality criteria in social sciences has become a key focus in recent years (Bryman et al., 2008). Whilst there are established quality criteria for quantitative methodology, there is a lack of consensus regarding what

constitutes quality in qualitative studies (Bryman et al., 2008). Despite mixed-method research growing considerably in recent years, defining quality in mixed-method studies is still in its infancy, with a need to establish consistency in the operationalisation of quality and subsequently a consensus of quality criteria (Fàbregues & Molina-Azorín, 2017). Therefore, quality in this study was considered separately for each method.

B.7.1. Quantitative Quality Assurance

The quality of quantitative research is usually considered regarding the reliability and validity of measures and methods used. As parts of the survey were newly developed, the face validity of survey items was considered, that is whether items looked like they would measure what was intended. Each WA and TB item was reviewed and discussed in supervision, ensuring face validity. Internal consistency estimates the reliability of variances and covariances of all the items with each other, which were established for the newly developed WA and TB scales to ensure confidence in the findings. Furthermore, principal component analysis was completed to determine if the WA and TB scales were statistically sound as well as theoretically. This process and the results (see *Reliability of Component Scales* section below) indicated that the scales were reliable, therefore increasing confidence in the quantitative findings. Furthermore, to ensure the sample was large enough to be confident in the quantitative findings, a power analysis was completed to indicate the minimum sample size required, as described above (see *Sample Size* section above).

B.7.2. Qualitative Quality Assurance

There is no consensus approach to assessing quality of qualitative research, although it is acknowledged that it needs to be completed in a rigorous and methodical way to ensure meaningful and useful results (Nowell et al., 2017). Furthermore, there are several different types of qualitative methodologies in which each may have different epistemologies and approaches to answering the research question (Willig, 2013). Therefore, it would not be appropriate to use quality criteria not relevant to the method used.

For this study, Clarke and Braun's (2019) quality checklist was used to consider the quality of this research. For example, to remain aware of the researcher's own perspective, a reflexive diary was used throughout to record their own thoughts and feelings. Nevertheless, some aspects of the criteria may be susceptible to subjectivity regarding whether a criterion has been met or not. In the development of phase two, decisions were made regarding the type of thematic analysis used that would be credible in the context of this research. For example, applying a purely inductive approach to analysis would not have been plausible considering that the researcher

was unable to remain independent of existing literature and findings from phase one. Likewise, the quality of identified themes was explored in supervision to ensure that identified themes were not a reflection of the interview questions, whilst also checking for overlap between themes; a recognised means of establishing trustworthiness in thematic analysis (Nowell et al., 2017).

Chapter C: Extended Results

This section reports additional results that were not included in the journal paper section. These will be presented in terms of additional phase one quantitative results and quotes to support the themes identified in phase two.

C.1. Phase One

The sample size in phase one ($n = 161$) exceeded what was required for statistical power, resulting in greater power ($\alpha = 0.05$; $\beta = 0.97$; Effect size = 0.3). Frequencies of therapists prior and current use of remote therapy is presented in Table 12.

Table 12 *Proportions of Psychological Therapists Prior and Current Use of Remote Therapy*

Remote therapy characteristic	Frequency (%)
Prior training on remote psychological therapy	
Yes	14.3
No	85.7
Use of phone or videoconferencing prior to Covid-19	
Telephone	28.7
Videoconferencing	8.8
Both	17.5
Neither	45.0
Use of phone in therapy during Covid-19	
Yes	88.8
No	11.2
Number of sessions via phone during Covid-19	
Fewer than 20	39.6
Between 20 and 50	35.2
More than 50	25.2
Use of videoconferencing in therapy during Covid-19	
Yes	84.2
No	15.8
Number of sessions via videoconferencing during Covid-19	
Fewer than 20	39.6
Between 20 and 50	27.9
More than 50	32.5
Location of remote therapy	
Inside your home	87.0
Outside your home	13.0
Location free from interruptions	
Yes	60.3
Somewhat	36.0
No	3.7

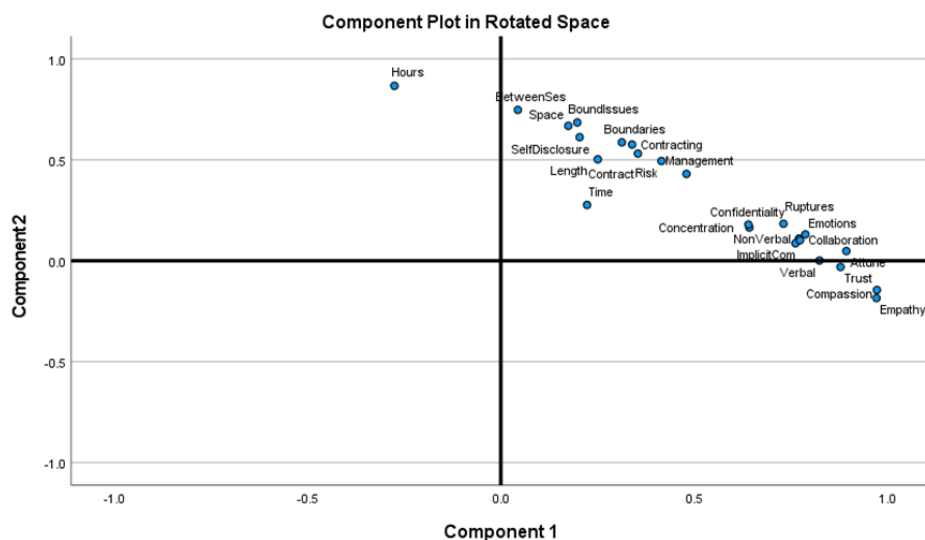
C.1.1. Principal Component Analysis

The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy statistic (Kaiser, 1970) indicates the proportion of variance amongst variables that could be caused by an underlying component, with values close to '1' indicating relatively compact

components. The KMO statistic for this study was .931 which is considered 'superb' (Hutcheson & Sofroniou, 1999) and, therefore, could be expected to produce reliable factors.

The use of the oblique rotation was supported by the correlation component matrix indicating a correlation of .616 (Appendix U), exceeding the criteria for using oblique rotation proposed by Tabachnick and Fidell (2019). Results from the principal component analysis supported two components, interpreted as a WA component and a TB component, as seen in Figure 4. It has previously been argued that the significance of a component loading depends on the sample size, proposing that for a sample size of 100 the loading should be $>.512$, and for a sample of 200 the factor loading should be $>.364$ to be significant (Field, 2018). Thus, considering our sample size, .512 was used as a more conservative criteria to determine which variables contributed to each component. Furthermore, items that loaded equally onto both factors were excluded.

Figure 4 *Principal Component Analysis Following Oblique Rotation.*



Results showed that all WA survey items loaded onto the WA component scale. One TB survey item also loaded more onto the WA component scale but was excluded on theoretical grounds. For the TB component scale, the loading of three items did not exceed .512, thus, were omitted from the final TB scale (Appendix U).

C.1.1.1. Reliability of Component Scales. Reliability analyses were run on both component scales identified. The WA scale indicated excellent internal consistency ($\alpha = .96$), as did the TB scale ($\alpha = .90$).

C.1.2. Assumption Testing

Statistical assumptions are conditions that, when met, allow the test statistic to be accepted at face value. Where assumptions are not met, this could lead to

inaccurate statistics and wrong conclusions being made. For bivariate correlations, the two assumptions considered most important are normality and linearity (Field, 2018). Thus, these assumptions were checked for variables included in each linear model used, as described below. Where assumptions were violated, methods were used to ensure the robustness of the model, as described below.

C.1.2.1. Linearity. Linearity is the assumption that predictor and outcome variables are linearly related. Scatterplots were used to test for linearity (Appendix V). Violation of the linearity assumption is suspected when there is a curve in the graph. As no curves in the plots are observed, it can be concluded that the assumption of linearity is met.

C.1.2.2. Normality. It is assumed that data is normally distributed. Histograms and the Shapiro-Wilk test are two methods that are often used to assess normality, although are not without limitations and may indicate incompatible results (Kim, 2013). To overcome these limitations, Kim (2013) proposed using z-scores by dividing the skewness and kurtosis values by the respective standard error, with the critical value depending on the sample size. For medium sample sizes ($50 < n < 300$), if the z-scores for skewness and kurtosis are outside of the range of -3.29 to 3.29, then the distribution is considered non-normal.

Table 13 *Statistics for Normality Testing*

Variable	Sample size (n)	Skewness	SE _{skewness}	Z _{skewness}	Kurtosis	SE _{kurtosis}	Z _{kurtosis}
WA	160	1.060	.192	5.521	.362	.381	.950
TB	160	1.014	.192	5.281	1.495	.381	3.924
HI	161	-.234	.191	-1.225	-.201	.380	-.529
SI	161	.263	.191	1.377	-.649	.380	-1.708

Note. SE = Standard Error.

As shown in Table 13, the WA and TB scales violated the normality assumption. Methods to address non-normality have been proposed to ensure statistical models used remain appropriate and, therefore, conclusions are valid and defensible (Pek et al., 2018). The bootstrap method is one possible approach that keeps the data within the linear model whilst addressing the issue of non-normality by

estimating the properties of the population distribution from the sample data (Field, 2018). Thus, bootstrapped confidence intervals at 95% were applied.

C.1.3. Associations with Working Alliance

Further associations between therapists' characteristics and the WA scale can be found in Table 14 below.

Table 14 *Associations Between Therapists' Characteristics and the WA Scale*

Characteristic	Correlation (<i>r</i>)	Confidence interval		<i>p</i> -value
		Lower	Upper	
Gender	.078 _{pb}	-.191	.049	.341
Age	.336	.164	.495	.010**
Qualified or in training	.123 _{pb}	-.054	.270	.129
Years practicing psychological therapy	.210	.039	.357	.010**
Present state of wellbeing	.213	.056	.362	.009**
Prior training on remote psychological therapy	.206 _{pb}	.009	.387	.011*
Use of phone or videoconferencing prior to Covid-19	.137 _{pb}	.009	.282	.092
Use of phone in therapy during Covid-19	.021 _{pb}	-.133	.199	.801
Number of sessions via phone during Covid-19	.057	-.105	.231	.492
Use of videoconferencing in therapy during Covid-19	.264 _{pb}	.159	.356	.001**
Number of sessions via videoconferencing during Covid-19	.254	.103	.418	.002**
Location of remote therapy	.166 _{pb}	.010	.296	.040
Theoretical orientation:				
Psychodynamic	.071	-.100	.264	.387
Behavioural	-.020	-.193	.151	.804
Cognitive	-.106	-.287	.076	.199
Humanistic	.136	-.034	.318	.098
Interpersonal	-.009	-.164	.156	.909
Systemic	-.006	-.183	.160	.939
Integrative	-.107	-.265	.057	.192

Note. _{pb} = point biserial correlation. * indicates $p < .05$; ** indicates $p < .01$.

C.1.4. Associations with Therapeutic Boundaries

Further associations between therapists' characteristics and the TB scale can be found in Table 15.

Table 15 Association Between Therapists' Characteristics and the TB Scale

Characteristic	Correlation (r)	Confidence interval		p-value
		Lower	Upper	
Gender	-.131 _{pb}	-.253	-.004	.106
Age	.311	.150	.456	.010**
Qualified or in training	.148 _{pb}	-.004	.291	.068
Years practicing psychological therapy	.150	-.022	.306	.067
Present state of wellbeing	.304	.166	.430	.010**
Prior training on remote psychological therapy	-.229 _{pb}	-.403	-.038	.004**
Use of phone or videoconferencing prior to Covid-19	-.060 _{pb}	-.212	.098	.458
Use of phone in therapy during Covid-19	.031 _{pb}	-.118	.215	.704
Number of sessions via phone during Covid-19	.087	-.081	.259	.291
Use of videoconferencing in therapy during Covid-19	-.145 _{pb}	-.270	-.028	.073
Number of sessions via videoconferencing during Covid-19	.186	.001	.332	.023*
Location of remote therapy	-.103 _{pb}	-.237	.042	.205
Theoretical orientation:				
Psychodynamic	.051	-.118	.224	.535
Behavioural	-.094	-.249	.064	.255
Cognitive	-.108	-.279	.067	.190
Humanistic	.133	-.039	.294	.105
Interpersonal	-.065	-.222	.111	.429
Systemic	-.026	-.174	.117	.756
Integrative	-.201	-.372	-.011	.014*

Note. _{pb} = point biserial correlation. * indicates $p < .05$; ** indicates $p < .01$.

Therapeutic boundary items that were not included in the TB scale following the PCA were correlated with the SI and HI scales ('the way I explain the limits of confidentiality'; 'my ability to create risk management plans'; 'the agreed length of therapy sessions'; 'my ability to effectively manage my client's risk'; 'my ability to attend appointments on time'). As two items were based on risk and were found to highly

correlate ($r = .841$), these items were merged to form a single 'risk management' score. Associations between these individual TB items and SI and HI scales can be found in Table 16.

Table 16 Association Between Remaining Therapeutic Boundary Items Omitted from the TB Scale and HI and SI

Item	Healing involvement				Stressful involvement				Note. *
	Correlation (<i>r</i>)	Confidence interval		p-value	Correlation (<i>r</i>)	Confidence interval		p-value	
		Lower	Upper			Lower	Upper		
Risk management	.405	.261	.528	.000**	-.225	-.351	-.090	.004**	
The way I explain the limits of confidentiality	.308	.136	.456	.000**	-.170	-.300	-.040	.031*	
The agreed length of therapy sessions	.207	.037	.373	.008**	-.215	-.362	-.066	.006**	
My ability to attend appointments on time	.209	.047	.363	.008**	-.243	-.388	-.089	.002**	

indicates $p < .05$; ** indicates $p < .01$.

Recognising that the work involvement patterns and present state of wellbeing both correlate with scores on the TB scale, the association between work involvement patterns and present state of wellbeing was considered. Present state of wellbeing positively associated with HI, $r(158) = .316$; $p < .000$; 95% CI [.195, .432], whereas SI negatively associated with wellbeing, $r(158) = -.539$; $p < .000$; 95% CI [-.637, -.430]. Partial correlations were completed to establish to what extent present state of wellbeing moderates the relationships between HI and SI with therapists' perceived abilities regarding therapeutic boundaries when working remotely. Results indicated that, when present state of wellbeing is controlled for, there remains a positive correlation between HI and TB experiences, $r(157) = .302$; $p < .000$; 95% CI [.150, .449]. There remains a negative correlation between SI and TB experiences when wellbeing is controlled for, $r(157) = -.255$; $p < .001$; 95% CI [-.407, -.109], although this is somewhat diminished compared to when wellbeing is not controlled for ($r = -.371$).

C.2. Phase Two

Additional quotes will be provided to support the themes and subthemes and increase the representation of participants. A critical approach will again be adopted to further expand upon considerations made in the journal paper.

C.2.1. *Different Experience of Boundaries in The Therapy*

Therapists described different experiences in their therapeutic boundaries when working remotely compared to face-to-face therapy, focusing specifically on the type of boundaries and their ability to maintain boundaries in therapy sessions.

C.2.1.1. Different Boundaries. Whilst there was a prominent theme that there were different therapeutic boundaries when working remotely, some boundaries were reported as being like face-to-face therapy: "it's pretty similar in the way, you've got to manage the time in particular, things like confidentiality. You know, I don't know all the other boundaries I mentioned in relation to face-to-face work still exist" (Derek). Similarly, regarding deliberate self-disclosure John reported using this "where I think it might be appropriate and helpful for the client, and that is no different in either situations, face-to-face or remote". Others described trying to adapt and transfer boundaries from face-to-face to remote therapy where possible:

So, I think it's just kind of translating that where we can to, and in terms of trying to maintain some of that therapy element a bit, and so when that hasn't been maintained just in the same ways pre-Covid, I would have said we are in a different room today, yeah if I've used the same room for someone most of the time and then use a different room as a one off, I would usually comment on it.

Yeah, it was that same kind of thing, the same process playing out I think in terms of being like why I'm not here. (Victoria)

Despite trying to maintain a 'therapy element', many therapists described a change in the boundary of what could be explored in therapy as indicated by Katie stating, "I guess sometimes it may be felt more like a check-in as opposed to a therapy session a lot of the time with clients". This perception of therapy being different was echoed by others. For example, Emily stated "I think it feels like they're not having real therapy or like it's a stopgap until they can have a face-to-face". Furthermore, some identified that this different perspective of therapy was also adopted by the service they worked in:

I think in the service I worked in, it was quite normalised therapy felt like it was no longer therapy and I think that was an experience of a lot of the clinicians that they were frequently saying, argh well it's just how it is, just got to get on, it's not going to be proper therapy until we're back in the room with people.
(Katie)

As also suggested by Katie, several participants described this different boundary of what therapy could focus on along with a desire or longing for face-to-face therapy to return. Whilst Jayne also described this longing, she considered if clients were well enough:

I think it's more checking in rather than the therapy hour if that makes sense. It feels as though it changed to, until she is well enough really to be able to, or until we can perhaps go back face-to-face it, I think it's going to be difficult to have, I suppose a traditional sense of what therapy is.

As well as the focus of therapy, many participants described changes in the formality of the therapeutic encounter when working remotely, which was considered a change in boundaries, as indicated by Derek stating:

I guess there's something about that that leads to a sort of informality that they don't feel so under pressure and I tend to have a cup of tea with me as well if I need one. So, I think that is a slight loosening of boundaries.

Whilst Derek considers a loosening of boundaries by both the therapist and client being able to "have a cup of tea", several therapists discussed the informal way in which clients presented for remote therapy. For example, Mandy spoke about "seeing people arrive in their own homes, dressed in their dressing gown and really observing that lack of preparation". This was also echoed by Victoria reporting "a

boundary issue is them being in things like pyjamas” whilst also recognising that this related to clients “taking it seriously...this is not like a fun chat”.

Furthermore, there was a common acknowledgement of a loss or removal of some boundaries compared to face-to-face therapy. Almost all participants reflected on the content of the therapeutic encounter, specifically regarding the loss of resources and techniques that they would normally use. Few participants described how they would typically use physical resources in face-to-face therapy that they were unable to use in remote therapy:

There's so much that I can't do, I haven't got my sand tray, I haven't got all my, you know, little crystals that I take in, you know, my felt tip pens, can't spread across the table and do a timeline or anything like that. It's shrunk a little bit in terms of the creativity that I would normally use. It's shrunk my resources.
(Jayne)

This appeared to add another layer of complexity when working with some individuals, such as individuals with learning disabilities, by limiting the method of engagement, as indicated by Emily:

With her having learning difficulties like I, she could understand what I was saying but I was very aware that she doesn't process things verbally well. So, in a different world I would be writing and drawing and colouring and playing with Play-Doh with her.

However, the most frequent reflection regarding therapists' experience of therapeutic boundaries was the loss of access to body language and how this impeded their therapeutic engagement with clients. It appeared that whilst the use of body language was helpful for building the therapeutic relationship, it is also used to guide therapists' boundaries with clients by being able to gauge how they are responding:

... you have to see the person, well the whole person let's say, and it's not about only the face or something but mostly about body language and how the person behaves... you see the body language feedback and it's really important for therapy because of course, online it's only this (pointing to head) and you lose a lot of information, I would put it that way. (Kimberley)

Several participants reflected upon the loss of access to their colleagues. This appeared to create a therapeutic boundary issue for participants as colleagues were viewed as resources that were often used to deal with and reflect upon difficulties

encountered in the therapy. Losing access to colleagues resulted in participants having to be more autonomous in their decision-making and feeling alone with this:

So, it's again sort of thinking about my resources that are available remotely as opposed to being in face-to-face therapy, surrounded by peers or being able to ask peers. So, I think yeah, I think it's sort of working on my own with that has been a bit of a challenge as well. I feel like I have to think on my toes a lot more. (Susan).

Although participants reflected on losses they had noticed and the impact that this had on therapeutic boundaries, there was an acknowledgement of remote therapy broadening the boundaries of therapy. A few therapists acknowledged that remote therapy provided the option of working with clients from different countries, as Derek indicated having "various clients in France and Switzerland and places like that, who I can only see remotely". Similarly, Derek also acknowledged the new possibility of being able to relocate himself whilst still being able to complete the therapy stating, "I'm moving location...and it's kind of really good because I am able to finish off or continue to see my clients over zoom".

Furthermore, some participants described how remote therapy provided "insight into how people live" (Danielle) or "a whole new avenue of exploration" (Susan):

The client who greeted me from her bed with a glass of wine in her hand was signalling something... If I had had the presence of mind, I could have used that as an opportunity to ask her, in effect, what it meant to her to restage the site of the encounter as she had done. (John)

C.2.1.2. Ability to Maintain Boundaries. Therapist's perceptions of their ability to maintain boundaries when working remotely varied. A third of participants spoke about the ease of which they were able to enforce boundaries, particularly regarding starting and ending the therapy session. For example, Derek described noticing the ease of which he could end sessions when working remotely:

Could you tell me more about that next week we're out of time now. Click, and it's done. And it feels less personal...This woman just would not stop talking and I did have to switch her off, I was five minutes over the end of the session, and I said look I am just going to switch off and I did.

Mandy also recognised the ability to physically end therapy sessions "with ease", although identified difficulty shifting between having "a set of rules that include seeing clients one-to-one and then to shifting to not", possibly further indicating

differences in therapy when working face-to-face compared to remotely. Whilst some participants appeared able to maintain therapeutic boundaries with ease in remote therapy, some therapists appeared to have more difficulty:

I think with face-to-face therapy it's a lot easier because you have body language, in terms of space that is, you have more of a sense of what's comfortable for the client and more of a sense of what's comfortable for me is the therapist as well. (Susan)

As indicated by Susan, her perceived ability in maintaining boundaries appeared to relate to the loss of access to body language, whereas for others this was harder because of new considerations, as indicated by Katie:

I found boundaries a lot harder to maintain, so ones that I hadn't really considered before... We could have an agreement about what we would do if we weren't able to get hold of each other, but I felt like that was never really very clear... So, I felt like those kinds of things were a lot harder to maintain and to be sure about what the actual clients wishes were.

Considering the type of boundary that therapists appear to have difficulty with, over half reflected upon the increased awareness of maintaining self-disclosure and that this was a different experience in remote therapy:

I want the focus on the professional relationship and what the client brings ...But there is material here which I guess is potentially distraction... if I were to alter the angle of the screen you will discover this room is full of musical instruments. Now there is no reason why clients need to know that. (John)

As indicated by John, one of the ways therapists managed this was to plan where they would do remote therapy from, particularly if therapy were via videoconferencing and clients could see into their homes. For example, Victoria described the area behind her that clients would see as being "a blank slate", whereas Emily reported carefully organising her space with items that she would be comfortable talking about:

I've kind of carefully cultivated my background, it's a white wall and I have a picture...so if anyone does ask, I'm happy to talk about it and use it as a conversation point. There's nothing behind me that I feel could give anything away of me personally.

Furthermore, recognising the differences in therapeutic boundaries and their ability to maintain these, therapists reported using different strategies. Most therapists described having clear expectations that would be contracted at the outset of remote therapy. Some therapists suggested that this would help them to feel more able to maintain or reaffirm boundaries if needed, by being able to return to the contract:

I think most people are fine to start with and then the boundaries might slip a little bit but then because we haven't set up that initial thing it's hard to sort of come back to or have a baseline, [by saying] ooo we did discuss that you would be wearing daytime clothes and had a shower or whatever else. (Victoria)

Whilst taking steps to maintain boundaries, a few therapists described having to balance this with being more flexible when working remotely, which appeared to depend on the client's situation:

It's actually not cut and dry, it depends on the relationship with the individual client and the client circumstances. So, a mother with a young child who is not exactly going to be trussed up in a corner so she can't interfere for an hour whilst we're working...So, I guess what I'm saying is that there's slightly more flexibility involved in having to learn how to accommodate peoples individual lives rather than having them in the relatively sterile setting of my consulting room. (John)

When also talking about reaffirming boundaries in remote therapy, some therapists described explaining that the session would need to be rescheduled if the boundaries could not be maintained, as suggested by Kimberley:

Usually clients are fine with it, they just close the door and say they're having sessions, and those clients that are still crossing the boundary, I either ask them to please ask your partner to leave the room and we will continue, or we will have to reschedule.

Finally, whilst a few therapists described how reaffirming boundaries resulted in a premature termination of therapy, Mandy reported choosing to stop providing therapy remotely because of the different experiences she had observed and feeling unable to provide effective therapy stating, "working remotely, I had to let go of it, I can't do it... And I guess that is a personal boundary, to arrive at that place where I go this doesn't work for me as a therapist."

C.2.2. Work Home Boundary

Many therapists identified a blurring of the boundary between their home and work lives. This appeared to be particularly present for therapists who provided therapy from a clinic and not their own home. This blurring of boundary was described mostly in relation to the loss of commute and distance between work and home:

I'm finished with the client and I'm back in my home with my family, so I suppose the distance between, the distance and I'm going to use the word unwinding from a session, you know, if I'm face-to-face and driving so have got so many minutes before I get home to kind of debrief and regroup, you know, if it's been a difficult session. (Jayne)

For others, this blurring related to an overlap of what their personal space was being used for, as indicated by Victoria stating, "I was also using that as my place where I did some of the physical exercise, yoga and stuff like that... So, there was just a very, a lot of blurring of what that space was used for".

This blurring of work and home boundaries affected therapists' ability to 'switch off' from work, as indicated by Amy who also related this to no longer being able to commute to work stating, "I don't have a car journey home, I don't have that switch off... Whereas I shut my laptop off and then I'm rattling around at home". For some, the content of thoughts that they would have about the session or clients were described as similar to what they would experience in face-to-face therapy, but that this was a longer process, perhaps because of not having the transition of a commute:

So, I so would still be sat thinking for longer, all is that what I should have done or should I have done this. So, yeah, I think I would probably mull over it a bit longer than I would normally in the office. (Katie)

Additionally, therapists described how working remotely also involved aspects of their personal lives that would not present if they were not working at home, contributing to this blurring of their work home boundary. For example, considering family members or others that therapists might share their home, as suggested by Susan stating, "I share my space with one other person and... protecting them as well which was challenging at first".

To cope with this blurring of boundaries, many therapists reported taking steps to create a work-home boundary for themselves. For some, this involved creating a physical space from which they could work, as suggested by Danielle:

I haven't had that very defined now is the time I'm going to work, now is the time leaving work bit. So, I've created it artificially by having a room that I go to,

and then I shut the door and I genuinely do think that's helped me, I really do think that's helped me to hold boundaries around work.

Alternatively, some therapists described replicating behaviours that they would do in face-to-face therapy to help them step into their working role:

I, oddly I find it comforting, reassuring, and useful for myself to replicate many of the behaviours online that would be present in normal face-to-face... normally I am fully suited and booted when I'm working with clients... this is actually quite important to me in, inhabiting the role and being fully present with it. (John)

Similarly, Emily described engaging in behaviours to maintain the transition between work and home, although noticed the impact that this had on herself when she did not maintain the transition whilst working remotely:

I had some annual leave and I let it slip towards the leave where I would like have pyjama bottoms on and I could really feel how that impacted how I felt, I didn't ever feel like I'd left work at the end of the day. Whereas keeping those transition times, getting dressed in my work clothes, and taking my workload off when I home, that's really really helpful.

Finally, to help create the separation between work and home, some therapists described having to involve the planning of their personal lives to help maintain a boundary with work. For Emily, this appeared to involve contracting interactions with her partner to help her maintain that separation between her work and personal life:

I also said to my partner, so my partner gets home a little bit before me, when I'm sat at my table it's because I'm at work and if I get up and come to you that's fine, we can chat, but please don't come there... So now I set it up so that when I'm sat there, I can't talk to you because I want that physical, metaphorical separation.

C.2.3. Changes in the Therapeutic Safe Space

'Changes in the therapeutic safe space' refers to a frequent observation that therapists noted regarding changes to the safe therapeutic milieu that they would typically strive for in face-to-face therapy. Whilst relating to a central theme of therapeutic safe space, these changes were observed in relation to the actual space in which therapy was held as well as external disruptions and distractions to that space for both the therapist and client; thus, two subthemes were created: 'therapeutic safe space' and 'disruptions and distractions'.

C.2.3.1. Therapeutic Safe Space. The need for a safe space to do therapy was acknowledged by many therapists and how this safe space enables clients to “say whatever they believe necessary or appropriate for them to be saying to help them” (John). Kimberley considered the boundary of a safe place for clients to be “the most important in face-to-face therapy”. The safe therapeutic space of a clinic was described by some therapists as being containing for clients, as suggested by Julie:

I think there's something about the clinic space... I think it feels like a safe place that's kind of not connected to anything that, you know, it's so, what's the word I'm looking for, I suppose it is that clinical environment. You know, I can bring the stuff here, I can open it up here, then I can actually, you know, leave it there with you. I think there's a level of safety in that.

When considering how a therapeutic safe space is experienced in remote therapy, therapists described a shift in responsibility between the therapist and client. In face-to-face therapy the therapist would be responsible for the environment, whereas in remote therapy the therapist and client are each responsible for their respective environment. Whilst therapists would ask clients if they were in a safe space, many reported the difficulty that clients had with this and the impact that this had on therapy:

So, some people for whom it's still very difficult to have active kind of intervention because they are still concerned that family can hear them, even if they were trying take themselves off to a private space, they're still worried that if there's family in the house it will be overheard. (Julie)

This was also echoed by Derek who also identified the impact on clients feeling able to access therapy if they were unable to provide themselves with a safe space:

It can be slightly tricky for them to find a private space within the home, so that's a boundary issue, you know, that's the boundary issue for the client. And certainly, one couple I was seeing before the lockdown, they couldn't continue because it would be impossible for them. They had a teenage daughter and felt like they couldn't have enough privacy, so they stopped their sessions.

For some therapists, this shift in responsibility appeared to represent a change in their perceived control over the therapeutic encounter. Like the clinic being containing for clients, this perceived control of the therapy appeared to be containing for therapists, which is challenged in the realm of remote therapy when control is given to the client regarding the therapeutic space:

Maybe there's something about feeling in control of the situation because in face-to-face that's what it was. I was, it was my domain because it was my workplace, I was in control of the situation. I was now, people are in their own homes, I'm not in control, so it's hard to manage things. (Emily)

Kimberley also indicated that she preferred face-to-face therapy where she has more control over the environment, which enables therapy to focus on what is needed:

Of course, it should be private, that's why I prefer face-to-face at my place because then I make sure that it's private confidential, and we have the space to spend an hour in a way that we need to do this.

C.2.3.2. Disruptions and Distractions. Therapists described external disruptions and distractions to the therapeutic space. When working remotely, therapists experienced these disruptions as “happening outside of my control” (Susan), whilst also causing a break in therapy that would not typically happen in face-to-face therapy:

I phoned this family and then the door went on I thought arghhh I'd forgotten I was waiting for the dog walker. So, having to say to this parent on the phone, I'm really sorry, hold on for one sec, I've just got to get the door, and apologise. And again, parents doing that with theirs as well... There's been a few times like that where things have been interrupted where you wouldn't normally be if you were in the office, you wouldn't normally have to go to answer the door. (Victoria).

This was also experienced by Katie who stated, “I had one appointment where a delivery driver just kept knocking at the door and in the end, I had to say to the client, I'm really sorry but I'm going to have to answer the door”. Furthermore, Katie reported having had the opportunity to provide remote therapy from a clinic base reporting this to have been “slightly easier to manage in some ways ” because “you're not going to be disrupted”. Nevertheless, this would not address the difficulty of disruptions and distractions at the clients end, which were also said to occur.

Where these examples were of distractions from outside of the space in which the therapist or client were engaging in the therapy, several therapists described the distraction of others entering the client's space:

I have had patient sort of, you know, someone comes into the room and they're saying hang on a minute, and they've turned and are having a full-on

conversation with whoever is coming into the room, giving them shopping lists or whatever and I'm thinking okay, we sort of need to get on here.

Likewise, John described a client being distracted by their child, encroaching on what would be a protected space in his office stating, "what I have had is the classic noticing client distracted for a moment and then hearing a small voice saying from her elbow, mommy need a wee. That doesn't tend to happen in my office."

Finally, issues with technology were also considered a disruption to the therapy process, as indicated by Kimberley:

I don't know if it's boundaries but disruptions like Skype disruptions or Zoom when only one person can talk and the other should be silent, and sometimes you have to interrupt your client, so really it's a process and can be a big distraction. In face-to-face, you don't have that problem... But there are sometimes where there are just technical disruptions or you don't have internet connection or stuff like that, you have to call again and then you lose the topic, you lose the process.

C.2.4. Impact of Boundaries When Working Remotely

'Impact of boundaries when working remotely' captures the effects that therapists perceived the different experiences of therapeutic boundaries when working remotely to have had on themselves, the client, and the therapeutic process.

C.2.4.1. Impact on Therapists. Considering therapists engagement in therapy, several described an increased effort when working remotely. For example, Derek reported having "to concentrate harder to pick up the nuances... So, it means that it does get quite tiring". Emily also described an increased effort to connect with the client, which appeared to challenge her sense of boundary between herself and the client:

I have to reach through the screen a lot more, so I have to, this is going to sound really strange, so I have to be a lot more present with person to pick up on all these tiny cues that are going on... So, I kind of have to put more effort in and push through which means that I can't have as clear a barrier as I did before.

Despite therapists describing an increased effort in the therapy sessions, several therapists described how the different therapeutic boundaries impacted how present they were in therapy:

I don't know if I'm as present as I would like to be in those situations, and there's far too much I think going off in, like I feel less able to distinguish what actually is countertransference when I'm up in my own head, if that makes sense. (Amy)

Mandy also acknowledged this lack of presence in remote therapy, whilst also considering the impact that this would have on the relationship:

But working online, oh my God. There's a wonderful piece of writing actually somewhere that some therapists did that said to constantly be in the presence of somebody's absence is destructive to the relationship. It's just a mirror of that stuff.

Therapists frequently described an unpleasant emotional impact of the therapeutic boundaries they described when working remotely. Furthermore, the intensity of therapists emotional experience varied, appearing to range along a continuum from "feeling a little bit frustrated" (Amy), to finding an experience "really embarrassing" (Katie), to feeling "profoundly hurt, profoundly exhausted, profoundly blown apart by the experience" (Mandy).

Conversely, few therapists acknowledged aspects of remote therapy and changes in therapeutic boundaries to have been helpful for the wellbeing:

Which in lots of ways, has reduced my stress as well... Because of not doing the commute, not having the initial stress things like at work as well, often parking was okay but we hot desk and there's not always a desk, so removing that stress was helpful in some ways in terms of me having capacity to start my day feeling a little bit calmer and have more thought or capacity for my job.

Therapists also described experiencing self-doubt in their capabilities as a therapist:

I think they made me feel a lot more unsure as a therapist and I guess worrying about if I were actually following some of the guiding principles that we would normally follow... And I guess that left me feeling a bit like maybe I wasn't doing the role that I was meant to be doing. (Katie)

This experience of questioning their ability to do their job was also described by Mandy stating, "I went through a good two months of absolute, I've lost the word now but, persecutor complex of being a fraud, of ooo I'm incompetent or, it was a horrible feeling of shouldn't be doing this, I should stop".

To cope with the impact on themselves, therapists described an increased need for carefully managing their own well-being as Derek stated, “so I have to be more careful about taking breaks and, you know, looking after myself”. Jayne reported the need for self-care to “protect myself from burnout or vicarious trauma, it’s like the antithesis to it”, although the form of self-care varied between therapists. Some described engaging in practical activities or adjustments, such as “exercise” (Julie) or investing in a “very comfortable chair” (Derek) to do remote therapy from, whereas others described efforts to rebalance themselves:

It’s just something about the change of pace like being somewhere different for a minute. I think that, even like just basic, you know we might teach clients like basic grounding strategies or like they need to use distraction techniques.
(Amy)

C.2.4.2. Impact on Clients. Therapists reported the different therapeutic boundary experiences to have impacted on client’s engagement in therapy. Several therapists described clients as being inhibited and more cautious about what they shared in therapy because of others in their presence. For example, Katie reported “I found, particularly people who weren’t able to access that maybe safe and private space, they tended to be much more guarded in what they will talk about”. This was also echoed by Jayne who reported one of her clients to “whisper quite a lot, and she feels that there is somebody, her daughter-in-law standing or listening in. So, she has to be very careful about what she says”. Whereas the engagement of these clients was inhibited because of other people being present, John described the impact on a client’s engagement due to other factors:

There is another interesting, almost covert thing that happens with perhaps two clients, she and one other, where I checked whether she was actually using another device at the same time, again because of her eye movements and apparent distractions.

On the contrary, Emily considered if “some clients have enjoyed the fact that they don’t have to be as boundaried back” and how this may have increased their engagement by being able to “bring more and more stuff in... you know, it depends for everyone, but sometimes I think they do because they’re like all this is my dad”.

C.2.4.3. Therapy Process.

Therapists also spoke about the impact of the different boundary experiences on the therapeutic process. Specifically, several therapists discussed the impact on the therapeutic relationship. This impact, however, appeared to range from being

considered a positive experience to hindering the relationship at the other end of the continuum. Where experiences were viewed positively, this appeared to be when something positive was added to the therapy experience:

It's actually helped the relationship and that she knows that I'm not being censorious as the other client seemed to have found it on that occasion, and that I am collaborating with her in a difficult situation, and I trust her to manage it in the best way, so, I think that's been quite useful in that respect. (John)

Alternatively, where boundaries appear to have negatively impacted on the relationship, this seemed to occur when there was a loss of opportunity perhaps:

And then, sort of interrupts that rapport that you have with the client because it might be a crucial point in the therapy where there might be, they might be starting to open up and sharing something that they might not have shared with anyone else before, but then you might hear a lawnmower or leaf blower, or someone is arguing with someone and that comes through the wall.

Kimberley, however, reported observing no change in the therapeutic relationship stating, "I think building the relationship hasn't changed at all. I'm also surprised but this didn't change, I would say it's the same case, some people go, some people stay, it's fine".

Finally, therapists described changes in the focus and quality of the therapeutic work because of changes in the therapeutic boundaries when working remotely. Some therapists described therapy as being less focused. For example, when talking about the changes in the formality of therapy sessions and how this "blurred" the therapeutic relationship, Mandy described herself as being "not so explorative of what I'm doing and what I'm saying, why I am saying it". Jayne also identified the focus of therapy as being less explorative stating, "we've really struggled to actually get any work, any real sort of exploratory work done because of confidentiality and her not feeling able". However, some therapists held divergent views that therapy had, in some circumstances, remained focused on the task at hand:

So, there's times where actually just feels, it's been great, it's been fine doing it remotely rather than face-to-face and that has had either little impact in terms of negative I guess or even a positive impact in terms of, you know, that felt like a really good session... I mean in terms of being aligned the therapeutic task, what we're trying to achieve. (Amy)

Chapter D: Extended Discussion

This section will further expand on the discussion provided in the journal article. This will include a discussion of study findings in relation to existing literature and theory, clinical implications, strengths and limitations of the study, and recommendations for future research.

D.1. Study Findings in Relation to Existing Literature and Theory

D.1.1. Working Alliance and Remote Therapy

Considering the WA when working remotely, previous literature has indicated that therapists rate the alliance lower, which was not the case for client ratings (Norwood et al., 2018). This study provides a unique contribution to the literature by beginning to explore what those different experiences are for therapists, specifically in relation to their perceived abilities regarding the alliance. This study highlights therapists feel less able to effectively communicate nonverbally with their clients, gauge client's implicit communications and emotions, and attune with clients when working remotely. However, they were able to be compassionate and empathic, and work collaboratively with clients to achieve their goals. This supports previous findings where therapists acknowledged that developing a WA online is possible, although a broader spectrum of communication happens in face-to-face therapy (Bengtsson et al., 2015). Furthermore, the results in this study relate to recent findings by Irvine et al (2020) who reported no significant differences between therapists' ability to be empathic and attentive when working via telephone compared to face-to-face. Irvine et al (2020) considered this in the context of existing literature claiming that clients perceive nonverbal body language as less important than therapists validation, which may provide a possible explanation for client ratings of the alliance being comparable in remote therapy. This study adds further support to this hypothesis inasmuch that the aspects of the WA that therapists reported more difficulty with were based on perhaps having less access to body language. Nevertheless, this finding should also be considered in relation to the established finding regarding the impact that therapists' experience of the WA has on client outcome in face-to-face therapy, which is greater than clients' (Wampold & Imel, 2015).

Previous findings suggest that empathy accounts for less variance in therapy compared to goal consensus (Wampold & Imel, 2015). The study findings can be considered in relation to the different aspects of Bordin's (1979) conceptualisation of the WA (i.e., goal, task, and bond) and their relevance when working remotely. Although only focusing on cognitive therapy, Webb et al (2011) found the relationship (i.e., bond) to be less predictive of outcome compared to agreement on goal and task in face-to-face therapy. Similar results have been found when aspects of the WA have

been explored in internet-based therapies, such as counselling via a text-based medium (Cook & Doyle, 2002). Berger (2016) therefore considered whether the bond was also of less importance in internet-based therapies compared to the agreement on goal and task. Considering remote therapy where there is a synchronous interaction between therapist and client, findings from this study indicate that therapists may experience changes to different aspects of the alliance, such as relating nonverbally to clients whilst being able to maintain collaboration on tasks. These differences may support Simpson and Reid's (2014) findings that therapists rated the level of 'bond' as being lower in the videoconferencing therapy compared to face-to-face, although bond was still considered to be high in both conditions. Acknowledging that the WA may be used as a change process in remote therapy, which has been supported for videoconferencing (Norwood, 2019), understanding differences in therapists' experience of the WA in remote therapy and the potential impact on outcome would enable therapists to monitor the alliance, and make changes accordingly to improve outcome. For example, if task and goal are of more importance in remote therapy processes and outcomes then therapists could monitor these aspects of the alliance more specifically.

D.1.2. Therapeutic Boundaries and Remote Therapy

Considering the paucity of research into TB in remote therapy despite claims that differences may be observed (Drum & Littleton, 2014), this study provides novel contributions by beginning to explore this area. The survey findings indicated that the most notable differences observed regarding TB involved therapists ability to: only work during working hours, attend appointments on time, and to stop thinking about their client's problems in the time between therapy sessions. Furthermore, phase two further highlighted differences that therapists noticed, including changes to the therapeutic space, requiring clients to take some responsibility in this. This supports previous literature which argues that therapists lack control over the environment in telephone therapy (Brenes et al., 2011), although this study suggests that this is also likely to be the case for videoconferencing psychotherapy. Simpson et al. (2020) considered changes to the therapeutic space following the move to video therapy during COVID-19, challenging the dogma of TB in conventional therapy, which may not remain necessary in remote therapy. For example, a loss of control over the therapeutic space may create a balance in the interpersonal power between therapist and client (Haas et al., 1996). Brenes et al (2011) proposed setting firm boundaries from the outset in terms of how sessions would be conducted as a way of managing this change in control; similarly, therapists in this study described establishing boundaries with a contract at the outset so that this could be returned to if needed. Others, however,

argue that therapists should hold a fluid construction of boundaries in remote therapy which may facilitate the development of a deeper therapeutic relationship, whilst recognising that this may provide challenges in terms of boundary violations (Simpson et al., 2020).

Furthermore, therapists described a change in the formality of sessions in the way clients behaved and the nature of the relationship. This supports Drum and Littleton's (2014) argument that remote therapy is likely to "prompt more frequent and casual interactions and behaviours" (p. 310), which could result in an increase in boundary crossings and violations. Whilst this study highlights and explains therapists' experience of boundaries when working remotely, conclusions cannot be drawn regarding whether the informality in remote therapy sessions consequently increases boundary crossings or violations. The British Association for Counselling and Psychotherapy (BACP, 2017) consider the 'formal nature' of the therapist-client relationship, claiming that this protects both parties, which has been commonly accepted dogma in face-to-face therapy. Except for what may be considered explicit boundary transgressions, such as sexual intercourse with a client, a reduction in the formality of therapy may arguably provide some benefits to therapy. Nevertheless, Simpson et al. (2020) argue that whilst increased flexibility might be warranted in video therapy, therapy may become less formal and more casual requiring the upholding of professional boundaries. This was noticed in this study whereby some therapists reported having to re-establish boundaries when a reduction in the formality of sessions occurred or, in more extreme cases, re-scheduling or terminating therapy. It raises the question however, regarding the impact that these different TB have when working remotely on therapy processes and outcome compared to face-to-face therapy.

Finally, the survey and interview findings highlight the difficulty therapists encountered with their work-home boundary and 'switching off' from work. This finding can be considered in the context of existing literature on therapists' intersession experiences; that is the thoughts, feelings, dreams, and images that therapists experience about the therapy or client in the time between sessions (for a systematic review see James et al, in press). Qualitative exploration of therapists' intersession experiences highlights that they may occur when boundaries are becoming blurred or potentially crossed (Bimont & Werbart, 2018; Knox et al., 2018). Therefore, in relation to the point raised above regarding boundary crossings and violations, it could be considered that boundaries experienced when working remotely may increase therapists' intersessions experiences, in turn potentially indicating possible boundary crossings. However, this would warrant further exploration.

D.1.3. Therapist Work Involvement and Remote Therapy

To the authors knowledge, this is the first study exploring therapists' work experience through the lens of established work involvement patterns in remote therapy. Compared to existing data for face-to-face therapy, this study indicated higher rates of SI. As noted in the journal paper, this finding could be considered in relation to the unpleasant emotional experiences that therapists described during the interviews. Furthermore however, therapists also described experiences of self-doubt in their ability to manage boundaries when working remotely. Professional self-doubt has been found to be the most commonly experienced difficulty that therapists experience in face-to-face practice (Orlinsky & Rønnestad 2005), with therapists experiencing professional self-doubt being more likely to experience intersession experiences (Schröder et al., 2009). Furthermore, this supports recent findings during COVID-19 where increased rates of self-doubt were found in therapists using videoconferencing compared to pre-pandemic data (Aafjes-van Doorn et al., 2020). Considering that SI is associated with difficulties in practice, it is therefore unsurprising that there were increased rates of SI found in this study. Nevertheless, these findings highlight potential reasons for increased SI and, therefore, enable therapists to be aware of this when working remotely and take steps to reduce SI and perhaps move into 'effective practice'.

D.2. Clinical Implications

The clinical implications of this research are twofold; firstly, increasing therapists awareness of potential changes in their perceived abilities regarding the WA and TB when working remotely and, secondly, supporting therapists with these changes and the impact on their experience of therapy. Such implication should also be considered in the context of current healthcare policy (e.g., Topol Review, 2019). Whilst individuals will be given more choice and control over their care and treatment, the NHS aims to provide a 'digital first' approach within the next ten years (NHS, 2019). Within mental health services specifically, the use of technology is considered necessary due to the rising demand (Roland et al., 2020). This raises the question of how much choice therapists will have in the mode of therapy they will provide. Contrastingly, therapists working in private practice may have more choice depending on their preferences. Where therapists do not have a choice, particular attention may need to be given to the perceived differences observed in this study between modes of therapy.

Clinically, this research highlights areas for therapists and services to be aware of when providing remote therapy. This research indicates potential changes in therapists' perceived ability to establish and maintain a WA when working remotely,

which will enable therapists to think about how to overcome and/or work with such changes. For example, being more aware of their vocal tone or use of verbal communications when there is a loss of visual cues, particularly in telephone therapy. The use of a 'digital navigator' has been proposed (Wisniewski et al., 2020). Considered a new member of the healthcare team, this non-clinical role would support the use of digital technology within services. As well as having call smart phone and technology troubleshooting skills, digital navigators are trained in 'engagement techniques', such as motivational interviewing skills, to support clients with the technology, which is proposed to aid the therapeutic process and alliance. The digital navigator may therefore provide a helpful role in addressing some of the perceived barriers in remote therapy. However, recognising the association between alliance and outcome, specifically the magnitude of therapists' contribution to this association (Wampold & Imel, 2015), therapists' routine monitoring of the WA may still be pertinent in remote therapy alongside support from the digital navigator.

Furthermore, these findings will help therapists to be more aware of certain TB that they might experience when working remotely. Several experiences were observed, such as others being present and client's informal behaviours and interactions. Increased awareness of these changes would enable therapists to better manage boundaries and minimise potential boundary crossings or violations, therefore, protecting clients and therapists. Considering the boundary seesaw model (Hamilton, 2010), therapists can shift along a continuum between maintaining safe and helpful boundaries to experiencing boundary crossings or violations. Therefore, being aware of potential boundary experiences when working remotely will enable therapists to consider how they may stay in the 'safe and helpful zone'. For example, therapists in this study identified needing to establish boundaries using a therapy contract from the outset.

Considering the clinical utility of the findings in relation to the impact on therapists and their experiences, there are clear implications regarding supporting therapists with the emotional impact, perceived abilities in their work, and ways of coping. This is especially important considering the associations found between SI and therapists burnout (Steel et al., 2015; Zeeck et al., 2012). However, ways of increasing experiences of HI have been proposed, suggested focusing on cumulative career development, theoretical breadth, and currently experienced growth (Duncan, 2010). Services could therefore support therapists to experience more HI when working remotely, which would reduce experiences of self-doubt and the risk of burnout. Duncan (2010) suggests that routine collection of client feedback enables therapists to monitor their outcomes and plot their cumulative career development. Supporting

therapists to track their outcomes may also provide a microscopic view of their currently experienced growth, providing an opportunity to learn from what is or is not beneficial in remote therapy and develop their practice. Similarly, therapists in this study spoke about the importance of supervision and time for reflection with peers. This provided opportunities to also learn new ways of coping and may increase therapists' confidence when working remotely. Furthermore, it has been proposed that with time may come increased confidence in remote therapy (Aafjes-van Doorn et al., 2020) and, therefore, possibly reducing therapists' self-doubt and unpleasant experiences.

Overall, this study indicates that some aspects of remote therapy are experienced differently in relation to the WA, TB, and therapists work experience. However, these differences vary in terms of being experienced as positively or negatively. Recognising that clients do not fit into a 'one size fits all' service model and, similarly, therapists may have different preferences regarding the mode of therapy they provide, it is likely that services may benefit from having more flexibility and choice regarding how therapy is provided and received in the longer-term following COVID-19. Mind (2021) also support the argument for individuals having a choice in how they receive mental health services, as well as the need to support and equip staff in providing remote therapy.

D.3. Strengths and Limitations

The sequential explanatory design could be considered a strength of the study as this enabled further exploration of the findings from phase one, therefore adding depth the survey findings. Furthermore, this design would enable timely dissemination of the findings, which is important considering the context of therapists rapid uptake of remote therapy in response to COVID-19. This may not have been possible in a longitudinal design. Nevertheless, the cross-sectional nature of the study limits the conclusions that can be drawn specifically in comparison to face-to-face therapy. As data from face-to-face therapy was not collected as part of this study, direct comparisons cannot be drawn and by comparing to existing data may limit how much confidence we may have in there being a difference between modes of therapy. However, steps were taken to try to capture differences between face-to-face and remote therapy, such as recruiting therapists who had recently changed from providing therapy face-to-face to remote modes and including positive, negative, and neutral response options on the survey.

In addition to the limitations discussed in the journal paper regarding the sample, further sampling limitations presented in phase two. It is possible that there was a self-selection bias of therapists wanting to engage. This may somewhat explain the absence of therapists who may experience 'disengaged' or 'distressing' practice

who, by virtue of their characterised coping styles being avoidant, may be less likely to engage in such research. Furthermore, whilst efforts were taken to adopt a maximum variation sample for phase two, participant scores on the therapeutic boundaries were overall more negatively weighted, with few participants having positive scores. Although qualitative findings are not intended to be generalisable (Braun & Clarke, 2013), this may potentially limit how representative the phase two findings are of psychological therapists. That being said, the critical realist approach does not aim for generalisation but instead to develop a deeper understanding of a phenomenon (McEvoy & Richards, 2016), which has been achieved in this study.

D.4. Recommendations for Future Research

Whilst these novel findings provide insight into the different experiences that therapists have of the WA and TB when working remotely, it does not enable us to draw direct comparisons to face-to-face therapy. It would therefore be plausible to explore these differences more directly. Considering arguments regarding the importance of different components of the WA in internet therapies (Berger, 2016), whether this is the case or not for remote therapy where there is a synchronous interaction compared to face-to-face could be explored. Such research could use a validated scale that explores each component of the WA, such as the Working Alliance Inventory (Horvath & Greenberg, 1986). Furthermore, whether the alliance is a predictor of outcome is still under explored in remote therapy where there is a synchronous interaction (Berger, 2016). Whilst the clients rating of the alliance has been considered most important in relation to outcome (Norwood, 2019), therapists' perceived abilities regarding the WA could also be explored in relation to the impact on therapeutic outcome between remote and face-to-face therapy conditions.

Similarly, this study highlights several areas in relation to TB that would warrant further exploration. The study findings indicate that novel boundaries occur in remote therapy, such as changes in the formality of sessions and therapists increased ability to attend sessions on time, with existing literature suggesting that such changes may result in boundary crossings or violations (Drum & Littleton, 2014). However, this was beyond the scope of this study. It would be interesting to know if therapists do experience aspects of TB differently in remote therapy compared to face-to-face, including considerations of boundary crossings and violations, and the impact this has on therapeutic processes and outcomes. Additionally, therapists described changes in the therapeutic space and challenges particularly when others are present and the impact this has on clients engagement. The impact of this change in space would also be an interesting avenue of further research.

Considering the findings in relation to existing literature, it is possible that therapists working remotely may experience increased intersession experiences, unpleasant emotions, and difficulties in practice including professional self-doubt. However, the extent of this potential increase and impact on therapeutic processes and outcome was beyond the scope of this study, although would warrant further exploration. Considering the dynamic nature of work involvement patterns, it would also be helpful to further explore the frequency of these patterns when working remotely. This would enable therapists to be aware of potential differences between the modes of therapy and to be provided with support accordingly, such as clinical supervision, to help therapists experience more 'effective practice'.

Chapter E: Critical Reflection

This section critically reflects on the challenges and issues I encountered throughout my Doctorate in Clinical Psychology (DClinPsy) research journey. As the research presented in this study was not the initial project I set out to complete, I will firstly reflect on my overall research experience and, secondly, reflect specifically on aspects of the study presented here. Where appropriate, extracts from my reflexive journal will be used to support reflections.

C.1. Research Process Throughout the DClinPsy

On reflection, my research journey throughout the DClinPsy is best described as an emotional rollercoaster ride. Whilst there have been very good, high times where I have felt excited, invested, and committed to my research, there have been low times where I have doubted my ability to do research and resorted to wanting to just do any research to get me through the course. Nevertheless, had I have not experienced my rollercoaster journey of research, I very much doubt that my research skills and knowledge would have developed to the level that they have.

The study presented here is the third research project considered, which thankfully came to fruition. My initial research idea was one proposed by the course in their book of suggested ideas. This project related to older adults, a population that I enjoyed working clinically with from my experiences prior to training; therefore, I decided to pursue this project and felt invested in it. However, during a few different opportunities where we were able to present our thesis idea to course staff, I was strongly advised against pursuing the project as it was. This posed several challenges regarding whether I continued with the research idea or completely change topic. Considering that I had already made changes following concerns raised in the initial presentations, I thought the project did not feel feasible to do and give due thought to within the time frame of the DClinPsy. Therefore, I decided to completely change topic. This was my first low experience in my research journey, where I doubted my research abilities considering that this was a project suggested by the course and, in my mind, was an established idea. Nevertheless, it taught me the importance of having a clear research question and epistemological position, something that could not be rushed as I had perhaps previously thought. Furthermore, the reading I had done at the time developed my knowledge of existing literature in relation to the topic, as well as epistemology and methodology.

Through discussions with research supervisors, we agreed that changing topic was possibly the most responsible step to take at that point. I subsequently began exploring another area of interest, which was also a proposed idea from the course. This idea was also of interest because of my previous experiences and own

observations when providing therapy but, at the time, I was also developing an interest in therapeutic process research, specifically regarding what makes therapy work and how I can use research in this area in my own clinical practice. Considering that this was a completely different area of research with a possible different epistemology and methodology, being interested and invested enabled me to fully engage with the literature. As well as immersing myself in the existing literature, taking the time to explore this idea in supervision was particularly helpful in shaping the research question and design, as I had learned the value of this from my initial research venture.

Based on therapists' intersession experiences, this research idea appeared to be coming to fruition, receiving favourable feedback from course staff on my research project proposal. This project had also received support from a potential field supervisor who had agreed that I could recruit through their social enterprise therapy service, which was considered a feasible recruitment strategy that would save time by not having to apply for NHS ethics. Furthermore, this provided the opportunity of presenting my project to others, whilst also increasing my awareness of considering other stakeholders in the project, such as thinking about how therapists in practice would facilitate data collection. Additionally, I had completed a systematic literature review of existing literature on therapists' intersession experiences, which further strengthened my investment and interest in the area. Feedback from my project proposal and systematic literature review, as well as my literature review recently being accepted for publication (James et al, in press), increased my confidence in my research abilities and the prospect of successfully completing this as my thesis in partial fulfilment for the DClinPsy.

As I was about to commence data collection in March 2020, the COVID-19 pandemic unexpectedly resulted in the therapy service closing as they were not able to provide remote therapy. Due to the time constraints of the course, this resulted in a total collapse of my project, which was a particularly low time of my research journey. Despite not having a project, I was keen to complete a thesis to enable me to begin a job as a qualified psychologist upon completion of the DClinPsy, which resulted in me adopting a passive approach to research. Having lost all interest and investment in the research process, this involved me saying to supervisors that I wanted them to give me a project to do to simply pass the course. After being provided with a data set that could have been used as secondary analysis, I was struggling to establish a research question. This resulted in a discussion with supervisors about how this difficulty perhaps reflected my loss of interest in research. Subsequently, we considered that it was perhaps still possible to develop a new project, which resulted in the development of the study presented here (the conceptualisation of which will specifically be reflected

upon below). Despite this low period, having completed the project in exactly one year I believe has been testament to the learning I experienced from previous research failures and the dedicated support of my research supervisors.

Overall, the rollercoaster journey has taught me several key insights that I will use in future research prospects: (1) interest and investment in the topic area are key to continued engagement despite it being emotionally difficult if it does not succeed as intended, (2) taking the time to establish a viable research question will subsequently benefit the research process, and (3) projects that are not pursued or completed does not result in lost knowledge, instead it better prepares you for subsequent research endeavours.

C.2. Reflection on Completed Project

C.2.1. Conceptualisation of the Project

As described above, this project was born out of the collapse of my previous study because of COVID-19. Discussions in supervision enabled me to reflect on my areas of interest, which broadly focused on thinking about what makes therapy work. We discussed how the pandemic provided an opportunity to explore experiences of remote therapy and that there appeared to be a paucity of research into therapeutic processes in therapy provided via videoconferencing and telephone. Interestingly, as a Trainee Clinical Psychologist working clinically in the pandemic, I had experienced first-hand having to provide therapy via these modes. Therefore, I decided to pursue this new line of investigation. This highlighted to me how observations in my clinical practice could be used to inform research projects, in line with the scientist-practitioner approach of a Clinical Psychologist. Nevertheless, one of the key challenges in the conceptualisation of the project was that I was aware of my own negative experiences of remote therapy, of which I did not want to bias the design or findings, as highlighted in the extract below from my reflexive log.

After being unable to continue with my previous thesis due to COVID-19, I have had to establish a new thesis. In supervision we spoke about potentially doing a new topic on remote therapy and discussed some of the experiences colleagues of ours had spoken about. I also reflected on the difficult experiences that I have been having as a clinician providing therapy remotely and wondered if this were something that could be explored further. We discussed my interest in therapeutic processes generally and what makes therapy work and considered how working remotely affected therapeutic processes. From my own observations, I am aware of some of the challenges in forming a relationship with clients whom I had not seen but was expecting them

to share personal aspects of their lives with me. I am also aware of doing therapy from my back bedroom and having to think about how I switched from being at work to then being at home.

Working with others (i.e., my supervisors) to develop the project, I believe helped protect the project against my potential biases by exploring the rationale for the decisions we made. For example, when developing my survey response scale, I wrote in my diary that “I have decided to use a scale that allows therapists to have positive, negative, and neutral experiences, despite being aware that I think there may be negative experiences based on my own experiences to date”.

Furthermore, despite being worried about the short time frame I had to develop the project, we decided to use a sequential explanatory design given the paucity of research in the area. On reflection however, I was aware that this probably contributed to me rushing the early phase of the project somewhat, at times having to remind myself of my previous research experiences which enabled me to take a step back.

C.2.2. Reflection on Recruitment Process and Data Collection

Despite feeling time pressured and worrying about the time it would take to collect data by adopting a mixed-method approach, I was pleased at the response rate for phase one reaching the desired responses for statistical power within one month. Despite acknowledging the time pressure of the course, I was aware that the sample at that point was biased towards psychologists, perhaps because the main recruitment was from my social networking accounts. Whilst acknowledging that there are inherent flaws in all research, I decided to extend the survey recruitment time to hopefully capture therapists from other professional backgrounds, which was achieved and strengthened the sample overall.

For the second phase in which I interviewed therapists, I was aware that despite my clinical interviewing skills, I had not conducted research interviews before. In preparing for the research interviews, it was helpful to discuss and reflect upon this in supervision, including how best to conduct the interviews. Nevertheless, during my first interview I was aware of thinking that I was falling into using clinical skills rather than simply collecting the participants views, as indicated in the below diary extract:

I have just completed my first interview which was interesting but difficult. I was aware that the participant was saying things that I think I would understand from my clinical experiences whilst being aware that I need her to explain this so it is in the data and so it was clear what she meant. I also think I was perhaps falling into summarising what she was saying with perhaps some formulation, which I don't think I should be doing at this stage and do not want to bias the results.

Following the initial interview, it was helpful to reflect on my experiences and to review the transcript to see if the interview schedule captured data relevant to answering my research question. This was a particularly helpful process as it enabled me to become more aware of falling into 'clinical mode' instead of being in 'researcher mode' and think about how I might overcome this in subsequent interviews. Whilst I believe my clinical skills aided this phase of data collection, such as being able to establish a rapport with interviewees, I learned the importance of not falling into formulating and interpreting the data before analysis had begun. This also strengthened my appreciation for maintaining a reflexive journal, where I was able to record the thoughts and reflections that I had during each interview.

C.2.3. Reflection on Analysis

Considering my limited experience of research prior to beginning the DClinPsy, completing a mixed-method project challenged me by having to engage with different methodologies, whilst trying to present a coherent story. Despite considering that epistemologically I would probably favour more of a constructionist position, I was aware of the benefits of adopting a critical realist position and mixed-method design. Nevertheless, my natural tendency to perhaps value individuals meanings and the nuances between these over numbers and statistical analyses presented challenges particularly when analysing phase one. Regardless of my lack of confidence in statistical analysis, I reached a position where I was able to question suggestions made by my supervisor, such as when the analysis they proposed did not make sense to me in the context of my study and what I had read and understood. Seeking a third opinion in this instance was helpful and increased my confidence in my skills and knowledge, rather than simply doing what I had been told. For me, this marked a significant development in my doctoral research skills, abilities, and confidence.

Whilst qualitative analysis was perhaps more aligned with my personal epistemological position and way of thinking, it was the first time I had completed analysis on a whole new data set. Initially, I felt overwhelmed with the amount of data, as indicated in my diary where I wrote "I have at least 85 codes for each participant with the most being 162. I do not know how I am going to get this down to a few key themes". Reflecting in supervision was helpful, as this reminded me to take qualitative analysis one step at a time, which helped me to feel less overwhelmed. Finally, using another person to review themes was helpful and highlighted how difficult it can be to consider different perspectives and themes when you have been fully engaged in the analysis yourself.

C.3. Final Reflections

Overall, despite a range of emotions experienced and perhaps thinking at times that I would not complete a thesis, I am pleased with my final project and hope it will be of value and clinical use to therapists alike. Not only do I think the project presented here demonstrates my doctoral research skills, but by having previous successive projects fail strengthened my overall research knowledge and skills, as well as making me a more thoughtful and resilient researcher.

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APPENDICES

Appendix A Electronic database search terms.

Grouped Terms for Concept: 'Therapist'

Psychotherap* OR therap* OR counsel*

Grouped Terms for Concept: 'Intersession Experience'

"Intersession experi*" OR "inter-session experi*" OR "between session experi*" OR
"between-session experi*" OR "intersession process*" OR "inter-session process*" OR
"mental representation*"

Final Search

Psychotherap* OR therap* OR counsel* AND "Intersession experi*" OR "inter-session
experi*" OR "between session experi*" OR "between-session experi*" OR "intersession
process*" OR "inter-session process*" OR "mental representation*"

Ad-Hoc Search on Therapists' Dreams

Psychotherap* OR therap* OR counsel* AND dream* AND client* OR patient*

Appendix B Online Survey

Providing remote psychological therapy during the Covid-19 restrictions.

(Configured and disseminated on Jisc survey software)

Participant Information Sheet

Screening questions:

I am qualified or training in a professional therapy role.

Yes

No

I have changed to providing remote (i.e. via telephone or videoconferencing) psychological therapy during the Covid-19 restrictions.

Yes

No

I am providing remote psychological therapy to individual clients.

Yes

No

I agree to participate in this study. (Screen out question)

Yes

No

Contextual/ Demographic Questions

1) What is your gender?

Male

Female

Other (please specify)

2) What is your age?

20-29

30-39

40-49

50-59

60+

3) What country are you currently practicing in?

UK

Europe

America

Canada

Australia

Other

4) Are you qualified or training in a professional therapy role?

Qualified

In training

5) What is your professional background?

Psychotherapist

Psychologist

Counsellor

Psychiatrist
 CBT Therapist
 Other (Please Specify)

- 6) How much is your current theoretical practice guided by each of the following theoretical frameworks?

(0=Not at all, 2=Slightly, 4=Somewhat, 6=Moderately, 8=Greatly, 10=Very greatly)

Analytic/psychodynamic.....0 1 2 3 4 5 6 7 8 9 10
 Behavioural.....0 1 2 3 4 5 6 7 8 9 10
 Cognitive.....0 1 2 3 4 5 6 7 8 9 10
 Humanistic.....0 1 2 3 4 5 6 7 8 9 10
 Interpersonal.....0 1 2 3 4 5 6 7 8 9 10
 Systemic.....0 1 2 3 4 5 6 7 8 9 10
 Integrative/ Eclectic.....0 1 2 3 4 5 6 7 8 9 10
 Other (Please Specify).....0 1 2 3 4 5 6 7 8 9 10

- 7) For how many years have you practised psychological therapy?

Less than 5 years Between 5 and 15 years More than 15 years.

- 8) Prior to the Covid-19 restrictions, had you used telephone or video conferencing to provide psychological therapy?

Telephone Video Both Neither

- 9) During Covid-19 restrictions, have you provided psychological therapy via telephone?

Yes No

- 10) During the Covid-19 restrictions, how many psychological therapy sessions have you provided via telephone?

Fewer than 20 Between 20 and 50 More than 50

- 11) During Covid-19 restrictions, have you provided psychological therapy via videoconferencing?

Yes No

- 12) During the Covid-19 restrictions, how many psychological therapy sessions have you provided via videoconferencing?

Fewer than 20 Between 20 and 50 More than 50

- 13) Where have you mostly provided remote psychological therapy from?

Inside of your home Outside of your home

- 14)** From where you have mostly provided remote therapy during the Covid-19 restrictions, have you been free from interruptions?
- Yes Somewhat No
- 15)** Prior to the Covid-19 restrictions, had you received training specifically on providing remote psychological therapy?
- Yes No
- 16)** How would you describe your present state of emotional and psychological wellbeing?
- Quite poor; I am barely managing to deal with things.
- Fairly poor; life is pretty tough for me at times.
- So-so; I manage to keep going with some effort.
- Fairly good; I have my ups and downs.
- Quite good; I have no major complaints.
- Very good; I get along much the way I would like to.

Working Alliance

Response format for questions:

(-5 = very negatively; 0 = neutral; +5 = very positively)

-5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5

Compared to face-to-face therapy sessions, providing remote psychological therapy during the Covid-19 restrictions has affected:

- 17)** My ability to be empathic towards my clients.
- 18)** My ability to be compassionate towards my clients.
- 19)** My ability to build a sense of trust with my clients.
- 20)** My ability to effectively communicate verbally with my clients.
- 21)** My ability to effectively communicate non-verbally with my clients.
- 22)** My ability to gauge my client's emotions.
- 23)** My ability to gauge my client's implicit communications.
- 24)** My ability to attune with my clients.
- 25)** My ability to work in collaboration with my clients to achieve their goals.
- 26)** My ability to maintain my concentration on the client and/or task.
- 27)** My ability to effectively manage ruptures in the therapeutic relationship.
- 28)** If you would like to provide any additional information to your answers above, please do so below.

(Space provided to respond)

Therapeutic Boundaries

Response format for questions:

(-5 = very negatively; 0 = neutral; +5 = very positively)

-5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5

Compared to face-to-face therapy sessions, providing remote psychological therapy during the Covid-19 restrictions has affected:

- 29) My ability to establish a therapy contract with the client.
- 30) The way I contract with clients.
- 31) My ability to maintain therapeutic boundaries with my clients.
- 32) The way I explain the limits of confidentiality.
- 33) My ability to attend appointments on time.
- 34) The length of agreed therapy sessions.
- 35) The amount that I self-disclose to clients.
- 36) My ability to effectively managing my client's risk.
- 37) My ability to create risk management plans.
- 38) My ability to maintain a consistent space where I engage in the therapy.
- 39) My ability to only work during my working hours.
- 40) My ability to stop thinking about my client's problems in the time between therapy sessions.
- 41) The therapeutic boundary issues I experience as a therapist. (Please elaborate on your answer to this item in the space below)
- 42) If you would like to provide any additional information to your answers above, please do so below.

(Space provided to respond)

Therapist Work Involvement

Considering your work recently during the Covid-19 restrictions...

[0 = None 5 = Total]

43) How much satisfaction do you currently find in your work as a therapist? 0 1 2 3 4 5

44) How much dissatisfaction do you currently feel in your work as a therapist? 0 1 2 3 4 5

[0 = None 5 = Total]

45) How much satisfaction do you currently find in your work as a therapist? 0 1 2 3 4 5

46) How much dissatisfaction do you currently feel in your work as a therapist? 0 1 2 3 4 5

[0 = None 5 = Total]

47) How much satisfaction do you currently find in your work as a therapist? 0 1 2 3 4 5

48) How much dissatisfaction do you currently feel in your work as a therapist? 0 1 2 3 4 5

Overall, at the present time when engaging in remote therapy ...

[0 = Not at All 5 = Very much]

49) How effective are you at engaging patients/clients in a working alliance? 0 1 2 3 4 5

50) How 'natural' (authentically personal) do you feel with patients/clients? 0 1 2 3 4 5

51) How empathic are you in relating to patients/clients with whom you have relatively little in common? 0 1 2 3 4 5

When working remotely, how would you describe yourself as a therapist – your actual style or manner with patients/clients?

[0 = Not at All 5 = Very much]

52) Accepting	0	1	2	3	4	5
53) Committed	0	1	2	3	4	5
54) Detached	0	1	2	3	4	5
55) Effective	0	1	2	3	4	5
56) Friendly	0	1	2	3	4	5
57) Guarded	0	1	2	3	4	5
58) Intuitive	0	1	2	3	4	5
59) Involved	0	1	2	3	4	5
60) Organised	0	1	2	3	4	5
61) Reserved	0	1	2	3	4	5
62) Skillful	0	1	2	3	4	5
63) Subtle	0	1	2	3	4	5
64) Tolerant	0	1	2	3	4	5
65) Warm	0	1	2	3	4	5

Currently, while working remotely, how *often* do you feel ...?

[0 = Never 5 = Very often]

66) Unsure how best to deal effectively with a patient/client.	0	1	2	3	4	5
67) Lacking in confidence that you can have a beneficial effect on a patient/client.	0	1	2	3	4	5
68) Unable to have much real empathy for a patient's/client's experiences.	0	1	2	3	4	5
69) Demoralised by your inability to find ways to help a patient/client.	0	1	2	3	4	5
70) Unable to withstand a patient's/client's emotional neediness.	0	1	2	3	4	5
71) Distressed by your powerlessness to affect a patient's/client's tragic life situation.	0	1	2	3	4	5
72) Unable to generate sufficient momentum to move therapy with a patient/client in a constructive direction.	0	1	2	3	4	5
73) Conflicted about how to reconcile obligations to a patient/client and equivalent obligations to others.	0	1	2	3	4	5

When encountering *difficulties* in remote therapy, how often do you ...?

[0 = Never 5 = Very often]

74) Review privately with yourself how the problem has arisen.	0	1	2	3	4	5
75) Seek some form of alternative satisfaction away from therapy.	0	1	2	3	4	5
76) Try to see the problem from a different perspective.	0	1	2	3	4	5
77) Simply hope that things will improve eventually.	0	1	2	3	4	5
78) Consult about the case with a more experienced therapist.	0	1	2	3	4	5
79) Discuss the problem with a colleague.	0	1	2	3	4	5

80) See whether you and your patient/client can together deal with the difficulty.	0	1	2	3	4	5
81) Seriously consider terminating therapy.	0	1	2	3	4	5
82) Avoid dealing with the problem for the present.	0	1	2	3	4	5
83) Show your frustration to the patient/client.	0	1	2	3	4	5
84) Criticise a patient/client for causing you trouble.	0	1	2	3	4	5
85) Just give yourself permission to experience difficult or disturbing feelings.	0	1	2	3	4	5

Recently in remote sessions with patients/clients, how often have you found yourself feeling...

[0 = Not at All 5 = Very often]

86) Absent	0	1	2	3	4	5
87) Anxious	0	1	2	3	4	5
88) Bored	0	1	2	3	4	5
89) Challenged	0	1	2	3	4	5
90) Drowsy	0	1	2	3	4	5
91) Engrossed	0	1	2	3	4	5
92) Inattentive	0	1	2	3	4	5
93) Inspired	0	1	2	3	4	5
94) Overwhelmed	0	1	2	3	4	5
95) Pressured	0	1	2	3	4	5
96) Stimulated	0	1	2	3	4	5
97) Trapped	0	1	2	3	4	5

98) If you would like to provide any additional information to your answers above, please do so below.

(Space provided to respond)

Phase Two Study Information

The research team will be completing a further part of the study, where we would like a more detailed account of an experience you have had whilst providing remote therapy during Covid-19 restrictions. This part of the study would require you to either provide a written account of an experience you have had or engage in an interview with a researcher. If you would like to be included in this part of the study, please tick below and provide your contact email address. If you choose to provide your email address, then your survey items will become identifiable to the research team and may be used towards phase two. However, if you decide not to be contacted for phase two, then your answers will remain anonymous to the research team.

I would be willing to provide a written account of an experience to the research team.

Yes No

I would be willing to take part in an interview with the researcher.

Yes No

My contact email is:

Email: _____

Final Page

Dear participant,

Thank you for taking part in our study. We were interested in investigating psychological therapist's experience of providing remote psychotherapy during the Covid-19 restrictions. Specifically, we are interested in therapists' experience of the therapeutic working alliance, therapeutic boundaries, and their work involvement patterns. We hope this helps to develop the understanding into this form of psychotherapy to inform future clinical practice.

The results of this project are expected to be written up by February 2021. If you would like a copy of the results or need to contact the research team, then please do not hesitate to contact Thomas Schröder or Georgina James on the details below.

Thank you for your participation!

Appendix C Research Supervision Log: Review of Online Survey



**Trent Doctorate in Clinical
Psychology**



**University of
Nottingham**
UK | CHINA | MALAYSIA

RECORD OF FORMAL SUPERVISORY MEETING

Name: Georgina James

Intake: 2018

Title of Project: Changing to remote psychological therapy during Covid-19: Psychological therapists' experience of the working alliance, therapeutic boundaries, and work involvement.

Primary Supervisor: Thomas Schröder

Secondary Supervisor: Danielle De Boos

Field Supervisor: N/A

Supervision No.	Date	Approx. Time spent	Supervisor(s) present
16	29/05/20	90 minutes	Thomas Schröder Danielle De Boos
Trainee's comments			
SUMMARY OF PROGRESS since last recorded meeting (edit/expand sub-sections as necessary): Review of agreed actions from last meeting: • GJ to make changes to SLR ready for publication. – Done and submitted to journal. • GJ to make amendments to protocol and survey and send to TS and DdB ASAP for them to look over. – Done. • TS to send guardian read with background info. • To arrange further supervision. General Comments: • Agreed to spend this supervision going through feedback on the survey. • Need to include a screen out page – to look at tutorials on Jisc. If they don't meet the criteria/ or consent they will be re-directed to screen out page. • To consider how identifiable certain answers might be if asking for specific info compared to bracketing answers. To look at how previous studies have bracketed age and years of experience in regard to what is consider novice, expert etc. • Reviewed how I had developed the items based on previous theory/literature. No standardised scales for WA and boundaries. TWIS is already used. • To include item on emotional boundaries - although this may be captured more in the qualitative phase also. • GJ to ask peers to go through the survey as a pilot.			

- To include wellbeing question – may be used towards analysis, but also considered in context of covid.
- Discussed consenting to phase two and how this makes the data identifiable but allows for stratifying sample e.g. based on HI and SI.
- Discussed options for withdrawal – using a unique identifier to make withdrawal options fair.

Supervisor's Report (Brief details of any problems and how they have been resolved. Detailed information is required only if trainee progress is unsatisfactory):

PLAN OF ACTION until next recorded supervisory meeting (to be briefly itemised by trainee, discussed with and approved by, supervisor)

- **GJ to make changes to survey**
- **GJ to make TS know when my ethics application is ready to be reviewed.**

Trainee's concerns/problems/comments:

Signed:	(Supervisor)	Date:
Signed: G. James	(Trainee)	Date: 29/05/2020

Appendix D Recruitment Poster



University of
Nottingham
UK | CHINA | MALAYSIA

Psychological therapists working remotely during the Covid-19 restrictions needed for study.

Have you been providing psychological therapy remotely during the Covid-19 outbreak? If so, you may be eligible to participate in a study looking into psychological therapists' experience of working remotely.

To participate you:

- Must be either qualified or training in a professional therapy role (e.g. psychotherapists, counsellors, psychologists, CBT therapist, specified 'other').
- Must identify as having predominantly provided psychological therapy in a face-to-face setting prior to the Covid-19 restrictions (i.e. more than 50% of their caseload).
- Must have changed from face-to-face psychological therapy to actively providing therapy via telephone or videoconferencing software during the Covid-19 restrictions.
- Providing psychological therapy forms a large part (i.e. at least 50%) of your job role.
- Must be providing the remote psychological therapy to individual clients, not couples or groups.
- Must be able to read and understand the English language, although can be practicing remote therapy in any country.
- Can be of any gender, age, and working from any theoretical orientation.

It would involve:

- Completing an online survey, taking approximately 20 minutes.
- Being invited to participate in a further part of the study, choosing to either provide a written account or participate in an interview.

If you meet the criteria and would like to participate, please follow this link:

<https://nottingham.onlinesurveys.ac.uk/remote-therapy-during-covid-19>

Please share this post/ link with people or groups who might also be interested!

Appendix E Phase Two Semi-Structured Interview Schedule

Phase Two

Question:

'How do psychological therapists experience and manage therapeutic boundaries when working remotely?'

1. Before changing to remote psychological therapy during Covid-19, what were your views or experiences of therapeutic boundaries?

2. What have your experiences of therapeutic boundaries been when providing therapy by telephone or videoconferencing?

Prompting questions:

Can you give an example of a therapeutic boundary experience you have had whilst working remotely?

Do you think providing therapy remotely changed your experiences of therapeutic boundaries? If so, how? If not, why not?

3. What impact, if any, do you think the boundary experience had on the therapy?

Prompting questions:

Can you tell me more?

What other impact did it have on the therapy?

Do you think it: impacted on the engagement or relationship / your ability to engage in therapy remotely / your sense of wellbeing?

4. How did you manage or cope with the boundary experience?

Prompting questions:

What did you do?

How would others have seen you respond?

Did you talk to others, if so, who?

Compared to face-to-face therapy, did your way of coping change? If so, how did it change and why? If not, why not?

5. Is there anything that you think would help you to maintain therapeutic boundaries when providing therapy via telephone or videoconferencing?

Prompting questions:

How would this help?

Who would provide this?

How do you think this would affect the therapy process and/or outcome?

Appendix F Research Supervision Log: Review of First Interview Transcript



Trent Doctorate in Clinical
Psychology



University of
Nottingham
UK | CHINA | MALAYSIA

RECORD OF FORMAL SUPERVISORY MEETING

Name: Georgina James

Intake: 2018

Title of Project: Changing to remote psychological therapy during Covid-19: Psychological therapists' experience of the working alliance, therapeutic boundaries, and work involvement.

Primary Supervisor: Thomas Schröder

Secondary Supervisor: Danielle De Boos

Field Supervisor: N/A

Supervision No.	Date	Approx. Time spent	Supervisor(s) present
23	11/11/20	40 minutes	Danielle De Boos
Trainee's comments			
SUMMARY OF PROGRESS since last recorded meeting (edit/expand sub-sections as necessary): Review of agreed actions from last meeting: • GJ to look at previous papers of mixed inductive-deductive and create framework. Add into analysis plan and share with DdB/ TS. - Done • Book in interviews and then book some time with DdB/TS following first transcription. – Done. • Contact Sarah Hardie re accessing transcription pedal. - Done • Complete intent-to submit. – Done • Submit ethics amendment for updated questions. – Done and approved. This meeting was organised to review my first transcript. General Comments: • Time was spent reflecting on my experience of conducting the research interview, particularly my dual role as a clinician and as a researcher. Discussed how I had to ask the participant what she meant by few concepts that I theoretically understood from my own clinical experiences and existing literature. Discussed how I could explain at the beginning of the interview that I might ask follow-up questions getting them to explain what they mean by certain terms. • Don't need to include 'Urmmm' and 'err's' unless they appear significant. • Reflected on the need to judge when to reflect and summarise what the participant has said versus just asking direct questions. • Considered what the interpretation phase would look like based on an example quote.			

- Don't be afraid to use closed questions to clarify what they say, followed by an open question if the need to explain more.
- Discussed response from initial interview - one interview now completed; two more participants returned consent forms. Discussed sending reminder emails once more and approaching other participants who consented to be contacted whilst trying to apply sampling strategy as best as possible.

Supervisor's Report (Brief details of any problems and how they have been resolved. Detailed information is required only if trainee progress is unsatisfactory):

PLAN OF ACTION until next recorded supervisory meeting (to be briefly itemised by trainee, discussed with and approved by, supervisor)

- **Continue with data collection for phase 2**
- **Transcribe data for phase 2**

Trainee's concerns/problems/comments:

Signed:	(Supervisor)	Date:
Signed: G. James	(Trainee)	Date: 11/11/2020

Appendix G Confirmation of Ethics Approval



DPAP Committee

22/06/2020

Supervisor: Thomas Schroder

Applicant : Georgina James

Project: Project Id Changing to remote psychological therapy during COVID-19: Psychological therapists' perceptions of the impact on working alliance, therapeutic boundaries, and work involvement.

A favourable opinion is given to the above named study on the understanding that the applicants conduct their research as described in the above numbered application. Applicants need to adhere to all conditions under which the ethical approval has been granted and use only materials and documentation that have been approved.

If you need to make any any changes (for example to the date or place of data collection, or measures used), an Amendment Form should be submitted. This can be done by the Supervisor in 'Create Sub Form' in the Actions Menu on the left hand side of the page on the on-line system: Select 'Amendment Form'

yours



Professor David Daley

Co-Chair of DoPAP Ethics Subcommittee



Professor Amanda Griffiths

Co-Chair of DoPAP Ethics Subcommittee

Appendix H Confirmation of Ethics Approval Following Amendment



DPAP Committee

05/11/2020

Supervisor:

Applicant : Georgina James

Project: Project Id Changing to remote psychological therapy during COVID-19: Psychological therapists' perceptions of the impact on working alliance, therapeutic boundaries, and work involvement.

Your amendment ref: DPAP - 2020 - 1626 - 1 has been approved. Please conduct your study following your approved procedures or you will be operating outside your ethical approval. yours sincerely



Professor David Daley

Co-Chair of DoPAP Ethics Subcommittee



Professor Amanda Griffiths

Co-Chair of DPAP Ethics Subcommittee

Appendix I Phase One: Participant Information Sheet



University of
Nottingham
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PARTICIPANT INFORMATION SHEET

(Final Version 1.0: 22/06/20)

Title of Study: Changing to remote psychological therapy during Covid-19: Psychological therapists' experience of the working alliance, therapeutic boundaries, and work involvement.

Name of Chief Investigator: Thomas Schröder

Local Researcher(s): Georgina James, Danielle De Boos

What is the purpose of the study?

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. We are looking to recruit psychological therapists who have changed to providing therapy remotely (i.e. via telephone or videoconferencing) during the Covid-19 restrictions. The aim of this study is to investigate what impact changing to remote psychotherapy during the Covid-19 restrictions has had on psychological therapists' experience of the working alliance, therapeutic boundaries, and their work involvement.

Would I be able to participate?

The study requires participants to be qualified or training in a professional therapy role and to spend at least 50% of their job role providing psychological therapy. The study also requires you to have changed from providing face-to face psychological therapy sessions to remote forms of therapy, for a minimum of 50% of your caseload. You need to be working with individual clients, to base your answers to the survey on. We are hoping for approximately 100 participants who meet these criteria.

What will happen to me if I take part?

If you were to take part, you would be asked to complete a survey, which would take approximately 20 minutes. Survey items include questions relating to your current characteristics, your experience of the working alliance when working remotely, managing therapeutic boundaries when working remotely, and your work involvement. Your answers will be anonymous so the researchers will not be able to identify you. However, if you agree to participate in phase two of the study and provide your email address, then your survey answers will become identifiable to the research team. Participation will end when the survey is completed unless you choose to stop before the end.

Do I have to take part?

Participation in the study is completely voluntary; it is up to you to decide whether to take part. If you do decide to participate, it will be assumed that you have fully read and understood this information and that your completion of survey questions indicates your consent to participate.

What will happen if I don't want to carry on with the study?

You are free to stop answering the survey at any point you wish. If you stop before the end of the survey, your responses will not be saved and used towards the study. If you consent to taking part and complete the survey by clicking 'finish', you will be able to withdraw your responses up until the point of analysis by contacting the researcher with the unique identifier you provide. If you agree to being contacted for phase two of the study and provide your contact email address, then this will make you identifiable to the research team because your survey answers may be used to select participants for phase two. Where you do not agree to being contacted for phase two, your data will remain anonymous to the research team. All data in the study will be reported anonymously, so you will not be identifiable.

Expenses and payments

Participants will not be paid to participate in the study and are not expected to incur any expenses as part of participation.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. Contact details are given at the end of this information sheet.

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you participate in the study, we will use information collected from you during the research. This information will be kept **strictly confidential**, stored in a secure and locked office at the University of Nottingham or electronic files will be password protected and stored on a secure One Drive account at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we collect minimal personal data in the Survey, so that you cannot be identified. However, if you agree to provide your email address to participate in phase two of the study, this will be identifiable information which will be stored securely on a password protected file on a secure One Drive account at the University of Nottingham.

You can find out more about how we use your information and to read our privacy notice at:

<https://www.nottingham.ac.uk/utilities/privacy.aspx>.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information, we will seek your consent for this and ensure it is secure.

Although what you say to us is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen to the results of the research study?

The results of this research will be written for partial fulfilment of the requirements for the Trent Doctorate in Clinical Psychology (DClinPsy). We would also hope to submit the research for publication in a peer-reviewed journal. Any publications arising from this study will ensure participant's information remains anonymous. If you wish to be informed about any publications following completion of the study, you can ask the researcher to be informed of the details.

Who is organising and funding the research?

This research is being organised and funded by the University of Nottingham.

Who has reviewed the study?

All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Division of Psychiatry and Applied Psychology Research Ethics Committee.

Further information and contact details

If you would like to discuss this study further or have any queries regarding your participation, then please contact Thomas Schröder or Georgina James the details below:

Thomas.schroder@nottingham.ac.uk

Thomas Schröder, Chief Investigator

georgina.james@nottingham.ac.uk

Georgina James, Researcher and Trainee Clinical Psychologist

Ethics approval number: 1626

Appendix J Phase Two: Participant Information Sheet



University of
Nottingham
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PARTICIPANT INFORMATION SHEET

(Final Version 1.0: 22/06/20)

Title of Study: Changing to remote psychological therapy during covid-19: Psychological therapists' experience of the working alliance, therapeutic boundaries, and work involvement.

Name of Chief Investigator: Thomas Schröder

Local Researcher(s): Georgina James, Danielle De Boos

What is the purpose of the study?

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. We are looking to recruit psychological therapists who have changed to providing therapy remotely (i.e. via telephone or videoconferencing) during the Covid-19 restrictions. The aim of this phase of the study is to explore what therapeutic boundary experiences psychological therapists have encountered when working remotely during the Covid-19 restrictions and how have they managed these.

Would I be able to participate?

The study requires participants to be qualified or training in a professional therapy role and to spend at least 50% of their job role providing psychological therapy. The study also requires you to have changed to providing psychological therapy from face-to-face sessions to remotely for a minimum of 50% of your caseload. To participate in this phase of the study, you will have completed the survey in phase one and entered your contact information, consenting to be contacted about this phase of the study and to either participate in an interview. We are hoping for approximately 12 participants in total.

What will happen to me if I take part?

If you were to take part, you would be asked to engage in a semi-structured interview. It is anticipated that the interview may last for up to an hour. If you choose to engage in an interview, this would be with one of the researchers either via videoconferencing (e.g. Microsoft Teams) or in person, where possible, depending on social distancing restrictions at the time. The interview will be recorded on an audio recording device, with the recording being uploaded onto and stored on a secure file at the University of Nottingham, and then immediately deleted from the audio recorder.

Do I have to take part?

Participation in the study is completely voluntary; it is up to you to decide whether to take part. If you do decide to participate in this phase of the study, you will be asked to sign two copies of a consent form before participating, one being for you to keep.

What will happen if I don't want to carry on with the study?

If you decide that you do not want to carry on with the study, you can inform the researcher of your decision to not complete the interview. If you wish to withdraw your data from this part of the study, you can contact the researcher up to one week after participation and your data will be deleted. After one week, your data will still be used anonymously towards the study findings.

Expenses and payments

Participants will not be paid to participate in the study and are not expected to incur any expenses as part of participation.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. Contact details are given at the end of this information sheet.

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you participate in the study, we will use information collected from you during the research. This information will be kept **strictly confidential**, stored in a secure and locked office at the University of Nottingham or electronic files will be password protected and stored on a secure One Drive account at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally – identifiable information possible. Your email address that was used to contact you for this phase of the study will be stored securely on a password protected file on a secure One Drive account at the University of Nottingham. Following data collection for phase two, this file will be deleted. In writing up the results, pseudonyms will be used where quotes from the data are used.

You can find out more about how we use your information and to read our privacy notice at:

<https://www.nottingham.ac.uk/utilities/privacy.aspx>.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use for secondary analysis (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information, we will seek your consent for this and ensure it is secure.

Although what you say to us is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen to the results of the research study?

The results of this research will be written for partial fulfilment of the requirements for the Trent Doctorate in Clinical Psychology (DClinPsy). We would also hope to submit the research for publication in a peer-reviewed journal. Any publications arising from this study will ensure participant's information remains anonymous. If you wish to be informed about any publications following completion of the study, you can ask the researcher to be informed of the details.

Who is organising and funding the research?

This research is being organised and funded by the University of Nottingham.

Who has reviewed the study?

All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Division of Psychiatry and Applied Psychology Research Ethics Committee.

Further information and contact details

If you would like to discuss this study further or have any queries regarding your participation, then please contact Thomas Schröder on the email address below:

Thomas.schroder@nottingham.ac.uk

Thomas Schröder, Chief Investigator

georgina.james@nottingham.ac.uk

Georgina James, Researcher and Trainee Clinical Psychologist

Ethics approval number: 1626

Appendix K Phase Two: Consent Form



PARTICIPANT CONSENT FORM

(Final Version 1.0: 22/06/20)

Title of Study: Changing to remote psychological therapy during Covid-19 restrictions: Psychological therapists' experience of the working alliance, therapeutic boundaries, and work involvement.

Name of Researcher: Georgina James

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number 1.0 dated 22/06/20 for the above study. ☐
2. I understand that my participation is voluntary and that I am free to withdraw up to one week after my participation. I understand that for up to one week after my participation I can request for my data to be erased. I understand that after one week, if I request to withdraw, my data will still be used anonymously towards the study findings. ☐
3. I understand that the interview data will be stored in accordance with University of Nottingham guidelines and General Data Protection Regulation (GDPR). ☐
4. I understand that the interview will be recorded and that anonymous direct quotes from the interview group may be used in the study reports. ☐
5. I understand that relevant sections of my data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
6. I agree to take part in the above study. ☐
7. Please enter your initials if you give permission for your data from this study to be shared with other researchers in the future provided that your anonymity is protected. ☐

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

1 copy to be given to the participant and 1 copy kept for the project notes

Appendix L Phase Two: Deductive Coding Framework

Deductive Coding Frame

- 1a Boundary type – structural or logistical (e.g., physical space, time/ therapist working hours, length of session, contract, payment)
- 1b Boundary type – content or conceptual (e.g., what is discussed between therapist-client, exchange of gifts, confidentiality, boundaries influenced by theoretical orientation, such as non-sexual contact or self-disclosure, transference, countertransference)
- 2a Reason for boundary – protection for client
- 2b Reason for boundary – protection for therapist
- 2c Reason for boundary – supporting working alliance/ integrity of relationship
- 2d Reason for boundary – focus on client welfare/ therapeutic aims and outcome
- 3a Boundary issues – ‘crossing’ between therapist and client (‘grey areas’ that can be considered conducive to therapy but have the potential to become a violation, e.g., self-disclosure of personal problems, dressing differently for a particular client)
- 3b Boundary issue – ‘violation’ between therapist and client (e.g. abuse, sexual relations, intimate encounters, aggression, racism)
- 3c Boundary issue – work-life boundary, working outside usual hours
- 3d Boundary issue – work-life boundary, not being able to ‘switch off’ from work/ stop thinking about the patient’s problems in the time between sessions.
- 3e Boundary issue – risk management

Appendix M Phase Two: Example Extract of Reflexive Diary

17/04/2020: *After being unable to continue with my previous thesis due to Covid 19, I needed to establish a new thesis. In supervision we spoke about potentially doing a new topic on remote therapy and discussed some of the experiences colleagues of ours had spoken about. I also reflected on the difficult experiences that I was having as a clinician providing therapy at the time by working remotely and wondered if this were something that could further be explored stop. In shaping up the question, I have been interested in therapeutic processes generally and what makes therapy work. Therefore, I was interested in how working remotely affected therapeutic processes. From my own observations I was aware of some of the challenges in forming a relationship with clients whom I hadn't seen but was expecting them to share personal aspects of their lives with me. I was also aware of doing therapy from my back bedroom and having to think about how I switched from being at work to them being at home.*

07/05/2020: *I have decided to use a scale that allows therapists to have positive, negative, and neutral experiences, despite being aware that I think there may be negative experiences based on my own experiences to date.*

20/05/2020: *Being a clinician but wanting to research something that I had personal experience in, I am aware that I have my own assumptions of what I might expect to find from this study. I have really struggled with not seeing the client. This has made me feel ineffective at times as a therapist at times. It is going to be important that I remain aware of this throughout the research.*

17/07/2020: *I have been really happy and quite surprised by the response to the survey. However, I am aware that there seem to be many psychologists completing this, which may be because of that being my profession and being 'friends' with more psychologists on social networking. Therefore, I perhaps need to think about how I can make the survey more accessible to therapists from other professions.*

09/11/2020: *I have just completed my first interview which I found interesting but was also aware of a few things that I perhaps need to explore in supervision. I was particularly aware of how I responded to the therapists when they were saying things that were like my experiences of remote therapy as well as when things different, as I did not want my responses to lead the therapist to answer in a certain way. This made it quite difficult. I was aware that I was also possible paraphrasing a lot instead of asking direct questions and I am not sure how helpful this was. I felt like I was falling into my clinical role and would sometimes find myself perhaps interpreting what they said which should not be happening at this stage. It will be helpful to review this in supervision to think about how I can manage the balance between being a clinician and a researcher.*

Appendix N Example Extract of Coding

235	I think it left me feeling generally quite de-skilled as a therapist. So, not feeling like I was making	10.235 Impact – therapist doubting self.	
236	a difference to anyone’s life and I guess part of this might be the reluctance maybe that I had to		
237	go to those more difficult things, feeling that maybe sometimes we were just talking about, I	10.237 Different experience of therapy.	
238	guess sometimes it <u>maybe</u> felt more like a check-in as opposed to therapy session a lot of the		
239	time with clients and I guess that left me feeling a bit like maybe I wasn’t doing the role that I	10.239 Impact – therapist doubting self.	
240	was meant to be doing but it felt sometimes too risky to do what I should, what we would	10.240 Increased awareness of risk.	10.240 Boundary issue – risk management.
241	normally do in a room. Does that answer?		
242	Yeah. I’m wondering what is it about that feeling too risky that makes you think about it is a		
243	boundary experience as well?		
244	I think partly the risk issue might have been as a result of changing placements during lockdown	10.244 Contextual info.	
245	so I guess not having like a pre-remote therapy knowledge of the clients and even the same with		
246	working with children and young people so having not worked with children young people		
247	before, I think in terms of, so in terms of risk, I guess that’s partly what made me air on the side	10.247 Awareness of risk.	10.247 Boundary issue – risk management.
248	of caution a lot of the time about not pushing them too far because we had never been able to		
249	have those conversations about how I would know if things were too much or too difficult. And, I		

Appendix O Research Supervision Log: Review of Coding



**Trent Doctorate in Clinical
Psychology**



**University of
Nottingham**
UK | CHINA | MALAYSIA

RECORD OF FORMAL SUPERVISORY MEETING

Name: Georgina James

Intake: 2018

Title of Project: Changing to remote psychological therapy during Covid-19: Psychological therapists' experience of the working alliance, therapeutic boundaries, and work involvement.

Primary Supervisor: Thomas Schröder

Secondary Supervisor: Danielle De Boos

Field Supervisor: N/A

Supervision No.	Date	Approx. Time spent	Supervisor(s) present
24	21/01/21	60 minutes	Danielle De Boos
Trainee's comments			
SUMMARY OF PROGRESS since last recorded meeting (edit/expand sub-sections as necessary): Review of agreed actions from last meeting: • Continue with data collection for phase 2 - completed. • Transcribe data for phase 2 – completed. This meeting was organised to review initial coding. General Comments: • Discussed thesis submission date. Outstanding tasks include phase 2 analysis, write up of phase 2 and discussion, references, appendices, proofreading. Advised to use supervisors to review different things i.e., one reviewing journal paper and one reviewing structure of extended. Extended part is more about looking at what territory you have covered. • Set hand-in date as Monday 29th March 2021. • Agreed to having a supervision on Friday 12th February to review phase 2 themes. • Agreed to send thesis draft to Danielle on 11th of March for her to return it on the 12th. Need to liaise with Thomas to arrange time for him to review a part. Review of coding: • Always return to question. When looking at text, is this about boundaries when working remotely? If so, what are they saying? What do they mean? Don't have capacity to review how before, but look for when they talk about what's the same/different/alike etc. When not referring to working remotely, code as a big chunk. • Discussed how the interpretive thinking can happen at different levels. Initial code is the interpretive idea. Sometimes have a descriptive code that when clustered with			

other codes, the interpretation can develop out of the cluster. Have a flexible approach to level of interpretation needed for each piece of text, aim for interpretation but don't push for an interpretation if it is not there.

- Reviewed code 2.8 where they refer to 'the relaxed end' and coding this is a 'continuum of boundaries' compared to where I have literally described what the said.
- Make codes shorter where possible. Where people are talking about the same thing, have parts of the same code that enable you to then group them together when clustering, even if contradiction, variance etc. This is within and across transcripts. Cluster and then re-cluster into themes.
- Discussed integrating inductive and deductive codes and consideration of parts of the deductive frame that are not used. Different ways of doing the assimilation, either at point of coding or later. If deductive does not stand alone well, may bring them into the inductive. Acknowledge that this is not my entire thesis. Thinking about what the main story is. What organisation of the data makes the most sense?

Supervisor's Report (Brief details of any problems and how they have been resolved. Detailed information is required only if trainee progress is unsatisfactory):

PLAN OF ACTION until next recorded supervisory meeting (to be briefly itemised by trainee, discussed with and approved by, supervisor)

- **Continue on phase two analysis.**
- **Supervision booked for Friday 12th to review themes.**
- **To send Danielle part of thesis to review by 11th March.**
- **To liaise with Thomas re above plan and arranging deadline with him to review part of thesis.**
- **To inform Dave and Roshan of planned hand-in date.**

Trainee's concerns/problems/comments:

Signed:

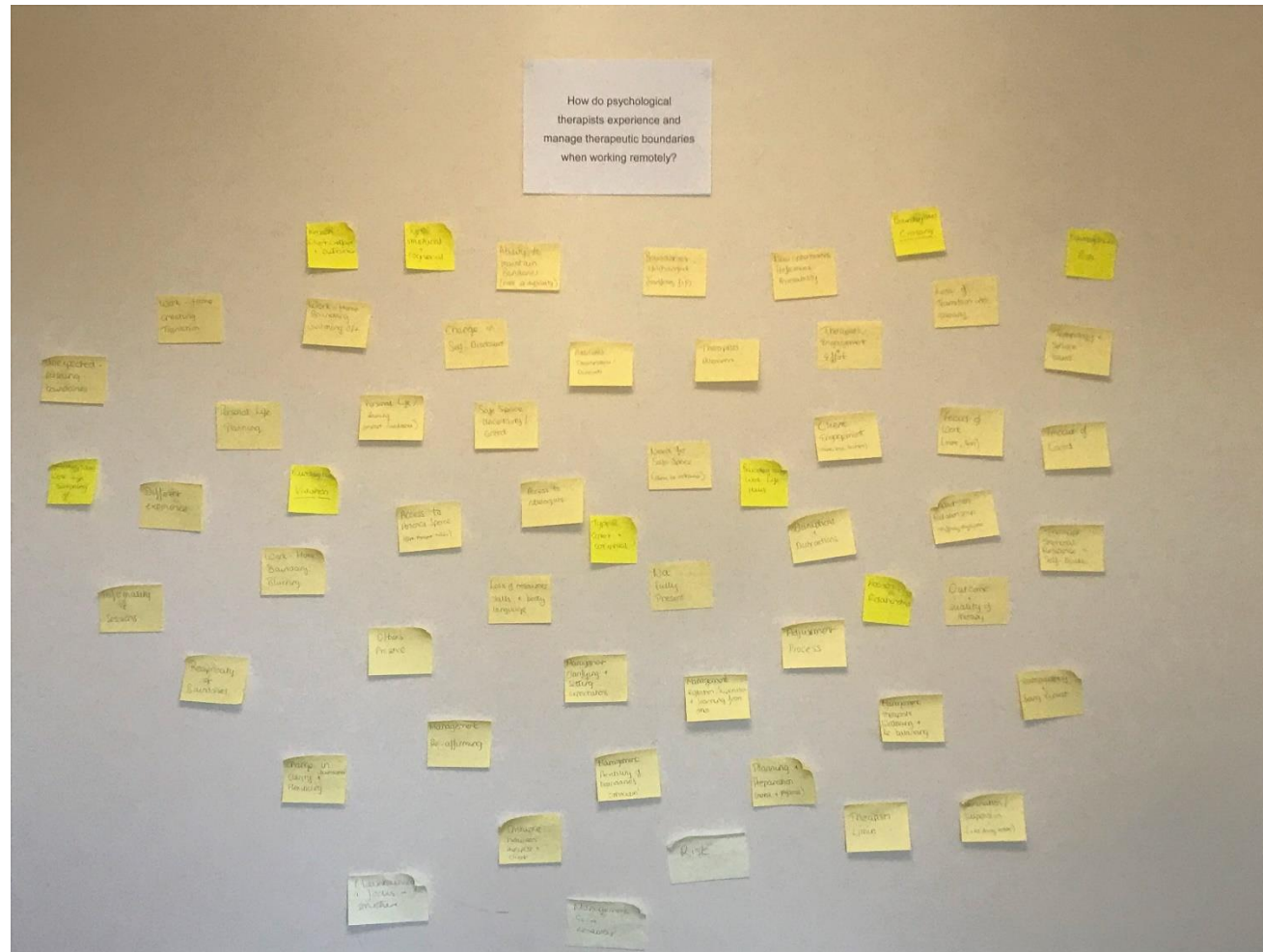
(Supervisor) Date:

Signed: G. James

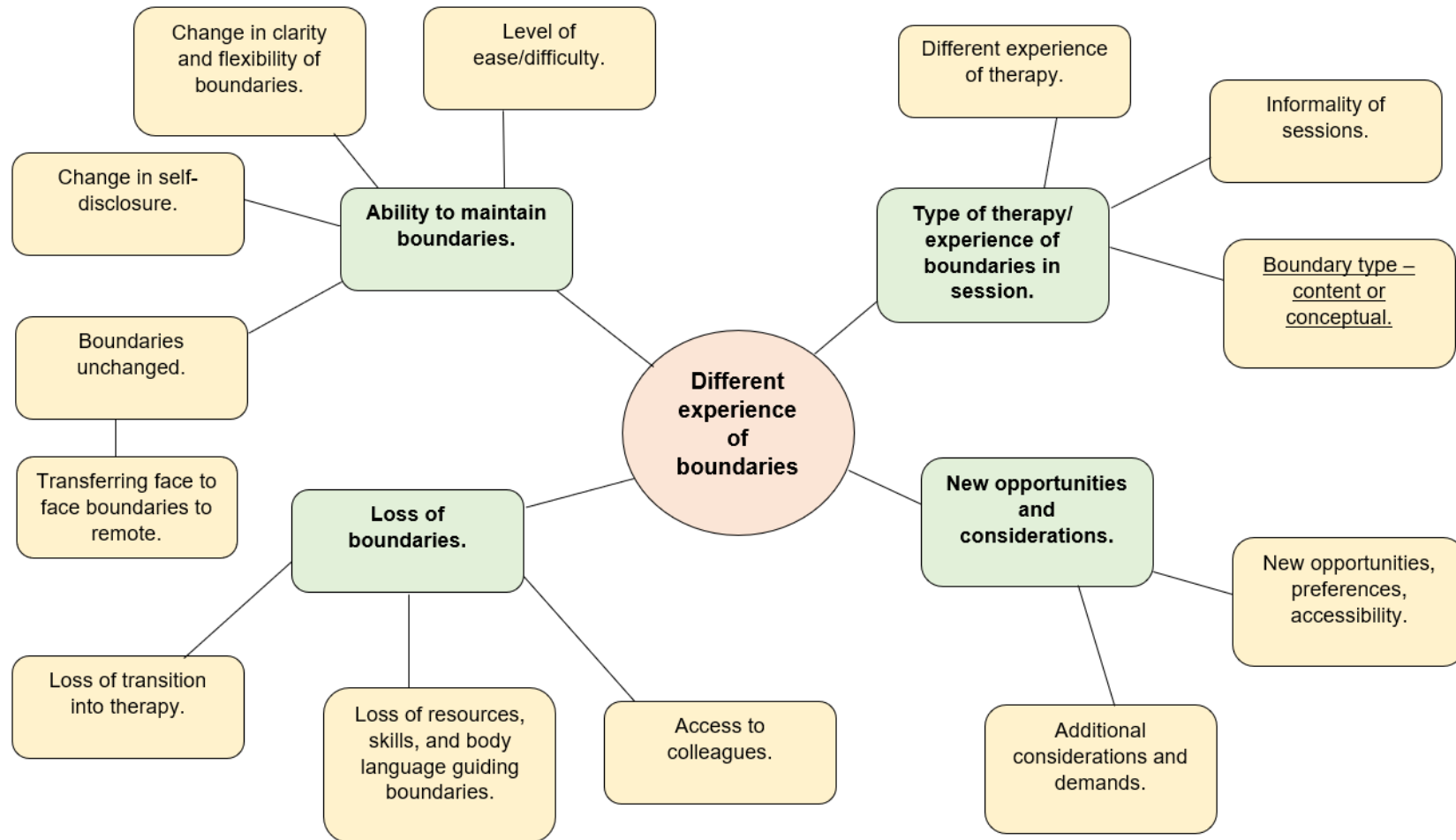
(Trainee)

Date: 21/01/2021

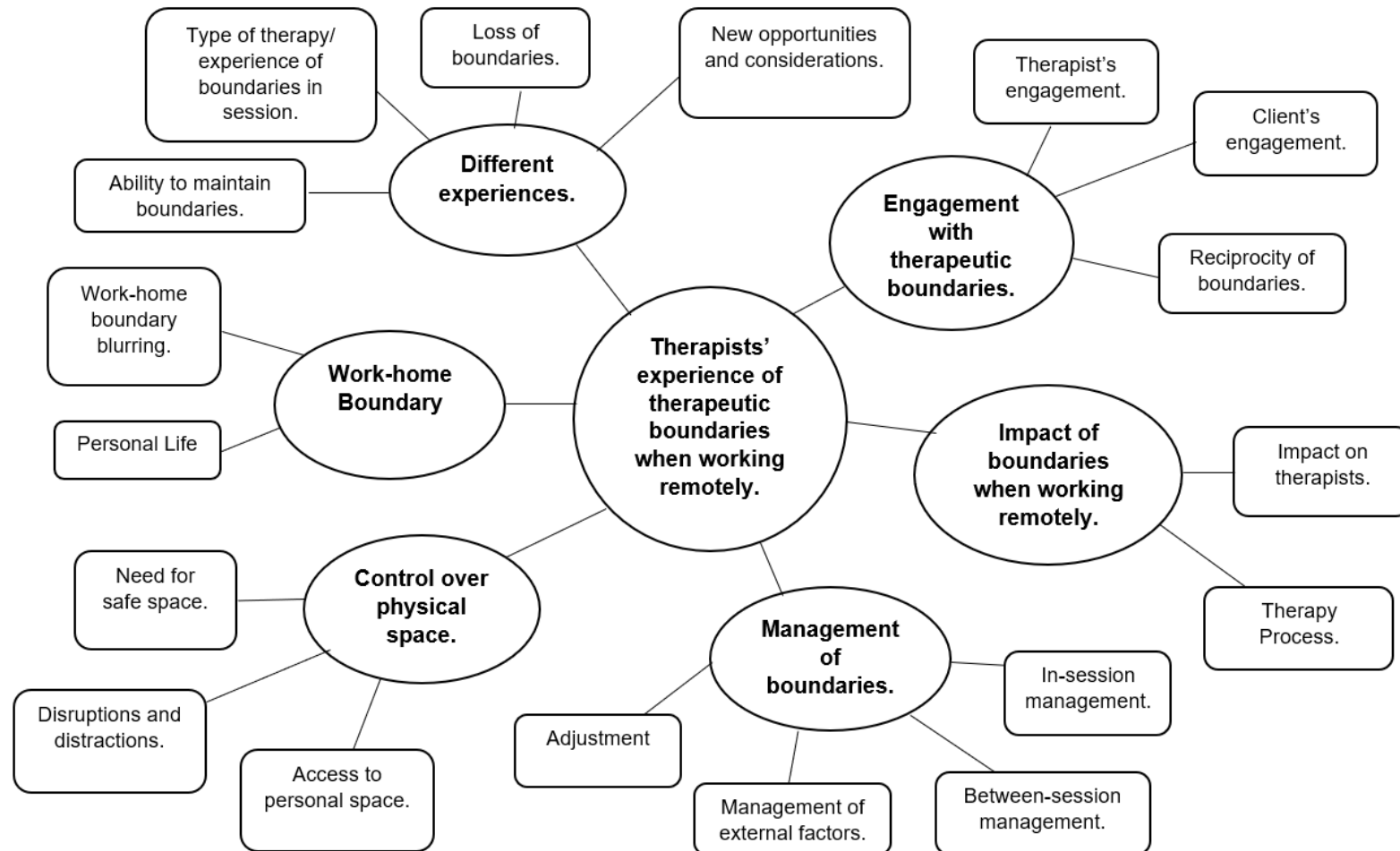
Appendix P Initial Clustered Codes



Appendix Q Example Initial Mind-Map of a Potential Theme and Related Codes



Appendix R Mind-Map of Initial Themes



Appendix S Research Supervision Log: Review of Themes



**Trent Doctorate in Clinical
Psychology**



**University of
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RECORD OF FORMAL SUPERVISORY MEETING

Name: Georgina James

Intake: 2018

Title of Project: Changing to remote psychological therapy during Covid-19: Psychological therapists' experience of the working alliance, therapeutic boundaries, and work involvement.

Primary Supervisor: Thomas Schröder

Secondary Supervisor: Danielle De Boos

Field Supervisor: N/A

Supervision No.	Date	Approx. Time spent	Supervisor(s) present
25	12/02/21	90 minutes	Danielle De Boos
Trainee's comments			
SUMMARY OF PROGRESS since last recorded meeting (edit/expand sub-sections as necessary): Review of agreed actions from last meeting: • Continue on phase two analysis. – in progress. • To send Danielle part of thesis to review by 11th March. – to do following completion of draft write up. • To liaise with Thomas re above plan and arranging deadline with him to review part of thesis. – completed and agreed as per plan below • To inform Dave and Roshan of planned hand-in date. - completed. This meeting was organised to review initial themes. General Comments: • Talked through the initial thematic map and changes that I had considered where there was potential overlap. For example, an initial theme 'engagement with boundaries' appeared to overlap with the theme 'impact of boundaries when working remotely', although a separate subtheme for the 'impact on clients' needed to be added. Therefore, we agreed it was plausible for me to get rid of the engagement theme. • We discussed the theme of 'different experiences' and how this captures different therapeutic boundary experiences that therapists described within therapy. This was broken down into two subthemes, with 'different boundaries' focusing on the different type and content of boundaries that present when working remotely and a second theme of 'ability to maintain boundaries' which focuses on how able therapists felt maintaining boundaries when working remotely compared to face-to-face and how they did this. We discussed how the overarching theme 'different			

experiences' would benefit from a clearer title in terms of how this relates to the question.

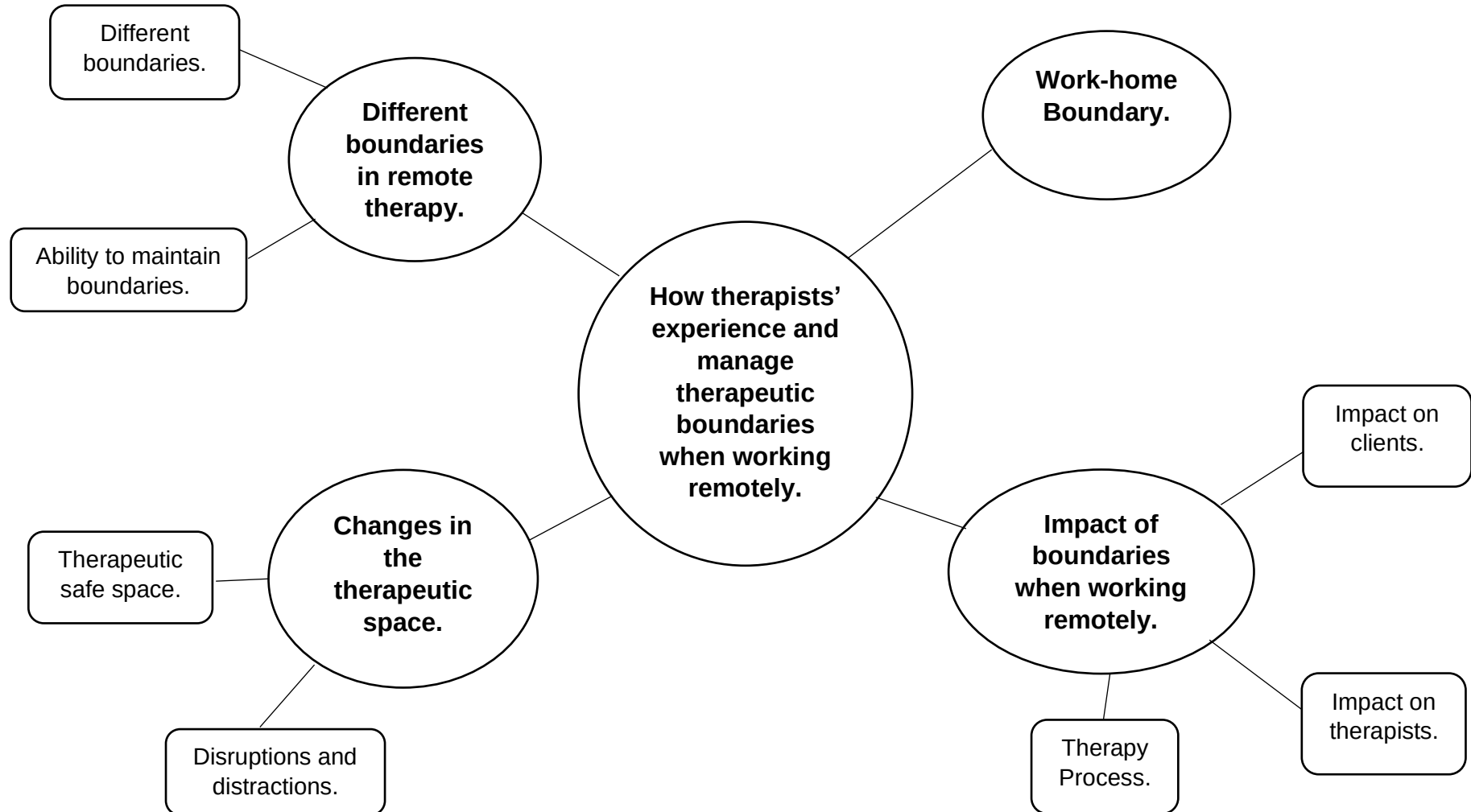
- A theme of 'work-home boundary' was discussed considering how therapists experienced a blurring between their work and home/personal lives. This was considered distinct from the 'different experiences' theme as the boundary was not about what happened in therapy per se. We discussed how therapists also spoke about how they created work-home transitions to manage this. These will only need to be discreet subthemes if it is easier to communicate that way.
- A theme of 'control over therapeutic space' was discussed regarding how therapists spoke about the need for a safe space and the changes in control that they experienced over the space. This also included therapy now taking place in peoples personal spaces and how this now involves external disruptions and distractions. From reviewing participants quotes, we reflected that this theme is not only about control but also has themes of responsibility and power between the therapeutic dyad. This theme would benefit from renaming, although was considered a distinct theme to the others.
- As above, changes were made from the initial thematic map where the engagement theme was incorporated into the 'impact' theme. We reviewed the subthemes of the 'impact of boundaries when working remotely' theme: 'impact on clients', 'impact on therapist', 'impact on therapy processes'. As part of this, we considered if the data suggests what helps to explain the divergence regarding the impact on the therapeutic relationship.
- Considering the final theme of 'management of boundaries', we considered if the subthemes would each fit better with the other themes. For example, how the subtheme of in-session management might fit with the 'ability to maintain boundaries' subtheme to explain how they did this.
- Finally, we discussed how this would be formatted in the journal and extended papers.

Supervisor's Report (Brief details of any problems and how they have been resolved. Detailed information is required only if trainee progress is unsatisfactory):

PLAN OF ACTION until next recorded supervisory meeting (to be briefly itemised by trainee, discussed with and approved by, supervisor)

- **Complete phase two analysis.**
- **Complete draft write-up.**

Appendix T Mind-Map of Final Themes



Appendix U Principal Component Analysis

Pattern Matrix	Component		Inclusion/Exclusion
	1	2	
My ability to be compassionate towards my clients.	.973	-.145	
My ability to be empathic towards my clients.	.972	-.185	
My ability to attune with my clients.	.894	.048	
My ability to build a sense of trust with my clients.	.879	-.031	
My ability to effectively communicate verbally with my clients.	.824	.001	
My ability to gauge my client's emotions.	.788	.131	
My ability to work in collaboration with my clients to achieve their goals.	.774	.102	
My ability to effectively communicate non-verbally with my clients.	.771	.110	
My ability to gauge my client's implicit communications.	.762	.087	
My ability to effectively manage ruptures in the therapeutic relationship.	.731	.183	
My ability to maintain my concentration on the client and/or task.	.643	.164	
The way I explain the limits of confidentiality.	.641	.179	Theoretically exclude
My ability to create risk management plans.	.480	.430	Equal loading on both.
My ability to only work during my working hours.	-.275	.866	
My ability to stop thinking about my client's problems in the time between therapy sessions.	.044	.747	
The therapeutic boundary issues I experience as a therapist.	.198	.685	
My ability to maintain a consistent space where I engage in the therapy.	.175	.668	
The amount that I self-disclose to clients.	.204	.612	
My ability to maintain therapeutic boundaries with my clients.	.313	.586	
The way I contract with clients.	.340	.575	
My ability to establish a therapy contract with the client.	.355	.531	
The length of agreed therapy sessions.	.251	.502	<.512 loading
My ability to effectively managing my client's risk.	.416	.494	<.512 loading
My ability to attend appointments on time.	.223	.276	<.512 loading

Extraction Method: Principal Component Analysis.

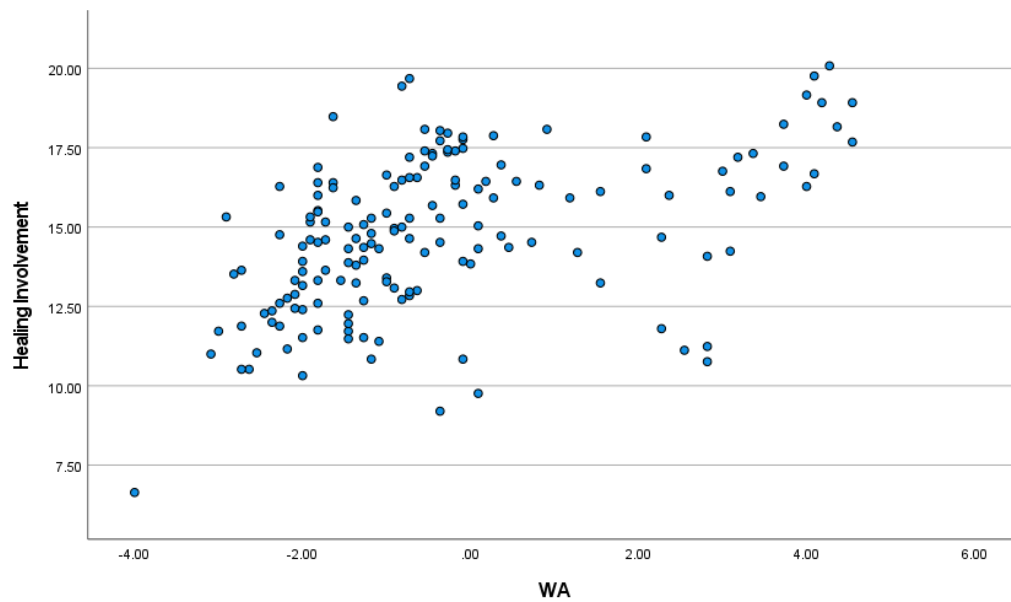
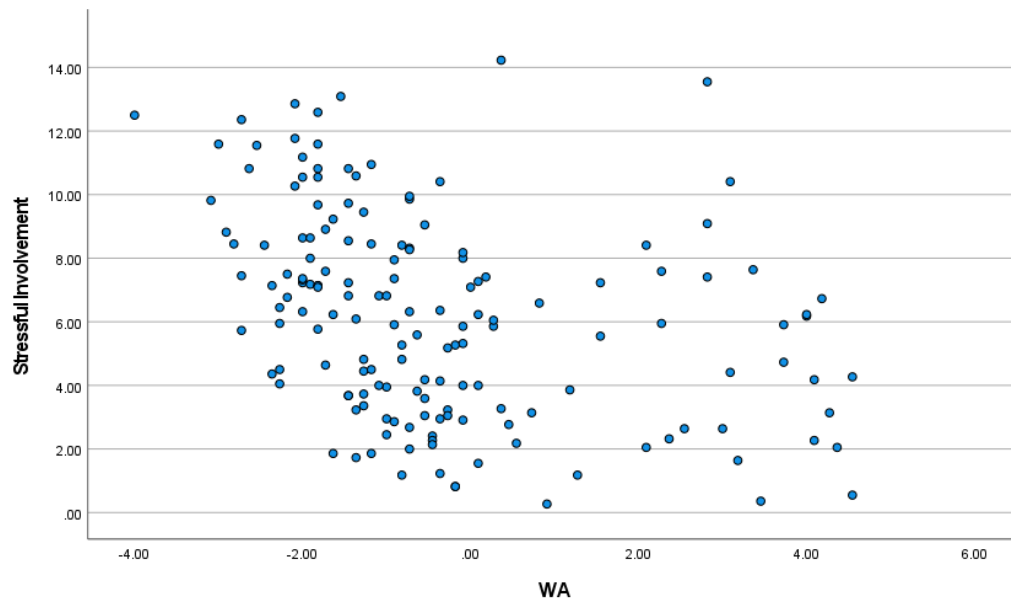
Rotation Method: Oblimin with Kaiser Normalization.

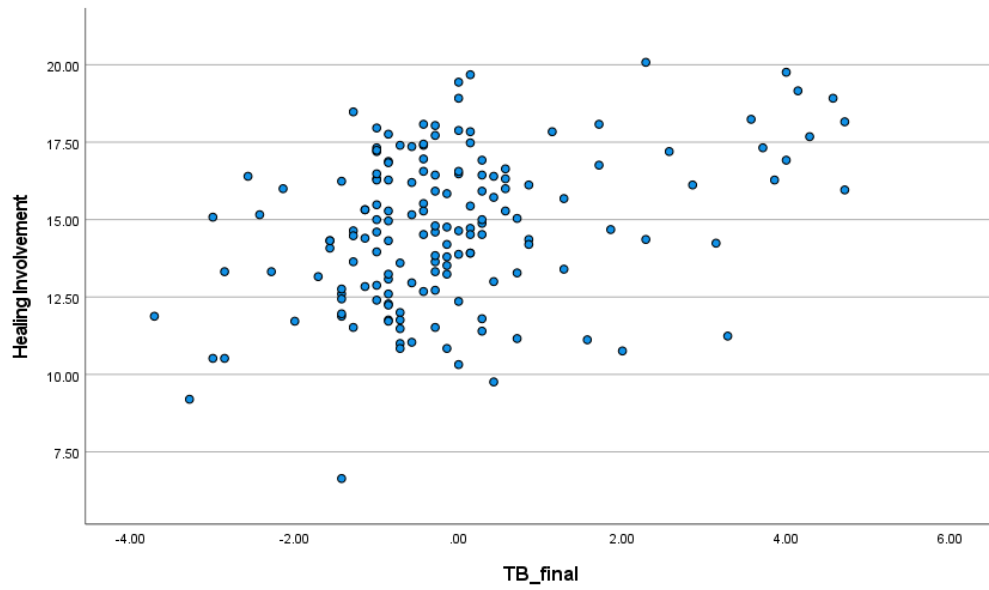
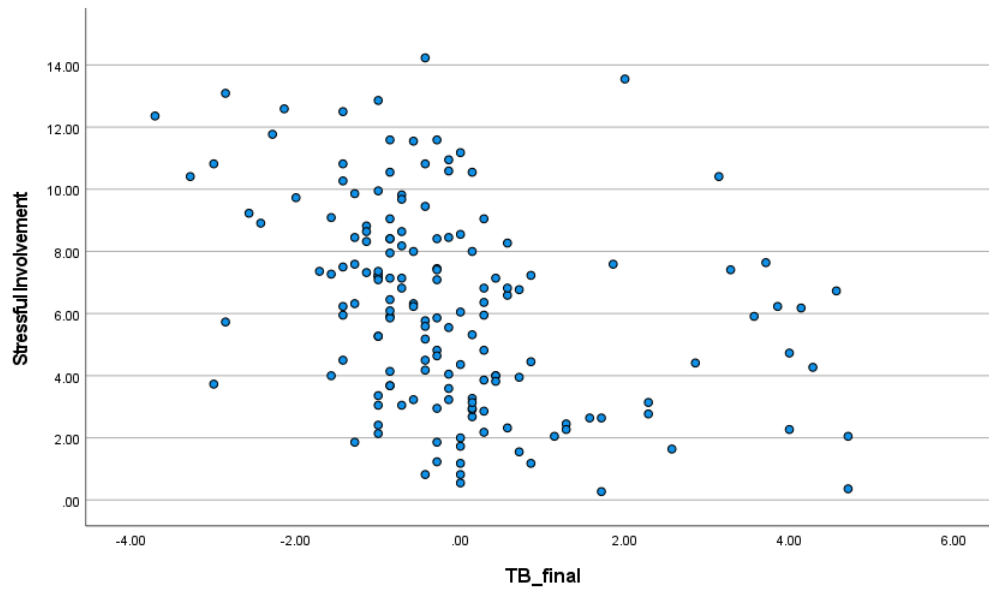
Rotation converged in 9 iterations.

Key:

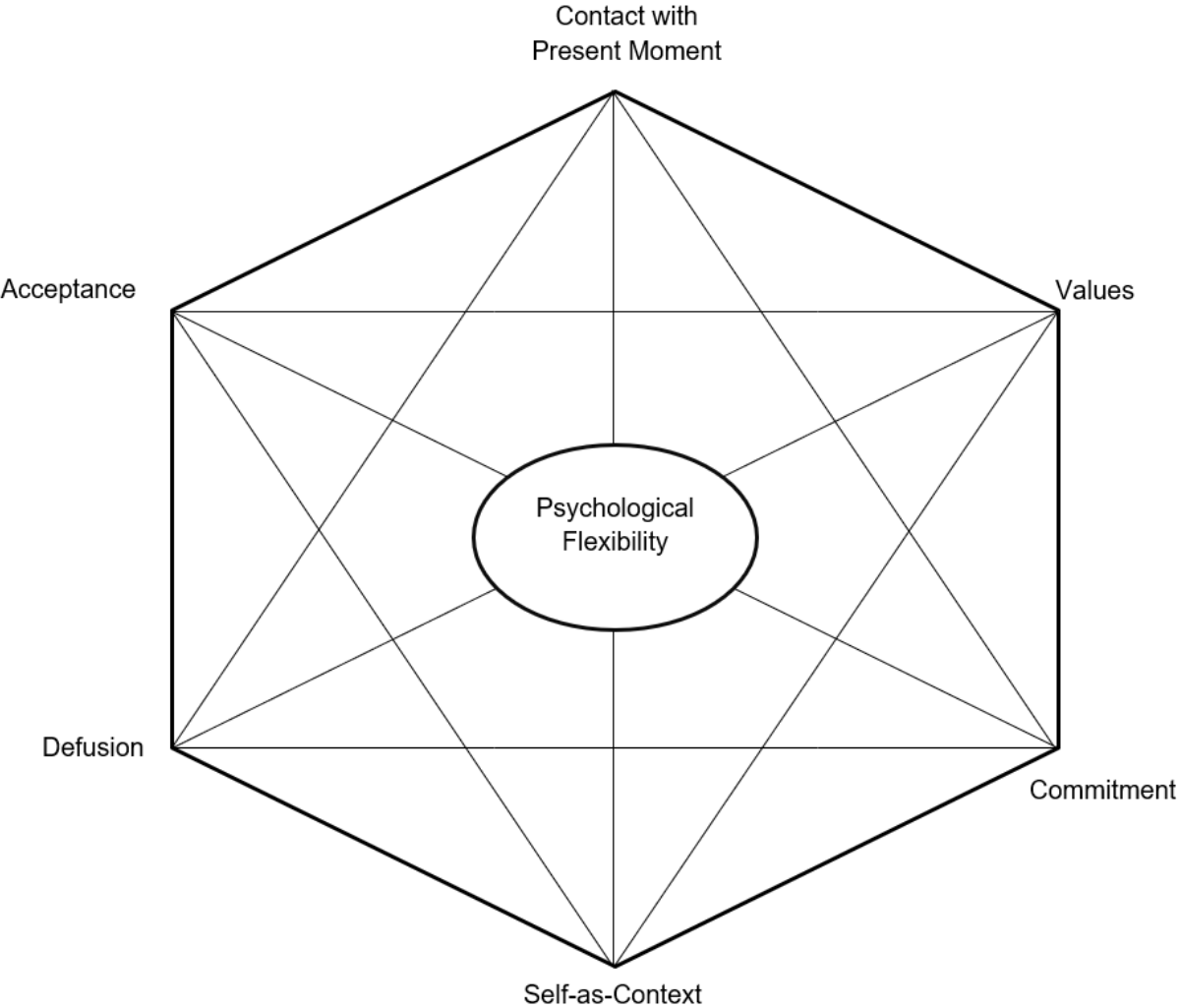
	Items included in the WA scale
	Items included in the TB scale

Appendix V Scatterplots Testing for Linearity

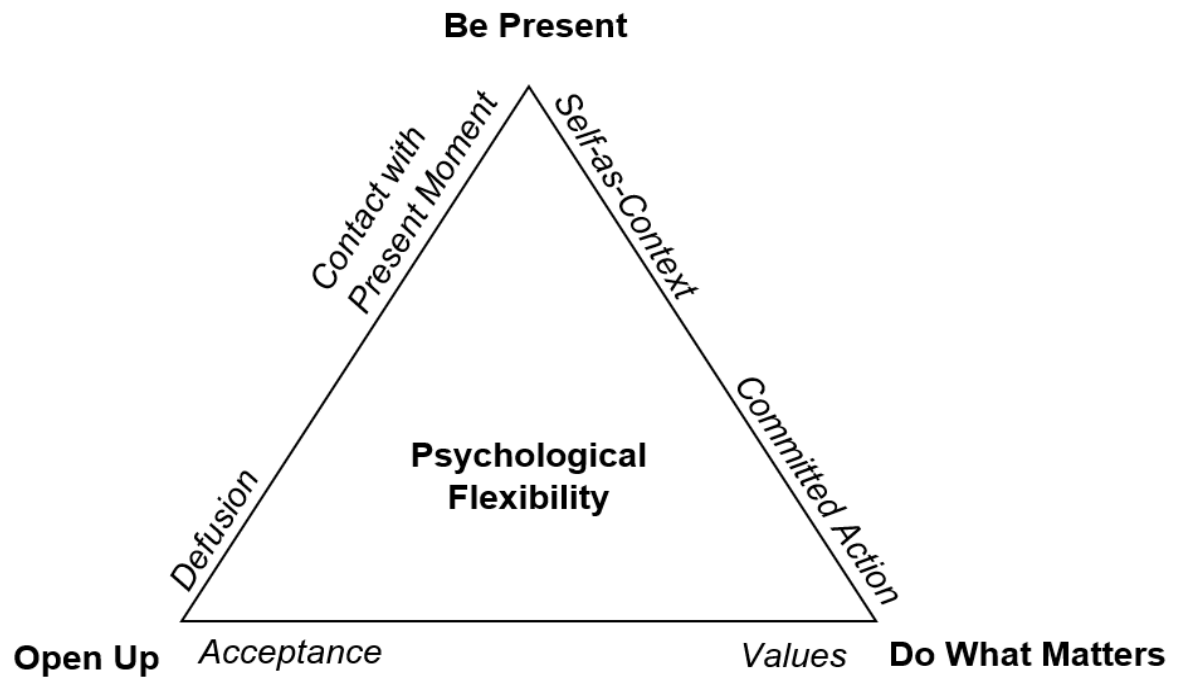




Appendix W The ACT Hexaflex



Appendix X The ACT Tri-flex.



Appendix Y Proportion (%) of pre-post RCI and CSC changes on the outcome measures between the three ACT groups.

Measure	Group	Recovered	Improved	Unchanged	Deteriorated
		Percentage (%)			
PHQ-9	Group 1	40.00	0	60.00	0
	Group 2	33.33	33.33	33.33	0
	Group 3	50.00	50.00	0	0
GAD-7	Group 1	80.00	0	20.00	0
	Group 2	33.33	0	66.66	0
	Group 3	100.00	0	0	0
BPI-S	Group 1	20.00	0	60.00	20.00
	Group 2	0	0	100.00	0
	Group 3	0	75.00	25.00	0
BPI-I	Group 1	20.00	40.00	40.00	0
	Group 2	0	66.66	33.33	0
	Group 3	25.00	75.00	0	0
CPAQ-R	Group 1	25.00	0	75.00	0
	Group 2	100.00	0	0	0
	Group 3	50.00	0	50.00	0

POSTER

Therapists' experience of the working alliance, therapeutic boundaries, and work involvement in remote therapy



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Trent Doctorate in Clinical Psychology



BACKGROUND

Psychological therapy usually takes place in a face-to-face (f-2-f) format. The COVID-19 pandemic resulted in psychological therapists having to provide therapy remotely, via videoconferencing or telephone¹. It has been questioned whether remote therapy is the same or a different experience compared to f-2-f².

Considering therapeutic processes, therapists have been found to rate the working alliance (WA) lower in remote therapy compared to f-2-f, whereas clients' ratings do not change³. Furthermore, it has been argued that remote therapy presents novel therapeutic boundaries (TB) when working remotely⁴, although this has not been empirically investigated. These points raise the question of how therapists experience the WA and TB when working remotely.

Furthermore, through factor analysis, therapists' experience of their work can be characterised as one of four work involvement patterns (see Figure 2) depending on their level of healing involvement (HI) and stressful involvement (SI)⁵. Therapists' levels of HI and SI have been found to relate to client outcomes⁵ and predict therapist burnout⁶. However, these findings are based on f-2-f therapy, raising the question of how therapists experience remote therapy.

AIMS

- 01 To investigate how psychological therapists experience the WA, TB, and their work involvement patterns when working remotely via videoconferencing or telephone.
- 02 To explore how therapists' perceived abilities regarding the WA and TB relate to experiences of HI and SI.
- 03 To explore what therapeutic boundary experiences psychological therapists encountered when working remotely and how they managed these.

PHASE 1

161 therapists completed an online survey investigating therapists' experience of the WA, TB, and their work involvement. Analysis included descriptive and inferential statistics.

Determined quantitative results to explore further in phase two. Maximum variation sampling used to select participants for phase two.

PHASE 2

12 semi-structured interviews exploring therapists' experience of TB in remote therapy. Hybrid inductive-deductive thematic analysis.

Interpreted how the qualitative data explained quantitative findings by synthesising results.

Figure 1: Sequential Explanatory Mixed-method Design Used for Data Collection.

RESULTS

PHASE 1

DESCRIPTIVE RESULTS

- WA and TB survey items rated most negatively on a 5-point scale included therapists' ability to: 'effectively communicate nonverbally with clients' ($M = -2.04$, $SD = 2.62$); 'to gauge my client's implicit communications' ($M = -1.47$, $SD = 2.40$); 'gauge client's emotions' ($M = -.92$, $SD = 2.29$); 'to only work during working hours' ($M = -.86$, $SD = 2.51$); and, 'to stop thinking about my client's problems in the time between therapy sessions' ($M = -.78$, $SD = 2.36$).
- WA and TB items rated most positively included therapists' ability to: 'attend appointments on time' ($M = 1.32$, $SD = 2.15$); 'be compassionate towards my clients' ($M = .60$, $SD = 2.04$); and, 'explain the limits of confidentiality' ($M = .54$, $SD = 1.75$).
- Frequencies of work involvement patterns compared to f-2-f therapy are shown in Figure 2.

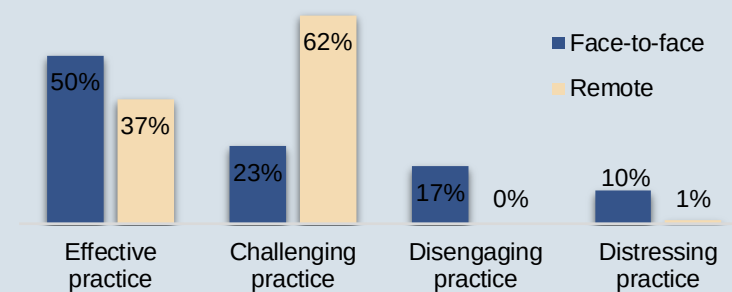


Figure 2: Frequency of Work Involvement Patterns.

INFERENTIAL RESULTS

- Principal component analysis of the WA and TB survey items supported two component scales with excellent reliability: a WA scale ($\alpha = .96$); and, a TB scale ($\alpha = .90$).
- HI correlated positively with therapists' perceived abilities regarding the WA, $r(159) = .478$; $p < .01$; 95% CI [.327, .595], whereas SI negatively correlated, $r(159) = -.356$; $p < .01$; 95% CI [-.493, -.218].
- HI positively correlated with therapists' perceived abilities regarding the TB, $r(159) = .369$; $p < .01$; 95% CI [.215, .498], while SI negatively correlated, $r(159) = -.370$; $p < .01$; 95% CI [-.493, -.218].

PHASE 2

- Data was organised into four key themes, as seen in Figure 3.

SYNTHESIS OF PHASE ONE AND PHASE TWO

- Therapists' experiences of the WA and TB differed compared to f-2-f therapy, although this varied amongst therapists.
- Therapists experienced different TB, describing a change to or a loss of some boundaries but also new opportunities in remote therapy.
- Therapists' level of SI is increased in remote therapy, as indicated by the higher rates of 'challenging practice'. This was supported by therapists report of unpleasant emotions and self-doubt when working remotely.

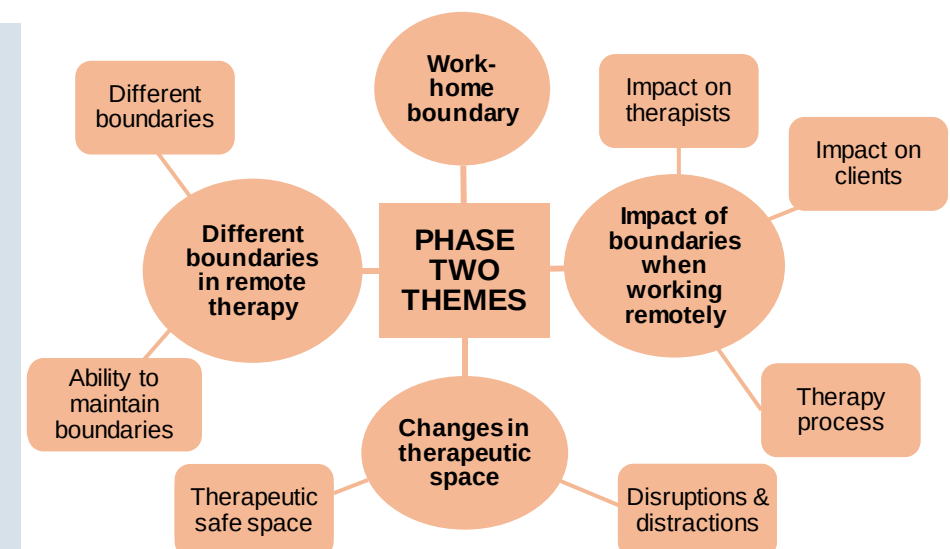


Figure 3: Thematic Map of Themes Developed in Phase Two.

DISCUSSION

- Therapists' perceived abilities regarding the WA and TB differ when working remotely.
- Remote therapy presents novel therapeutic boundary experiences and presents challenges for therapists' ability to manage boundaries.
- Therapists' experience high rates of SI when working remotely, which may be characterised by unpleasant emotional experiences and self-doubt.

IMPLICATIONS

Should therapists continue to use remote therapy following the COVID-19 pandemic, having an awareness of the potential different experiences will help to mitigate against the changes.

LIMITATIONS

Whilst providing insight into therapists' experiences of remote therapy, the cross-sectional nature of the study does not enable conclusions to be drawn regarding the potentially dynamic nature of therapists' experiences and work involvement when working remotely.

FUTURE RESEARCH

Future research may consider what, if any, impact the different perceived abilities regarding the WA and TB have on therapeutic outcomes when working remotely.

It would also be interesting to know whether therapists' work involvement patterns change over time when working remotely and, if so, what contributes to the change.

SMALL-SCALE RESEARCH PROJECT

Evaluating the effectiveness of an ACT group for chronic pain in a secondary healthcare setting.

Abstract

Purpose

Acceptance and commitment therapy (ACT) has been evidenced in controlled trials for chronic pain. Using routinely collected clinical data (practice-based evidence) compliments the larger controlled studies. The purpose of this service evaluation is to report the effectiveness of an ACT group for patients with chronic pain and distress related to their pain.

Design/ Methodology/ Approach

Reliable and clinically significant change methodology was applied to routinely collected outcome data for 12 individuals who completed the group. Outcome data included measures of anxiety, depression, pain severity, pain interference, and acceptance of pain. Group outcomes were compared to data available for patients receiving individual therapy in the service.

Findings

Outcomes from the ACT group showed that 58%, 42%, 8%, 16%, and 36% of patients demonstrated clinically significant changes, whilst 8%, 33%, 33%, 50%, and 0% showed reliable change, in their levels of anxiety, depression, pain severity, pain interference, and acceptance of pain, respectively. No patients deteriorated in their levels of anxiety, depression, pain interference, or acceptance of pain, whilst one patient deteriorated in their level of pain severity. Overall, these results compare similarly to patients receiving individual therapy in the service.

Originality

This evaluation compliments the existing evidence base by evaluating routinely collected, practice-based evidence. Furthermore, it differs to previous evaluations in the service by evaluating a group intervention whilst comparing this to individual therapy, informing service planning and delivery.

Keywords: Chronic pain, ACT, Service evaluation, Practice-based evidence, Clinically significant change, Reliable change.

Classification: Research paper.

Introduction

This paper evaluates the provision of an Acceptance and Commitment Therapy (ACT) group for chronic pain in a secondary healthcare setting. Using reliable and clinically significant change methodology, the effectiveness of the ACT group will be considered in order to contribute to future service planning and patient care.

Service Background

This publicly funded (UK National Health Service) clinical psychology pain service provides individual and group psychological treatment to individuals having difficulty managing their chronic pain or are experiencing distress associated with their pain. Individuals are mostly referred by consultants in anaesthesia and pain control but also by specialist pain nurses. The service is provided by specialist clinical psychologists (one 0.6 WTE and one 0.4 WTE). This service accepts referrals of patients with any chronic pain condition but is separate from the Back Pain Management Service³¹ (BPMS). Following the Health and Social Care Act (2012), Clinical Commissioning Groups (CCG) were established to plan and buy services based on local requirements and infrastructure, including pain services. Bids to provide such services are considered from the NHS, voluntary organisations, social enterprises, or private providers. Whilst not always required, some CCG's request clinical outcomes to inform commissioning (British Pain Society, 2019). At the time of planning this evaluation, the BPMS lost its tender to a private health provider, whilst the clinical psychology pain service continued being publicly funded. Demonstrating clinical and cost effectiveness is pertinent to continue securing the tender for this service and its patients.

In recent years, the service moved from providing cognitive-behaviour therapy (CBT) approaches to third-wave ACT. Whilst the effectiveness of psychological therapy with individual clients using either CBT or ACT approaches has previously been evaluated (Macey *et al.*, 2015; Sheldon *et al.*, 2015), the ACT group has not. It is hoped that this evaluation contributes to service planning and improving outcomes for individuals accessing the service.

Psychological Treatment of Chronic Pain

Chronic pain is considered a major health problem, largely impacting on the individual's physical, psychological, and social functioning, as well as on society (Breivik *et al.*, 2013), though difficult to treat (National Institute of Health and Care Excellence, 2018). Whilst pharmacological and physical interventions are also used, psychological interventions

³¹ Individuals with back pain as their primary difficulty would be referred to the BPMS.

have demonstrated modest effect sizes, with CBT considered the standard treatment (Veehof *et al.*, 2011).

More recently, there has been a move towards a focus on acceptance of pain to improve functioning (Turk *et al.*, 2011; Veehof *et al.*, 2016), with more acceptance and mindfulness-based approaches being applied, as was the case for this service. Developed by Hayes *et al.* (1999), ACT aims to increase individuals' psychological flexibility to reduce suffering. Psychological flexibility is developed through six interconnected core processes, commonly known as the ACT Hexaflex (see Appendix A): acceptance, cognitive defusion, contact with the present moment, self-as-context, values, and committed action.

A recent meta-analysis concluded that ACT was as effective as CBT in treating chronic pain (Veehof *et al.*, 2016). Furthermore, it was reported that only small to moderate effects were found for depression, anxiety, and quality of life, whereas pain interference demonstrated large effect sizes. Larger effects in pain interference were proposed to reflect the process of acceptance, suggesting that patients "go along with life in the face of pain" (p.20; Veehof *et al.*, 2016), compared to the small effect size found in pain severity. This finding is further supported by significant increases in the six processes of psychological flexibility following ACT treatment for chronic pain (McCracken and Gutiérrez-Martínez, 2011). Systematic reviews of Randomised Control Trials (RCTs) have also shown ACT as an effective psychological treatment for chronic pain (Hann and McCracken, 2014; Hughes *et al.*, 2017; Simpson *et al.*, 2017; Veehof *et al.*, 2016). However, some argue that evidence regarding the mediating factors that account for behaviour change during ACT is insufficient (Simpson *et al.*, 2017).

Practice-Based Evidence

Evidence-based practice, such as using evidence from the beforementioned RCTs, has widely informed clinical practice. Despite RCTs being considered gold standard, it has been argued that they may lack external validity due to the rigorous sampling techniques employed (Kennedy-Martin *et al.*, 2015). There is a growing argument for using practice-based evidence, that is, routine data collected in clinical settings, alongside evidence-based practice to inform psychological therapies (Barkham and Mellor-Clark, 2003). Larger controlled studies often use statistical methods comparing group means. However, this does not allow for individual differences and, if employed in clinical practice, may result in type II errors due to the small samples of data often used. Reliable Change Indices (RCI) and Clinically Significant Change (CSC) methods provide a global, objective, and standardised method for statistically analysing individual-level data (Jacobson and Truax, 1991). Furthermore, these methods enable us to consider what proportion of patients improve or not (Barker, 2016).

This evaluation follows previous evaluations, specifically one that evaluated individual-level data from group and individual clients between 2013 and 2014 (Sheldon *et al.*, 2015). However, this paper did not distinguish between the outcomes of individual versus group data in terms of the proportions of reliable or clinically significant changes. Following changes in service provision, with reduced psychologist hours and groups generally being considered more cost-effective (i.e. psychologists treating more patients in less time), the service began providing a regular ACT group for pain in November 2017. This warrants evaluation to establish if this is an effective treatment modality in comparison to individual-based interventions, whilst contributing to the wider evidence base.

Aims

This service evaluation aims to firstly evaluate the effectiveness of the ACT group for chronic pain. Using measures routinely collected by the service, effectiveness was considered in terms of reliable and clinically significant changes on measures of anxiety, depression, pain severity, pain interference, and acceptance of pain. Secondly, the effectiveness of the ACT group was compared to individual-based psychological interventions provided in the service. The evaluation aims to consider how future evaluations could be improved to aid service planning. Specifically, the evaluation aimed to answer the following questions:

1. How effective is the ACT group for chronic pain in this secondary healthcare setting?
2. How does the ACT group compare in effectiveness to individual psychological therapy for chronic pain in this service?

Method

This service evaluation was approved by the relevant NHS trust's Research and Development department and adhered to BPS ethical standards (Cooper *et al.*, 2005). Data used was routinely collected by the service, placing no additional burden on staff or patients.

Inclusion Criteria

Considering that the ACT group has not previously been evaluated in this service, existing data for three treatment groups completed between November 2017 and January 2019 were included. For comparison, a selection of available data for individual based interventions were included.

Treatment Pathway

Following referral, patients attended an information session where they were presented with an explanation about the role of psychology in managing chronic pain. Subsequently, patients opted into an assessment with one of the clinical psychologists to

assess whether psychology would be appropriate for them and, if so, whether this would be group or individual treatment; this decision would be made jointly between the patient and psychologist. Patients would then be placed onto a waiting list for the respective treatment choice.

Whilst ACT is not considered a manualised treatment (Harris, 2009), the group followed a developed treatment plan in accordance with the ACT Tri-flex (see Appendix B). The ACT Tri-flex is considered a simpler way of explaining the model compared to the Hexaflex (Harris, 2009). Whilst the clinical psychologists in the service used the terms 'open', 'aware', and 'engage' to represent each process, as also used by Feliu-Soler *et al.* (2018), other terms are used interchangeably, such as 'open up', 'be present', 'do what matters' (Harris, 2009). Table 17 summarises the key focus of each session.

The group was run by two clinical psychologists at Band 8a (NHS Agenda for Change) and lasted two and half hours (3 hours including administration tasks). A physiotherapist was present for the beginning of each group to review engagement with physical activity, and an Occupational Therapist facilitated during session five. The group ran over eight sessions and patients were invited to attend a follow-up review after three months.

Table 17 *Outline of the ACT group content and respective ACT Tri-flex processes.*

Session	Aim/ Focus of session	ACT Tri-flex process(es)
1. Introduction and Exercise	Group introduction and ice-breaker activity Introduction to 'Open, Aware, Engaged' Introduction to chronic pain Introduction to exercise (Physiotherapist)	Aware
2. Stress	Understanding stress (Fight, Flight, Freeze) Impact of stress on pain Danger in Me (DIMS) & Safety in Me (SIMS) Introduction to relaxation & practice exercise	Open Aware Engaged
3. Choice Point	Introduction of Choice Point Identifying 'hooks' (thoughts, sensations, feelings, emotions, behaviours, other people's actions) Pros and cons of 'hooks' Role of 'helpers' and willingness Completing a group choice point	Open Aware Engaged
4. Thoughts	Thoughts & why we have negative thoughts Fusion with thoughts Defusion techniques	Open
5. Pacing	Introduction to pacing and recognising boom/bust cycles (Occupational Therapist) Identifying individual activities for pacing Gym exercise session (Physiotherapist)	Open Aware Engaged
6. Mindfulness	Introduction to mindfulness Difference between mindfulness and relaxation Mindfulness practice	Open Aware Engaged
7. Values	Introduction to values Value card sort exercise Difference between values and goals Using values to set goals	Aware Engaged
8. Communication	Communication skills Sleep hygiene Planning for setbacks & maintenance	Aware Engaged

Outcome Measures

It is worth noting that the service changed the use of outcome measures for distress. Therefore, the individual data available for comparison used a different outcome measure to those in the group, although both used the brief pain inventory.

Patient Health Questionnaire-9 (PHQ-9)

The PHQ-9 (Kroenke *et al.*, 2001) is a 9-item measure of symptoms of depression. Respondents are asked to consider how they have felt over the previous two weeks in

response to items, such as “feeling down, depressed, or hopeless”. Responses are based on a 4-point Likert scale, ranging from “not at all” to “nearly every day”. Psychometric properties reported include excellent reliability ($\alpha = 0.89$) and validity (a PHQ-9 score ≥ 10 demonstrated 88% sensitivity and 88% specificity). This measure was completed by all patients in the group during the first, last, and review sessions, if they attended.

Generalized Anxiety Disorder-7 (GAD-7)

The GAD-7 (Spitzer *et al.*, 2006) is a 7-item measure of generalised anxiety. The questionnaire asks people to consider how they have felt over the previous two weeks in response to items, such as “feeling nervous, anxious, or on edge”. Responses are based on a 4-point Likert scale, ranging from “not at all” to “nearly every day”. The GAD-7 has been reported to have excellent internal consistency ($\alpha = .93$) and good test-retest reliability ($\alpha = .83$) (Spitzer *et al.*, 2006). This measure was completed by patients in the group during the first, last, and review sessions, if they attended.

Clinical Outcomes in Routine Evaluation-10 (CORE-10)

The CORE-10 (Barkham *et al.*, 2013) is a shortened version of the Clinical Outcomes in Routine Evaluation – Outcome Measures (CORE-OM; Evans *et al.*, 2002). Comprising of 10 items, this measure assesses common presentations of psychological distress, including anxiety, depression, trauma, physical problems, functioning, and risk to self or others. Each item is rated on a 5-point scale, ranging from “not at all” to “most or all of the time”. The CORE-10 has excellent internal reliability ($\alpha = .90$). This measure was used with patients seen for individual therapy instead of the PHQ-9 and GAD-7.

Brief Pain Inventory (BPI)

The BPI (Cleeland, 2009) measures subjective pain experience through two related but independent constructs, pain severity (BPI-S) and pain interference (BPI-I). Pain severity is assessed by four items rated on a 10-point scale (0 = “no pain”; 10 = “pain as bad as you can imagine”). Total pain severity is the mean sum of the four responses. Pain interference, the extent to which their pain interferes with common dimensions of feelings and function, is assessed over seven items rated on a 10-point scale (0 = “does not interfere”; 10 = “completely interferes”). Respondents are directed to answer each item by considering how much their pain has interfered with areas of their life (e.g. general activity, mood, sleep, enjoyment of life) over the previous week. Originally developed for use in cancer related pain, the BPI has been validated for use on non-malignant chronic pain, demonstrating excellent reliability on the BPI-S ($\alpha = .85$) and on the BPI-I ($\alpha = .88$) subscales. Although validated on an American sample, the BPI has been recommended by British Pain Society and Faculty of Pain Medicine (2019) for use with chronic pain. This measure was completed

by all patients in the group during the first, last, and review sessions, if they attended, and also during individual therapy sessions.

Chronic Pain Acceptance Questionnaire - Revised (CPAQ-R)

The CPAQ-R (McCracken *et al.*, 2004) measures acceptance of pain through two independent factors, activity engagement and pain willingness. Respondents are asked to rate the truth of each statement on a 7-point scale (0 = “never true”; 6 = “always true”). Activity engagement items include statements regarding their pursuit of life activities regardless of pain. For example, “when my pain increases, I can still take care of my responsibilities”. Pain willingness items explore the understanding that avoidance and control are often unworkable methods of adapting to pain. For example, “I need to concentrate on getting rid of my pain”. Higher scores reflect higher levels of acceptance. The CPAQ-R has demonstrated excellent internal consistency on both factors ($\alpha = .82$ for activity engagement; $\alpha = .78$ for pain willingness). This measure was completed by all patients in the ACT group during the first, last, and review sessions, if they attended.

Analysis

Data was recorded by the service as part of their routine monitoring of outcomes. A trainee clinical psychologist created an anonymised version of the data using Excel, and both Excel and IBM SPSS were used for analyses.

Reliable and Clinically Significant Changes Criteria

Reliable Change Index (RCI; Jacobson and Truax, 1991) is a method for assessing whether the magnitude of change is statistically reliable, that is, beyond what could be reasonably attributed to measurement error or chance variation. This method uses standardised scores that are equivalent to z-scores, therefore allowing for the z-distribution to interpret RCI scores (a RCI score greater than ± 1.96). Jacobson and Truax (1991) further suggest that, whilst reliable change is a precondition, we should also establish if there has been a clinically significant change (CSC). Clinical significance refers to whether a change constitutes a change in clinical status. For example, whether someone has moved from the ‘clinical’ range to ‘borderline’ or ‘non-clinical’.

Jacobson and Truax (1991) argue that questions regarding efficacy should tell us something about the impact on the client’s lives. Therefore, they developed the following criteria to classify changes that might happen:

Recovered: *Reliable improvement that also meets criterion for clinically significant change.*

Improved: *Reliable improvement only.*

Unchanged: *No reliable change.*

Deteriorated: *Reliable change in the direction of decline.*

Depending on the available clinical and non-clinical norms for each measure, clinical significance can only be established based on different criteria, as seen below. Criteria 'b' or 'c' are preferred as they consider the non-clinical population, whereas criterion 'a' does not. Criterion 'a' is considered less accurate because it does not consider how close an individual is to the cut-off point (Jacobson and Truax, 1991).

Criterion 'a': *Is met when a post-treatment score falls outside of the clinical range for that measure (at least two standard deviations away from the 'clinical' mean). Used when non-clinical norms are unavailable.*

Criterion 'b': *Is met when a post-treatment score falls within two standard deviations of the non-clinical population mean. Used when clinical and non-clinical norms are available but do not overlap.*

Criterion 'c': *Is met when the post-treatment score is closer to the mean of the non-clinical population than the mean of the clinical population. This criterion is preferred when the population means are overlapping.*

Whilst alternative RCI and CSC methods exist, it has been argued that the Jacobson and Truax approach is most useful overall (Atkins *et al.*, 2005). Compared to using group means, RCI and CSC methodology allow us to establish difference at an individual level (e.g. how many patients in the group changed and in what direction compared to individual patients). This evaluation used these methods to analyse the ACT group and individual therapy data.

Comparison of Group and Individual Data

Both groups were directly compared on BPI scores using a one-way ANOVA. However, different measures of distress were used between treatment conditions (i.e. the ACT group and individual therapy). Therefore, prior to comparing proportions of RCI or CSC in the ACT group to patients receiving individual therapy, it needed to be established if the patients were comparable. To do this, group means were compared to the existing clinical normative data for each measure using z scores. Criteria was set at scores falling within one standard deviation to be comparable.

Results

Is the ACT Group for Pain Effective?

Group Characteristics

Seventeen patients were invited to attend the ACT group for pain between November 2017 and January 2019, over three consecutive groups. Overall, attendance of the group was 77.21%, ranging from 2-8 sessions.

Pre-post outcome data were available for 12 patients, of which ten were female (83%) and two were male (17%); mean age was 48 years ($SD = 7.93$). On the records reviewed, no data were available for why people did not complete the group. Of the five non-completers, four were female (80%) and one was male (20%). Average age for non-completers did not significantly differ to completers ($M = 50$; $SD = 7.39$; $p = .15$). One-way ANOVA revealed no significant differences between treatment completers and non-completers in their pre scores on the PHQ-9 ($p = .56$), GAD-7 ($p = .29$), BPI-S ($p = .06$), and BPI-I ($p = .91$). Follow up review data at three months was recorded for eight (47%) patients. It is worth noting that pre-post data for the CPAQ-R was available for 11 patients and pre-post data were available for seven patients, with no reason available for the missing data.

Descriptive Data

Table 18 presents descriptive data for the ACT group pre-treatment means and pre-post outcome effect size. Across all measures the group demonstrated large effect sizes.

Table 18 *Descriptive data for the ACT group pre-treatment means and pre-post effect sizes on each measure.*

Measure	<i>n</i>	Minimum	Maximum	Pre-Treatment	Standard	Effect
				Mean	Deviation (<i>SD</i>)	Size (<i>d</i>)
PHQ-9	12	7.00	27.00	19.33	5.48	1.38
GAD-7	12	9.00	21.00	16.42	4.03	1.53
BPI-Severity	12	4.00	9.25	6.85	2.08	0.84
BPI-Interference	12	5.25	10.00	8.45	1.68	1.66
CPAQ-R (Total)	11	13.00	96.00	43.18	25.78	0.84

Reliable and Clinically Significant Change: Pre-Post

To assess RCI and CSC on the depression scale (PHQ-9), criterion ‘b’ was applied (at the 95% confidence interval). As can be seen in Table 19, at post-treatment 42% of patients reached clinically significant change, 33% demonstrated reliable change, 25% demonstrated no change, and no patients deteriorated.

Regarding post-treatment anxiety scores (GAD-7), criterion ‘b’ was applied. The results showed that 58% of patients achieved clinically significant change, 8% reached reliable change, 33% demonstrated no change, and no patients deteriorated.

For changes in pain severity (BPI-S) and pain interference (BPI-I), criterion ‘a’ was applied as non-clinical norms for chronic pain patients were not available. For pain severity, 8% showed clinically significant change, 33% reached reliable change, 50% demonstrated no change, and 8% deteriorated. For pain interference, 16% reached clinically significant change, 50% showed reliable change, 33% showed no change, and no patients deteriorated.

Considering changes on the CPAQ-R total score, criterion ‘a’ was used as non-clinical norms were unavailable. Thirty six percent of patients showed clinically significant change in their acceptance of pain. Sixty-four percent showed no change, whilst no patients deteriorated. Further analysis showed that regarding the activity engagement factor, 36% demonstrated clinically significant change, 64% showed no change, and no patients deteriorated. This is compared to the pain willingness factor items, where 18% demonstrated clinically significant change, 82% remained unchanged, and none deteriorated.

Table 19 *RCI and CSC outcomes for each measure between pre and post ACT group sessions.*

Measure	<i>n</i>	Recovered	Improved	Unchanged	Deteriorated
PHQ-9	12	5**	4	3	0
GAD-7	12	7**	1	4	0
BPI-S	12	1*	4	6	1
BPI-I	12	2*	6	4	0
CPAQ-R	11	4*	0	7	0

*used criterion 'a'; **used criterion 'b'

Reliable and Clinically Significant Change: Pre-Review

Reliable and clinically significant change analyses were completed for the patients who attended for a follow up review. Table 20 shows how many patients reached reliable and clinically significant change for each outcome measure between the first and review sessions.

Table 20 *RCI and CSC outcomes for each measure between pre and review ACT group sessions.*

PHQ-9	8	2**	3	3	0
GAD-7	8	7**	0	1	0
BPI-S	8	0*	5	3	0
BPI-I	8	2*	5	1	0
CPAQ-R	7	5*	0	2	0

*Criterion 'a'; **Criterion 'b'.

Comparison between ACT groups

Overall effect sizes (Cohen's *d*) were used to compare how similar the three ACT groups were. As seen in Table 21, group one achieved a medium effect whilst groups two and three demonstrated large effects. It is worth acknowledging the large effect size in group 2 on the CPAQ-R and in group three on the PHQ-9, as potentially anomalous results. When comparing group effect sizes on the GAD-7 and BPI, all 3 groups achieved similar effect sizes (Group 1 *d* = 1.35; Group 2 *d* = 1.54; Group 3 *d* = 1.73). Due to the small samples, total effect sizes are likely to be influenced by individual variations in group members, making the results difficult to confidently interpret. Furthermore, comparing proportions of RCI and CSC in each group indicated that group three produced better reliable and clinically

significant results, except for acceptance of pain where group two showed more clinically significant improvement (see Appendix C).

Table 21 *Pre-post effect sizes for the three respective ACT groups.*

Group	n	Pre-post Effect Size (d)					Total Mean Effect Size
		PHQ-9	GAD-7	BPI-S	BPI-I	CPAQ-R	
Group 1	5	0.85	2.23	0.55	1.26	0.38	0.61
Group 2	3	1.39	0.85	0.73	3.05	6.00	2.40
Group 3	4	6.28	1.66	1.37	2.16	0.85	2.46

How Does the ACT group for Pain Compare to Individual Treatment for Pain?

To compare the RCI and CSC outcomes from the ACT group to individual treatment provided in the service, a sample of 11 complete data sets were selected from a file of available data sheets for the financial year 2017 to 2018³². Data sets were selected where pre-post were data available. This does not allow for some comparisons, such as demographic data, which may have benefitted from using a matched-pair design.

Of the 11 individual data sets, seven were female (64%), four were male (36%), with a mean age of 43 years ($SD = 10.96$). Individual patients were offered 12.82 sessions and attended 11.55 (87%); this compares to the eight sessions offered to patients on the ACT group and 77.21% attendance rate across the groups. It is worth noting that, compared with the annual report for this service, where 87% of patients were reported to have completed treatment, 18% opted out before completing all sessions offered, suggesting that 69% completed treatment from all sessions offered.

Comparison of Pre-treatment Means to Patients Receiving Individual Treatment

Considering how comparable the treatment conditions were, a one-way ANOVA was completed. Results showed no significant difference between treatment conditions on the BPI-S ($p = .77$) and BPI-I ($p = .94$). Data for individual clients used a different measure of distress (CORE-10). Therefore, z-scores were established for each distress measure used across treatment conditions, with a standard set for the means to fall within one standard deviation of the clinical mean to be considered comparable. As seen in Table 22, pre-treatment mean distress scores fall within one standard deviation of the clinical mean for all measures used in the groups and individual treatment; therefore, meeting our criteria to consider them comparable.

³² An annual report for this financial year was available for comparison.

Table 22 Z scores for sample mean compared to clinical mean.

Measure	<i>n</i>	Clinical Norm Mean	Clinical Norm SD	Sample Mean	z score
CORE-10	11	20.2	7.9	23	0.35*
PHQ-9	12	17.1	6.1	18.31	0.2*
GAD-7	12	14.4	4.7	14.75	0.07*

*z score falls within one standard deviation of the clinical normative mean.

Comparison of RCI and CSC Outcomes on the ACT Group to Patients Receiving Individual Treatment

Table 23 reports the RCI and CSC outcomes for the individual clients on their levels of distress (CORE-10), the BPI-S, and the BPI-I.

Table 23 Number of patients in individual therapy reaching RCI and CSC outcome criteria for each measure.

Measure	Recovered	Improved	Unchanged	Deteriorated
CORE-10	6**	2	3	0
BPI-Intensity	3*	1	7	0
BPI-Interference	3*	5	3	0

*used criterion 'a'; **used criterion 'b'

The proportion (%) of RCI and CSC changes in the ACT group compared to individual therapy clients is shown in Table 24. When comparing changes in psychological distress, approximately half of patients demonstrated clinically significant changes across treatment conditions. No patients in either treatment condition deteriorated in their psychological distress. Likewise, when considering levels of pain interference, most patients reached reliable change, with similar proportions remaining unchanged, and no patients deteriorated. Fewer patients reached clinically significant changes on the ACT group. More varied results are observed when comparing changes on levels of pain severity. Although a higher proportion reached reliable change in the ACT group, more patients reached clinically significant changes in individual therapy. Across both groups, at least half of patients' pain severity remained unchanged. In the ACT group one patient (8%) deteriorated in their pain severity compared to none in individual therapy.

Table 24 *Proportion of patient outcomes for individual and group therapy on measures of psychological distress, pain severity and pain interference.*

Measure	Outcome	Individual (%)		Group (%)	
Psychological Distress (CORE-10, PHQ-9, GAD-7)	Recovered	55	CORE-10	42	PHQ-9
				58	GAD-7
	Improved	18	CORE-10	33	PHQ-9
				8	GAD-7
	Unchanged	27	CORE-10	25	PHQ-9
				33	GAD-7
	Deteriorated	0	CORE-10	0	PHQ-9
				0	GAD-7
Pain Severity (BPI-S)	Recovered	27		8	
	Improved	9		33	
	Unchanged	64		50	
	Deteriorated	0		8	
Pain Interference (BPI-I)	Recovered	27		16	
	Improved	45		50	
	Unchanged	27		33	
	Deteriorated	0		0	

Discussion

Overall, the majority of patients completing the ACT group for chronic pain reliably improved in their levels of depression, anxiety, and pain interference, with no patients deteriorating in these areas. Approximately half of patients demonstrated clinically significant changes in their levels of anxiety and depression, which is consistent with findings in a previous evaluation (Sheldon *et al.*, 2015). Furthermore, large effect sizes were demonstrated for depression, anxiety and pain interference, comparing favourably with the moderate effects reported in a recent meta-analysis (Veehof *et al.*, 2016). For pain severity, however, half of patients remained unchanged and one patient deteriorated. This relates to previous findings where large effect sizes were found for pain interference compared to small effect sizes on pain severity (Veehof *et al.*, 2016). However, it is difficult to know what ACT processes contribute to the larger changes in pain interference.

Regarding acceptance of pain, more patients demonstrated no change compared to those that showed reliable or clinically significant improvements. With no fidelity measure

used to assess how consistent this group was with the ACT principles and processes it is difficult to ascertain how much change is because of ACT per se. Furthermore, this raises the question about how much of the large improvements on pain interference were mediated by acceptance of pain.

Considering the patients that attended for follow-up, 71% demonstrated clinically significant changes in their acceptance of pain. On further exploration, the four patients reaching clinically significant changes at pre-post, maintained this at follow up, with one additional patient improving over the time between pre and review sessions. Whilst this supports the maintenance of improvements in acceptance over time, these findings do not account for the patients who did not attend the review and may inflate the findings. This may affect the reliability of these results and should be interpreted with caution.

When comparing the patients receiving the ACT group to those in individual therapy, the outcomes appear comparable across measures of psychological distress, pain severity, and pain interference. Whilst small differences were observed between treatment conditions on levels of pain interference, more noticeable differences emerged when comparing levels of pain severity. In the ACT group, 8% reached clinically significant change on pain severity compared to 27% in individual therapy. Furthermore, one patient demonstrated deterioration on pain severity following the ACT group, compared to none in individual therapy.

Whilst a detailed analysis of economic and cost effectiveness has not been a focus of this evaluation, it is worth considering the outcomes of these different treatment modalities and the respective cost for service planning. Patients across both group and individual treatment conditions appeared characteristically similar regarding demographics, level of distress, pain severity, and pain interference, and demonstrated comparable outcomes. However, patients receiving individual therapy were offered approximately a third more sessions compared to the ACT group. This is likely to have cost implications for the service and, therefore, would warrant further investigation.

Critique

Whilst methods used in this evaluation allow for transparent and standardised analyses of individual-level data, they are not without limitations. Although patients who completed pre-post data for the ACT group did not significantly differ in their level of distress or demographics compared to those who did not complete the group, explanations for the missing data or why people dropped out of the group are not included. Furthermore, this evaluation is lacking information regarding the proportion of people who attend the information group but do not go on to pursue psychological intervention. This is likely to impact the reliability of the results and how typical the patients attending psychological treatment are of the general population experiencing chronic pain. Future evaluations should consider why people dropped out of therapy, and if this differs between treatment modalities.

Although between group comparisons were similar in their effect sizes on measure of anxiety, pain severity and pain interference, differences were observed on measures of depression and acceptance of pain. From reviewing the proportion of reliable and clinically significant changes between each ACT group, the third group appeared to produce better results, except for acceptance of pain where group two showed more clinically significant improvement. Whilst we cannot account for changes in individual patient circumstances, without the use of a fidelity measure or being able to say how similarly the groups were delivered, we are unable to conclude what may account for these differences between groups and changes over time.

Conclusions and Recommendations

Evaluating the effectiveness of a new and previously unevaluated ACT group for chronic pain has demonstrated similar outcomes to those receiving individual therapy and are favourably comparable to the existing evidence base. However, the results also indicate a few shortcomings in the current evaluation and ways in which the service can improve future evaluations to increase effectiveness and patient care. These include:

- Considering the reasons for patients withdrawing from the ACT group may provide services with opportunities to address such reasons to improve patient outcomes and minimise patient drop-out.
- Comparison of the cost and economic effectiveness of the ACT group compared to individual group. Secondary data, such as employment status, were not included in this evaluation but may yield further interesting comparisons when considering the economic and societal impact of chronic pain.
- It would be helpful to explore client satisfaction of the ACT group for pain and if this is comparable to those receiving individual therapy.
- The use of an ACT fidelity measure, such as the Acceptance and Commitment Therapy Fidelity Measure (ACT-FM; O'Neill *et al.*, 2019), would be helpful for investigating adherence to the model, training staff and ensuring treatment quality in future evaluations. Structured around the Act Tri-flex model, the ACT-FM would be applicable to the current service.

Conflicts of Interest

There are no conflicts of interest.

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