APPENDIX H

PORTFOLIO #3: Don: WHEN TELEPSYCHOLOGY FACILITATES IMPROVEMENT

H .1. Relevant History

Don (a pseudonym) presented as a quietly spoken, alternatively dressed, 40-year-old man. He described himself as the main domestic worker at home, in addition to occasionally recording music bands in his home recording studio. His presenting problem was described by the CMHT as depression associated with social anxiety, and panic attacks. His main source of anxious distress was interactions with women. Panic attacks and anticipatory anxiety about having to engage with women outside the home had increased such that his lifestyle was being impacted through a self-imposed reduction in social contacts, decreased work opportunities, and depressed mood.

Don's early attachment experiences were dysfunctional and negative. At various times he was forced to live with his grandparents or school friends for years at a time, because his own family of origin were either violent or rejecting toward him. He claims to have been rarely cuddled or touched by any family member, including his mother. He reported that he was also publicly humiliated in front of his relatives for various developmentally typical sexual explorations.

Women were dominant characters in his formative years but they tended to be cruel and dismissive, or idealised and "perfect". He reports that

he had no model for a loving heterosexual relationship with any members of his family.

Don's 28-year long marriage was unusual. Don and his wife Jan, first met in high school but they did not become a couple until many years later. They shared a house for two years, before becoming intimate. When they did, he described their relationship as incorporating a healthy sex life. On the day of their wedding, Don claims they never consummated their marriage. In the last 27 years they have had intercourse less than 10 times since their wedding day. Jan has refused to have children. His wife has had several female sexual partners in the last 28 years. Don believes that Jan still loves him, and he is unwilling to leave the marriage, as he feels it provides him with other positives.

H.2. Triggering events

His problems with anxiety and panic attacks around women stem from an incident 10 years ago where he attempted to solicit an affair with a women in town (at the suggestion of his wife). After he was rejected, rumours about his "womanising" and being a "safety risk to children" were circulated in town. He claims that he is still the victim of gossip and innuendo from this incident and has been rejected by former friends who shout abuse in the streets at him. He has become increasingly insular in his social contacts and for a long time avoided going into town. Ten years on, he is depressed that his problems seem to worsening, with his panic attacks increasing to the extent that they recently caused significant problems in his recording work. He feels

hopeless and helpless, and wishes this constant state of anxiety and low mood to be over.

Don's early attachment experiences suggest significant dysfunction. He has failed to develop a physical model or cognitive schema for intimacy and has an almost immature, pubescent understanding of the development of sexual relationships. His early life experiences included beatings, maternal rejection, and adolescent sexual relationships were traumatic. He appears to be attracted to women who continue to humiliate him sexually, by misinterpreting their friendship with him as an escalating level of intimacy that he assumes will end in sexual intercourse. He is desperate for affection and physical closeness, having had almost none since birth, but is unwilling to abandon his 30-year marriage of comradeship and what he perceives to be shared interests, to seek it out. He is surprised by the lack of sexual overtures made to him by seemingly available women, and attributes it to his unappealing appearance.

H.3. Intervention

Don's long history of experiencing his sexuality being paired with shame and humiliation, coupled with an interpersonal naiveté and desperation for physical intimacy have resulted in the development of panic attacks. These panic attacks are associated with increased sexual arousal (magnified by anticipatory anxiety and fantasy) and distorted cognitions associated with mind reading, catastrophisation and personalisation, particularly in relation to interactions with women. Given the therapist in the telepsychology intervention was female; this potentially posed significant problems for the

development and maintenance of therapeutic alliance, particularly from issues related to transference.

The use of telepsychology with a socially phobic man whose fear of women directly contributed to increased panic attacks and depressed mood, could be seen as either a hindrance or help to progress in therapy. It could be argued that the opportunities for the natural exposure elements, and therefore benefits, of face-to face therapy such as in-session experiments, naturally occurring behavioural reactions and observations, and direct exposure to the feared stimuli, (i.e. a “challenging” woman) were removed by the telepsychology technology. According to the client however, the limited exposure to feared stimuli that telepsychology afforded in the early sessions encouraged and supported the client’s continued engagement and also offered a point of contrast for in-vivo behavioural experiments conducted in later sessions. The visual cues of the telepsychology were enough for the client to feel engaged with the therapist, but the limiting of other sensory input such as smell and touch allowed the client to remain focused on the cognitive and emotional exercises without being overwhelmed by the proximity of an ostensibly caring woman, who by the nature of the professional relationship, would ultimately be seen as rejecting, and untrustworthy, because of transference reactions. Don reported in his satisfaction surveys that given the choice, he would have always chosen telepsychology over face-to-face therapy, especially with a woman therapist, and that he would not have attended past the first session had he been in face-to-face therapy as the sensory experience of such proximity to a woman would have been overwhelming, and he anticipated he would have had a panic attack. His

comments included “telepsychology is better - separation - no perfumes, no physical contact (even accidental)”, and “no legs...no person contact”, and when comparing telephone to telepsychology contact “I like to see the reaction to what I am saying”.

Don participated in a total of 8 different assessment collection points through his 5 months of intervention. Don appears to have been given assessment packages at Session 1, Session 2, Session 5, Session 8, Session 9 and Sessions 12-14 as well as at follow-up. His tests were not administered as per the administration schedule and it is unclear why he was given some test packages, but not others.

At baseline, Don’s BSI scores indicated a high level of psychopathology to begin with, with caseness indicated for any subscale value ≥63. Don’s highest subscale scores on the first testing session were highest on Interpersonal sensitivity (I-S; 78); Paranoid Ideation (Par; 76); Phobic Anxiety (Phob; 73) and Psychotocism (Psy; 70). These inflated subscales accurately reflected the subjective description of symptoms provided by the client, and the clinical hypotheses generated by the therapist as to the maintenance of the client’s problems. The next highest scores on the BSI which still indicated caseness were from obsessive-compulsive (69) and anxiety (64) subscales

Previous research has proposed that the face validity of some of the subscale items suggest they measure constructs other than their label would suggest (Slaughter, Johnstone, Petroski & Flax, 1999). This is most suggestive in the items of the obsessive-compulsive and psychoticism subscales of the BSI, and can be seen to impact in the larger clinical picture

of this particular client. The items in the obsessive-compulsive subscale include: “trouble remembering things; feeling blocked in getting things done; difficulty making decisions; your mind going blank; trouble concentrating; and having to check and double check what you do’. All of these items may be more representative of the cognitive slowing that is a hallmark feature of depression, or the cognitive distractibility of anxiety. Don’s ruminative thinking and mixed depression and anxiety may have contributed to a positive endorsement on these test items. While not accompanied by ritualistic behaviours, he did have a “routine” pattern to his activities of daily living which could also be seen to parallel an obsessive-compulsive quality. Furthermore, items from the Psychoticism scale (which includes the items “feeling lonely even when you are with people; never feeling close to another person; and the idea that something is wrong with your mind”) may also have been more reflective of Don’s interpersonal sensitivity and anxiety, rather than genuine psychotic features.

Don’s initial ratings on the State-Trait Anxiety Inventory indicated state anxiety scores of 87% and trait anxiety scores of 100%. His baseline BDI-II score was 23 (moderate).

H.4. Relevant Session Events – Session 1 and 2

In addition to taking a history and the details of the problem, the first session was plagued by a fuzzy televised image and delayed sound which Don found distracting. He struggled to locate the correct buttons to zoom and change the camera angle, and preferred to not use the remote (one can speculate that this was behind his low rating on ease of use). His first session

satisfaction ratings were quite low compared to other participants in the telepsychology intervention, but improved by Session 2 (see Figure 10.1 below).

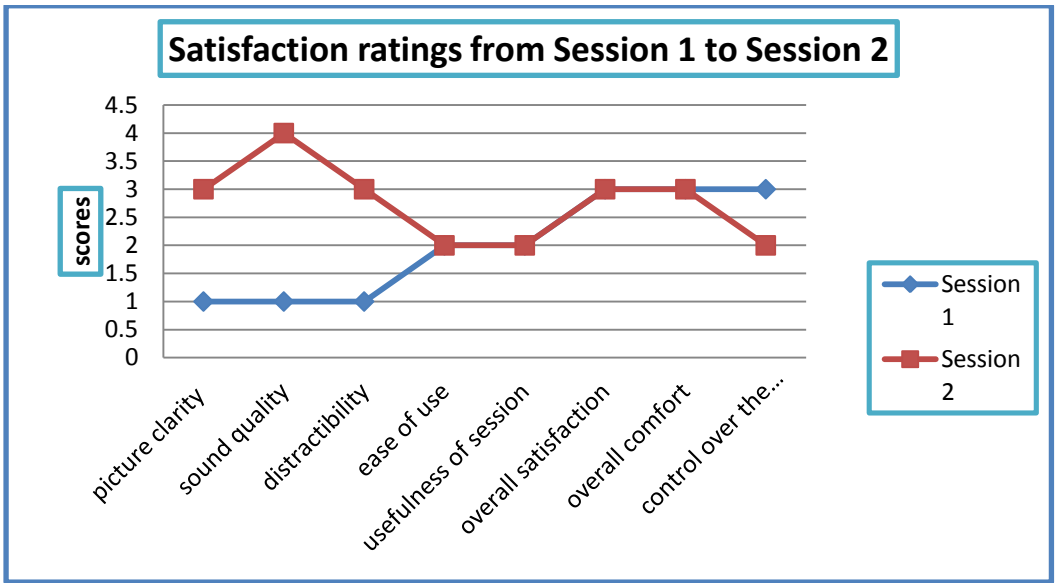

Figure H.1. Don's Satisfaction ratings at Session 1 and Session 2.

In the early sessions, Don made several unexpected comments. It was not clear whether he was being deliberately inappropriate or socially unskilled. For example, after a tearful second session exploring his feelings about females, when I asked him if there was anything that would enhance his comfort during the sessions he stated "as long as you don't try to crack on to me I'll be ok". I advised him that this would be both unprofessional and unethical, and would not be an issue for me, but explored with him his expectations for what therapy entailed and the limits of the therapeutic relationship. He commented again that he was "glad [I wasn't] here when [he] started to cry 'cos if [you had] given me a tissue that would have been the end of it". He explained that he would have been overwhelmed by the small token of kindness, perceived it as affection, probably had a panic attack and

subsequently been unable to continue in therapy. I noted at the time that my typical response would have been to offer a tissue. Had I done so, I may have unknowingly jeopardised ongoing work with this client. In this case, telepsychology gave me a more “neutral” quality that allowed the work to progress, even if it limited my normal repertoire of alliance enhancing techniques.

In the initial sessions, Don was occasionally tearful, however his restricted affective range made this hard to distinguish due to the lack of acuity in the picture, his pronounced facial hair, and his minimally demonstrative behaviours. I recorded in the field notes that I needed to question and reflect frequently with him to clarify the emotional behaviours he was displaying, and the thoughts underlying them. Often the questioning included inquiries that were phrased as “I can’t really tell if that is upsetting you or if you are not bothered by what you just said. Can you tell me what you feel about that? What you think about that reaction?” These particularly intensive questioning sessions took place at the beginning of therapy, in the initial history taking and problem formulation phases of the intervention. It could be speculated that this kind of interviewing style might impact negatively on the development of therapeutic alliance. Based on Don’s subscale results on the Agnew Scales of therapeutic alliance, it would appear to have not made a significant negative impact on Don’s total scores.

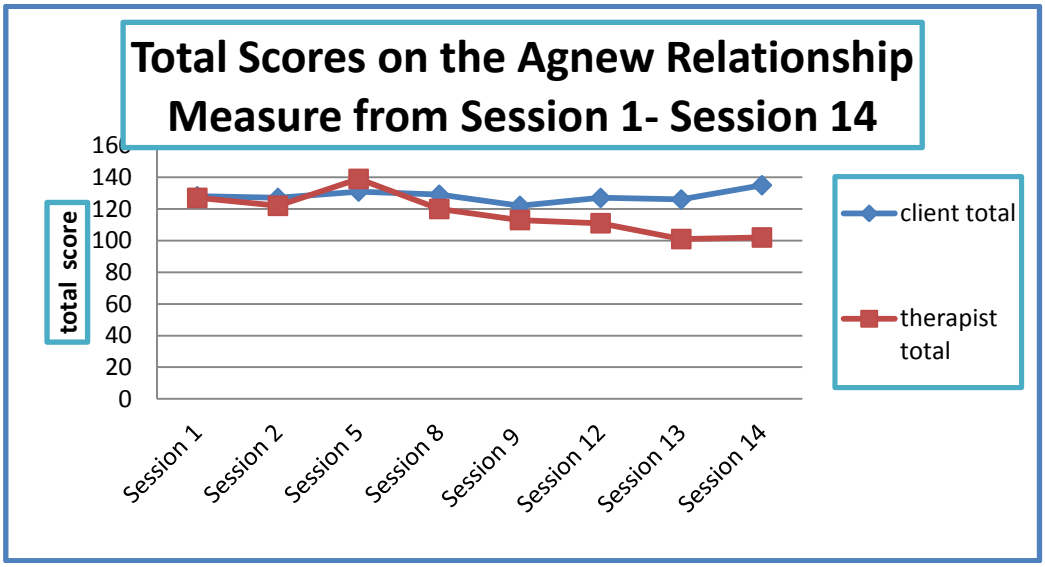

Figure H.2. ***Don's total scores of therapeutic alliance as measured by the Agnew Realtionship Measure (ARM) from Session 1 to Session 14.***

Early mean ratings of partnership and openness were higher for the therapist than for the client (See Figure H.3). I noted that his personal history was quite extraordinary and Don impressed as honest and open, despite the embarrassing nature of his disclosures.

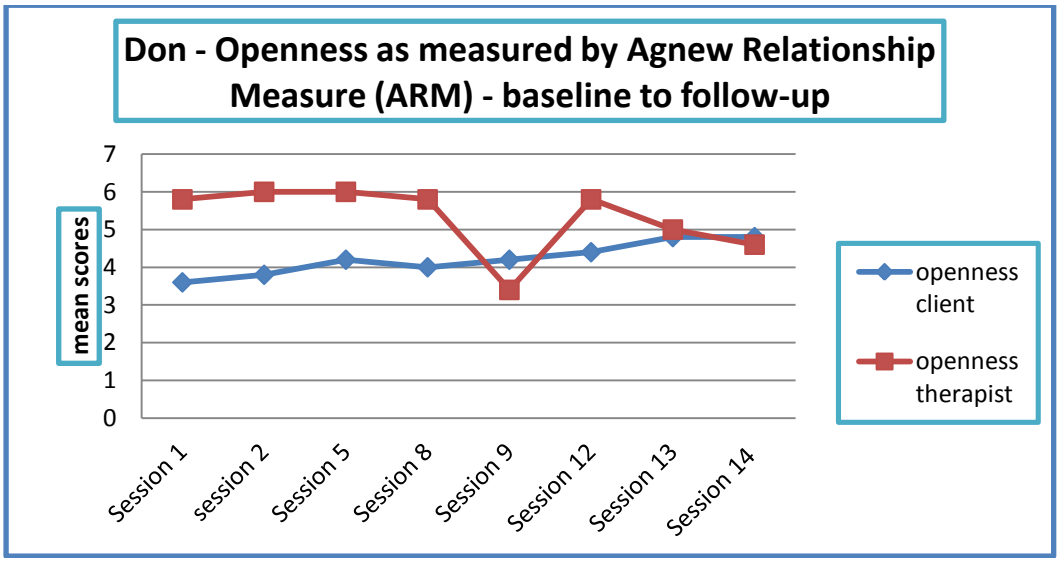

Figure H.3. ***Don's ratings of openness as measured by the Agnew Relationship Measure (ARM) from sessions 1-14.***

Ratings of bond, confidence and client initiative were lower for the therapist than for the client. Don expressed ambivalence about attending telepsychology, he had low expectations for symptom relief and he was difficult to engage with. He rarely offered spontaneous details, but when asked a direct question, he was brutally honest. However, as sessions continued, the trend of higher therapist ratings compared to client ratings was generally reversed (see Figure H.4).

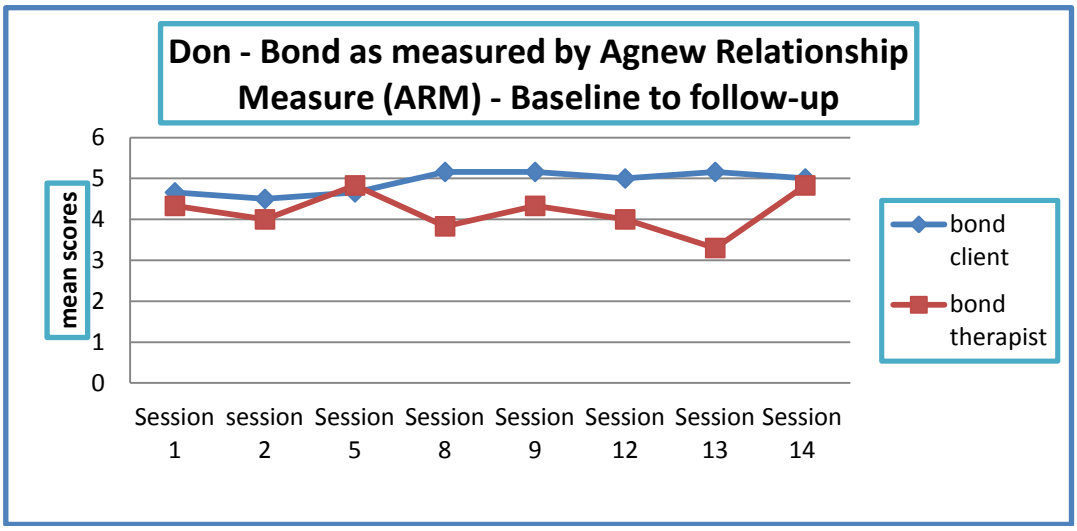

Figure H.4 ***Don's ratings of bond as measured by the Agnew Relationship Measure (ARM) from sessions 1-14.***

The general rating differential is reflected in the session notes and several early supervision comments, which describe my perceived difficulty with engaging with the client. My early reflections describe me feeling like Don's in-session reactivity was so minimal it was "like getting blood from a stone", and that the emotional engagement with the therapy tasks felt "one-sided". Interestingly, I also perceived the client as "open" in the sense that he was divulging significant traumatic and emotionally embarrassing life moments (see Figures above), and session notes include repeated thanks to

him for his candour. However, I noted at the time that the client seemed emotionally disengaged from the narratives, the in-session outcomes and insights, despite my enthusiasm and positive regard for him. This sense of expending significant effort to engage with Don reduced my own feelings of confidence at the time. My own ratings of confidence can be observed to be reducing, despite Don rating his confidence in my abilities as a therapist to be increasing (See Figure H.5).

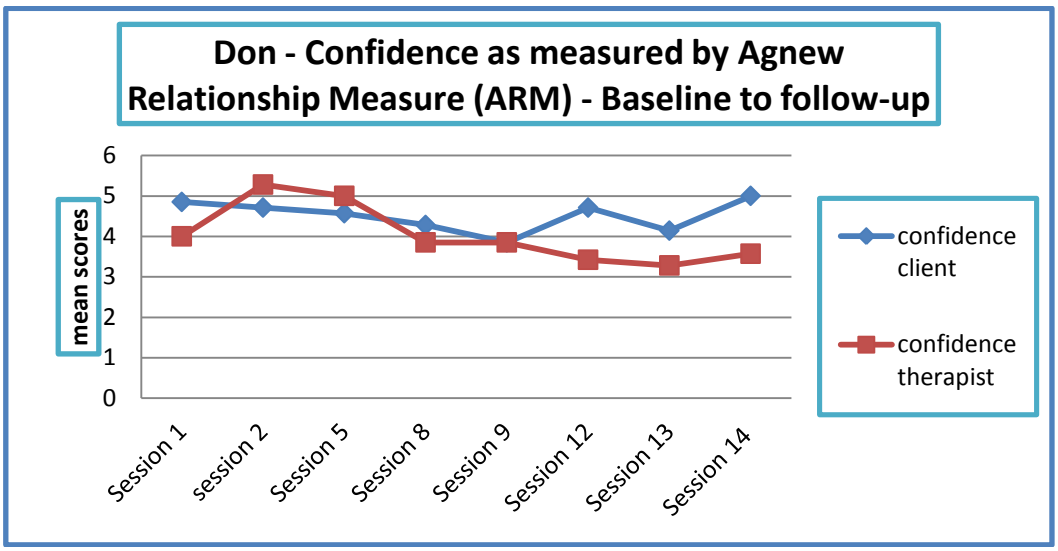

Figure H.5. ***Don's ratings of confidence as measured by the Agnew Relationship Measure (ARM) from sessions 1-14.***

My session records note that feedback in the form of nods, or smiles from the client to the therapist were not readily forthcoming. I speculated at the time that this may again have been a consequence of the limited acuity of video, coupled with the Don's "minimalist" body language, or a genuine lack of alliance relationship between the Don and myself. Despite my perceived high effort for clinical engagement, and the lack of warm responses from Don, the impact on therapeutic alliance, at least in the form of compliance, appeared minimal, and the client attended all 14 scheduled sessions over the 5 months.

When I began monitoring the close but dynamic relationship between the Don's and my ratings of partnership (see Figure 10.6 below), I began to feel more confident that what was occurring in sessions matched both of our expectations, despite occasionally feeling unsure of what was actually being achieved in terms of clinically significant changes.

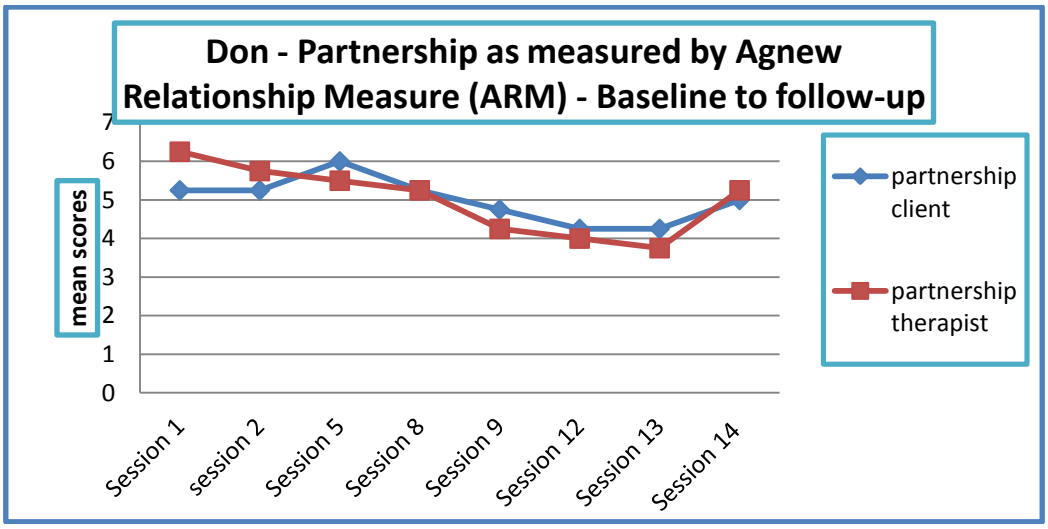

Figure H.6. ***Don's ratings of partnership as measured by the Agnew Relationship Measure (ARM) from sessions 1-14.***

In all the case studies documented in this thesis, the client's self-ratings of initiative in therapy have all been higher than the ratings of client initiative that have been made by the therapist. In Don's case, although I rated his initiative lower than he rated it, an equivalent synchronised pattern of change in initiative emerged over multiple assessment points (see Figure H.7). Again, this suggests that while the I may have interpreted Don's minimal responsiveness in sessions as limited engagement or alliance, the client and therapist both shared an awareness of changes to the level of effort in which the client engaged both with-in session and between sessions.

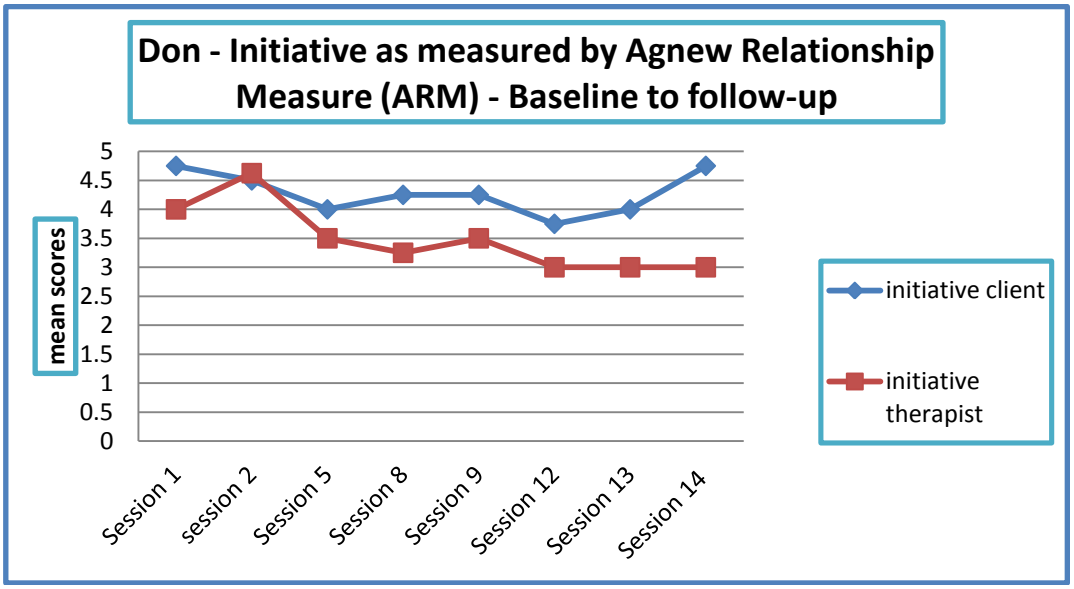

Figure H.7. **Don's ratings of initiative as measured by the Agnew Relationship Measure (ARM) from sessions 1-14.**

H. 5. Relevant Session Events – Session 3 to Session 5

Despite Don's referral to telepsychology being to assist with depression, it was clear that his depression was a secondary consequence of his paralysing social anxiety and cripplingly low self-esteem. In Session's 3 to 5, Don continued to disclose more of his childhood history which suggested he had been variously neglected, ignored, bullied or beaten by adults in his life. He was now afraid of women and had an almost adolescent understanding of his and other's sexuality.

Because of the difficulty Don had with connecting his emotions to his thought and behaviour, Sessions 3 and 4 concentrated on explaining and practicing the ABC model as described in the therapy manual. Deviations from the manual took the form of tailoring anxiety based examples, rather than using the "low-mood" examples, supplied in the text.

An excellent behavioural experiment occurred at Session 4, when Don's wife insisted that Don go to the Emergency Department of the local

hospital when he began complaining of chest pains and difficulty breathing. He was given a cardiogram and electroencephalogram, but was cleared and discharged home, with the explanation that, in all likelihood, he had experienced another panic attack. While waiting in the Emergency Department, Don was assigned several young nurses to monitor his blood pressure and temperature. Don's response to being spoken to or touched (i.e. when his blood pressure or temperature were taken) by these nurses, was to commence sweating, breathing heavily, struggling to find words, feeling achy and tingling. His feelings of embarrassment and shame that were associated with these extreme physical reactions, made it appear as if he was symptomatic. Despite the obvious changes, and his suspicions about their cause, he never explained his emotional symptoms to any of his nurses, nor did he tell any of them that he was feeling uncomfortable and anxious because of their presence.

This experience gave us ongoing examples of the relationship between thinking, behaviour and emotion, including catastrophic thinking and rationalisations related to the physiology of panic.

As he was relaying his history with various women, I noted a theme of exaggerated personalisation and responsibility. I assigned Don homework to visually represent his contribution to how responsible he was for his problems (i.e. the "blame pie"). This was completed, as was all homework that was assigned to Don throughout the sessions, and the results faxed back to me by the local clinic. These also formed the example base for challenging unhelpful automatic thoughts.

Because of the picture and sound quality (Don was very softly spoken) it was sometimes difficult to assess how distressed he was feeling during the session. He claimed that he usually became sweaty and shook when anxious. My camera's image of him was taken from the desk (his upper waist) and up. Above the desk he did not appear shaky, but at Session 5, when I asked him directly about whether his legs were shaking as he retold a rejection-based story, he confirmed that they were, and he was feeling quite anxious as he relived the experience in his mind. This was not particularly noticeable even when I zoomed in to see his face more clearly. This event also provided further contradictory evidence to his belief that "people could see" his anxious reactions. Telepsychology was particularly useful in this case because I could also use the screen-in- the-screen facility to show Don to himself. The video image allowed him to see the image of himself in the main screen with a smaller image of me in the bottom of the screen so that he could see his own reactions and test the veracity of his beliefs that his anxiety was "obvious". I used this tool on several occasions to demonstrate his faulty beliefs about how visible his anxiety was.

At Session 5, Don only returned the CORE-OM and satisfaction rating scales. As evident on Table H.1, Don's scores on each of the subscales changed between Session 1 and Session 5.

At Session 1, Don scored higher than the recommended clinical cut-off for males (Core System User Manual) with regard to impairment in his daily functioning and his total scores overall. At Session 5, his scores had increased with regard to his wellness and the number of problems he perceived he had, but these were below the cut-off for caseness. His

Table H.1. ***Total scores from CORE-OM subscales from Session 1 to follow-up. (NB: * = exceeds clinical cut-off)***

Subscale (Clinical cutoff)	Wellbeing (1.37)	Problems (1.44)	Functioning (1.29)	Risk (0.43)	Total (1.19)
Session 1	0.38	1.19	1.4*	0.4	1.47*
Session 5	1.0	1.41	0.4	0	0.76
Session 8	2.0*	2.25*	2.16*	0.4	1.85*
Session 9	0.375	1.92*	1.4	0.375	1.47*
Session 12	1	1.5*	0.9	0.25	1.06
Session 13	1.5*	1.83*	1.2	0.2	1.26*
Session 15	1.5*	1.5*	1.25	0.5*	1.24*
Follow-up	1.5*	1.5*	1.25	0.5*	1.24*

appraisal of his functioning had improved and his score on this domain had decreased.

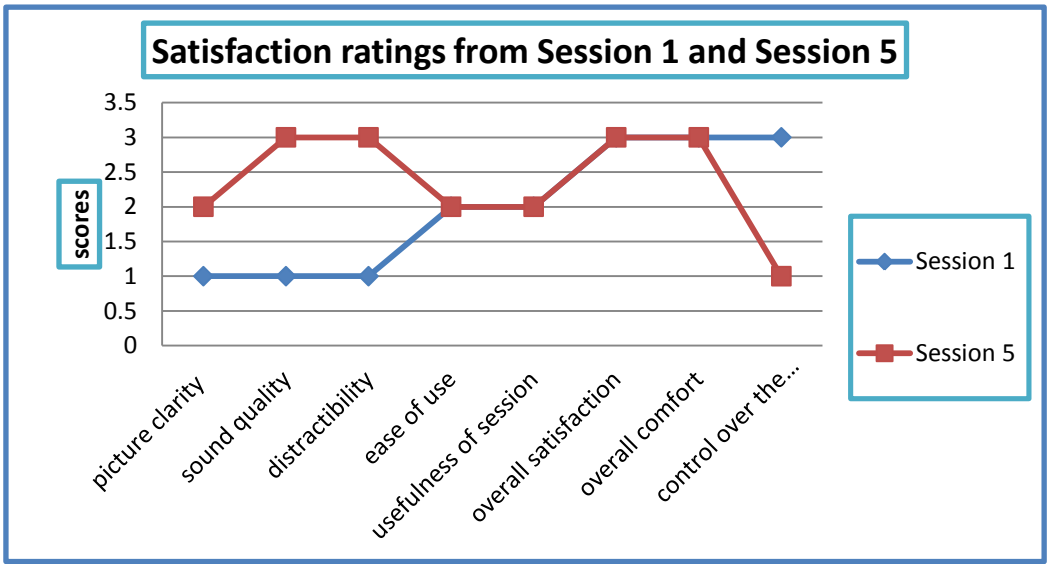

Figure F.8. Don's satisfaction ratings from session 1 and Session 5.

Don's satisfaction with telepsychology had generally improved with regard to the technical quality of the sessions (i.e. picture/sound quality and distractibility due to the technology). His ratings about the ease of use and the overall usefulness of the sessions themselves remained fairly neutral (score = 2/5). His sense of control over the session had also diminished

(score = 1/5). I assume this was because Session 5 had a more directive cognitive therapy focus that was driven by his personal thought monitoring and data collection examples from during the week.

H.6. Relevant Session Events – Session 6 - 9

Session's 6 to 9 focussed on further exploration of cognitive errors, the role of avoidance to increase anxiety, behavioural activation and development of exposure exercises to be practiced outside of sessions. The content that was recommended in the manual was incorporated into the session as discussion points, and the use of thought diary's and weekly goals worksheets were also used. Don faxed the completed sheets to me at the beginning of Session 7, and we then referred to them jointly. At session 8, Don had completed numerous examples and faxed several sheets to me at the near site after the session commenced. At session 9 he had written only a single incident on his thought diary, and we did not fax this worksheet. Instead, Don described the incident and I wrote the note to myself. All of these activities were components of the mood management manual, however they were modified to accommodate the focus on anxious thinking and behaving, including the cognitive management of panic attacks.

The diaries were a useful framework to guide Don's tracking of triggering events to unhelpful thinking styles, and engage in cognitive disputation in addition to behavioural experimentation. Don stated that he found the step-by-step procedure inherent in the ABC-type recordings of the thought diaries to be helpful to organise his thinking, although as yet, he used this as a tool for understanding his behaviour, rather than as a proactive strategy. However, the many examples he provided during Session 8

seemed to distress him, as describing his many distressing moments over the course of the week were a little overwhelming. He did not use the diaries as frequently in Session 9, but had become accustomed to describing his experiences in an ABC-type approach. When reviewing his satisfaction ratings at session 8 (see figure below), Don rated the usefulness of the session at 3 out of 4, and the ease of use of the technology, despite having to read his responses to me (instead of sharing them in person as one would normally do in a face-to-face environment, the highest possible rating (score = 4/4).

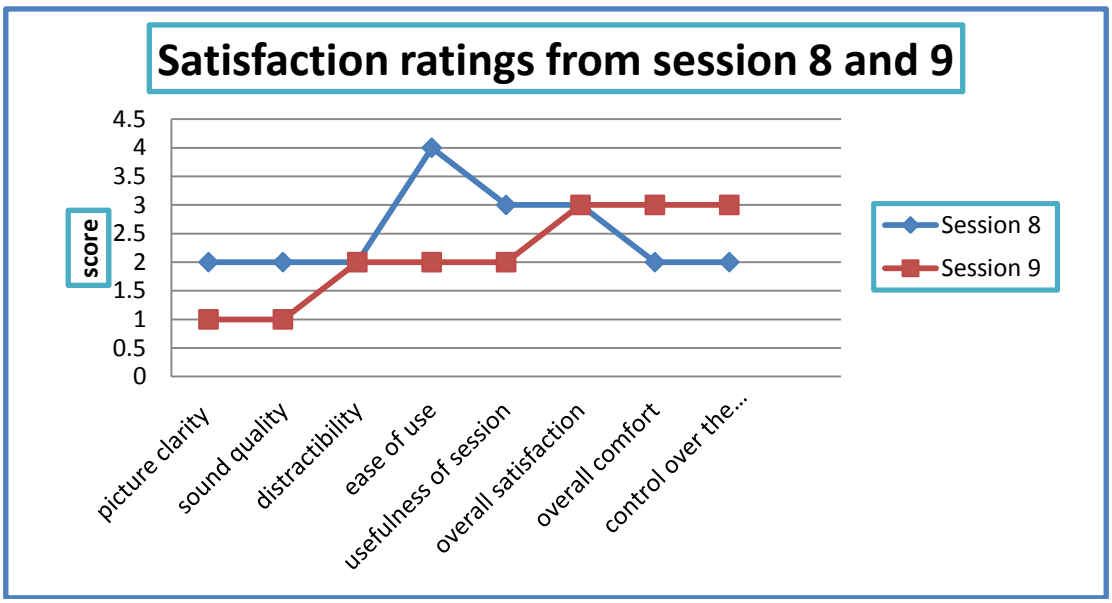

Figure H.9. Don's satisfaction ratings at Session 8 and 9.

Contrastingly, his results on the CORE-OM (see Table H.1) exceeded cut-off scores on all subscales except risk. In addition his, results on the BDI-II and state scores of the STAI peaked at their highest levels. My interpretation of these results was to assume that the deliberate focus and dissecting of distressing events had made him feel more vulnerable, and distressed as a consequence. The negative emotional experience did not

translate to a negative appraisal of the sessions or the telepsychology. The following session, Session 9, produced lower ratings of satisfaction in terms of the specifics of the technology, however overall ratings of satisfaction, comfort with the technology and control over the session improved from the previous session. Session 9 was noted as having a fuzzy, pixilated image and I had to ask Don to reposition the videoconferencing camera to the centre of the monitor. At the near site, Don's image appeared to be focussed away from my eyeline, which was distracting. By repositioning the camera to the centre above the monitor, Don appeared to be looking directly at me, even though his focus was on the monitor. This moment gave tangible test data to the issue of how to manage camera placement to maximise the impression of direct gaze, and importantly, how distracting not having direct gaze could be.

During the week of Session 9, Don had a successful exposure experience and spoke with a shop assistant and the local florist, without having a panic attack, or reviewing his performance negatively. He was extremely happy with his progress, and included the positive event on his thought diary, rather than a complete focus on negative experiences only. His results on the BDI-II fell to a moderate level, his state anxiety score fell from 98% to 87%, and he scored below caseness again on all subscales except "problems". Interestingly, despite his positive mood change, his awareness of the shortfalls of the telepsychology experience were noted in terms of sound and picture quality, but his overall satisfaction was rated at a moderately high level.

My rating of Don's initiative at Session 9 also increased, as did my ratings of bond. My ratings of partnership were slightly lower than at Session

8, and my ratings of confidence to assist Don stayed the same. Don's ratings of alliance overall remained slightly higher than mine, though his rating of openness plummeted below previous levels and even below my own rating. On the basis of this rating, I was suspicious that Don was not telling me everything about his successful week.

H.7. Relevant Session Events – Session 10 to final session and follow-up

Extending on from disputing unhelpful thoughts, evidence testing and reviewing behavioural social exposure experiments, the concept of schemas, as detailed in the manual (Module 5) was introduced, from Session 10 onwards. While the manual's worksheets were not expressly used, because their use gave an artificial and forced quality to the exchange, the concepts and exercises were covered in a similar fashion verbally during the session. Don would often write notes to himself during later sessions, particularly when we were agreeing upon exposure exercises. He reported that he referred to these between sessions, rather than the manual.

Don continued to make steady improvements in his mood which coincided with increasing exposure to social interactions he would previously avoided. He had become aware that his previous fear of being harassed by locals no longer seemed to be as prominent and that he felt less vulnerable in and around his town. He had not been the victim of shouting abuse or stares for many months. It may have been genuine reduction in these events occurring combined with his own more accurate appraisals of himself and the threats in his environment that underpinned these improvements in his mood

and confidence. These telepsychology sessions also felt smooth and focussed and we had fallen into a consistent routine to our sessions. This routine incorporated a standardised agenda of review past week experiences, problem solving through failures and successes, review and reinforcement of identifying thinking errors, disputing evidence and schema work, then set new tasks for the following week, and measures of success. To that end, the telepsychology session fairly closely mimicked a typical face-to face CBT for anxiety and depression session.

A review of the session notes at the time indicated that Don had experienced positive outcomes following a weekend trip to a different town, where he was unknown and where he had completed several behavioural exposure exercises which he perceived had been successful. In addition, some friends had been staying at his home and so he had been busy hosting them. He reported that he had been too distracted by his visitors to feel low, and he felt buoyed by his successes while on holiday. He reported to have practiced his exposure exercises while in a town where he was not known, and he approached several attractive female shop assistants for information and to make purchases. During these experiments he managed his anxiety with cognitive and relaxation techniques learned in therapy sessions. His wife was also with him and reinforced his achievements. It is possible that these factors together had improved his demeanour sufficiently that his results on these assessments reflected this positive mood change. In his satisfaction survey, he rated this week's session the highest of all previous and following sessions, and also rated the therapy overall the highest satisfaction rating of all subsequent and previous sessions.

During the sessions 10-14, Don made significant improvement on his standardised test results and his subjective self-reports were in agreement. His scores on the BDI-II reduced from 36 (severe) at session 8 to 20 (low moderate) at Session 14. His anxiety ratings also decreased to 83% and 71% on the state trait anxiety inventory respectively, at Session 12. These were his lowest ratings overall for the duration of the intervention.

From the first administration at baseline to the last administration at follow-up, when Don was administered the BSI, his scores changed from casesness in six of the nine primary subscales and all 3 global indices, to caseness in no subscales or indices. In a paired samples t-test between the BSI subscale scores at Time 1 and follow-up, differences between the scores were significant at C.I.=0.95 (i.e. M = 18.16, SD=5.15, t=12.22, p=0.000). An alpha level of 0.05 was used for the statistical tests.

Don indicated during the sessions and via satisfaction survey (see Appendix G) that he found telepsychology to be an acceptable and even facilitative approach to engaging in psychotherapy. Don repeatedly cited a preference for telepsychology over face-to face services stating that the distance between the therapist and client prevented him “smelling perfume…having accidental physical contact…seeing legs”. He explained that because “talking made him feel self-conscious…he liked the feeling of separation”. With regards to the ease of use of the technology and comfort with the technology, his satisfaction ratings increased from 1 (not easy/not comfortable) to 3 (moderately easy/comfortable) over the first three sessions suggesting that for this client, accommodations to the technology occur fairly rapidly. His background in sound recording may have assisted this adjustment

process as he was technologically “savvy” to begin with. In addition, on the measurement occurrences where the sound quality and picture clarity were rated lowest (i.e 1= poor quality), the client still indicated overall moderately high satisfaction with telepsychology (i.e. 3 out of a possible 4). On this satisfaction scale, a rating of ‘0’ was considered the lowest rating and ‘4’ the highest possible rating.

Table H.2. Table of scores of total AGNEW therapeutic alliance ratings cores from client and therapist compared to technological interference ratings from Don’s satisfaction ratings.

Time	Client alliance	Therapist alliance	Picture clarity	Sound quality	Distracted by technology
Session 1	*128*	*127*	*1*	*1*	*1*
Session 2	*127*	*122*	*3*	*4*	*3*
Session 5	*131*	*139*	*2*	*3*	*3*
Session 8	*120*	*129*	*2*	*2*	*2*
Session 12	*127*	*111*	*1*	*2*	*2*
Session 13	*126*	*101*	*2*	*2*	*3*
Session 14	*135*	*102*	*3*	*4*	*4*

As this table demonstrates, the lowest rating of participant alliance at Session 8 does not coincide with the lowest rating of picture and sound quality at Session 1 or Session 12. In contrast, the highest rating of alliance with the therapist made by the client coincides with some of the highest ratings of sound and picture quality, and loss of distractibility from the telepsychology technology. These findings suggest that a good telepsychology technology experience may enhance the good feelings about other aspects of the therapeutic exchange. In contrast, a bad telepsychology technology experience will not necessarily have a strong impact on ratings of alliance during a session. Thus, the technology may moderate how well other

aspects of therapy are experienced but has less impact on overall satisfaction with the session or connection with the therapist.

H.8. Discussion

Don attended therapy for 16 sessions over 5 months and I was astonished by his commitment to therapy, especially given his high expressed anxiety about working with a female therapist. Using a combination of narrative techniques to assist in the reprocessing of traumatic early memories, cognitive therapy to challenge thinking errors and behavioural therapy in the form of an exposure hierarchy, Don dedicated himself to changing his current way of coping. He was vigilant to complete all exercises given to him, and ruthless in his exposure of painful and embarrassing memories and thoughts. His problems were deep seated and entrenched and although progress was slow, progress was made.

By the end of therapy, Don had made a major cognitive shift in terms of his emotional presentation. While previously paralysed by fear and helplessness, Don was more frequently expressing anger and resentment about his situation, and acknowledged a need to abandon “fantasies” of being with young attractive women, and perceiving every 17-60 year old woman as a potential sexual mate. This revelation caused Don some initial grief associated with “letting go” this part of his life and self image, but allowed him some respite from perceiving every interaction with a woman as another failed seduction, and being able to more realistically appraise interactions as simply that; interactions.

Don's results on the standardised tests demonstrated a mixed range of success. His BSI scores were significantly different from Time 1 to Time 3 (i.e t=12.221 p=0.000), however his BDI and STAI scores were less so. Don's GSI scale score on the first and second testing occurrences was 76. By his third assessment his total scale score had decreased to lower than "caseness" (i.e. 51). His relationship to the therapist and achievement of goals did not appear to be affected by technology and he perceived that positive change had occurred as a consequence of his experiences in telepsychology.