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How different technological mediums may reduce attitudinal barrier to the utilization of psychotherapeutic relationships

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May Reduce Attitudinal Barriers to the
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ABSTRACT

This qualitative study explored the use of communication technologies in the context of psychotherapeutic relationships, examining how technology might affect attitudinal barriers preventing young people from utilizing psychotherapy. Research findings emerged from semi-structured Skype interviews with 10 participants (age 18-30 years) focused on their beliefs on psychotherapy, communications technology, and the idea of integrating technology into the psychotherapeutic relationship.

A theme analysis of the interviews produced four major findings: (1) psychotherapy is an especially difficult endeavor to begin and maintain; (2) certain qualities of the therapist (trust, expertise, and 'fit') are of particular importance; (3) voice and body language are critical to talking about emotional topics; and (3) the availability of psychotherapy over videoconference might greatly increase the willingness of young people to enter psychotherapeutic treatment.

The findings of this study suggest the potential benefits of using communications technology within the psychotherapeutic process. In particular, videoconference and other forms of technology may decrease attitudinal barriers faced by current and potential clients. These findings indicate that more research on the impact of further integrating the psychotherapeutic relationship with communications technology is important to clinical social work and mental health treatment.

HOW DIFFERENT TECHNOLOGICAL MEDIUMS MAY REDUCE

ATTITUDINAL BARRIERS TO THE UTILIZATION OF

PSYCHOTHERAPEUTIC RELATIONSHIPS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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This has been one of the most difficult and extended academic projects I have ever embarked upon. It offered me a great many challenges, but two major rewards: the confidence that I can conquer such a task, and the certainty that I have a great number of friends, family, and colleagues without whose support I would not be able to make an achievement like this thesis.

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CHAPTER I

Introduction

The subject of mental health continues to be a topic that receives growing attention in the national discourse. For reasons both warranted and not, the American public and policy makers have been louder than ever on the topic of how to address the problem of access to mental health treatment in the United States. Arguably, this in large part is due to the effects of tragic acts of violence over the past several years, such as the mass shootings in Oregon, Connecticut, Colorado, and Arizona, many by men in their twenties with identified histories of mental health concerns. While these tragedies are often inappropriately reduced to problems of individual mental health, they have at least had the effect of highlighting the problem of barriers to accessing mental health treatment for youths in the United States. This is especially important considering more than 50% of Americans aged 18-29 have met DSM criteria for a mental health disorder in their lifetime (Kessler et al., 2005).

The purpose of this study is to explore how the use of communications technologies in the context of psychotherapeutic relationships might affect attitudinal barriers preventing young people from utilizing psychotherapy. The research question of this qualitative study was: "How might the integration of communications technologies into psychotherapeutic relationships affect attitudinal barriers to access for young people between the ages of 18 and 30?" The communications technologies being assessed for the purposes of this study fall into three categories: (a) text-based technologies, both on the phone and over the Internet; (b) audio-based technologies, such as telephone or Voice-Over-IP; (c) video conference over the Internet, such as

Skype. The phrase *psychotherapeutic relationships* is used in order to distinguish from other technologically-mediated psychotherapies. More specifically, it distinguishes the object of this study from those psychotherapies that only feature either a minor or completely absent role for a clinician in the therapy, such as with guided self-help and many cognitive-behavioral therapies being offered over the Internet.

This study is interested in individual psychotherapy where the clinician serves a fundamentally major role in the therapy. The term *attitudinal barrier* is derived from existing literature on what factors impact the motivations of individuals to participate in psychotherapy (Campo, Bridge, & Fontanella, 2015; Jagdeo, Cox, Stein, & Sareen, 2009; Sareen et al., 2007). This term encapsulates a wide variety of attitudes preventing people from initiating mental health treatment, such as personal or social stigma, belief that one "should be able to handle it" themselves, mistrust of clinicians, and perceived unavailability of treatment. For the purposes of this study, *young people* is defined as individuals between the ages of 18 and 30.

This study used qualitative methods, using semi-structured interviewing as a methodology. This methodology was chosen for its ability to best represent individual beliefs, the assessment and analysis of which is the purpose of the study. Interviews were transcribed and coded by the researcher according to a content/theme analysis aimed at identifying positive, negative, and ambivalent beliefs towards (a) different forms of communications technologies, (b) psychotherapeutic relationships in general, and (c) potential integrations of communications technologies and psychotherapeutic relationships. The outcome of the data collection and analysis was used to inform a discussion of its implications on both clinical practice as well as the larger relationship of communications technology to psychotherapy.

Unfortunately there are significant barriers, structural as well as attitudinal, to accessing mental health treatment in the United States. These barriers are particularly powerful for youth, considering they have been identified as one of the social demographics least likely to seek help (Rickwood, Deane, Wilson, & Ciarrochi, 2005). Attitudinal barriers in particular, the focus of this study, have been noted within the existing literature as being arguably the most significant reason why individuals who would likely benefit from mental health treatment do not receive it (Campo, Bridge, & Fontanella, 2015; Pedersen & Paves, 2014). Fortunately there have been innovations within the field that show great promise in overcoming these attitudinal barriers. Modern communications technologies are being considered in particular as a means of enabling more persons to engage in psychotherapeutic relationships when they might otherwise not. Recent research has shown that the integration of technology with psychotherapy is fertile ground for engaging a youth demographic that is already generally experienced with the integration of computer technology in their personal relationships (Bradford & Rickwood, 2014; Stallard, Velleman, & Richardson, 2010). The goal of this study was to determine whether or not the use of technology as a medium for the clinical relationship might reduce attitudinal barriers to accessing psychotherapy, particularly for young people who are less likely than other demographics to seek help and could most benefit.

The achievement of this study's goal has significant implications for the practice of clinical social work, as it informs the development of future practices aimed at increasing participation in psychotherapeutic relationships among otherwise-untreated young people. The current available literature of interest to the study's aforementioned research question, as summarized in the following section, first recognizes that there is a significant problem in the field of mental health. Specifically, this problem is the unwillingness of those who would likely

benefit from psychotherapy to participate in these relationships, otherwise known as *attitudinal barriers.* Second, among the demographics identified as possessing attitudinal barriers, the literature identifies that these barriers are most significant for young people. Third, the reviewed literature shows a growing body of research indicating a legitimate evidence-basis for new technologically mediated forms of psychotherapy. When all of this is viewed in the context of young people's relatively high aptitude for using computer and communications technologies, we can see a significant justification for the following study.

CHAPTER II

Literature Review

This literature review is constructed to organize the current writing available that is pertinent to the research question, which is: "How might the integration of communications technologies into psychotherapeutic relationships affect attitudinal barriers to access for young people between the ages of 18 and 30?" The review is divided into five sections. The first section is a review of available literature produced on the topic of factors that are known to be significant in preventing persons with emotional or mental health concerns from utilizing psychotherapy. The second section is concerned with establishing that attitudes among young people, compared to other age demographics, serve as significant barriers to utilizing mental health treatment. The third section explores the existing literature on the relationship of young people to technology and the implications this has for mental health practice. The fourth section reviews the current evidence-basis that exists for computer-mediated psychotherapies, both in terms of clinical outcomes as well as their perception by users. The final section explores the important shift in the research on psychotherapeutic efficacy towards an emphasis on the working alliance, rather than specific modalities.

The purpose of these sections of the literature review is to establish that (a) attitudinal barriers to access are known to significantly prevent persons who would benefit within psychotherapeutic relationships from entering them; (b) young people constitute an especially vulnerable demographic when it comes to mental health problems and are comparatively less

likely to seek treatment; (c) there already exists an evidence-basis for the integration of technology into psychotherapy; (d) the positive relationship of young people to modern communication technologies suggests their use in mental health contexts; and (e) the existence of a strong client-therapist working alliance is essential in generating positive treatment outcomes. These five points create the foundation for the proposed study's inquiry into how greater use of communications technologies within psychotherapeutic relationships might reduce attitudinal barriers to access among young people. It should be noted that as of this writing there is little to no available literature that has sought to explore this specific question.

Identifying Current Barriers to Accessing Psychotherapy

Campo et al. (2015) have identified two categories of barriers to accessing mental health treatment: attitudinal and structural. The former category refers primarily to stigma surrounding mental health and the concern among those with diagnosable mental illness that seeking treatment will reveal their diagnosis and lead to negative social consequences. The 'desire to handle problems on one's own' was cited as a major reason that Americans in particular do not seek treatment or are quick to discontinue treatment (Mojtabai et al., 2011). Stigma also operates in the direction of the mental health profession itself, with a perceived ineffectiveness of mental health treatment being cited as another major form stigma takes as a barrier to access (Sareen et al., 2007). These two forms of stigma are regarded as one of the primary barriers to access among those that would benefit from mental health treatment but do not currently receive it (Andrade et al., 2013; Barney, Griffiths, Jorm, & Christensen, 2006).

Structural barriers to access include but are not limited to factors like cost, low insurance reimbursement rates, inability to travel, and loss of work time required to attend appointments. Research indicates that particularly those with no or limited insurance report suffering the

greatest from a combination of unmet need for mental health treatment and the facing of structural barriers (Walker, Cummings, Hockenberry, & Druss, 2015).

It should be noted that barriers to psychotherapy access have nuanced differences along demographic and cultural lines, regardless of insurance status (Campo et al., 2015; Miranda, Soffer, Polanco-Roman, Wheeler, & Moore, 2015). Some research has shown that racial and ethnic minorities, in particular, tend to underutilize mental health services for both attitudinal and structural reasons (Lee, Xue, Spira, & Lee, 2014). It has also been found that attitudinal barriers, such as internalized stigma, is greater among African Americans when compared to their white counterparts regardless of insurance status (Conner, Koeske, & Brown, 2009). Some scholars have explained these statistical differences among demographics in terms of cultural variance (Gonzalez, Alegría, Prihoda, Copeland, & Zeber, 2011). Gonzalez and colleagues noted there is a greater tendency among persons of color to rely on family and community bonds for emotional support. Perhaps more importantly, these researchers suggest that complex histories of general exclusion and oppression from institutions associated with the majority culture affect the feelings of minority groups towards mental health care.

While some of the structural barriers are in the process of being addressed by the Affordable Care Act (ACA) and the subsequent increase in availability of health insurance, there is no reason to believe that this will necessarily lead to increased access to mental health care for low-income individuals. However, the ACA as well as the Mental Health Parity and Addiction Equity Act (MHPAEA) do serve as political recognition of the severe impact of mental health concerns on the public in terms of quality of life, as well as the effects it can have on national productivity (Dewa & Hoch, 2015). While the importance of structural barriers should not be understated, the literature does consistently identify attitudinal barriers as correlating far more

with lower service contact and lower help-seeking behaviors, regardless of demographic (Handley et al., 2014; Mojtabai et al., 2011; Sareen et al., 2007; Urbanoski, Cairney, Bassani, & Rush, 2008).

The Impact of Mental Health Stigma Among Youth

It is well established that mental health stigma is one of the most powerful barriers, attitudinal or otherwise, to the seeking of mental health treatment among those that would benefit most (Andrade et al., 2013). It is also well established that age is perhaps the most important demographic when looking at the likelihood of an individual to seek appropriate treatment. Individuals under the age of 30 and above the age of 59 are significantly less likely to seek mental health support compared to the rest of the population (Young, Klap, Sherbourne, & Wells, 2001). There is also strong empirical evidence suggesting that young people, as a specific demographic, experience significant attitudinal barriers and stigma regarding the pursuit of mental health treatment (O'Connor, Martin, Weeks, & Ong, 2014; Pedersen & Paves, 2014; Rickwood et al., 2005). This is largely based upon the idea that they will be perceived negatively within their social environment and that mental health treatments themselves are generally ineffective. Reportedly, 48% of university student respondents indicated a need for help with an emotional or mental health problem in the past year, yet only 15% reported receiving treatment in that same time period (Lally, O'Conghaile, Quigley, Bainbridge, & McDonald, 2013). The same study concluded that personal stigma was the overwhelming reason that the students sampled did not receive treatment. Researchers and policy makers consider these findings deeply distressing, especially considering the high suicide rates among young people in the United States, compared to other age demographics (Sullivan, Annest, Simon, Luo, & Dahlberg, 2015). Leaving mental health issues untreated or undertreated, especially for people in transitional age

groups, has severe social consequences, particularly for families and communities struggling to support their members (Jivanjee, Kruzich, & Gordon, 2009). For these reasons young people constitute an acutely vulnerable population that should be accessed by mental health professionals in new ways.

While there is no consensus on the reasons that young people utilize mental health treatment at lower rates and experience greater attitudinal barriers, particularly stigma, some literature offers potential explanations. One study showed that young people appear to hold especially strong beliefs about self-reliance, which often prevents them from seeking treatment (Downs & Eisenberg, 2012). The same study found that another significant correlate with treatment utilization is the belief among young people regarding the effectiveness of therapy. These findings mirror those of the general adult population, but the experience of stigma is comparatively greater among young people. No current research has yet presented a definitive understanding of why young people tend to hold these attitudes more strongly than other age demographics. While the literature has been able to show that these trends exist, it has thus far been unable to articulate precisely why.

The Relationship between Young People and Technology in Psychotherapy

Considering that young people with mental health problems have particularly strong attitudinal barriers to accessing mental health treatment, it is important for the industry to look for innovative ways around this that are uniquely able to reach this population. It is the general wisdom that young persons who have grown up during the age of computers and the Internet tend to have greater comfort and competence with technology. There is in fact empirical evidence supporting this belief, suggesting that some young people feel more comfortable and even prefer text-based or written communication about sensitive topics, such as mental health,

because of the increased control that the medium offers compared to verbal communication (Bradford & Rickwood, 2014). This added comfort might have secondary benefits. The use of electronic communication is reportedly associated with positive elements of relationship intimacy among young people, as well as higher levels of mutual self-disclosure (Coyne, Stockdale, Busby, Iverson, & Grant, 2011; Subrahmanyam & Greenfield, 2008).

The potential benefits of integrating communications technology into psychotherapeutic relationships have been examined on a limited basis. One study of text-based psychotherapy showed that clients feel similarly or, in some cases, more positively about the therapeutic relationship over text, compared to face-to-face therapy (Reynolds, Stiles, Bailer, & Hughes, 2013). Considering the problem of young people's access to mental health treatment, evidence that young people feel more comfortable communicating about intimate topics such as mental health over mediums that are less interpersonally intensive demands that computer-mediated mental health treatment be explored. Research on this topic provides a significant opportunity to address attitudinal barriers to treatment access for young persons with mental health issues, particularly in the presence of growing literature showing the efficacy of such treatments.

Evidence-basis for Computer-mediated Therapies

There have been a wide variety of different psychotherapeutic interventions developed and used since communications technology became widely available, with its most advanced form represented by the Internet. For example, the telephone was used in psychoanalytic therapy as far back as the 1950s in recognition of the growing importance of technology in people's lives and as an innovative means of accessing patients (Saul, 1951). Today there exists a body of research (e.g. Dowling & Rickwood, 2014; Dowling & Rickwood, 2013; Johansson et al., 2012; Johansson, Frederick, & Andersson, 2013; Lederman, Wadley, Gleeson, Bendall, & Álvarez-

Jiménez, 2014; Rooksby, Elouafkaoui, Humphris, Clarkson, & Freeman, 2015) that provides an evidence-basis for computer-mediated therapies as an efficacious expansion of clinical interventions into the new, digital realm of telecommunications. These interventions can take many forms, including, but not limited to, web-based self help, self help guided by a clinician, text or chat-based therapy, therapy over phone, therapy using VoIP ("Voice-over-Internet Protocol"), and therapy over video conference (i.e. Skype).

The importance of the therapeutic alliance between client and clinician on mental health treatment outcomes has significant empirical support, and computer technology has the potential to make access to therapeutic relationships much easier (Horvath, Del Re, Flückiger, & Symonds, 2011). In some cases, psychotherapy delivered over the Internet is reportedly the preferred method of treatment delivery (Dowling & Rickwood, 2013, 2014; Johansson et al., 2012; Johansson, Frederick, & Andersson, 2013; Lederman, Wadley, Gleeson, Bendall, & Álvarez-Jiménez, 2014; Rooksby, Elouafkaoui, Humphris, Clarkson, & Freeman, 2015). Additionally, it has been shown that psychotherapy administered over the internet is likelier to result in higher completion rates than interventions with limited or no clinical contact (van Ballegooijen et al., 2014).

Current research on the efficacy of computer-mediated therapies that involve a clinical relationship shows that therapeutic alliance can also be achieved without notable difference through technological mediums, including text (Chu et al., 2004; Dowling & Rickwood, 2013). While the literature seeking to explain this is sparse, as is the overall use of computer-mediated therapies compared to face-to-face therapies, some does exist. For example, Suler (2004) has conceptualized the *online disinhibtion effect,* which he believes results from factors specific to the medium of electronic communication and contributes to a greater willingness to self-disclose.

Still, some have noted that using online mediums for therapy, particularly text, makes it more difficult to establish an effective working alliance (Bambling, King, Reid, & Wegner, 2008; Fenichel et al., 2002; Hanley, 2009). Nevertheless, Suler proposes that the online disinhibition effect offsets this difficulty and accounts for the initial research that shows the efficacy of online treatments. This early research suggests fertile ground for a further exploration of both how and why computer-mediated therapies can be used to successfully increase access to mental health treatment.

The Significance of the Working Alliance for Therapeutic Outcomes

The term *evidence-based treatment* is popularly associated with modalities grounded in cognitive or behavioral theory. Nevertheless, comparative studies and meta-analyses have shown that an evidence-basis does in fact exist for a wider range of psychotherapeutic treatments with different theoretical groundings (e.g. Luborsky, Singer, & Luborsky, 1976; Parker & Fletcher, 2007; Shedler, 2010). In an attempt to understand how different psychotherapeutic modalities can produce positive outcomes despite some fundamental differences in their theoretical foundations, the research literature has begun to identify what characteristics across different modalities produce positive outcomes, instead of attempting to study which modality is 'best' or 'most effective'. The concept of the *working alliance* has been used to understand what quality across different interventions actually correlates with outcome, rather than the particular modality of choice (Horvath, Del Re, Flückiger, & Symonds, 2011).

Greenson (1965) first developed the term of working alliance to refer to the positive collaboration between the therapist and client in the therapeutic process. The emphasis is on the relationship between therapist and client itself, one that exists with the sole aim of the client's healing, rather than the specific interventions used by the therapist, e.g. cognitive behavioral

therapy (CBT), dialectical behavior therapy (DBT), and psychodynamic. Edward Bordin (1979) later identified that the working alliance consists of three parts subject to fluctuation throughout treatment: the sharing of goals, the assignment of tasks, and the development of a relational bond. Bordin proposed that a strong working alliance required that none of these three qualities be over or under-emphasized in the therapy, while also emphasizing that the relational bond was the most critical link among the three. Since Bordin and Greenson, a strong correlation between the working alliance and positive therapeutic outcomes, regardless of treatment approach, has been well-established in the literature (Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012). A possible conclusion to be drawn here is that a strong working alliance carries a primary importance for the efficacy of a mental health treatment.

In other words, we now have empirical evidence to support the proposition that Greenson (1965) made 50 years ago. The aforementioned study findings (e.g. Flückiger et al., 2012; Horvath et al., 2011) emphasize the strong healing qualities of the actual relationship between therapist and client. They also suggest that the intimate client-therapist relationship needs to be maintained as an essential feature of mental health treatment, which means even as psychotherapy becomes further integrated with new technological modes of communication.

These developments have been co-occurring with the significant body of research conducted on *attachment,* the widely known theoretical model described by psychologist John Bowlby. Attachment theory was developed by Bowlby (1988) as a result of infant observation studies and clinical experiences in which the security of the relationship between infant and caregiver was seen to provide the basis for the infant's later relationships and the anxieties or pleasures received from them. In other words, Bowlby and attachment theorists believe that the consistent availability and quality of the caregiver's nurturance to the infant would create the

structure of how the infant experienced others as their life progressed into adulthood and beyond. Many studies (e.g. (Bucci, Seymour-Hyde, Harris, & Berry, 2015; Mallinckrodt & Jeong, 2015; Taylor, Rietzschel, Danquah, & Berry, 2015) have situated the working alliance within the understandings of human social interaction that attachment theorists have offered and researched, finding that the attachment styles of both therapist and client are associated with reporting on the strength and development of working alliance in the therapy. Other recent research on attachment (e.g. Drouin & Landgraff, 2012; Morey, Gentzler, Creasy, Oberhauser, & Westerman, 2013) has linked attachment style to preference for and comfort with the use of certain communications technologies. For example, a recent study by Weisskirch and Delevi (2011) found that young people aged 18 to 30 who are insecurely attached heavily utilize text messaging to reduce relational anxieties, and tend to hold positive attitudes towards text message as a means of doing so. In light of these prior studies, we can find a justification for exploring the interactions that therapist and client attachment style, their working alliance, and the therapy's medium of communication, all potentially have upon each other. Taken together the aforementioned research findings suggest that new technologies might also have the potential to enhance the therapeutic relationship, rather than marginalize it.

Summary

The literature that has been reviewed in relation to this study provides a strong justification for the pursuit of inquiry focused on how the integration of communications technologies into psychotherapeutic relationships might affect attitudinal barriers to access. First, the primary significance of attitudinal barriers in preventing people from utilizing mental health treatment was established. Second, the fact that young people tend to possess these attitudinal barriers much more strongly than other age demographics was also established. Third, the

encouraging current literature on how young people have so far received the integration of technology with psychotherapy was explored. Fourth, an evidence-basis for the positive outcomes of computer-mediated psychotherapies was established. Finally, the fundamental importance of the client-therapist working alliance to positive outcomes and its implications in the context of attachment research was also established.

In sum, the overall research question for this study was justified by the current literature and calls for an exploration of personal perceptions and beliefs of individuals who might benefit from psychotherapy. Therefore, an inductive qualitative methodology was most appropriate for the current study. The next chapter describes in detail the reason for selecting qualitative methods, the sampling process, ethical considerations for the study, the data collection process, and the chosen mode of data analysis. Briefly, the study's limitations will be discussed as well.

CHAPTER III

Methodology

The study used qualitative, semi-structured interviewing to assess attitudinal barriers to participation in psychotherapy among interested populations who may benefit from such services. Based on perceptions of the participants, the study explored whether online-mediated clinical relationships constitute a means of addressing attitudinal barriers about psychotherapy. Attitudinal barriers, such as stigma towards mental illness and the perceived ineffectiveness of mental health treatment, have already been identified as major reasons why individuals choose not to seek psychotherapy (Andrade et al., 2013; Barney et al., 2006; Mojtabai et al., 2011; Sareen et al., 2007). This study primarily sought to (a) examine the existence of attitudinal barriers as identified by prior research, (b) explore them with greater nuance through the use of interviews, and (c) evaluate how such attitudes might change if individuals were presented with technological solutions that made engagement in psychotherapy more accessible and less demanding. The underlying research question for this qualitative study was: how might the integration of communications technologies into psychotherapeutic relationships affect attitudinal barriers to access?

The study utilized an inductive qualitative method of inquiry relying on the collection and analysis of a sample of collected interviews. As Curry, Nembhard, and Bradley (2009) state, interviews "allow for the exploration of individual experiences and perceptions in great detail" (p. 1445). Since this study's research question was fundamentally an exploration of people's

experiences and perceptions of psychotherapy and technology, qualitative interviewing was the most appropriate choice of methodology. Considering the current lack of information collected on this subject, semi-structured interviewing is recognized as an appropriate methodological choice for this kind of exploratory study (Adams, 2010). The fundamental basis for the study was the idea that experiences of and beliefs towards psychotherapy and psychotherapeutic relationships constitute one of the primary barriers to accessing such services. Therefore, using a semi-structured interview approach was the most appropriate methodology for the purposes of this research. The interviews were approximately 30-45 minutes in length and took place over audio-only Skype conference, with the exception of the first participant who was interviewed via videoconference. Audio-only interviews were used after the first participant due to bandwidth concerns. Skype was also used as the only method of interviewing due to the fact that the study was fundamentally an exploration of how different modes of communication impact peoples' willingness to speak about intimate subject matter, as takes place in therapy. It was believed that using only one method of interviewing was necessary in order to ensure reliability.

Sample

The sample for this study consisted of individuals aged 18 to 30 of any race, class, gender, or sexual orientation, who either (a) considered seeking face-to-face psychotherapy but chose not to follow through with the process, or (b) had engaged in psychotherapy previously but self-reported the experience as unsuccessful. Early termination was defined as the subject's own reported experience that the psychological distress they entered therapy to treat was either completely unresolved or only very marginally resolved at the time of termination. The sample was drawn exclusively from open recruiting over social media. Approved flyers were also placed at Boston University, though these did not yield any participants. Participants recruited through

open forums such as social media were screened to ensure they had regular and private access to computers. This exclusionary criterion was important because an analysis of structural barriers to access is outside the scope of this study, despite being recognized as an important topic of investigation.

Since the research was oriented towards individuals who experience attitudinal barriers to engagement with psychotherapy, the sample originally excluded those who (a) do not identify as having any interest in engaging with psychotherapeutic relationships, or (b) those who self-report that they previously have been or are currently successfully engaged in psychotherapeutic treatment. Since this sampling criteria yielded few participants, with suggestion from the research advisor and the approval of the Smith IRB, the sample was expanded to include anyone between the ages of 18 and 30 who felt that psychotherapy was beneficial and had regular access to a private computer (See Appendix A). It should again be noted that this sampling necessarily excluded those who experience major structural barriers to access, for example not having access to a private computer, due to the limited scope of this study. The researcher acknowledges that such a scope may result in a lack of participant diversity across socioeconomic status as well as other intersecting social categories. The orientation towards utilizing technology in addressing attitudinal barriers also carries obvious limitations based in socioeconomic status. These limitations will be explored in detail in the discussion section.

Ethical Considerations

Using qualitative, semi-structured interviewing as a proposed methodology meant that the study was seeking to explore personal experiences with psychotherapy, which created the potential for the disclosure of sensitive information by the participant regarding themselves and others. In other words, this refers to previous clinicians with whom the participant perhaps had a

bad experience. It was of the utmost importance that this information be kept de-identified and confidential. Semi-structured interviewing in particular creates the potential for sensitive information to be casually disclosed in the process of conversational interview, so beginning statements about confidentiality as well as concluding statements about confidentiality, were given in order to maintain high ethical standards. This study received prior approval by the Human Subjects Review Board (HSRB) at Smith College School for Social Work (See Appendix B). Participants were asked prior to the interview to sign the consent form listed as Appendix C.

The researcher made participants aware of the potential risks involved in the study. The primary risk for participants was that the interviews potentially resulted in the disclosure of their mental health histories or previously distressing experiences they had with past providers. In the case of a participant becoming uncomfortable, it was made explicitly clear that the interview could be stopped at any time. The researcher also provided to any distressed participants the number of their respective university counseling services office, as well as the URL for PsychologyToday.com's local therapist directories. In addition to risks, participants were informed that the study is for the requirement of the researcher's Master's of Social Work degree and therefore to his personal benefit.

Data Collection

Recruitment of participants took place through the distribution of approved paper flyers on the Boston University main campus at locations approved by the university as well as through public open source means such as social media. Participants were met solely through Skype videoconference software at a previously agreed upon time that ensured privacy for both interviewer and participant. As stated above, the researcher encountered bandwidth problems

during videoconference, such that after the first participant all other interviews were conducted

through only audio. All participants were given a $20 cash compensation for their interview

upon its completion; compensation was provided either PayPal. Please see Appendix D for an

example of the flyer used in the recruitment of participants.

Data was collected in the form of 10 semi-structured interviews following a set series of

open-ended questions asked of each participant over an approximately 30-45 minute timeframe.

The main questions included further probing questions to increase the data collected and its

relevancy to the research question. The interviews began with demographic questions and then

continued with questions derived from three major categories informed by the reviewed literature:

(a) the participants' beliefs on and history with text, phone, and videoconference technologies; (b)

the participants' beliefs on and history with psychotherapeutic relationships; and (c) how their

beliefs might be affected by the use of the aforementioned technologies within psychotherapeutic

relationships. Within the questions divided among these thematic categories, there were also

probe questions asked that were intended at guiding the conversation towards greater and more

relevant information. Please see Appendix E for the study interview guide.

Interviews took place through Skype videoconference and were recorded using the Call

Recorder for Skype software by Ecamm. These recordings were automatically saved in MP3

format onto the researcher's password-protected personal laptop upon conclusion of the

interview. All interviews were also recorded on the researcher's password-protected iPhone for

the purposes of making a back up. Interviews were then transcribed and de-identified in order to

increase confidentiality, with all data being held on a password-protected laptop owned by the

researcher. Audio recordings, transcripts, and consent forms were stored in separate folders as a

further measure to protect confidentiality. Audio recordings were deleted within three weeks

after the interview was transcribed. Transcriptions were stored on the same password-protected laptop used for coding and analysis within one week of the interview. Transcripts were de-identified, with each participant's name being changed to a numerical pseudonym (i.e. Participant 1, Participant 2). All data other than audio recordings were maintained for a minimum of three years in accordance with federal regulations outlined in 45 CFR 46.115(b) established by the U.S. Department of Health and Human Services.

Data Analysis

Transcripts were coded line by line according to emergent themes and patterns that were identified by the researcher as emerging within the interviews; coding and data management was assisted through the use of ATLAS.ti software. A theme analysis was then used as the coding methodology in order to flexibly allow for patterns to emerge organically from the data. The goal was to identify patterns themes that were present within the data in terms of negative, positive, or ambivalent beliefs about communication technologies, psychotherapy, and the integration of these technologies into psychotherapeutic relationships. Throughout the coding process, similar codes were combined where appropriate. The original codebook consisted of 60 codes, and these codes were then reduced to 19 code groups based around negative, positive, and ambivalent commentary about text, audio, and video as mediums for communication. Code groups were also made for negative, positive, and ambivalent commentary on communication, technology, and therapy in general. Themes were then derived from the quotations. A general theme analysis provided the flexibility necessary for this exploratory, inductive study where there is a lack of significant pre-existing literature or theory on the specific research question (Braun & Clarke, 2006).

Rigor and trustworthiness were supported within this study throughout the period of inductive data analysis. The researcher took detailed field notes after each interview. These notes commented not only on the specific language used by the participant, but also the language used by the researcher himself in guiding the conversation. This had the effect of encouraging awareness on behalf of the researcher regarding how the use of language during the interview might have had the unintentional effect of directing participants towards certain answers. This process was necessary in the context of semi-structured interviewing so that researcher bias was minimized and noted when potentially present. Any possible influence the researcher may have had during the interview process was subject to discussion within the study itself. This form of critical reflection and researcher self-awareness was considered essential to ensure rigor and trustworthiness within the bounds of a qualitative study using a semi-structured interviewing methodology (Elo et al., 2014). As further means of supporting rigor and trustworthiness, the collected data and analysis was reviewed multiple times by the study's research advisor, Susanne Bennett, who herself reviewed the data analysis and management contained within the ATLAS.ti project file. The feedback received was used to assist the researcher in the coding, analysis, and interpretation of transcripts by providing outsider perspectives. Advisor comments helped the researcher to better identify themes present in the transcripts, as well as potential researcher biases. The following chapter will give further detail about the findings that were discovered throughout the research process and after a careful analysis of all the collected data.

CHAPTER IV

Findings

This chapter presents a thematic analysis of 10 participant interviews focused on the primary research question: how might the integration of communications technologies into psychotherapeutic relationships affect attitudinal barriers to access for young people between the ages of 18 and 30? The researcher interviewed the participants between 30 and 45 minutes, using video and audio-conferencing as a means of communication. The participants were all white females, with the exception of one white male, ranging in age from 18 to 30. They reported diverse socioeconomic and educational backgrounds. The participants described their relationships to technology in general, technological communication mediums in particular (text, audio, and videoconference), their relationships to therapy in general, and their thoughts on the integration of technology and psychotherapy. Throughout these interviews four major themes emerged regarding participants' relationship to therapy, technology, and their potential integration: (1) the belief that therapy is difficult to begin and maintain; (2) the belief that trust, expertise, and 'fit' are essential qualities of a successful therapy; (3) the belief that the presence of body language and tone of voice is critical to effective emotional communication; and (4) the belief that a greater availability of videoconference for use in therapy would significantly increase one's willingness to enter and maintain a therapeutic relationship. The sub-sections of this chapter offer further detail on the demographics of the participants and the content of their interviews.

Demographic Information

At the beginning of each interview, each participant was asked to disclose his or her age; self-identified ethnicity; self-identified gender; socioeconomic status; highest completed level of education; and primary mode of technologic communication. Later in each interview, participants were also asked whether or not they had ever been in therapy or if they were currently in therapy at the time of the interview.

The participants were young people ranging in age from 18 to 30. All participants identified as white and all participants identified as female except for one identified male. Participants reported their socioeconomic status as lower class, middle class, or upper-middle class. Their highest completed levels of education were high school, undergraduate, and a doctoral graduate. Of the participants without college degrees, all reported having at least some experiences with college coursework, with one being a junior at an undergraduate university at the time of the interview. Two participants reported also being enrolled in graduate degree programs at the time of the interview. All participants reported that texting, either through a phone or messaging applications like Google Chat and Facebook Messenger, were their most frequently used mode of communicating with others when not talking face-to-face. See Table 1 for a summary of the demographic information.

Participant Relationships to Technology

All participants involved in the study endorsed feeling comfortable, if not savvy, with technology in general. All participants also reported using technology, and text message for communication in particular, on a daily basis. Participants cited their use of technology as

Table 1

Demographic Characteristics of Study Participants

Characteristic	*n*	*%*
Gender		
Female	9	90.0
Male	1	10.0
Age		
18-20	3	30.0
21-23	0	0.0
24-26	2	20.0
26-28	3	30.0
29-30	2	20.0
Ethnicity		
White	10	100.00
Socioeconomic status		
Lower class	2	20.0
Middle class	6	60.0
Upper middle class	2	20.0
Highest completed education		
High school	3	30.0
Undergraduate	6	60.0
Doctorate	1	10.0
Most used communication technology		
Texting	10	100.0

predominantly due to personal and professional social demands. Participant 1 noted,

"[technology is] a big part of society nowadays so it's hard to get along without it." All

participants also noted that they use various social media accounts for communication with

others as part of their regular interactions with technology; 4 of 10 participants reported using social media for professional purposes as well.

Notably, several participants offered unprompted critiques of their own frequency of technology use when they were asked to describe if they were comfortable with technology in general. Participant 7 said, "I use it a lot, to the point where it's a bit excessive. I kind of use my phone as a crutch, so I'm on it all the time." Similarly, Participant 9 said, "I'm very comfortable with technology, but sometimes I question how much I use it." But perhaps Participant 4 summed it up best when saying:

> I feel a little conflicted. I feel like it is useful. I also feel like sometimes we are not really speaking to each other. Even when we are together, we are just... We are on our phone or texting while we are with somebody or there is a TV on something. I don't know. I just feel like it's a double-edged sword in some ways.

As stated above, all participants noted that their most frequent use of technology for the purposes of communication was text messaging, either through their phones or through various web-based applications such as Google Chat and Facebook Messenger. All participants reported that they used text messaging on a daily basis for personal purposes, while only four participants reported using text messaging in a professional context and described this as limited. Participants' use of audio-only communication, such as telephone and Voice-over-IP, had more variance from daily to approximately once-weekly use. Participants mostly reported being comfortable with using the phone for communication, and nearly all participants reported using audio-only communication in a professional context. All participants described feeling more likely to use audio with persons in their personal lives that they already had an established relationship with. Participants varied even more greatly when describing their frequency of using video-conference,

with Participant 5 reporting using video-conference "maybe three times a week" to speak with family members. The rest of the participants described using video-conference once- or twice-monthly. All participants reported feeling much more likely to use videoconference with close friends or family members, though three participants reported using videoconference in a professional context.

Participant Relationships to Therapy and Technology

After an analysis of the 10 participant interviews, four subthemes emerged regarding the participants' relationships to therapy and technology. First, participants reported a belief that therapeutic relationships were difficult to begin and maintain for intersecting structural and attitudinal reasons. Second, participants identified being able to trust that a therapist is neutral and non-judgmental, that the therapist has expertise, and that the participant and therapist are the right personality 'fit' for therapy to be successful. Third, participants described the importance of tone of voice and body language in effective and intimate communication, particularly when the content tends to arouse emotions. Fourth, participants unequivocally endorsed interest in having therapy over videoconference, as it would be more available. Many believed that the increased availability of therapy would increase people's willingness to begin and maintain psychotherapeutic relationships. The following explores these four themes in depth.

Therapy is believed to be difficult to begin and maintain. All participants expressed a belief that there are significant barriers to entering therapy, as well as continuing to be in therapy on a long-term basis. Many participants described their own personal experiences with both structural and attitudinal barriers to accessing psychotherapy, and in particular the first session with a new therapist. There were six primary barriers, many of which intersect with and exacerbate one another, which were identified by the participants interviewed. The first and

second barriers to access—insufficient insurance coverage and insufficient time availability—

were both well described by Participant 2:

>Well when I get home from work, all I want to do is kind of collapse on the couch and

>watch some TV and eat dinner and go to sleep and nowhere in that paradigm is there,

>"search for a talk therapist who is in my area who is in my insurance who would be a

>good fit for what I need." It's really that big barrier to entry, energy level.

>Participant 5 also described the difficulty of having insufficient insurance coverage,

saying, "It took me a month to find somebody who was available to take on new patients. Then,

when I did find her, she didn't take my insurance and I just paid out-of-pocket a lot of money."

Participant 10 also described the effect that time constraints had on willingness to engage in

therapy:

>I mean it's a commitment to say you're going to take an hour out of your day twice a

>week, or twice a month to let go and see a therapist. It's hard for me. I'm lucky that I have

>a job that is flexible to be able to do that. I don't think I know a lot of other people who

>have that flexibility in their job.

>The third barrier described was geographic limitations. This was succinctly described by

Participant 4 who said, "When I get really, really busy at work, it's really hard to take a full hour

plus travel time, which is about 10 minutes each way, to go see my therapist." The fourth barrier

described was the difficulty of finding a therapist who 'fit' the prospective client's personality.

The fourth barrier and the fifth, the sense that therapy is an emotionally difficult process, were

perhaps best described together by Participant 8:

>It's like shopping for a car or something. [laughs] No one chooses to do that unless

>they're in a situation where they absolutely have to. So, doing it preventatively instead of

reactively, like, "Well, my life isn't in shambles, but there is this one [thing] that I'd like to think about." It's pretty discouraging to get that kind of initiative going, just because there are so many things you have to jump through to possibly find someone that you might like.

The sixth barrier identified was mental health stigma. Participant 4 described facing mental health stigma first before encountering several other barriers afterwards. They said, "The first hurdle was the stigma. Then, once I recognized that I needed therapy, it was insurance/locale, not able to find somebody that I liked or trusted." The intersections between the multiple barriers to access facing potential users of psychotherapy were highlighted often. For example, Participant 8 highlighted the feeling that "it is pretty discouraging to get that kind of initiative going" when a person is simultaneously suffering from mental health problems and facing a process (of finding a therapist) that is beset with structural barriers. Participant 5 also highlighted the relationship between structural and attitudinal barriers:

> At the time I was super depressed. I didn't have the stamina to deal with all of the hassle of trying to find a good therapist who was accepting patients and accepted my insurance, and was available when I was because I was working regular business hours and needed somebody who would be available on the weekends. I think that it was just really difficult to get an appointment initially.

The participants interviewed all perceived significant barriers to accessing therapy and felt these barriers interact with and exacerbate one another, particularly when a person is already acutely distressed and thinking of therapy for that reason. Participants unanimously endorsed a desire for greater access, in particular the simplification of the process of finding a therapist who was locally available, was guaranteed to be covered under their insurance, and importantly, was

experienced as a good 'fit' for their personality. As a means of creating greater access, and in particular making the process of starting with a new therapist less burdensome, participants unanimously endorsed the idea of utilizing communications technologies within the therapeutic relationship.

While all participants expressed comfort with the idea of using videoconference to achieve greater access, they were mixed about audio-only communication and overwhelmingly against the use of text as a medium for conducting psychotherapy. Participants' positive and negative beliefs about using these technological mediums for therapy were primarily described in terms of their perceived effect on the ability to develop trust with their therapist, their therapist's ability to apply their expertise, and the client's ability to find the right 'fit' with a therapist. The following section describes these three qualities of a successful therapeutic relationship, as identified by the participants, in further detail.

Trust, expertise, and 'fit' are important qualities of a therapy. The participants interviewed identified three primary qualities of a therapy that they believed made it successful: (1) the ability to develop and maintain trust in the therapist's non-judgment of them, (2) the therapist's ability to apply expert knowledge to their mental health problems, and (3) the subjective experience of having a therapist who 'fits' with their personality and character.

The importance of trust was highlighted by all participants when they were asked to describe what they believed makes for a successful therapy. All participants reported having had exposure to psychotherapy among friends and/or family, and all participants with one exception reported having their own personal experience with psychotherapy either as a child or as an adult; only two of the participants were actively in therapy at the time of the interview. Regardless of the extent of the participant's history with therapy, 9 of 10 participants reported believing that

the client's ability to trust that their therapist does not morally judge them was critical to a therapy being successful.

Participants also expressed the related feeling that it was important for a therapist to be 'neutral' in their perspective, unlike friends and family, since the therapist is believed to occupy the position of a third-party expert. This idea was very well and concisely described by Participant 6 who said, "[Therapists] help you get through things. You can talk to someone who's not related to what you're talking about." It was also well described at greater length by Participant 4:

> I think in general the benefit [of therapy] is you get to talk to somebody who is objective about your life. You can talk to friends and the benefit to talking to friends is they are familiar with your life and your friends and your situations. That can be great but then that means they have a slanted lens that they view the world through because they know you in that way.

Somewhat related to the idea of a therapist's neutrality is the therapist's expertise, also identified as an important factor in a successful therapy. The therapist's assumed possession of expert knowledge about the workings of the brain and mind, and their ability to apply this knowledge in practice, was considered by many participants to be critical. As Participant 8 stated, "[Therapists are] supposed to have more insight into…problem solving, especially being on the outside as opposed to being in the thick of the issue and not being able to be objective about it." Participant 9 described at greater length the value of seeing someone who is presumed to possess expertise about the brain and mind for a person who is suffering from emotional distress:

When I started to feel overly emotional and kind of out of control, I was [thinking] maybe this is something that someone who has studied this for many years could tell me…some coping mechanisms. Or try to help me figure out why it's even happening.

Participants also repeatedly referenced the idea of 'fit' during their interviews. The exact definition of 'fit' was varied but generally referred to the subjectively felt experience of the therapist and client being able to communicate with a minimum level of ease from the very beginning of the relationship. For example, Participant 4 described the importance of having a therapist who is able to "communicate in the same way as their patient." Additionally, Participant 10 described the significance of finding a therapist they "got along with really quickly." She explained her mother's difficultly getting treatment because she "has struggled finding someone that she can connect with," which has "turned her off to [therapy]." Similarly, Participant 4 said:

P4: [Therapy] is really good because sometimes your friends don't really give you great advice or they don't understand. … It is nice to have a professional who has studied emotions and the human brain and social interaction and different types of communication, because you are getting a more educated person looking at your life and helping you.

The aforementioned qualities of the therapist being trustworthy and non-judgmental, possessing expertise and neutrality, and the therapist being a good 'fit' for the client's personality, were universally referenced by participants during discussions of what made a good therapist or for a successful therapy. The effect that using different forms of technologic communication might have on these qualities is what primarily informed each participants' expressed feelings towards the further integration of technology in the therapeutic relationship.

Despite the ubiquity of the above ideas concerning the qualities of a successful therapy, perhaps the most strongly expressed and ubiquitous idea that appeared in each interview is the belief that body language and tone of voice are both critically important to effective communication about emotionally-arousing subject matter. This belief will be explored in detail in the following section.

   The presence of body and voice is critical to emotional communication. All participants emphasized their belief in the critical role that body language and tone of voice played in communication. The ways in which body language and tone of voice does or does not exist in a particular technological medium of communication was fundamental to each participants' description of their thoughts about its use in therapy. Each participant reported their primarily mode of communication was text message when not in someone's immediate proximity, yet every participant also highlighted text as powerfully easy to misinterpret. Each participant said misinterpretation was due to the lack of additional information that is otherwise carried by tone of voice and body language. For this reason, many participants said they avoided having conversations over text if they were expected to contain significant emotion; participants noted that they also worried about themselves being misinterpreted and causing distress to their communication partner. As Participant 3 noted about text messaging, "I find tone and expression of humor are almost always lost, that I can be very sarcastic and that typically can also piss off a few people, including by accident." As a result, most participants reported they were most comfortable using text for logistical purposes and communications such as confirming appointments and giving directions, unless they had a significant prior history of using text message with a particular individual. Notably, several participants mentioned that their comfort using text message, even with emotional subject matter, was significantly increased if they

already had an established history of using that medium with a particular person. As Participant 2 called it, there was "comfort through repetition."

Audio-only communication, such as telephone or Voice-over-IP software, was described more positively than text because of the presence of tone of voice. Participants felt that this minimized the potential for misinterpretation because it contained more interpersonal information. They believed they were more likely to understand a communication because the tone of voice would offer greater specificity about how words or phrasing were intended to convey meaning from the speaker. Nevertheless, most participants described being more comfortable with speaking audio-only to someone if they were already familiar with that person. Put another way, the additional interpersonal information offered by audio communication was described as causing participants more discomfort when they spoke with people they did not know. Some participants attributed the demand for an immediate response and the inability to determine the attentiveness of the communication partner as causes for discomfort with audio-only communication. Participant 6 said:

> I'm not comfortable with it. I don't know. Because, I don't know the person well, and you can't think before you say things. And if you don't know it, you have to ask if you can put them on hold, and sometimes they don't like being put on hold because you have to carry the phone around with you everywhere.

Many participants highlighted the idea that the presence of body and voice makes a statement about the attentiveness of the speakers, and that this offered a greater ability to feel trust. Being able to know with certainty a communication partner's level of attentiveness was cited as a significant reason for feeling comfort and intimacy while speaking to another person. The overwhelming majority of participants cited this certainty as an explanation for why

videoconference was preferred over text and audio. Several participants also critiqued the lack of body in audio-only communication as having the potential to prevent the therapist from best "knowing" what is occurring to the client, thereby inhibiting their ability to best apply their expertise.

Interest in videoconference therapy was significant. All participants expressed an interest in videoconference being available as a medium for conducting therapy, and most participants expressed a desire for the availability of multiple mediums for conducting therapy, even if they did not intend on using these mediums either primarily or at all. Each participant cited in their interview the presence of body and voice as the reason they felt comfortable with the idea of videoconference therapy, and all participants reported a belief that the increased availability of videoconference and other technological mediums in the context of therapy would increase their willingness to participate.

The only critique of videoconference as a medium for therapy offered by multiple participants was a concern about the reliability of the technology. Many participants explicitly described an anticipated reduction in both attitudinal and structural barriers to access as a result, but Participant 2 and Participant 3 probably best described the potential impact. Participant 2 said:

> I think I would be much more likely to enter treatment. I think the activation energy is just lowered very significantly and I would be much more likely to seek that out, especially in maybe a casual situation where I feel like at this point I'm thinking, "Ugh if it gets worse I'll finally do something about it" but I'd be more likely to just say, "You know what? Let's just try it and see where it goes."

In addition, Participant 3 expressed the following opinion about videoconferencing:

> Definitely for crisis situations but also probably just overall ease, because right now if I think of a psychotherapist, I think of… okay, cool… I need a block of time, I need a car, I need to make sure I am not busy at this time, I need to show up, I need to make certain that I am healthy, I need to shove off a lot of things that I can do just to show up here, and then I need to know what my expectation is, I might come out rattled, now I have to drive, I have to worry about the weather, I have to worry about the traffic, maybe I would get lost and miss the appointment. Whereas, if I am just… "okay, I'm in kind of weird mood I have the computer." Accessibility is massively in favor of the digital world.

The belief among all participants was that the presence of greater choice over medium in therapeutic relationships would make people more likely to enter treatment. While no participants endorsed feeling comfortable with text in therapy, and few endorsed feeling comfortable with audio-only therapy, all participants were in agreement about their desire to have multiple mediums available for the therapeutic process. This opinion was evident despite the fact that four participants [P3, P4, P7, P9] simultaneously stated that in-person and face-to-face meetings would need to occur for them to have a successful therapy.

Conclusion

This chapter detailed the themes that emerged from interviews with 10 different participants for this study. After a theme analysis of these interviews, it was discovered that the participants all shared a sense of competency and familiarity with technology and different mediums of technological communication, and all participants cited text as the technology they most commonly used. Though all participants reported engaging with text, audio, and video as mediums for communication, they generally felt that text was the least useful for emotional

conversation; this was especially true in comparison to videoconference. Participants cited the importance of tone of voice and body language in communication as the reason for their discomfort with text message and the idea of therapy over text.

Three additional major themes emerged from participants on the topic of therapy and technology. One was the sense that multiple intersecting barriers make maintaining, and in particular beginning, therapeutic relationships appear difficult. Another was the perceived importance of the qualities of trust, expertise, and 'fit' for having a successful therapy. Lastly, there was a strong interest in the availability of videoconference as a medium for conducting therapy, with all participants expressing a belief that greater availability of different communication technologies in therapy would significantly increase people's willingness to enter and maintain treatment. In the next chapter, these findings will be discussed in the context of the already existing literature that was outlined in Chapter II. This discussion will include a reflection on how the study's findings might be understood alongside the existing literature, as well as the potential implications for future research, policy, and practice.

CHAPTER V

Discussion

The purpose of this study was to explore how the use of communications technologies in the context of psychotherapeutic relationships might affect attitudinal barriers preventing young people from utilizing psychotherapy. The research question that this study explored was: "How might the integration of communications technologies into psychotherapeutic relationships affect attitudinal barriers to access for young people between the ages of 18 and 30?" After interviewing 10 young people between the ages of 18 and 30 for a period of 30-45 minutes, a number of noteworthy findings were discovered about their beliefs towards psychotherapy, technology, and their potential integration. Among these findings, four stood out as most significant and were outlined with detail in the preceding chapter: (1) therapy is believed to be difficult to begin and maintain; (2) trust, expertise, and 'fit' and believed to be important qualities of a therapy; (3) the presence of body and voice is believed to be critical to emotional communication; and (4) there is significant interest in videoconference therapy.

This chapter will seek to compare these findings to the existing literature as summarized in Chapter II, as well as explore the study's strengths and limitations. The discussion of how the aforementioned four major findings can potentially be understood in terms of the existing literature will specifically focus on (1) the co-determining relationship between attitudinal and structural barriers; (2) the influence of voice, body language, and physical proximity on working

alliance and attachment; (3) the generally high comfort level that young people have with technology and their strong discomfort with using text-based psychotherapy. After contextualizing the study's findings within the framework of the existing literature, implications for future social work practice, policy, and research will also be considered.

Comparing Key Findings to the Existing Literature

   The interactive relationship between attitudinal and structural barriers. As detailed in Chapter IV, the overwhelming majority of participants described various ways in which they and others observed barriers to entering and maintaining psychotherapeutic treatment. The structural barriers identified by participants were consistent with the barriers identified in previous literature, such as cost, low insurance reimbursement rates, inability to travel, and loss of work time required to attend appointments (Campo et al., 2015; Mojtabai et al., 2011). They likewise identified attitudinal barriers such as public and personal mental health stigma, which is also emphasized by current literature (Pedersen & Paves, 2014). Discussed less in the literature, but highlighted by these participants, was the interactive relationship between structural and attitudinal barriers. In other words, the discrete conceptualization of structural and attitudinal barriers offered by writers like Campo et al. (2015) may be an inadequate way of perceiving barriers. Rather, based upon this study's findings, it may make more sense to conceive of structural and attitudinal barriers as inseparably intertwined. While Campo et al. (2015) conceive of these two forms of barriers as separate but layered, it may be more accurate to conceive of them as always informing and co-determining one another, such that they are two sides of the same coin, so to speak. The quote from Participant 5 offered in the previous chapter provides a strong description of how one's mental health state can significantly impact one's perception of the structural barriers faced and vice versa. It then seems likely that one's experience of

attitudinal barriers, whether it is due to stigma or acute emotional distress, carries the potential to make existing structural barriers appear even more insurmountable than if they were observed in isolation.

The influence of voice, body language, and physical proximity on working alliance and attachment. All participants involved in the study endorsed the importance of voice and body language in communication, especially during emotionally charged conversations. Many of them described the significance of being able to access a greater amount of interpersonal information when voice *and* body language were present, allowing them to more accurately perceive the intended meanings of their communication partner and vice versa. They also cited feeling generally better able to relate to others, and in the context of mental health treatment, the therapist. They largely described a feeling that the success of a therapy would not be negatively impacted by the absence of physical proximity, such as in the use of videoconference for therapy. That is, as long as the client can see and hear the therapist, they do not believe being physically separate inhibits the success of the treatment. In terms of the existing literature, it might be accurate to rephrase this in terms of the participants' ability to feel able to develop what Bordin (1979) called the *relational bond,* one of the three critical components of a working alliance. The working alliance is, as reviewed in Chapter II, strongly linked to positive therapeutic outcomes (Flückiger et al., 2012). Conspicuously absent from discussions of working alliance and, in particular, the element of the relational bond is any consideration of the potential for voice and/or body language, let alone the physical proximity of therapist and client, to be absent from their communication. While videoconference was not an available technology at the time of these original writings, audio-only therapy such as tele-psychoanalysis was, albeit in limited usage (Saul, 1951). It seems apparent at this point that the existing literature is unable to address the

role that voice and body language, if not physical proximity itself, play in the development of working alliance, perhaps because when these ideas were originally conceived, such technologies were unconceivable.

The language of and research on attachment seem similarly unable to address what precise role voice, body language, and physical proximity play in the client's ability to develop a therapeutic relationship. In attachment research and theory, the physical proximity of the attachment figure is assumed as a given, and again this can likely be explained by the fact that widespread, consumer video conference technology was barely conceivable at the time these ideas were initially developed. Some of the foundational studies on attachment by Mary Ainsworth (1970) were conducted via in-person infant observation, in which communication without physical proximity, voice, or body language, were either not possible in such a context or not considered. Nevertheless, the existence of literature linking attachment style to a person's proclivity towards different technological mediums in intimate relationships, combined with the suggestions of this study's findings, indicate that these are important variables to consider in the context of both attachment and psychotherapeutic working alliance (Drouin & Landgraff, 2012; Morey et al., 2013; Weisskirch & Delevi, 2011).

The strong comfort level with technology and overwhelming discomfort with text-based psychotherapy. Participants in the study overwhelmingly stated both their relatively high comfort levels with communication technology, as well their discomfort with text-based therapy and subsequent comfort with videoconference therapy, despite sacrificing physical proximity to the therapist. These findings were consistent with the popularly held assumption that young people aged 18-30 have widespread comfort with communications technologies. However, the findings were not consistent with the studies conducted by Bradford and Rickwood (2014) in

which a relatively small sub-section of their participants preferred talking about emotional issues, rather than texting about them; the participants in this study overwhelmingly criticized text as a medium for emotional conversations. Participants largely endorsed this critique regardless of whether their communication partner was from their personal life or a psychotherapist. One reason for this inconsistency might be that the Bradford and Rickwood study used a sample with participants as young as 12 years old, whereas the present study was exclusive to a post-adolescent demographic. This reasoning perhaps suggests that one's relationship to communication mediums changes throughout adolescence or that comfort levels with texting among young people as a demographic are rapidly increasing in general. It also is possible that the additional interpersonal information contained in voice and body is becoming devalued by new generations, which could be a profound statement about the influence of communication technologies on interpersonal relationships in society at large.

Another study by Reynolds et al. (2013) indicated that clients feel similarly, or in some cases more positively, about the use of text for therapy compared to face-to-face. This was definitively not the case in the findings of the present study, as the use of text for psychotherapy was overwhelmingly described as a discomforting idea. It should be noted, however, that in the present study participants were asked to offer their beliefs about hypothetical participation in such a relationship, whereas the Reynolds et al. study examined real experiences of text-based therapy. Since the findings of Reynolds et al. so completely oppose the findings of this study regarding text therapy, there is no comparison to be made about the potential discomfort created by the absence of voice and body language. Again, participants in the present study cited this absence as the primary reason they imagined they would be uncomfortable with text therapy and were instead comfortable with videoconference therapy.

It is unclear why such a severe discrepancy exists between these findings, but it should be noted that the sample for the Reynolds et al. study was significantly older (ranging in age from 28 to 62), and many of the participants were transitioning already-existing therapeutic relationships of unknown length from face-to-face to text for the purposes of the study. Since barriers to entering psychotherapy are a major concern of the present study, the latter fact becomes particularly important. As well, recruitment for the Reynolds et al. study was done on sites such as e-clinics, online counseling centers, and mental health message boards, which could imply that their sample contained a predisposition towards feeling comfortable with text-based discussion of emotional material. When the findings of this study are taken in context of the existing literature, whether consistent or inconsistent with previous findings, a number of relevant implications for social work practice, policy, and research emerge and need consideration.

Strengths and Limitations of this Study

The semi-structured nature of the interviews allowed the participants to freely engage in conversation and express their beliefs about psychotherapy, technology, and their potential integration in an uninhibited manner that sought to minimize how their responses would be directed. Through this conversational process, participants were encouraged to feel creative and comfortable, and as a result spontaneously provided thoughts to the researcher that reflected the exploratory nature of the study. Participants were asked to reflect not only on their own lived experiences and current beliefs, but also to project into hypothetical situations and imagine they might be impacted by the greater availability of communications technologies in therapy. The exploratory, conversational format of the interviews was appropriately reflective of the exploratory interest of the study itself.

Additionally, the rigor and trustworthiness of this study's findings were enhanced by the involvement of the researcher's thesis advisor, Susanne Bennett, who was able to review the research project on ATLAS.ti and provide regular feedback and input on the coding and analysis of data. The semi-structured nature of the interviewing also increased reliability, as all participants were taken through roughly the same categories of questions by the researcher despite being allowed the ability to be spontaneous and creative in the service of the study's goals.

In addition to this study's strengths, it has some limitations. As of the time this study was designed, there was no pre-existing literature on the specific topic of how the further integration of communications technology in psychotherapy might impact attitudinal barriers to access. This absence of pre-existing literature meant that the study had to be designed in such a way that allowed the participants to express themselves in an open-ended and hypothetical fashion, significantly restricting the study's ability to make any definitive claims about the real impact of communications technologies in therapy on attitudinal barriers. The conversational nature of the interview, combined with the participants' knowledge that the researcher was a psychotherapist and clinical social work graduate student, also potentially had an effect on participant responses. It is possible that participants having this knowledge about the researcher could have created a context in which participants might be inhibited from fully expressing beliefs that were critical of psychotherapists, psychotherapy, and its effectiveness. As well, the structure of the research question could potentially be read as leading participants towards the idea that the researcher is biased towards a perception of greater use of technology in therapy being necessarily positive or decreasing attitudinal barriers. Since interviews were conducted with audio, it is also possible that the researcher's tone of voice, if not the researcher's improvised questions themselves

during the interview, could have betrayed the biases of the researcher and led participants towards giving responses they perceived as desired.

Additionally, the sample group was small, being limited to 10 participants, and lacking in racial and gender diversity. For example, all participants self-identified as white or Caucasian and were all female, with one exception. As a result, the findings of this study cannot be generalized beyond the population of these 10 participants. The sample was further affected by the fact that interviews took place primarily using audio-only technology, excluding individuals who have discomfort speaking with strangers or having their voice recorded. This is noteworthy because it potentially means that individuals who might more favorably view text-based therapy because of the absence of voice and/or body language would be inhibited from participating. This limitation more broadly references how the use of a specific technological communication medium has the potential to distort results. A circumstance is thus created in which the object of study is simultaneously the subject, namely, technological mediums for communication and their effects on how people relate. Despite the fact that it is unknown how this might impact findings, it is worth noting as an issue in the future study of specific communication mediums via interviews that themselves use specific communication mediums. Regardless of these limitations, the findings of this study make it clear that future research on the subject is prescribed.

Implications for Social Work Practice

Based on the major findings of the study as well as comparisons with pre-existing literature, the implications for social work practice seem clear: current and potential clients desire more integration of communications technology in the psychotherapeutic relationship, particularly videoconference. The ubiquity of responses from participants regarding their interest in having more technologic options available to them indicates a demand from current and

potential clients to make psychotherapy more accessible in terms of addressing both structural and attitudinal barriers. The more we begin to understand these barriers and what seems to be a co-determining relationship between them, the more important it seems to be to alter clinical practice in ways that address them simultaneously. Greater availability of different technological mediums for communication seems to accomplish this task.

Of course, the lack of significant data and established theory on the real effect of losing physical proximity to the therapist, as well as voice and/or body language in the case of text and audio-only communication, is a critical issue. It is important to note that despite the demands of current and potential consumers of psychotherapy for these technologies, the long-term effectiveness of psychotherapeutic relationships over these mediums is absolutely not established. Nevertheless, as has been covered above, existing literature does offer good cause for optimism (Bradford & Rickwood, 2014; Chu et al., 2004; Dowling & Rickwood, 2013; Reynolds et al., 2013; van Ballegooijen et al., 2014). This is of course in addition to other relatively low-intensity, cognitive-based computer-mediated therapies, which have a somewhat established evidence-basis for their effectiveness (Lederman et al., 2014; Rooksby et al., 2015).

Implications for Social Work Policy

One of the most widely cited structural barriers to access cited by participants in this study, as well as prior research, was inadequate or no access to health insurance. This is particularly true for telemedicine and especially psychotherapy conducted online. The laws regulating insurance reimbursement for telemedicine, which refers to a wide variety of text, audio, and video-based treatments and consultations for physical as well as mental health, are overwhelmingly inconsistent from state-to-state (Chan, Parish, & Yellowlees, 2015). This has created an atmosphere of confusion for practitioners and clients alike, making online

psychotherapy as of today only accessible to those who are able to privately pay for their treatment. This, of course, all but eliminates the potential for greater use of technology in psychotherapy to address barriers to access.

In addition, there are no current ethical guidelines for how psychotherapy is to be conducted outside of the face-to-face, in-person environment. Privacy and confidentiality concerns in particular become much more complicated when psychotherapy is conducted online. To name just a few examples, there exists the potential for clients (or therapists) to record sessions, for text-based sessions to be permanently archived with relative ease, or for the client's chosen location to not have completely ensured privacy. Some organizations, such as the non-profit American Telemedicine Association, have attempted to generate guidelines in accordance with general ethical considerations and federal laws governing electronic communication and privacy (Yellowlees, Shore, & Roberts, 2010). However, such efforts are informal and made without the input of licensing authorities such as the National Association of Social Workers (NASW) and the American Psychological Association (APA). These are complicated, intersecting issues with legal, ethical, even technical components that demand careful consideration by practitioners, advocates, clients, and policy makers. Nevertheless, it is the role of practicing clinicians to ensure that policies and regulations are constructed in a manner to benefit the current and potential clients whose access to necessary mental health treatment stands to be dramatically increased as technology becomes a tool for psychotherapeutic treatment. In order to properly accomplish this significant task, future research into the effects and effectiveness of communication technology's integration into the psychotherapeutic relationship seems both appropriate and necessary.

Implications for Future Research

It is apparent that further study is important and necessary in order to determine the real impact that greater integration of communications technologies in psychotherapeutic relationships might have on attitudinal barriers to access. The findings of this study indicate that there is fertile ground for further and more rigorously assessing how this integration, particularly of videoconference, might impact people's willingness to enter and maintain a psychotherapeutic relationship. As well, it seems important that future research explore how the effectiveness of psychotherapy, in terms of relational bond, working alliance, and attachment, might be differentially impacted across the various technological mediums. Understanding how attachment styles and/or diagnoses might predict an individual's relationship to different technological mediums of communication may be important. It seems possible that attachment style or diagnosis might impact one's preference for medium as well as one's comfort level with different mediums. It could prove useful to discover what makes someone willing or unwilling to engage in treatment over a text, for example. It may also help to predict and understand whether treatment or a particular technological medium will be successful or possibly even iatrogenic. Due to the lack of literature on this specific topic and the implications this study has for decreasing attitudinal and structural barriers to access, further exploratory research is recommended.

Conclusion

The purpose of this study was to examine how communications technologies in the context of psychotherapeutic relationships might affect attitudinal barriers preventing young people from utilizing psychotherapy. After performing semi-structured interviews with 10 participants, a theme analysis revealed four key findings. It revealed that therapy is believed to

be a difficult endeavor, that certain qualities of the therapist are of particular importance, that voice and body language are critical to talking about emotional topics, and that the availability of psychotherapy over videoconference might greatly increase the willingness of young people to enter treatment. The findings of this study suggest the potential benefits of using communications technology within the psychotherapeutic process. In particular, videoconference and other forms of technology may decrease attitudinal barriers faced by current and potential clients. Further research on the topic seems important to the field of clinical social work and the mental health profession.

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Appendix A

SMITH COLLEGE

February 19, 2016

Collin Browne

Dear Collin:

I have reviewed your amendments and they look fine. The amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Susanne Bennett, Research Advisor

Appendix B

SMITH COLLEGE

January 19, 1016

Collin Brown

Dear Collin,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Susanne Bennett, Research Advisor

Appendix C

SMITH COLLEGE

FA2015-2016
Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA

....

Title of Study: Communication Technologies in Psychotherapeutic Relationships and their Connection to

Attitudinal Barriers: A Qualitative Study

Investigator(s): Collin Browne, Smith SSW, xxx-xxx-xxxx

....

Introduction
- You are being asked to be in a research study of *whether greater use of technology in therapy might increase the willingness of young people to enter therapy or return to it.*
- You were selected as a possible participant because *you are between the ages of 18 and 30, currently hold a belief that you might benefit from psychotherapy or have benefitted from it in the past, or you are a current or former psychotherapist.*
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study
- The purpose of the study is *better understand whether using technology in therapy might increase the willingness of young people to enter therapy or return to it.*
- This study is being conducted as a research requirement for *my Master's of Social Work degree.*
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures
- If you agree to be in this study, you will be asked to do the following things: *participate in one audio recorded 30-45 minute interview via Skype.*

Risks/Discomforts of Being in this Study
- The study has the following risks. First, *the interview questions will ask about past experiences that might have been uncomfortable, and so they could potentially trigger new discomfort as you think about them.*
- *If emotional discomfort results as a result of the interview, please refer to these resources:*
  - *Boston University Counseling and Wellness Center: 617-353-3569*
    Tufts University Counseling and Mental Health Services: 617-627-3360
    www.PsychologyToday.com > "Find a Therapist"

Benefits of Being in the Study

- The benefits of participation is *the potential for renewed interest in receiving psychotherapeutic treatment, as well as the identification and working-through of reasons why you may have held back from pursuing these services up to this point.*

- The benefits to social work/society are: *an expanded understanding of the potential utility of using technology in psychotherapeutic practice.*

Confidentiality

- Your participation will be kept confidential. *Interviews will take place via Skype audio or videoconference with the researcher located in a private residence. Audio recordings will be made both on a password-protected computer directly and on a password-protected phone recorder, the latter serving as a backup. A transcript of the interview, to be stored on the same password-protected laptop, will be produced within one week of the interview. The information contained in the transcript will be de-identified so that data cannot be linked to you as an individual. In transcripts, participants will be consecutively assigned letters they are associated with rather than their names (i.e. participant A, participant B, and so on). In addition, records of this study will be kept strictly confidential. Only the researcher will have access to audio recordings. Consent forms and transcripts will be stored in separate folders on the same password-protected laptop to further ensure that consent forms cannot be linked to participant interviews.*

- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift

- *You will receive the following payment/gift: $20 cash compensation immediately following the interview sent via PayPal or through physical mail in the form of a VISA cash gift card.*

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled, including the $20 cash compensation. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by March 1, 2016. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, *Collin Browne* at *cbrowne@smith.edu* or by telephone at xxx-xxx-xxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this

study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

....

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

....

[if using audio or video recording, use next section for signatures:]

1. I agree to be [audio or video] **taped for this interview:**

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

Appendix D

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

PARTICIPANTS NEEDED

($20 CASH COMPENSATION PROVIDED)

A study on how using technology in psychotherapy might increase willingness to enter therapy among young people

Do you feel you might benefit from therapy but have never tried it?

If you've tried therapy, do you think it ended earlier than it should have?

If yes and you are between ages 18 and 30, please participate in a 30-45 minute Skype interview.

For more details please contact Collin Browne at cbrowne@smith.edu

Appendix E

Demographic Questions:

What is your age?

How do you identify your gender?

How would you define your socioeconomic status?

How would you define your ethnicity?

What is your current level of education?

What is your current major and/or degree program?

History and Beliefs: Technology

How would you describe your overall utilization and comfort level with technology?

How often and comfortably do you use social media for communication?

How often and comfortably do you use text for communication?
> Probe: What do you like or dislike about using text?
> Probe: Do your feelings about text differ depending on whether it's being used for a professional or personal context? If yes, how so?

How often and comfortably do you use the phone for communication?
> Probe: What do you like and dislike about using the phone?
> Probe: Do your feelings about using the phone differ depending on whether it's being used for a professional or personal context? If yes, how so?

How often and comfortably do you use videoconference (e.g. Skype) for communication?
> Probe: What do you like and dislike about using videoconference?
> Probe: Do your feelings about videoconference differ depending on whether it's being used for a professional or personal context? If yes, how so?

Of the three aforementioned technologies (text, phone, videoconference), which do you use the most frequently? Why?
> Probe: If you have preference for a particular technology that is different from the one you use most frequently, why?

Of the three aforementioned technologies, do you prefer them differently for different situations? Why or why not?
> Probe: For each preferred situation(s) detailed above, why do you prefer that technology for that particular situation?

History and Beliefs: Psychotherapy

What are your general beliefs about psychotherapeutic relationships, both positive and negative?

Why do you believe you would benefit from a psychotherapeutic relationship?

If you have never had a psychotherapeutic relationship, what has prevented you from entering one?

If you have previously had a psychotherapeutic relationship that you would describe as unsuccessful, what do you believe made it unsuccessful?

How would you describe a successful psychotherapeutic relationship?
    Probe: How important is it to see a person face-to-face or in-person for that to be achieved?

Psychotherapy and Technology

How would you feel if you could begin and maintain a psychotherapeutic relationship over text? Over the phone? Over videoconference?

How do you think a psychotherapeutic relationship might be affected, both positively and/or negatively, if conducted primarily over text? Over the phone? Over video conference?

How might the availability of psychotherapeutic relationships over the aforementioned mediums impact your interest in or motivation to enter a psychotherapeutic relationship?

How would you feel if you could enter a psychotherapeutic relationship beginning over a technological medium (e.g. text, phone, video) with the potential to change to different mediums or to face-to-face over time?

Conclusion

What additional information, if any, would you like to offer on this subject that has not been covered by the questions already asked?