# Online couple therapy: Reflections from reluctant converts

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## Introduction

When the COVID-19 lockdown arrived, many therapists were forced to shift their therapy online. We are two couple therapists working in Aotearoa (New Zealand) with over 25 years experience in the field. We were curious to observe the effects of switching from in-person couple therapy (IPCT) to online couple therapy (OCT) on the therapeutic process and outcomes. The lockdown period served as a kind of natural experiment. Delivering only OCT for nine months allowed us to compare it closely with IPCT and to note the specific benefits and challenges it offers.

As relationship therapists, we know that wonderful online relationships are no guarantee of in-person compatibility. In our experience, people can have years of deep intimate online interactions—with mental, emotional, sexual, and even spiritual depth—and discover within weeks of trying to live together that they are fundamentally unsuitable. So we know that online relationships are different from in-person ones.

On top of that, outcome research tells us that it is not our training, nor our models, but the therapeutic relationship itself that contributes the biggest benefit to our clients (Ellis et al., 2020; Falkenström et al., 2014). We had assumed, prima facie, that delivering therapy online via videoconference attenuates the relationship and that this must be a bad thing. Considering the interpersonal complexity of couple therapy compared with individual therapy (Borcsa & Rober, 2016; Symonds & Horvath, 2004), we believed that the negative impacts of working via videoconference would be magnified. We considered ourselves qualified to make this judgment as, since 2005, we had done videoconference follow-up sessions with clients who lived out of town. We were fortunate in having this experience as it meant that, when the COVID-19 lockdown arrived and therapists were abruptly forced to shift their therapy online, we were better placed than many by virtue of being familiar with both the technology and “feel” of doing therapy by videoconference.

What we were not prepared for and what, in large measure, provided the impetus for this article, was how our view of OCT changed once we were doing it full-time. Both as a result of our subjective experience and the wealth of research about one-to-one online therapy that was highlighted at this time (e.g., Berryhill et al., 2019; Karyotaki et al., 2018; Luo et al., 2020), we came to the view that OCT has unrecognised advantages in comparison to IPCT. We suggest that those advantages sufficiently compensate for the

disadvantages we had previously focused upon. Other articles suggest that we are not alone in this shift to viewing online therapy more favourably (e.g., Békés & Aafjes-van Doorn, 2020; Stoll et al., 2020).

We do want to stress that we have not conducted formal research and that this is not intended to be an academically rigorous article. What we are offering is a report of clinical experience, strictly a reflection piece on a change in practice that was imposed on many of us by unfortunate circumstances. We offer it intending to stimulate thought and dialogue with our professional community. As such, we present our conclusions tentatively and hope that, as online therapy of all kinds becomes more prevalent, others will be able to conduct more formal and rigorous explorations of the relative merits and benefits of OCT when compared with IPCT.

We are lucky enough to practise within a supportive community of peers and were able to share and discuss our observations and compare our experiences of OCT together during the lockdown and since. We are grateful for their input and ongoing support but would stress that this article represents our personal views. In particular, we draw the reader's attention to two aspects that will strongly influence the nature of our experience. Firstly, that we are very experienced couple therapists who are unusual in our degree of specialisation in this modality. It has been the main focus of our work for over 25 years and we have supervised and taught in this area. Our degree of specialisation may mean our perspective on OCT is also not typical. Secondly, we are people who have adapted easily to working online. This is not everyone's experience, and we recognise that some therapists (and some clients) will continue to see videoconference as a lesser or more difficult means of conducting therapy (Bekes & Aafjes-van Doorn, 2020; Wind et al., 2020).

Another factor to highlight in our experience is that the abruptness of the imposition of lockdown created something of a natural experiment, in that we had a whole cohort of clients with whom we worked in both modes—initially using IPCT and then OCT. This allows us to make a direct comparison of the subjective effectiveness and "feel" of working in both ways. We had several direct conversations with clients about their experience of the change, what was different (for better and worse) and what was the same. Subsequently, we have had similar conversations with new couples who had previously done IPCT with other therapists and were trying OCT for the first time. The natural experiment was complicated by the fact that, during the mandated lockdown periods, online therapy was a necessity and so the appraisal of OCT was coloured by clients' appreciation that they were able to maintain continuity in their therapy whilst also remaining safe from exposure to disease. Now, in Aotearoa, we have been fortunate to have been free of the necessity for social distancing for some months now; however, we are mostly seeing clients who could seek IPCT elsewhere and are choosing to stay with OCT.

## Convenience Versus Technological Dependence

The most striking advantage of OCT is its convenience (Jardine et al., 2020). Therapists no longer have to be centrally located to be accessible to clients. They no longer need to maintain a therapy room large enough to accommodate three people. They can work from home and even from a location well away from the expense and pressure of a big city, as long as they have a good internet connection.

In the same vein, it is hard to overstate the convenience of OCT for clients. The lack of a need to physically travel to therapy makes it much less disruptive of a client's day, requiring a much smaller portion of their time to be able to attend and much simpler logistical demands. For clinical reasons that are outside the scope of this article, many experienced couple therapists do sessions that are longer than a 50-minute "therapeutic hour" (Bader, n.d.). Our practice is to offer couples a 90-minute session. Attending a session of this length in-person places considerable organisational and logistical demands on clients. Both partners have to get from wherever they are in Auckland to our offices and back again. Many clients talk about needing to take "half a day" off work to attend therapy—usually meaning three hours. Simply halving that time requirement makes OCT a lot more convenient. Likewise, removing the need to travel means people do not need two vehicles, can still be available to children or workplaces in an emergency (yet, interestingly, we have found that interruptions are not a worse problem c.f. IPCT), and do not arrive at your session stressed from driving in city traffic!

In couple therapy, it is common for one partner to be reluctant or sceptical about attending (Hubbard & Harris, 2020; Spiker et al., 2018). Removing practical barriers makes it more likely that they will be willing to "give it a go" in the first instance. Since we shifted to OCT, we have had many comments from the person initiating therapy that the convenience of OCT makes it much more likely that their partner will attend or that it gives them fewer excuses to not attend.

The big trade-off for this convenience is the dependence on technology. With IPCT, it is unlikely that your client will suddenly be rendered mute or simply disappear from the session without warning. With OCT, the risk of something like this happening is always present (although it rarely occurs). Technical issues can be very disruptive to the session and intensely frustrating to all involved. Though there is much that can be done to mitigate this risk (some of which we cover in our "Suggestions From What We Have Learned" section below), it is not possible to eliminate it. In our opinion, it is very important to the therapeutic relationship that nothing disturbs the link. We think it is part of making clients feel valued and important that the therapist does everything within their power to ensure that the technology operates seamlessly. The meta-communication in failing to do so can be likened to a therapist turning up late for an in-person session or terminating a session early.

However, the technology, like therapy itself, is a two-way street and the stability of the video connection is at the mercy of the care your clients take in setting up at their end. This can, in and of itself, be informative therapeutically. For example, there is scope for unconscious sabotage by reluctant clients who spend 10 minutes of session time fiddling with the settings, rather than doing this beforehand, or who "can't get a good connection"

and so make it easy for themselves to disengage (sometimes literally) from the therapy session. Their partners may, understandably and accurately, read this as a lack of commitment to the therapy process. As with anything that clients do that impacts the therapeutic process, this can then become a focus for exploration and intervention.

Even if the technology is working flawlessly, there will always be clients who are unskilled, unfamiliar with, or intimidated by using videoconferencing technology. If this is the case, we feel it is our clinical responsibility to help them become familiar with the technology—we have become quite adept at troubleshooting Zoom (our platform of choice). Happily, we have had less difficulty in this regard than expected. We have both had clients in their 70s who were new to the technology but, as long as they were confident in our patience with them, were able to adapt readily to online therapy. Indeed, they became quite proud of their new-found technical skills. Again, if people feel flustered or intimidated, this can be used as grist to the therapeutic mill.

## Benefits and Challenges of Greater Accessibility

As systemic therapists, we are mindful of the power of *homeostasis* (the tendency of families or couples to return to well-established behavioural patterns) (Seshadri, 2019). Particularly in the early stages of therapy (e.g., first 10 sessions), we have found that clients benefit from frequent sessions, ideally weekly, to help them move into new patterns of interaction. A flow-on effect of the convenience of OCT is that we are seeing better attendance and, consequently, greater continuity. When therapy is easier to access and takes less time, clients are more likely to attend regularly. This is to the benefit of all clients as, in our experience, the momentum for change built by regular attendance is a significant factor in a successful outcome of therapy. The convenience of OCT also translates into greater accessibility. Although across Australia and Aotearoa the vast majority of people now live in large centres, we still have a significant minority who live rurally and even remotely. Until the rise of online therapy, these people have had very little choice when it comes to accessing mental health support. Now, provided they have reliable internet, clients in rural and remote areas have the same opportunity as their city-dwelling compatriots to receive therapy from specialist practitioners. This does not mean that everyone has coverage. There are still those who, often for reasons of poverty, don't have ready access to the technology that allows OCT. Nonetheless, we would argue that the overall increase in accessibility must be counted a win for equity and fairness.

For therapists, OCT enables drawing on a much wider catchment area than their local geographic community and this can raise new challenges. If therapists are receiving referrals from all over Aotearoa or all over Australia, this requires them to develop knowledge of other therapists and support systems (your referral network) across a much larger geographical area. For example, in support of our sex therapy work, we will want to know of gynaecologists, urologists, sexual health physicians, and physiotherapists to whom we can refer clients. We have spent years building those contacts in Auckland and are now in the process of building them in the rest of the country. When working with rural clients, it becomes quickly apparent how limited their access is to services, compared with people in major centres. While this can be a cruel blow for the clients who cannot get

the help that others take for granted, it can also lead to increased stress on the therapist, a more onerous duty of care as we struggle to provide the needed support without networks of other professionals, agencies, and organisations that we are accustomed to accessing in our IPCT practice (e.g., women's refuges, family violence programmes and advice, mental health crisis services).

## Implications of Lack of Face-To-Face Contact

In the earliest works about online disinhibition (i.e., the lack of restraint people can feel communicating online when compared with face-to-face), Suter (2004) noted that this can take toxic and benign forms. Given that we, as therapists, are not dealing with a situation of anonymity we, thankfully, experience none of the toxic behaviour. What we subjectively observe is that some clients are notably more forthcoming. Some clients who during IPCT were "walled off" and guarded seemed freer and more open in their communication during OCT. Although this increase in openness could have been a function of the emotional atmosphere that prevailed during the initial COVID-19 lockdown, we suspect it may be due to the differing social demands of OCT (e.g., less pressure to make or maintain eye contact), as this effect has continued to be observed for an extended period of six months. In discussions of sexual behaviour, in particular, we have noted that the increased distance appears to allow people to be more direct and forthcoming about the details of their sex lives, with less prompting.

As well as the potentially disinhibiting effect of being online, there is the simple fact that most people are more relaxed in their own environment. Particularly when they are joining a session from home—being in their own territory, with their sense of self extending through the architecture, furnishings, and objects of their familiar surroundings—people appear more secure, relaxed, free, and open. This can even apply to people joining a session from a workplace if it is one in which they are comfortable or if they have the luxury of a private office.

Of particular relevance to the practice of couple therapy, which is typically more directly challenging than individual therapy (Weeks et al., 2005), is that some people seem less threatened by, or reactive to, challenges. We are noticing a marked reduction in defensive and aggressive behaviours from clients in sessions. We offer the tentative observation that there appears to be a gender difference in this respect, with men seeming more open to challenge in OCT compared with our experience in IPCT.

It must be acknowledged that some clients and therapists will come from cultures (in the widest meaning of the word) that place a premium on face-to-face contact. Certainly, many Māori and Pasifika people are likely to fall into this category and there are plenty of people whose personal preference is for doing important business in person. Except where necessary for health reasons (like during a pandemic!), OCT is not for those people and, while OCT remains the modality of a minority of couple therapists, these people should have continued access to good quality IPCT.

While there may be people who were never suited to OCT, there will also be those clients who start out quite happily but then find they are struggling with the challenges of therapy. The novel nature of OCT gives them something to blame other than themselves for therapy “not working”. The therapist has the option of exploring this possibility with the client or referring them on for IPCT with the suggestion that, if they choose the latter, they make sure they get permission to do a fulsome handover to the next therapist, so the client is not able to avoid whatever issues triggered their sudden dislike of OCT.

## Changing the Power Dynamic

The extent to which there is a power differential between therapist and client is highlighted in most therapists’ training. Clients come to us with very personal and vulnerable issues and look to us to structure and direct a helpful experience. Walking into our therapy room, some have reported they feel at the mercy of how the therapist chooses to respond. Clients are very much in our territory and can be caught up in, or reactive to, “obedient patient” type roles with the associated status and power difference between therapist and client. We are finding that OCT reduces this sense of vulnerability to the therapist, to some extent. We observe our clients seem to have greater ownership of the process with OCT. The therapeutic space is co-created and exists between us (rather than the client being in a therapist’s professional office space). From their point of view, we enter their world—we are present in their home, or office, or car—and therapy takes place more on their terms. We are consultants whom they invite into their lives to offer assistance.

Practically, this change in the power gradient leads to less reflexive compliance and more honesty and directness. We have both noted that OCT allows most clients more freedom to move; they can “leave the meeting” online by clicking a button or even get up and physically leave the screen, without having to leave the session. Couple therapy can lead to high levels of emotionality and reactivity in clients. With OCT, a client can, if they need to, exit and re-join the meeting with a lot less drama than staging a walkout in your office (from which most people find it hard to return). Indeed, we have started suggesting that clients do this to take time to settle themselves down.

For the therapist, this reduction in control over the shape of therapy can raise difficulties with some clients. In some instances, it can make it less easy to exert authority when it is necessary, for example when being actively resisted by defensive, disengaged clients. Compensating for this effect can be quite demanding, even for experienced couple therapists. Given that couple therapy sometimes involves engaging with very volatile people, being able to maintain control over the process is an essential skill for any couple therapist. This is already challenging in IPCT and is often the cause of the greatest anxiety among novice couple therapists.

## The Ability to Separate Clients

It is in working with volatile clients that OCT offers one particular advantage over IPCT: it allows the therapist to decrease the clients' reactivity to each other by working with them while they are on separate devices in different rooms. One of us does this routinely from the outset of therapy by having each partner in the couple in separate rooms on separate devices, while the other starts with the couple sitting side by side in front of one device and then suggests that each partner goes out into separate rooms on separate devices when needed. We find that there are pros and cons to both approaches.

When people are sitting side by side on the same device they can touch each other and offer each other physical comfort and non-verbal support. When the couple is together like this, the therapist has more information about how they relate to each other non-verbally—how they manage their personal space when close, how much they turn to look at the other, when and how they touch, etc. On the other hand, sitting side by side, it can be harder for them to track their partner's non-verbal communication, although some people will also have an image of themselves on screen and they will register their partner's facial expressions on that. Perhaps more importantly, it is quite difficult, compared with IPCT, for the couple to make eye contact. They have to turn their head a full 90 degrees and, consequently, lose sight of the therapist. This is something that can be utilised therapeutically, but it does represent a change from IPCT. Should a client become focused on and reactive to their partner, they are in very close proximity and this can lead to rapid escalation. Our limbic system is much more likely to regard someone as a threat if they are in our personal space (Kennedy et al., 2009). It can also work the other way, in that with both clients facing the therapist on screen, and their partner being largely out of sight, the client can focus more intently on what the therapist is saying and doing and get less caught up in their partner's responses. Of course, close proximity can also act to intensify moments of tenderness and connection between couples as they are physically more alone. The therapist, to some extent, can recede in those moments as being only present as an image on a screen.

Most clients who present for couple therapy are trapped in cycles of morbid co-regulation through ineffective attempts to self-soothe by either blaming and controlling (high conflict) or disengagement (conflict avoidant). Having the option to physically separate couples can be an enormous boon to doing relationship therapy with highly volatile or otherwise enmeshed couples. The ability to attenuate the amount of personal distance or eye contact is a plus for some people, contributing to their relaxation with the process. Gender-wise, we have observed this seems especially true with males who appear to be prone to feeling under attack. Interacting through a screen seems to effectively diminish the psychological and emotional impact of their partner upon them. As a result, people in this kind of relationship become less reactive and more available to therapy. They seem more willing to be open and direct, more willing to take emotional risks, and more willing to self-confront.

The question can be asked whether insights and behavioural change that are possible with this degree of physical separation will be maintained when the couple are again face-to-face. However, it is a standard part of our therapy to teach couples a "time out"

technique, which includes physical separation, to allow people to calm down and buy time to act in a more considered fashion. Though this tool is not without its problems and needs to be implemented with care (Wistow et al., 2016), it is our experience that this kind of separation can lead to new behaviours that will generalise. So, if people are dependent on physical separation to maintain their pro-relationship behaviour, this option remains available to them once they are face-to-face.

When working with couples like this, using this kind of physical separation also offers another example of how clients take more ownership of the process. When people who previously have needed to be in separate rooms to remain safe and civil suddenly turn up sitting side by side on the same couch, this can be a significant meta-communication about their view of the improved state of the relationship. In situations where the clients are each joining on separate devices, they have more control—through the choice of "gallery view" options—over how they are seeing the other two people on screen in the session. This arrangement can make it easier for one person to stay in simultaneous visual contact with both their partner and the therapist others as the two images are visually closer than IPCT.

## More of Some Types of Information, Less of Others

A further corollary of the therapy session taking place in the client's world is that the therapist gets a great deal of collateral information about the client. Information sources that you do not have in your therapy room include seeing the interior of their homes or workplaces, meeting their pets, being shown the view out the window, observing how they dress when they are relaxed, being introduced to their children, seeing their favourite mug, and so on. It is true that clients can curate and edit what is shown to the therapist but, in our experience, they seem remarkably candid about how they live, and we have both noted that this gives us a richer and broader intuitive "feel" for our clients. You get an expanded sense of who someone is if they choose to meet with you in their dressing gown from their bed! This flow of contextual information is, of course, two-way. One of our suggestions below is that therapists are mindful about how the environment they share on camera is going to be interpreted by the client. It can create novel ways for building rapport, for example by showing animal-loving clients our pets.

A reduction in the amount of visual information the therapist receives is inevitable with OCT. Therapists will not be able to see the whole of the other person's body (unless they are sitting so far away as to render their facial expressions indecipherable). This means that therapists will not be able to see clients' anxiously tapping feet or jiggling knees. If the clients are using separate devices, it is also frequently harder to determine if one client is watching the other, which is the kind of thing that one tracks effortlessly in IPCT.

Therapist needs to be sitting close enough to the camera for clients to easily "read" their face. In doing so, therapists inevitably cut off the view of their lower bodies. While this permits the joy of wearing of track pants and slippers to work, the restricted view means that, if therapists are prone to using their hands to assist in communication, they must

remember to make gestures where clients can see them (which is usually higher than is “natural”). As mentioned above, if the two clients are using separate devices, this change to the amount of visual input they are receiving applies to them also.

How well therapists can see their clients’ faces is determined by a range of technical factors. If everything is set up correctly (e.g., high-quality video camera, good lighting, and client close enough to the camera) it is possible to be able to see clients’ expressions more clearly in OCT than in IPCT—rather like a close-up in a movie. However, if clients are a long way from the camera and poorly lit (or, worse, backlit), it can be very difficult to “read” their expressions. It can take a few sessions to train clients to set up properly for OCT and some clients are reluctant to put in the effort to do so, which may be explored therapeutically in much the same way you might talk with someone about the meanings behind frequent lateness to therapy.

As mentioned above, some therapists find this diminution of visual information a significant loss. They feel disconnected, struggle to “read” their client, and generally regard doing OCT as working with “one hand tied behind their back”. Ways therapists communicate care and concern (genuine positive regard) have a strong non-verbal component (posture, tone, etc.), and it can be hard to have confidence that these are being communicated clearly to clients. We know that, for some colleagues, the fact that the therapist is, literally, not there for the client presents as an insurmountable obstacle to the therapeutic relationship. This is not our experience; we feel very able to “be there” for our clients in a way that is more-than-sufficient for the therapeutic process. In discussion with colleagues, we note we have found various ways to compensate for the reduced visual information being offered to the client. For example, putting a hand to our heart to signify compassion or feeling for them, and using clear, deliberate facial expressions of concern, warmth, etc.

## Changing the Way Therapy is Done – Harder and Easier

The implication is that shifting to OCT requires some adaption to the way we do therapy. We found that the hardest shift was probably to remember to use the name of the person we are addressing at the beginning of a sentence. In OCT, clients can find it hard to determine which of the two clients present the therapist is looking at just from the visual cues. One’s posture does not change and eye movements are very subtle. It does seem to disconcert clients when they do not know whom the therapist is addressing, and many seem to feel foolish that they do not know. For this reason, it is worth making a big effort not to place clients in that position.

Another significant change is the “artificiality” of eye contact. It is possible to give clients the sensation of making eye contact with them, but it requires the therapist to look at the camera, rather than at the image of their client on screen. In our experience, this is highly effective but it requires a non-intuitive skill set that draws on screen acting skills rather than psychotherapeutic ones. Both of us have a background in theatre and so are comfortable with the notion of doing something “unnatural” to convey a sincere effect. We

can understand that this kind of artifice may feel quite incongruous and, indeed, disingenuous to some therapists but we have now integrated this naturally into the flow of how we work.

In the past, both of us have had a strong tendency to use a whiteboard as a visual aid. We have yet to find a way to use a whiteboard effectively in OCT. Instead, our favourite diagrams have had to be translated into animated slides, which we can then screen share with clients or scan and email to clients before a session. This is an effective solution for diagrams that you use repeatedly, but requires preparation and does not replace the spontaneous use of the whiteboard for exploring a novel idea or drawing a client's genogram. We have yet to find a way to compensate for this loss.

For those in private practice who are used to having clients pay at the end of a session, OCT means having to be on top of invoicing. Understandably, we do find more people forget to pay us with OCT and, although they are always fine when we remind them, this represents a significant increase of administrative time in our week compared to running an EFTPOS machine. One solution is offered by colleagues who have swapped to a "pay online before the session" model, with the invoice sent out with the invitation to the meeting.

For us, the extra effort involved in adapting the way we work in these ways is well compensated for by a reduction in the emotional demands of a session. Most therapists agree that couple therapy is, on average, more demanding of the emotional resilience of the therapist. Many therapists refuse to do it or only do a small amount of it for just this reason. As practitioners who specialise in relationship work and whose clinical load is primarily couple work, we are among those therapists who value having a greater sense of emotional distance from our clients. In discussion with like-minded couple therapist colleagues, we have noted feeling a healthy sense of detachment, of being less caught up in all the emotional nuances and, at times, considerable activation in the room. This may be why we do not have the same experience of "Zoom fatigue" that many individual therapists report. In return for the extra effort required to make online therapy work effectively, we get a diminishment in the amount of effort required to maintain a therapeutic emotional distance. Therapists like this, who are perhaps highly sensitive, report no diminishment in their ability to "read" their clients (e.g., infer mood states from non-verbal cues) and instead talk about relief at the attenuation of the non-verbal information, of the volume of emotionality. This is not a universal experience, and some colleagues report feeling disconnected from their clients and it being more effortful to read non-verbal cues and communicate effectively. These therapists talk about leaning in close to the screens, speaking loudly and experiencing, in general, a lot of strain from the greater effort to "read" their clients. Speculatively, this may be an important criterion by which therapists decide whether they like or dislike or are suited or unsuited to OCT.

Whilst Berne (1966) talks about diagnosing with all senses and some may see this as an advantage of IPCT, one thing that we do not miss about doing IPCT is the smell! Colleagues who only do individual therapy often look at us in confusion when we talk about this. It would appear that in couple therapy sessions, people are often anxiously

stressed to a much greater degree than in individual therapy. We certainly know that relationship conflict produces stress hormones (Malarkey et al., 1994). This frequently results in a very distinctive and unpleasant odour in your therapy room, of which you are unaware until you exit and then re-enter the room shortly after a session. Or until your colleague walks into your room, sniffs and says, “Tough session, eh?” We have often speculated regarding the adverse impact on our nervous and endocrine systems of being immersed for hours at a time in these stress pheromones. Being online means being free of this olfactory and hormonal assault and our wellbeing has benefitted greatly from having it gone from our working lives. Of course, working online also protects you from germs. The whole purpose of moving to telehealth during lockdown was to prevent the transmission of disease. This is effective for COVID-19 but also for the common cold and influenza that, historically, clients have brought into our therapy rooms.

Overall, we believe it is easier for therapists to attend to their self-care during OCT. This is increasingly being viewed as essential to prevent burn-out and to ensure our wellbeing in the highly demanding field of therapy in general and couple therapy in particular. We both have tools and practices that we find nourishing and helpful in maintaining our equilibrium. When we do not have clients in the same room as us it is possible to employ many more of them during sessions; burning a scented candle or having a wheat pack on one’s lap might not be appropriate with IPCT, but is easy in OCT. Likewise, the pleasures of working in comfortable, rather than professional, clothing were experienced by many during lockdown and are not to be underestimated. Added to this is that, for many people, OCT opens up working from home with all the ease and comfort that attends. The joys of being able to get the washing in between sessions when un-forecast showers are on the horizon, or being able to tinker on a project in the shed at lunchtime are all opened up when one commits to OCT.

## Suggestions for Therapists Based on Our Learnings

1. Make sure that your internet connection is as good as you can make it. We have fibre to the house and use ethernet cables to connect to the modem. Cable is old-fashioned, ugly, and restrictive but with much bigger bandwidth and greater stability and reliability than any Wi-Fi system can offer. That said, most people do use Wi-Fi and find it perfectly acceptable. We even have a colleague who lives rurally and who “hot-spots” her laptop from her mobile phone and has never had a problem as she lives in line-of-sight from a cell tower. So, it is a matter of finding a system that works for you, that you can trust.

2. Make sure that you are using a high-quality camera and microphone. Most modern laptops are well equipped in this department but, if you are using older equipment, it pays to check. You can get someone with a high-quality computer to do a call with you and ask for their honest feedback about the clarity of your sound and image. The other factor that has a huge impact on how you come across visually is lighting. Try to make sure that you are lit more from above rather than below (being lit from below makes you look sinister) and that you are getting light from two sides (to avoid deep shadows on your face). Where you are using artificial light, make sure that it is warm in tone. A strong lamp “bounced” off a wall gives a diffuse light, which is kinder to your appearance. Another factor is to consider the position of the camera relative to your eyeline. Ideally, you want the camera at roughly the same height as your eyes, though this is hard to achieve if you are using a laptop. This is to try and avoid looking down too far—you do not want your clients to feel you are “looking down your nose” at them. Some people use a second screen so that they can look straight ahead at the image of their clients. This also allows you to look at a larger image of your client.
3. There is important communication in the clothes you wear and the room you work in. You can use these to help create the atmosphere and enhance the connection. This is equally true in IPCT, but some of the considerations are different. What your clients can see over your shoulder is important in terms of how friendly, how professional, and how organised you appear. Likewise, you can use your clothing to highlight your presence. A crucial first step is to make sure the clothing your clients can see contrasts with whatever is behind you. Beyond that, you can use warm colours to bring life into the call and to signal your personal warmth and vibrancy. While many people favour the “flattering” nature of black clothing, its ability to obscure your outline means it is not the best choice for communicating your body language on screen.
4. Become intimately familiar with the videoconferencing platform you use. We took the opportunity of video calls with friends and colleagues during lockdown to explore various features and to get feedback on the technical aspects of the calls. We asked them to comment on the clarity of our sound and image, the quality of our lighting, background, audio levels, etc. We also practised things like talking to two people on different devices, screen sharing diagrams, etc., before we tried these with clients. Many therapists do not realise they can turn off “self-view” so they do not have to take up screen space with an image of themselves.
5. We developed a list of “Zoom tips” that we send to clients before the first session to help them make the best use of the technology and guide them so they are not stressed by the technical aspects of OCT. This is included as Appendix 1, but please note that a) some of this is specific to the Zoom platform, and b) we think everyone should write their version in their own style and reflecting their own experience.
6. Part of this information should be clear instructions about what to do if the call is interrupted. For example, we ask clients to email us in the first instance if they are having technical difficulties and that, if they are not able to make contact with us that way, we will try and call them on their mobile phone.

7. Confidentiality is crucial to clients' safety. Do your due diligence about which platform(s) meet the requirements of your licencing agency, professional bodies, etc. However, be aware that the biggest threat to security is the interception of links. For this reason, after the first session, we only send out the invitation to the meeting 10-15 minutes before the session is due to begin. We have had positive feedback from clients in the IT industry for this unusual approach.
8. We tend to start the first video-call with new clients a little early to make sure there is time to sort out any technical issues before the session itself begins.
9. If clients are joining from different locations, you need to decide if you are going to wait until they are both in the "waiting room" of the call before beginning the session. This was our practice with IPCT, with a rationale that we did not want one client walking in to find their partner having a cosy chat with the therapist. Thus far, we have not carried that practice over to OCT because of client anxiety about whether they are joining the call properly.
10. Ensure clients' physical comfort at the start of the session—attending to the technology may distract them from this. As a result, they may start the session in an awkward or unsupported posture and get uncomfortable and restive in the middle of the session.
11. Have a way to settle and centre clients if they have rushed into the session from something else. We use a brief 3–5 minute exercise that gets them breathing slowly and then focusing, first, on what their particular intention is for this session and, then, on what qualities, attitudes, or behaviours they are going to need to use to support that intention.
12. As mentioned above, it is important to use the client's name at the start of any sentence where it is not obvious whom you are addressing.
13. Let people locate you in space. Not knowing where you are can create a psychological barrier. Give clients information about where you are. If you are in different areas, acknowledge the differences (e.g., the weather here compared with there). Casual chatting, as you might do with IPCT when leading clients into your room, is still important. We need to take time to establish the connection, otherwise clients may not feel connected enough at the start of the session.
14. Check your indemnity insurance before you agree to see clients from overseas. At this stage, we restrict ourselves to Aotearoa for this reason, despite having been approached by people in Australia.

## Conclusions

For us, like many therapists, COVID-19 necessitated a reappraisal of the relative merits of online versus in-person therapy. While some of our initial concerns remain, our overall experience has been that the benefits, both to many of our clients and ourselves, more than compensate for the detrimental aspects. It is a way of doing therapy that is not for everyone. It requires adaptation on the part of both therapist and clients but, for those willing and able to adapt, OCT provides new opportunities for quality therapy. In the

interests of full disclosure, we should confess that we believe in this so strongly that we never returned to IPCT; our practice has remained solely online and continues to thrive with many satisfied clients now drawn from all over Aotearoa.

## Authors

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## Appendix 1: Tips for Using Zoom

- Here is the link for downloading Zoom if you don’t already have it installed: https://zoom.us/download. For your computer, you want the “Zoom Client for Meetings” button, for your tablet or phone there is a link further down the page to the App Store (for Macs) and Google Play (for Android).
- As far as possible, plan to have your session in a location where you are physically plugged into the internet or have a strong and reliable Wi-Fi connection.
- Using a laptop, computer or iPad is usually better than using a phone, for many reasons.
- Shut down any applications that use audio and video, such as facebook, YouTube, Skype, and Spotify.
- Please switch off all email notifications both visual and audio (these are very distracting for you during a therapy session). Likewise, turn off all other phones.
- If you have problems connecting, or the connection is lost during the session, contact me by email (I do not have my phone in my office during sessions).
- Shut doors and ensure no one is going to walk into your room and interrupt you.
- It is best to close the picture of yourselves on screen and only have my image on the screen. You can do this by opening the drop-down menu from the three dots in the top right-hand side of the screen and clicking on “hide self view”.
- It is best not to rush into your meeting straight from business or have to rush straight out of the meeting into some other business. A small transition phase of, say, 15 minutes before and after is recommended.
- Make sure your face is well lit. If you have a window behind you, please draw the curtains to prevent excessive backlighting so I can see your face clearly.
- Sit somewhere comfortable. It is best not to hold your laptop, phone, or iPad (this gets very tiring), but to have it on a table, preferably, or propped up so that it will not slide or shift during the session if you move.
- It is also important to regularly install any Zoom updates. Click on Zoom.us at the top left on your main menu bar (or you can click on your initials at the top right) and read down until you get to “check for updates” and click on that.

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