Online Therapy: Client and Counsellor Experiences

by

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Abstract

Online therapies have begun to gain recognition as therapy that is conducted via the internet, using text or audio/visual tools to connect the client and therapist (Hanley, 2012; Murphy & Mitchell, 1998). Unfortunately, research has not kept up with the rate of uptake in online therapy services. The present study investigated the experiences of therapists and clients who had engaged in online therapy during the past 12 months. Two studies were conducted, using narrative and thematic analysis to extrapolate the main themes across participants' narratives. The first involved six female clients and focused on the ways in which individuals construct their online therapy experience. Themes emerging from Study 1 include: accessibility, convenience, affordability, time to think, reflect and respond, autonomy and control, and the qualities of the counsellors. Study two examined the ways in which four online therapists storied their experiences of engaging in online therapy. Themes from Study 2 that described practitioners' online therapy experiences included: convenience, therapeutic alliance, online counselling skills, assessing client suitability, reaching diverse clients, assessing client satisfaction, legal and ethical concerns: client identity, privacy and confidentiality, and, personal and professional goals. Findings also suggested that the different mediums of communication (e-mail, instant message, and videoconference) offered unique benefits and challenges. Recommendations for clinical practice, limitations and future directions are discussed.

Preface

This dissertation is an original intellectual product of the author, Shereen Khan. All procedures

of this research were carried out with adherence to the guidelines and ethical grounds for

research involving human subjects presented by the University of British Columbia Behavioural

Research Ethics Board. The study, Online Therapy: Client and Counsellor Experiences received

ethical approval from the University of British Columbia's Behavioural Research Ethics Board

(certificate number: H12-00766).

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Dedication

I dedicate this work to my husband, Ather. Without you, this project would not have been possible. From the very conception of my idea to pursue a PhD you selflessly provided more support than I could ever have hoped for. Thank you for all the technical support, bringing me chai; more importantly not letting me lose sight and reminding me to breathe.

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Chapter 1: Introduction

It is impossible to ignore the influence of modern technological developments in our society. Specifically, the development of the internet, along with broadband and wireless access to information, has changed how we conduct our daily living. Fertik and Thompson (2010) note, " unlike any other medium that has been before it, it offers powerful, global, instant, interactive communication...everyone can broadcast and everyone can listen." (p.45). The way people interact with this technology has shaped the culture online, "What was once private is now public, what was once local is now global, what was once fleeting is now permanent and what was once trustworthy is now reliable." (p.44).

The internet celebrates its 25th anniversary in 2014 (Web at 25, 2014). During this time, internet usage has become ubiquitous in the lives of North Americans and is also rapidly increasing in the rest of the world (Fox & Rainie, 2014; Rosen, 2012). More specifically, as of June 2012, based on the Internet World Stats ("Internet usage statistic", 2012), there were an estimated 2,405,518,376 internet users in the world, with a penetration rate for North America of 78.6%. In Canada, which has an estimated population of 34 million, there is an approximate 83% penetration rate with 28,469,069 internet users having been reported by the International Telecommunication Union (ITU, 2014). Indeed, according to the January 2014 survey from the Pew Internet and American Life Project, 87% of American adults use the Internet, and 58% of them access the internet through wireless means such as laptops, mobile devices (e.g., smart phones, iPads, iPods), or game consoles. This means that they are connected to the internet all day, every day, where ever they go (Rosen, 2012). Moreover, the number of people who have access and the amount of time they spend online continues to increase (Colbow, 2013; Olusupo, 2013; Rosen, 2012; Whitty & Joinson, 2009). I acknowledge that there are many societies in the

world who do not have access to technology or who choose not to interact digitally. However, there is no question that internet technology and telecommunications will continue to expand and develop radically throughout this century. Technology is not only changing the nature of the problems people experience, but also how they seek information about, and treatment for, their problems (Rosen 2012; Russ; 2012; Wilkinson, Ang, & Goh, 2008; Young, 2005). For example, health information is one of the most important and frequent topics that is researched online (Fox, 2011). Information and Communications Technologies (ICTs) have also transformed how we communicate with each other, providing opportunities for asynchronous (e.g., e-mail, text messaging) and synchronous (e.g., Instant Messaging, Skype, ichat, Face time) virtual communications. As such, it is not surprising that there has been a rapid increase in the number of individuals who seek mental health information and/or online therapy, and that there has also been a concomitant rise in the supply of counsellors and psychotherapists offering online services (Lintvedt, Sørensen, Østvik, Verplanken, & Wang, 2008; Luxton, 2014; Mattison, 2012). It has been asserted that this rapid rise in the availability of online therapy is the result of positive outcomes combined with client demand and acceptance (Bozkurt; 2013; Evans 2014; Lintvedt, et al., 2008; Schoech & Finn, 2008).

Historically, counselling has involved face-to-face interactions between a client and therapist through which a unique and close relationship develops. The resulting intimacy is often credited with the client's personal change and progress (Bedi, Cook, & Domene, 2012; Hovarth & Bedi, 2002; Murphy & Dillon, 2003). Indeed, numerous studies have shown that a trusting, caring, respectful, and goal-oriented relationship between the client and the counsellor is the most influential component of successful therapy (e.g., Duncan & Miller, 2000; Hovarth & Bedi, 2002; Slone et al., 1975; Summers & Barber, 2003). The quality of this counselling relationship,

often referred to as the "therapeutic alliance", is viewed as the single most significant predictor of successful therapy (Bedi, Cook, & Domene, 2012; Hackney & Cormier, 2009; Hanley, 2009; Hovarth & Bedi, 2002; Ribiero, 2009), accounting for between 22% (Knaevelsrud & Maercker, 2007) and 30% (Fletcher-Tomenius, 2009) of variance in therapeutic outcomes, regardless of the therapist's theoretical orientation.

During a typical counselling session, the therapist attends to the client's use of verbal (e.g., content, tone of voice, and speed of utterances) and non-verbal behaviours (e.g., gestures, posture, and movement) to continually observe, process, and monitor the client's behaviours and feelings (Egan, 2002; Nelson-Jones, 2009). The subtleties of this practice have been identified by many practitioners as the essence of the counselling process (Trepal, Haberstroh, Duffey, & Evans, 2007). It has even been argued that, without them, the therapeutic process is rendered incomplete or must be redefined (Tyler & Guth, 2004; Shaw & Shaw, 2006). Whereas online therapy uses the power of the internet as a medium through which to facilitate communication between a client and a therapist using a variety of communications media (videoconferencing, audioconferencing, e-mail, chat and text messaging), some or all verbal and non-verbal cues may be missed using this process. Thus, it is not surprising that it has faced resistance from traditional psychotherapeutic practitioners who remain cautious (Callahan & Inckle, 2012; Evans, 2014; Glasheen & Campbell, 2009; Finn & Sumi, 2008; Mallen, Day, & Green, 2003; Mattison, 2012). Potential privacy and confidentiality concerns that emerge in an online environment are another source of resistance (Bozkurt, 2013; Colbow, 2013; Houghton & Joinson, 2010; Luxton; 2014; Shaw & Shaw, 2006; Rummell & Joyce, 2011).

However, as technology permeates our lives, so too do the means and desire for providing and receiving mental health services online. Online therapies have begun to gain

recognition as a new form of therapy that is offered via the internet using text or audio/visual tools to connect the client and therapist at a distance (Barak, Klein, & Proudfoot, 2009; Colbow; 2013; Evans 2014; DeLucia, Harold, & Tang, 2013; Grohol, 1997; Hanley & Anthony, 2006; Murphy & Mitchell, 1998; Rochlen, Zack, & Speyer, 2004). Not long ago, the telephone was a newly-considered innovative therapeutic communication technology that allowed for the development of crisis call centres. Likewise, in recent years the internet has also provided new opportunities for people in distress to reach out for help (Greidanus & Everall, 2010; Hadjistavropoulos & Pugh, 2012; Mattison, 2012).

Online therapy is burgeoning and can no longer be considered experimental (Mattison, 2013). Studies have begun to demonstrate the effectiveness of various types of online therapies (Andersson & Cuijpers, 2009; Cowpartwait & Clarke, 2013; Guanipa, Nolte & Lizarraga, 2002; Hilty et al., 2013; Mallen & Vogel, 2005; McFadden & Jencius, 2000; Shernoff, 2000; Stefan & David, 2013; Vernmark et al., 2010). These studies provide optimistic findings regarding the internet's potential as a means for providing effective psychotherapy. However, Chester and Glass (2006) noted that small sample sizes and the rapid progression of technology may limit the generalizability of study results to the growing population of online clients and counsellors. Essentially, research has not kept up with the rate of development in online therapy services (Barak, Klein, & Proudfoot, 2009; DeLucia, et al., 2013; Hanley, 2009; Grover et al., 2002; Nobis, et al., 2013, Rojubally et al., 2013). In particular, there is a scarcity of qualitative research to illuminate the nuances of online therapy and how the client/counsellor relationship unfolds in this space (Hanley, 2012; Lillevoll et al., 2013; Dunn, 2012). Working online challenges counsellors to adapt their communication techniques in order to maintain an effective alliance

while engaging with clients via text or audio/visual modes of communication. The current study aims to qualitatively explore the online therapy experiences of both the clients and counsellors.

Background and Rationale

As the internet becomes a preferred mode for communication, therapists need to be prepared and to develop skill in providing therapy to clients who feel most comfortable receiving services online (Colbow; 2013; Long, 2007; Mattison, 2012). Although studies have begun to examine the impact of interfacing online technologies for psychotherapy, research remains sorely under developed, particularly with respect to theory development, techniques, efficacy, as well as ethical, legal, and cross-cultural issues. The therapeutic relationship has been studied extensively in traditional face-to-face counselling settings (Asay & Lambert, 2000; Bedi, Cook, & Domene, 2012; Hovarth & Bedi, 2002; Lambert & Barley, 2002; Ribiero, 2009). As noted, it has been identified in these settings as one of the most important factors for successful therapy (Bordin, 1994; Horvath & Symonds, 1991; Kazdin, Holland, Crowley, & Breton, 1997; Lambert, 1986). Similarly, some studies have established that an equally strong therapeutic alliance can be developed in online therapy (Hanley, 2009; Reynolds, Stiles, Bailer, & Hughes, 2013; Preschl, Maercker, & Wager, 2011; Sucala et al., 2012).

However, few qualitative studies have unpacked the experience of the therapeutic relationship in online therapy. For instance, Beattie, Shaw, Kaur, and Kesseler (2009), examined the effectiveness of CBT provided by synchronous chat with a therapist using repeat semi-structured interviews to measure symptoms of depression and found that the online medium enables greater self-disclosure and openness for some clients, while for others the online relationship is experienced as cold, distant and superficial. Further, Lillevol et al. (2013) explored clients' experience of taking part in a clinical trial using ICBT with MoodGym (self-

help program) and brief clinical consultations with a therapist. They found clients valued active engagement, content knowledge provided through the structured treatment program (ICBT) and the guidance and support of a therapist with whom they could share their thoughts and feeling and receive feedback. Also, in the UK, Hanley (2012) conducted a mixed method study with youth using the online youth service Kooth.com. He specifically examined the therapeutic relationship and found that the client-counsellor match determined positively influenced the therapeutic alliance. Further, 76% of the 46 young service users reported the quality of alliance to be medium or high in quality (Hanley, 2009). Lewis, Coursol and Wahl (2003) conducted a case study analysis of videoconferencing experience between two graduate students who participated as counsellor and confederate client. And Dunn (2012) explored the client-counsellor online therapy experiences in text-only therapy. Both studies identified several themes including convenience, time for reflection, increased sense of control and client empowerment. Nevertheless, we know little about the process and development of this relationship in both text and video contexts. As such, the current work, which uses a qualitative multiple case narrative study approach to examine the experiences of both counsellor and clients is significant, timely, and necessary.

This work expands understanding of online therapy by examining both the experiences of the client (Study 1) and the therapist (Study 2) with respect to the phenomenon of online counselling. The majority of the literature — what little that exists — has examined this from the therapist's perspective (DuBois, 2004; Allahan & Inckle, 2012; Leibert, Archer, Munson & York, 2006; Hanley, 2008; Sucala et al., 2012; Trepal, 2007). Client ratings of therapeutic alliance have largely been quantitative (Preschel et al., 2011; Reynolds et al., 2013) and mixed methods (Hanley, 2012). Clients' story and experiences of online therapy is currently sparse

from the literature, which is an omission this work will help rectify. A second goal of this study

is to provide a richer and deeper understanding of how internet technologies are used and

perceived by therapists and clients. Third, and more generally, we add new knowledge to this

under-researched area that will benefit mental health professionals, social scientists, health care

providers, policymakers, and counsellor educators by helping them better understand the nuances

of online therapy.

Definition of terminology.

Three key concepts that are referred to throughout this work are *counselling*,

psychotherapy, *online therapy*, and the *therapeutic alliance*. The definitions of each of these

concepts, as they are used in the current work, are provided, as well as terms that may be used

interchangeably for each construct.

Counselling and psychotherapy. The term *counselling* and *psychotherapy* are used

differently in different contexts and in different countries. In Canada, where the practice of

counselling and psychotherapy is only beginning to be regulated, it is perhaps best to use the

definition proposed by the Canadian Counselling and Psychotherapy Association (CCPA), the

only national association for counsellors and psychotherapists in the country:

> Counselling is a relational process based upon the ethical use of specific professional
>
> competencies to facilitate human change. Counselling addresses wellness, relationships,
>
> personal growth, career development, mental health, and psychological illness or distress.
>
> The counselling process is characterized by the application of recognized cognitive,
>
> affective, expressive, somatic, spiritual, developmental, behavioural, learning, and
>
> systemic principles. (Who are Counsellors, para.8)

CCPA further asserts that:

> It is not possible to make a generally accepted distinction between counselling and
> psychotherapy. There are well founded traditions which use the terms interchangeably
> and others which distinguish between them. If there are differences, then they relate more
> to the individual psychotherapist's or counsellor's training and interests and to the setting
> in which they work, rather than to any intrinsic difference in the two activities. (Who are
> Counsellors, para.2)

Taken together, these definitions suggest that the explicit nature of the relationship, which is respectful, accepting, and offered within certain ethical parameters, has proven over time to be at the centre of counselling and psychotherapy. This definition transcends the paradigmatic conceptualisations of such work and reveals that, within the Canadian context, the terms 'counselling,' therapy,' and 'psychotherapy' overlap substantially. Consequently, they have been used interchangeably in the present study. We must also clarify that, within this study, counselling/psychotherapy is defined as a professional activity conducted by practitioners who have received substantial post-graduate training in a relevant discipline such as social work, marriage and family therapy, school counselling, clinical or counselling psychology. Work conducted by lay counsellors is outside of the scope of this research.

Online therapy.

Online therapy (also known as internet counselling, cybercounselling, and web therapy) involves asynchronous and synchronous distance interaction between counsellors and clients by using email, chat, and videoconferencing features of the internet to communicate. (NBCC, 2005, p.4).

For the purpose of this research, we have operationally defined *online therapy* as interactions between one client and one therapist; group-based interventions, couples therapy,

and work between a client and a computerised programme (web-based interventions) are excluded. Where other modes of communication are used, this is explicitly highlighted for the reader. Other terms such as *e-therapy*, *cybercounselling*, *telemental health* and *online counselling* are used as equivalent terms to online therapy in this study.

Therapeutic alliance. The term *therapeutic alliance* is commonly used within the counselling and psychotherapy research literature (Bedi, Cook, & Domene, 2012; Bordin, 1994; Hanley, 2009; Horvath & Symonds, 1991; Lambert, 1986; Wolfe & Goldfried, 1988). This term historically also had multiple definitions within the literature. Although the concept is discussed in considerably greater depth within the Literature Review Chapter, it is useful to provide a brief definition at this stage. Horvath and Bedi (2002) refer to therapeutic alliance as the quality and strength of the collaborative relationship between client and therapist. Thus, for the purpose of this work, it can be viewed as the collaborative nature of the relationship between the counsellor and client, which is both potentially curative and facilitative, regardless of the counsellor's theoretical orientation. Other terms have been used to reflect similar concepts, such as *working alliance*, *counselling alliance,* and *therapeutic relationship*; however, for the sake of consistency we will only employ the terms *therapeutic alliance* (TA) and *alliance*.

Significance of the Study

This study contributes to knowledge about the experiences of both counsellors and clients in using online therapy using a comprehensive qualitative research strategy that employed narrative analysis. Although the research in online therapy is sparse, some of the research has highlighted the client experiences (Dunn, 2012; Ellis et al., 2013; Hanley, 2012; Lillevol et al., 2013; Trepal, Haberstroh, Deffy & Evans, 2007) and others on counsellor experiences (Callahan & Inckle, 2012; Finn & Barak, 2010; Fletcher-Tomenius & Vossler, 2009; Mishna et al., 2013;

Sekerler, 2008; Sucala et al., 2013). This study addresses the need to understand the unique

relationship that develops online with respect to both the clients' (Study 1) and counsellors'

(Study 2) perspectives. Two studies have previously examined the experiences of client and

counsellor experiences in a counselling relationship; Lewis et al., (2003) explored the

videoconferencing medium using a single case study to extrapolate the experience of the client-

counsellor dyad using graduate students participants. Whereas, Dunn (2012) examined e-mail

based therapy by including a young college population and university counsellor participants,

who may have been more suited to the online approaches and familiar with providing textual

information. The present study expands on the experiences and gives voice through individual

narratives of experienced clients and clinicians who are actively engaged in the process of online

therapy using both text-only and/or videoconferencing modalities. Not only is this information

valuable for online therapy practice, program development, and counsellor training, but also for

the development of online counselling ethics, policy, and legislation.

Rationale for Qualitative Methodology

There exists a substantial body of evidence supporting an empirical base for online

therapy. Research into online therapy has employed a variety of methodologies. Quantitative

research has been conducted to determine the effectiveness and outcomes of online therapy

(please refer to Aardoom, Dingemans, Spinhoven, & Van Furth, 2013; Bickel, et. al, 2008;

Cohen & Kerr, 1998; Day & Schneider, 2002; Glueckauf et al., 2002; Hilty et al., 2013; Hopps et

al.,2003; Kiropolous et al., 2008; Lange et al., 2001, Murphy et al, 2009). Numerous reviews

have examined the effectiveness of computerized CBT packages and self-help programs online

(Johansson, Frederick, Andersson, 2013: Kaltenthaler, Parry, & Beverly, 2004; Kaltenthaler et

al., 2006; Nobis et al., 2013; Shrier, Rhoads, Fredette, & Burke, 2014; Ybarra & Eaton, 2009).

Much of the work examining therapeutic alliance is also quantitative (Hanley & Reynolds, 2009; Leibert et al., 2006; Rochlen et al., 2013). In contrast, there has been little work examing online therapy from qualitative perspectives; limited to, a study that analyzed outcomes with volunteer client participants (Jedlicka & Jennings, 2011); a single-case study (Lewis, et al., 2003; Pugh et al., 2013); inquiry related to client attitudes (Casey & Joy, 2013; Rochlen, Land, & Wong, 2004; Hanley, 2012), inquiry related to counsellor's attitudes (Haberstoh et al., 2008; Wells, Mitchell, Finkelhor, & Becker-Blease, 2006), client and counsellor experiences of e-mail based therapy (Dunn, 2012) and client experiences of ICBT clinical trial (Lillevol et al., 2013). The current work will expand upon this body of research. Based on the nature of the research problem, which is concerned with the experiences of both client and counsellor, will utilize a narrative inquiry approach to explore online counsellors' and clients' experiences in-depth. The story of the lived experience, the meaning of which unravels in counselling, is the very hallmark of the endeavour. Within the qualitative research paradigm, narrative inquiry is situated under a social constructionist epistemology. Thus, narrative inquiry falls under an interpretive and relativist framework.

The purpose of qualitative inquiry is to understand and explain the meanings, understandings, and perspectives of the participant engaging with a phenomenon (Morrow & Smith, 2000). Hancock (2002) describes qualitative research as being concerned with the discovery of answers to questions that begin with: what? how? and in what way? Social phenomena are described as they occur naturally, and understanding of a situation is gained through a holistic perspective (Stainback & Stainback, 1988). The data generated within this study are narratives that consist of opinions, attitudes, experiences, and feelings that are unique and central to human understanding. Additionally, using a qualitative methodology permits the

inclusion of context as an essential component, further addresses the researcher's reflexivity and self-awareness, and uniquely constructs the meaning of the experience directly from clients and counsellors who engage in online therapy.

Moreover, narrative methods, which are recognized for gaining an in-depth understanding of people's lives, are particularly important for understanding the human experience within the field of social sciences (Josselson, 1995; Josselson & Lieblich, 1999; Larsson & Sjöblom, 2009; Lieblich, Tuval-Mashiach & Zilber, 1998; Riessman & Quinney, 2005). Patsiopoulos and Buchanan (2011) describe narrative inquiry as a lens into how humans understand their lives within the context of their culture and time. "Humans are storytelling organisms who, individually and socially, lead storied lives" (Connelly & Clandinin, 1990, p.2). Culture produces the conventions for living and engaging with the world around us (Berg, 1998; Berger, 1997; Fraser, 2004), and narratives help people organize their experiences into meaningful episodes that call upon these cultural modes of reasoning and representation (Berger, 1997). Therefore, studying the way that humans experience the world via the construction and reconstruction of personal stories is relevant to the study of the experiences of client and counsellor in online therapy. By engaging the participants in a meaning-making dialogue, this study aims to explore the online therapy phenomenon through the collaborative work of the client, therapist and researcher.

Thesis Organization

The research project that is discussed in the chapters that follow aims to respond to the changing nature of counselling service provision. I intend to qualitatively examine the practice of engaging in online therapy, thereby providing a significant contribution to the literature in this area. The proposed research involves two separate studies. Study 1 explores the clients' online

experience and how it contributes to our understanding of the online therapeutic relationship. Study 2 focuses on the counsellors' perspective of online therapy and how the therapeutic relationship unfolds from this perspective.

There are five chapters to this work ('Introduction', 'Literature Review', 'Study 1,' 'Study 2,' and 'Conclusion'). This section (Chapter 1, the 'Introduction') reveals the context within which the study is conducted. A definition of terms and the presentation of the thesis are intended to contextualise the study and support the reader in working through this thesis. Chapter 2 includes an extensive literature review that provides the readers with background and history on the evolution of online therapy. Chapter 3, 'Study 1: the clients' experience of online therapy,' summarizes previous research addressing client perspective of online therapy, discusses the research question, explains the proposed methodology for answering the research question, describes in detail the theoretical underpinnings behind the selected methodology, outlines the data collection and analysis for the study, and presents the findings. Within this section, I provide context regarding the specifics of the naturalistic setting in which the study has taken place and outline my own motivations for undertaking this work. Chapter 4, 'Study 2: the counsellors' experience of online therapy' presents an overview of the existing research in this area and follows a similar sequence adopted in Study 1, except that it focuses on the counsellors' experiences of online therapy. It is important to highlight that the clients and counsellors are independent and there is no attempt to link the data in the two studies beyond thematic considerations. Finally, Chapter 5 encompasses the combined discussion, implication, recommendation and conclusion of the two studies.

Chapter 2: Literature Review

As technology has developed and gained a greater reach in society, and as we have

expanded our skill at using that technology, our reliance on computers and other digital mobile

devices for communication has increased tremendously. Indeed, the internet has been described

as ". . .the most participatory form of mass speech yet developed" (Koomen, 1997, p. 272). The

most profound of the impacts have, perhaps, been on accessibility of information and

communication. The internet has closed the gap of distance and time by allowing families who

are separated by miles to communicate with each other instantaneously making postal mail and

long-distance telephone carriers obsolete. Further, the internet influences the consumer choices

we make, how we shop, how we study, how we network, look for jobs or relationships and also

how we access health care services. Kraut and colleagues (2002) found that individuals with

internet connections in their homes used the technology predominantly for interpersonal

communication. When individuals do use the technology for information-seeking behaviors,

internet search engines are typically the first stop. When we wish to find something out, we just

"Google it" – using the search engine Google to look up our query (Google, n.d.).

Fox (2011) reported that health information is one of the most frequent and influential

topics searched by internet users. Indeed, this trend was noted by Murray (2003) a decade earlier

in a cross-sectional, nationally (U.S.) representative survey of doctors where it was found that

85% of physicians have consulted with patients who brought in information they had found on

the internet (Murray, 2003). Many options are available to consumers of health information,

including knowledge-based self-help prevention programs (e.g. Beating the Blues; Proudfoot et

al., 2004; MoodGYM; O'Kearney, Kang, Christensen, & Griffiths, 2009), evidence-based

interactive Cognitive Behavioural Therapy (CBT) programs (e.g Panic Online; Kiropoulous et al., 2008; Musiat et al., 2014; Pugh, Hadjistavropoulos, Klein, & Austin, 2013; Ruwaard et al., 2009), interactive therapy-based games (e.g. SPARX; Merry et al., 2012; Treasure Hunt; Brezinka, 2008; see also Freddolino & Blaschke, 2008 and Kharif, 2004), avatar therapy (e.g. Virtual Iraq; Halpern, 2008; also see Langlois, 2012; Nagel & Anthony, 2011; Russ, 2013), and mobile health apps (Proudfoot, 2013; Harrison et al., 2011). The internet has also proven to be a viable source of information about many behavioural health interventions including those related to dietary change (Winett et al., 1997), exercise (Prochaska, DiClemente, Velicer, & Rossi, 1993), anger management (Morland et al., 2010), and smoking cessation (Buller et al., 2006; Marcus, et al., 1998; Prochaska & Norcross, 2003). Further, online therapies have already begun to be used for many concerns such as eating-disorders treatment (Shingleton, Richards, Thompson-Brennes, 2013; Zabinski et al., 2001), long-distance couple's therapy (McCoy, 2013), parenting (Strongest Families Program, McGarth et al., 2013). treatment for tinnitus (Hesser, 2012), alcohol abuse (Riper et al.,, 2011), marijuana use (Schuab et al., 2013; Shrier et al., 2013), erectile dysfunction (McCabe, Price, Piterman, & Lording, 2008) and sex offender treatment (Kernsmith & Kernsmith, 2008).

As noted earlier, the effectiveness of online therapy is not as well established as the effectiveness of face-to-face counselling. A recent meta-analysis of 92 studies (involving a total of 9,764 clients who represented the full gamut of client groups in terms of age, gender, race, and language) examined the effectiveness of internet-based psychotherapeutic interventions and found effect sizes comparable to those that have been found for face-to-face interventions (Barak, Hen, Boniel-Nissim, & Shapira, 2008). The authors concluded that "internet-based therapy, on the average, is as effective or nearly as effective as face-to-face therapy" (p. 147).

The authors further suggest that these findings provide evidence that online counselling should be accepted as a legitimate therapeutic modality, but cautiously call for more extensive research in this area (Barak et al., 2008). Furthermore, there is emerging evidence suggesting that meaningful therapeutic alliances can be established online (Cook & Doyle, 2002; Hanley, 2009, 2012; Leibert, Archer, Munson, & York, 2006, Reynolds et al., 2013; Preschl et al., 2011; Whitty & Joinson, 2009). This is important, given that decades of research has shown that the therapeutic alliance is associated with treatment success (Ribeiro, 2009), with the vast majority of studies indicating it is a consistent predictor of therapy outcomes (Horvath & Bedi, 2002; Martin, Grasker, & Davis, 2000; Horvath & Symonds, 1991).

Other findings indicate that online counselling can be effective in reducing presenting problems such as depression (Pugh et al., 2013; Ruwaard et al., 2009; Vernmark et al., 2010), anxiety (Day & Schneider, 2002; Spence et al., 2005; O'Kearney, Kang, Christensen, & Griffiths, 2009), post-traumatic stress disorder (Bush et al., 2014; Litz, Engel, Bryant and Papa, 2007), panic disorder (Kiropolous et al., 2008), substance abuse (King et al., 2009), erectile dysfunction (McCabe, Price, Piterman & Lording, 2008), body image disorders (Paxton et al., 2007) eating disorders (Shingleton et al., 2013; Serfaty &Robinson, 2008), and obesity (Tate, Wing, & Winett, 2001).

Although it is not possible to accurately track the growth of credentialed and non-credentialed online therapy services being offered, research suggests that there is an increase in public demand for online access to counsellors (Barak, Klein, & Proudfoot, 2009; Hanley, 2009; Grover, Blanford, Holcomb, et al, 2000; Luxton, 2014; Richardson, 2009; Rojubally et al., 2013). Statistics from over a decade ago indicate that the percentage of psychologists registered with the American Psychological Association who integrated technology in their counselling

ranged from 2% for online therapy to about 15% for email and faxes (VandenBos & Williams, 2000). A simple Google search conducted on March 30, 2014 using the term 'Online Counselling' retrieves over 79,900,000 hits, a significant increase from the results of my initial search on April 15, 2011, which resulted in 4,260,000 hits, suggesting that the numbers have increased dramatically. Similarly, given the number of books written solely for counselling practitioners to help them provide services over the internet, it would appear that a growing sector of counsellors are incorporating ICTs into their practices (Bloom & Walz, 2004; Colbow, 2013; Derrig-Palumbo & Zeine, 2005; Evans, 2013; Jones & Stokes, 2008; Hsiung, 2002; Mattison, 2012; Russ; 2012; Stricker, & Speyer, 2010; Kraus, Zack & Stricker, 2004).

The growth of online mental health services has not been without controversy. Rochlen, Zack, and Speyer (2004), have noted that "the integration of technology with the practise of psychotherapy has been, arguably, one of the most vigorously debated topics among mental health professionals within the last 15 years." (p.269). Although the parameters of online therapy are not yet defined, it is already present and will most likely continue to grow in dynamic and innovative ways (Anthony, 2003; Luxton, 2014; Russ, 2013). The discussion about the use of technology in counselling, specifically online therapy raises many questions. Unlike traditional therapy, which generally takes place between one or more clients and a clinician in a shared physical space (usually the counsellor's office), the large majority of internet therapy is conducted asynchronously, via text-based email, although synchronous text-based chat services and video chat options are growing in popularity; (Chester & Glass, 2006; Stefan & David, 2013; Hilty et al., 2013). According to Fenichel et al. (2010), this calls into question three of the basic tenets of the therapeutic interaction, namely, that it must include: (1) observable contact (e.g., face-to-face); (2) conversation; and (3) synchronous (real-time) interaction. However, Fenichel et

al. acknowledges that regardless of how we define the therapy processes and outcomes, the documented successes of online therapy are undeniable. Moreover, according to Grohol (2001), communication needs to occur within a therapeutic relationship for psychotherapy to be effective. He states that "…nothing about online therapy makes these two components any more difficult to achieve. Nor does their achievement come at a cost in terms of quality of understanding." (Best Practices in eTherapy, para. 2).

Unique Features of Online Therapy

Researchers tend to think that online therapy is a distinct form of psychotherapy, and not merely traditional therapy in an online format (e.g., Gore, Leuwerke, & Krumboltz, 2002; Suler, 2004). Moreover, online therapy has a number of advantages over face-to-face counselling for both clients and counsellors, and these advantages may have contributed to its growth (Barak &Bloch 2006; Efstathiou & Kalantzi-Azizi, 2005; Olusupo, 2013; Richardson, 2009; Richardson & Tangney, 2008)

Anonymity. It has been hypothesized that the anonymity afforded in the online environment may facilitate self-disclosure and truthfulness in clients' accounts (Dunn, 2012; Joinson, 1998; Lewis et al., 2003; Migone, 2013; Suler, 2004). According to Holland (1996), communicating on the internet can be likened to traditional contexts in which the listening party is present but invisible, such as in confessionals, where the priest sits behind a screen, as well as the psychoanalytic couch, where the analyst is seated behind the client. These modes encourage the confessor to reveal things that they might not speak so easily about face-to-face. Thus, the anonymity and physical invisibility afforded on the internet may allow clients to let go of inhibitions and reveal more to their therapists. Suler (2004) refers to this as the disinhibition effect. Reynolds et al., (2013), refer to the online calming hypothesis that proposes both clients

and therapists find online environment more comfortable and less threatening than face-to-face interaction.

The online text communication found in email, chat, and blog formats may allow people to 'know' a great deal about the writer without the writer making his or her identity visible. Physical invisibility may amplify the disinhibition effect when communicating with therapists because clients do not have to worry about how they look or sound when they reveal something, nor do they have to see the frown or smile or hear the sigh or any other subtle expressions of disappointment or disapproval. Text-based communication, in particular, allows for both the client and therapist to 'keep their eyes averted.' The impact of visual anonymity and asynchronous interaction afforded through text-based communication changes psychological states during online communication by offering people an opportunity to both engage in more careful self-presentation and have a sense of increased control over the interaction (Hanley, 2012; Joinson, 2003, Whitty & Joinson, 2008). In this way, it is possible that an online environment affords greater opportunity for revealing and discussing deep personal and emotional issues. Indeed, Lombard and Ditton (1997) describe 'telepresence' as the phenomenon where individuals report that they feel closer to others they meet online. The phenomenon has also been described as ''swift trust'' that is developed in online relationships (MacFadden, 2005).The internet and email in particular, allows the client to achieve an ideal distance from the therapist and bring the therapist into their world, collapsing distance, all at the same time (Malater, 2007).

Text-based language. Online therapy also differs from face-to-face counselling because it provides the option of engaging almost exclusively in text-based language (e-mail or instant messaging) as the means of communication with a clinician (Murphy & Mitchell, 2008). When

clients type a message, it is hypothesized that they must take the time to reflect and organize

their thoughts, which may serve to alleviate awkward on-the-spot thinking. In other words,

typing the message affords both the client and the counsellor the time to reflect on the session

and to respond rather than to simply react. This is compatible with evidence that has shown that,

although synchronous communications may produce more immediate, direct responses,

asynchronous communications allow for greater reflection and more purposeful responses

(Davidson-Shivers, Tanner, & Muilenburg, 2000; Dunn, 2012). However, synchronous

discussions may lend themselves to social interactions, whereas asynchronous discussions may

be more task-oriented (Im & Lee, 2003/2004), suggesting that different forms of communication

may serve different purposes (Trepal et al., 2007).

      Enhanced control and access. Online therapy also offers clients more ownership and

control over the mode, frequency, and termination of their therapy sessions (Beattie et al., 2009;

Hanley, 2012; Mallen, Jenkins, Vogel, & Day, 2010; Maples & Han, 2008). For example,

depending on the nature of their concerns, clients could engage in frequent email or chat sessions

or one-off exchanges (Grohol, 2001). In fact, the convenience and increased access to therapy

has been found to compensate for the lack of physical presence (Hanley, 2008; Maples & Han,

2008; Zack and Speyer, 2004). With the recent development and subsequent widespread

availability of webcams for videoconferencing with ease, the issue of the lack of visual and

verbal cues in online communication has also been reduced. Clients can now potentially choose

an expert (with whom to discuss not-so-easy subjects) from anywhere, regardless of their or their

potential therapist's, geographic location (Gardner, 2008; Luxton, 2014). Regarding termination

of the session, online clients have the option to end the session by logging-off at any given time,

something that is much easier to do than to walking out in the middle of a face-to-face session (Suler, 2004).

For the counsellor, the advantages of online therapy include reaching diverse and underserved populations, having access to complete, automatically generated transcripts of sessions, gaining more flexibility in arranging interactions, having lower overhead costs (e.g., no office rental), and easily standardizing services (Luxton, 2014; King, Bambling, Reid & Thompson, 2006; Mattison, 2012). When online therapy is conducted via chat or email, fully transcribed session records are available, granting both clients and counsellors the ability to review and assess the progression of therapy based on actual conversations (Evans, 2014; Murphy & Mitchell, 1998; Whitty & Joinson, 2009).

Despite these advantages and the increase in demand for online therapy services, the research examining the experience of receiving and providing online therapy is limited. In fact, qualitative research which explores the phenomenon in depth is scarce. McAdams and Wyatt (2010) contend that our technological capabilities far exceed our current understanding of the implications of using this type of counselling modality, ultimately impacting our ability to ensure positive impact on clients and to address ethical and legal considerations.

Potential Concerns

Maples and Han (2008) provide a comprehensive list of concerns that are present in online therapy. First, counselling via text or video does not offer a physical presence that some say is "essential" to counselling (Olusupo, 2013; Wells et al., 2007). Second, the textual nature and lack of non-verbal cues may increase the chances of miscommunication between clients and online clinicians (Haberstroh, 2009; Murphy & Mitchell, 1998). Third, the process of reflecting and writing may preclude the chances of spontaneous responses, which are viewed as significant

in the psychodynamic modality (Migone, 2013). Fourth, as computer literacy is a prerequisite for using online therapy, this may limit access to those who are tech-savvy and comfortable with typing/writing. Fifth, some professionals are concerned that research is lagging behind practice and that as such, online therapy lacks wide recognition and acceptance in the field (Colbow, 2013; Mattison, 2012; Sinclair et al., 2013). Sixth, regulation with respect to who is permitted to practise online counselling is lacking. Rojubally et al., (2013) recently reported that the field of psychology, social work, and counselling have minimal stated policies within their regulatory colleges, and those that do exist are conservative and restrictive towards mental health practice online.

Also, Wells, et al., (2007) found that 80% of practitioners in their study (N = 2098) were concerned with issues of confidentiality of client information as well as their own liability with respect to maintaining client privacy and confidentiality. These questions raise some serious ethical and legal concerns that have been discussed in length in the literature (Childress, 1998; Finn & Barak, 2010; Hilty et al., 2013; Luxton 2014; Mattison, 2012; Shaw & Shaw, 2006). Finally, internet speed, connectivity, and the potential for technology to fail are also real concerns, in that they can result in disruption of sessions at important moments in the therapeutic process.

Theoretical Underpinnings

Online and offline communication have far more similarities than differences (Holmes, 2005; Lewis, et al., 2003). No recognized, distinct therapeutic model or framework exists for online therapy. Peng and Schoeh (2008) reviewed existing theories from the fields of psychotherapy, social work, health promotion, gaming, and innovation dissemination, and outlined the strengths and weaknesses of these approaches as they relate to online interventions.

They found that some online interventions have been developed specifically on existing

theoretical models. For example, both *Beating the Blues* (Proudfoot et al., 2004), a depression

intervention, and *Fear Fighter* (Marks et al., 2003), an anxiety intervention, are based on

cognitive-behavioural therapy. Similarly, *Refuse to Use* and *Alcohol 101* are programs based

respectively on social learning theory and the theory of planned behaviour (Anderson, 2002).

Many online phobia interventions are based on exposure therapy (Klein, 2000; Wald, 2004).

Some researchers have suggested that crisis intervention theory could be an effective framework

through which to examine e-mail interventions (Polauf, 1998). Finally, Laszlo, Esterman, and

Zabko (1999) have proposed narrative therapy (White & Epston, 1990) and solution-focused

approaches (deShazer, 1988) for use in online therapy (Murphy & Mitchell, 1998; Childress,

1999).

However, no specific theory has yet been proposed regarding how the therapeutic

alliance is formed and developed in the context of online therapy. Additional qualitative research

and in-depth analysis is needed to delineate this phenomenon and to develop online therapy as a

clinical practice. The current study contributes to the body of foundational knowledge that will

lead to the development of good theories and practice of online therapy.

Text-based therapy.

Researchers have linked text-based therapy to writing therapy (Collie et al., 2002;

Murphy & Mitchell, 1998; Wright, 2002; Wright & Chung, 2001). Writing therapy is defined as:

"client expressive and reflective writing, whether self-generated or suggested by a

therapist/researcher" (Wright & Chung, 2001, p.285). The power of reflective, focused writing

draws on imagination and creativity, which then enables individuals to become more

knowledgeable about themselves and to increase their sense of agency (Wright, 2002). Other

work has also shown that therapeutic writing is an excellent tool for enhancing client growth and wellbeing (Penn, 2001; Wright, 2002). Writing for the self in journals and diaries has a long literary history and function (Abbs, 1998). 'Journal therapy' has developed into an established form of self-help (Adams, 1990; Progoff, 1975), and is sometimes recommended as homework in face to face therapy (Ryle, 1990). Rogers (1993) espoused writing as a companion to the inner journey. Indeed, the beneficial effects of self-expressive writing have been recorded (Smyth, 1998). Other research has also shown that during times of physical and social distress, writing provides clients with a crucial avenue for emotional healing (Penn, 2001; Soper & Von Bergen, 2001).

Based on the established links between written expression of emotions and increased physical and emotional health (Campbell & Pennebaker, 2003; Penn, 2001; Pennebaker, 1997), it not surprising that initial research has shown that online therapy is effective (Barak et al., 2008; Spek et al., 2006; Watts et al., 2012). Some online clinicians suggest that the computer screen may allow for more honest, uninhibited expressive writing which facilitates self-disclosure, ventilation, and the externalization of problems and conflicts, and that it may also promote self-awareness (Barak, 1999; Dunn, 2012; Fenichel et al., 2002).

Indeed, in light of the fact that online therapy may utilize both written (text) and more recently oral (audio/video chat) language, it is probable that asynchronous email or text-based chat interventions may harness the power of therapeutic writing, while video chats may more closely resemble therapeutic conversations. As Anthony asserts, "The rapport between counsellor and client in cyberspace is developed not by reacting to another person's physical presence and spoken word, but by entering the client's mental constructs via the written word" (2000, p. 626).

Research examining the non-therapeutic use of ICTs echoes the existing findings regarding the positive effects of text-based communication. Walther (1996) examined the effects of relational communication in asynchronous communication versus conferencing. Asynchronous communication was found to promote positive relational effects because it allows users to respond to messages at their own convenience, as opposed to other forms of communication that require users to be co-present. Additionally, Burgoon and Walther (1990) found that the lack of physical cues available when using many ICTs allows the communicator to devote increased cognitive resources to the construction of a message, whereas in face-to-face communication, the communicator must attend to heightened levels of emotional involvement and arousal, sensory and psychic features, increased cognitive stress, and conversational and relational demands.

Videoconferencing.

The widespread use of devices with built in HD cameras and availability of free videoconferencing programs such as Skype has made audio/visual communication a reality for more clients and practitioners. Bell (2012) recounts his first experience as a therapist using Skype to meet a client. For him the picture-in-picture (being able to see himself in a window as well as see his client) was distracting as he tried to maintain eye contact with the client without trying to look directly into the camera. The sessions also featured some minor technical concerns and negotiating the camera position (nuances of Skype). However, Bell reported that this did not hinder the counselling sessions. In the end, Bell and his client reported that sessions over Skype were incredibly helpful. Although, the picture-in-picture feature has been noted as a distraction it also can be facilitative for online therapy. In couples therapy it allows partners to see not only their partner's non-verbal facial expression but also their own (McCoy, Hjelmstad, & Stinson,

2013). The author's noted that the picture-in-picture setup can increase each partner's insight into their own behavior, and allows them to immediately adjust any maladaptive behaviors. This level of self-awareness takes longer in face-to-face therapy.

Videoconferencing has been in use for over a decade in a variety of clinical settings including the treatment of trauma, mood, anxiety, and eating disorders, and has shown therapeutic alliance and clinical outcomes comparable to face-to-face therapy (Backhaus et al., 2012; Day & Schneider, 2002; Nelson, Barnard, & Cain, 2003; Stefan & David, 2013). Further, new technologies such as visual reality, avatar and mobile apps are being used increasingly to aid psychotherapy and are becoming an integral part of mental health treatment (Bray, 2010; Proudfoot, 2013; Russ, 2013). At the present time Skype and other free videoconferencing software do not guard client confidentiality. In fact personal identifiable data is collected; messages, pictures and videos may be stored for up to 90 days. Further, the privacy policies with Skype clearly state that personal information, communications content and/or traffic data may be released to an appropriate judicial, law enforcement or government authority lawfully requesting the information (Skype, 2014). However, to counter the privacy threats clinicians are now able to subscribe and use encrypted videoconferencing software such as securevideo.com and Vsee. This however adds cost to the clinician's online practise set up and may in the end increase the session cost for clients. Also in order to engage in medium to high quality video call increased bandwidth (upload and download speed) is required. Ensuring secure and reliable videoconferencing requires significant bandwidth (Molyneaux et al., 2009). Thus, clients who wish to engage in videoconferencing will likely need high speed internet connection, which may drive the cost up as compared to using IM or e-mail.

Therapeutic Alliance in Online Therapy

Much of the existing therapeutic alliance research is based on face-to-face practice, where counsellors and clients engage in various forms of therapy in real time and in a shared physical space (e.g. Horvath & Bedi, 2002). However, some studies have established that a strong therapeutic alliance between a client and therapist can be developed in online therapy (Cook & Doyle, 2002; Leibert, Archer, Munson & York, 2006, Hanley, 2012; Preschel, et al., 2011; Reynolds, et al., 2013; Stefan & David, 2012; Summers & Barber, 2003). This work has begun to explore the ways in which therapeutic alliance is created, deepened, evaluated, and exhibited when the client and therapist are not co-present.

One of the first studies to examine alliance formation in online therapy was by Cook and Doyle (2002), who conducted a mixed method study of therapeutic alliance with 15 online text-based therapy (i.e., email and chat) clients, and a comparative group of 25 face-to-face clients. The researchers found that the clients reported therapeutic alliance levels, as measured by the Working Alliance Inventory (WAI, 1989), comparable to those of clients who received face-to-face therapy: The total WAI scores and scores for each subscale (i.e., Task, Bond, and Goal) were as strong as for face-to-face therapy. Qualitatively, the clients expressed experiencing a strong alliance with their online therapist and also described the disinhibiting effects associated with the medium, which was perceived to be a unique benefit of receiving services online. Despite the limitation of having used a small, self-selected sample, this study demonstrated the potential for developing therapeutic alliance online.

Furthermore, Leibert et al. (2006) surveyed 81 self-selected participants who had experienced online therapy. They found participants' scores on the Working Alliance Inventory-Short Form (Tracey & Kokotovic, 1989) to be significantly correlated with online therapy

satisfaction. In fact, Leibert and colleagues noted that the effect size in their study ($r = .72$) was almost double what has been reported in meta-analyses regarding therapeutic alliance for face-to-face counselling outcomes ($r = .25$ to $.35$; Horvath, 1994; Horvath & Symonds, 1991). Again, despite several limitations to this study, it can be seen to provide support for the work of Cook and Doyle (2002).

More recently, Hanley (2009) conducted a mixed methods study by means of a self-report quantitative measure using the Therapeutic Alliance Quality Scale (Bickman et al., 2007), and in-depth qualitative interviews with service users of a UK-based youth online counselling service (i.e., Kooth.com). The study found that 76% of the 46 service users reported the quality of alliance to be of medium or high quality. Similar positive findings were reflected in the seven in-depth interviews, specifically identifying convenience, privacy, anonymity, control, and lower power differential to be major advantages of online therapy (Hanley, 2012).

Additionally, Stefan and David (2013) examined the efficacy (i.e., reduction in distress and the level of irrational beliefs) and perceived quality of the working alliance by randomly assigning participants to two experimental groups: face-to-face and online therapy conducted through an advanced video-conference system, specifically the EON Holopodium. Participants consisted of 49 females and 7 males ranging in the ages of 20 and 44. The results revealed no significant differences between the two conditions, suggesting that face-to-face and videoconference are equally effective in reducing distress and irrational beliefs, given that distress and irrational beliefs significantly drop from pre to post intervention. Further, this study also showed that the quality of the working alliance was equally strong in face-to-face and online therapy conducted through videoconferencing.

Finally, Reynolds et al., (2013) compared the therapeutic alliance of online therapy to

previously published results in face-to-face therapy. Participants were 30 therapists and 30 clients engaged in e-mail or text chat online therapy that were recruited from private practitioner sites, e-clinics, online counseling centers, and mental-health-related discussion boards. The therapists were predominantly women (70 percent), Caucasian (90 percent), aged 28–62 years, and licensed in the United States. The 30 clients' ages ranged from 19 to 55 with 83 percent women, 73 percent Caucasian, presenting with depression as a primary concern. For duration of at least six weeks they each visited an online site weekly and completed the Session Evaluation Questionnaire (Stiles, Gordon, & Lani, 2002), the Agnew Relationship Measure (ARM-12) (Agnew-Davies et al., 1998), the Social Support Questionnaire (Sarason, Levine, Basham, & Sarason, 1983), and the Global Assessment Scale (Endicott, Spritzer, Fleiss, & Cohen, 1976). Mixed-effect modeling analytic techniques indicated that the impact of exchanges and therapeutic alliance in text therapy was similar to, but in some respects more positive than, previous evaluations of face-to-face therapy. The significance of participant factors previously found to influence impact and alliance in face-to-face therapy (i.e., client symptom severity, social support, therapist theoretical orientation, and therapist experience) was not replicated, except that therapists with the more symptomatic clients rated their text exchanges as less smooth and comfortable.

In sum, it appears that evidence is beginning to emerge that establishes online therapy to be a viable means of offering therapy in which a strong therapeutic alliance can be developed. The technological advancement experienced within Canadian society and our increasing reliance on the internet for access and delivery of goods and services has necessitated a re-evaluation of how practitioners deliver counselling services. Online therapy is one of many avenues of online help that is currently available. Due to the novelty and unprecedented progress in the

development of this form of therapy, research continues to describe the potential uses of online therapy (Bush et al., 2014; Hsin, 2013; Molyneaux et al., 2009; Russ, 2013; Simms, Gibson, & O'Donnell, 2011; Wells, et al., 2007), and studies are beginning to establish treatment effects (Barak et al., 2008). What has been missing from the existing literature, however, is the client and counsellor's voice which is presented in the two studies to follow. Overall, it is evident that online therapy is here to stay and will continue to be a focus for researchers as they attempt to discern the role of online therapy in the experiences of those seeking help for emotional distress. The next two chapters describe two research studies that providing further evidence of the benefits of online therapy by exploring therapeutic alliance in an online setting, from both the client's and the counsellor's perspectives.

Chapter 3: Study 1 The Clients' Online Therapy Experiences

The purpose of Study 1 is to elicit descriptions of clients' experiences of online therapy, specifically by exploring how six clients construct their realities in the form of narratives. The therapeutic alliance has been credited for positive client change and has been extensively studied in face-to-face counselling settings (Bedi, Cook, & Domene, 2012; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin, Grasker, & Davis, 2000; Ribeiro, 2009). However, less is known about the process and development of this relationship online, and several studies have highlighted the need for research in this area (Cook & Doyle, 2002; Dunn, 2012; Hanley, 2012; Leibert, Archer, Munson, & York, 2006). Despite the identified need for more information, research has not kept up with the development, accessibility, and availability of online therapy services (Anthony, 2003; Delucia et al., 2013; Evans, 2014; Maples & Han, 2008; Rochlen, Zack, & Speyer, 2004; Mattison, 2012). More specifically, there is a paucity of qualitative research revealing the nuances of online therapy and how the therapeutic relationship unfolds in this setting. Rochlen et al. (2004) note that "few research projects have directly tested whether these [online counselling] benefits and challenges are perceived as such by practitioner and end users of online therapy i.e., therapists and clients" (p.279). The current study aims to address this need by exploring and describing the clients' experiences when engaged in online therapy.

In this chapter, I first provide a brief overview of the literature pertaining to online therapy clients; discuss the epistemological rationale for the social constructivist paradigm that I have used, and show how it is grounded in the research questions. This is followed by an overview of the research design and rationale for using narrative analysis. I also provide an outline of the methodological procedures related to the description of the participants, recruitment, procedures for data collection and analysis, ethics, and validity arising from this

study. I then provide details of my research position within this study. Finally, I describe my findings, discussion, conclusion and the research limitations specific to this inquiry.

Online Therapy and the Client

This research field is in its infancy, although there has been an increase in recent research in this area (Barak, Klein, & Proudfoot, 2009; Hanley, 2012; Reynolds et al., 2013; Richardson, 2009). However, very little of it is qualitative, and further, studies that present the client's perceptions and experiences are minimal. Indeed, published research that refers to client characteristics often does so from the therapist/researcher perspective (Chester & Glass, 2006; DuBois, 2004; Leibert, Archer, Munson, & York, 2006; Tsan & Day, 2007). The literature review below focuses on this research, but attempts to draw links and identify gaps, as necessary.

One of the first studies to explore online counselling was by Dubois (2004). For this work, she surveyed 217 clients seeking online therapy from her counselling website in an attempt to understand the demographics of people who sought online counselling. Her results revealed that15% were men and 85% were women. The predominant age group was 21-30 years old (28%), followed by the 41-50 age group (25%) and 31-40 age group (23%). These characteristics were similar to those found by Chester and Glass (2006), who surveyed 67 online therapists and reported that 70% of their clients were female and ranged between 25 and 44 years of age. Finally, Leibert et al. (2006) reported 82.7% of the participants in their study to be females, with a mean age of 29.4. A large majority (82.7%) of the participants were Caucasian. In addition, the authors reported that 76.3% were unmarried, nearly half (48.1%) earned less than $20,000 annually, and 36% had an undergraduate degree or higher.

Regarding why people were seeking online therapy, most of the people in the aforementioned studies presented with relationship problems and mood disorders such as

depression and anxiety (Chester & Glass, 2006; DuBois, 2004; Leibert et al., 2006). Chester and Glass found that most of the clients in their study sought short-term therapy – an average of five sessions, and over half engaged in therapy for less than one month. Finally, Young (2005) found that 85% of the participants had sought online therapy as their first experience of psychotherapy. However, 80% of participants in the study by Leibert et al. (2006) had previously attended face-to-face counselling.

Reviewing qualitative studies, Beattie, Shaw, Kaur, and Kesseler (2009) examined the effectiveness of CBT provided by synchronous chat with a therapist using repeat semi-structured interviews to measure symptoms of depression. They found that for some clients the online medium enables greater self-disclosure and openness, while for others the online relationship is experienced as cold, distant and superficial. They further link this to client expectation. The researchers posit that online therapy may be more attractive to clients who are comfortable with communicating using ICTS, but also to like to reflect on their own experience through writing. Overall, client's expectation of the therapist's ability to understand them and their self-efficacy using the online medium influenced client attitudes for viewing CBT online as a viable treatment for depression.

Also, Lillevol et al. (2013) explored clients' experience of taking part in a clinical trial using ICBT with MoodGym (self-help program) and brief clinical consultations with a therapist. Using a phenomenological-hermeneutical approach the researchers engaged 14 participants in semi-structured interviews. Three major themes were identified (1) clients valued active engagement, that is, action oriented towards solving ones' problems, (2) the knowledge provided through the structured treatment program (iCBT) and (3) the guidance and support of a therapist with whom they could share they thoughts and feeling and received feedback. Overall,

this study revealed the quality of client engagement to be similar to face to face psychotherapy. Regarding attitudes for engaging in online therapy, Tsan and Day (2007) explored clients' attitudes towards online therapy using a series of personality tests, the NEO Personality Inventory (NEO-FFI), and the Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-S) to determine who is more likely to use online services. A total of 30 men and 146 women aged 18 to 63, participated in the study. They found that women generally had a more positive attitude than men toward seeking face-to-face counselling and counselling via e-mail, while no significant difference existed between men and women in their attitudes toward counselling via videoconference or synchronous chat.

Furthermore, Ellis et al. (2013), examined Australian young men's attitude and behavior in relation to mental health and technology using a mixed-methods approach. Participants consisted of 486 males (aged 16 to 24) who completed an online survey and 17 focus groups involving 118 males (aged 16 to 24). Findings suggested that young men are heavy users of technology, particularly involving entertainment and connecting with friends, but they are also going online to find information and support. The qualitative data from the focus group suggested young men have a preference for self-help and action-oriented strategies and would be less likely to seek professional help for themselves. The authors highlighted the need for future work to develop and design action-based user-driven psychological intervention for young men.

Finally, regarding motivations for seeking online therapy, Dunn, (2012), Maples & Han, (2008), Hanley, (2009) and Young (2005), report anonymity, followed by convenience to be the main motivators for clients engaging in online therapy. The availability and visibility of counsellor credentials and information, in terms of specialty or area of practice, were also essential (Young, 2005).

As noted, much of the existing work on online therapy focuses on basic quantifiable information such as demographic factors and preferences, and are also mostly from the counsellor's perspective. The present study moves beyond this and aims to deepen our understanding and conceptualization of the experience of online therapy by incorporating the client's perspectives and by using a qualitative methodology.

Potential Utility for Online Therapy

One of the major advantages of online counselling highlighted in the current literature is the ability to reach geographically and/or financially underserved clients (Duffett-Leger & Lumsden, 2008; Frueh et al., 2000; Greene et al., 2010; Hilty et al., 2013; Layne & Hohenshil, 2005; Leibert et al., 2006; Luxton, 2014; Mallen et al., 2003; Stummer, 2009). Gaining access to mental health professionals has been an ongoing challenge for individuals from remote and rural communities in Canada (Rojubally et al., 2013). As is evident throughout the world, urban areas have more resources for mental health care than rural areas. In the urban-rural divide there exists incongruence between population needs and the expertise and specializations of practitioners. Specifically, rural and northern communities, in particular, suffer from a severe shortage of psychiatric expertise (Parker, Steele, Junek et al., 2003). Furthermore, the literature suggests that rural populations have an equal or greater need for mental health services than do their urban counterparts (CPA, 2011). Some researchers also suggest that rural settings may be more stressful, have more limited resources, and experience higher risks of unemployment, poverty, accidents and natural disasters (Barbopoulous & Clark, 2002). Geographic and professional isolation make rural communities less attractive to mental health professionals, and it is a challenge to recruit and retain specialists, who tend to concentrate in larger urban locales (Boydell, Volpe & Pignatiello, 2010). Fortunately, this is a challenge that may be remediated by

using Information and Communications Technologies (ICTs) (Barbopoulos & Clark, 2003;

Delucia et al., 2013; Simpson, 2009). Indeed, the Canadian Counselling and Psychotherapy

Association (2011) has proposed that ICTs may provide significant benefits in terms of

accessibility to counselling. Clients can access services on their own schedules and avoid cost

and travel time. Further, the mental health commission of Canada (2012) notes that tele-mental

health is increasingly used to provide services in northern and remote areas, and broader internet-

based approaches e.g. online therapy, iCBT, virtual therapy have incredible potential to meet the

needs of the population. For example, in the Spring of 2011, the Thunder Bay Counselling

Centre announced a $98,000 grant to provide eCounselling services to rural and remote areas in

Northwestern Ontario (Murray, 2011).

Similarly, clients from cultures where mental health concerns are stigmatized can also

use online therapy to reach out for help beyond their immediate communities. Currently, due to

this stigmatization, we do not know how many individuals have unmet mental health needs.

There is a growing body of literature in the field of online therapy that suggests that online

therapy has met specific needs for participants who otherwise would never have accessed

therapy (Hilty et al., 2013; Mattison, 2012).

Regarding affordability as a barrier, research on this is, again, limited (Stummer, 2009).

In British Columbia, the Medical Services Plan (MSP) does not cover the cost of counselling

services, though some private extended health insurance plans will pay a portion of the fees.

Some clients are able to access short term counselling services through their employee and

family assistance program (EFAP) as a benefit provided by their employers. The current

recommended rate to see a Registered Clinical Counsellor (RCC) in British Columbia is $110 for

one 50 minute face-to-face session, according to the British Columbia Association for Clinical

Counsellors (BCACC). However, there are no standards for online counselling fees, "Unfortunately we do not have any recommended fees for this type of counselling." (Bisset-Covaneiro, personal communication, January 20, 2014). Further, consultation with the CCPA office manager also concluded they did not have any recommended rates for online therapy (Nicole Maurice, personal communication, January 20, 2014). With some disparity and no standardized fee structures, some counsellors are charging fees similar to face-to-face sessions while others offer online services at a reduced fee. At first glance, online therapy may seem to reproduce the fees that make accessing face-to-face counselling expensive. However, the nature of online counselling is such that clients from around the world can access services with clinicians from around the world. Fee structures that are not standardized allow for more choices as individuals are not limited to one geographical location or price. Essentially, it is a global free market for counselling services online.

Finally, regarding geographical barriers, one of the primary objectives of counselling involves reaching those individuals who are outside the mainstream and in need of support (Luxton, 2014; Mallen et al., 2005; Mattison, 2012). Online therapy provides a means to meet this objective due to the accessibility and perceived privacy offered by this modality. As such, it may be particularly appealing to those clients who would otherwise not have access such as those living in a rural community without a locally available clinician (Barak et al., 2009; Mallen, Vogel, Rochlen & Day, 2005; Rojubally et al., 2013). Furthermore, Hilty et al., (2013) propose that online therapy allows clients of different ethnic backgrounds to access mental health care from service providers that are from similar backgrounds, thus increasing cultural sensitivity and engagement. Diverse clients can reach expert clinicians from similar cultural and language backgrounds regardless of physical location, which may help minimize potential

misunderstanding and misdiagnosis (Yeung et al., 2011). Though the potential exists to reach these populations, the present reality is unknown.

ICT-Based Concerns about Online Therapy

The text-based nature of synchronous chat and asynchronous e-mail requires users of these online therapy media to be fluent in written communication (Hackerman & Greer, 2000). This limits clients from accessing services for whom writing (and typing) is not a strong attribute. Clients must also be computer literate; – that is, having sufficient knowledge and skill at using computer hardware and software (Maples & Han, 2008) – and must have access to a computer in a private setting. These requirements for minimum baseline skills and resources create a "digital divide" that may make online therapy inaccessible to potential users based on socioeconomic factors (Mallen et al., 2005). Industry Canada sponsored the Canadian Internet Use Survey (2012) and found that 83% of Canadians had internet access at home. However, only 58% of households in the lowest income quartile had internet at home compared to 98% in the top income quartile. It is suggested that online therapy has the potential to reinforce health service inequalities (E-mental Health in Canada, 2014). Unfortunately, we know very little about the impact of this digital divide.

Another concern about online therapy is the absence of face-to-face contact in crisis situations. Based on the ethical principal of nonmaleficence – doing no harm – which is a central component to mental health services, practitioners need to evaluate the limitations and benefits of online therapy when considering engaging with a client online (NBCC, 2007). The International Society for Mental Health Online recommends clients with profound psychopathology and suicidality are better served with face-to-face counsellor contact so that counsellors are accessible in times of crisis and able to collaborate with other members of the

client's case management team locally (ISMHO, 2000). However, Watts et al., (2012) examined the ICBT program with depressed and suicidal clients (excluding actively suicidal clients) and found a reduction in suicidal ideation and depression. Clients with higher suicidal ideation were excluded from RCTs and participating in ICBT but this study provides evidence for change.

Although online crisis counselling is a fairly new modality, its use has increased over the past few years (Whitlock, Powers & Eckenrode, 2006). In fact, one of the main sources of "free" online counselling services is crisis counselling, such as that provided at youthinBC.com, befrienders.org, and samaritans.org. Unfortunately, empirical research on the effectiveness of these services is lagging. However, recent studies indicate that increasing numbers of youth are using the internet for counselling support when they are in emotional distress (Becker & Schmidt, 2006; King et al., 2006; Lal & Adair, 2013; Madell & Muncer, 2007). It is hypothesized that they may be particularly drawn to the anonymity of this form of communication (Hanley, 2012); the increase may also reflect their comfort with online communications (Boydell, et al., 2010). Online crisis counselling is a fairly new modality, in comparison to telephone hotlines, and has seen increasing use over the past few years (Whitlock, et al., 2006).

Finally, threats of hacking, identity theft, and electronic breaches in confidentiality are real concerns with online therapy (Collie, Mitchell, & Murphy, 2000; Manhal-Baugus, 2001; Rummell & Joyce, 2011; Sude, 2013). Regardless of the modality being used to provide psychotherapy, it is important for counsellors to protect client identities and information, stay current with ethical guidelines, and inform clients about their security practices (American Psychological Association, 2013; Canadian Psychological Association, 2006). Although online counselling is a growing industry (Hanley & Reynolds, 2009), there has been little consensus

about the ethical, practical, legal, and therapeutic implications of online therapy (Mattison, 2012; Shaw & Shaw, 2006). Specifically, further research is needed to elucidate which interventions lend themselves to effective translation to online counselling methods, and which client populations are best served by these modalities (Greidanus, 2010). Also research can guide program development, counsellor training and ethical and legal guidelines.

Research Questions and Theoretical Underpinning

The present study explored the experiences of clients who have received online therapy, thereby expanding the modest existing literature base about people's experiences of receiving online therapy (Haberstroh, Duffey, Evans, Gee & Trepal, 2007; Mann-Layne & Hosenhil, 2005). Specifically, I have qualitatively examined the perceptions of clients who have engaged in an online therapeutic relationship. The overarching aim of this narrative research was to understand and describe client experiences of online therapy, including the therapeutic relationship that they experienced. This work is also based on narrative theory, which suggests that the meaning of experiences is represented within the context of life events, relationships, and time. In narrative research, research questions are often generated from experience rather than being theoretically informed, and this makes it unique from many other methodological approaches (Trahar, 2011). Consequently, my research questions are:

(1) What are the salient events that contribute to seeking online therapy?

(2) How do clients construct their online therapy experience?

In order to ensure a rich and holistic description, and to gain a complete picture of the events, procedures, and experiences that occurred in the natural setting (Stainback & Stainback, 1988), I recruited participants from a naturalistic setting — that is, actual clients who have engaged in online therapy. To understand the nuances of what takes place online, it was most appropriate to

engage with the lived experience of clients of online therapy through the narrative process of meaning making. To restate Polkinghorne's (1991) assertion: the quality of research is not a function of the method, but of the appropriateness of the method for the given question, and then the quality of its execution. Similarly, Smith posits that research methodology must be "based on the skill of matching the problem with an 'appropriate' set of investigative strategies" (1999, p.173). Researchers have compared qualitative research methodologies to the arts and literature, concluding that there are no "wrong" genres, but there is a "right" genre for the occasion. The research question of this study — how a client construct their online therapy experience — seems to be most appropriately approached through qualitative methods.

As a qualitative research project, this study is grounded in a relativist ontology and social constructionist paradigm. Ontology is the study of being (Carrozzon, 2012) and paradigm can be defined as the "basic belief system or world view that guides the investigation" (Guba & Lincoln, 1994, p. 105). As such, the contemplation of meaning, asking fundamental questions and searching for answers, is central to human life and can be linked back to Greek philosophers like Aristotle. The roots of relativist ontology and the constructivist paradigm can be found in some of the writings of renowned 20th century philosophers such as Søren Kierkegaard, Friedrich Nietzsche, Edmund Husserl, and Martin Heidegger. Many forms of qualitative research are based on a relativist and constructionist ontology, which reject the belief in an absolute reality (Becvar & Becvar, 2003). Rather, there are multiple realities that are socially constructed and vary across cultures, time, and context (Gonzalez et al., 1994).

Denzin and Lincoln refer to epistemology as the way in which we come to know the world: "…what is the relationship between the inquirer and the known? Every epistemology…implies an ethical-moral stance towards the world and the self of the researcher"

(2000, p.157). Likewise, Dobson (2002) contends that the researcher's theoretical lens plays an important role in the choice of methods, just as the underlying ontological assumptions of the researcher mostly define the choice of methodology. Heylighen explains that social constructionism "sees consensus between different subjects as the ultimate criterion to judge knowledge. Accordingly, truth or reality will be accorded only to those constructions on which most people of a social group agree." (1993, p. 2). The social constructionist approach assumes that social and psychological worlds are produced and reproduced through interactions and practices that take place in specific socio-historical contexts (Avdi & Georgaca, 2007). This means that people process their life experiences in an effort to construct meaning, and that meanings are the cognitive categories that make up an individual's view of reality and with which actions are defined. In general, according to Chen (2001), life experience generates and enriches meanings, at the same time that meanings provide explanation and guidance for the experience. Cognitions and emotions are our internal processes by which the information presented is screened, translated, altered, assimilated, and at times rejected in light of prior knowledge and experiences that exist in the system; the experiences that give meaning to the resulting knowledge are idiosyncratic and purposefully constructed (Lycott & Duschl, 1990).

Thus, the main aim of social constructionism is to unveil how individuals and groups participate in the construction of their perceived social reality. The internet is a global phenomenon and the digital revolution has created many new possibilities. Specifically, new forms of ICTs make the medium cost-effective, efficient, and convenient for users (Duffett-Leger & Lumsden, 2008; Evans, 2014). The internet offers the ability to communicate synchronously in real-time via chat, delivering and sharing information instantaneously. The internet also still allows for the asynchronous feature of e-mail. And it is the textual nature of the

medium that encourages space for active thinking, engagement, and reflection (Dunn, 2012; Morrisett, 1996). Accordingly, I acknowledge human experiences are ongoing and socially constructed in a dynamic process.

Method

Narrative research.

Qualitative methods are ideal for the current inquiry because they are well suited for studying areas of human life that have not yet been adequately explored to develop quantitative hypotheses (Flick, 2002) . In particular, narrative research is useful for understanding participants' subjective experiences with social phenomena. Narrative research 'eschews certainty' (Trahar, 2008, p.262) and acknowledges that the social world is multifaceted and interpreted differently by different narrators.

Connelly and Clandinin (1990) view narrative as the way in which we characterize the phenomena of human experience. Therefore, it seemed most appropriate to use narrative research to generate holistic understanding and contextualize the meaning of online therapy from the client's perspective in the present research. Additionally, narrative methods are especially useful when trying to gain an in-depth understanding of a phenomenon (Fraser, 2004; Hollway, Lucey, & Phoenix, 2007; Riessman & Quinney, 2005).

From the outset, narrative research differs from the positivist stance, and does not expect a single or absolute truth to be discovered; rather, there is adherence to the notions of pluralism, relativism and subjectivity (Leiblich et al., 1998). Convinced that realist assumptions from the positivist methods are too limited for understanding social life (Riessman, 2002) I have turned towards methods which I consider more suited to the complexity and heterogeneity of the social world and human experiences.

Narrative research involves hearing, recording, and retelling stories; consequently, many authors use 'story' and 'narrative' synonymously. However, narrative researchers assert that narrative research represents much more than simple storytelling (Arvay, 2000; Bishop, 1996; Bruner, 1990; Riessman, 1993). Riessman identifies narrative as a larger socio-cultural discourse — a web of culturally constructed beliefs about the self and others. Essentially, it is everything that the individual or society holds to be true about the nature of things. Riessman also posits that "narrative truth is excruciatingly complex" (p.150) and, accordingly, narrative researchers should deliberately create multi-layered accounts that combine perspectives, including but not limited to those of the participants and researchers. Collaborative and multi-voiced narrative research contextualizes the individual's experiences into a broader understanding (Arvay, 2000; Bishop, 1996; Crook, 2000).

Given that little is known about the phenomenon of online therapy, narrative methodology was well suited to answer the two research questions posed in the present study. Narrative research is a more appropriate choice than other forms of social constructionist qualitative research because this approach allows the participant to guide and tell the story with themes that are significant to them. Further, narrative research facilitates creativity and collaboration between the participant and the researcher. Narrative research allows the participants and researcher to engage in a process of co-constructing and meaning-making, focusing on the participant's experience, which is central to the context of psychotherapy and narrative. Anderson and Goolishian state that "we live with each other in a world of conversational narrative, and we understand ourselves and each other through changing stories and self-descriptions" (cited in Hart, 1995, p.184). Consequently, the focus on clients' stories is essential to both therapy and narrative methods. Storytellers are both experts and authorities on

their own lives (Clandinin, 2007); they are not just reporting sets of events but also revealing how their stories evolved (Larsson & Sjöblom, 2010). "Story, in the current idiom, is a portal through which a person enters the world and by which their experience of the world is interpreted and made personally meaningful. Narrative inquiry, the study of experience as story, then is first and foremost a way of thinking about experience" (Clandinin, 2007, p.37). Given the inter-subjectivity and complexity between the individual's experience and their understanding of the social world, narrative knowing is not just relevant to social reality at the individual level, but also at the collective level. Despite being unique and individual, stories are constructed inter-subjectively and situated within specific social fields and in light of the cultural stock of stories' available to them (Zilber, Tuval-Mashiach & Lieblich, 2008, p.1048).

Participants and recruitment.

 Six participants met the criteria set forth for the study. They were over the age of 19, capable of communicating fluently in written English, and had engaged in online therapy via e-mail, chat, or videoconferencing within the past 12 months. Morse (2000) contends that sample size in qualitative research is only significant in relation to the desired objectives of a study, and has emphasized that smaller sample sizes may be appropriate for research intended to invoke in-depth analyses of participant narratives. Female participants were selected because the existing literature states that a greater proportion of women use online therapy services (Chester & Glass, 2006; Dubois, 2004).

The age of majority varies between countries and provinces. However, in order to gain informed consent, all participants were at least 19, the age of majority in British Columbia. The choice of the English language was for pragmatic reasons. Namely, recent studies show that although online clients are geographically diverse, most reside in primarily English-speaking

countries such as the USA, Canada, the UK, and Australia. Because previous studies have documented the distorting effect of timing in retrospectively recalling life events (Brown et al., 1973; Paykel & Hollyman, 1983; Roy-Byrne, Geraci, & Uhde, 1987), the study invited stories only from clients who have had a recent experience with online therapy, specifically within the last 12 months. For further information, see the "Participant Profiles" section. Also given the time commitment, participants were compensated with an honorarium of a $30 gift card.

Participants were recruited through purposeful sampling. I posted announcements via e-mail lists of the National Board for Certified Counselors (NBCC), the British Columbia Association for Clinical Counsellors (BCACC), and with Therapy Online (www.therapyonline.ca). I also posted announcements on Craigslist in major metropolitan areas of the US and Canada, on LinkedIn, and on Twitter. Further, snowball sampling, in which I asked online therapy counsellors to refer potential participants to the study, was also used. The objective of gaining access to online therapy clients was best served by purposeful and snowball sampling methods that facilitated intentionally seeking appropriate individuals to learn about and understand the phenomenon under study (Malterud, 2001).

Participant profiles.

This section provides brief profiles of the six participants who graciously agreed to tell their stories of online therapy. I have used pseudonyms and removed other identifying information to protect their identities. At the time of the interview, clients ranged in age from 31 to 46 (M = 38). Three were located in the US, two in Canada, and one in China. Three were of Caucasian ethnicity, two Asian, and one Middle-Eastern. All the clients had at least a bachelor's degree, and two had graduate degrees. Five of the six participants reported having previous experience with face-to-face counseling before trying online therapy. They also reported

spending from 4 to 12 hours (M = 8 hours) per day in online activities. The complete client

narratives can be found in appendix (F).

Table 1. Clients' Demographic Information

Participant	Ethnicity	Age	Education	Employment Status	Marital Status	Hours online per day	Online counselling Modality
Ping	Asian	36	Bachelors	Full-time	Single	12	Email, IM
Jess	Caucasian	31	Bachelors	Full-time	Divorced	6	Video
Kat	Caucasian	37	Bachelors	Full-time	Separated	8	IM, Video
Lily	Asian	38	Graduate	Full-time	Married	8	Email
Mel	Caucasian	46	Bachelors	Full-time	Married	8	Email, IM
Shiraz	Middle-eastern	41	Graduate	Full-time	Single	8	Email, IM & Video

Ping's profile.

Ping is in her mid-30's and works as a business professional in New York State. She has

a background in sales and marketing. She sought online counselling because she felt unable to

afford face-to-face therapy. She received online counselling off and on for a year, to cope with

stress at work and in her personal life. She reports using an anonymous e-mail account to

communicate with her therapist. Ping reports her female therapist was available when she needed

her and she found the anonymity of online counselling to be appealing.

Jessica's profile.

Jessica is a freelance writer in her early 30's and lives in California. She has a

background in creative writing. She described a history of mental illness on her father's side and

says she has been in and out of face-to-face therapy for mood problems since she was a teenager. She reported often having withheld information from her therapists, and found herself unable to fully confide in her most recent face-to-face therapist about the extent of the abuse she was experiencing in her romantic relationship. Subsequently, Jessica heard about online therapy, thought it might be "easier and more economical," and sought it out when she needed to speak to a professional, using both e-mail and videoconferencing with her female therapist.

Kat's profile.

Kat is in her early 30's and works as an English as a Second Language teacher in China. She has a background in English. She travelled there to put a "safe distance" between her and her parents, and has been in therapy off and on since she was a teenager for Obsessive Compulsive Disorder (OCD) and anxiety. She reported she has had mixed experiences, some helpful, some not, with face-to-face counsellors. Kat found that her anxiety increased dramatically living as a Caucasian woman in a small town in China without a therapist there as a "life raft." In a moment of desperation, she Googled for a counsellor and found a male therapist who was available to speak with her. They had been videoconferencing for seven months at the time of her research participation.

Lily's profile.

Lily is in her late 30s and works in higher education in Ontario. She has a background in liberal arts. She received face-to-face counselling 25 years ago to cope with the death of her parents and found it helpful. She recently sought online counselling through her Employee Assistance Program (EAP) due to problems in her relationship with her spouse, who has taken early retirement and returned to school. Her male therapist worked with her through e-mail, but

the therapy ended prematurely after two e-mail sessions. There was no subsequent follow-up by her therapist.

Mel's profile.

Mel is a woman in her mid-40s who works in higher education in British Columbia. She has a background in psychology and a diploma in Guidance Studies. She previously accessed face-to-face counselling both as part of her studies and for personal reasons. Mel was introduced to online counselling through her university's Employee Assistance Program and used it for some "life coaching." The online sessions she received were with a male therapist and conducted via e-mail and chat. She reports being skeptical of the modality at first. Over time, Mel found that online counselling worked well for her particular goals, but experienced it as being inferior to face-to-face counselling in several ways.

Shiraz's profile.

Shiraz is in her early 40's and working in higher education in the State of Florida. She has a background in pharmacy science. She sought online counselling because of both the general stigma in her country of origin (Iran) around seeking mental health services, and specifically because of the government persecution she might have faced for identifying as lesbian. Her family members in the US encouraged her to seek therapy online and helped her set up secure accounts and payment methods that would ensure her safety and anonymity. Shiraz presented with severe depression, which she attributed to having to conceal her sexual orientation and live a "double life." Her therapist, who was a woman, worked with her using CBT and mindfulness-based CBT techniques. Over time, they moved from using solely e-mail to videoconferencing once a month and using e-mail between these sessions.

Data collection.

I used semi-structured interviews to elicit personal narratives reflecting the perspective of the research participants. Narrative researchers use interview data collection methods (Fontana & James, 1998) because entering into dialogue allows them to uncover hidden or subordinated ideas (Anderson & Jack, 1991; Borland, 1991; Fraser, 2004). I conducted the preliminary interview (to assess eligibility, explain procedures and obtain consent) through e-mail and the narrative interviews through instant messaging (IM) via Skype. This ensured that the participants communicated with me in a way that was similar to how they communicated when they experienced the phenomenon, given that the nature of online therapy calls for communication over the internet.

Moreover, according to Kivitis (2005), interviewing over the internet is cost effective and enables researchers to conduct interviews with participants from diverse geographical locations. E-mail interviewing affords "a personal and thoughtful form of communication" (Kivitis, 2005 p.35), and pragmatically, it also allows participants to respond at their leisure. On the negative side, however, it may contribute to forgetfulness and reduced response rates. However, IM is more dynamic than e-mail as it is synchronous and therefore engages the respondent (Mann & Stewart, 2000). Data collection was achieved through both synchronous IM (narrative interview) and asynchronous e-mail (demographic questionnaire, consent and member-checking). Using a combination of these methods harnessed the benefits of text-based online communication.

Data collection was completed in three phases. Phase 1 entailed recruitment, providing information and gaining consent from the potential participants. Upon being contacted by interested individuals, I sent an electronic package to invite them to participate. The e-package included pertinent information about the study, a demographic questionnaire, and a consent

form. I also provided options of e-mail or chat and timings for preliminary interviews (sample recruitment e-mail and information letter are included in the Appendix A-D). All participants choose to have the preliminary interview via email.

In Phase 2, within one week of sending the e-package, I followed up with potential participants to conduct a screening interview and explain the purpose of the study, procedures, and representation of the findings. This provided an opportunity for participants to ask questions and receive clarification about the study. The screening interview was conducted via e-mail. Participants submitted the informed consent electronically, either scanned or digitally signed, along with the demographic questionnaire. Twenty-two individuals responded to the posting; fourteen individuals did not respond to the follow up e-mail and I assumed they were no longer interested. One person decided not to participate after learning more about the study and interview process, leaving six participants who were interviewed.

Phase 3 was comprised of eliciting the narratives. The narrative interviews were scheduled within approximately two weeks of receiving the signed consent forms. An appointment was set at a mutually agreeable time that was negotiated between researcher and participants, giving consideration to work schedules and time-zone differences. I was able to schedule the interview at a time that was convenient for the participant. Individual open-ended interviews were conducted online, via IM over Skype. The interviews were completed in a single session, between 60 to 90-minutes in length. The narrative interview entailed inviting the participants to share their stories about online therapy. Hearing their stories through the text without the audio-visual meant I asked many clarification questions (e.g., Can you please expand on that process?) via the text-based chat and at times followed up through e-mail if necessary. I actively reflected on the interview process by asking questions posed by Fraser (2004), such as

"How are emotions experienced during and after the interview?" I did this by reflexively writing and documenting responses in my journal and asking the participants to write down their thoughts about the interview process and share them with me after the interview. Further, the meaning-making occurred dialogically in the narrative way, as the participant told their story and I took up the role of narrator and researcher, as per Arvay (2003, p. 6): "The narrative researcher takes up a dual consciousness — performing the story as narrator and reflecting on the story being told as researcher, continually moving between these and other subjectivities as the conversation unfolds".

Data analysis.

The data were read, interpreted, and analyzed based on an adaptation of the narrative collaborative approach (Arvay, 2003), as well as descriptions of narrative data analysis of personal stories by Fraser (2004). My research does not follow a predefined approach but uses general guidelines for analyzing narratives that are outlined by existing researchers in the field of narrative research (Arvay, 2000; see also Bishop, 1996; Connelly & Clandinin, 2006; Crook, 2000; Fraser, 2004; Josselson & Lieblich, 2003; Riessman, 1993). As Fraser points out, "…it is simply a rough guide that I offer for others to siphon ideas from, modify and rework in light of their own research experience, interests and goals" (2004, p. 197).

Phase one, I began by reviewing the transcripts from the interview chats and e-mails in their original form. I used Arvay's (2003) collaborative approach to read and interpret the transcript on four levels: (a) reading for content; (b) reading for the self of the narrator, paying attention to who is telling the story; (c) reading for the relevance to the research question; and (d) critically reading for relations of power and culture. In addition, I read and reread the narrative to identify common themes, contradictions in the story, and points of agreement and disagreement

between the interviewee and interviewer. I also read to identify my own voice, to attempt to discern how I influenced the construction of the story. I analyzed how each story began, unfolded, and ended to develop insight into the genres of the narrated stories (Cohler, 1994; Fraser, 2004; Plummer, 2001). Although the participants often did not tell their stories in the structure of a beginning, middle, and end, I attempted to construct a narrative to illustrate the beginning of their therapeutic relationships and how these relationships progressed throughout the sessions. I wrote a separate narrative for each participant, resulting in six individual narratives that contained a description of each participant's experience of online therapy. I then wove together the individual stories to relate them to the research questions posed. As Fraser (2004) suggests, several drafts are necessary to hone the analysis and check for researcher subjectivity, coherence, and credibility. I wrote two drafts and the second draft was sent to the participants for review which is the progression to phase two.

Phase two involved member checking. I e-mailed each participant's individual narrative to that individual for verification. I asked each participant to read their own narrative for accuracy and persuasiveness. As a collaborative, dialogical co-construction, this member-checking process allowed for clarifications of ambiguity in the data. It also allowed me to identify whether any additions need to be made by asking, "Is there anything else you would like to add to the interpretation?" (Arvay, 2003, p.171). All six participants agreed fully with the narrative that I sent them, but made minor changes to the grammar and structure of the sentences. One participant requested a change to their alias but did not change any content. After receiving the consensus from the participants, the third final draft was ready for cross-narrative thematic analysis.

In *phase three*, I conducted a cross-narrative thematic analysis of each story to search for patterns and themes that are common among the participant stories. In this phase, the focus of the readings shifted from looking within each narrative to looking across the six narratives for similarities and oddities among the participants' experiences. By examining the narratives collectively, I was able to identify some common themes. My cross-narrative analysis was guided by Braun and Clarke's (2006) six stages of conducting thematic analyses; however, I adapted their model to fit the study. Stage one of the thematic analysis was a natural progression from the fourth reading of the narrative reading for patterns or codes. The second stage involved placing the codes into broader categories or themes, and evaluating whether enough codes were present to support an independent theme. Stage three involved reviewing, evaluating, and naming the themes. Throughout stage four, I needed to fully immerse myself in the stories; therefore I mapped out the themes on a large poster paper and began the process of charting codes and naming themes. This was a multi-iteration process of going back and forth among the data to ensure that the themes were represented in the all of the narratives, and to make decisions about disparate and juxtaposed themes that stood alone on my poster paper. Each narrative was read five times holistically (i.e., to gain an understanding of the individual story and overarching theme of the narrative) and four times thematically (i.e., as themes became evident in reading the narratives, I searched for similar themes across the six narratives). At this point, I discussed important decisions around whether to include or exclude certain themes with my research advisor.

In *phase four*, I sent the narratives to peer reviewers who were not otherwise involved in this study to review the results of the cross-narrative thematic analysis. This was part of the validation process. Specifically, two graduate student researchers with experience in qualitative

research and experience with forming various kinds of online relationships (therapy, courses, or social networking) reviewed the narratives. They considered and provided feedback on the persuasiveness (how plausible and convincing the narratives are), coherence (evidence of thick descriptions that are understandable), resonance (how the description resonates with one's own experiences), and pragmatic usefulness (how the findings can be used in the field and for practice?). The reviewers and I then met to reflect on and discuss the meaning of the interpretations, as well as the sharing of the final narrative. One of the peer suggestions was to exclude one of the narratives for lack of depth and also inconsistency in terms of positive experience. However, after consulting with my research supervisory committee, I decided to keep the narrative as it provided an additional client perspective which was different from the other five narratives.

Validation process.

In order to verify the trustworthiness of the narrative analysis, two processes took place: member checking and expert peer reviews. The following criteria were employed:

Credibility.

Thick descriptions and concrete details were included; the co-constructed nature of the narrative calls for a continual revision, and consultation took place with the participants over the written narrative from the beginning to the end (Connelly & Clandinin, 1990). This was done through member checking with the participant that allowed me to identify whether any additions needed to be made by asking "Is there anything else you would like to add to the interpretation?" (Arvay, 2003, p.171).

Triangulation.

Triangulation was achieved through the cross-narrative analysis that was conducted in phase

three. In this process, multiple participants' perspectives were examined to formulate the answers to my research questions (Cohen & Manion, 2000; Stake, 1995).

Consensual validation.

Consensual validation was achieved through the previously described peer review process conducted in phase four of the analysis. Peer reviewers read the narratives for persuasive, coherence, resonance and pragmatic usefulness.

Researcher subjectivity.

As with any research, it is impossible to extricate the researcher's position from the research paradigm — the ontological belief system that guides the researcher in terms of epistemology and methodology (Guba & Lincoln, 2005). Recognizing how one is situated in terms of power relations impacts methodologies, interpretations, and ultimately knowledge production (Saltana, 2007). We all bring with us a certain cultural lens on how we view reality, and this impact the work we create. Thus, my identity as a woman from an ethnic minority, my experiences as a counsellor educated in the Western tradition of counselling psychology, my ongoing private practice in cross-cultural and online counselling, my previous experience as a client receiving online therapy, and my social constructionist epistemology have guided the interpretation of these findings.

As noted, the role of the narrative researcher is that of a co-creator and collaborator (Larsson & Sjöblom, 2010). This means that the story that is constructed in the research is a product of the dialogic exchange between the participant and researcher (Riessman, 2002, 2003). ". . . [N]arrative inquirers recognize that the researcher and the researched in a particular study are in a relationship with each other and that both parties will learn and change in the encounter" (Pinnegar & Daynes, 2007, p. 9). Fraser (2004) conceptualizes narrative conversations as pieces

of fabric and the researcher as the one who stitches these ideas together. Given this metaphor, it is clear that the researcher has an important role in the interpretation and representation of the final product. I am an insider in both realms, having experienced online therapy as both client and counsellor. Moreover, my belief as a therapist is that we live storied lives; it is the way we create and recreate our realities and ourselves.

I recall my experience as a client receiving online counselling. I was a graduate student in a small Midwestern town in the United States, working in the counselling office at the University and completing my internship at the same office. I remember feeling isolated and unable to disclose my stresses within that small community because I was in the counselling program and most of the local psychologists were faculty members in the department or colleagues I was likely to meet at conferences and workshops. My fears around confidentiality and being 'found-out' by my department led me to explore online counselling. Through a web-search I found a therapist three States away from where I was living. These were the early days of online counselling. Neither I nor my therapist were concerned with encryption and privacy. With some trepidation, I used my usual Yahoo e-mail without any fears of being hacked; I paid my fees via PayPal. My intention was to engage in short-term therapy. I laid out my concerns, possible directions, outcomes and consequences I was faced with and hoped for some support around decision-making. I was not sure what I expected to find or experience, because I had not read about online therapy, nor was this discussed in my graduate program. My hope was that this was not going to be money wasted.

Contrary to this, I remember the relief and positive emotions I felt with the first response back from my e-therapist. My therapist connected with me by restating and clarifying my situation and empathizing with me. She further coached me on the next steps to take and I felt

validated, heard, and supported. As I reflect and write about my personal encounter with online therapy, I am not aware that my experience as a client was distinct because I was not accessing services for an on-going mental health concern, nor was I in a crisis situation. I was intentional, specific, and solution-focused, which may not match the profile of most clients that seek counselling in face-to-face counselling settings. However, my own experience as client matched that of the participants as they navigated the mental health system and choose to engage in online therapy for themselves.

Several years later, in my position as a student counsellor with counselling services at a university, I increasingly experienced that some of my clients e-mailed me between sessions. This was very useful because students were able to continue accessing support when they were on Spring Break or when they went back home for the summer. I began to see the beneficial aspects of e-mail and telephone counselling with clients who were feeling too depressed (increased symptoms of fatigue and lack of motivation) to get out of bed and drive to campus for a session. Additionally, clients with anxiety found it helpful to send me a quick e-mail when they were feeling overwhelmed; I could then e-mail back some relaxation techniques and breathing exercises that they could read and reread as needed. I specifically remember a client who preferred text-based chat sessions because she said she could express her pain best in writing. She was aware of her shyness and would not have been able to share the details in a face-to-face conversation. At this stage, however, I was aware that my training had not prepared me for the integration of technology and counselling, and this is what sparked my interest in online therapy research, and motivated me to obtain specific training in how to practice in this medium.

Relative to this study, I have attempted to deconstruct any hierarchal researcher-participant relationship by honouring the voices of the participants and continuously checking for

my own biases. To address the biases, I have consulted and dialogued with my supervisor and committee members. I acknowledge my role as a co-constructor of the narratives; therefore, I will include direct quotes from participants' narrative writing along with my summarized interpretation of the narrative. A great advantage of narrative research is the ability to take the story back to the person whose story is being told and give them a say in what the story should look like in the final presentation (Arvay, 2003; Clandinin, 2007).

As I began conceptualizing my research, I started writing a reflexive journal to help clarify and hone my research aims and questions, as well as to diminish the impact of my biases on the participant selection and data analysis processes. During the processes of gaining approval from the Behavioural Research Ethics Board (BREB) at UBC, recruitment, and data analysis, I maintained close dialogue with my research supervisor to clarify questions and identify areas of development. An important role of the narrative researcher is to refrain from establishing a 'correct' reading or interpretation of the text (Lieblich et al., 1998), the 'right knowledge' and the truth (Fraser, 2004); rather, through the art of co-constructing the narrative, the researcher aims to understand how individuals interpret events and experiences.

Throughout my research, it was critical to recognize the power dynamic between the researcher and participant, so as not to recreate the power differential that existed within the counsellor-client relationship that the participants had experienced. One example of the realization of the power difference was brought to my attention by Ping, one of the participants. I was having a hard time with the simple yes and no answers I was receiving from her in our chat. In my effort and persistence to get rich, thick data, I shared examples with her of narratives from other published studies. Ping responded, ". . . I don't have such problems and after reading the narratives that you shared I wonder if my story is good enough?" At this point I realized I was

pushing her to give me an elaborate or moving story that would signify how and why online

therapy worked for her and I had been unable to take her statement at face value. I realized that,

in my quest to gain rich and in-depth information, I had created an implicit power imbalance in

which the participant assumed I had the ultimate power to decide whose story was legitimate and

"good enough" to be included in my study. I quickly corrected myself. Fortunately Ping was

forgiving and we decided to include the story in the way she presented it, as an account of her

reality and a legitimate experience. As a researcher, I recognized this as her truth and that I

cannot be the arbiter of whether her truth deserves to be included or excluded. As a researcher, I

am inherently in a position of authority, but I accept that the research participants are the

authorities on their experiences of online therapy. In this research, I attempted to maximise the

control participants had over their story, how much to share, and where the story started and

stopped. The power positions were further addressed as the participants were invited to

contribute to the construction of the story and to approve the final text of their narratives in phase

two of the data analysis.

Findings

Although presented as separate procedures, the process of data analysis began at the time

of the interviews themselves, when ideas began to emerge from readings of relevant literature

and the process of dialog with the research participants. The individual narratives that were

created and modified in phase 1 and 2 of the analysis process can be found in Appendix F. What

follows is a description of the results of the entire analytic process, incorporating the feedback

from the participant validation and peer review processes. Four overarching themes emerged

from the analytic process: (a) accessibility: (sub themes of convenience, immediacy and

affordability); (b) client autonomy and control (subthemes of time to think, reflect, and respond;

getting to the focus of therapy faster); (c) issues of privacy/confidentiality and (d) counsellors' qualities. Each theme was consistently present in each of the six individual narratives.

Accessibility: convenience, immediacy, and affordability.

Within the category of accessibility I found sub-themes of convenience, accessibility and affordability as the major attractants to online therapy. The participants' narratives of their experiences with online counselling reflected a perception that it was more convenient than traditional face-to-face counselling in that online counselling was perceived to be available and accessible anytime and from any corner of the globe.

Accessibility. The ability to access counselling service from any part of the globe that offers internet connection make online therapy appealing. For clients' who frequently travel for work, or have physical limitations that prevent them from getting to the counselling office or perhaps have geographic limitations i.e. live in rural areas where counselling services are not available, online therapy offers continuity of care. Offering more choices, clients can find clinicians with specific specialities and language abilities. As well as continue to benefit from therapeutic relationships that have been developed over time in the event that either the client or counsellor moves away.

Kat: I will most likely want to continue with my online therapist — the beauty of online therapy is that I can now move to any location and time zone but continue to work and make progress with my therapist rather than starting new with someone else.

Convenience. Below are specific participant typed statements that reflect their experience with the convenience with online therapy.

Lily: The reason why I tried online therapy is because I don't have time to make an appt and wait in an office for an appt. I am at work for at least 12 hrs a day so online was/is really my only option.

Jessica: It was also more convenient (no driving!) and cheaper (presumably because there was no overhead).

Ping: I am a busy professional and it is hard to make time to go to appointments. So the convenience and not having to travel was great.

Jessica: I can do it in the comfort of my own home - as a rule, I hate to drive, especially in Los Angeles (where I live). The stress of driving to my therapist appointments (which always took place across town) made the experience of going to traditional therapy difficult at times. With online therapy, there's less stress and it's more freeing.

Further, the immediacy and reliability of the modality makes it feasible and pragmatic for busy clients. Not having to make phone calls for appointments weeks in advance, be waitlisted in a community mental health setting, find a mutually convenient appointment time during the work day to see a local therapist in private practice, or being able to cancel at the last minute without penalty all made online therapy more alluring.

Immediacy. Kat's story of how she first encountered online therapy is particularly resonant of the immediacy sub-theme:

Kat: I was starting to recoil and soothe myself by cradling in the corner of a room. It was probably one of those nights that I went on to my computer and googled 'need help now' and landed on a page that seemed to be a list of directories of all the therapist that provide online therapy and what do you know there was somebody available for live chat right now.

Affordability. As Ping explained, "Also in person counselling if you cancel within 24hrs you get billed for a session. That is stressful especially if you are a shift worker and get called into work."

Online therapy directories can make counselling available in real time, the moment you need it. The difference between online therapy and other sources of help like hotlines and support forums is that most of the directories provide counsellor profiles from which clients can choose from, including their training and qualifications.

Autonomy and control.

Autonomy. In many of the participants' narratives, greater perceived autonomy and control within the counsellor-client relationship emerged as an important over-arching theme that was connected to developing more insight and empowerment. Autonomy in the context of this study is the ability to impose one's free will. It is intertwined with control, which should be understood as the ability to regulate one's environment by exercising judgement and making decisions. The participants in this study expressed the ability to make decisions about how to engage (e-mail or video) with the therapist and to feel that the therapeutic relationship was not counsellor dominated to be empowering. For example, as Jessica notes:

> If I could sum the entire experience up in a word, it would be freeing. I felt as though I could say and do anything without the threat or pressure of immediate, palpable judgement from another person (not that therapists *should* judge, but it's always been my fear and something I've used to prevent myself from speaking the whole truth with them). The absence of having an actual person there to listen to me speaking initially made me feel weird, like I was talking into the void or something. Once I realized that my therapist was actually listening to me and had constructive things to say, however, it

actually felt freeing (like I said earlier). Being a step removed from someone makes it even easier to open up to them, I feel. In the end, I ended up revealing more to my online therapist than I had with any of my one-on-one therapists. (Jessica)

Control. Online the client has more control. For Shiraz, accessing online therapy was a life-changing event, but had it not been for the control that was ultimately up to Shiraz, the therapy outcomes could have been very different. To fully understand the importance of control in Shiraz's story, it is first necessary to understand that she perceived face to face counselling in her home country to be unsafe, and involve giving up control of her private information:

Shiraz: The concept of mental health is stigmatized; the general population does not seek to speak with a therapist nor a life coach. The reasons being most are employed by the government and no one trusts them. There was no way I could risk coming out to a therapist locally because I don't have any way of knowing where my clinical records are being stored nor who will audit those files.

In contrast to Shiraz's perception of face-to-face counselling, her story of engaging in online counselling with a therapist in the United States included an emphasis on being able to retain control of her information and privacy, which was vitally important for Shiraz:

The therapist did not push me to come on the webcam or provide proof of my identity because this would have driven me away. I needed the anonymity for opening up and also for security- something people in democratic countries may not understand.

Gradually their e-mail communication progressed to video chats, but only when Shiraz was ready to move to the webcam and have scheduled appointments. In Shiraz's narrative, it was clearly evident that using e-mail at the beginning helped her to build trust with the counsellor, before proceeding to being able to see each other on a webcam.

Even for Mel, the skeptical client, autonomy and control played an important role in exploring online therapy. The ease with which a client can 'try-out' online therapy and not have to commit is desirable in testing the readiness for change.

> Mel: Starting off I was a bit skeptical. I thought that counselling via this method wouldn't work nearly as well. It creates a fundamentally different kind of relationship. It is easier to ignore what's being said via a screen, you can just push a button and disconnect. In person it is much harder to do that. If you don't like what is being said you can always pretend you didn't get that last e-mail, press delete that's that. It is not as reciprocal. You feel less on the hook in some ways. In the end, I had a more positive experience than I expected.

Sub-themes that emerged as part of autonomy and control include time to think, reflect, and respond; getting to the focus of counselling faster; and privacy and confidentiality.

> *Time to think, reflect and respond*. Contemplation and pre-contemplative phases are important to making decisions about change. The modality of asynchronous e-mail therapy makes this contemplation more powerful, as with writing there is reflection and a record that can be read and reread. As noted by Ping:

> I like the fact that I can read the e-mail and respond on my own time. I can save a draft and continue writing when I have more time. I like that I could freely express myself and I was not on a clock.

> *Getting to the focus of counselling faster*. Studies have suggested that online, small talk is greatly lessened and individuals address important issues faster (Boucher, Pronk, & Gahling, 2000; Tidwell & Walther, 2002). The phenomenon known as the disinhibition effect has been widely described in literature (Joinson, 2001; Suler, 2004; Whitty and Joinson, 2009) as the

ability for people to disclose their true selves and develop hyper personal relationships on the internet. Similarly, the anonymity offered by online therapy allows clients to disclose more sensitive information from a distance, and for rapport and trust to be developed at a faster pace in the online therapy environment than for in-person counselling. Jessica suggests:

the physical distance between me and my therapist seemed to make it easier to really open up and tell her how I really felt and what was really troubling me. It had a sense of anonymity - like sharing your feelings or opinions on the Internet. I didn't fear or anticipate as much judgement in that environment as I would in a one-on-one experience.

Trust and acceptance emerge as clients reveal more information about themselves (Dunn, 2012). This contributes to the client-counsellor relationship and ultimately contributes to therapeutic change.

Privacy and confidentiality.

Privacy and confidentiality concerns can fall on a continuum and are complex. On one end of the spectrum, Kat and Jessica had minimal concerns about privacy, while Shiraz, at the other end of the spectrum, had significant caution about confidentiality and took steps to ensure her identity was protected. The socio-cultural-political context, individual life circumstances, and attitudes towards breaches to Internet security contribute to each participant's concerns and choices.

Some participants consciously engaged in protecting their identity by taking extra precautions, for example:

Ping: I created a separate e-mail (account) and communicated via that e-mail and never disclosed my real name.

Shiraz: My cousin in the U.S. opened my web-based e-mail account and also showed me how to use a different IP address so that it could not be traced back to me. This was my portal into receiving the help I have needed but was to afraid to get.

Other participants, however, were less concerned with the confidentiality and did not take extra precautions other than what was predetermined by the therapist:

Jessica: When it comes to issues of confidentiality, I didn't look for it, to be honest. I assumed it would be like any other therapist. I just checked the website, though, and it's easy to find this information.

Kat: I have not been overly concerned about the confidentiality of it, but to me a Skype session seems more secure as we are talking live and I am assured this is not being recorded than an e-mail or chat that can be intercepted and leaves a trail. Also, end of day I am not a celebrity nor a politician so I don't think my therapy sessions hold much value to the general population. One of the real concerns was identity theft but we use secure payment methods and an alias encrypted account to chat from.

Counsellor qualities.

In the participants' narratives, those who shared positive experiences with online counselling identified several qualities of a "good therapist" that they experienced in their own online counselling, including warmth, genuine interest, support, and the installation of hope. Intriguingly, these qualities are consistent with Rogerian elements of effective face to face counselling.

Ping: In the beginning it was quite intimidating, I didn't really know how it worked and what to expect. However, she (therapist) did a great job of putting me at ease and making me comfortable by writing soothing words. I could imagine I am right there having a

conversation with her. I was able to quickly build trust and disclose my deepest fears to

the counselor because I was anonymous; my counselor exhibited non-judgmental and

accepting attitude.

Mel: My therapist was approachable and personal, which can be hard to do via this

medium (text-only). He also had a sense of humour which I appreciated. He had to prove

himself before I could develop a trusting and collaborative relationship online. He gave

me some exercises and once I had found them helpful I was more trusting. The

intervention seemed to be the yardstick.

Furthermore, as Jessica explained, in a good therapist, qualities of non-judgment, compassion,

caring, and genuineness seem to transcend the technological barrier.

Jessica: My therapist was very warm, had a caring demeanor, and always seemed like she

was interested in what I had to say. Her attention never wavered from me. She didn't

seem cold or stiff at all, which is an experience I've had with other therapists. I think she

did a great job from the get-go. She seemed to really care, and she expressed that very

well despite the barrier of technology. That being said, perhaps nothing can replace a

human element when it comes to talking about issues like this. I may have just lucked out

with my therapist - perhaps she was so good at what she did, it transcended the barrier of

technology separating our physical selves.

   In contrast to the experiences shared by Ping, Mel, and Jessica, Lily's narrative reflected

a more negative experience with online counselling, in general, and with the therapist's lack of

effort to develop a positive therapeutic relationship.

Lily: I don't feel my therapist did anything to make me feel more comfortable, nor did we

develop a therapeutic relationship. There were no technical difficulties as it was e-mail.

But there was no follow up or outreach and the therapy ended prematurely. I got an e-

mail that said if you are going to hurt yourself see a doctor, otherwise try to remember a

time you were happy, what you were doing and try to do that again.

Interestingly, Lily ascribed this negative experience to having a bad therapist rather than

the online modality: "I do see the value in online therapy and it is a good field, I just had a bad

therapist." In Lily's story, the qualities associated with her bad therapist included his failure to

make her comfortable by engaging her in supportive dialogue. Instead, her counsellor's lack of

follow up and outreach prevented a therapeutic relationship from developing and led to a

premature termination of counselling. Furthermore, Lily reported that her counsellor did not

build hope or agency with her.

Discussion

Convenience, privacy, and anonymity have been the most frequently cited reasons for

using internet counselling services (Beattie, et al., 2009; Dunn, 2012; Leibert et al., 2006), and

have been suggested as key advantages of online over face-to-face counselling (Evans, 2014;

Hamburger and Ben-Artzi, 2000). All the narratives share the common theme of accessibility,

which encompassed convenience, immediacy and affordability. In the digital age, finding the

time to take care of one's mental health needs becomes less of a priority when there is difficulty

reconciling therapy appointments with busy schedules. Online therapy can be a solution for busy

individuals. In addition to convenience, individuals who need privacy within the local

community are able to use the internet to create an ideal distance with their counsellor, a distance

that they need to feel safe and comfortable when disclosing personal issues. Leibert et al.

speculated that people who are especially sensitive to the presence of others, who have

experienced emotional trauma, social marginalization, or judgment from others may need to communicate without fear of a listener's first reaction (Leibert 2006, p. 83).

The participants' narratives emphasize the importance of the positive therapeutic alliance. Online therapy met their goals, that is, reduction in disruptive emotional, cognitive and behavioural symptoms and an increase in agency to achieve relief and restore self-efficacy. It is well established that the therapeutic alliance is critical to successful counselling (Gelso and Carter, 1994; Wampold, 2000). Horvath and Luborsky (1993) identify openness, respect, and a collaborative bond as essential components of the therapeutic alliance. Clients need to feel they are speaking with a real person, not an automated robot on the other side of the screen. The humanness helps make them feel more comfortable, while the clinician's genuine interest in learning more about the client and their current situation helps in developing trust. Consequently, the counsellor's warmth, genuineness, empathy, and humanness impact the collaborative working relationship with the clients. As several of the participants have alluded to the counsellors' qualities that help create a positive online therapy experience, it seems that first and foremost, the client needs to feel that the online therapist cares. Then the treatment plan can follow.

Two participants sought online therapy through their Employee Assistance Program (EAP). This was a free counselling service and based on a solution-focused brief therapy model. Mel described the counselling approach as "coaching," and stated her experience was surprisingly good but she would not use the service for personal problems. Lily tried to access the same service for personal problems, but perceived that her therapist made insufficient efforts to learn about her situation. She also felt a lack of empathy and felt she received no assistance with the resolution of her problems. Further investigation is needed to identify the differences

between online therapy offered through EAP services and that offered in private practice settings. Perhaps there is a wider range of qualification and experience in online therapists that are hired by EAPs. Incidentally, the two participants who engaged with online therapy through EAP both worked in higher education and exclusively experienced therapy through email and text-based chat. Though there is evidence that email therapy can have positive outcomes there might have been a missing human element due to the lack of audio-visual contact. As research is lacking in counsellor training and motivation specific to EAPs, we can only speculate that the there exists a lower level of engagement of some EAP counsellors' providing online therapy. One exception is Murphy et al., 2009, who compared online therapy and face-to-face therapy offered through an EFAP service using a client satisfaction survey and Global Assessment of Functioning (GAF) scores. They found no significant difference between face-to-face and online clients' assessment of counselling being a valuable benefit (Murphy et al., 2009). However, the current study adds a qualitative dimension and illuminates the experience of online therapy clients who may be similar to the outlier cases in Murphy's study, such as the case of Lily, who states that online therapy did not meet her goals and she was dissatisfied with the process, but attributes this to failure on part of her "bad therapist."

This study supports previous research findings from Centore and Milaacci's (2008) research on the advantages of online therapy for clients: the sense of increased safety and anonymity, reduced social stigma, greater counselor selection and accessibility, and service affordability. These were all cited by the participants in the current study as reasons and motivation for seeking online therapy. Further, online therapy affords a safe distance, as previously found by Fletcher-Tomenius and Vossler (2009) who concluded that anonymity was an important factor in enhancing trust in the online therapy relationship. Lingley-Pottie and

McGarth (2007) noted clients reported enhanced therapeutic alliance with the increased self-disclosure, and decreased stigma with distance services when compared to face-to-face services. Both anonymity and self-disclosure have been studied by Suler (2004), who has written extensively about the 'disinhibition effect.' Cook and Doyle (2002) found that clients welcomed the freedom to express themselves without the fear of being judged. Also, Lewis et al., (2003) stated clients in their study found an unexpected depth of emotions. Supporting but going beyond the conclusions of previous research, Jessica uses the term 'freeing' in her narrative to describe the safe distance and comfort that allows her to get honest about what is going on for her beneath the surface. This described sense of freedom suggests that some clients perceive face-to-face therapy as constraining; for them, receiving therapy online appears to deepen engagement and enhances disclose in a way that would not otherwise occur. Reynolds et al., (2013) refer to this as the online calming effect, proposing that online communication can facilitate feelings of increased comfort and less intimidation than face-to-face therapy.

Furthermore, the study found that client autonomy and control are important factors in engaging in online therapy. Dunn (2012) in her qualitative investigation of online therapy relationship between client and counsellor also found that the clients' increased control and choice over how and when to engage helped develop and maintain the therapeutic relationship. Hanley (2012) pointed out that the initial engagement phase is dependent on how both client and counsellor navigate the technical aspects of online therapy utilizing netiquettes, and negotiating the preferred modality. Next is the rapport building and establishing control phases which Hanley (2012) has conceptualized using Bordin's (1979, 1994) original formulation of alliance as bond, tasks and goals. The current study adds to the literature on the clients' perception of the counsellors' disposition that impacts the therapeutic relationship. Lily used the term 'very warm'

as opposed to 'cold and stiff' which was experiences she had had with in-person counselling. Also, being experienced and skilled was another therapist quality that Kat described "my therapist seemed experienced with online therapy as there are subtleties such as scheduling, time differences, and technical difficulties that I was not apprised of but he was always on the ball. Finally, the findings in this study suggest a need to shift our understanding of online therapy. Many established practitioners remain preoccupied with face-to-face therapy and potential clients question 'how real is online therapy?' The autonomy and disinhibition afforded in the context of online therapy generates trust and helps clients to verbalize and disclose elements about themselves previously held back. This can be harnessing the power of therapy and getting to the focus faster as mentioned by several participants in this study. To answer the question posed at the beginning of this paragraph, for some clients, though certainly not all of them, online therapy is more real and the relationship they develop with their online therapist is more authentic than in their experiences in face to face therapy.

Limitations

The study shares limitations that are common to narrative studies generally. First, the findings are not intended to be statistically generalisable. Narrative analysis may provide insights to researchers and practitioners, but due to its highly contextualized nature prevents generalizations to other individuals and contexts (Borup et al., 2013). Nonetheless, the study has transferability, as the findings have applicability to other clients beyond the six participants. Second, the current study has not addressed the gender gap shown in previous online counselling studies that cite predominant samples of Caucasian, college-educated women as a methodological weakness (Cook & Doyle, 2002; Leibert et al., 2006; Prado & Meyer, 2003; Reynolds, et al., 2013). The present study focused on experiences of female participants and may

not reflect the experience of other genders or age groups. With the exception of one participant, the majority of the participants associated with North American culture. Thus, the experiences of online therapy within other cultures are not adequately represented. Further, all the participants had a minimum of a college education and this does not necessarily reflect the average population.

Another limitation is the short time I spent interviewing the participants. The nature of online interviewing did not call for small talk or spending much time building rapport or getting to know the participants on a more personal level. As participants did not have any questions, we preceded right into the interview questions. After I completed the interviews, I asked if the participant had any questions or any further information they wanted to share, but I did not receive any additional details. There are always stories within the stories that were not explored.

Conclusion

Over the next decade, online therapy will become more commonplace (Calahan & Inckle, 2012; Hanley, 2012; Whitty & Joinson, 2010). In an age in which people publicly and voluntarily share information about themselves, their families, and their daily habits and rituals via Twitter, Face book and Blogs, information that was previously private is now public. Because what is considered "private" information is set in a socio-cultural context and is constantly evolving, it seems likely that people who already have an active online presence would have fewer concerns about breaches in confidentiality in regards to online therapy. Regardless of the reasons why it is expanding, the reality is that an increasing number of individuals will be seeking counselling services online.

The narratives presented in this study revealed that the six clients' experiences of online therapy were generally positive, but are also greatly influenced by the quality of therapeutic

relationship that developed online, in much the same way as in face-to-face counselling. Collaboration and empowering client autonomy were crucial in building a therapeutic relationship.

Online therapy has been cited as a gateway to seeking face-to-face help (Attridge, 2004; Evans, 2014). However, none of the six participants indicated that they would be moving on to in-person counselling, Thus, face-to-face counselling should not be seen as a 'universal goal' (Dunn, 2012). The findings of my study instead suggest that online counselling can be a viable long-term alternative to face-to-face counselling for some people. Three of the participants had a history with in-person counselling and all of them concluded that, although they were initially skeptical, they found online therapy to be a good match for their lifestyle and personal needs, and benefited from receiving counselling online.

Chapter 4: Study 2 The Counsellors' Online Therapy Experiences

In keeping with technological advances, online therapy has grown in practice in the past 15 years. Empirical evidence that demonstrates the potential of the internet as a viable means to reach prospective clients has been presented in previous chapters (Fang, et al., 2013; Guanipa, Nolte & Lizarraga, 2002; Mallen & Vogel, 2005; McFadden & Jencius, 2000; Shernoff, 2000). The focus of the current study is on the experience of counsellors. In their meta-analysis, Spek et al. (2007) found much larger effect sizes for therapist-supported online interventions for anxiety and depression than for online self-help interventions. The existing literature has debated the effectiveness of online therapy, including benefits and drawbacks, as well as the question of whether it is possible to develop a therapeutic alliance online (Barak, Klein, & Proudfoot, 2009; Hanley, 2009; Grover, Blanford, Holcomb, et al, 2002, Richards and Vigano, 2013).

Even the term "online therapy" itself stirs strong reactions from the members of the counselling profession and this growing service modality remains complex and controversial (Barak et al., 2011; Bloom, 1998; Callahan & Inckle, 2012; Mallen, Vogel, & Rochlen, 2005). Regardless of the various concerns that I describe later in this chapter, it must be recognized that credentialed and non-credentialed therapists have been offering online services for over 15 years (Bloom & Sampson, 2001; DuBois, 2005; Dunn, 2012; King & Poulous, 1999; Manhal-Baugus, 2004, Mitchell & Murphy, 1998, 2003; Rochlen, Zack, & Speyer, 2004; Russ, 2013).

Although the body of literature on online therapy is growing, it does not adequately explore the human experience of online therapy. In particular, there is a scarcity of qualitative research illuminating the nuances of online therapy and how the client and counsellor relationship unfolds when the counsellor connects with the client remotely via a screen, whether seeing them through a webcam or in text-based environments such as e-mail and chat. The

current study addresses this gap by qualitatively examining counsellors' experiences of online therapy practice. A review of the literature that pertains to the counsellors' perspectives and experiences follows next. Although I have attempted to avoid repetition with the previous chapters, some redundancy is necessary.

Therapist Characteristics and Experiences

Much of the work exploring online therapist characteristics is demographically-focused. For example, Chester and Glass (2006) conducted a worldwide survey of 67 online therapists to explore their characteristics and services, using The Online Counselling Questionnaire (OCQ). Therapists mostly self-identified as middle-aged (range = 28 to 69 years, M = 47), highly educated (master's degree = 58% and doctoral degree = 25%), qualified (87% licensed or registered), and experienced in this modality (range of online practice = 2 months to 8 years, M=2.3 years). The majority also had over 10 years of experience in practice as counsellors. They resided in geographically diverse areas, with the majority in the USA, United Kingdom, and Australia (62%, 13%, and 7%, respectively). The counselling modalities that they most frequently identified with were cognitive-behavioral (CBT; 40%) and eclectic (32%). Based on these findings, the authors concluded that online counsellors are, for the most part, highly trained, experienced, and well-educated.

This work is consistent with findings from Finn and Barak (2010), which involved self-identified e-counsellors (n =93). In this study, the median therapist age was 48, with 80% of respondents residing in the United States. Their preferred counselling modalities were CBT and eclectic (35% each), and their mean amount of counselling experience was 14.2 years, with 5 years' experience conducting therapy online. Finn and Barack also found that, overall, therapists were satisfied with their practice and believed it was effective. Although participants were all

trained counsellors with a minimum of a master's degree, they generally received no formal training or supervision in practicing online.

More recently, Hertlein, Blumer and Smith (2014) examined marriage and family therapists' use and comfort with online communication with clients. The sample consisted of 169 MFT clinicians, composed of (75.6 %, n = 127) females and (24.4 %, n = 41) accounted as the male respondents. Further, 80.4 % (n = 136) of participants were Caucasian. Participants were employed in a variety of clinical settings; approximately 54.4 % of the sample (n = 95) were private practitioners. They found that about half of the sample (n = 85, 50.3 %) reported they rarely used e-mail, and 16.6 % (n = 28) stated they have never communicated using e-mail with clients. Forty-seven (27.8 %) participants indicated they often communicated with clients via e-mail, and nine (5.3 %) noted they always communicated with clients via e-mail. In regards to video conferencing, 133 (78.7 %) participants stated they never communicated using video with clients; 31 (18.3 %) reported they rarely participate, four often communicated this way with clients (2.4 %), and one (0.6 %) always used video. A poignant finding in the study was a high level of discomfort using the internet as the sole format for treatment. Authors posit, this might be due to the limited sense of therapist control over an internet-based treatment.

Moving beyond demographics, Bambling, King, Reid and Wegner (2008) explored counsellors' experience with online therapy. They found that counsellors generally reported the primary benefit of the online environment to be client perceptions of emotional safety due to the reduced proximity between the clients and counsellor. However, this reduced proximity in combination with solely text-based communication was also cited as the main disadvantage. Therapists are trained to pay attention to the subtle emotional cues and nonverbal behaviours in a face-to-face environment; thus, assessment in text-based online therapy can be negatively

impacted by the absence of audiovisual cues (Mallen et al., 2010). Accurate assessment and

diagnosis have been linked to developing successful treatment plans with clients in face-to-face

therapy (Stout, 1991). The lack of these contextual and nonverbal cues could potentially result in

miscommunication and difficulty in effectively assessing clients' concerns (Luxton 2014). Their

absence also means that counsellors must develop the therapeutic bond in a different manner

when working online (Mallen & Vogel, 2005; Mitchell & Murphy, 1998; Williams, Bambling,

King, & Abbott, 2009).

To investigate the process of online counselling, Mallen et al. (2010) recruited 54

counsellors-in-training who conducted one synchronous online session with confederate clients.

The session transcripts were coded for client-counsellor closeness, therapeutic alliance, and

diagnosis using the DSM-IV-TR. The researchers found that participants used many of the same

clinical skills that they would in a face-to-face session, with the most common being questions to

explore the clients' issues in greater depth and reassurance. Rapport-building skills such as self-

disclosure and immediacy were used more often than in face-to-face settings, perhaps to

compensate for the lack of visual cues (Mallen et al., 2010; William et al., 2009). One important

implication from both these studies is that counsellors need to explicitly indicate their

understanding of the client's emotional responses to compensate for the lack of visual cues.

Haberstroh (2009) further emphasizes the need to communicate empathetic understanding in text

form in online counselling.

The counsellors-in-training were able to provide accurate diagnoses when the symptoms

were clear; however, when the symptoms were mixed, their accuracy was much lower (Mallen et

al., 2010). The authors suggest that this is likely similar to accuracy rates in face-to-face

counselling, where it is easier to discern a single diagnosis than a more complex, comorbid

diagnosis. Additional reported problems were that information gathering was more time consuming and the amount of therapeutic work done over an hour of chat was considerably less than what is typically achieved in an hour of face-to-face or telephone counselling (Bambling, King, Reid, & Wegner, 2008). The authors discuss overcoming these problems by having the clients complete a pre-counselling questionnaire to obtain their history, problems, and goals prior to meeting the counsellor online.

Likewise, Haberstorh et al. (2008) conducted a qualitative study with counsellors-in-training (Caucasian, 4 females and 2 males, ranging from mid-20s to mid-40s) who facilitated chat-based online counselling sessions. The major themes that emerged centered on factors that impede and facilitate online counselling. For these counsellors-in-training, technical problems and technological barriers were frustrating, and the lack of visual and verbal cues limited their ability to make comprehensive assessments. Participants also raised concerns about the clinical appropriateness of online counselling because it was difficult to assess the severity of clients' concerns, as well as the pace of counselling (time lags between responses). Finally, some ethical concerns were raised about boundary issues for counsellors who worked from home.

All forms of counselling and psychotherapy have strengths and weaknesses, which were discussed at length in chapter 3. The core competencies for counselling include establishing rapport, attending, asking questions, seeking clarifications for assessment, offering interpretation and recommendation for interventions, and maintaining a therapeutic alliance (Bogo, 2006; Messer & Wamplod, 2002; Trepal, Haberstorh, Duffey, & Evans,, 2007). The integration of technology into counselling provides an opportunity to continue to think critically about counselling skills and make changes to improve the process. The online counselling modality calls for a diversified skill set that research has already begun to identify, such as using

emotional bracketing and descriptive immediacy (Murphy & Mitchell, 1998), typing quickly and accurately (Barnett, 2005), and using emoticons and changing the font, size, or color of text to denote changes in tone (Ragusea & VandeCreek, 2003). This is not an exhaustive list, but an illustration of some of the distinctiveness of online counselling.

Barak, Klein, and Proudfoot (2009) provide suggestions about buffering against the shortcomings of online therapy. For instance, those using online communication can use denser wording to describe and illustrate their concerns, use punctuation and emoticons to place emphasis in text, and intentionally verbalize emotions to avoid misunderstandings in the use of metaphor and sarcasm. Therapists should also make plans for emergency situations (e.g., high suicide risk) and clearly outline these to clients in the informed consent, prior to engaging in therapy. The authors also recommend that therapists undertake specialized training in online clinical work to better understand the unique characteristics of online therapy. A more recent study by Mishna et al. (2013) suggests that special focus and attention are needed by the counsellor to address cross-cultural challenges in cyberspace. This point was highlighted ten years ago by Jencius (2003), who suggested that online counselling courses should prioritize content that is meaningful and respectful for cross-cultural counselling.

Ethical and Educational Issues

Centore and Milacci (2008) surveyed 854 mental health professionals who used some form of distance counselling (phone, e-mail, text-based chat, and videoconferencing), about their perceptions and use of distance counselling. Across all modalities (text, phone, chat and videoconference), their most salient concern was that they perceived a decreased "ability to fulfill ethical duties." The authors did not clarify whether this perception is due to counsellors'

lack of training or confidence in their abilities, characteristics of the modality that make it difficult to take action, or the lack of legislative regulation surrounding online therapy.

There is also very little consensus about training and competency requirements for practicing online therapy. Based on the previously described studies, online therapists appear to be highly educated and well-trained practitioners. However, counsellor education programs typically provide little or no guidance in working online. Some universities have begun to offer online counselling post-graduate certificate programs and are including cybercounselling courses and internships within the curriculum (Mishna, Levine, Bogo & Van Wert, 2012; Trepal et al.,2007). Several authors indicate a need for additional training opportunities (Cardenas, Serrano, Flores, & De la Rosa, 2008; Colbow, 2013; Colon, 1996; Mishna, Tufford, Cook, & Bogo, 2013; Mitchell & Murphy, 1998) and tools to assess the competence of online counselling trainees and professionals (Fang, et al., 2013; Mishna, Tufford, Cook & Bogo, 2013).

Further, Kerka (2000) described several ethical concerns that are specific to online therapy, including potential threats to confidentiality posed by the internet, and the lack of regulations around practicing across state and national borders. The International Society for Mental Health Online (see the ISMHO White Papers) and the Canadian Counselling and Psychotherapy Association have also detailed a number of important legal and ethical issues being raised about online therapy. Stephen Behnke (as cited in Scarton, 2010), ethics director for the American Psychological Association, acknowledged the struggle of drafting policies because the field is growing and we are only beginning to understand the ethical issues the internet may raise. Benke contends that the challenge is in writing rules that allow the field to grow and develop and yet prevent patient harm at the same time.

In addition, some of the confidentiality issues that have been raised about online therapy

are directly related to Internet security. Threats to security are ever-growing and constantly evolving, as we become aware of instances of government surveillance or attempts of cyber-attacks to the National Security Agency (Conley, 2014). It becomes natural for online therapy practitioners to be concerned about maintaining the confidentiality of sessions, and their clients' counselling records and information. However, experts posit that it is possible to maintain confidentiality when communicating over the internet by using technologies like firewalls and encryption. Various encrypted e-mail programs are available such as hushmail and PrivacE-mail. Videoconferencing programs such as Vsee, Securevideo.com and counsol.com are also being used by counsellors who wish to expand their practice online. This may conceal the content of our communication but the metadata (digital finger prints) may be harder to conceal. Thus, the dynamic and evolving nature of the internet requires counsellors who practice online therapy to stay up to date with the latest developments relevant to their practice (Childress, 1998; Haberstroh, 2009; Rummell & Joyce, 2010; Shaw & Shaw, 2006).

To address the various ethical and practice issues that can arise in online therapy, several guidelines have been created by national and provincial associations to provide education and increase awareness for both practitioners and consumers of online therapy. For example, the British Columbia Association of Clinical Counsellors (BCACC, 2006, 2011), the Canadian Psychological Association (CPA, 2000), the National Board of Certified Counselors (NBCC, 1997, 2013) and the American Psychological Association (APA, 2013) have provided guidelines for online therapy.

Unfortunately, due to the cross-cultural and cross-border accessibility of online therapy, locally or even nationally-based guidelines likely fall short. For example, psychologist licensing is conducted on a state-by-state basis in the US and province-by-province in Canada. In order to

deliver care legally across state and provincial boundaries via online therapy psychologists need to be licensed and registered in all the jurisdictions in which their clients reside (Godleski et al., 2008; Rojubally, et al. 2013). The only exception being the State of Virginia, which permits licensed psychologists in Virginia to practise with clients from another state. Similar restrictive regulation exists for many registered social workers in Canada. The situation for counsellors is further complicated by the fact that, with the exception of Quebec, Ontario, and Nova Scotia, the entire profession is unregulated in Canada; that is, there is no legislation governing the practice of either face-to-face counselling or online counselling. More specifically, the counselling profession does not have any legal ruling of jurisdiction in Canada (BCACC, 2011). Thus, the current licensure and regulatory climate is not responsive or conducive to online therapy practise; the field may require international regulations to be developed in the near future, which in itself is problematic given that laws and licensures of practice are not international. The highly dynamic nature of the internet and technologies for online therapy has made it difficult to draft policies. However, the rising and innovative uses of online therapy (Bloom, 2014), have made it incumbent upon the field to update the regulations. Recently, Dr. Marshall Korenblum, a psychiatrist at the Hincks-Dellcrest Centre for Children and Families in Toronto has stated on CBC News, '...the horse has left the barn-patients want to communicate this way and I think the field has not responded quickly enough to figure out how to communicate with them and protect their confidentiality." (Bloom, 2014).

Clinical Issues

The importance of the therapeutic alliance has already been discussed and is well established in literature as an essential component of the counselling endeavour (Bedi, Cook, & Domene, 2012; Horvath & Luborsky, 1993; Wampold, 2000). However, given that online

therapy requires qualitatively different communication than face-to-face counselling, Mitchell

and Murphy (1998) have proposed some recommendations for developing therapeutic alliance in

an online space. For example, they recommend promoting presence through the use of emotional

bracketing – a technique used to describe emotions in square brackets after the comment (e.g.,

"That sounds very interesting [feeling excited for you]"). Another presence-enhancing technique

is descriptive immediacy, which is used to highlight an intense emotion and descriptive imagery

in a situation where a verbal response in not enough (e.g., " I am smiling from ear to ear after

reading about your experience of overcoming your fear and taking the train to work.[standing up

to do my victory dance for you]"). More details about emotional bracketing and descriptive

immediacy can be found in Mitchell and Murphy (1998) and Collie, Mitchell, and Murphy

(2000). Further, they assert that asking questions is an integral part of text-based therapy

(Murphy, Parnass, Mitchell, & O'Quinn, 2010). Researchers have recommended asking minimal

questions so as to facilitate flow on online therapy, specifically not asking a flood of questions

while a client is considering responses to previous questions as this may confuse clients about

the direction and focus of the session (Trepal et al, 2007; Haberstoh, 2009).

      Additionally, Haberstroh et al. found that sessions flowed seamlessly when online

counsellors shared process observations with their clients, for instance, "When you said that, I

smiled and wanted to respond right away, but took some extra time to really appreciate your

growth in this area" (2008, p.12). Furthermore, when counsellors report information about their

nonverbal and physical reactions (e.g., the smile described above) in an online session or while

reading clients' e-mails, it can help generate the "here and now" focus, create a therapeutic

dialogue, and provide a sense of validation for the clients (Haberstroh, 2009).

      Reviewing the limited number of studies that specifically examine the counsellor's

experience of engaging in online therapy provides information about the skills that are necessary, and highlights the importance of adapting ethical guidelines. However, what remains missing from the literature is the individual voices of how online therapists develop and maintain a therapeutic alliance over the internet, how they practice to connect with, and assist clients from a distance, and how they address the ethical and legal complexities of practicing in this modality.

The Current Study

Given the many gaps in our understanding of online therapy processes, the present study aims to supplement the modest literature base (Haberstroh, Duffey, Evans, Gee & Trepal, 2007; Mann-Layne & Hosenhil, 2005) by qualitatively examining the perceptions and experiences of counsellors who have engaged in therapeutic relationships online. The present study is a multiple case narrative inquiry, comprising the same social constructionist epistemology and methodology as the previous study (see Chapter 3).

According to Marvasti (2011), the narrator's truth cannot be separated from the social context, nor can the researcher's truth be separated from the analysis. Narrative is considered a core psychological and social process as well as a concept that can help to examine the relations among experience, meaning, social structures, and culture (e.g. Mishler, 1986; Polkinghorne, 1988; Sarbin, 1986). A central component of narrative research is human interaction and experience, which is also the core of therapy and seems appropriate for elucidating narratives from therapists. Based on this, my research will draw from therapists' individual narratives about their experiences with online therapy to answer three key questions:

(1) How do therapists negotiate the therapeutic relationship in online therapy?

(2) How do therapists use their clinical skills to engage and assess clients online?

(3) What ethical guidelines do they follow?

Method

Participants.

I recruited four therapists for this study. A sample size of four participants is appropriate for an in-depth exploration of a phenomenon using narrative approaches (Creswell, 2006, Mason 2010, Morse, 2000). All participants had a minimum of a master's degree in counselling or a related profession, engaged in training or self-learning specifically in how to conduct online therapy, were capable of communicating primarily in the English language, and had engaged in individual videoconferencing or text-based (e-mail or chat) online therapy in the previous twelve months. Additional information about the participants is presented below, in the "Counsellor Profiles" section. Each participant was offered an honorarium of a $30 gift certificate for their time.

Recruitment.

Participants were recruited through two approaches: Purposeful sampling, by posting announcements on professional counselling association websites and e-mail lists (i.e., BCACC, NBCC, LinkedIn online therapy forum, Therapy Online) and snowball sampling; that is, by asking online therapy counsellors to refer potential participants to the study. Utilizing purposeful sampling allowed me to gain access to target individuals who met the criteria to be included in the sample and snowball sampling provided access to information-rich participants within the specialized context of online therapy.

Phase one of the recruitment process consisted of providing information, and addressing consent with potential participants. Upon being contacted by interested participants, I sent an electronic package to invite them to participate. The package included pertinent information about the study and a consent form. I determined that they met the criteria via e-mail

conversations (See Appendix C). In phase 2 of recruitment, I contacted the clients via email within a week of sending the initial information package, to verify they met the inclusion criteria and to provide an opportunity for the potential participants to ask questions about the purpose, procedures, and representation of the findings and to receive clarification about the study. Within two weeks of beginning recruitment, ten counsellors had responded. Three dropped out due to a busy schedule, two were involved with online group therapy but not individual counselling, and two counsellors did not meet the minimum level of education for participation. I interviewed the remaining three participants in the Fall of 2012. Given that two of the three participants had relatively similar background characteristics and experiences with online counselling, I recruited one additional participant who was interviewed in the Spring of 2013.

     Data collection.

     Data collection began immediately after the participants submitted their signed informed consent via digital signatures or scanned copy and demographic questionnaire as an attachment to the e-mail exchange. Specifically, I scheduled interviews approximately one week after receiving the signed consent forms. I conducted individual open-ended online interviews via videoconferencing (Skype) as my primary form of data collection. At the start of each interview, the study was reintroduced, the letter of consent was revisited, and any questions that the participants had were answered so that they felt comfortable sharing their stories. I then invited the participants to share their stories about online therapy, to which I attended and actively listened. The interviews were semi-structured, and I used prompts (e.g., tell me more? Can you elaborate?) and question asking to encourage them to reflect on their experiences and the emotions they felt. See Appendix I for the semi-structured interview questions. Every participant agreed to be audio recorded via Skype videoconferencing.

The co-construction of the narrative began at the time of the interview process as participants responded to and shared their experiences with the researcher. Morse and Richard (2002) posit that constructing data is an ongoing collaborative process in which data are interactively negotiated by the researcher and participants; the data are rarely fixed, and never completely replicating what is being studied.   I took up the role of the narrator of the stories discussed. "The narrative researcher takes up a dual consciousness — performing the story as narrator and reflecting on the story being told as researcher, continually moving between these and other subjectivities as the conversation unfolds" (Arvay, 2003 p. 166). Knowing that the researcher's story is intrinsic to narrative research, the process of examining my position and privilege as researcher was an important part of this study. Recognizing the dangers inherent in making the researcher's voice too central and dominant (Etherington, 2004; Trahar, 2011), I actively engaged in using reflexivity. As recommended by Fraser (2004), I kept a research journal for writing and documenting doubts and responses and by checking in with my participants about their experiences during and after the interview process. The data from the research journal is not included in the analysis but guided me in addressing the power dynamics between my roles as researcher and co-constructed the narrative.

Data analysis.

The interview data were kept on a secure flash drive in a locked cabinet when not in use. I chose pseudonyms and removed other identifiers such as workplace names to protect confidentiality. Three of the four interviews were transcribed professionally and I transcribed the final interview conducted in 2013. In discussing the confusing variety of meanings attached to the term *narrative research*, Etherington (2004) acknowledges that there is no one 'right way', but suggests, 'what does seem important is that I describe what it means to me (at this point in

time) and the assumptions upon which my ideas and practices are based' (p.71). Thus, I read, interpreted, and analyzed the data using a combination of the narrative collaborative method (Arvay, 2003), as well as narrative data analysis of personal stories approach by Fraser (2004). This comprised five phases:

Phase one: The first step in analysis was multiple reading and interpretation of the transcript on four levels, as outlined by Arvay (2003): reading for content; reading for the self of the narrator, paying attention to who is telling the story; reading for the relevance to the research question; and critically reading for relations of power and culture. After reading the transcripts, I started the writing process and created a preliminary individual narrative from each participant's interview, resulting in four individual narratives.

Phase two: Each participant was then invited to review, edit, and make changes to my preliminary narrative description of their individual experience. This process of member-checking provided an opportunity for the participants to verify the accuracy of the data and provide clarification and additional information. It was conducted asynchronously, by email. In addition to sending the narrative to participants, I asked them to answer the following questions: Does this resonate with me? Is it comprehensive? Is it believable? I allowed the participants full control in how they wanted the final data to be presented in tone and content. All participants took an active role in editing the document for grammar and tone. One of the participants removed a statement related to types of clothing that can be worn when counselling online, and another participant expressed concern over the number of times the participant used the word "like" in the quoted sentences. "I really sound like I am from [location removed to maintain participant anonymity]!" Another participant removed all the "ums" and "hmms" because it seemed to distract from the story. The minor changes and clarifications that participants made to

the transcripts did not substantively change the content of the interviews. The transcript review

and release process was very important to balance the power relationships and signify that

ownership of the narratives belonged to the participants.

Phase three: In phase three, I conducted a cross-narrative thematic analysis to identify

patterns and themes that were common among the participant stories. I used constant comparison

across narratives to develop groupings in similar concepts of participants' perspectives. The

thematic analysis for this study was guided by the methodology of Braun and Clarke (2006),

which involves six stages: 1) read/reread data to become familiar with it; 2) Identify broader

themes; 3) Review the themes; 4) Evaluate the themes; 5) Name the themes, and 6) Weave

themes together to develop the findings. It should be noted that the six stages do not represent a

linear process, but rather a recursive process of moving back and forth across the stages as

needed. Additionally, there was considerable overlap between the narrative analysis process

(phase one) and the *stage one* for the phase three thematic analysis, as both begin with becoming

familiar with the data, transcription, and reading and re-reading of the text. Particular ideas

began to stand out and I started generating a list soon after the final narratives were released by

the participants.

Stage 2 of phase three involved placing the codes into broader categories or themes. The

process involved evaluating whether enough codes were present to support a theme. Stages three

to five (reviewing the themes, evaluating the themes, and naming the themes) occurred

simultaneously and involved back and forth within the data to ensure that the themes were

represented in all the narratives. At this point I discussed my decision to include or exclude

certain themes with my research advisor, and chose to include a theme that was present in only

one participant's narrative but seemed like an important finding that had relevance in the

literature. Themes represented here were in keeping with the principle that a theme should "capture something important in relation to the overall research question" (Braun & Clark, 2006, p. 82). The final stage, stage six, entailed the writing process, weaving together the themes from the narratives to represent the findings. The cross-narrative thematic analysis yielded eight themes that support findings in the current literature and provide depth in understanding the concepts outlined by the individual unique experiences of the online therapists.

Phase four: Following the completion of Phase three, my preliminary findings were reviewed by peers. The peer reviewers consisted of an assistant professor and a graduate student with experience in qualitative research and thematic analysis. We reviewed the data for accuracy (to verify whether codes were categorized in the appropriate themes), verisimilitude (trustworthiness of what is being shared), and pragmatic value (practical use in the field). This review process was a collaborative, reflexive discussion between myself as researcher and my peer reviewers to explore the meaning of the interpretation, as well as the sharing of the final narrative. The discussion helped synthesize the findings and no concerns were reported.

Validation process.

To increase the trustworthiness of the research process, I employed the following criteria recommended by Tracy (2010):

Worthy Topic: Online therapy research is timely and relevant in the digital age, given the potential to reach a diverse population. It is significant because the current development of the practice is ahead of the research and this study addresses the lag by providing an in-depth analysis of the nuances of online therapy.

Authenticity: I practiced self-reflexivity and transparency throughout the research by recording in a research journal questions, ideas, and assumptions as they arose. The contents of

the journal are not included in the data, but helped me, as the researcher, to stop and ask the questions of "Whose voice is this? And what is the purpose of it?" I also consulted with peer reviewers, my research supervisor, and dissertation committee members from the beginning of the recruitment process through data analysis so as to maintain accuracy and rigour.

Credibility: Thick descriptions and specific details are included within the final narratives (see Appendix J). The co-constructed nature of the narrative research approach calls for a revision and consultation with the participants over the written narrative (Connelly & Clandinin, 1990). This was established through member checking. Triangulation (Stake, 1995) was achieved through cross-narrative analysis, as it consults multiple participants' perspectives in regards to the research questions.

Consensual validation: Consensual validation was achieved by asking peers to review the results of the analysis. More specifically, two researchers who were not otherwise involved in the study reviewed the narratives for persuasiveness (how plausible and convincing the narratives are), coherence (evidence of thick descriptions that are understandable), resonance (how the experiences relate to their own clinical practice), and pragmatic usefulness (how can the findings be used in the field and for practice?).

Researcher subjectivity.

As noted earlier, the role of the narrative researcher is of a co-creator and collaborator (Larsson & Sjöblom, 2010). As such, the story that is constructed in the research is a product of the dialogic exchange between the participant and researcher (Riessman, 2002, 2003). I have maintained a reflexive journal in order to help clarify and hone my research aims and questions, as well as to diminish the impact of my biases on the participant selection and data analysis process. I shared questions and concerns from the journal with my supervisor and I have

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continually engaged with my supervisor and committee members in dialogue to hone the research. The contents of the journal are not included in the data, but helped me, as the researcher, to stop and ask the questions of "Whose voice is this? And what is the purpose of it?" To restate the procedures from Study 1, the steps taken to address biases included consultation and dialogue with my supervisor and committee members. I acknowledged my role as a co-constructor of the narratives but sought to honor the voice of my participants. Thus, I included direct quotes from participants' narrative writing along with my summarized interpretation of the narrative.

The co-creation process of narrative research makes it important to reveal my own relationship with the phenomenon, so the reader can independently assess the degree to which my own experiences have informed the findings. To elaborate on the detailed self-description that I provided in the previous chapter, I am a practicing certified counsellor with 12 years of experience providing services internationally and in various academic, health care and agency settings. Additionally, I have training and experience as an online therapist and have spent the past seven years studying and practicing online therapy. Prior to beginning this research, my perspective on the use of online therapy was one of curiosity; I was approached by clients who wanted this service and I prepared myself to offer it with the best of my abilities but still felt guarded as online therapy had not gained widespread acceptance within the field. Thus, my research was fuelled with the desire to uncover what was taking place at the micro level with individuals who have adopted online therapy within their practice.

Counsellor profiles.

This section provides an introduction to the four counsellors who agreed to share their stories in this study. In agreement with the participants, I have used pseudonyms and removed

other identifying information to maintain their confidentiality. All four therapists who took part

in the study were of Caucasian ethnicity. They were between the ages of 53 to 73 (M = 62.5).

Three of the counsellors were based in Canada and one in the United States. Three had master's

degrees and one held a doctorate. Their clinical experience ranged from 18 to 33 years in

practice (M= 27 years), and their online therapy experience ranged from 4 to 10 years (M= 8

years). All the participants had experience with conducting psychotherapy in face-to-face

settings before they began working online, and their current practices were not exclusively

online. Their full narratives can be found in appendix (J). The table below provides

demographic information for the four participants.

Table 2. Counsellors' Demographic Information

Participant	Ethnicity	Age	Gender	Educ.	Employ.	Years of practise	Years of online practise	Preferred Modality	Time spent online
Ben	C	64	M	G	F	18	9	Text, IM	2hrs
Francine	C	53	F	G	P	27	9	IM, E-mail, & Video	8hrs
John	C	73	M	D	P	33	4	Video	3hrs
Carl	C	60	M	G	F	30	10	E-mail	8hrs

Note: Ethnicity C = Caucasian; Gender M= Male, F= Female; Education G=Graduate degree,
D= Doctorate; Employment F=full-time, P=part-time

Ben's profile.

Ben has a master's degree and has been a mental health clinician in the United States for

over 15 years. He began online therapy to supplement his monthly income. He had initially

intended to build a mental health site to provide information for people. However, once he

started looking into online therapy, he felt that having a practice online was a better fit for him.

He has been an online therapist for over six years and uses a combination of e-mail and text-

based chat for therapy. Ben views online therapy as another point on the continuum of services

available to individuals. His therapeutic approach is primarily mindfulness-based cognitive

behavioural therapy. He has worked with clients from around the world. Half of his client-base is

high functioning individuals who work in high-level positions within international organizations

such as the UN or re-settlement programs around the world. The other half are US-based clients

who find him online because the like what they have read about his work.

Francine's profile.

Francine has a master's degree and was a practicing counsellor for over 15 years when

her work motivated her to explore the intersection of technology and helping work. She sought

specific training in online counselling, completed two levels of training in 2005, and began

practicing online the following year. She is an affiliate counsellor with a major provider of online

therapy services. She offers a combination of videoconferencing and e-mail counselling. Her

approach draws from a variety of approaches and resources, including CBT, clinical intervention

resources from Australia, and mindfulness. She has clients in Canada and in other countries, but

has chosen not to work with clients in the US because of legal issues. At the time that we spoke,

she suspected she would also discontinue working with clients in Quebec, Ontario and the

Maritimes due to uncertainty with the legality as counselling has become regulated in those

jurisdictions.

John's profile.

John has a doctorate and is a semi-retired therapist in his 70's who enjoys working with

clients and keeping his counselling skills sharp by offering sex therapy and sex therapy training online. After a colleague introduced him to Skype four years ago, he decided that practicing online was far preferable to his monthly commute into a major urban centre to offer specialized therapy on behalf of his colleagues. He has taught himself how to use the video software and has not received any specific training in online therapy. He has since been practicing exclusively through Skype. According to him, he likes working via Skype because far more people are able to access his specialized services around the world, regardless of geographic or cultural constraints. Among other approaches John uses the Kinsey interview method. Though most his clients are from North America, he continues to work with clients from around the globe, in countries such as Saudi Arabia.

Carl's profile.

Carl has a master's degree and is a social worker who has been in the field for over twenty years. He began offering online therapy in 2003, and did so for two years prior to seeking formal training in using this modality. He completed the training and started his own fulltime practice, offering most of his sessions online via e-mail. He now oversees the clinical management for the e-counselling program offered by his employee and family assistance program (EFAP) organization. He also teaches online therapy through a training institute. Carl has primarily worked via e-mail, but has been exposed to chat in his clinical role with EFAP. His work draws from a variety of sources and exercises, including CBT, narrative therapy, and behaviour tracking. He has worked with clients all over the world, but says the majority of them have been in Canada and the US. However, more recently, he has decided to stop working with clients in other geographical areas as there are too many unknown when it comes to handling

emergency situations, data security, and being knowledgeable about the local resources and referrals in the client's geographic location.

Findings

The final interpretive phase of the analysis is the interpretation of the findings; as Lincoln and Guba (1985) stated it is the 'lesson learned' from the case. The analysis process revealed eight major themes: convenience, therapeutic alliance, online counselling skills, assessing client suitability, reaching diverse clients, assessing client satisfaction, legal and ethical concerns: client identity, privacy and confidentiality, and, personal and professional goals. Three of the narratives shared 100% of the themes. One individual narrative (John) did not consist of two themes (online counselling skills and assessing client suitability). Findings also suggest that the various mediums of communication (e-mail, chat, and audiovisual) offer considerably different benefits and challenges for conducting online therapy.

Convenience.

One of the major draws to online therapy noted by all participants is the convenience and ease of being able to work from wherever they are located. Other forms of convenience that participants described include time, as many counsellors' experienced working with busy professionals who did not seem to have time to attend therapy during 'business hours.' Further, the convenience of asynchronous e-mail communication that provides time for reflection and responding at one's own pace was also identified as a benefit. For the therapists, the relatively easy and inexpensive set-up made online therapy appealing and convenient.

John: I had a client once who was sitting in his car outside an office building, connected

through the wifi in the office and Skyping with me. I have an appointment today at 9:30

pm - that's a working single mom who said, "Can I talk to you after I put my kids to

bed?" There was no way she could fit in an in-office appointment like this. Now, in [city name omitted for confidentiality reasons], the traffic's horrible, you don't want to get out and drive to the therapist's office. The convenience of being able to do it from home, it is just great. I don't want to go out and drive there.

Francine: I have noted that the people I have been working with were extraordinarily busy professionals. And they just had no time. It seemed like that was part of the reason they needed counseling. They need time management, stress management. The amount of time involved in getting to a therapist's office, meeting with them face-to-face, and then getting home involved making adjustments and taking time out of their busy work day during the hours that a therapist would be able to accommodate them in an office. However, with online therapy they could sit down at night and just do this, and then go to bed. I think it's the element of they can do it whenever it works for them. I think that is the majority of the people. Some of my clients who do videoconferencing have said to me, "It's just so nice to be able to do it from my home at a time that mutually works. So then I don't have to travel to your office and then travel back home."

Therapeutic alliance.

Participants in this study revealed several characteristics of online therapy that can facilitate therapeutic alliance. For example, the lack of physical contact with the therapist can act as a catalyst in bringing out the issues that a client may not bring up for several sessions in a face-to-face environment. Francine describes this phenomenon in her narrative:

Francine: For some people, they seem to be able to really tell me really deep things very quickly, than normally you'd be getting it face-to-face so. . . Just this past spring, I had a man I that was working with who, the first time we had a session, he was a little hesitant

telling me about sexual difficulties, (which is also an issue that sometimes I'm dealing with in an online environment). Because it's more comfortable for men or women, I find, to talk in that kind of more anonymous environment, and so then it's, "Ok, I'm telling a complete stranger all these things about myself that are very intimate." And I can sense those shifts in terms of how they write, or how they address me back. And I can see immediately after seeing that kind of nervous, "Ok, I just told this person all these things," and the response they got from me, they can feel like, "Oh, oh, it's ok, oh, it's not something terribly wrong with me, they can help, there are things that we can do, there are some ways that this can be resolved. There's some practical information that I'm getting, and so I feel this can help me even more," about what's going on in his life and how he feels, so there's those.

Further, the pace at which sessions are scheduled or e-mails are exchanged can expedite the therapeutic relationship. Clients and counselors can start working towards a collaborative goal from the get-go. Some participants also perceived text-based online counselling (i.e. the ability to re-read, take time to reflect an edit responses), as having an advantage over working in a face-to-face context, at least for some people.

Francine: The Rogerian approach of, "Ok, I'm not judging you for what you're telling me and I'm accepting you for who you are," goes a long way to developing that trust really fast. And I think that with the writing makes it stick longer, because in your office, I can walk away and I can go, "Oh, that person was really not judgmental," but in online therapy, I can read their words over again and say, "Oh, look, see. That person is saying something or they've noticed something about me." It seems to have a stronger impact

for some people. I don't know if it does for everybody, but it seems to stick, I'm not going to forget this, because you've written it down.

Online counselling skills.

According to the participants, the competency required for online counselling is not simply an extension of foundational counselling skills such as active listening, empathy, and building rapport. Although these are important, they have to be expressed in different ways in an online environment. Moreover, there are further distinctions, depending on the kind of online environment. For example, a text-only modality offers the benefits of reflection and editing, whereas audio-only allows for more focused attention to the spoken words, the silences, the subtle changes in tone and breathing. Although videoconferencing with software like Skype does allow for both the audio and visual, the visual is usually only from the neck up. During a session, the client could be tapping their foot or picking at their fingernails (body language that would indicate they are feeling annoyed/anxious), and yet they might verbalize something different (e.g., "Oh that doesn't bother me.") and the online counsellor would miss the discrepancy because the feet and hands are not visible. Thus, online therapists are attuned to the slightest change in client's presentation and will use questions to clarify what is going on for the client in the moment. The participants describe their skills in this regard:

Carl: The asynchronous, or the e-mail type of platform allows the counselor and the client time to think about what they want to write, to really process it, to really create it, and then to deliver it, whereas with chat, it's spontaneous, it's live. In a way, it's like being with a client in a room. Of course, you're not with them in the room, but you have to think on your feet, you have to think quickly, and in that sense, with the audio and the visual, you can't worry too much about how your text is looking. You don't want it to

look scrambled; but on the other hand, you can't put the kind of attention that you would

when creating a carefully scripted e-mail exchange. There's a big difference there.

Ben here further elaborates on the skills that enable him to perform many of the same

mindfulness and relaxation exercises that he would face-to-face.

> Ben: It is different — you use different muscles. There are some things that are more
>
> difficult to do online. Believe it or not I do visualizations and relaxation exercises online,
>
> even the empty chair. But it is a bit trickier than doing it face-to-face. There are certainly
>
> some techniques that work well in person and are more difficult to do online. I have
>
> already written passages that I can cut and paste. There are some shorter, more
>
> spontaneous visualizations and metaphors. And then at times I will say let me cut and
>
> paste something. Let me tell you the story about the girl and the umbrella and then I will
>
> cut and paste the 6-7 paragraphs and then we will talk about it. I have been amazed at
>
> what you can do online. I was skeptical like everyone. It is not perfect but I don't
>
> necessarily think one is better than the other. I think it comes down to who the person is
>
> and what they need. It works for different people, just another point on the continuum of
>
> services available.

Further, the ability to decipher the meaning within the typed words calls for special attention and

being attuned to the client. Also not being afraid to ask for clarification so as not to misinterpret

the client is important. Carl illustrates this process in his narrative:

> Carl: I'm talking in terms of the asynchronous (text only) format right now, we check it
>
> out. If somebody writes something that is hard to understand, what they're actually
>
> saying and we don't want to misinterpret. We write back and say, "I need to check
>
> something out with you. When you wrote this, did you mean this, or did you mean

something else?" The language, the way they use it, sure, we're going to be a little bit more challenged in these conditions, because we're relying totally on the written word in this type of modality of service.

Further, trying to create a presence can be challenging for the counsellor. The distance anxiety of not being able to reach the client can be based on the counsellor's performance anxiety as well as concerns about being able to fulfill their ethical duties, as described in Francine's narrative:

Francine: Once this woman said to me, "I was wondering what I'm going to do when I start crying, when I'm on Skype." And then shortly after that she said something , or I asked her a question and she just burst into tears. It was a very intimate moment still, even though we were on camera, even though she's not in the room with me, so I can't convey to her as much as I would if the person was in the room. You know, "I really hear you," or "I'm here." I had to make little noises to indicate the connection hadn't gone dead on her. And at the end, she was like, "Wow, I didn't expect to do that and that was actually ok, and I feel just as heard as if I'd been in a therapist's office having this tearful moment, or expressing this hurt".

Assessing client suitability.

The counsellors' narratives revealed that online therapy is not a replacement for face-to-face therapy but offers an alternate choice in treatment. At the same time, online counselling is not for everyone. A certain group of individuals will self-select to use this service, based on their preferences. However, the participants recommended assessing clients early on to ensure that the clients will benefit from online therapy and that risks can be minimized as counsellors are physically at a distance, can potentially work in different time zones and, as a result, may not always be available if the client has immediate needs.

Carl: When it comes to assessing client suitability, there is a screening questionnaire that I have them complete, and some of the questions deal very specifically with risk issues. I say on my website, when people are just reading about me and about cybercounseling, that it's not for everyone. And I explain the situations where it wouldn't be appropriate. I talk specifically about clients who may be suicidal, or in psychiatric crisis. I tell them upfront that, if you go into crisis and you send me an e-mail that you're in crisis, I can't actually physically get that e-mail right away. It may take a few days depending on when I access my e-mails, and what I do with them. They need to understand that there isn't the immediate kind of action available if they need it. We can prepare them for that; we can explain it. We can have it on our websites; we can have them sign a consent. So we do our due diligence, and then hope that, if they do go into crisis, they will follow some of what we had suggested. They can try to call us, perhaps, or call 9-1-1. Or get through to an emergency department. All of the things we would tell a client when we're actually working with them, on a phone, for example. So I think we have to be very thorough, anyone setting up a practice online, in thinking this through, in thinking about who they are, in terms of the practitioner, whether they have any kind of backup if they're not immediately available, all of these things. I've never experienced someone calling me because they were in crisis, it hasn't happened yet.

Therapists who may be starting to work online may take on more than their capacity to practise if they do not carefully screen clients for suitability. Ben shares his personal experience in coming to the realization that assessing client suitability for the modality of online counselling is important for evaluating if the online counsellor is able to help the client meet their counseling goals:

Ben: In online therapy I am very didactic, I see myself as a coach and teacher more than a psychotherapist just because of my approach. One of the most important aspects of engaging in online therapy is to assess client suitability. I remember when I first began my online practice and was desperate for clients like any new therapist in private practice. I soon realized I didn't want to be in this situation and having to deal with someone who is unstable, needs to be in an intensive out-patient program (IOP) or partial hospitalization. That is when I think the lack of non-verbals can really hurt because when you are working with someone who cannot regulate their emotions you can't really be on top of everything. To assess client suitability, I have them fill out two questionnaires for intake prior to even considering taking them on as clients. If they have information missing I will tell them we can't work together. The intake forms can be very comprehensive from collecting history, family, and current life functioning information to assessing substance use and suicidality. I am looking to ensure that people are stable for online therapy.

Reaching diverse clients.

Online therapy provides a means of reaching diverse people due to the convenience, accessibility and perceived privacy. It is particularly appealing to those clients who would otherwise not have access, such as those living in rural communities where a clinician is not available locally, or who are located in a country such as Saudi Arabia where it may be difficult to find specialized services, such as sex therapy. It is also appealing to someone who lives in an urban setting but has a heightened sense of anxiety related to the stigma associated with seeing a counsellor (for example being worried about coworkers, neighbours, or community members seeing them access mental health services).

Ben: There are also people who would be too embarrassed to access mental health

services locally and for those people if they didn't access online counselling there would

probably never get help.

Francine: Clients have shared that they are really glad they're doing it this way because

they may be too embarrassed or ashamed to face someone in person. Or they live in such

a small town that there are too many other elements of concern for them. And one woman

did actually say, 'I'm just glad you can't see me because I'm so ashamed of how I look.'

But she was able to start to move through that to, 'Oh, counseling might be ok.' Because

she was so afraid of judgment, online counselling seemed to be able to move her into a

place where she might actually be able to walk into an office and talk to a person in

regards to the self-esteem and body image concerns.

Several participants elaborated on the experience of working with diverse and geographically

distant clients as positive experience.

John: Also, I'm able to reach people who before did not have access to these services and

now because of technology they do. Something really interesting is that I'm from a

Jewish background, and for the first time last week, I saw a client from Saudi Arabia.

What are the chances of that happening without Skype?

Ben describes the value in online therapy for clients who travel for work or are posted in rural

locations such as in the military.

Ben: I have worked with clients from Korea, China, Africa, Europe and the Middle East.

Most people I work with are functioning professionals. It is usually English speaking

people who cannot find the mental health help they need locally because they are either

in a foreign country or they don't feel comfortable with the services available locally, so

they come online and find me and like what they see when they read about me on my website. …I have had some clients who travel a lot whether working for the military or the UN, moving from one state to another so they have continuity of care with me. Some of my clients just like to have a therapist who can be easily accessible and they can talk things out with.

Assessing client satisfaction.

In applying therapeutic skills online, counsellors are mindful of the technical challenges that they will encounter. Online therapy is one option now available to the client. The previous chapter has illustrated the client experience of online therapy. Some of the ways that counsellors decipher whether the client is satisfied include when they book a second appointment and when they provide feedback about the service and convenience.

John: When measuring success, I think what is really telling is when a client makes the second appointment. It indicated to me that they've been comfortable with the technology, and there's therapeutic alliance, there's a relationship that they want to come back and have a second session. To me, that's what success is.

Ben: The client feedback has generally been very good. A client once said to me this is the coolest thing, "I am here on a Sunday morning in my pajamas getting therapy." My clients have thanked me. When people go out and look for help there are many choices and this just happens to be one of them. For the right person, online therapy can be the perfect choice.

Another important concern is comfort with the computer hardware and keyboarding skills. Counsellors have to be comfortable with the modality and some participants also posited

that the client who can benefit more from online therapy is also skilled at using the ICTs. Carl

illustrates this in the following statement:

> Carl: I think what distinguishes those who really can use it to the optimum, are people
>
> who are good writers, people who have the ability or the inclination to be reflective, to
>
> think, as opposed to spontaneously venting. There's a certain kind of person, who,
>
> ideally, can benefit, much more so than the average user. If someone is having trouble
>
> typing on a keyboard, then what you end up getting is a scrambled conversation that you
>
> have to decipher, try to make sense of all the spelling errors, people who write one huge
>
> paragraph without any sort of spacing, and you have to go through and if you were to
>
> print it, pages and pages of this long paragraph of words that run onto each other. It
>
> makes it much more difficult for the counselor. The client might be venting. They're just
>
> typing away everything that's on their mind. Thus a person who's a bit savvier around
>
> computers, more articulate, will likely get more out of it.

Legal and ethical issues.

The legal and ethical ramifications of online therapy have been deliberated on in the

literature and at conferences. Participants have expressed concern around the legal and ethical

issues but have resorted to self-regulation and making up their own rules to protect themselves

and their clients. The following are examples of how these participants had to develop their own

guidelines for conducting themselves online:

> Carl: even though I would say online counseling's been around for 10 or 15 years.
>
> There's still such uncharted territory. So the bigger issues, the screening issues, tend to be
>
> more the safety issues, and I have some age restrictions. I have chosen not to work with
>
> teenagers. I've actually chosen not to work with citizens of the United States, and that's

primarily because of so much uncertainty about the legality of cross border counseling.

And as I teach it and talk about it a lot in our work in the classroom because of my

involvement with other clinicians over time, working in a different country, I just made

the decision for now to not work with clients in the U.S.

Ben: I don't worry too much about the law regulating online therapy. It is a grey area.

Lots of people have their opinions about online therapy. There are no court cases that I

have heard of and basically my way of dealing with all they unknown grey areas is

making sure my clients are happy. So if it not worth their time or money I am happy to

return their fees. This only happened one time. If the client is not satisfied with the

treatment I gladly refund their fees.

The participants describe their concerns with issues of legal and ethical responsibility,

and resultant ambivalence about certain aspects of practice. From these concerns two sub-themes

were identified: client identity and privacy and confidentiality.

Client identity.

Client identity is a concern online as some clients may try to maintain their anonymity

by using aliases or resorting only to text communication and avoiding visual contact. It is

possible for individuals to forge names and aliases to access online counselling. It is also

possible for individuals to conceal their age when it comes to giving consent for counselling.

Thus the issue of client identity is frequently questioned in the literature. The counsellors in this

study take special care and precaution when it comes to working with clients online, they ask for

information such as full names and addresses as they try to gain some assurance the clients are

you they say they are. Some choose not to work with anonymous clients in their private

practices.

Carl: We need to make sure that when they register, we have proper contact information. Could someone be masquerading as someone else? And it's an interesting question. We could argue that when people come to see us, they could be saying that they're John Smith, when in fact, they're not John Smith. They're someone else. We gather information. We get a phone number, an address, but do we know in that moment that what they're telling us is accurate? But isn't this also true of in-person counselling? There are a lot of questions that anyone going into practice online need to be aware of. Screening, registration, ensuring as best as we can proper identity, providing a secure – I would add encrypted – way in which to communicate with our clients, is critical.

Ben: Anonymity is important in online therapy, however, ethically I will not take on someone without their full name, number and address, should something happen and I need to follow up off line. I find even with all the identifying information the lack of physical presence makes people open up fairly quickly.

Privacy and confidentiality.

Privacy and confidentiality are central tenets to counselling that are continuously questioned in current and emerging literature pertaining to online therapy. The concept of confidentiality is central to therapy and something that counsellors grapple with both online and in person.

Ben: No one has ever really asked much about the confidentiality or had privacy concerns. Most people find my website and read the confidentiality statement before we begin therapy. However, recently I had a client from Saudi Arabia, and I don't know if it is a cultural thing, but he wrote nothing about his childhood in the intake forms. So I insisted he write me something about his childhood and he told me that he would not

send it through e-mail but would send it through Skype, which he felt was safer. And he

said that as soon as I had read it I would have to delete it. Now I have never had that

happen to me before. But he was very concerned about the privacy. And I asked him is

this part of the culture worried about people getting into your information or is this about

you. But I never really got a clear answer. But other than that incident, clients never even

ask about the confidentiality. The reality is that people can hear through the walls where I

worked, phones can be tapped, and medical files can be stolen. I don't perceive the online

risk as being any different. I tell clients in the (intake) questionnaire that they do not need

to write identifying data on the forms; they can supply their names and addresses

separately so the questionnaire wouldn't have any identifying information if someone got

a hold of it. Clients seemed more concerned about confidentiality at my workplace than

online. Clients worry about their medical and mental health records in the hospital and

how safe those records are.

Counsellor's professional and personal goals.

Internet technologies have opened up a new horizon for counsellors. They are no longer

limited in their practice to geographic locations or traditional office hours. Further, the

convenience and flexibility afforded by online therapy may lead to more counsellor career

satisfaction as they can work as much or as little as they wish, continue to practice beyond

retirement; potentially travel and consider moving for career/family without losing their client

base and having to rebuild a practice. The online therapy practice is not bound to a political

boundary, office location, or referral source.

Ben: My goal in two years is to buy an RV and have satellite internet so I can provide

online therapy from wherever I may be. I got into online therapy when the incentive

program at work ended to supplement my income but it really is also my retirement program. As a therapist on the road, then I just have to keep my time zones straight. I have some clients now that are 13 hours ahead to 3 hours behind.

John: I'm content with how I'm working. I choose to work less. I'm retired. I work when I want to and that's how I want to keep it.

Discussion

Numerous issues with online therapy modalities have been identified and critiqued in the literature, from the effects of the loss of micro-cues to the legal implications regarding the delivery of services. Despite such criticisms, computer-assisted technologies, including online therapy, have flourished (Colbow, 2012; Hanley, 2009; Norcross, Hedges, & Prochaska, 2002; Richards & Vigano, 2013; Rochlen, et al., 2014). The narratives of online therapists provide us with depth and nuances of how these individuals have engaged with their clients; how they self-regulate in the absence of legal guidelines; how they assess clients and plan for crises or technological glitches, and how online therapy has become part of their long-term career goals and retirement plans.

In relation to previous research, the findings in the current study illuminate the experiences of online counsellors who use their clinical skills to assess and assist clients over the internet. The individual narratives described and analyzed here may help dispel the image of hapless quacks offering incompetent help online, as portrayed in popular shows such as "Web Therapy" (L Studio, 2014). Data from the current study suggests that convenience is a major benefit for counsellors and they perceive it to be so for clients as well. Indeed, convenience has been cited as one of the major benefits in online therapy literature (Chester & Glass, 2006; Mishna et. al., 2013; Richards & Vigano, 2013; Richardson, 2009; Richardson & Tangney, 2008;

Sucala et al., 2012). In the narratives, the counsellors' specific descriptions of the conveniences of online therapy included being able to provide therapy from the comfort of their own homes, being able to work without travelling, and being able to offer flexible hours by working on weekends and later in the evening in order to accommodate their clients.

The findings from this study also revealed that, from the counsellor's perspective, therapeutic alliance can be developed online. Moreover, the findings from this study also suggest that therapeutic alliance can be developed in multiple online contexts, such as videoconferencing, as well as text-based chat and email. One of the concerns cited in the existing online therapy literature has been whether a therapeutic alliance can be established between a client and therapist in the absence of nonverbal cues (Cook & Doyle; Leibert et al., 2006). This study, in combination with other emerging literature, reveals that therapeutic alliance can be developed in synchronous online contexts (Hanley, 2012; Knaevelsrud & Maercker, 2007), e-mail therapy (Cook & Doyle, 2002; Dunn, 2012), as well as videoconferencing (Backhaus et al., 2012; Stefan & David, 2013). Research has also begun to examine the therapeutic alliance in online therapy and found the quality to be similar to face-to-face counselling (Anderson et al., 2012; Hanley & Reynolds, 2009, Hanley 2012; Reynolds et al, 2013). Further, Murphy et al., 2009 also found client satisfaction of online therapy to be similar to face-to-face studies. Participants in the current study reported that despite the challenges that are unique to online therapy, such as technical difficulty at times and the absence of visual-cues with text-only therapy, therapists are able to develop a good working relationship. They are able to stay present and attuned to the client's emotional state and provide an emotionally engaging and confiding relationship with their clients.

Assessing client suitability emerged as an important theme for the online counsellors in this study. Ben and Carl's narratives provide examples of how counsellors may be ethically compromised if they do not do their due diligence in making the assessment initially. Suler (2001) recommends that counsellor's assess clients' amenability to online therapy in various domains, including: communication style, assessment preferences, comfort with using a computer, presence of personality disorders, suicidality, concurrent mental health treatment and history, as well as auditory, visual or other motor disabilities and chronic medical conditions that may interfere with their ability to engage in online therapy. Despite a lack of regulation in this regard, it appears that the participants in this study practised precaution and did not find themselves in a compromised situation with an unsuitable client. They were concerned about being able to conduct accurate assessments, which has been cited as an essential online therapy competency (Cohen & Schouten, 2007; Mishna et. al., 2013).

One of the social justice objectives of counselling involves reaching those individuals who are outside of the mainstream and in need of support (Hilty et al., 2013; Mallen et al., 2005; Mattison, 2012). Online therapy provides a way of meeting this objective. It is particularly beneficial to those clients who would otherwise not have access, such as those living in remote or rural communities (Mallen & Vogel, 2005; Rojubally et al., 2013) or who have extreme concerns about privacy. There still exists stigma in accessing mental health services and the anxiety and fear of being vulnerable can be so great that it inhibits people from seeking help (Olasupo, 2013; Vogel, Wade, & Hackler, 2007).

Online therapy also has the capacity to reach marginalized individuals, such as those who identify as Lesbian, Gay, Bisexual or Transgendered (LGBT), as well as other populations who traditionally underutilize the mental health care system (Chow et al., 1999; Pachankis, Lelutiu-

Weinberger, Golub, &Parsons, 2013). For example, online counseling provides the possibility of connecting people from a variety of cultures where seeking mental health might not be supported (Hilty et al., 2013; McFadden & Jencius, 2000; Shernoff, 2000). According to James and Prilleltensky (2002), in many cultures, the stigma attached to therapy is so prevalent that a "good person" would not seek help from a mental health professional. Many immigrants hesitate to openly discuss emotional and personal matters (Crandall et al., 2005; Green, 2004), and may find the anonymity of online therapy very appealing (Hundley & Robertson, 2007). Additionally, online therapy may allow better access to multicultural counselors and allow clients more therapeutic choices (Guanipa, Nolte & Lizarraga, 2002; Luxton, 2014). Finally, online therapy may also benefit clients who are physically limited and not able to travel outside their homes or travel long distances. Taken together, it appears that online therapy has the capacity to make mental health consultations and services more reachable cross-culturally, cross-specialty, and globally. The findings from this study indicate that the practitioners are very much aware of and foster this potential.

Findings from the current study provide indirect evidence in support of client satisfaction, based on client self-report and feedback to their therapist. Studies have used the session evaluation questionnaires SEQ (Reynolds et al., 2013) that yielded the similar positive results of using SEQ in face-to-face sessions. Regarding ethics, in the study by Centore and Milacci (2008) there was a perceived decrease in the online therapist's ability to fulfill ethical duties. On the contrary, the current findings suggest that counsellors consult ethical guidelines that are available, and base their individual decisions on relevant ethical and legal principles. For example, Carl made the decision not to work with clients from the Unites States primarily for ethical reasons, and Francine decided to no longer accept clients from certain provinces in

response to newly enacted legislation. The findings from this study did not suggest that practitioners felt compromised in their ability to make ethical decisions. However, a lack of clarity surrounding cross-province or state counselling was raised as a concern. It should be noted that Centore and Milacci (2008) and Hertlein et al., (2014) did not clarify whether the perception of counsellors' decreased ability to fulfill ethical duties was due to lack of confidence in their abilities or a lack of training, or whether it is related to the lack of regulation surrounding online therapy. The findings of the present study suggest that, at least for the well-trained, highly experienced online therapists in this study, the problem does not reside within the counsellor.

The concern with regards to client confidentiality and privacy on the internet has been prevalent in much of the literature (Anthony & Goss, 2009; Baker & Bufka, 2011; Bloom, 1998; Callahan & Inkle, 2012; Kraus, 2011; Sude, 2013). Counsellors in this study echo similar concerns, as there exists much ambivalence and therapists have to navigate much of the online counselling landscape on their own; for instance learning about software with encrypted delivery systems and establishing their own boundaries in regards to the scope of their practise. However, one counsellor also challenged the confidentiality and privacy concern in the broader counselling context. Ben described equivalent concerns that face-to-face clients have at the hospital he works at. Far more face-to-face clients ask about the confidentiality of their records, as hospitals and large agencies rely on administrative and clerical staff for billing and record maintenance. However, the current online literature does not do justice to this by avoiding a discussion of threats to confidentiality in traditional face-to-face counselling versus threats to confidentiality on the internet. For instance in recent news was a Toronto hospital security breach that spurred multiple investigations after the confidential information of more than 8,000

patients was stolen and sold to a financial firm (Margison, 2014). Thus, the threats to client confidentiality are not an online or internet security concern only.

A second concern is the issue of client identity (whether the client is who they say they are) has long been debated in literature (Callahan & Inkle, 2012; Childress, 1998; Kraus, 2011; Suler, 2004). In fact, counsellors in this study had the same questions and concerns regarding identity as counsellors do for face-to-face clients. Conducting the counseling online did not seem to increase these concerns for any of the participants. In general, counsellors in this study reported using an honour system in a similar fashion as they would if someone accessed their private practise in person. That is, they asked for detailed information (e.g., full name and mailing address) and then took client identity at face value, with no independent background check to verify that the client is who she/he claims to be.

Many theorists view cyberspace as a space for playing with ideas, relationships, and personal identity where exploration, creativity, self-discovery, and self-development can occur (e.g., Suler, 2004). Indeed, literature on computer mediated communication (CMC), has established that higher levels of self-disclosure are possible with visual anonymity (Joinson, 2004, Murray, 2003). In fact, several crisis counselling services such as Kidshelp and YouthInBC encourage and permit anonymous chat with a trained volunteer crisis counsellor, to increase the likelihood that teenagers will access needed mental health information and assistance (Timm, 2011). However, Childress (1998) points out that the difficulty in verifying client identity becomes significant when treating minors without parental consent, and in situations of crisis (suicidal or homicidal ideation). This issue of client identity and working with minors remains complex and contentious within the online counselling literature. Thus, treating client identity similar for online and face-to-face counselling, which was the predominant view

expressed by the participants in this study, contradicts existing research about online communication in general. Future work needs to explore this further, including identifying whether this contradiction matters. For instance, as per Suler (2004), it may be the case that online therapy, where clients may choose to mask their identity, could lead to more efficient and effective self-discovery and growth. On one end of the spectrum the 'online disinhibition effect' (Suler, 2004) increases the depth of emotional connection and enables clients to get to the core of their issues faster, on the other hand, it creates unexpected ethical and legal concerns for the therapist.

A unique finding of this study was the fact that online therapy meets counsellors' personal and professional goals. It appears that online therapy allows counsellors to incorporate flexibility into their work environment – enabling them to work as much or as little as they want (fulltime/part-time, past retirement age, etc.), and wherever they want (e.g., from a home office; while they are traveling; etc.). In addition, the findings suggest that the ability to help clients cross-culturally and globally may enhance the counsellor's professional experience, confidence, and be linked to career satisfaction.

Limitations

Although this study had several strengths, some limitations must also be recognized. First, the attitudes towards online therapy that these participants expressed reflect the fact that they are actual online practitioners and all of them were content with practicing online. It is likely that practitioners who do not practice online therapy or who have tried it and decided not to continue may have more negative perceptions and different kinds of concerns. As with all narrative research, this study was not designed to be representative of the entire population of counsellors. Nonetheless, future work should explore how practitioners who do not practice

online perceive online counseling, and what their hesitations and concerns are about moving into this modality for practice.

Further, snowball sampling, while providing access to the target sample was also a limitation regarding participant anonymity and confidentiality. That is, asking online therapists to refer their colleagues to the study was necessary in order to obtain a sufficient number of appropriate participants, but also may have compromised participant anonymity as the number of practising online therapists in Canada in not very large. Consequently, extra precautions needed to be taken in writing up this study, in terms of how much to disclose about the participants' identities had to be considered. While it is unlikely that participation in a research study itself would have potentially damaged the reputation of the participants, confidentiality was promised as part of the process of obtaining informed consent. Therefore, caution was taken to change as much identifying information as possible and when decisions had to be made between presenting evident to support the conclusions being made and preventing inadvertently revealing participants' identities, the choice was made to omit information.

The current study was qualitative, and the thematic analysis is not used for generalizing but for understanding the complexity of each narrative. The goal of using a narrative methodology is to elicit individual experiences. This means that narrative methodologies do not generate set of generalizable results or a list of universal recommendations; rather they produce rich stories and experiences that provide a glimpse into someone's experience (in this case, their online counselling practice). Thus, the current study cannot conclude with a 'how to' list about online therapy. Instead, it provides insight into the professional experiences of counsellors online that may resonate with other practitioners in the field, which in turn may influence their practice. Although the current study is important and provides foundational knowledge, future

work in this field should build on these findings and utilize research designs that can focus on developing concrete recommendations and strategies for practitioners who provide online therapy.

Conclusion

Within the counselling research and practice there is a growing tradition of narrative inquiry that explores the stories that clients construct about their lives and their healing. The exploration of counsellors' experiences with online therapy provides an opportunity to examine more closely how they provide psychotherapy using the internet. It further provides a framework for enhancing the development of services that harness the power of the internet to provide mental health service delivery. My hope is that, by sharing these narratives from the field, other helping professionals may have the means to increase their understanding of this novel form of therapy.

In the next decade, online therapy will become much more commonplace (Dunn, 2012, Khan, Bower, & Rogers, 2007). However, with the technological landscape constantly changing, it may look very different over time. For example, five years ago when I began my research, most online therapy was conducted only via text or e-mail. By the time that I was writing my research proposal, videoconferencing had become more common, as high-speed Internet, HD cameras, and mobile technologies had become more accessible and affordable. As I am concluding my study, I realize that I have only overturned and explored a pebble. The internet offers vast potential and there remain many uncharted territories. With advances in mobile devices, text-based therapy is a very real possibility. Similarly, Russ (2012) has recently shown that therapy offices within a virtual world such as Second Life are a viable method for offering mental health information and psychotherapy. Advances in virtual reality technologies, such as

Facebook's Oculus Rift and Sony's Project Morpheus (Garrett, 2014; Yarm, 2014), also have

potential to change the nature of online therapy in the not so distant future. There is little doubt

that we will see an increase in forms of therapy and human interaction being offered at a distance

and online; thus it is our ethical responsibility in the field of social sciences to engage with and

stay on top of the research in online therapy technologies.

Chapter 5: Conclusion

This chapter provides a summary of the previously described research, an integration of the findings from Studies 1 and 2, an expansion on some of the more salient points made in this study, as well as a discussion of the implications of this study for the field of counselling. As online therapy gains increasing prevalence, the growing need for an examination of this modality has been identified (Callahan & Inckle, 2012; Derrig-Palumbo & Zeine, 2005; Evans, 2009; Fink, 1999; Rochlen, Zack, & Speyer, 2004). The overall purpose of this work was to provide a more in-depth exploration and understanding of online therapy from the perspectives of both clients (Study 1) and counsellors (Study 2), using a qualitative methodology to uncover the nuances of online therapy in a completely naturalistic multimedia online environment. The study used narrative analysis followed by an across-case thematic-analysis, and attended to the lived experiences of both counsellors and clients through storytelling within a naturalistic setting. The salient findings from this study suggest that online therapy is a viable method of conducting and engaging in therapy with specific benefits of convenience, perceived anonymity, access and affordability that contribute to the therapeutic alliance.

Discussion of Findings

The intention of Study 1 was to give voice to client experiences, and the study generated six client narratives (see Appendix F). The findings from Study 1 suggested that the factors that precipitate the desire to seek professional help online, such as stress or depression, are similar to the concerns that would lead people to seek out face-to-face counselling. Motivating factors for participants to access online therapy emerged in the theme of accessibility (sub themes of convenience, immediacy and affordability). The ability to access counselling at an affordable cost and from the convenience and comfort of the client's own home was a major attraction. The

sub factor of immediacy was also important. For example, in the case of Kat the ability to access a therapist online promptly helped reduce her rising anxiety. Potential clients are able to search therapist profiles and, once one is found, to connect with them without long waits for appointments. These findings elaborate on the results of several previous studies that have reported accessibility and convenience to be major benefits of online therapy (e.g., Dunn, 2012; Hanley, 2012; Rochlen et al., 2004). Related to this, the ability to bypass driving, traffic, the office receptionist, and waiting rooms were also experienced as things that made online therapy desirable. Participants in the study valued the ability to transcend geographical distance and time zones as both the client and counsellor engaged in therapeutic dialog. The notion of being able to have access to services at the tip of their fingers is reflective of the cultural and societal shift towards technology as more and more individuals are plugged in and conduct their lives online: Experts believe that by 2015 80% of the world's population will have access to a smart phone, tablet or laptop (Rosen, 2012).

The findings of this study also demonstrate the value of accessibility of online therapists for clients who have re-located to foreign countries. In the case of Mel she had traditionally needed to seek therapy most her adult life while residing in the United States and while on a teaching assignment in China found the convenience and accessibility to a therapist life-enhancing. Also as exemplified by Shiraz's narrative, online therapy was sought because she was located in a geographic region where an expert was not available and where local mental health services were not considered safe or reliable. For her, online therapy was the only viable avenue through which she could get in contact with a mental health professional. She continued treatment with the same online therapist after moving to the Unites States. Thus the portability

and continuity of care that is achieved through online therapy in a highly mobile, global environment is a clearly advantageous for both clients and counsellors.

The second most significant finding from Study 1 was the client autonomy and control theme (subthemes: time to think, reflect, and respond; getting to the focus of therapy faster; and perceived privacy). In general, the clients in this study seemed to feel as though they had more ownership and power in the process of online therapy. The client is able to set the pace, tone, volume, screen size and parameter of self-disclosure without the threat of the judgement or other subtle leads, positive or negative. The screen provides a sense of boundary and containment that enhances the client's sense of privacy, which in turn, contributes to a disinhibiting effect, resulting in their ability to more quickly address core issues. This study expands on a sense of egalitarian relationship (Lewis et al., 2003) that promotes client trust and empowers the client in the online counselling process. This sense of an egalitarian relationship is influenced by the client's perceptions regarding the counsellor's qualities: openness, compassion, skills and warmth all contribute to positive client experience. Though online therapy is a different experience to face-to-face psychotherapy, the findings from this study suggest that the core elements of the client-counsellor relationship that contribute to the therapeutic alliance remain equally important across modalities. The ways that these elements are manifested in an online environment may be different, but clients still value such things as therapist openness, warmth, compassion, and skills when receiving services online.

Study 2 focused on the experiences of the counsellors with respect to online therapy, and the findings complemented those of Study 1. One of the research questions focused on how therapists negotiated the therapeutic relationship in online therapy, which as noted, plays a central role in successful therapy outcomes. Study 1 revealed important information on client

perceptions of what is important for them to experience a good alliance. This was elaborated upon in Study 2, where participants perceived that the therapeutic alliance developed at a faster pace in online therapy as clients were inclined to get to the core of their concerns faster. The therapists attributed the faster development of therapeutic alliance to the safe distance that a screen can provide, hypothesizing that perceived safety and comfort is enhanced by being able to speak from one's safe space, such as home. The noted difference that communication modality made also provides information about the development of therapeutic alliance in online therapy. For example, the visual anonymity of text-only communication was felt to further enhance self-disclosure since clients had time to think and respond without being watched. Counsellors in the study also experienced that they stayed attuned to the clients' emotional state by allowing the client to disclose and move at their own pace. These findings are all compatible with and reflect the themes of the control, autonomy and perceived privacy themes reported by clients in Study 1.

It has previously been noted that synchronous communications may produce more immediate, direct responses, whereas asynchronous communications allow for more reflection and purposeful responses (Davidson-Shivers, Tanner, & Muilenburg, 2000; Dunn, 2012). In addition, it has also been suggested that synchronous discussions lend themselves to social interactions, whereas asynchronous discussions may be more task-oriented (Im & Lee, 2004), suggesting that different forms of communication may serve different purposes (Trepal et al., 2007). The choice of the online modality is also a matter of personal comfort for counsellors and clients. This is reflected in the outcomes of this work. For instance, participant John from Study 2 decided early on not to engage in email therapy, because he found he missed too many visual cues. Similarly, Carl preferred the process of writing and reflecting in email therapy versus spontaneous, synchronous communication on chat and video. Many of the clients in Study 1

started with email and progressed into video chat once they had tested the waters with only therapy and more specifically developed trust and bond with their online therapist. The process of beginning with less risky, asynchronous communications and then proceeding to higher-risk, synchronous communication only after a good TA has been established is an option that is not available in face-to-face counselling. This option of beginning with asynchronous written interactions opens up the possibility of providing therapy services to individuals who are too anxious or guarded to engage in spontaneous interactions with complete strangers and, as a result, would never be willing to engage in face-to-face counselling.

Study 2 was also interested in understanding how therapists use their clinical skills to engage and assess clients online. Participants revealed that clinical skills, such as staying attuned to the slightest change in the client's tone and presentation or patterns of typing, were important as it is easy to miss the cues or misunderstand if the counsellor is not closely following and observing the client's communication patterns. Also, participants adjusted their communications to mirror their clients' emotional states and 'meeting them where they are' was reported as an important factor in developing the relationship and in keeping the client engaged in the therapeutic relationship.

Finally, Study 2 also explored counsellor's perspectives of ethical issues around online counselling, which tend to be ill-defined and ambiguous (Hanley & Reynolds, 2009; Shaw & Shaw, 2006). For example, there is a large grey zone around the ethical use of Skype. The ethical guidelines do not explicitly prohibit using Skype for communication or therapy. However clinicians and clients need to be aware that even with the on-going improvements the encryption on Skype can be intercepted. Results from this study found that counsellors interpreted these ethical issues differently. That is, some participants engaged in counselling using this software,

while others reported they steered away from using Skype because they were uncertain regarding the privacy levels and confidentiality connected to this medium. Similarly, some counsellors practiced internationally and across provinces because there are no 'laws or bylaws' preventing them from doing so, whereas other counsellors made a personal and professional decision to practice only within their own geographic parameters.

The ambiguity experienced by the counsellors in the study is prevalent in the field. The American Psychological Association (2013) released a long-awaited guideline (for practice of online therapy. Though a first step in recognizing the widespread use of technology in the field, it falls short of clarifying practice out of jurisdiction, with individuals across the globe. Although their recommendation to consider the cost/benefit of providing distance services to a potential client via the internet is a new development, it leaves the responsibility on the practitioner to operationalize the standards into ethically and legally sound practice behaviours. Basically, it is on the onus of the practitioner to 'cobble together an understanding about relevant laws regarding informed consent, patient confidentiality, privacy and security' Baker and Bufka (2011, p. 410). Further, Mattison (2012) points out that, with the absence of firmly recognized competency standards, no prevailing best-practice standards currently exist, against which a practitioner will be judged if charged with practice or ethical misconduct online. For this reason many counsellors remain skeptical about the use of online therapy or at least consider it to be too risky, despite the increasing evidence for its usefulness with various symptoms and populations (Luxton, 2014; Sucala, et al., 2013; Sude, 2013). Carl and Francine's decision not to accept clients from the United States, because of the complex legal and jurisdictional issues governing counselling in that country represents one reaction to this climate of uncertainty. On the other hand, Ben's statement, "I don't worry too much about the law regulating online therapy ….There

are no court cases that I have heard of and basically my way of dealing with all they unknown grey areas is making sure my clients are happy," represents the other end of the spectrum of counsellor reactions to the situation.

Implications, Recommendation, and Future Research Directions

Numerous implications and recommendations for practice emerge from the findings of this study. In the age of access to instantaneous information, globalization and consumerism, we are witnessing an increased role of ICTs in the everyday lives of individuals. The field of mental health and counselling is not immune to these changes. Studies have noted that online therapy is on the rise (Cowpertwait & Clarke, 2013; Musiat, 2014). This is exciting, but also should be a wakeup call for the profession. At present, research in the field of counselling and therapy has not kept pace with the flourishing demands for online services. Mattison (2012) and Childress (2000) warn that the psychology profession faces an inherent danger if we do not address consumer demands and accelerate the development and regulation of online services. Specifically, consumers will likely turn to unregulated and untrained providers who may also be offering these services. It is incumbent upon us to continue to investigate the approaches to online counselling and to create greater level of social awareness that would enable the population to learn about their options as consumers of mental health services. This will help protect the online mental health consumers from being harmed or duped by untrained counsellors. In addition, based on the findings of this work, I think it is imperative that policies be developed by national and provincial health care systems to ensure accurate dissemination of information regarding online therapy: online therapy awareness can be achieved through media publicity and exposure within the following systems: education, faith based, justice, health, counselling and social services.

These recommendations echo throughout the research on online therapy (e.g. Barak, Klein, & Proudfoot, 2009 ; Grohol, 1997; Hanley & Anthony, 2006; Murphy & Mitchell, 1998; Rochlen, Zack, & Speyer, 2004). CPA (2011) has identified the shortage and need for access to mental health services, and some programs have already begun to address this. For example, Pugh, Hadjistavropoulos, Klein and Austin (2013) describe the development of an Internet-based cognitive behaviour therapy program for anxiety and depression at the University of Regina (ICBT). In fact, ICBT is already being included in clinical practice and is showing optimistic results (Andersson, et al, 2005; Cowperwait & Clarke, 2013; Ruward, et al., 2009). More interest and funding are needed to advance large scale research and program development to enhance accessibility.

The current study informs future research about some of the methods for designing and undertaking research with online clients and counsellors. Future research can use the current study as a foundation through which to develop a questionnaire to administer to a larger population of clients and counsellors in order to obtain quantitative and generalizable results. Future studies can examine the role of online therapy with populations who have traditionally felt stigmatized about accessing psychological services such as in the case of Shiraz and also with populations where mental health services are limited in the case of Kat. In studying multicultural populations, research should focus the use of online therapy by vulnerable minorities such as LGBT communities and ethnic women. Also focus on the immigrant and refugee population who have been displaced and the expatriate and international student populations who have moved geographically to pursue a career or an education. Future work exploring therapeutic alliance in online therapy should examine the therapeutic dialog in an online session which can be achieved through recorded video sessions or asynchronous e-mail

exchange. Studying the sessions can provide further information on how the therapist guides and directs the client whist providing sense of autonomy and control to the client. Additionally, it may be useful to use research methods that are explicitly designed to elicit information from both clients and therapists about what has hindered the development of therapeutic alliance in the online therapy that they experienced.

The recommendation for increasing training in online therapy techniques within standard counsellor education programs is voiced by the counsellor participants from Study 2. Currently, online therapy training is offered through private entities (e.g., Therapy Online Inc. and the Online Therapy Institute). However, given the increase in demand for this service, there is a need for counsellor preparation programs at public universities to develop online therapy programing that will provide practical experience to potential future practitioners. Presently, counselling graduate students have little or no exposure to using ICTs in the context of therapy, despite indications in the present research that online therapy is becoming part of the cultural and social milieu. With this in mind, it seems that students who are not exposed to this kind of training may not be prepared to work in a field that is clearly exploding in terms of demand for online services. Colbow (2013) outlines a training model and proposes a curriculum for integrating electronic-mediated therapy into an APA accredited program. The need for online training within counsellor education programs has also been identified in other research (Cardenas, Serrano, Flores & De la Rosa, 2008; Colbow, 2013; Mattison, 2012; Mishna et al., 2013; Sude, 2014).

Furthermore, to tackle the ethical practice issues of online therapy, a formal certification or license in online therapy practice is recommended. This can be achieved in two ways, either provincial or national accreditation bodies could create a task force and committee dedicated to reviewing applications for online therapy practice. Ideally, an international accreditation and

licensing body could offer international guidelines, regulations, and license for online therapy practice across the globe. An organization such as the International Society for Mental Health Online or the Online Therapy Institute can develop a competency based exam for trained professionals to be voluntarily certified to begin and develop a n online practice standard. This will necessarily call for broader involvement of government policy makers, legislatures, possibly the World Health Organization, counsellors and the community. The mental health commission of Canada (2012) also recognizes that for internet based mental health therapies to be better utilized,

> "these approaches must be better supported with adequate infrastructure, resources to operate and maintain the systems, and technical training and support. In addition to paying consultation fees to specialists, funding for tele-mental health should also cover case conferencing, education, and other approaches that build capacity for collaborative care" (The Mental Health Strategy for Canada, 2012, pp. 64).

For these recommendations to be implemented, it would call for the field to move beyond the debate of the legitimacy of online therapy and consider the need for more awareness, research, education, competency training and standards of practice that are supported by provincial and international policies and regulations governing online therapy. Increasing the use of online therapy to reach diverse and remote clients would call for building better infrastructure, providing on-going training and support, and larger flexibility in how services are funded (The Mental Health Strategy for Canada, 2012, pp. 65). The current guidelines seem to have developed in an ad hoc manner which are both restrictive in terms of practise out of jurisdiction and contrary to the Canadian health mandate of making mental health care accessible to all. Barak et al., (2009) note that the provision of therapeutic interventions through the internet has

encountered considerable amount of opposition, based on the ethical-related issues especially at the beginning, its subsequent pervasive use and success showed that opposition was based on prejudice and myth rather than on reality. Rojubally et al., (2013) and Mattison, (2012) call for regulatory reform to keep up with the pace of development of technology and client-centered delivery of care. This will necessitate cooperation and coordination between regulatory boards so that therapeutically effective treatments are accessible and meeting the mandate of the health care for all Canadians.

Summary

The results of this dissertation offer encouragement for future therapists and clients who are considering engaging in online therapy. The two studies occurred in a fully naturalistic multimedia online environment. The highly experienced online counsellors who participated in this study generally reported a comparable depth in the therapeutic alliance in online counselling as they experienced in face-to-face therapy. Moreover, they reported positive experiences with meeting clients online and felt they were able to meet their ethical obligations, despite struggling with the complexities of remaining ethical in an online practice. Furthermore, the clients in this study clearly noted flexibility and openness as an advantage of online therapy. The findings of this study suggest that online therapy is not a less desirable alternative to face-to-face therapy, and that it holds promise as a legitimate manner of conducting psychotherapy. For example, text therapy may be a less threatening initial alternative to face-to-face psychotherapy, especially for clients with anxiety disorders (e.g. social anxiety). Indeed, according to Ben (a participant from Study 2) "Online therapy is just one of the services available on the continuum of care." Many practitioners will continue to prefer the higher level of intimacy, well established ethical

guidelines, legal policies and therapeutic benefits of traditional face-to-face interaction with clients.

Nevertheless, it is evident that the field of online therapy will continue to grow as long as the demand for convenient, accessible, and professional mental health services exists (Norcross, Hedges, & Prochaska, 2002; Rochlen, Zack, & Speyer; 2004). One of the recommendations from the mental health commission of Canada is "to develop a mental health research agenda for Canada, encompassing psychosocial and clinical research, neuroscience, as well as knowledge from lived experience and diverse cultures" (The Mental Health Strategy for Canada, 2012, pp. 89). As such, a growing need for research has been noted, and some researchers will continue to explore alternate virtual spaces online. As Wilkinson et. al. (2008) posits, entire communities could benefit from the growing wealth of therapeutic options. Indeed, it is hoped that this dissertation has conveyed both the implications of online therapy practice and recommendations for future research that truly reflect the need within the counselling profession for integrating this new form of therapy.

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APPENDICES

Appendix A: Recruitment Posting

My name is Shereen Khan and I am a doctoral student at the University of British Columbia, I am also a Registered Clinical Counsellor. I want to request your participation in my research titles 'Online Therapy: Client and Counsellor Experiences'. This study has been approved by the Behavioural Ethics Board at UBC (certificate number: H12-00766).

As a participant, you will be asked to complete a brief online survey covering your basic demographic information. We expect the survey to take between 5-10 minutes to complete. You will then be requested to participate in 1-2, 90 minute interview sessions via text-based chat. I will further contact you to and present to you my summary of findings for your review and feedback.

Your input may guide researchers and practitioners better understand the online counselling processes and help establish better guidelines for engaging in online therapy and developing therapeutic relationship.

As no names or personal information will be linked to the study, your participation will be completely confidential.

To be eligible for the study, you must be: 19 years or older and must have engaged in online therapy in the past twelve months.

If you meet the above criteria and are interested in participating in the study, you can access the information at: www.noorify.com
If you do not qualify for the study but you know others who might be interested in participating, feel free to forward this message.
Thank you for your interest and participation.
Sincerely,

Shereen Khan

Appendix B: Client Information Letter

Title of Study: Online Therapy: Client and Counsellor Experiences.

Principal Investigator: Dr. Jennifer Shapka, University of British Columbia
Doctoral Researcher: Shereen Khan, MA, RCC, NCC (PhD.Candidate), University of British Columbia.

INVITATION TO PARTICIPATE IN RESEARCH
You are invited to participate in this study because you have identified yourself as having engaged in online therapy in the past twelve months. This study is the project of Shereen Khan, a doctoral student at UBC. She will be supervised by Dr. Jennifer Shapka, at UBC, and Dr. Marla Buchanan also at UBC and Dr. José Domene at the University of New Brunswick.

WHY IS THIS STUDY BEING DONE?
This study is being done to understand the experiences of clients who have engaged in online therapy. This study may help researchers and other health professionals to provide better understand the nuances of online therapy and provide a framework for improving practice.

WHAT AM I BEING ASKED TO DO?
You are being asked to participate in 1 to 2 interviews online over the next few weeks. Each interview will take about 90 minutes. These interviews will be conducted via text-based chat and will be recorded. Every effort will be made to ensure confidentiality for the interviews, as your name will not appear on the transcription. At a later date, you will be provided with a copy of a summary of the previous interview(s) for your review and feedback. Details of this task will be provided after the first interview.

ARE THERE ANY RISKS?
You will be asked questions to try to understand your experience of your recent therapy. The questions are not designed to cause any discomfort. You do not have to discuss anything you do not want to discuss. If a question causes any discomfort, you can choose not to answer it. During the time of the interview or thereafter if you feel uncomfortable efforts will be made to connect you with a counsellor for immediate support.

ARE THERE ANY BENEFITS?
There is no direct benefit to participating in this study. Participation in this research provides an opportunity for you to tell your story and to think about your experiences. The information which comes from this study may benefit other individuals in similar situations who may be contemplating online therapy. Further, your story helps our field of counselling understand the phenomenon from your perspective. You will be offered a copy of a report about this study when it is complete.

WILL I BE PAID TO PARTICIPATE IN THIS STUDY?
You will not be paid to participate in this study. If you do choose to participate you will be offered a gift certificate worth $30.00 for your time.

WILL THERE BE ANY COSTS TO ME IN THIS STUDY?
You will need a computer with Internet connection for the interview. There are no other anticipated costs to you.

WHAT WILL HAPPEN TO MY PERSONAL INFORMATION?
All identifying information, and the interview transcripts will remain confidential.
This study will collect demographic information such as your name, your age, and the name and telephone number of your family doctor for emergency purposes. This information will be kept separate from any interview information which will be identified only with a study number. The only person who will have access to both your name and interview information will be Shereen Khan. The dissertation supervisor and dissertation committee for Shereen Khan will read transcripts but will not know who you are. The information will be stored on a password protected computer file and in locked filing cabinets at the University of British Columbia. This will be kept for 10 years, and then destroyed. At no time will your story or what you have said be identified by name in the study.

CAN PARTICIPATION END EARLY?
You may withdraw from this study at any time. You may stop an interview at any time, or you may choose to answer only certain questions. If there is any new information about the study that arises after this, you will be informed and given the opportunity to decide whether to continue. If you do withdraw, you will be asked whether or not you give permission to use the information and interviews collected to that point in time.

IF I HAVE QUESTIONS ABOUT THIS STUDY, WHO SHOULD I CONTACT?
If you have questions about this study, please contact Shereen Khan at the email: xxxx@ubc.ca or telephone number 604-xxx-xxxx or Dr. Jennifer Shapka at yyyy@ubc.ca or 604-xxx-xxxx.

IF I HAVE CONCERNS ABOUT MY RIGHTS AS A RESEARCH PARTICIPANT, WHO SHOULD I CONTACT?
If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-xxxx, or, if long distance, e-mail to RSIL@ors.ubc.ca.

<h1 align="center">Appendix C: Client Consent Form</h1>

Title of Study: Online Therapy: the client and counsellor experience.

Principal Investigator: Dr. Jennifer Shapka, University of British Columbia

Doctoral Researcher: Shereen Khan, MA, RCC, NCC (PhD.Candidate), University of British Columbia.

Consent: Your consent is entirely voluntary and you may refuse to participate or withdraw from the study at any time without negative consequences.

Participant:
I have read the information letter. I have had an opportunity to ask questions and all of my questions have been answered to my satisfaction. I agree to participate in this study. I understand that I will receive a signed copy of this form.

Name:

Signature:

Date:

Appendix D: Client Interview Questions

Preamble to interview questions

Thank you for willing to participate in the interview today. This interview should take about an hour and a half and the information you provide will be kept anonymous. I would like you to speak about your recent experiences in online therapy.

However, I'd like to begin by asking you about your life before you sought online therapy. I have a number of questions which I would like to ask you and so I will keep track of the time and try to move from one question to the next so that we finish in the anticipated time. What was happening in your life that made you engage in online therapy?

Focus on the online therapy experience:

e.g. I want to find out more about peoples experiences of engaging in online therapy.

1. What was your experience like?

2. What words you use to describe your online therapy experience?

3. What does online therapy mean to you?

4. How did you learn about online therapy?

5. What mode of communication (email, chat, video conference or both) for online therapy was used?

6. How did the absence of visuals make you feel?

7. How was it expressing yourself only through text? did you use any techniques to compensate for not being face-to-face?

Focus on online therapeutic relationships:

8. How did your therapist make you feel comfortable?

9. Were you able to develop a trusting and collaborative relationship with your online therapist?

10. Did you encounter any difficulties while meeting with a counsellor?

11. What do you wish your therapist did differently?

Encourage discussion of challenges of working in this environment:

12. What did you like/ dislike about online therapy?

13. Was it easy to find information about confidentiality and security over the internet from your therapist's website?

14. Do you feel online therapy met your goals for counselling?

15. How do you feel online therapy has impacted your life?

16. Would you access online therapy again?

Conclusion:

Now that you have had this experience, what suggestions might you have for improving the online counselling services in general? What would you like to see as an added feature?

17. Is there anything else you would like to share with me today?

18. Is there something that I should have asked you that I didn't think to?

Focus on the interview experience:

19. How was this interview experience? How do you feel right now?

Thank you for participating. You will be receiving an email from me soon with some themes and questions and I would be asking you for your availability to a second interview.

Appendix E: Demographic Questionnaire

Please answer the following questions:

1. Please indicate the gender that you identify with:

    ☐ Male

    ☐ Female

    ☐ Other

2. What year were you born? _____

3. Please indicate your marital status:

    ☐ Common-law

    ☐ Married

    ☐ Widowed

    ☐ Divorced

    ☐ Separated

    ☐ Never married

4. What is the highest degree or level of school you have completed? If currently enrolled, mark the previous grade or highest degree received.

    ☐ Elementary or secondary schooling, no diploma

    ☐ High school diploma

    ☐ Post graduate diploma, technical certification, or other 2-year training

    ☐ Bachelor's degree

    ☐ Graduate or professional degree

5. Please indicate your current employment status:

    ☐ Employed part-time

    ☐ Employed full-time

    ☐ Student

    ☐ Unemployed

    ☐ Retired or not working for other reasons

8. Who else lives in your household (you can choose more than one)?

- ☐ No-one, I live alone
- ☐ Spouse/partner
- ☐ Children
- ☐ Brothers/sisters
- ☐ Other relatives
- ☐ Non-family members
- ☐ Anyone else
- ☐ Please specify: _____

9. Please indicate your total household income:

- ☐ Less than $10,000
- ☐ $10,000 to $29,999
- ☐ $30,000 to $49,999
- ☐ $50,000 to $69,999
- ☐ $70,000 to $89,999
- ☐ $90,000 to $149,999
- ☐ $150,000 or more

10. Please specify your ethnicity:

- ☐ Aboriginal/ First Nations
- ☐ Asian
- ☐ Middle Eastern
- ☐ Latino/Hispanic
- ☐ African
- ☐ Caucasian
- ☐ Mixed race
- ☐ Other_____

11. On average how much time do you spend online daily? _____

12. On average how much time do you spend online engaging in the following activities:

Social Media (Facebook, Twitter, Linkedin, Instagram etc)_____

Web surfing, research_____

Viewing movies or videos online for entertainment_____

Playing online games_____

Participating in blogs and public forums_____

Email_____

Other_____

Appendix F: Clients' Narratives

Jessica

Jessica is a freelance writer in her mid-twenties and lives in California.

I've been in and out of traditional therapy since I was about 14 or 15 years old - when I was a teenager, I went through a lot of emotional problems, and was on all sorts of medications to try to regulate my mood (none of which worked in any profound sort of way - I got the impression that my parents were just trying to medicate me to shut me up). The father's side of my family has deep, documented problems with mental illness - none of them have/will accept it, though, they all just act like everything's fine. My childhood wasn't particularly great - I didn't feel like my parents were particularly supportive or present most of the time. My grandparents raised me, more or less. I didn't have many friends throughout school; I always knew I was "different." I was an only child until I was 10 years old; at that point, my parents had another kid (even though, as a kid myself, I could tell there was no reason for them to be together, on account of the fact that they fought constantly).

My parents broke up shortly thereafter. As a result, I ended up spending a lot of my time watching my sister - we lived in the country, so I would be alone and isolated with an infant, a child myself. I resented the responsibility. When I was 13, however, my sister died - she contracted spinal meningitis and was brain dead within days. I didn't even know how to feel or process this information. I still don't think I have fully. I've always felt bad because I viewed her more as a liability than an asset - having to watch her meant that I had less time to myself to be a kid, and when she died it was one responsibility I didn't have to take care of. Reconciling my feelings about that, and about my parents, combined with the genetic depression I already had,

was hard. I went to a psychologist in high school, but that was more about medicating me and less about having me talk about my issues.

I went to a number of traditional therapists in my teenage and post-teenage years, none of which I really felt a strong connection with. Either they didn't really seem to care, or I'd withhold information from them because I was embarrassed (I've always had a problem with talking about myself to others, probably because the expression of feelings was frowned upon in my childhood household).

The most recent traditional therapist I had was in Los Angeles, where I live. He was located on the other side of town, though, which meant that I had to swim through traffic to get there. That also meant that any time I went to therapy, I'd already be frustrated by the time I got to my appointment (since, as you probably know, traffic is legendarily bad here). And while he wasn't bad by any stretch of the imagination, I still didn't feel comfortable enough with him to express the issues that were really going on in my life at the time (at the time, I was in an abusive relationship - I told my therapist about the emotional abuse, but not the physical). I guess being in the same room as someone made me feel uncomfortable enough for me to not feel like I could tell him the whole story. I don't know; I've always had a problem with eye contact and talking about myself. Eventually we reached an impasse, probably because I wasn't willing to really open up to my therapist. I felt like I had gotten everything I could out of the sessions, and had spent enough money, so I quit going. The money issue was a big deal. I didn't (and still don't) have insurance, so spending money on something I didn't feel like I was getting much out of wasn't all that great.

As time went on post-therapy, I became upset again and felt the need to speak to a professional. I was tired of all the experiences I had with previous therapists, though. I didn't want to do what I had done in the past because I felt like that hadn't gotten me anywhere. At one point, though, I heard something about online therapy on the news or something - I don't remember off the top of my head the specifics. It intrigued me, as it seemed like an easier and more economical way to procure therapy. I did a Google search and pretty soon found the site where I met the doctor that became my therapist. I initially experienced a bit of trepidation, because this was something I had never done before - I didn't know if the whole experience would be cold and unfeeling, or what. It seemed weird to share so many intimate details with someone who wasn't speaking to me face to face. That being said, I always had more luck expressing myself via text than via speaking - there's something about talking to another person about myself that makes me incredibly uncomfortable.

It felt strange expressing so much about yourself in such an inorganic format. As time went on, though, I traveled over that hump and was able to treat it like a normal therapy session. In a weird way, I ended up feeling more comfortable - the physical distance between me and my therapist seemed to make it easier to really open up and tell her how I really felt and what was really troubling me. It had a sense of anonymity - like sharing your feelings or opinions on the internet. I didn't fear or anticipate as much judgement in that environment as I would in a one-on-one experience.

Pretty soon after finding my therapist, however, my trepidation evaporated. Even though she wasn't *directly* in front of me, she appeared to genuinely care and was very supportive. I didn't find myself feeling as though the lack of actual human companionship was lacking - if anything, I found it easier to express myself freely without the constraints of being in the same

room as the other person. If I could sum the entire experience up in a word, it would be freeing. I felt as though I could say and do anything without the threat or pressure of immediate, palpable judgement from another person (not that therapists *should* judge, but it's always been my fear and something I've used to prevent myself from speaking the whole truth with them). The absence of having an actual person there to listen to me speak initially made me feel weird, like I was talking into the void or something. Once I realized that my therapist was actually listening to me and had constructive things to say, however, it actually felt freeing (like I said earlier). Being a step removed from someone makes it even easier to open up to them, I feel. In the end, I ended up revealing more to my online therapist than I had with any of my one-on-one therapists.

My therapist was very warm, had a caring demeanor, and always seemed like she was interested in what I had to say. Her attention never wavered from me. She didn't seem cold or stiff at all, which is an experience I've had with other therapists. I think she did a great job from the get-go. She seemed to really care, and she expressed that very well despite the barrier of technology. That being said, perhaps nothing can replace a human element when it comes to talking about issues like this. I may have just lucked out with my therapist - perhaps she was so good at what she did, it transcended the barrier of technology separating our physical selves. When it comes to issues of confidentiality, I didn't look for it, to be honest. I assumed it would be like any other therapist. I just checked the website, though, and it's easy to find this information.

Online therapy is a more economical form of therapy. It was also more convenient (no driving!) and cheaper (presumably because there was no overhead).Easy because I can do it in the comfort of my own home - as a rule, I hate to drive, especially in Los Angeles (where I live). The stress of driving to my therapist appointments (which always took place across town) made

the experience of going to traditional therapy difficult at times. With online therapy, there's less stress and it's more freeing.

I'd definitely do it again, and definitely recommend it to others. I may be an anomaly, but compared to other forms of traditional therapy I've done in the past, this was by far the most beneficial. It isn't just the experience I have to thank for that, it's my therapist. But, for me, the two worked very well in tandem together. It may be on account of the fact that I traditionally have a problem with opening up and talking about myself on a person-to-person basis, but I found the online experience rather liberating.

Lily

Lily in her mid thirties works in higher education and lives in Ontario.

I am married to an older man who took early retirement. He is now in school and very unhappy. We don't have any sort of life together anymore; we are just two people living in one house. I won't leave until he is done school as he has no income or insurance without me. I am not a martyr but also not mean. I am the go to person for all my friends, and also am an orphan so have no other family. I felt like I had no one else to talk to. The last time I had counselling was about 25 years ago when my parents passed away. I talked to a professional and it was helpful to go through the phases of grief with support. So recently feeling very lonely and useless at home, and completely competent at work I was living two lives. I thought going to counselling would help me find some coping tools.

I did not have a good experience with my jobs EAP online counselling. I tried it after a friend told me it had worked for her for a similar issue. It basically is a cheaper form of professional help, however my experience was disappointing and unsuccessful. It was email based counselling and I provided a lot of details about my situation, however the response I got was a cookie cutter response and felt very impersonal. I believe I had two email exchanges. Literally, I got an email that said if you are going to hurt yourself see a doctor, otherwise try to remember a time you were happy, what you were doing and try to do that again.

I don't feel my therapist did anything to make me feel more comfortable, nor did we develop a therapeutic relationship. There were no technical difficulties as it was email. But there was no follow up or outreach and the therapy ended prematurely. I did not achieve my therapy goals. My initial goal was to find strategies on getting back to happy and it ended with an email as stated above.

The reason why I tried online therapy is because I don't have time to make an appt and wait in an office for an appt. I am at work for at least 12 hrs a day so online was/is really my only option. As my husband is unwilling to go with me I did not feel either that an in person would be any better. I am looking to move out soon...so will see if that helps.

I think for online therapy to work, the counsellor has to get to know the person, the response I got was almost a cut and paste I had found online. In the end, I do see the value in online therapy and it is a good field, I just had a bad therapist. I have 3 university degrees, I can figure out a lot myself, I was looking for some professional strategies for coping with this very stressful situation and unfortunately did not get any.

Kat

Kat is in her early thirties and teaches English as a second language (ESL) in China.

Low self-esteem, issues with food, and a dysfunctional relationship with my parents have been the focus of discussion for most my therapy life. Over the years my parents and I have created a safe distance, which means I have had to travel across two continents. I teach ESL in China.

I have sought out therapy on and off throughout my life. My earliest memory is probably when I was a teenager and my mother was concerned I was not developing physically at the rate of my peers and also may have OCD tendencies. My therapist believed I had anorexia but the truth is I just didn't like to eat and it wasn't about losing weight or the fear of not gaining weight, eating just wasn't fun; I also was diagnosed with OCD and got on Paxil. Anyhow, the point is that I have probably had a half dozen different therapist throughout my life. Some of them were probably good but no help to me, others like my university counsellor helped me through my anxiety and fear of public speaking.

So after taking on this adventures job to explore the world, I discovered I still needed to have access to a therapist and knowing that my conception of needing therapy as a life raft (knowing it is there should I need it) was not available in the small town I am currently living in, made my anxiety shoot up. I was anxious and fearful to the point that the medication I was on was not working. I would have nightmares of having a panic attack while I am teaching in front of my students and I would wake up in sweats and what do you know it was an actual panic attack. I bought an anxiety and phobia workbook to start practising my old skills that perhaps were rusty. Doing some thought stopping and behaviour activation but this seemed so overwhelming to do alone. I was starting to recoil and soothe myself by cradling in the corner of

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a room. It was probably one of those nights that I went on to my computer and googled 'need help now' and landed on a page that seemed to be a list of directories of all the therapist that provide online therapy and what do you know there was somebody available for live chat right now. There was a brief blurb about the therapist, their training and a picture.

I initiated the chat and I recall there being a pop up about security and confidentiality but I didn't read it because at this point it didn't matter to me if my chat appeared on the front page of the news paper I was in survival mode. I accepted, charged my credit card and we proceeded.

At first the video chat was awkward I was now talking to somebody I didn't really know. And it felt awkward to see my own reflection and then I was consumed with thinking how I presented myself. However, my therapist was probably aware of this and he indicated to me that if I could enlarge his picture image and disable mine as he becomes quite self aware when he sees himself on screen too. This allowed for me to feel more in the moment working with my therapist and less distractions of looking at my own facial expressions on the screen. This was great- I instantly felt relieved and connected to somebody who understood my anxiety without having to verbalize it. And my therapist seemed experienced with online therapy as there are subtleties such as scheduling, time differences, and technical difficulties that I was not apprised of but he was always on the ball.

The time zone differences allowed me to teach during the day and attend to online therapy at night. I have been working with my etherapist for 7 months. I think this is longest I have committed to therapy. Part of it may be that I recognize I need my life raft nearby and another part of it is also the acceptance of my OCD and highly anxious personality, I need more help than the average Joe going through a life transition. We began work on calming my nerves,

my therapist and I also practised the emotional freedom technique- also known as tapping to help reduce anxiety. I think we probably spend 40 minutes practicing the skill in one of the sessions and then I kept log of all the times I felt anxious and practised EFT. There are probably real difference in the approach my therapist uses, there is more emphasis on doing, coaching and guiding rather than sitting back and letting me talk for 50 minutes about the latest disasters in my life. I am not saying there isn't value in venting because I definitely have done that and continue to want to tell my story but I recognize the interventions and skills that I need to learn, develop and practise in my daily life are going to eventually help me more than simply venting my feelings.

I have to say that with online therapy the convenience is great, it is not cheap but certainly makes therapy more affordable and accessible on a teacher's pay. Generally the chat sessions were smooth sailing. At times we would have connection problems and the screen would freeze up or have garbled sound. We would then switch to audio only also there might have been one occasion where my internet connection was really bad and we switched to a telephone call.

I have surely met my goal for therapy. In my opinion if you think about change in therapy there is only so much a therapist can do for you. I think at the point that I started online therapy I was ready for change I was ready to be free of anxiety and start living my life worry free. Also, I will most likely want o continue with my online therapist- the beauty of online therapy is that I can now move to any location and time zone but continue to work and make progress with my therapist rather than starting new with someone else. I also have not been overly concerned about the confidentiality of it, but to me a Skype session seems more secure as we are talking live and I am assured this is not being recorded that an email or chat that can be

intercepted and leaves a trail. Also, end of day I am not a celebrity nor a politician so I don't think my therapy sessions hold much value to the general population. One of the real concerns was identity theft but we use secure payment methods and an alias encrypted account to chat from. And if anything I know that technology is evolving so we will most likely see better safe guarding methods in the future and this form of online therapy can be guaranteed confidential.

Ping

Ping is in her mid –thirties, working professional and lives in New York.

I was experiencing a lot of stress both at work and in my personal life. I turned to family and friends who I thought were trying to listen but were not really hearing what I had to say. I thought to myself I need more support. Since, I don't have insurance going to a private therapist was out of the question- the financial burden would only exacerbate my stresses. I turned online to seek help. I found myself on different forums, I found group support. At times I would log in and just observe what other people posted I think I was a bit intimidated to say too much on the group site.

And then, I discovered a counselor who did distance counseling and we started communicating via email. In the beginning it was quite intimidating, I didn't really know how it worked and what to expect. However, she did a great job of putting me at ease and making me comfortable by writing soothing words. I could imagine I am right there having a conversation with her. I was able to quickly build trust and disclose my deepest fears to the counselor because

I was anonymous. I created a separate email and communicated via that email and never disclosed my real name. Though the counselor explained confidentiality and its limit, she also had a page on her website. Also my counselor exhibited non-judgmental and accepting attitude. I found that writing or typing was an effective way to express myself for the most part. But there were times that I felt I had to type too much to explain what was happening. That is when I missed the freedom of being able to speak. sometimes it just wasn't easy using just written words, it's like you need to write a whole essay to express yourself, so a lot of times I would insert icons 😫 😕 ☹ 😵. My counselor and I compensated for the lack of facial expression by using emoticons through out our email and chat. It was non-traditional but I believe effective.

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I am a busy professional and it is hard to make time to go to appointments. So the convenience and not having to travel was great. Also in person counselling if you cancel within 24hrs you get billed for a session. That is stressful especially if you are a shift worker and get called into work. I like the fact that I can read the email and respond on my own time. I can save a draft and continue writing when I have more time. This convenience and accessibly are the pros for online therapy. I like that I could freely express myself and I was not on a clock. What I disliked was lots of typing, lots of text to express myself, it felt non-human like. Definitely there were times I was missing the human element of just being able to talk without having to type to get my thoughts and emotions across. However, everything has its pros and cons, generally I think it is a great service. I communicated with my therapist on and off for a year. This helped me get through a stressful period of my life. I would recommend online therapy to my family and friends any time.

Mel

Mel is in her early forties, works in higher education and lives in British Columbia

My background is in psychology, I have a diploma in Guidance studies and several years ago I was required to get some counselling. Then again, I also had accessed in person counselling a few years ago when there was a need in my life to speak to somebody outside my circle of family and friends and generally having the knowledge that talking to a professional can help with new insight. I learned about online therapy though my Employee and Family assistance program that is offered through the large research university I work at, so I decided to take advantage of their online therapy program for some life coaching. I generally hate technology for the most part but with my busy schedule, I did not have time to set up in person counselling. So it was either via email and chat or not at all. So the convenience played a big role. Starting off I was a bit skeptical. I thought that counselling via this method wouldn't work nearly as well. I hadn't heard much about it anyway. But I decided to take the risk so to speak. But the fact that I did not have to pay for it and it was part of my benefits program made it easier to explore. I don't think I would have tried it, if I had to pay for it myself. The experience of online therapy with the lack of visual cues was a bit frustrating, especially at first. I like using visual cues and they aren't there so you have to get used to an entirely different way of interacting, it was like operating in a vacuum. All you have to go on is a typed word. You don't have tone of voice, inflection, facial expression etc. It creates distance I think. The emails/chat were very involved....like typing an essay. My therapist asked me a lot of questions to keep me involved. I like to write in my personal life so I think that helped a lot. I reflect a lot on journal entries etc. so this was a similar process. I did reflect a lot and found it helpful. But I can see it not working for lots of different people. My therapist was approachable and personal, which can

be hard to do via this medium. He also had a sense of humour which I appreciated. He had to prove himself before I could develop a trusting and collaborative relationship online. He gave me some exercises and once I had found them helpful I was more trusting. The intervention seemed to be the yardstick. I think in person, personality seems much more important. Via email the exercises etc. seem more important.

There were some technical challenges as you can always expect such as when you have a big presentation and your projector won't work or you can't get the sound on. Similarly there were times when our scheduled chat sessions didn't go according to plan but email was always successful. So when chat wasn't working we would switch to email and the session would be salvaged. I don't like being at the mercy of technology. I also don't think I type as fast as I talk so that is frustrating as well. However, with email, you can save a draft and come back to it; also you can respond at your own time and convenience. I would think the only thing that this mode has going for it is the convenience.

It is easier to ignore what's being said via a screen, you can just push a button and disconnect. In person it is much harder to do that. It is much easier not to take the relationship seriously online. It creates a fundamentally different kind of relationship. If you don't like what is being said you can always pretend you didn't get that last email, press delete that's that. It is not as reciprocal. You feel less on the hook in some ways. In person there is a more serious vibe and you are more likely to listen and take the time to do the work. If you felt so inclined, you could even get a friend to type the email and go on the chat. The counsellor might never know the difference. So you are faceless with the text-based online therapy, a bit anonymous I guess. But if I wanted to be faceless, I could go on a random internet forum and talk to anyone. Also at times I imagined the counsellor could have several windows up on his computer and be talking

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to a few people at the same time if they chose to. I also think that this form of communication allows for multiple distractions. In person in an office those don't exist.

However, I think online therapy might be better if it was couples with a couple of in person sessions occasionally. That way you could put a face to the person you are emailing, it makes it a bit more real. I don't think I would use this medium for more serious issues. I think the issues that can be addressed via online therapy are qualitatively different that in person counselling. I would still only choose online counselling if I moved and I couldn't see someone in person. Additionally, I would probably be more concerned about the privacy and confidentiality of online therapy if I was accessing it for more personal issues.

However, as far as life coaching goes, online therapy has met my goal. That being said, for the generation who uses Skype and chat constantly it might actually work better for them since they are used to it. In the end I had a more positive experience that I expected. But ultimately I think this paradigm doesn't work for me as well.

Shiraz

Shiraz is in her forties, doctoral student and currently living in the United States.

Being a middle-aged, homosexual woman in a male and religion dominant society (Iran) I was a minority and the government may even think I was a criminal for my sexuality. The concept of mental health is stigmatized; the general population does not seek to speak with a therapist nor a life coach. The reason being most are employed by the government or have some close association to the authorities and no one trusts them. There have been too many people I know who have become arrested and imprisoned for sharing family secrets. My reasons for seeking online therapy were two fold; first I needed to speak to a professional to help me come to terms and accept my sexuality that I have been struggling with for most of my adult life. Second,

I needed to speak to someone for whom my identity was a non-issue. There was no way I could risk coming out to a therapist locally because I don't have any way of knowing where my clinical records are being stored nor who will audit those files. Some of my family members reside in the United States and they encouraged me to speak to a therapist via online. I jumped at the opportunity, but not without caution. To protect my identity, I used a pseudonym and paid via a third party. My cousin in the U.S. opened my web-based email account and also showed me how to use a different IP address so that it could not be traced back to me. This was my portal into receiving the help I have needed but was to afraid to get.

We exchanged a few emails using an encrypted and secure software. I informed my therapist of my struggles. The past five years had all meshed together. I had the same routine of working, coming home to watch TV and fall asleep on my couch, wake up in the middle of the night and walk to my bed and try to fall asleep again. My house was falling apart- I had not cleaned my house in a year, it was such a mess and chaos I had stopped socializing. I constantly

felt worthless and stopped searching for meaning in my life. After sharing with her, she asked me more questions and I did an online depression and anxiety assessment only to figure that I had been severely depressed. For the first time I felt validated, my feeling of insecurity, paranoia and guilt were validated. I wasn't just a lazy old spinster. I had a problem and apparently many other people around the world suffered from depression as well.

I appreciated that my therapist did not push me to come on the webcam or provide proof of my identity because this would have driven me away. I needed the anonymity for opening up and also for security- something people in democratic countries may not understand. There were several resources such as web links, online support groups and books that the therapist got me connected to. I did Cognitive Behavior therapy based exercises. I did a lot of reading and a lot of bibliotherapy.

Our emails gradually turned into video-chats. I figured there was much more that could be expressed in person than a long lengthy email in which I kept repeating myself or rambling my way into confusion. We would set a time and meet online, it wasn't every week. It was usually once a month but I took away so much from those once a month meetings. In between I would email my homework and tell her of my accomplishments. I would express to her the days that were challenging and the negative thoughts that would start flooding my mind. She would be the mirror gently reminding me to confront those negative thoughts and use self-affirmations. After CBT, she introduced me to mindfulness based CBT. I learned how to be present with the emotion- whether good or bad. She said it was like a wave just passing over me. I could let it consume me or stay grounded.

I wasn't planning to end my life, but that doesn't mean I did not think about ending my life. I discovered that I had been depressed for a long time because I was living a double life and

trying to shut down my desires to live according to what was expected of me. I had to be careful about expressing my sexuality- it is not to say we did not have any homosexuals in Iran, we have our fair share. But to be found out by the authorities could result in the death penalty. I am not much of a social activist and nor was I ready to accept responsibility for the fate of a group that I wasn't even sure I belonged to. All I knew was if this is who I am I couldn't continue living my double life. That is when I talked to my therapist about my choices and the career coaching was introduced into the picture. It resulted in me applying to a doctoral program in the United States and getting accepted.

It was through the support from my therapist I gained confidence to think of a life outside of Tehran-I am now free to be myself. I would definitely recommend online therapy, for many people struggle with issues in silence. The societal stigma, the family name and the internal guilt prevents them from seeking professional help. I think this would is a great resource and I wish more people knew about it.

Appendix G: Counsellor Information Letter

Title of Study: Online Therapy: Client and Counsellor Experiences.

Principal Investigator: Dr. Jennifer Shapka, University of British Columbia
Doctoral Researcher: Shereen Khan, MA, RCC, NCC (PhD.Candidate), University of British Columbia.

INVITATION TO PARTICIPATE IN RESEARCH
You are invited to participate in this study because you have identified yourself as an Online Cousnellor. This study is the project of Shereen Khan , a doctoral student at UBC. She will be supervised by Dr. Jennifer Shapka, at UBC, and Dr. Marla Buchanan also at UBC and Dr. José Domene at the University of New Brunswick.

WHY IS THIS STUDY BEING DONE?
This study is being done to understand the experiences of counsellors' who practise online therapy. This study may help researchers and other health professionals to provide better understand the nuances of online therapy and provide a framework for improving practice.

WHAT AM I BEING ASKED TO DO?
You are being asked to participate in 1 to 2 interviews online over the next few weeks. Each interview will take about 90 minutes. These interviews will be conducted via videoconference and/or text-based chat and will be recorded. Every effort will be made to ensure confidentiality for the interviews, as your name will not appear on the transcription. All identifying information will be removed and to protect client confidentiality. At a later date, you will be provided with a copy of a summary of the previous interview(s) for your review and feedback. Additionally, I will be asking sending you my analysis of themes from the interviews I conduct, for your review and feedback via e-mail.

ARE THERE ANY RISKS?
You will be asked questions to try to understand your experience of your recent therapy experience with a client. The risk of participation is minimal. The questions are not designed to cause any discomfort. You do not have to discuss anything you do not want to discuss. If a question causes any discomfort, you can choose not to answer it.

ARE THERE ANY BENEFITS?
There is no direct benefit to participating in this study. Participation in this research provides an opportunity for you to tell your story and to think about your experiences. The information which comes from this study may benefit the field of counselling understand the phenomenon from your perspective. You will be offered a copy of a report about this study when it is complete.

WILL I BE PAID TO PARTICIPATE IN THIS STUDY?
You will not be paid to participate in this study. If you do choose to participate you will be offered a gift certificate worth $30.00 for your time.

WILL THERE BE ANY COSTS TO ME IN THIS STUDY?
You will need a computer with internet connection for the interview. There are no other anticipated costs to you.

WHAT WILL HAPPEN TO MY PERSONAL INFORMATION?
All identifying information about you, your practise and your clients as well as the interview transcripts will remain confidential.
This study will collect demographic information such as your name, your age, and the name and telephone number of your family doctor for emergency purposes. This information will be kept separate from any interview information which will be identified only with a study number. The only person who will have access to both your name and interview information will be Shereen Khan. The dissertation supervisor and dissertation committee for Shereen Khan will read transcripts but will not know who you are. The information will be stored on a password protected computer file and in locked filing cabinets at the University of British Columbia. This will be kept for 10 years, and then destroyed. At no time will your story or what you have said be identified by name in the study.

CAN PARTICIPATION END EARLY?
You may withdraw from this study at any time. You may stop an interview at any time, or you may choose to answer only certain questions. If there is any new information about the study that arises after this, you will be informed and given the opportunity to decide whether to continue. If you do withdraw, you will be asked whether or not you give permission to use the information and interviews collected to that point in time.

IF I HAVE QUESTIONS ABOUT THIS STUDY, WHO SHOULD I CONTACT?
If you have questions about this study, please contact Shereen Khan at the email: xxx@ubc.ca or telephone number 604-xxx-xxxx or Dr. Jennifer Shapka at xxx@ubc.ca or 604-xxx-xxxx.

IF I HAVE CONCERNS ABOUT MY RIGHTS AS A RESEARCH PARTICIPANT, WHO SHOULD I CONTACT?
If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-xxxx, or, if long distance, e-mail to RSIL@ors.ubc.ca.
UBC Behavioural Research Ethics Office 604-827-xxxx

Appendix H: Counsellor Consent Form

Title of Study: Online Therapy: the client and counsellor experience.

Principal Investigator: Dr. Jennifer Shapka, University of British Columbia

Doctoral Researcher: Shereen Khan, MA, RCC, NCC (PhD.Candidate), University of British Columbia.

Consent: Your consent is entirely voluntary and you may refuse to participate or withdraw from the study at any time without negative consequences.

Participant:
I have read the information letter. I have had an opportunity to ask questions and all of my questions have been answered to my satisfaction. I agree to participate in this study. I understand that I will receive a signed copy of this form.

Name:

Signature:

Date:

Preamble to interview Questions

Thank you for willing to participate in the interview today. This interview should take about an hour and a half and the information you provide will be kept anonymous. I would like you to speak about your experiences in online therapy. I would like to begin by asking you, when and how you got started in providing this service? And how long have you been practising online counselling?

Focus on the online therapy experience:

e.g. I want to find out more about counsellor's experiences of engaging in online therapy.

1. What has your experience been like?

2. What words you use to describe your online therapy experience?

3. What does online therapy mean to you?

4. How did you learn about online therapy? Did you receive any training?

6. What mode of communication (email, chat, video conference or both) for online therapy do you use?

7. How do you feel about the absence of audio/visuals?

8. How is it expressing yourself and responding to clients only through text? did you use any techniques to compensate for not being face-to-face?

9. How do you assess client suitability for online therapy?

Focus on online therapeutic relationships:

1. What instructions or guidance do you provide to your clients in regards to online therapy?

2. What techniques do you use to build rapport and establish a trusting relationship?

3. Were you able to develop a trusting and collaborative relationship with your client?

4. Did you encounter any technical difficulties while meeting with a client?

5. What do you wish had done differently?

6. Have you experienced any difficulty in terms of your professional ethics?

7. When you are faced with an ethical dilemma online, what do you do?

Encourage discussion of challenges of working in this environment:

8. What do you like/ dislike about online therapy?

9. Is it easy to find information about confidentiality and security over the internet from your website?

10. Do you feel online therapy meets your professional goals for counselling?

11. Do you ask for client feedback? What have their feedback mostly been like?

12. How has your online practise changed?

Conclusion:

Now that you have had this experience, what suggestions might you have for improving the online counselling services in general? What would you like to see as an added feature?

13. Is there anything else you would like to share with me today?

14. Is there something that I should have asked you that I didn't think to?

Focus on the interview experience:

12. How was this interview experience?

Thank you for participating. You will be receiving an email from me soon with some themes and questions and I would be asking you for your availability for a second interview.

Appendix J: Counsellors' Narratives

Ben has been in the mental health filed for over 15 years and has been providing online therapy for over a decade.

I have been practicing since 1996 and I got into online therapy in 2005. Getting into online therapy was more out of necessity. Where I was working we used to have an incentive program where I could work extra hours but this program was out phased and at the same time I had been thinking about developing a mental health site because it was of interest to me. But as I got into researching mental health sites, the idea morphed into, well, why not do online therapy and at that point I wasn't even aware it was out there.

When I built the website, my intention was purposeful and so I built it with the guidelines outlined by ISHMO and the standards that existed in the industry that was just finding itself. I am not particularly IT or web development oriented but I did all my research and completely built the entire website solely by myself. I went out and researched other the online therapy websites and evaluated what were the main elements and what needed to be included. I didn't make it well known with my peers as to what I was developing but the ones who did know thought it was pretty cool and just said tell me how it goes. I have never really felt stigmatized with online therapy, even when I have to do case management with a psychiatrist or social worker it is pretty much like how it would be at the office. I was thinking there might be because many professionals are skeptical but they just accepted me like any other professional.

The primary mode for my online therapy practise is IM (instant messaging), I do 99% of my work synchronously through instant messaging on Skype with the occasional use of telephone when my clients and I are experiencing technical difficulties. Similar to what therapist do with inclement weather at times move in the person appointment to a telephone appointment.

I used to provide email therapy but phased it out for personal reasons. First I could not keep it under one hour and then it just wasn't as cost effective. IM is much more flexible. Of course email works great for some clients like this one person on a ship who did not have access to Skype or IM.

I have worked with clients from Korea, China, Africa, Europe and the middle-east. Most people I work with are functioning professionals. It is usually English speaking people who cannot find the mental health help they need locally because they are either in a foreign country or they don't feel comfortable with the services available locally so they come online and find me and like what they see when they read about me on my website.

There are also people who would be too embarrassed to access mental health services locally and for those people if they didn't access online counselling there would probably never get help. Some of them have since moved on to local help. There are people who live busy lives, don't have time in their regular schedules. That is about half my clients the other half is from within the United States. I have had some clients who travel a lot whether working for the military or the UN, moving from one state to another so they have continuity of care with me. Some of my clients just like to have a therapist who can be easily accessible and they can talk things out with. Many other clients are short-term brief. But the vast majority of them are living functional lives they are not like the clients I have worked with in the community mental health center where I am dealing with the chronically mentally ill. So I don't really work with chronically mentally ill clients online. The way I see it is that online therapy is just another option on the continuum of care and for the right client it can be great therapy and for the wrong client it can be a disaster just like any other form treatment.

In online therapy I am very didactic, I see myself as a coach and teacher more than a psychotherapist just because of my approach. One of the most important aspects of engaging in online therapy is to assess client suitability. I remember when I first began my online practise and was desperate for clients like any new therapist in private practise. I soon realised, I didn't want to be in this situation and having to deal with someone who is unstable, needs to be on IOP or partial hospitalization. That is when I think the lack of non-verbals can really hurt because when you are working with someone who cannot regulate their emotions you can't really be on top of everything.

To assess client suitability, I have them fill out two questionnaires for intake prior to even considering taking them on as clients. If they have information missing I will tell them we can't work together. The intake forms can be very comprehensive from collecting history, family and current life functioning information to assessing substance use and suicidality. I am looking to ensure that people are stable for online therapy.

One of the biggest advantages I find is that you can save transcripts. Not for myself but for the clients who find it very helpful to be able to read over the sessions. I have been in numerous sessions (in person) where clients say 'oh I wish I could record this", I tell them they could but no one ever does. However in online therapy there is always a transcript that they can save and read over as needed. This can be immensely helpful for clients.

Further, online therapy is more affordable. I am charging $50 a session which is at times cheaper that the co-pay at most hospitals.

Anonymity is important in online therapy however ethically I will not take on someone without their full name, number and address, should something happen and I need to follow up off line. I find even with all the identifying information the lack of physical presence makes

people open up. It is astounding how much they will share, quickly. Also when you are not face to face there is less distraction. I find people are more focused on therapy.

Also the convenience from being able to work from anywhere, I can wrap myself in blanket early morning, with a cup of coffee and I am ready to work and go into online therapy. In my full time role, I see face to face client in a hospital outpatient clinic and the hospital is always so cold.

I like doing both, it is a good mix. I work 4 days at the hospital. I limit my online therapy to the weekends. It is different- you use different muscles. When I do online therapy I can be drinking coffee and wearing sweatpants and it is really different.

Each one has its advantages/ disadvantages- you have a transcript, there is the anonymity that allows people to open up quickly, and you don't have all the distractions that you would in the office. It is really about the therapy. This was a surprise to me. We get less into tangents and stick close to the issues. There is no way for me to know if they are IMing with other people or web surfing as well as getting therapy. Once I know their rhythm and I find they are distracted I will ask them is there something else going on. And this will usually bring them back to focus. Also certain clients feel safer. I have had clients in the office who have been so uncomfortable that at times I will give them my back and tell them let's start this way. They are so intimidated being in an office. For people who are uncomfortable in the office, online therapy can be great.

Advantages of face to face are of course you have the entire verbal and visual. Granted, there are some things that are more difficult to do online. Believe it or not I do visualizations and relaxation exercises online, even the empty chair. But it is a bit trickier then doing it face to face. There are certainly some techniques that work well in person and are more difficult to do online. An example is Dan Segal's work where he talks about neurobiology and he shows the fist to

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explain each part of the brain and how they fit together. I had to have it written out and copy and paste the information when in IM. But in person you can show them the fist and point at the parts as you give them the verbal understanding. So at times the lack of visual can limit the techniques you use.

I have already written passages that I can cut and paste. There are some shorter more spontaneous visualizations and metaphors. And then at times I will say let me cut and paste something. Let me tell you the story about the girl and the umbrella and then I will cut and paste the 6-7 paragraphs and then we will talk about it. When I do visualizations it is more like I will give them the instructions and close your eyes and follow the script and chime back when you are done.

I have been amazed at what you can do online. I was skeptical like everyone. It is not perfect but I don't necessarily think one is better than the other. I think it comes down to who the person is and what they need. It works for different people just another point on the continuum of services available.

I think people are more open to you because they have the distance. They will talk about things that they have never talked about before. Now that is usually an advantage however it can be a problem. But people can get into things that can be overwhelming and they get flooded and get traumatized. I have had that happen to maybe two clients in the ten years. I screen them very well based on what the tell me, but then what would come out later is a lot of abuse from the past and it came out and they got flooded and at that point one person was in Korea and because of that she has nothing else available to her. She was seeing a psychiatrist but she did not have a local therapist. I stuck with her even though I probably wouldn't have if she had other options.

For other people I have said to them online therapy is really not appropriate for what you have disclosed to me and I give them resources and referrals locally for people to continue working with them. And then I have one client who just wouldn't do it. She would not see anyone else. It was either me or nothing. I had to once call the police, her husband, and then an IOP. This is what you want to avoid. But for this client she was unwilling to see anyone else. So I stuck with her; it was a roller coaster ride and I try to avoid that at all costs. I couldn't abandon her and she was unwilling to go anywhere else. This is why screening is so important.

A roller coaster ride in my full time job is different because you have the whole hospital behind you for support. In private practise you are isolated and even more so in online therapy. If you are getting into online therapy you better screen carefully.

I don't have anyone for online peer supervision. I think through it on my own. I never really had a dilemma, even with the at risk client I knew what I had to do- I had to call the police. She was making direct suicidal statements.

With international clients I have never had to call emergency line. Most the clients are pretty high up. Some in the UN, refugee settlement, most are high functioning.

IMing is slower than talking but early on I decided to add the extra ten minutes, I do 60 minutes because I felt like the 50 mins was not enough. The extra ten minutes allows to close the circle of therapy.

Whether face to face or online as a therapist I always try to assess if "this was a good session," and most of my online session feel like "good sessions." So much of what I do is mindfulness-based cognitive behavioural therapy. It is based on teaching and getting their heads out of the way and is very conducive to online therapy.

At times to make up for the loss of audio/visual/ non-verbal, I will periodically stop and ask them what is going on right now. What is your mind thinking, what are you feeling and what is happening in your body right now? It also allows the clients to go inward and practise some of the mindfulness. I use a lot of metaphor and analogy. I talk about the wounded child or critical parent.

No one has ever really asked much about the confidentiality or had privacy concerns. Most people find my website and read the confidentiality statement before we begin therapy.

However, recently I had a client from Saudi Arabia, and I don't know if it is a cultural thing, but he wrote nothing about his childhood in the intake forms. So I insisted he write me something about his childhood and he told me that he would not send it through email but would send it through Skype, which he felt was safer. And he said that as soon as I had read it I would have to delete it. Now I have never had that happen to me before. But he was very concerned about the privacy. And I asked him is this part of the culture worried about people getting into your information or is this about you. But I never really got a clear answer. But other than that incident, clients never even ask about the confidentiality.

In reality people can hear through the walls where I work, phones can be tapped, medical files can be stolen. I don't see the risk as any different. I tell them in the questionnaire that they do not need to write identifying data on the forms; they can supply the names addresses separately. So if someone got a hold of the questionnaire it wouldn't have any identifying information. I probably get more concerns about confidentiality at work. Clients worry about their medical and mental health records in the hospital, how safe those records are.

Further, I don't worry too much about the law regulating online therapy. It is a grey area. Lots of people have their opinions about online therapy. There are no court cases that I have

heard of and basically my way of dealing with all they unknown grey areas is making sure my clients are happy. So if it not worth their time or money I am happy to return their fees. This only happened one time. If the client is not satisfied with the treatment I gladly refund their fees.

The client feedback has generally been very good. A client once said to me this is the coolest thing, "I am here on s Sunday morning in my pajamas getting therapy." My clients have thanked me. They sometime send me periodic updates about their accomplishments. Sometimes the clients will come back when they face another hurdle in their life and find online therapy has helped them in the past. Some clients I have worked with for 5 -7 years not on a continuous basis but as they move around and develop in their life they have just kept me as their therapist.

My goal in two years is to buy an RV and have satellite internet so I can provide online therapy from wherever I maybe. I got into online therapy when the incentive program at work ended to supplement my income but it really is also my retirement program. I have already done a lot of research. The one problem is the delay problem with the satellite and I don't know how bad it would be for IM. WIFI and direct internet would be possible. Most parks you would stay at have direct internet. A therapist on the road, then I just have to keep my time zones straight. I have some clients now that are 13 hours ahead to 3 hours behind.

The key to successful online therapy is screening (the most important), your style of therapy, and your comfort level with computers and working with few non-verbals? When people go out and look for help there are many choices and this just happens to be one of them. For the right person, online therapy can be the perfect choice.

John

John has been in the field of mental health for over 30 years and has been practising online therapy for nearly five years.

My colleagues in (Canadian city- de-identified for confidentiality) wanted me to come and to do sex therapy, provide some specialization on that side, and I would be flying about once a month to (Canadian city- de-identified for confidentiality). I did that for a couple of months, but weather cancelled my flights in both directions. I took about an eleven-and-a-half hour bus ride to Alberta and back to (Canadian city- de-identified for confidentiality), BC. Have you been on a long bus ride? Do you know what that ride would be like? Well, after that, I knew I never wanted to do that again. And then one of my colleagues introduced me to Skype, and since then I have been primarily using Skype for communicating and providing therapy.

I have offices in United States and Alberta – that's where my colleagues work and provide therapy, and my home office in (Canadian city- de-identified for confidentiality), BC. I only provide therapy through Skype because I love that I can be in shorts and sandals, and, you know, just put on a nice dress shirt; you can see me from chest up. Also, I'm very excited about Skype and connecting to people from around the world. I believe it is a marketing thing; you need to be specialized in what you offer. If you're a generalist, there are lots of people out there who are generalists. People are coming to me because they want to work with me, they're coming to me not because they don't want me to ask those questions – I don't have a magic pill that's going to help them get better. I ask the hard questions; that's what I do.

It is quite interesting the kind of work we do, peer into people's lives and try to assist them with their deepest concerns. You have to be interested in hearing about their experiences and their life stories. I think in terms of quality, it's pretty similar to what you would find face to face;

however, on Skype, I have preferred not to do in-depth work. I'm not getting into the depth, and that's a choice I've made because I just don't want to work that hard, right now. I'm 72 years old, I'm not in that phase where I have to work. I don't have any financial obligations. I work when I want to work. Some of my friends do email or telephone therapy for some EAP companies – but I just don't. I'm content with how I'm working. I choose to work less. I'm retired. I work when I want to, and I only work two days a week, and that's how I want to keep it. I don't market myself; it's just people hear about me from my website, or from others, and can find me.

I keep it simple and straightforward when it comes to asking for payment, I ask them when we get online, "Would you prefer to pay with VISA or Mastercard today?" I take their number and expiration date and say, "The time is now yours." I don't like to have them pay me before the appointment through Paypal. That's just not the kind of guy I am. That's just not how I work. Also, when it comes to sliding scale, I just don't accept that, because I don't want the client to get half my attention. I wouldn't want to discount the attention that I give. So, I charge full, and I expect full attention, as well. It's not good for the therapeutic alliance because then it would be like "Oh yeah, there's that client who asked me for a discount. I don't even want to be here."

For instance, I've had a client in Vietnam. Once I had a client who was sitting in his car outside an office building, connected through the wifi in the office and Skyping with me. I have an appointment today at 9:30 pm that's a working single mom who said, "Can I talk to you after I put my kids to bed?" There was no way she could fit in an in-office appointment like this. Now, in (Canadian city- de-identified for confidentiality), the traffic's horrible, you don't want to get out and drive to the therapist's office. The convenience of being able to do it from home, it is just great. I don't want to go out and drive there.

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Also, I'm able to reach people who before did not have access to these services and now because of technology they do. Something really interesting is that I'm from a Jewish background, and for the first time last week, I saw a client from Saudi Arabia. What are the chances of that happening without Skype?

I do videoconferencing only and use Skype. I don't use e-mail and telephone therapy. There are just too many cues: the subtleties, the hesitation, the gestures of the hands, and the twitch of the eye that can be missed over the phone or text only.

When measuring success, I think what is really telling is when a client makes the second appointment. It indicated to me that they've been comfortable with the technology, and there's therapeutic alliance, there's a relationship that they want to come back and have a second session. To me, that's what success is.

Francine

Francine has been working in the mental health field for over 20 years and providing online therapy for nearly ten years.

I've been a therapist since 1987, I finished my Masters degree at (Name of University de-identified for Confidentiality). So I had been working since '99 at a youth employment centre, we were using a lot of computers, a lot of technology around helping youth figure out job search work, and I kept going, "Hmm, there's gotta be a way to combine these two, there's gotta be a way to combine doing the. . . you know, online counseling just seemed to me to make a lot of sense, so I started searching around to see if there was anybody that was offering it, or doing readings about it. And I came across Dan Mitchell and Lawrence's work. And I think I met them at a conference, and kind of asked Dan more about the course, and then it was a couple of years before I was ready to do it, just in terms of my own timing. So then in 2005, I started it – the course. I knew before I started the course that the youth employment agency was that I worked for was closing. So I was looking for, ok, what else can I do, beyond that? Being around youth and seeing that they're using technology all the time, there's gotta be a way. And, so, just searching around and came across it. I took the online counseling course through Therapy Online at the University of Toronto Cybercounselling Level 1 and 2 in 2005.

I'm now an affiliate counselor with an online therapy provider and have been since September of 2006. I was looking at setting up my own website, and doing all of that kind of stuff, getting my own private practice rolling, in face to face as well as online, and then they offered the affiliate, and that's been so busy I haven't really developed my own private practice that way. I've just stuck with being an affiliate with them.

For me online therapy has been wonderful. It's been a really interesting experience, it's been challenging at times. There's always a learning curve with technology, with how to convey. . . every new person that we deal with, there's a way that you have to convey. It's like starting new, I guess, is what I'm saying. Often, with each new person, explaining how it works, trying to get them engaged and involved in really doing therapy that way.

When clients first start, they get a welcome message, whether that is through their EAP, or that is through Therapy Online. And this letter consists of information around what to expect, how to log in, the nuts and bolts really. And as I go I tell them what I am doing and I try to create a sense of conversation. And some people buy it, and will really go with it themselves, and will use the emotional brackets and tell me what they're thinking, or what they were doing, or that descriptive immediacy, describe where they are, how things are going. Other people just seem to say they enjoy that. They don't really go there themselves.

Some people do, and some people don't, and either way, it really does bring about a deeper level of that conversation, I think. Yeah, so some of it is that explanation, or I'll put that in. I start always, every first session with a client, to say, here is what I'm doing, and here is -- my intention with this is, I'm trying to create a sense that we're in the same room together having a conversation. From the outset, that's when I'm saying those things, you know, this is where I'm at, or this is what I can see out the window, or my cat's in the room with me today. You know, any of those kinds of things, or that I have my chair set up and waiting for us, or I'm inviting them into my space.

My practice is combination of videoconferencing and e-mail and I'm certainly about to add a whole lot more videoconferencing component. I think, for some people, there is that element of, "You can't see me, this is wonderful" I went over some of my old cases and just kind

of looked at what people had to say, and where they were coming from, and it's not a big number, but there's enough of them who've said, "I'm really glad we're doing it this way because I can't walk into an office. I'm too embarrassed, I'm too ashamed, I'm too whatever. Or they live in such a small town that there are too many other elements of concern for them. And one woman did actually say, "I'm just glad you can't see me because I'm so ashamed of how I look." But she was able to start to move through that to, "Oh, counseling might be ok." Because she was so afraid of judgment, online counselling seemed to be able to move her into a place where she might actually be able to walk into an office and talk to a person in regards to the self-esteem and body image concerns. But for other people, I think it's the element of they can do it whenever it works for them. I think that's the majority of the people. Some of my clients, then, who do videoconferencing have said to me, "It's just so nice to be able to do it from my home at a time that mutually works. So then I don't have to travel to your office and then travel back home.

I have noted that the people I have been working with were extraordinarily busy professionals. And they just had no time. It seemed like that was part of the reason they needed counseling. They need time management, stress management. The amount of time involved in getting to a therapist's office, meeting with them face to face, and then getting home involved making adjustments and taking time out of their busy work day during the hours that a therapist would be able to accommodate them in an office. However, with online therapy they could sit down at night and just do this, and then go to bed. Or they could do it while they were making supper – not that those are ideal conditions, but at least they're getting help or the support that they needed, and they could fit it in when it worked for them.

In terms of the client population, well, it feels like it's everyone, from all over. Some people that I have been surprised that have really done really well with e-counseling, and I think I'm surprised initially because they are in their 60's, you know, with the technology. They found it to be really a good experience and a positive one. Struggling through the technology to make it work. I was more surprised initially that that age group would try it at all.

The kinds of issues I see, well, I'm dealing with a lot of depression, anxiety, recently had somebody who said, "I think I'm going into bipolar again," you know, so some people quite severely anxious. I would rate them quite high on an anxiety scale. Lots of relationship abuse. Depression and anxiety has been fairly consistent over six years. I've dealt with a whole lot of people who are suffering from both and different levels. We have questionnaires they're answering, so I have a sense of them scoring themselves, on how many days I've been feeling fatigued or tired. Those kinds of scales, or "I feel like I'm letting people down". We do check-ins that way, - I haven't worked with anyone with eating disorders – no, sorry, I take that back. I had somebody come into therapy, and I recommended she go see somebody in her community. Rather than do it with me online. But for her going to e-counseling was her entry into being able to get to other counseling. And her eating disorder, I would have said, just because of what she told me, just the tip of the iceberg, might have been fairly severe. Sometimes people have talked about cutting or have had suicidal ideation, but again, we talk about moving them into resources in their community. Maybe talking with their physician or their psychiatrist, if that's on their care team.

Same with drug and alcohol counseling, because some people have come in to seek e-counseling, saying, can you help me with my drug addiction. Uh, yeah, there's a limit to how much I could possibly do online. However, we can at least start and transition to other resources.

I let my clients know if it is not an area of my expertise. So here is what I do know and then here's where I would refer you. For a lot of people, it seems to be an entry.

There's kind of a mix of tools and resources that I pull from, I've been doing a lot of the CBT with people. I use a lot of resources from Australia, clinical interventions. Some of that is, they're not calling it cognitive behavioral therapy, but a lot of it is kind of along those lines. Sometimes there's a mix. Sometimes I'm working with a mindfulness kind of approach. It depends on the individual, I think, as to what I think works best, but a lot of the CBT, for sure, seems to be there. I've been doing some more reading about the dialectical behavioral therapy, but have had no training in that, so I haven't gone there with people. Sometimes I use things, even, like Byron Katie's work, so sometimes I will refer people to that, to The Work, to go to the site. Or sometimes I'll just give them the questions to work with, and we'll have that kind of dialogue. So sometimes I've got them logging, tracking symptoms, doing all of this, but it really depends on the individual. In online therapy it is important to pay close attention to the client's use of language, you know, like some people are very direct. They are like "Cut to the chase, let's get going," or they'll say, "I want some homework, I want something to do."

Some people, they come in and they don't have a lot of insight, so something like "I'm really angry," and "I have no clue in particular what triggered it". That to me is a really obvious, "Ok, let's start with. . ." Because I can't help you manage your anger until I have some ideas about when it occurs. So, you know, let's chart this. Here are the reasons. And I'm very transparent, saying, "This is the reason we're going to do this," or, say, with anxiety, somebody saying, "Well, I'm anxious all the time." Well, let's chart that. How high is that anxiety? And then let's start figuring out what we can do for you to intervene. In some respects, it's like having a coach for self-help.

Sometimes it is language, sometimes it's what they say, sometimes when I make a suggestion, but then they report back to me about what worked or what didn't. Even today, I have somebody who didn't really want to let go of a specific experience, and so I had suggested writing, and I had given her 3 or 4 suggestions about ways she could use writing as a tool to do that. "Well, you're the third person to tell me that "But if I asked for help and they told me what to do, then I should just do it." So I went back and said, "You know, it's out of your comfort zone, so let's talk about ways that you could make it more ok for yourself and, guess what, you might try it and it could not work. So that's ok too. Then we'll figure out another way, give it a shot, let me know how it goes, and then we'll take it from there. Or try something different. Try to get across the idea its ok for something to not work. Ok, let's talk about, if this is discomfort, how long can you tolerate discomfort for? Set a timer. How'd that work for you? So, some people are very self-directed.

I think that the therapeutic alliance happens faster than it does face to face. I think that's where some of that disinhibition effect seems to work well. For some people, they seem to be able to really tell me really deep things very quickly, that normally you'd be getting it face to face so. . . Just this past spring, I had a man I that was working with who, the first time we had a session, he was a little hesitant telling me about sexual difficulties, (which is also an issue that sometimes I'm dealing with in an online environment). Because it's more comfortable for men or women, I find, to talk in that kind of more anonymous environment, and so then it's, "Ok, I'm telling a complete stranger all these things about myself that are very intimate." And I can sense those shifts in terms of how they write, or how they address me back. And I can see immediately after seeing that kind of nervous, "Ok, I just told this person all these things," and the response they got from me, they can feel like, "Oh, oh, it's ok, oh, it's not something terribly wrong with

me, they can help, there are things that we can do, there are some ways that this can be resolved. There's some practical information that I'm getting, and so I feel this can help me even more," about what's going on in his life and how he feels, so there's those. The Rogerian approach of, "Ok, I'm not judging you for what you're telling me and I'm accepting you for who you are," goes a long way to developing that trust really fast. And I think that with the writing makes it stick longer, because in your office, I can walk away and I can go, "Oh, that person was really not judgmental," but in online therapy, I can read their words over again and say, "Oh, look, see? That person is saying something or they've noticed something about me. It seems to have a stronger impact for some people. I don't know if it does for everybody, but it seems to stick, I'm not going to forget this, because you've written it down.

I'm thinking that after my experience with videoconferencing, I think there is still some of that distance, right? Between you and me on video because you're on camera, so you're not actually sitting in a room with me looking at me. So there's a little bit of that. I can say things, but I am in more control I am behind a screen and not actually having to say them to your face. There's a little bit of that. Once this woman said to me, "I was wondering what I'm going to do when I start crying, when I'm on Skype." And then shortly after that she said something , or I asked her a question and she just burst into tears. It was a very intimate moment still, even though we were on camera, even though she's not in the room with me, so I can't convey to her as much as I would if the person was in the room. You know, "I really hear you," or "I'm here." I had to make little noises to indicate the connection hadn't gone dead on her. And at the end, she was like, "Wow, I didn't expect to do that and that was actually ok, and I feel just as heard as if I'd been in a therapist's office having this tearful moment, or expressing this hurt." This was interesting, because I didn't quite expect that. I was like, "I don't know what I'm gonna do if you

cry online." You can't reach over and pass the tissue box. But it can be quite powerful for people. They're able to connect as they would in a session, they're able to express as they would, especially with the videoconference, is the feedback I receive from my clients.

Then again with technology come technical difficulties. With video, I tell people, this is Skype, it might freeze, don't take it personally. It might freeze, it might drop the call. I've had to set it up that, if we're going to, if it does happen, I will call you back so they don't wonder what to do. So there's always a backup plan in place, so you have a phone number to reach them. And if that doesn't work, then I'll phone you and all of that kind of stuff. It's helpful, because then people know what to expect. And Skype will cut out all the time. Or the quality's bad or the person freezes, or whatever. . .it depends on whether they're hardwired or on wifi, and how strong the bandwidth is and all that. So we just put it out there. And also, and this happened a couple times where someone's told me something really, you know, big and then we got cut. From my perspective, it was like, "Panic, get back on! Don't lose that moment!" But when the person reset the button they hardly even noticed that it had happened. SO being prepared, having a backup plan and knowing that if you missed the moment because of technical difficulty it is not the end, in therapy moments often reoccur.

Also, something that I've learned over time is that a lot of information in an e-mail can be overwhelming. Sometimes, early on, I found I was putting too much information, too many resources, too many ideas together, in an e-mail session. And I know that because they'd go "Holy cow! Whoosh. . . that was a little. . . I'm overwhelmed. I need time to absorb what you've said." So I'm like, "Ok, backup, backup." If I find myself struggling as I'm writing, you know, like, "Do I need to add something here? What do I need to do? And I'm like, ok, stop, I need to remember that I'm not trying to solve everything at once. Some of that's about learning to back

off and probably I do that in person as well. "Oh, got some great ideas for you!" It's about

remembering to stay simple.

I think I'm much better at that than I was earlier, honing in. What's important here, what

have they said, and also much better at reading between the lines of what they've said. So where

did they need that encouragement, what was behind the feeling they might have written. That all

has become easier, and more honed, and it's much easier to get at the what is it that you need,

what are you hoping to get out of this, let's have that conversation right up front. So that I can

make sure this is directed at something that's going to work for you. And I often do ask my

clients, "What have you done in the past? What's worked? What hasn't?" I don't want to repeat

stuff that you've tried that didn't work, or let's talk about why it didn't work and maybe we can

find a way around it. That kind of stuff I do much more at the beginning than I used to. I also

learned to set a timer for myself to remind myself how much time was passing so that I stick as

close as I can to a regular client hour (i.e. 50 – 60 minutes).

I think one woman sent me 17 pages of single-spaced. It was the most I've ever had, and

that's when it was like, like, I can read this, but I'm going to need to pick some things to focus

on in my reply because I can't address 17 pages in an hour. One thing that I remember of her that

I did, was sometimes I would put extra question marks, like 3, so her response to that, and as a

young woman, at 17 years old, was, "Are you telling me I'm really weird?" The question marks

suggested that I thought it was such a strange thing that it needed to be really questioned. No,

sorry, I just was wanting to make sure that I understood what you were saying, so I was

questioning. Even the kind of nuance of that, she was really paying attention to.

And I try to invite clarification. I always say, "You know, if you have any questions

about anything I've said, if you want clarification, please feel free to call my office," if they

want. And some of them have actually phoned me directly. Which is an odd experience to talk to somebody that you've only e-mailed. And some of them have just sent another message saying, "What did you mean by this?"

Until fairly recently, I had clients in Ontario, as well as other parts of western Canada. Certainly nobody in Quebec, but I have had clients in the Maritimes as well. The rules and regulations about counselling and things are changing. Those are shifting boundaries as well. So Ontario, I don't think, nor do I think we'll be doing the Maritimes anymore because those are becoming regulated in a way that's – I think you have to be certified in Ontario to do counseling for people in Ontario. As I've seen, some of those things are changing. So now I mostly deal with. . . I do have some clients who are overseas, but we don't have anybody in the U.S. That's something we've chosen not to do because of the legal implications there. But I have had clients in the U.K., in Spain, in New Zealand. Fewer of those now and some of that is just because we need to figure out all of those legalities. Certainly, I am checking out where do they live, I have their address, so I know where they live, because that's part of the registration process, but checking out what resources are available to them. I need to know what those are, in case an emergency arises. So that's where some of those things come in. Do I want to practice that far away? It's easy for me to find out what the resources are in Canada, it's real easy for me to find out what the resources are in Victoria, or Vancouver, or wherever in BC. It's very easy for me to plug in people, because I know the system. Get anywhere beyond that, and I really need to educate myself about what is going on in their community, what's possible, what's available. What the resources are, and who to connect them up with.

But the clients who are entering therapy overseas, they are informed, that they are engaging with a therapist in Canada, and so they already know that. In my view, it is part of their

informed consent. This is what they're choosing to do. However, we wrestle with informed consent all the time. What does informed consent mean? How much explanation can you give? We try to do as much coaching as possible. To illustrate, my experience with a client in Spain, she was actually an English expat living in Spain. She was searching online, and found Therapy Online, and so, decided that that would work for her. She could have chosen, probably, other services, but this was what she found that seemed to fit for her. She was a busy professional, but living in a smaller kind of community was there weren't a lot of English services. That was why she chose that. It didn't come up for her, but it could have, that she needed emergency mental health services, but she and I had talked about that. "Who would you go see if an emergency came up in terms of that kind of services, what's available, who are you connected with in that community?" But before she even registered, she would have had to go through the process of reading "Here's what we can do and what we can't."

There is one recent client story that I want to share, one that I think was a nice little success for her. She came into e-counselling largely because she wanted to make a decision about whether or not to continue pursuing a certain professional designation. She was struggling at work. First, she was an immigrant at some point many years ago to Canada, so had struggled with language and had had on-and-off difficulties with schoolwork and balancing school, home, heavy volunteer commitments, lives in a house with people who are addicted to and are recovering from addictions. So is also kind of a house parent. So a very busy life, and was like, do I need to finish this designation or drop it, and then what do I do with my career? You know, so that's it. So through the time, because she was so stressed about doing the course, because there's the issues of ESL, issues of self-doubt, issues of time, she was getting really anxious, and understandably, based on past history and wanting to succeed, but not knowing – even if I do

succeed, where is it going to take me? In the time that we spent together, it became clear that she made a decision, "Yes, I am going to go through with this." So we created an action plan to get her through the next three courses. How was she going to do it, what did she need to put in place? What supports could she maybe. . . So, "Yes, you need to learn the word 'No'." N-O spells no. That might mean you have to say no to some things. But it was only for a time. So it was little pieces of those conversations back and forth. It was about dealing with her procrastination as well. By the end of that, she was like, the way that she was talking to me was certainly, "Oh, you can see now why I need this help, but it's been so helpful, and I really understand it." The suggestion that I'd given her for managing or dealing with it, creating an action plan, she felt just really supported, and I felt like she really was taking what I had to say and running with it, beyond, and that she had now decided and was moving forward to her goal and had a plan to stick, to get through. So there was those both sides of that. Even beyond that, there was a whole lot more for her – she was a very faith-based person, and so to have that. . . And I think her final question to me was, now I'm worried when I finish this designation, will I find work? Because I see my friends who are searching, but for me to be able to come back to her faith and say, "Do you trust? You've been saying this is what you want, and you can trust that you will get the calling, or you will know when you're finished there's a reason for this." Again, based on what she'd said earlier and putting that forward. It was such a lovely way to end, putting that in that moment of, she had that hope to go forward with it, beyond even just "I've got a plan of action." I helped her visualize it. See yourself -- you're succeeding, and having faith. And it's not about getting the high-powered position for you. Maybe other people that you see are aiming for that. But you're coming from a different perspective, where you want

to live a life of service. Getting at her values and bringing them back. Just lovely conversations all the way through.

The more that I do it, the more I think there what is possible, in terms of ongoing research. I think there's a lot more research that can be done. I think there's a lot more – I was going to say paradigm shifting, is what we're looking at. That, to me, online is not just now about the translation of what I do every day in my office with my face to face clients. . . it's no longer just picking up the traditional format into online format. I think there's more possibilities for, not just one to one, but one to many, many to many, kinds of ways in which people can connect with each other in therapeutic kinds of ways. So some of those things are kind of out there on the edge. I'm not even 100% clear on what those all are yet. I've certainly been doing a lot more reading and research lately about career kinds of counseling that are being offered in different formats that really can shift that paradigm of just two people in a room talking.

I think online counselling will continue to grow. I think it's not ever going to be for everybody. It's not going to be for every client, it's not going to be for every therapist, but I think that there are some huge benefits that can come if we can harness it and utilize it and learn how to utilize it really well. I'm just thinking about the conference that just took place from the International Association of Educational and Vocational Guidance – the IAEVG. They just had a conference in Anaheim. And part of it is about the social justice. If you look at it, digital divide is shrinking, so it becomes more inclusive, so more people have access to the services that are possible for them. So to my mind that's exciting about what can happen in our profession, if we can have a broader reach, that we can achieve more, reach more people, make more impact, in different ways than we have in the past.

And also there's some ways in which some of that help-seeking for the younger generation that I see in youth that are coming up and growing and developing, that they're much more. . . where do they go for help? Well, they go here, to the computer, often. Again, it's not going to be for every youth, it's not going to work for everybody. Some people are still very skeptical at all that this type of counseling can work, that it's ethical, that it's safe, that it's secure, and that it's private. If only they can stop having that conversation and start talking about more of the research and show about how it is and what impact it's having and how other people can shift into that because I think there's enormous possibilities. Partly it comes down to that social justice kind of piece and that inclusivity and that it's much more far-reaching, so that people can have the possibilities of getting helpful information and a sense of control over their own lives. The only thing that I keep emphasizing is definitely that we need to keep doing more research, like what you're doing, like what other people are doing. Let's find the evidence; let's show it works. Then we can keep improving our practice.

Carl

Carl has been a mental health clinician for over 25 years and has been practising online therapy for over ten years.

I first started doing e-counseling back in 2004, 2003. So I was doing e-counseling for 2 years before I actually did some training. I did the two levels of training. The training was completed back in 2006 so it's been 6 years. Also, in 2006, I launched my own practice, fulltime counseling practice, most of which has been cybercounseling. And I did that for about ten years. So I was doing a lot of cybercounseling. Part of it was my own private clients and I also was doing a lot of contract work with EAP, so I probably had hundreds of clients, cyberclients, over the years. I have clients from different parts of the world, mostly Canadian or American, but people who have moved or are travelling. The bulk of the clients I've had, I would say are from Canada. Now, more recently, it's been much less I am now overseeing the clinical management of the e-counseling program for an EFAP organization.

We have introduced a new system in which to deliver both chat and e-counselling exchanges. I was involved in the testing stage. Although I don't actively do chat, I was involved in the testing, which gave me my first exposure to using a chat platform for counseling. And I could see very quickly that there were things that really needed a different way of thinking, in terms of how to work with folks through chat, the modality as opposed to through email exchange. The asynchronous, or the e-mail type of platform allows the counselor and the client time to think about what they want to write, to really process it, to really create it, and then to deliver it, whereas with chat, it's spontaneous, it's live. In a way, it's like being with a client in a room. Of course, you're not with them in the room, but you have to think on your feet, you have to think quickly, and in that sense, with the audio and the visual, you can't worry too too much

about how your text is looking. You don't want it to look scrambled, but on the other hand, you can't put the kind of attention that you would when creating a carefully scripted e-mail exchange. There's a big difference there. Because I work so much with asynchronous, it's more comfortable to me. I could see, possibly, with certain clients down the road, doing chat. It wouldn't be my preferred mode at this point. And I say that mostly out of the lack of experience, level of comfort, or, I guess, lack of level of comfort at this moment with it. If I needed to provide it, if I was asked to provide it, if I chose to take on some cases, I could do it. But it would be a learning curve. But I have grown so enamored to the asynchronous format. And because I continue to teach it through the (Name de-identified for confidentiality) I'm much more passionate about it. I'm much more familiar with all of the challenges and all of the unique opportunities that it presents.

In terms of client preference to chat-based therapy versus email, I can see that those in a younger age group, anywhere from late teens, early twenties, into their thirties, those who use texting as a major means of communicating, that they just see that's a natural extension and want to get help online. But the asynchronous users really do vary in age, and I've seen people into their late 60's. Probably the higher percentage would be somewhere in, say, mid to late thirties to fifties, using asynchronous.

In my experience within the EFAP world of e-counselling I have observed that when you offer a service at no cost to them, people get on board, they're interested, they come from all walks of life. People are curious, people see it's available, people appreciate the accessibility, and so there's a range in terms of age. I think what distinguishes those who really can use it to the optimum, are people who are good writers, people who have the ability or the inclination to be reflective, to think, as opposed to spontaneously venting. There's a certain kind of person,

who, ideally, can benefit, much more so than the average user. Those who really want to get something out of it if they are able to write relatively well – and I'm not talking about creative writer – but we're talking about people who are able to express themselves, who are able to use a computer and a keyboard relatively adequately. If someone is having trouble typing on a keyboard, then what you end up getting is a scrambled conversation that you have to decipher, try to make sense of all the spelling errors, people who write one huge paragraph without any sort of spacing, and you have to go through and if you were to print it, pages and pages of this long paragraph of words that run onto each other. It makes it much more difficult for the counselor. The client might be venting. They're just typing away everything that's on their mind. Thus a person who's a bit savvier around computers, more articulate, will likely get more out of it.

But even the average user, they will do what a lot of clients will do sometimes face to face, they will come to a counselor, and they will say, "This is my problem, now fix it." Tell me what to do. And that's not unusual in counseling. But I think, from what I've seen in the e-world, I think, even more of that, because people can use the written word to communicate what's on their mind, they might write a couple sentences, and then expand that view to answer, and actually, as the clinician, it is our job to work with what we have. That might be carefully asking some very judiciously thought through questions to expand our assessment, and our dialogue with our client, but nevertheless, we will have to work with what we have.

I'm a social worker by training and I still believe strongly in beginning where the client is, and so, we work with people who come from different histories than we do, different cultures, different countries, and we work with what we have. And I think online, it's a similar kind of experience. But because I've done so much e-work and I've seen a range of different clients

using the service, I'm much more accustomed and comfortable to working with people where it's evident that English isn't their first language, or they may not be the most articulate of people, but nevertheless, they have issues that they want to talk about, and I think we work as best as we can with what they give us. If it's that we're unsure about something that a client is writing, and I'm talking in terms of the asynchronous format right now, we check it out. It's true of any client. If somebody writes something that it's hard to understand what they're actually saying and we don't want to misinterpret, we write back and say, "I need to check something out with you. When you wrote this, did you mean this, or did you mean something else?" The language, the way they use it, sure, we're going to be a little bit more challenged in these conditions, because we're relying totally on the written word in this type of modality of service. Whereas in face to face, or even telephonic, you have either the visual, or the audio, or at least auditory or telephonic, you can tell by a person's voice certain things that you will not pick up as easily in email or chat. But, again, with chat and with asynchronous, there's other ways of communicating in a deeper, richer way, with our clients, in the hope that we can really pick up on those cues.

There is a lot to be said about the use of asynchronous counseling. I think there are ways to write to our clients that really do reflect a meaningful connection, and a deep interest in understanding their story. Certainly, when you have the physical presence of a person before you, such as in Skype, you can see their facial expressions. You can't really see anything else in their body language, but the face itself obviously is meaningful. My concern about Skype is simply that I don't believe it's secure enough. I think we have to be really careful these days in how we're using technology, where we're using it. And we, the clinicians, have to take the lead. You know, if a client say, and I've heard counselors say this. I've said it myself, you know, "This may not be secure enough, but if you want to try it, I'm willing to try it." And I had one

client, overseas, in another country. And at that time, what we experienced were a lot of technological problems. It just kept dropping, dropping image, losing our connection, our signal, and we ended up doing a Transatlantic phone call. Now, that was years ago. Skype is a lot more enhanced now. But I still worry about the security. So we have to take the lead. We have to be the ones, the clinicians, to educate our clients. And they have to make choices. If we're going to decide, "I'm going to do Skype," it's a clinician's decision, but they need to really be assured that what they're doing is ethically, legally, technically, technologically, as appropriate as it can be. You can inform your clients, you can get them to sign consents, but as you can tell, I feel strongly about ensuring that what we're doing is secure.

In the past, I've also had a couple of cases where I've done a combination of face-to-face, telephonic, and cybercounseling. But for the most part, I'd say 99% of the clients I've worked with, in the cyber world, I've never met physically. I've never met in person, or spoken to in person. I've done the odd case through Skype, but quickly realized it's not really, at least in my opinion, not really secure. There were technical issues as well, which could occur, I suppose, with any platform, but I don't feel comfortable, really, doing counseling through Skype. I had the odd client where I've got e-mail and live face to face. It's a wonderful combination. Because it does allow for all of the advantages of e-counselling, especially the asynchronous, the ability for a client to access it when they wish to, write when they wish to, knowing their counselor will write back.

When it comes to assessing client suitability, there is a screening questionnaire that I have them complete, and some of the questions deal very specifically with risk issues. I say on my website, when people are just reading about me and about cybercounseling, that it's not for everyone. And I explain the situations where it wouldn't be appropriate. I talk specifically about

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clients who may be suicidal, or in psychiatric crisis. I tell them upfront that, if you go into crisis and you send me an e-mail that you're in crisis, I can't actually physically get that e-mail right away. It may take a few days depending on when I access my e-mails, and what I do with them. They need to understand that there isn't the immediate kind of action available if they need it. We can prepare them for that; we can explain it. We can have it on our websites, we can have them sign a consent. So we do our due diligence, and then hope that, if they do go into crisis, they will follow some of what we had suggested. They can try to call us, perhaps, or call 9-1-1. Or get through to an emergency department. All of the things we would tell a client when we're actually working with them, on a phone, for example. So I think we have to be very thorough, anyone setting up a practice online, in thinking this through, in thinking about who they are, in terms of the practitioner, whether they have any kind of backup if they're not immediately available, all of these things. I've never experienced someone calling me because they were in crisis, it hasn't happened yet.

So the bigger issues, the screening issues, tend to be more the safety issues, and I have some age restrictions. I have chosen not to work with teenagers. I've actually chosen not to work with citizens of the United States, and that's primarily because of so much uncertainty about the legality of crossborder counseling. And as I teach it and talk about it a lot in our work in the classroom because of my involvement with other clinicians over time, working in a different country, I just made the decision for now to not work with clients in the U.S.

Some counselors tell me there may even be cross provincial issues, within Canada. This is still a relatively new way of working, even though I would say online counseling's been around for 10 or 15 years. There's still such uncharted territory. So with respect to how I make decisions about who I will work with, there's a screening mechanism. And if, during the course

of the work we do, I become concerned about the client being at risk, being in a safety situation, there are a number of things that I will do. Number one, I will pick up a phone. We need to make sure that when they register, we have proper contact information. In the course, we talk a lot about whether the information that clients present to us online is truthful. In other words, are they who they say they are? Could someone be masquerading as someone else? And it's an interesting question. We could argue that when people come to see us, they could be saying that they're John Smith, when in fact, they're not John Smith. They're someone else. We gather information. We get a phone number, an address, but do we know in that moment that what they're telling us is accurate? There are a lot of questions that anyone going into practice online need to be aware of. Screening, registration, ensuring as best as we can proper identity, providing a secure -- I would add encrypted – way in which to communicate with our clients, is critical. The software we use privacy mail allows for us to provide chat and asynchronous counseling in a secure and encrypted way. In my own practice, I use privacy mail for the asynchronous format. It is secure, it's encrypted. And I'm very confident that I'm able to work confidentially with the clients that I'm working with because of the software.

In the course that I teach, I have our students, as one of their exercises do a search of websites. We Google e-counseling, cybercounseling, and it takes us to so many hundreds and hundreds of clinicians' websites. And very quickly, you can see which clinicians have thought through these ethical, legal, political issues and who hasn't. And it speaks to the fact that we need to have reliable, proper training. And we're probably going to move at some point to some sort of real accreditation. You know, in order to become a cybercounsellor, it'll mean more than taking the course, but having to become certified in some very standardized way, There is none, that I'm aware, no such college, association, organization, that at this point in time can provide

that level of legal certification. So there are courses, and clinicians. They get good experience, they're training, and they go out on their own, or they work with EAPs and they get the exposure to a variety of different clients.

In terms of my theoretical orientation I think I tend to draw from different sources. I wouldn't say that I use really one or another. I will work with some CBT techniques. I will have people track their thoughts and their behaviors and monitor that kind of activity. I will suggest workbooks that we could actually speak about, speak to in the way of exercises. Also narrative is something I've done a little bit of training in. I really think that what we do inside of counseling is in a way storytelling. We're conveying the client's story, and we can talk with them about how to change the direction of their story. They are who they are, they bring with them what they have, but it doesn't mean that life has to continue the way it is. So we can draw on their stories. We can draw on experiences. And writing provides the opportunity for people to do that, and to have the evidence, to have it available to them. Every time they log in, they can see what they've written; they can see what I've written. They can see how they're changing in their way of thinking, or maybe staying the same. When I was at my previous position, I used a lot more material that I would add in as attachments, quotes, things that I could draw from, but I don't have the kind of access that I had then. One builds a library. And this could be part of any practitioner's practice, that would be true face to face, telephonically. . . you try to have articles and resources available. So the more that you have available to use -- tools, articles, quotations, meaningful quips that have some depth to them that you can place into an exchange or maybe even a chat -- then you get more creative. But at the end of the day, I think it's how we write, it's what we write, it's the comfort we show in how we connect with our clients, and that's, for me, always very present on my mind.

With online counselling, the clients have the ability to reflect –the ability to really give a lot of thought to what they're about to write, what they've written, what the counselor has written, and they can change what they're writing, as they're sending or even after they've sent it. They can come back and say. "You know what? What I wrote a week ago isn't holding up as much now as it did then. Today I'm feeling this, I'm feeling that." They have a marker. They have a way of going back and reviewing that. Sometimes I will say to clients, with care, if you want to keep a copy of what you've written or what I've written, you can print it out, but if they do that, they are out of the secure zone, where the material is protected. So they need to be mindful of where they're putting whatever they've printed. Or if they want to move what they've written from a secure encrypted program to somewhere else on their computer, they have to know that if they move it elsewhere onto their computer, it can be traceable. Other people could see it, but that being said, they have the opportunity to keep a copy of something that they truly hold and value. I have clients say to me, "You know, what you wrote, what I wrote, I would pull it out from time to time. I'd keep a piece of paper on which I had a piece of an exchange, and it just reminded me of something so important." So they have the ability to physically enwrap themselves with something that they've written either by themselves or with their clinician or both, that kind of collaborative effort, to just go back and review it. And in face to face work, you don't have that same experience.

My dream still is, one day, I'll probably retire, to continue to work as a counselor and probably to do a lot more of that online. I think that the training I've had, the experience I continue to have teaching, and now the added experience of building a clinical team, a counseling team, is invaluable. So that even though I don't have an active practice of lots and lots of e-clients at the moment, I'm almost on a daily basis, in some respect, thinking about e-

counseling. When I'm teaching, I am checking in every day with the students, and responding and doing and rereading articles. So I'm immersed in it. So in terms of my goals, for sure, I could see, years down the road – I don't know exactly when – doing more and more of this. When I left my previous job, my dream then and my goal then was to be a fulltime cybercounselor. It was really unrealistic, because anyone that has had the experience of working from their home, you think about the kind of isolation that can create. And you think about the fact that the kind of work you're doing is work where you're never talking to anyone or looking at anyone, but you're writing. To do that, seven hours a day, what could be seven days a week, sometimes, it's not realistic in that respect. But, certainly, having a cyberpractice, building on it, probably changing my website, enhancing that, and continuing to grow as a cybercounselor, for me, this is very important.

Moreover, there are enough cyberstudents graduating and interested in setting up their own practice that probably, in the next five years or more, we'll be seeing a lot more networks. There will be a lot more networks developing. There is an organization, the International Society for Mental Health Online, ISMHO as they're known. They're been around for years, and they've gone through different growth spurts and issues in terms of being an organization. But I think the real value of having an organization like that is that you have people from around the world who do have a passion and a sincere interest in working with people online. And so they are grappling with all the challenges that continue to exist in this field. All of the issues around ethical issues, legal issues, crossborder counseling often being a big one, dealing with kind of rogue therapists, people who're saying they have training but they don't. Thus, having an organization for networking and support can be valuable.

Also, I think we need to move towards some sort of serious, real certification program. I'd like to see colleges, and professional associations, begin to really tackle the issue of setting standards. There are some, I think, I remember, because the students also have, as part of their exercise, an opportunity to go around to their respective professional associations and check in with them and see what they have developed in a best practices or standard. I think it's Ontario – one of the Colleges of Psychologists has begun to address it. I don't believe the Colleges of Social Work have yet actually set up anything formally. I think there's been a lot of talk and discussion about that, that there is a need for that to emerge in the counseling world, to have professional associations begin to really acknowledge the fact that there are lots of their members beginning to work online and to develop standards. I think typically what they will say is "Well, you're a social worker, you have to abide by the typical standards of your college that they provide as a. . . referring to the delivery of social work practice, as an example."

But when you get online, you get into a whole world of different scenarios that, although you may still be a social worker, and thinking and acting as one, you're in a world where things – well there are different challenges. And so they need to be addressed. I'd like to see more of that. Beyond that, just continue dialogue, continue communication across boundaries, borders, with folks in this field, who want to keep learning and communicating with each other, whether it's an ISMHO or some other kind of organization that addresses that, I think there's a need for that. Otherwise, as happens to some private practitioners during face to face, you become very isolated and somewhat disengaged from what the issues are. Lastly, there's a need for a lot more integration and communication by those of us doing Cybercounseling.