

Psychotherapy via videoconferencing: An interpretive phenomenological analysis study among individuals
experiencing body image dissatisfaction

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Abstract

During the COVID-19 pandemic, a new phenomenon of “Zoom dysmorphia” emerged in the empirical literature, implying a causal link between time spent on videoconferencing calls and increased appearance dissatisfaction. Videoconferencing is also used in psychotherapy, including for clients experiencing body image dissatisfaction (BID). Existing literature on videoconferencing psychotherapy (VCP) and BID, stemming primarily from the field of eating disorders (EDs), explores therapeutic alliance, client satisfaction and overall experiences of VCP. Some authors have suggested a link between VCP and self-consciousness; however, none have explored the texture and meaning of the self-view, nor individuals’ experiences of being seen in this context. This study investigates the lived experiences of seven individuals with BID regarding being seen and seeing themselves in VCP. Data were collected through semi-structured interviews conducted via a videoconferencing platform and analysed using interpretive phenomenological analysis (IPA). Three group experiential themes (GETs) were identified. GET 1: Absence of the (Whole) Physical Body highlighted how VCP introduced a sense of distance and limited full-body visibility. GET 2: Shifting Control in VCP explored participants’ feelings of control through appearance curation and the uncertainty from not knowing the therapist’s focus and experiencing technical glitches. GET 3: The Mirror of VCP captured participants’ experience of VCP as a mirror, leading to varying levels of self-scrutiny and comparisons with the therapist’s image. The study is particularly relevant to counselling psychology (CoP), given its emphasis on relationality (being-in-the-world-with-others) and pluralism (actively engaging with a multiplicity of truths and perspectives). The study can also aid counselling psychologists (CoPs) in being more reflexive in their practice and in continually questioning their assumptions about VCP as a therapeutic medium.

Keywords: body image dissatisfaction, videoconferencing psychotherapy, interpretative phenomenological analysis, counselling psychology

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Psychotherapy via videoconferencing: An interpretive phenomenological analysis study among individuals experiencing body image dissatisfaction

Chapter 1: Introduction

In recent decades, advancements in digital technology have resulted in significant shifts towards technology-mediated communication, with videoconferencing playing a pivotal role. Videoconferencing involves the use of technological devices to receive and transmit audio-video signals among users, enabling real-time communication (American Psychological Association, 2024). This trend was significantly accelerated by the COVID-19 pandemic, which necessitated the adoption of online platforms as the primary mode of communication across various sectors, including mental health (Rice et al., 2021). For instance, in their study with mental health care professionals in the Netherlands, Feijt et al. (2020) observed a dramatic increase in the daily use of videoconferencing software for client work during the pandemic, marking a four-fold increase compared to pre-pandemic levels. Before COVID-19, most practitioners (85%) reported using these digital platforms for psychotherapy sporadically or rarely (Feijt et al., 2020).

The shift towards videoconferencing through platforms like Skype, Microsoft Teams and Zoom has been linked to increased body image dissatisfaction (BID), which in turn is associated with social anxiety, low self-esteem, depression and eating difficulties (Kirby, 2016; Stice, 2002). In the context of aesthetic medicine, Rice et al. (2020, 2021) have argued, based on survey data collected during COVID-19, that as individuals spend more time on videoconferencing platforms, they become more aware of their appearance and how they appear to others. However, the relative proximity of the camera, which generates one's own image (self-view), can distort facial features by making the nasal area appear larger (Ward et al., 2018). This distortion often leads to appearance dissatisfaction and an increased likelihood of seeking cosmetic or facial treatments (Rice et al., 2020, 2021).

Using the survey method, Chen and Zhou (2023) found that the self-view in videoconferencing increases objective self-awareness (heightened awareness of oneself as an object of attention), leading

to a more critical and negative self-perception. Moreover, Li and Lee (2023) explored the effects of the self-view function and facial filters on users' positive and negative emotions and the experience of videoconferencing fatigue; that is, emotional and physical exhaustion following videoconference meetings. Contrary to Rice et al. (2020, 2021), they found no significant effect of the face filter or self-view function on positive or negative emotions. However, Li and Lee (2023) speculated that their experimental setup might have encouraged participants to focus more on their partner, regardless of whether the self-view was enabled. This aligns with results from Chen and Zhou (2023), who found that self-view did not negatively impact self-awareness when the individual was listening, suggesting that the effect of self-view depends on the communication role of the person. Lastly, Gullo and Walker (2021) examined whether self-viewing time during videoconferencing increased during lockdown in the United States (US) from February to April 2020. They found no significant link between self-viewing time and appearance satisfaction but suggested that future research should focus on at-risk groups, such as those with existing body image (BI) concerns.

Veale et al. (2016) have shown that appearance concerns can arise after just 2.5 minutes of mirror exposure. This finding is supported by other studies exploring various mirror exposure durations (Kollei & Martin, 2014; Windheim et al., 2011). Researchers have also shown that viewing and posting selfies (self-taken photos) on social media harms BI (Butkowski, 2019; Mills et al., 2018). Furthermore, the proximity inherent in video calls, where the visual space between participants mimics that of close personal relationships, places individuals at a distance closer than typical social interactions (Bailenson, 2021). For instance, to match the head size seen on screen, conversation partners would need to be about 50 cm away from each other, a distance classified as intimate according to Hall's (1966) theory of proxemics. This proximity to the other person, along with the constant self-view, can heighten self-scrutiny and trigger negative thoughts (Bailenson, 2021). Despite these concerns and the rise in videoconferencing therapy (VCP), there is a noticeable research gap in understanding how individuals with BID experience being seen and seeing themselves during VCP

sessions, which typically last 50 minutes and include a concentrated focus on the client. Addressing this gap is crucial for tailoring therapeutic approaches that effectively support this population, particularly as individuals with BID may already struggle with their reflection, often fluctuating between excessive checking and avoidance (Griffen et al., 2018; Silver & Farrants, 2016).

In the field of mental health, the term videoconferencing has been used interchangeably with telehealth, telemedicine, teletherapy, online therapy and VCP (Backhaus et al., 2012). Throughout this study, I will use the term VCP to refer to psychotherapy conducted online via videoconferencing platforms. In the following sections, I will introduce the reader to VCP, its origins and its recent rise in popularity; explore the phenomenon of embodiment and digital (dis)embodiment to set the stage for discussing BI, its complexity and its essential function in social interactions; and describe BID, highlighting its subjective nature and the suitability of a phenomenological approach to investigation. Lastly, I will explore how age influences technology use, which is relevant to understanding how different age groups engage with VCP, before examining the study's link to counselling psychology's (CoP's) values of relationality and pluralism.

1.1 The Evolution of Videoconferencing Psychotherapy (VCP): From its Origins to Becoming the Norm During COVID-19

Traditionally, psychological therapies have depended on physically co-present interactions due to limited alternatives and established norms (Cataldo, 2021). However, recent technological advances have introduced new methods like telephone therapy, text messaging, email and videoconferencing, with videoconferencing most closely resembling traditional, physically co-present psychotherapy (PCP; Thomas et al., 2021).

Videoconferencing was first used for group psychotherapy in 1961 using early television technology to extend mental health services to remote areas (Wittson et al., 1961). Video signals were transmitted over dedicated telecommunication lines through closed-circuit television setups, enabling real-time visual and audio communication. As telecommunications technology improved and personal

computers became more widespread in the 1980s and 1990s, videoconferencing evolved into a more accessible and flexible tool for delivering psychotherapy. The benefits of VCP include reduced travel time and financial costs, increased accessibility, greater flexibility in scheduling and fewer barriers to treatment, such as stigma, self-consciousness and geographical limitations (Abrahamsson et al., 2018). VCP can also present therapeutic opportunities that may not be apparent in traditional settings, such as gradually increasing clients' comfort in anxiety-provoking situations (Datta et al., 2020).

Before COVID-19, research on VCP focused on its use as an alternative for those in remote or rural areas (Gonzalez & Brossart, 2015) and those unable to attend PCP due to limited mobility (Langarizadeh et al., 2017). Although studies showed that VCP and PCP provide similar outcomes and client satisfaction (Norwood et al., 2018; Thomas et al., 2021), the global uptake of VCP had been slow due to practitioners' concerns about the ease of technology use, obtaining informed consent, confidentiality, loss of control, risk management, lack of access to crucial non-verbal communication and the perceived disruption to the therapeutic alliance (Simpson et al., 2020). For example, a survey of private practice mental health practitioners in the US during the initial months of the pandemic showed that up to 46.8% had never used VCP before and 42.36% of those who had reported using it for less than a quarter of their clients at the time (Phillips et al., 2021).

The therapeutic alliance refers to the "quality and the strength of the collaborative relationship between client and therapist" (Horvath & Bedi, 2002, p. 41) and is often viewed as a major predictor of therapy outcomes. It forms part of the broader concept of the therapeutic relationship, which encompasses all dimensions of the interpersonal dynamics between therapist and client and the way these are expressed (Cooper, 2008). Given that CoP places high importance on the therapeutic relationship as central to the therapeutic process (Milton, 2016), it is noteworthy that concerns about therapeutic alliance have been identified as a major obstacle to the adoption of VCP (Rees & Stone, 2005; Simpson & Reid, 2014). For example, Rees and Stone (2005) conducted a study in which psychologists rated the therapeutic alliance in either a recorded PCP or VCP session. Despite both

tapes being identical, the therapeutic alliance in VCP was rated as weaker, indicating potential negative biases against VCP. From an existential-phenomenological standpoint, Spinelli (2015) argued that therapists place great importance on certain conditions they consider essential for effective psychotherapy, such as how and where therapy is conducted. However, it is the belief in the necessity of these conditions that gives them significance, not the conditions themselves (Spinelli, 2015). In a lecture on relatedness and online therapy, Spinelli (2020) suggested that resistance to VCP among therapists often stems from a reluctance to modify these perceived essential conditions, fearing that such changes could compromise the relational depth that is central to therapeutic work.

While the COVID-19 pandemic has significantly increased the use of VCP as the primary treatment format (Webster, 2020), entrenched beliefs about the prerequisites for genuine human connection and therapeutic efficacy may still limit counselling psychologists' (CoPs') acceptance of VCP (Cataldo, 2021). These beliefs, in turn, might strongly influence clients, as psychologists have a powerful impact on public opinion through media and other channels (Kasket, 2024), ultimately limiting clients' access to therapy. By exploring clients' experiences of being seen and seeing themselves during VCP, this study seeks to provide CoPs with an opportunity to challenge some of their preconceptions and approach online therapy with individuals experiencing BID with greater openness and creativity.

1.2 Embodiment: The Bridge Between the Self and Others

Embodiment is a pivotal concept in the therapeutic process, particularly for individuals struggling with BID due to its deep connection to the body (García et al., 2022). It refers to the subjective experience of living in and through one's body (Cash & Smolak, 2011). Bailey et al. (2018) further explained that embodiment involves a dynamic interaction between the body, mind and environment, highlighting that our bodily presence and interactions form the basis of how we understand and experience the world.

Embodiment is also considered one of the existential givens (Cohn, 1997), a concept deeply rooted in phenomenological literature. Merleau-Ponty (1945/2005), a key figure in this field, argued that being-in-the-body is an integral aspect of being-in-the-world, highlighting that the body and mind, or the entity of perception, are inseparable. He emphasised that embodiment research must delve into lived experiences – an example of which is BI, a specific aspect of embodiment related to one's perceptions, thoughts and feelings about physical appearance (Cash & Smolak, 2011; see Section 1.4 below).

The body is the primary medium through which humans experience the world, facilitating growth, social interaction and relationship-building (Cash & Smolak, 2011). This perspective underscores the fundamental role of the body in all aspects of human existence, including therapy, where the relational and communicative functions of the body are paramount. Specifically, addressing embodied experiences helps clients connect with their physical selves, fostering a holistic understanding of their existence (Tschacher & Pfammatter, 2016). From an existential-phenomenological perspective, Spinelli (2005) highlighted the centrality of the body in shaping one's self-concept and experiences. He suggested that therapy should include an exploration of how individuals perceive and relate to their bodies, as this can impact their overall psychological well-being. Similarly, van Deurzen (2012) emphasised that understanding clients' embodied experiences can bring significant insights into their existential concerns and life challenges. Embodiment also plays a crucial role in understanding intersubjectivity; that is, the dynamic interaction between self-perception and how we are perceived by others (Kiss, 2021). Being with someone means that the other has a subjective perception of us that we can never fully access, just as they also never see themselves from our point of view (Merleau-Ponty, 1945/2005). The intersubjective nature of embodied experience highlights the importance of considering the presence of the "other", not merely one's own perception of the body when exploring BID.

Merleau-Ponty (1945/2005) extended the notion of intersubjectivity to encompass intercorporeality, defining it as the mutual modulation of bodies within shared spaces. He argued that our bodily presence and interactions are fundamental to how we understand and experience the world, suggesting that consciousness and bodily experiences are deeply intertwined with our relationships with others. To illustrate this, Merleau-Ponty (1945/2005) used the example of a blind man who, over time, integrates a cane into his embodied perception, so that it becomes an extension of his body rather than merely a separate tool.

1.3 Digital (Dis)embodiment

The advent of videoconferencing presents both a challenge and an extension to the foundational insights into embodiment and intersubjectivity, notably those of Merleau-Ponty (1945/2005), who positioned the body as the primary medium through which we experience the world and others. Early writers on digital (dis)embodiment, such as the existential-phenomenological philosopher Dreyfus (2008), argued that digital spaces lack the “actual embodied presence” of individuals (p. 3), suggesting that online interactions detach us from our “vulnerable, embodied selves” (p. 6). This view frames the offline world as synonymous with embodiment and fulfilling human needs, while the online world is seen as disembodied and inadequate for meeting these needs (James & Leader, 2023). Fuchs (2014), while adopting a less binary stance, also expressed concerns about the depth of empathy in online interactions, noting that the absence of physical co-presence might limit genuine, empathetic engagement, potentially turning it into a projection of one’s feelings rather than a genuine understanding of the other’s experience.

Recent technological advancements and our neurocognitive adaptations to these technologies have prompted a re-evaluation of what constitutes “real” and “embodied” experiences (García et al., 2022; James & Leader, 2023). The concept of “disembodiment” has become less applicable in online contexts, challenging traditional notions of embodiment and suggesting a more integrated understanding of digital and physical experiences. Jiang et al. (2011) explored this integration in a lab

experiment by comparing physically co-present encounters with online (text-based) conversations. Participants in the online condition, who received an intimate self-disclosure from a confederate, reported feeling more intimacy and connection than those in the physically co-present condition. These findings suggest that digital interactions can foster vulnerability, connection and empathy, challenging earlier notions of digital disembodiment and highlighting the potential for genuine and meaningful embodied experiences online.

Further exploring embodiment in the digital context, scholars like Heersmink (2017) and Stokes (2021) have discussed the concept of the distributed self, where a person's bodily experience extends into both their environment and another's via the screen. This idea builds on Clark and Chalmers' (1998) theory of extended cognition, which posits that our minds are distributed across our interactions with the environment and others. If minds are "smeared" across the environment in this way, so are we when we engage in online communication (Heersmink, 2017). The concept of the distributed self blurs the strict separation between the embodied and disembodied self, suggesting a more fluid boundary where digital interactions seamlessly integrate into our sense of personhood. Merleau-Ponty's (1945/2005) example of a blind man using a cane – where the cane becomes an extension of his body – can be extended to illustrate how tools and technologies become integral to our embodied experience (Willatt & Flores, 2022).

In VCP, the therapist and client engage in an embodied interaction that remains deeply rooted in the sensorimotor engagements characteristic of physical co-presence despite being physically distant (García et al., 2022; Smart, 2014). This mediated form of relating expands traditional notions of co-presence and intersubjectivity, allowing for the perception of bodily expressions, tone of voice and emotional responses, albeit digitally. Thus, VCP has become the new context for embodied presence and intersubjective therapeutic encounters.

1.4 Body Image (BI)

BI encompasses a person's thoughts, perceptions, feelings and actions regarding their physical appearance (Cash, 2008). This can involve negative aspects, such as thinking "I am too overweight", perceiving oneself as larger than one is, feeling anxiety or shame, or avoiding social situations due to self-consciousness. Conversely, BI can include positive aspects, such as pride in one's appearance, viewing oneself as strong and healthy and engaging in activities that boost BI, such as exercising or dressing confidently.

BI constitutes an integral part of the self; perceived challenges to the self-image (e.g. not fulfilling the ideal BI) can result in dissatisfaction and distress, potentially affecting other areas of life and overall well-being (Kirby, 2016). Conversely, BI can contribute to satisfaction and well-being (Tylka & Wood-Barcalow, 2015). Using written reflections on BI by individuals with eating disorders (EDs), Fogelkvist et al. (2016) demonstrated that BI holds different meanings for individuals, with some focusing on body evaluation, others on the alignment of body perception with external views and some linking BI closely to self-esteem or their relationship with their body.

The terms BI and embodiment are sometimes used interchangeably (e.g. Cash, 2008, defined BI as a person's experience of their embodiment), yet they arguably represent distinct concepts. Specifically, how a person experiences embodiment may be overlooked when they are focused on their BI. For instance, feeling one's heartbeat would be an aspect of embodiment, but a person may completely disregard that experience if focusing on how they look in the mirror or to others. Thus, BI seems to be more about the experience of one's appearance rather than embodiment. BI is also dynamic and context-dependent, though some individuals may perceive it as a static part of their identity (Espeset et al., 2012). The variety of definitions and perspectives on BI highlights its complexity and points to the multifaceted nature of BI, which includes cognitive, perceptual, emotional and behavioural components (Kirby, 2016).

1.5 Body Image Dissatisfaction (BID)

BID has been defined as discontentment with one or more aspects of one's physical appearance (Cash, 2008). It involves a preference for body characteristics different from those currently perceived by the individual (Wertheim & Paxton, 2011). However, this perception does not occur in isolation but, typically, within a social context, involving the gaze of others and social comparisons (Roth, 2020). From an evolutionary perspective, humans are inclined toward social comparison due to an instinctual drive to gauge their status within a group, as higher status can lead to better access to resources, mates and overall survival (Festinger, 1954). In recent decades, the online context has further amplified social comparative behaviours in relation to BI, extending our tribe beyond those who are physically co-present to global online connections (Rosenthal-von der Pütten et al., 2019). This has intensified the impact of social comparisons on BI (Grogan, 2021), potentially exacerbating the phenomenon of “normative discontent” (Rodin et al., 1984, p. 267), which describes the widespread experience of BID across genders (Fiske et al., 2014) and ages (Finch et al., 2023). Given its prevalence across different demographics and its strong association with psychological distress (Stice, 2002), CoPs are likely to encounter clients with BID, making research in this area especially relevant to the profession and crucial for informing therapeutic practices.

Every human being navigates a relationship with their body, encountering moments of self-critique and judgement throughout their lifespan, for example during adolescence, pregnancy or minor injury (Cash & Smolak, 2011). For some, however, these feelings are persistent, profoundly affecting their daily lives and social interactions (Kirby, 2016). Social interactions are increasingly occurring online (e.g. via videoconferencing), adding another layer to how individuals perceive and evaluate their appearance in social contexts. When preoccupation with physical appearance leads to significant distress, accompanied by repetitive compulsive behaviours and lack of insight, individuals may be diagnosed with body dysmorphic disorder (BDD), as outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013). Additionally, the DSM-5

identifies a disturbance in the way body weight and shape are experienced as a crucial diagnostic feature of anorexia nervosa and bulimia nervosa (American Psychiatric Association, 2013). Distorted perception of body weight and shape is also a risk factor for the development of these EDs (Stice, 2002) and for relapse after remission (Keel et al., 2005). While concerns in EDs primarily revolve around body shape and weight, the preoccupations of a person living with BID vary, including concerns with facial features, skin and hair (Mitchison et al., 2013). Virtually any part of the body may be a concern in BID, but the areas most affected are those frequently visible on video, such as the head and face, with a particular focus on the nose, skin and hair (Sarangi et al., 2022). The multidimensional nature of BI and the recognition that BID is, to varying degrees, experienced by a large proportion of people at some point in their lives lends itself to a more phenomenological approach to investigation rather than one focused strictly on medical diagnoses. This approach aligns with the values of CoP, emphasising the exploration of lived experiences, personal meanings and the complexity of human interactions (Amari, 2020).

BID is closely connected to shame: it is characterised by overvalued fears of an assumed bodily ugliness or defect, particularly related to the face, which is the main area where shame is focused (Fuchs, 2003). With social interactions and communication often relying on facial expressions to infer what the other person is thinking, individuals experiencing BID might experience heightened levels of shame and anxiety around being observed by others. This can lead to attempts to avoid the gaze of others, most commonly by retreating from social interactions as much as possible (Fuchs, 2003). Similarly, in their phenomenological research into eating difficulties, Mancini and Esposito (2021) highlighted how the gaze of others can intensify individuals' preoccupation with physical appearance, increasing self-consciousness and anxiety.

Overall, BID has been associated with eating problems (Stice, 2002), an intense preoccupation with physical appearance (Mancini & Esposito, 2021) and heightened levels of shame, anxiety and self-consciousness (Fuchs, 2003). However, these experiences are not prerequisites for participants in this study. Consistent with the interpretative phenomenological framework that underpins this research, the

focus is on understanding participants' perspectives of their own lived experiences. This approach prioritises subjective experiences over medical diagnoses or predefined standards, which is why I sought to recruit individuals who self-identify as having BID, without requiring them to conform to existing categories of "symptoms" (see inclusion criteria in Section 3.7).

1.6 Technology Use: Does Age Matter?

Historically, age was assumed to significantly impact how individuals engage with technology, including online psychotherapy, with older generations presumed to be less adept or more resistant to technological advancements (Kasket, 2024). This belief stemmed from Prensky's (2001) "digital natives"/"digital immigrants" divide, which categorised people based on whether they were born before or after the rise of digital technology in 1985. However, later research has questioned this binary view, suggesting that age is not the sole factor in technological engagement (Bennet et al., 2008; Benini & Murray, 2014).

Recent studies and theoretical frameworks have moved beyond age as the primary determinant of technology use to more nuanced understandings. White and Le Cornu (2011), for instance, critiqued the simplistic division based on birth year, instead proposing a distinction between "digital visitors" and "digital residents". This classification focuses on users' engagement patterns rather than age, with digital visitors using the online world sporadically and digital residents integrating their online and offline lives, often blurring the boundaries between the two (White & Le Cornu, 2011). Such distinctions privilege motivational and contextual factors over chronological age, offering a more accurate representation of how people of all ages interact with technology, including videoconferencing platforms.

The participant inclusion criteria in the present study encompass a wide age range to align with these insights and the phenomenological framework underpinning this research, which prioritises lived experiences without preconceived notions about age and technology use. Accordingly, the only age-related criterion is that participants must be adults, defined as 25 years or older (see Section 3.7).

While individuals aged 18 to 25 are not considered children or adolescents, they are often categorised

as being in the phase of emerging adulthood (Arnett & Mitra, 2020; Wood et al., 2018). Research on BID and related clinical health domains, such as EDs, suggests that emerging adults face issues that are qualitatively distinct from those experienced by older adults (Potterton et al., 2020; Keel, 2017). Including individuals aged 18 to 25 alongside older adults could compromise the homogeneity of the sample and introduce additional ethical considerations unique to this age group. Therefore, restricting participation to those aged 25 and older ensures greater consistency in the sample while maintaining alignment with the study's methodological approach.

1.7 Rationale for the Present Study

This study is rooted in the growing body of research linking videoconferencing to appearance dissatisfaction (e.g. Chen & Zhou, 2023; Rice et al., 2020, 2021). As therapeutic services are increasingly moving online (Hanley, 2021), it becomes crucial to explore the experiences of clients engaging in VCP, particularly those with BID. Existing literature on BI-related concerns and VCP has primarily focused on individuals diagnosed with EDs. However, BID extends beyond formal medical diagnoses such as EDs or BDD, affecting individuals who do not meet the diagnostic criteria for these conditions or seek a formal diagnosis. To address this gap and ensure the inclusion of underrepresented voices, this study specifically focuses on BID.

Research indicates that appearance concerns can surface after as little as 2.5 minutes of mirror exposure (Veale et al., 2016). Given that VCP sessions typically last around 50 minutes, this raises important questions about how clients experience seeing themselves on the screen in this medium. This concern is especially pressing for clients with BID, who may already have a complex relationship with their reflection (Griffen et al., 2018). Additionally, the unique nature of VCP – where the therapist's face appears in close proximity and the camera focuses on specific parts of the client's body (usually the face and upper body) – highlights the need to understand how these clients experience being seen by their therapist in this context.

As shown in the following literature review, much of the existing research on VCP and BI-related concerns comes from the field of EDs and has been conducted using quantitative approaches (e.g. Abrahamsson et al., 2018; Mitchell et al., 2008; Raykos et al., 2021). While these studies provide valuable insights into VCP effectiveness, client satisfaction and the therapeutic alliance, they reduce complex concepts to measurable outputs and outcomes. As discussed in Chapter 1, both BI and technology (VCP) intertwine with personal experiences in multifaceted and not easily measurable ways. This suggests that a more nuanced, qualitative approach is necessary to explore the interaction between BID and VCP, allowing for a deeper understanding of these phenomena.

Early qualitative and mixed-methods studies on BI-related concerns and VCP (e.g. Fernández-Aranda et al., 2020; Simpson et al., 2005; Simpson & Slowey, 2011) have provided insights into the role of self-view and the associated feelings of self-consciousness and discomfort. However, these studies often lack methodological rigour and fail to capture the nuances of these experiences. More methodologically robust studies on BI-related concerns and VCP exist (e.g. Frayn et al., 2021, Murphy-Morgan et al., 2024; Vuillier et al., 2021), but they focus on the impact of COVID-19 on individuals with EDs and their overall experiences with VCP, despite acknowledging the need for more specific exploration of the self-view.

The intersubjective nature of BI underscores the importance of considering the therapist's gaze – or “the other” – when exploring how individuals with BID experience VCP. This aspect of VCP remains unexplored in the literature, aside from one study on BI disturbance by Grignoli et al. (2021), which speculates about its potential effects. Given that the presence of another person's gaze in physically co-present interactions can intensify preoccupation with appearance and feelings of shame (Mancini & Esposito, 2021; Fuchs, 2003), it is vital to investigate how individuals with BID experience being seen in a medium where the therapist's face is more proximal and exposure is often limited to the face and upper body. To address this research gap, this study adopts a qualitative phenomenological approach to explore how individuals with BID experience both being seen and

seeing themselves in VCP. As such, it aims to provide insights into aspects of online therapy related to BI that have yet to be fully understood. The insights gained may pave the way for more reflective practice, stronger therapeutic relationships and a nuanced appreciation of both the possibilities and constraints that VCP presents in addressing appearance-related concerns.

1.8 Relevance to Counselling Psychology (CoP)

CoP is distinctive among the applied psychologies for its emphasis on understanding individuals as relational beings, accommodating a plurality of viewpoints and prioritising the therapeutic relationship (Milton, 2010). This section links the present study specifically to CoP's values of relationality and pluralism. It also references existential-phenomenological philosophy, which aligns with CoP through its focus on a holistic understanding of the human condition, reflexivity and the importance of human agency in shaping one's life (Milton, 2012).

As technology-mediated communication evolves, it is crucial for CoPs to cultivate flexibility and responsibility in adapting to it. This necessity aligns with the CoP principle of relationality, which refers to the understanding that individuals are deeply connected to others and the world around them (Amari, 2020). CoPs are not isolated practitioners; they are embedded in and responsive to the same social, cultural and historical contexts as their clients. This relational stance requires CoPs to continually adapt their therapeutic practices, ensuring they remain attuned to the evolving mediums through which people now communicate and form relationships (Woolfe, 2016). The importance of adapting to changing circumstances and embracing technological advancements is also highlighted by the Health and Care Professions Council (HCPC, 2023).

Another fundamental tenet of CoP that is particularly relevant to this study is pluralism, which involves actively engaging with the vast diversity of experiences and perspectives, necessitating flexible and individualised therapeutic approaches (Cooper & McLeod, 2010; Donati, 2016). VCP presents an opportunity for CoPs to practise in a more pluralistic manner. By delving into the intricacies of VCP, CoPs can better tailor their approach to align with clients' unique perspectives and

needs, thereby upholding their autonomy in accordance with the guidelines set forth by the British Psychological Society (BPS, 2018a). Additionally, a deeper understanding of technology's role in therapeutic formulations and interventions allows for a more nuanced and holistic approach to care. Cooper (2008) highlighted a significant gap between practitioners' assumptions about client experiences and clients' actual experiences. Therefore, delving into clients' meaning-making processes in the context of VCP is especially relevant.

As shown in the literature review below, current literature on videoconferencing (Pfund et al., 2020; Pikoos et al., 2021; Rice et al., 2021) often portrays individuals as passive recipients of technology's influence, overlooking the agency they possess in their interactions with technology. Heidegger (1954/2003), an existential-phenomenological philosopher, argued against viewing technology as an external tool separate from human agency, instead viewing it as an integral aspect of our being-in-the-world. He illustrated this with the analogy of a hammer, which can be utilised for diverse purposes, both beneficial and detrimental. Similarly, technology can be extractive, dehumanising and reductive, but it also holds the potential for saving power – its ability to foster deeper connections, self-awareness and more meaningful lives. According to Heidegger (1954/2003), harnessing the saving power of technology requires a willingness to constantly question our relationship with it. This dynamic engagement with technology aligns closely with reflexivity, a key concept in CoP, which involves critical self-awareness and active engagement with how our agendas, motivations and assumptions shape what is (or is not) happening in our practice (Donati, 2016).

Whilst I have argued that VCP embodies the core tenets of CoP, some CoPs have used these same principles to argue against technology-mediated therapy, claiming it is inferior, less genuine and has less potential than PCP, as reported in Kasket (2012a). Interestingly, these assumptions were made without any direct experience or research-based evidence (Kasket, 2012a). CoP is not just a collection of values, such as relationality, pluralism and reflexivity; it represents the active application of those values (Cooper, 2009). However, it seems that participants in Kasket's (2012a) study did not fully

apply their professional values, as they tended to focus on the potential limitations of technology without engaging with the possibilities it offers – reflecting Heidegger’s (1954/2003) argument that technology tends to become dehumanising if we fail to engage with it reflectively, thereby overlooking its potential saving power. This study invites practitioners to reflexively question their preconceptions about what is possible and not possible in VCP and to view this therapeutic medium afresh. It aims to encourage CoPs to foster curiosity and openness about their own experiences of VCP before they fully engage with the plurality of experiences of their clients.

1.9 Focus and Aims of the Study

This study focuses on exploring the experiences of individuals with BID within the context of VCP, aiming to provide insights into how they experience both being seen and seeing themselves in this therapeutic medium.

1.10 Reflexivity Statement

This section documents my reflections on the research topic and my relationship to that topic. It delves into my background, preconceived notions, expectations and any underlying assumptions that shaped my approach to the research process. In line with phenomenological principles, reflexivity is pivotal to the research process as it allows the researcher to cultivate openness and curiosity towards the phenomenon under investigation (Finlay, 2002b).

When thinking about my doctoral research topic, I was faced with the task of finding something that would engage me for three years, be interesting enough for others to read and be relevant to CoP. This brainstorming occurred in the late stages of the COVID-19 pandemic, when most psychotherapy, including my personal therapy, was still taking place online. Before the pandemic, I had not received any online therapy myself, but I had some experience of providing online support to individuals with eating problems.

Initially, I was hesitant about having VCP from my apartment, partly due to a desire to hold on to how things were during a time of such uncertainty. I associated my therapist's consulting room with her calming presence, particular conversations and my walk home, where I could reflect on the session in a neutral environment. When PCP became no longer possible, I even considered stopping psychotherapy until services went back to my preferred "normal". However, my therapist's passion for online therapy persuaded me to give VCP a try and, in the end, I had online therapy for months.

I thought of the first session as a trial and was quite sceptical – I anticipated that I would not feel as connected to my therapist as when we met "face-to-face" and that I would find the technology unnatural and distracting. During this session, I noticed some important differences between VCP and PCP. For example, there was environmental disclosure on my therapist's part. Before the pandemic, I did not know anything personal about my therapist, but with VCP, I could suddenly see part of her home; that is, the room from which she was conducting her sessions. Despite these differences, I did not feel less connected to my therapist. Instead, I questioned whether I felt more connected at times.

Her study was quite messy, with lots of books and papers everywhere, which made her more human to me. However, I am unsure if this increased connection was due to the room's messiness or the shared uncertainty around the pandemic (we started every session by checking on each other).

My choice of topic was also shaped by my experience of attending lectures and seminars via videoconferencing and discussions with classmates about our experiences of these online classes. This was when I became interested specifically in VCP and BID, as many of our discussions focused on appearance dissatisfaction and the presence of the camera in VCP.

My initial assumption was that individuals with BID would not like VCP due to having to look at themselves whilst on the call and having a constant reminder of their “dissatisfying” bodies. When I reflected on the origins of these assumptions, I realised they were based on my experiences of studying and working from home during the pandemic, not having easy access to my usual “beauty treatments”, such as hairdressing, and not caring as much about my clothing as there were no reasons to dress up, all of which added up to discomfort around seeing myself in a close-up view and being seen by others. Furthermore, the discussions with my classmates often reflected negative sentiments, such as not enjoying being on camera early in the morning or having “a bad hair day”.

Prior to embarking on my research, I aimed to manage my views about VCP and BID by bracketing, so that I could focus on the participants' experiences and remain faithful to their words and the meanings they ascribed to their experiences, rather than letting my own experiences interfere. However, I was aware that my subjectivity was not only impacting my study from the initial stage of research topic identification but that it would continue to impact every subsequent decision during my research (Lazard & McAvoy, 2020). Hence, the preliminary interrogation of my assumptions and bracketing described above was only a starting point. As time went on, I continually reflected upon *how* my preconceptions, assumptions and involvement in the study shaped the research process and the knowledge that was being generated as a result (Willig, 2012). To critically engage with the research process and my research journey, I kept a reflexive diary in which I documented the research process

from the formulation of the research question through to my actual research experiences, as well as the design choices I made and the rationale behind them. I also used regular supervision to support reflection on the decisions made throughout the research process and to explore my emotional responses to various aspects of the research journey, such as data collection. My ongoing reflexivity will be shown throughout the thesis and explicitly discussed in Section 5.9 to help the reader understand the (inter)subjective processes that have influenced the research, enhancing the study's integrity and trustworthiness (Finlay, 2002b).

According to Heidegger (1927/1962), our fore-understandings may only be apparent once we are presented with the new (i.e. the data). Hence, I knew that some of my assumptions and biases would only become clear through engagement with the participants' material. Bearing this in mind, I set out to prioritise focusing on the data and participants rather than trying to bracket myself in the Husserlian sense (that is, setting aside my past theoretical knowledge, context and history to get to the universal essence of a phenomenon as it presents itself to consciousness; Husserl, 1900/2001). Instead, I aimed for "a more enlivened form of bracketing as both a cyclical process and as something that can only be partially achieved" (Smith et al., 2022, p. 20). By continuously engaging in reflexivity, I challenged my interpretations of the data, asking myself whether they were grounded in the participants' accounts or my own beliefs and assumptions.

Chapter 2: Literature Review

2.1 Overview

In the following chapter, I will examine the use of VCP for individuals with BI-related concerns, beginning with literature on “Zoom dysmorphia”, a phenomenon in which individuals perceive themselves critically due to increased exposure to their image on video platforms. I will then introduce research studies among individuals with EDs, outlining the evidence for the effectiveness and acceptability of VCP, the role of the self-view in self-consciousness and the importance of considering individual preferences in this medium. Next, I will discuss the only existing study on BI disturbance and VCP, before moving to studies exploring therapists’ experiences of conducting VCP with clients experiencing EDs. This exploration of the literature will provide context for this study’s central question: How do individuals with BID experience being seen and seeing themselves in VCP?

2.2 “Zoom Dysmorphia” – The Negative Impact of Videoconferencing on BI

“Zoom dysmorphia” is a term that was coined during the COVID-19 pandemic, describing the phenomenon in which individuals perceive themselves negatively, focusing on their flaws or imperfections due to prolonged exposure to their self-view during video calls (Rice et al., 2021). In the US, Cristel et al. (2020) found that nearly 41% of surveyed participants (aged 21-60) who had not previously undergone any facial cosmetic treatments planned to pursue such treatments due to concerns arising from their videoconferencing appearance, underscoring the influence of these platforms on appearance concerns. Pikoos et al. (2021) investigated the link between video call usage, appearance dissatisfaction and interest in cosmetic procedures. The study was conducted in Australia and utilised an online survey of 379 “healthy” adults aged 18 years and older. The survey examined various aspects of videoconferencing usage, including employing video manipulation techniques to enhance appearance and visual focus during video calls (self-view versus others). The Dysmorphic Concern Questionnaire (Mancuso et al., 2010) was utilised to ascertain whether behaviours related to

videoconferencing use correlated with increased BI disturbance. The authors found that over a third of participants reported new appearance concerns while using videoconferencing, with dysmorphic concern (a preoccupation with a perceived flaw) being associated with self-focused attention, engaging in video manipulation and increased appearance concerns (Pikoos et al., 2021)

These findings from Pikoos et al. (2021) indicate that videoconferencing can exacerbate BI concerns not only in individuals with pre-existing BID but also in those considered “healthy”. However, the specific context of the pandemic, with its unique constraints on social interaction and physical activity, might have influenced these findings. The increased concerns about appearance observed in the study could stem from factors such as more time spent at home with mirrors, changes in body shape due to decreased physical activity or anxiety about the future, prompting people to control what they can, including their appearance. Although Pikoos et al. (2021) did not seem to control for any of these factors, their findings offer important insights for understanding the potential impact of videoconferencing on appearance-related concerns.

Pfund et al. (2020) explored the impact of videoconferencing platforms on appearance satisfaction for 438 women (aged 18+) in the US. The study involved surveying participants on their use of videoconferencing services, the extent of appearance comparisons made during video calls and women’s overall satisfaction with their appearance. The researchers found that, although spending more time on video chats like Zoom was not directly linked to how participants felt about their appearance, certain behaviours during these calls had significant effects. Individuals who often compared their appearance to others during calls and those who engaged in self-objectification were more likely to use features to alter their appearance on screen. This included frequent use of Zoom’s “touch up my appearance” feature, which was associated with lower satisfaction with faces and bodies. However, participants who spent more time on video calls with family generally felt better about their appearance. This suggests that the context and nature of video interactions are crucial in influencing how individuals perceive themselves.

Cristel et al. (2020), Pfund et al. (2020) and Pikoos et al. (2021) have suggested a relationship between videoconferencing and appearance concerns. However, none of these studies investigated the relationship between videoconferencing and appearance (dis)satisfaction in the therapeutic context – an important context to consider now that therapists are increasingly turning to such platforms (Hanley, 2021). Instead, these studies were conducted in the context of aesthetic medicine by individuals with professional interests in cosmetic procedures, which might have influenced the interpretation of findings by emphasising the cosmetic impacts more heavily. Moreover, Pikoos et al. (2021) implied a binary between healthy versus unhealthy individuals, which runs counter to both the phenomenological stance I seek to take in this study and to CoP’s holistic view of the human condition, which advocates for a nuanced exploration of BI beyond strictly medical or health-related classifications (Woolfe, 2016).

2.3 Technology and Individual Agency in Digital Communication

The above literature on Zoom dysmorphia (Cristel et al., 2020; Pfund et al., 2020; Pikoos et al., 2021) seems to portray technology as having a somewhat monolithic, reducible and predictable impact on individuals, with people seen as passive, receptive agents who are lacking choice or agency. As such, technology is treated as having *ontological* properties (creating a singular, uniform experience for everyone), specifically as something that causes or aggravates people’s BI concerns. However, researchers in the field of cyberpsychology have indicated that the potential uses and applications of any given technology are broad and largely dependent on individual factors. Meier et al. (2021), for instance, demonstrated that the big five personality factors (extraversion, agreeableness, conscientiousness, neuroticism and openness to experience) played a significant role in the use of online communication during lockdowns in the COVID-19 pandemic. Individuals who scored high on extraversion and openness to experience were more likely to embrace this mode of interaction as a tool to avoid loneliness. People with higher openness to experience were also more motivated to continue meeting online even after the pandemic.

However, it is not just the big five that seem to influence people's decisions to embrace or resist online communication. Clark and Green (2018) have shown that the range of affordances in online communication largely depends on the attitudes, behaviours and beliefs individuals hold about it before engaging with it. They highlighted the importance of exploring users' attitudes as predictors of online communication outcomes and argued that individuals differ in the extent to which they regard this mode of interaction as a meaningful way to form and maintain close relationships – a concept labelled as the “perceived reality of online interactions” (PROI; Clark & Green, 2013), with the term “reality” chosen to reflect a layperson's view of online interactions and relationships as “not real” (Clark, 2014). Individuals with high PROI perceive digital communication to be as satisfying as physically co-present interactions, focusing not on the limitations of technology but on how to utilise it to fulfil their needs. Consequently, they are more inclined to participate in relationship-building communication, such as self-disclosure. Conversely, those with low PROI view digital communication as inherently inferior to physically co-present engagements, believing such communications cannot meet their needs, regardless of the technology's quality. Thus, attitudes towards online communication can become self-fulfilling prophecies: those convinced of its potential benefits are more likely to make choices that enable them to experience these advantages and vice versa (Clark & Green, 2018). This perspective challenges the narrative that technology has a uniform, deterministic impact on our lives, as suggested by the discussion of Zoom dysmorphia. Instead, it emphasises the role of individual perceptions and attitudes in shaping the experience of online communication. The diversity in how individuals engage with and perceive the efficacy of online interactions underscores the need to move beyond simplistic narratives of technology's impact.

In line with this perspective, in my study, I am interested in the *ontic* experience of technology – the relative contribution of internal factors when people are using the medium (i.e. the intersubjectivity happening between individuals as mediated by the technology) – rather than assuming that technology is monolithically or predictably doing something to them. There is, indeed, an extent to

which humans are influenced by their subconscious awareness, and there are also certain fixed elements about technology in general and VCP specifically (e.g. not being in the same room as the other person) over which individuals have no control. However, individuals can still exercise a great deal of agency when using VCP in service of their various desired ends (e.g. manipulating the camera in different ways and bringing different attitudes, assumptions and beliefs that align with their lived experience and context).

2.4 Research on VCP Among Individuals Experiencing BI-Related Concerns

In this section, I will review studies on VCP with individuals experiencing BI-related concerns. Quantitative studies in the field of EDs have examined the effectiveness of VCP, client satisfaction and the therapeutic alliance, consistently reporting high ratings in these areas. Early qualitative and mixed-methods research in the same field suggested that individuals often feel self-conscious when viewing themselves in VCP. More recent studies have focused on the impact of the COVID-19 pandemic on individuals with EDs and their experiences of transitioning to VCP, highlighting the variability in individual experiences. While no studies have specifically addressed BID and VCP, one explored BI disturbance, reporting on two participants who experienced great discomfort with the self-view and speculating on how individuals with BI disturbance might feel being seen in VCP. Lastly, therapists' recommendations for working with clients experiencing BI-related issues have highlighted the importance of exploring the experience of being seen and seeing oneself for individuals with BID.

2.4.1 Effectiveness, Therapeutic Alliance and Client Satisfaction in VCP Among Individuals with Eating Disorders (EDs). Research on VCP for EDs has predominantly been quantitative, focusing on measuring therapy effectiveness, therapeutic alliance and client satisfaction (Abrahamsson et al., 2018; Raykos et al., 2021). Most of these studies have concentrated on a specific therapeutic modality – cognitive-behavioural therapy (CBT) – which tends to use specific, quantifiable outcomes to measure success (e.g. reduction in negative thoughts or behaviours). This focus often misses qualitative aspects of the therapeutic experience, such as the clients' subjective experiences.

Mitchell et al. (2008) conducted a randomised controlled trial in the US with 128 participants to examine the efficacy of CBT for bulimia nervosa delivered via PCP versus VCP. They found no significant differences in outcomes between the two formats regarding the frequency of binge eating and purging at the end of treatment and at 3- and 12-month follow-ups. In a follow-up study, Ertelt et al. (2011) found that patient ratings of TA, as measured by the Working Alliance Inventory (Horvath, 1982; Horvath & Greenberg, 1989), were comparable for PCP and VCP. Authors of other studies exploring smaller, single-group samples in within-subject study designs also reported reductions in ED symptoms in VCP sessions (Abrahamsson et al., 2018; Giel et al., 2015; Hamatani et al., 2019; Simpson et al., 2006) and high client satisfaction (Abrahamsson et al., 2018; Giel et al., 2015; Simpson et al., 2005). For instance, Abrahamsson et al. (2018) conducted a study in Sweden examining the effectiveness of videoconferencing-based CBT for EDs and client satisfaction with this treatment mode, focusing on therapeutic alliance and technological difficulties. They conducted a quantitative study with a small sample size of five participants and found that for four out of the five participants, VCP effectively increased meal frequency and improved ED symptoms, with participants expressing high satisfaction with the treatment mode.

More recently, Raykos et al. (2021) conducted a study in Australia investigating the effectiveness of VCP for treating 25 individuals diagnosed with EDs during the COVID-19 pandemic. The results showed significant improvements in both ED symptoms and mood. Participants gave high ratings to treatment quality and TA, suggesting that VCP is an effective method for delivering therapy for individuals with EDs. While the quantitative studies described in this section have consistently provided evidence for the efficacy (based on outcome measures) and general acceptability of VCP among individuals with EDs, it is essential to go further and explore the nuanced experiences of these individuals when engaging in VCP. This will offer a deeper understanding of what it is like for them to be on video with their therapists.

2.4.2 The Self-View Function in VCP and its Role in Self-Consciousness for individuals

with EDs. Early qualitative and mixed-methods research on VCP among individuals with EDs explored experiences of VCP, providing insight into how these individuals engage with the self-view function. Using a single-case-series design, Simpson et al. (2005) examined client satisfaction with CBT via VCP and the therapeutic alliance with six clients (aged 28-36) diagnosed with bulimia and living in the United Kingdom (UK). Participants rated the therapeutic alliance every three sessions using the Agnew Relationship Measure (Agnew-Davies et al., 1998) and completed a self-developed qualitative questionnaire assessing their satisfaction with VCP, image and sound quality, ability to focus and sense of control over sessions. Additionally, a post-psychotherapy qualitative interview explored participants' experiences with VCP, which were then categorised into advantages and disadvantages. All participants gave medium to high ratings for TA, satisfaction with VCP and sense of control over sessions. Advantages of VCP included an equalised power balance between therapist and client, attributed to each having their own "territory", and an increased sense of control due to the ability to walk out at any time; disadvantages included a fear of being overheard and the screen feeling like a barrier at first. As part of their practical recommendations, Simpson et al. (2005) suggested that VCP might be particularly beneficial for individuals with EDs, especially those who experience high levels of shame and appearance-related self-consciousness and those with a strong need for control during psychotherapy. In qualitative interviews, two participants reported feeling less self-conscious and intimidated in VCP compared to PCP, based on their previous experiences, while three noticed no difference. These observations were made during sessions with the self-view function turned off. However, these conclusions may be misleading as four out of six participants felt more self-conscious when the self-view was activated. This raises questions about the specific aspects of VCP being evaluated – the experience of being seen by the therapist, seeing oneself or both. The authors did not clarify whether sessions began with the self-view function enabled or if this feature was discussed with participants beforehand. Two clients did not report increased self-consciousness, but the reasons for

this discrepancy remain unexplored, such as whether the self-view was consistently deactivated. This suggests that the self-view can significantly affect the VCP experience. However, Simpson et al. (2005) did not thoroughly investigate its role or other factors which have been hypothesised to be linked to self-consciousness, such as the gaze of the other (Mancini & Esposito, 2021). Furthermore, while quantitative data were gathered, no inferential statistical analyses were reported. The study also lacked a thorough analysis of the post-treatment interviews and did not specify the methodology used. These methodological and analytical gaps and a lack of transparency undermine the study's contributions to understanding the role of self-view in VCP for individuals struggling with their BI. In a subsequent study on CBT delivered via videoconferencing for clients with bulimia, Simpson et al. (2006) did provide statistical evidence supporting the effectiveness of VCP; however, they did not explore any other aspects of VCP beyond assessing its effectiveness.

In another study, Simpson and Slowey (2011) piloted the feasibility of schema therapy via videoconferencing for EDs using a single-case design. The study, conducted in the UK, focused on a 39-year-old woman with obesity and co-morbid atypical ED. Through standardised measures, client interviews and tracking of food intake and ED symptoms, client satisfaction and changes across various domains were observed. The video aspect was not a primary focus of the study, but in the post-therapy interview, the participant commented on her experience of seeing herself on camera. Initially, the camera induced self-consciousness and feelings of discomfort; however, these sensations were pivotal in realising that addressing this trigger should be a core part of her therapy. Through experiential therapeutic techniques, she learned to confront body-related concerns and employ positive self-talk before sessions, as introduced by her therapist. Overcoming her fear of self-view was a therapy goal she achieved, meaning she ultimately felt less self-conscious about her body through VCP. This case study illustrates the unique learning opportunities VCP may offer, which are not always available in PCP. However, the study's focus on a highly motivated individual raises questions about its applicability to those less ready to confront their fears. Furthermore, schema therapy's

emphasis on self-compassion and challenging negative thought patterns (Young et al., 2003) might have been particularly suitable for addressing the client's distress, potentially confounding the results by amplifying the observed therapeutic gain. Furthermore, an informal assessment of client perceptions of inpatient group psychotherapy during COVID-19 by Datta et al. (2020), conducted in the UK with 31 participants, reported a case of a patient with anorexia who initially avoided VCP due to self-consciousness about seeing herself on screen. As in Simpson and Slowey's (2011) study, however, this avoidance transformed into an opportunity, allowing the patient to increase her comfort with video exposure. Whilst both the pilot study by Simpson and Slowey (2011) and the informal study by Datta et al. (2020) show that VCP can be particularly beneficial for individuals with BI-related concerns, further research is necessary to explore the depth of individuals' experience with the self-view.

In another informal study conducted during the COVID-19 pandemic, Fernández-Aranda et al. (2020) analysed group chat conversations among eight Spanish anorexia patients and their carers (ages of participants not reported). They suggested that pandemic-related psychological distress acted as a further trigger for ED symptoms, while the chat conversations also highlighted clients' longing for the structure and regular weigh-ins provided by physically co-present treatment. Although the ability or inability to adhere to a treatment protocol does not directly reflect individuals' subjective experience of VCP, the authors suggested that participants experienced heightened awareness of their appearance during VCP, which fostered further self-criticism that was detrimental to their recovery (Fernández-Aranda et al., 2020). This contrasts with findings from Simpson and Slowey (2011) and Datta et al. (2020), who reported that heightened awareness of one's appearance in VCP can benefit recovery, leading to decreased self-consciousness. Given the informal nature of Fernández-Aranda et al.'s (2020) analysis, it is important to consider these findings as preliminary. Once again, more methodologically robust studies are needed to build on and deepen these initial insights.

2.4.3 Experiences of VCP Amongst Individuals with EDs Transitioning to VCP During the COVID-19 Pandemic. Since Fernández-Aranda et al.'s (2020) study, several additional studies have explored the experiences of individuals with EDs who transitioned to VCP during the pandemic. In contrast to earlier work, these more recent studies offer greater methodological rigour through transparent data collection and robust analysis techniques, enhancing the reliability and validity of their findings. The findings highlight significant variability in participants' experiences, underscoring the need for qualitative research to capture the nuanced, individualised nature of these experiences.

Frayn et al. (2021) conducted a comprehensive qualitative study in the US exploring the views of clients with EDs (aged 18+) on transitioning to VCP during the pandemic. Many participants reported VCP as a suitable alternative to PCP, primarily for its convenience. However, the researchers noted varied participant experiences, indicating potential individual or context-dependent attitude differences. Some clients found the less personal nature of VCP beneficial, particularly those who felt that their anxiety or fear of judgement would deter them from participating in PCP. Conversely, other participants preferred the personal interaction offered by PCP, disliking the impersonality of VCP. Frayn et al. (2021) suggested that VCP might particularly benefit more anxious or avoidant clients by providing a less intimidating mode of treatment. However, they emphasised the need for further research to identify who might be best served by VCP. Notably, these authors highlighted concerns regarding increased self-focus and social comparisons due to the ability to see oneself during VCP, although this was not explicitly investigated. The researchers recommended that future studies investigate how this phenomenon – seeing oneself on the screen – is experienced by individuals with BI concerns (Frayn et al., 2021).

Using a mixed-method design, Vuillier et al. (2021) explored the experiences of individuals aged 18+ experiencing EDs adjusting to online psychotherapy, including both telephone and videoconferencing formats, in the UK. The study included 182 participants in total, with qualitative analysis conducted on a subset of responses to provide in-depth insights. A thematic analysis of

participants' experiences showed substantial personal variation. Some individuals described the connection with their therapist as less personal and more detached compared to PCP, leading to reduced engagement (e.g. a reluctance to disclose important information). Other participants were so anxious about online psychotherapy that it deterred them from engaging with this form of support altogether. However, it remains unclear whether the anxiety experienced by participants was related to being seen or seeing themselves in any way. Some individuals experience technology-related stress or technophobia, characterised by discomfort with excessive use and dependence on information and communication technology, as well as concerns about data surveillance (Daruwala, 2020). Thus, the anxiety participants experienced could have stemmed from negative attitudes towards online presence, in addition to or instead of the self-view or being seen (Clark & Green, 2018). The diverse perceptions of VCP – from embracing it to avoiding it – and the unexplained anxiety underscore the need for deeper exploration of individuals' lived experiences, specifically being seen and seeing themselves.

Vuillier et al.'s (2021) findings align with Stewart et al.'s (2021) mixed-methods study, which investigated the experiences of adolescents undergoing online treatment for EDs during the COVID-19 pandemic. Conducted in the UK, Stewart et al. (2021) examined how transitioning to remote therapy, including both videoconferencing and telephone formats, impacted the therapeutic process and client-therapist connection. Some participants reported a disrupted client-therapist connection during remote sessions, describing the therapy as feeling "less real" and struggling to retain session content. Others found online therapy more accessible, citing reduced anxiety and lower levels of commitment compared to PCP, with the absence of travel requirements adding to its overall convenience. Importantly, participants with a pre-existing therapeutic relationship reported feeling safe, heard and connected, suggesting that a strong therapeutic relationship may act as a buffer against feelings of disconnection in remote treatment. It is important to acknowledge that the participants in this study were adolescents; however, broader themes, such as feelings of disconnection and the centrality of the therapeutic relationship, may also be relevant to adults. Nevertheless, the study did not explore

individuals' experiences with the camera – neither being seen nor seeing themselves – leaving this aspect of VCP unexamined.

Building on this focus on adolescent ED treatment, Wolfe et al. (2023) explored a similar context – client experiences of connection within video-based ED care – but in a group therapy setting. Conducted in the US with individuals aged 13 and older, the study examined how clients engaged with and experienced connection in group VCP. Using thematic analysis, the researchers analysed interviews with clients showing that many experienced a strong sense of community due to the accessibility of remote care, the structured therapeutic environment and shared experiences with other clients. The virtual setting often enhanced participation by removing logistical barriers and creating a sense of safety and openness for those who felt hesitant in PCP. Nevertheless, some participants experienced challenges in the form of technological difficulties (such as the video showing up sideways at times) and occasional feelings of disconnection due to the lack of physical presence. The study highlights that for some individuals with BI-related issues, VCP can foster meaningful connections and build a supportive community, whilst others might experience feelings of disconnection. However, as the study's findings reflect the experiences of adolescents in a group therapy setting, their applicability to individual therapy with adults may be limited. Furthermore, while participants occasionally referenced aspects of being seen or seeing oneself – for example, commenting on how technical difficulties altered their image on screen – these experiences were not explored in detail, leaving a gap in understanding how these visual aspects are experienced by individuals with BI-related concerns in VCP.

Expanding beyond adolescent group therapy, Murphy-Morgan et al. (2024) conducted a qualitative study in the UK, exploring the retrospective experiences of individuals aged 18 and older who received ED treatment via VCP during the pandemic. The study, which involved semi-structured interviews with 15 participants, found that the default self-view feature in VCP significantly contributed to self-scrutiny and appearance-related anxiety, particularly among those with pre-existing

BI concerns. While some participants valued the accessibility of remote care, others noted that the lack of physical proximity made it harder to feel connected with their therapists.

Murphy-Morgan et al.'s (2024) study underscores the need for further exploration of how individuals with BID experience seeing themselves during VCP, as its findings suggest that the self-view may cause distress and potentially impact client engagement. While the study acknowledged the role of self-view, it did not examine in depth how clients experienced this feature, leaving this critical area underexplored. Furthermore, it did not consider the experience of being seen by the therapist – another significant aspect of VCP that may hold particular relevance for individuals with BID (Mancini & Esposito, 2021).

In contrast to the studies described in Section 2.4.2, which were often informal and/or lacked methodological rigour (e.g. Fernández-Aranda et al., 2020; Simpson et al., 2005), recent studies have offered more methodologically rigorous insights into clients' experiences with VCP, grounded in the lived experiences of participants rather than informal feedback or researchers' speculations. These studies highlighted the variability in individuals' experiences of VCP and underscored the need for research focused on subjective experiences. However, they did not delve into the nuances of the self-view, despite acknowledging that this aspect of VCP might be problematic for individuals with BID. Furthermore, these studies largely overlooked the significance of the therapist's gaze – a crucial element considering we live in a social world where BID does not exist in isolation (Roth, 2020).

Lastly, apart from Murphy-Morgan et al. (2024), which explored clients' experiences of the pandemic but was conducted post-pandemic, the above-mentioned studies were conducted during a time of global crisis, a unique circumstance that likely influenced participants' experiences and perceptions of VCP. During the pandemic, online therapy was often the only available treatment option, removing clients' typical choice between PCP and VCP. This lack of choice, coupled with the heightened stress and anxiety associated with the pandemic, may have impacted participants' views on

VCP. Anxieties and dissatisfaction reported in these studies might be more related to the lack of alternatives and the general distress of the pandemic context rather than inherent issues with VCP.

Notably, there has been no research specifically examining VCP and BID-related concerns since the pandemic. This could be due to the time it takes for studies to be published, meaning research conducted post-pandemic may not yet have emerged. Alternatively, it might reflect the increasing normalisation of VCP, which has become so widespread that there is less interest in further exploration of this topic.

Additionally, existing studies have primarily focused on adolescents or individuals aged 18 and older, often referred to as emerging adults (Arnett & Mitra, 2020; Wood et al., 2018). While these studies provide valuable insights, there remains a gap in understanding how adults (individuals aged 25 and older) experience VCP, as BI concerns can persist or evolve across an individual's life. In the present study, I focus specifically on adults living with BID, exploring how they experience being seen and seeing themselves in VCP in a post-pandemic context. Although participants were asked to reflect on their VCP experiences from up to two years ago – meaning some may have experienced VCP during COVID-19 – they did so in a post-pandemic era when therapy options were available.

2.4.4 Research on VCP Among Individuals with BI Disturbance. As the only study on BI disturbance and VCP, Grignoli et al. (2021) explored the therapeutic alliance between psychotherapists and patients in a psychiatric setting in Switzerland, presenting two clinical vignettes of patients experiencing disturbed BI. The vignettes showed that the videoconferencing technology did not seem to hinder the therapeutic alliance; however, participants experienced distress due to the presence of the camera. Initially offered telephone sessions, patients were given the option to switch to VCP. One patient, a 38-year old woman who struggled with obesity and a sense of shame, immediately declined VCP, citing discomfort with confronting her own image due to the self-view feature and opting to continue with telephone sessions. This finding aligns with Vuillier et al.'s (2021) study where some

participants also declined VCP as it was too anxiety-provoking. However, it is unclear in that study what the anxiety pertained to and whether it was related to the self-view or not.

The other patient in Grignoli et al. (2021), a 54-year-old woman struggling with binge eating and weight gain following corticosteroid use, initially accepted VCP but experienced discomfort during the first session, described as overwhelming and akin to a panic attack, leading to the cessation of VCP in favour of telephone sessions. These cases suggest that the visibility inherent in VCP can provoke severe distress in individuals experiencing BI-related concerns, impacting their preference for and engagement with the medium. Grignoli et al. (2021) hypothesised that the mirror feature in VCP can lead to disorientation and impact the quality of relational contact by affecting natural facial expressions, potentially pushing psychotherapy into a “pretend mode”, where clients lose connection with their bodily experiences. They also mentioned that seeing the therapist’s face might evoke associations with news reporting or police interrogations, making clients feel more scrutinised. Grignoli et al. (2021) underscored the importance of researching not only clients’ experiences of seeing themselves in the self-view but also the impact of being seen by the therapist during VCP, which is inherently different from PCP and could affect clients’ comfort and engagement. However, the study seems to rely heavily on the researchers’ opinions and theoretical frameworks instead of the patients’ lived experiences. Therefore, further research in this context is warranted to better understand these intricate dynamics.

2.4.5 Therapists’ Experiences of VCP with Clients Experiencing Eating Difficulties. The literature discussed thus far has primarily focused on clients’ perspectives of VCP; however, there is also literature focusing on therapists’ observations of clients’ behaviours and engagement in VCP. Examining therapists’ experiences can offer valuable insights into the challenges and opportunities that arise when working with clients experiencing BI-related concerns. While these insights do not replace clients’ direct accounts, they contribute to a broader understanding of the complexities involved in delivering VCP for individuals with BI-related difficulties. Much of the literature examines working

with eating difficulties in general, often without specifying the age of clients. Where age information is provided, I have included it to offer a clearer context for the findings.

Reflecting on her experience of delivering VCP to individuals with EDs and their families during COVID-19, a UK-based psychoanalytic therapist Ben-Salmon (2021) argued that therapists, who are traditionally introspective during sessions to benefit the therapeutic process, suddenly found themselves confronted with their own image, just as the client saw them. This new dynamic made them conscious of their appearance, facial expressions and how they presented themselves while speaking, which might have impacted the therapeutic process. She further suggested that the ability to adjust visibility, turn off the camera or end the entire call at any point are unique characteristics of VCP that provide clients with an increased sense of control over their visible body parts, which could initiate discussions about BI. These observations align with those of Simpson et al. (2005), who found that some clients felt increased control in VCP due to the ability to end the session easily, and Simpson and Slowey (2011), who showed that initial discomfort with the self-view could be translated into therapeutic benefits. Overall, Ben-Salmon's (2021) observations highlight the importance of thoroughly exploring clients' experiences of being seen (as she suggests that clients might feel more in control over their bodies) and seeing themselves (as this could lead to therapeutic opportunities).

Murphy et al. (2020) provided clinical guidance in the UK for delivering online CBT amidst the pandemic. They suggested that clients with EDs may find seeing themselves on camera leads to an increased focus on their appearance and in-session body checking, which could be distracting. However, therapists could recommend that clients turn off the self-view while remaining visible to the therapist. Simultaneously, the camera's presence allows clients to build tolerance for their self-image and practice avoiding unhelpful body-checking behaviours, such as scrutinising certain body parts. Murphy et al. (2020) proposed that therapists encourage clients to gradually become accustomed to viewing themselves on video through experiments, such as shifting their focus to different video elements (e.g. the background or a neutral body part such as the hair or hands). Thus, while other

forms of online psychotherapy exist (e.g. therapy via mobile apps), VCP could be uniquely beneficial for individuals with BI-related concerns due to its therapeutic opportunities. However, whether there is an entirely “neutral” body part is questionable. For example, hair can have significant cultural importance for Black clients and may be the subject of challenging narratives and white-centred conventions (Byrd & Tharps, 2014; Tate, 2007).

Similarly, as part of their advice to clinicians supporting individuals via online ED treatment, Waller et al. (2020) in the UK highlighted the critical role of therapist-client collaboration in VCP, advocating for adjustments to the therapeutic approach based on clients’ comfort levels, including starting sessions with audio-only if the presence of the camera causes discomfort. Furthermore, providing recommendations for enhancing VCP for individuals diagnosed with EDs across various ages, Cook-Cottone et al. (2024) in the US suggested that telehealth could reduce the tendency for clients to engage in unhelpful comparisons with their therapists since interactions are limited to seeing only their therapist’s face (not their whole body). This could help clients stay more focused and engaged during their sessions.

Shaw (2020), a psychodynamic psychotherapist working in a specialist ED service in the UK, reflected on her experiences of delivering online art group psychotherapy for adolescents with anorexia. She shared client feedback and her reflections and identified key themes from her work, including an intensified experience of gaze, BI concerns and a desire for control over what was seen (e.g. by turning the camera off or angling it to reduce visibility). Shaw (2020) noted that being online may evoke associations with social media for adolescents, heightening awareness of their appearance on camera and the “lens” through which others view them. However, these dynamics might not fully apply to adults, who may have different relationships with social media and BI concerns than adolescents.

The above literature on therapists’ experiences suggests that clients may require support and time to adjust to the video and online context; however, how well these strategies work in practice and

how clients respond to them remains unclear. Findings also point to the potential of VCP to benefit therapeutic work and address issues directly, although therapists' assumptions about VCP could be misguided. Overall, this literature highlights the importance of exploring the dynamics of being seen and seeing oneself among individuals with BID. Therefore, in the current study, I will examine clients' experiences of these aspects to help CoPs adapt and enhance VCP for this client group. Research from clients' perspectives is crucial, as clients' preferences significantly shape the therapeutic process, enhancing engagement and fostering more meaningful experiences (Cooper & McLeod, 2011; Swift et al., 2018).

2.5 Summary of Literature Review, Research Question and Study Aims

In the context of aesthetic medicine, Cristel et al. (2020), Pikoos et al. (2021) and Pfund et al. (2020) linked the use of videoconferencing to appearance dissatisfaction, coining the term “Zoom dysmorphia” to describe individuals viewing themselves negatively due to increased exposure to their own image on Zoom. While this research underscores the importance of investigating the experiences of those living with BID and engaging in videoconferencing, it has not explored the relationship between videoconferencing and appearance satisfaction in a therapeutic context. It has also tended to depict individuals as passive entities influenced by technology, overlooking the extensive autonomy and choice individuals possess in their online interactions, including being seen (e.g. due to the ability to only show certain body parts) and seeing oneself (e.g. being able to turn the camera off). This indicates the need for a phenomenological approach, which is well-suited to exploring the subjective, lived experiences of individuals as they navigate the dual experience of being seen by the therapist and seeing themselves.

Existing quantitative research on VCP and BI-related concerns from the field of EDs has focused on therapy effectiveness, client satisfaction and the therapeutic alliance. These studies have shown that clients are satisfied with VCP and rate the therapeutic alliance highly (e.g. Abrahamsson et al., 2018; Raykos et al., 2021). Furthermore, no significant differences in efficacy have been found

between VCP and PCP (Mitchell et al., 2008). However, due to their quantitative nature, these studies reduce complex concepts to measurable outputs and outcomes, leaving the intricacies of individuals' experiences and perceptions unexplored.

Early qualitative and mixed-methods studies in this field (e.g. Fernández-Aranda et al., 2020; Simpson et al., 2005; Simpson & Slowey, 2011) offered insights into individuals' experiences of VCP, highlighting that seeing oneself on the screen might lead to self-consciousness and discomfort. Despite these insights, they did not fully capture the complexity of individuals' experiences due to their informal nature or lack of methodological rigour. More recent studies with greater methodological rigour have emerged (e.g. Frayn et al., 2021; Murphy-Morgan et al., 2024; Vuillier et al., 2021); however, they focus on the overall experiences of VCP in the context of the COVID-19 pandemic and do not explore the self-view. As discussed in Chapter 1, individuals with BID tend to have a challenging relationship with their reflection, making the self-view in VCP a crucial aspect of their experience that demands careful exploration. Moreover, none of the existing studies from the field of EDs explore individuals' experiences of being seen by their therapist in VCP, an important area to investigate as the therapist's face appears more proximal than in PCP and the camera focuses on specific parts of the client's body (face and upper body).

Phenomenological research on BID has highlighted the importance of the gaze of the other due to intensified concern over appearance (Mancini & Esposito, 2021). As the only study on BI disturbance and VCP, Grignoli et al. (2021) speculated that seeing the therapist's face might evoke associations with news reporting or police interrogations; however, they did not investigate this aspect of VCP.

Furthermore, existing studies have primarily examined adolescents or individuals aged 18 and older, often categorised as emerging adults (Arnett & Mitra, 2020; Wood et al., 2018). Research suggests that emerging adults may have qualitatively different experiences of BID compared to older adults (Potterton et al., 2020; Keel, 2017), which could influence how they engage with VCP.

Therefore, to ensure greater sample homogeneity and address this research gap, this study focuses specifically on adults aged 25 and older, capturing their nuanced experiences of seeing themselves and being seen in VCP.

Lastly, literature on therapists' experiences of working online with individuals experiencing BID (e.g. Shaw, 2020) has offered indirect insights into clients' experiences of VCP, primarily through second-hand information. Although this literature is limited to informal feedback and reflections rather than formal research methods, it underscores the significance of examining both the experience of seeing oneself and being seen by the therapist in VCP, suggesting that both elements play a crucial role in shaping the therapeutic process.

The literature review has highlighted the need for a nuanced exploration of how individuals with BID experience being seen and seeing themselves in VCP. The current study seeks to capture the texture and meaning of clients' experiences in this context, aiming to build on insights from existing literature, provide guidance for CoPs working with individuals experiencing BID and identify potential improvements for enhancing client experiences. This inquiry is grounded in key principles of CoP, including relationality (being-in-the-world-with-others) and pluralism (a commitment to active engagement with difference). Reflecting on the reviewed literature, I have formulated the research question as follows:

How do individuals with BID experience being seen and seeing themselves in VCP?

Chapter 3: Methodology

3.1 Design

I employed a qualitative methodology for this study, using online, semi-structured interviews to obtain data from a small and homogenous sample. The data were analysed using interpretative phenomenological analysis (IPA).

3.2 Rationale for Adopting a Qualitative Research Paradigm

Both qualitative and quantitative designs serve as empirical means of collecting, analysing and interpreting data (Ponterotto, 2005). Quantitative studies tend to measure and analyse causal or correlational relationships among variables (Ponterotto, 2005), while qualitative studies focus on exploring meanings, understanding experiences and generating theories (Willig, 2013). In the present study, I sought to explore what it is like for individuals experiencing BID to be seen and see themselves in VCP. As such, I was interested in individuals' subjective experiences and the meanings they attach to those experiences. In line with the research aim and literature review, which showed a need for further qualitative studies to deepen our understanding of BID and VCP, a qualitative design was deemed most appropriate. Furthermore, the aim was to gather idiographic rather than nomothetic data, making an in-depth, qualitative approach particularly suitable for this research.

3.3 Rationale for Adopting Interpretative Phenomenological Analysis (IPA)

As discussed in Chapter 2, while existing qualitative studies have offered some insights into how individuals with BI-related concerns experience VCP, they have not fully captured the complexities of being seen or seeing oneself in this context, despite acknowledging the need for this focus. IPA (Smith et al., 2022) is ideally suited to answering the current study's research question about the experiences of being seen/seeing oneself among individuals with BID due to its concern with an in-depth exploration of experiences of particular individuals in a particular context and the meanings they attach to these experiences.

Other methodologies might answer different kinds of questions. For example, grounded theory (GT; Glaser & Strauss, 1967) is a useful approach for building theories about the social processes and interactions that lead to particular phenomena. If the research question were, “What social dynamics shape how individuals with BID engage with VCP?”, GT might be a good fit. However, GT is less concerned with the personal meanings and subjective experiences of individuals, focusing instead on identifying broader processes (Glaser & Strauss, 1967), which makes it less suitable for the current study’s goal of deeply exploring how participants make sense of their individual experiences.

Discourse analysis (DA; Potter & Wetherell, 1987) is useful for research questions focused on how language is used to construct, negotiate and maintain social interactions and identities. If the research question were, “How do individuals with BID construct and communicate their sense of self during VCP?”, DA might be an appropriate methodology. However, as DA focuses on language as a medium for social interaction (Potter & Wetherell, 1987) rather than exploring the subjective experiences behind these interactions, it is less suitable than IPA for understanding how individuals experience being seen and seeing themselves in VCP.

Descriptive phenomenology (DP; Giorgi, 2009) could also be used to explore the experiences of individuals with BID in VCP by capturing the essence of these experiences. However, DP focuses on describing experiences without interpreting them in the context of each participant’s unique circumstances (Giorgi, 2009). As discussed in Chapter 2, BID and VCP experiences are deeply subjective, requiring a context-sensitive approach, which the current literature lacks. IPA offers this by not simply describing the phenomenon but also interpreting it within the specific context of the individual experiencing it. It goes beyond defining the “whatness” of a phenomenon to explore how it affects individuals’ relationships, experiences of their bodies and interactions with the world around them (Matua & van der Wal, 2015).

While GT, DA and DP are useful in their respective areas, they lack IPA’s ability to explore the subjective and meaning-making aspects of personal lived experiences. IPA is uniquely suited to

this study's research question, which seeks to understand how individuals with BID experience and make sense of being seen and seeing themselves in VCP. IPA resonates well with the core values of CoP, which prioritise the exploration of subjective lived experiences, personal meanings and the complexity of human interactions (Woolfe, 2016).

3.4 IPA and CoP

In the UK, the field of CoP emerged from the collective efforts of psychologists influenced by psychotherapy and the humanistic principles of phenomenology, uniqueness, difference and meaning-making (Donati, 2016; Henton & Kasket, 2017). These humanistic values have remained central to the profession, as exemplified by the British Psychological Society's (BPS) portrayal of CoP as a discipline that engages profoundly with individuals' unique subjective psychological experiences (BPS, n.d.). The foundational ethos of CoP underscores its symbiotic relationship with IPA, as both prioritise understanding and valuing the rich tapestry of personal experiences and perspectives. Further reinforcing this connection, the Standards for the Accreditation of Doctoral Programmes in Counselling Psychology, outlined by the BPS (2019), resonate closely with the core principles of IPA, emphasising the distinctive nature of CoP as a discipline that integrates phenomenological inquiry into both its practice and research. By prioritising individuals' subjective and intersubjective experiences, these standards affirm the importance of first-person narratives and advocate for a respectful engagement with diverse worldviews without privileging any single perspective. CoP's approach is fundamentally relational and reflexive, focusing on the co-construction of knowledge through a shared therapeutic process (BPS, 2019). This reflects a bottom-up methodology for understanding psychological phenomena, closely aligning with IPA's commitment to "explore experience in its own terms" (Smith et al., 2022, p. 1) rather than imposing predefined theoretical frameworks. This alignment underscores the mutual emphasis on capturing the richness of human experience, making both CoP and IPA well-suited for a nuanced and empathetic exploration of psychological phenomena.

3.5 Overview of IPA

IPA (Smith, 1996) is a qualitative methodology focused on exploring and understanding the lived experiences of individuals concerning specific phenomena. Since its inception, IPA has been widely adopted across various domains of applied psychology, including health (e.g. Volpato et al., 2018), clinical (Charlemagne-Odle et al., 2014) and counselling psychology (e.g. Rizq & Target, 2008), as well as in other social and health sciences such as nursing (e.g. Eatough & Shaw, 2019) and, more recently, in disciplines such as education (e.g. van Scoy & Even, 2020), fashion (e.g. Carr & Mercer, 2017) and film studies (e.g. Rowlands & Handy, 2012). This broad applicability underscores IPA's versatility and ability to provide rich, nuanced understandings of individual experiences across diverse contexts.

IPA is rooted in three primary theoretical underpinnings: phenomenology, which focuses on exploring lived experiences; hermeneutics, the theory of interpretation; and idiography, which emphasises the detailed examination of individual cases (Smith et al., 2022). The essence of IPA lies in its proponents' dedication to understanding personal, lived experiences, the significance these experiences hold for participants and the process by which individuals construct meaning from their experiences. IPA researchers champion the notion that people are inherent meaning-makers, engaging with and interpreting their worlds in deeply personal ways. As stated earlier, the objective of IPA is to explore participants' lived experiences without fitting them into pre-existing categories or theories. This allows researchers to capture the depth of their experiences from their own perspectives (Smith et al., 2022).

3.6 IPA's Theoretical Underpinnings

In this section, I will explain IPA's epistemological and ontological standpoint and delve into IPA's three main theoretical concepts: phenomenology, hermeneutics and idiography.

3.6.1 IPA's Epistemological and Ontological Standpoint. The discourse around IPA's epistemological stance is complex, with various scholars referring to paradigms such as contextualism

(Madill et al., 2000) and critical realism (Leonard & Willig, 2021). However, none of these paradigms captures IPA's epistemological stance as fully and directly as hermeneutic phenomenology. Specifically, while contextualism aligns with IPA's aim to understand a "person-in-context" (Larkin et al., 2006, p. 106), it omits other aspects of IPA, such as its phenomenological focus on lived experiences. Critical realism (Bhaskar, 1978) shares with IPA an interest in understanding the subjective interpretation of an objective reality but involves a more nuanced commitment to understanding the deep or hidden structures that underpin the social world (Larkin, 2022). In contrast, the present study does not necessarily delve into these deep mechanisms but instead focuses on how individuals experience and interpret their realities.

Situating IPA within the framework of interpretative phenomenology best explains the focus of the current study and how it applies IPA's philosophical foundations in practice (Larkin, 2022). Specifically, my focus on participants' experiences of being seen and seeing themselves in VCP aligns with the core phenomenological principle of investigating how individuals experience phenomena in their everyday lives, and the way I achieve this is by making sense of their sense-making and using the hermeneutic circle to bridle my assumptions (see Section 3.6.4 for more details on the hermeneutic circle; Smith et al., 2022).

Ontologically speaking, IPA is "broadly realist" (Reid et al., 2005, p. 21): it assumes that there is a real world that exists independently of our perceptions and that, as researchers, we engage with real-world problems and phenomena by exploring how individuals make sense of their experiences. This belief is crucial because there would be no purpose for data collection or analysis without accepting the existence of a real or subjectively real world (Larkin, 2022). Specifically, exploring individuals' experiences of VCP presupposes a real world where these experiences unfold, and understanding someone's feelings about VCP indicates a tangible context for these feelings.

3.6.2 Phenomenology. Phenomenology is a philosophical approach concerned with the study of human experience (Langdridge, 2007). IPA connects with the key values of phenomenology

through its interest in lived experience in its own terms, which can be understood by examining the meanings that individuals attribute to their experiences (Cassidy et al., 2011).

Inaugurated by Husserl in the early 20th century as a new approach to philosophical inquiry, phenomenology refers to a body of work from several thinkers as well as Husserl, namely Heidegger, Merleau-Ponty and Sartre. The inherent value of phenomenological philosophy for IPA resides in its capacity to offer various ideas about exploring and understanding lived experience (Smith et al., 2022).

Husserl (1900/2001) defined phenomenology as the study of the essence of conscious experience. He aimed to understand a phenomenon's essential qualities by engaging with it directly, prior to interpretation – “going back to the things themselves” (p. 168). The approach requires stripping away (or “bracketing”) one's preconceptions and biases to reveal the essence of a phenomenon, transcending personal and contextual dimensions. Husserl argued that through various reductions, a phenomenon could be described in its purest form, free from pre-existing categories or assumptions, revealing universal characteristics applicable to various individuals' experiences.

In contrast to Husserl's phenomenology, IPA researchers do not adhere to a priori bracketing as a vital procedural step that can be conclusively completed. Instead, they recognise that an understanding of preconceptions develops throughout the research process, making bracketing in IPA a cyclical process rather than a single procedural step (Larkin, 2020; Motta & Larkin, 2023; see Section 3.6.3 below). Furthermore, while Husserl considered it important to progress from individual experiences to discover the essence of experience for all individuals, IPA takes a more modest approach. It focuses on capturing specific experiences as they are subjectively lived and described, thus operating at an earlier stage than Husserl's vision of an “ambitious program for phenomenology” (Smith et al., 2022, p. 33).

This focus on the particular aligns with Heideggerian phenomenology, which informs IPA's approach to experiential research. Heidegger (1927/1962) emphasised that individuals are “thrown” into a pre-existing world of objects, language, culture and history. This perspective resonates with

IPA's view of individuals as deeply embedded in a complex web of objects, relationships, language, culture, projects and concerns (Smith et al., 2022). Heidegger (1927/1962) argued that transcending the personal and conceptual is impossible. Consequently, his phenomenological inquiry placed a central emphasis on interpreting the process of meaning-making (Larkin et al., 2006). In agreement with this, IPA researchers adopt a more interpretative and worldly position, moving away from Husserl's descriptive and transcendental phenomenology.

Heidegger introduced the concept of "Dasein", translated as "being-in-the-world" (Spinelli, 2005, p. 107), to emphasise the interconnected relationship between individuals and the world around them. This challenges the Cartesian separation of person/world and subject/object, offering a more holistic understanding of human existence (Eatough & Smith, 2017). Building on this, Kasket (2003) referred to the concept of "being-in-the-world-with-others-via-the-Internet" (p. 64) to illustrate how online experiences have become a key part of how we perceive ourselves and connect with people around us.

As shown in Chapter 1, Merleau-Ponty's (1945/2005) phenomenology emphasised the role of the body in shaping our understanding of the world. He argued that perception is deeply rooted in our bodily engagement with our environment, highlighting the distinction between the subjective body, experienced pre-reflectively, and the objective body, which is observed and analysed externally. This dual nature underscores how our bodies are both personal and subject to external observation (Smith et al., 2022). Merleau-Ponty's (1945/2005) focus on embodiment within phenomenology is particularly relevant to the current study. Although he was writing before the invention of computers and videoconferencing, his work on embodiment can be extended to VCP, where individuals have an internal experience of seeing themselves while also being aware of how others might see them.

3.6.3 Hermeneutics. Hermeneutics is the theory of interpretation (Cassidy et al., 2011). It originated as a guide to interpreting Biblical texts and meets with phenomenology through the work of hermeneutic phenomenologists, the most relevant ones to IPA being Schleiermacher, Heidegger and

Gadamer. It is concerned with the process of interpreting texts, our ability to understand an author's initial intentions and how the context of a text's creation influences its later interpretation (Smith, 2007; Smith et al., 2022). In IPA, interpretation is a dual process known as the "double-hermeneutic". Participants actively strive to make sense of their experiences while the analyst works to interpret this sense-making. Double hermeneutics is rooted in the idea that individuals actively interpret rather than passively experience events (Smith & Nizza, 2021).

According to Schleiermacher (1838/1998), interpretation involves both grammatical (i.e. objective textual meaning) and psychological (i.e. the author's intentions) elements. This is relevant to the present study because when I analysed the data, I accepted that phenomena are lived within a shared context but uniquely experienced by each person. According to Schleiermacher (1998), a thorough analysis (i.e. an analysis based on both grammatical and psychological interpretation) gives rise to meaning beyond the explicit statements made by an individual. This suggests that the researcher might offer a perspective on the text that the participants themselves cannot, because they are too immersed in their own experience. In IPA, this process involves a detailed and systematic analysis of the text, where the researcher identifies connections within the larger data set and engages in a dialogue with relevant theories to develop a nuanced understanding (Smith et al., 2022).

Heidegger (1927/1962) observed that the word "phenomenology" consists of two Greek words: "phenomenon" and "logos". Phenomenon means "appear(ing)" or "show(ing)" (Smith et al., 2022). He argued that appearance has a dual quality – that things have visible meanings (which may or may not be deceptive) but also concealed meanings. Hence, for Heidegger, phenomenology is concerned with understanding the thing that is latent or disguised, as it is brought to life, but also the visible thing as it appears on the surface, as this is linked to the deeper latent form (Smith et al., 2022).

In the present study, cues on the surface of the transcripts guided me to specific sections, and by engaging reflectively with those sections, I was able to identify and interpret deeper meanings that were not immediately apparent. This focus on drawing out hidden meanings contrasts with Husserl's

approach, which emphasises the direct description of experiences as they present themselves to consciousness, with the aim to capture their essential qualities without delving into concealed meanings (Smith et al., 2022).

Unlike the phenomenon, which is more perceptual, logos is more analytical and can be translated as “discourse”, “reason” or “judgement”. This makes phenomenology a hermeneutic process as it helps the analyst interpret and understand the appearing. The primary aim of IPA is to examine the text as it shows itself (the spontaneous appearing). However, it is the analytical thinking connected to the logos aspect that helps draw out the appearing data and make sense of it. Thus, in line with Heidegger, one cannot do the “P” without the “I” in IPA; one cannot bring the phenomenon forth without analytical work (Smith et al., 2022).

Heidegger (1927/1962) introduced the idea of fore-understandings (or preconceptions), which connects to reflexivity as it relates to how the researcher is implicated in the research process. Researchers inevitably bring their fore-understandings and view the phenomenon through these lenses. Heidegger (1927/1962) encouraged “working out the fore-structures in terms of the things themselves” (p. 195) rather than the other way around. This means privileging the phenomenon (the data) and using that to understand our fore-understandings, as these may not become apparent until we have engaged with the analytic process. This challenges the idea that researchers can fully articulate all their assumptions at the outset. While my fore-understandings preceded my encounter with the study’s data, I only began to understand these through engaging with the data itself. According to Smith et al. (2022), Heidegger’s association of interpretative work with fore-understandings necessitates re-evaluating the bracketing process as a dynamic, circular process that can only be partially achieved. Following this, I prioritised the data rather than attempting to bracket my preconceptions in the traditional sense.

Gadamer (1990) also suggested that researchers may only fully grasp their preconceptions once interpretation begins but proposed a more dynamic interaction. He suggested that our understanding of

a phenomenon shapes and is shaped by fore-understandings in a bidirectional process, whereby fore-understandings are continually revised in light of new interpretations of the phenomenon. As meaning is made through interpretative efforts, these fore-understandings are adjusted, prompting new questions of the text, leading to further meaning-making (Cassidy et al., 2011). In this research, such interpretative work necessitated a constant openness and adaptability in the interpretative approach, ensuring that analysis remained reflective and responsive to evolving insights gained through engagement with the data (Smith et al., 2022).

Gadamer (1990) doubted Schleiermacher's argument that an interpreter could understand the author better than the author understands himself/herself; he argued for focusing on the meaning of a text rather than the author's intention. He also doubted the feasibility of recreating the author's original intent due to the historical gap, suggesting instead that we should learn anew from the text in the context of the present rather than attempting to relive the past. His perspective is relevant for historical texts; however, Schleiermacher's holistic approach to interpretation aligns more closely with IPA, which seeks to interpret texts produced in contemporary contexts (Smith, 2007). In IPA, interpretation involves a thorough analysis of the text and its context, allowing the researcher to understand the participant's experiences in their current reality (Smith et al., 2022).

3.6.4 The Hermeneutic Circle. The hermeneutic circle is based on the principle that understanding a phenomenon involves a continuous movement between the parts and the whole at various levels. For example, understanding a single word requires considering the sentence it is part of and vice versa, reflecting the iterative process of interpretation. This process necessitates an openness to shifting interpretations of what the data might signify (Cassidy et al., 2011). Therefore, while traditionally outlined in a series of methodological steps (initial reading, exploratory noting and so on), IPA involves a continual back-and-forth analysis (Smith et al., 2022).

In this study, I used the hermeneutic circle to manage my preconceptions, where the whole represented my ongoing biography and the part was the encounter with the participant. Dahlberg

(2006) referred to the reflexive engagement with fore-understandings as “bridling”, a concept that I found better suited to this research than Husserlian (1900/2001) “bracketing”. While bracketing suggests suspending one’s preconceptions entirely to access a phenomenon in its purest form, bridling acknowledges that this is neither possible nor necessarily desirable. Instead, it involves restraining and critically engaging with preconceptions throughout the research process, maintaining openness to the phenomenon as it unfolds.

Rather than attempting to eliminate my fore-understandings, I remained aware of them but deliberately focused on my participants’ accounts, ensuring that their experiences, rather than my assumptions, guided my interpretations. Bridling enabled me to actively work with my preconceptions as part of a continuous process of revising and refining initial assumptions within the hermeneutic circle. As I deepened my understanding of my fore-understandings, I related them to my developing interpretations, constantly re-examining and integrating them into more nuanced and constructive insights. In line with Smith et al. (2022), the interpretive process became a composite of my participants’ narratives and my evolving understandings, informed by both pre-existing and newly uncovered biases, as well as professional and theoretical knowledge. This ongoing engagement with both the data and my fore-understandings, facilitated by bridling, allowed me to flexibly integrate these insights, enriching the depth and nuance of the analysis (Smith et al., 2022).

3.6.5 Idiography. Idiography is concerned with the particular; that is, the unique experiences of specific individuals and the context in which those experiences took place (Smith et al., 2022). As demonstrated in Section 3.15 below, IPA entails a thorough, systematic analysis of a single case before moving on to the next. Findings from the first case are set aside as much as possible through bridling to remain sensitive to each individual’s unique story (Cassidy et al., 2011). Finally, the researcher conducts a cross-case analysis. At this final analytical stage, the researcher tries to stay faithful to the individual by capturing the particular lifeworlds of the participants who have shared their experiences whilst demonstrating how the particular illuminates (and is illuminated by) characteristics of the

lifeworld we all share (Eatough & Shaw, 2019). The result of this process is a picture based on the general as well as the unique experiences of individuals (Cassidy et al., 2011).

3.7 Participants

In line with IPA's commitment to idiography, data were collected from a small, homogeneous sample (Smith & Osborn, 2008). IPA typically follows the "less is more" principle (Hefferon & Gil-Rodriguez, 2011; Reid et al., 2005) and although Smith et al. (2022) recommend that sample size be judged on a case-by-case basis, they suggest six to ten participants for doctoral research. As such, I aimed to recruit a minimum of six and a maximum of ten individuals who self-identified as experiencing BID. Existing literature on BI-related concerns and VCP has primarily focused on EDs; however, BID is not limited to individuals with EDs or other diagnoses related to BI, such as BDD. Therefore, the inclusion and exclusion criteria were not restricted to medical diagnoses, ensuring that the study captured the experiences of individuals with BID regardless of diagnostic status.

Further inclusion criteria were proficiency in English, being based in the UK, age 25 or older, experience with VCP within the last two years (recent enough to recall the experience) and access to Microsoft Teams for interviews. I did not specify the number of VCP sessions required, as the literature review indicated that VCP can be anxiety-provoking for some, which might limit them to just one or even half a session. Specifying session length could have excluded valuable experiences. Ultimately, seven participants were recruited.

These above criteria were chosen to ensure homogeneity, which is crucial for IPA's aim of exploring how a particular group experiences a specific phenomenon. While BID can be understood as a broad or even normative issue, the study's focus on BID within the context of VCP ensured a sufficient degree of homogeneity for meaningful analysis. Maintaining homogeneity in the areas specified above allowed for a focused analysis of how individuals with BID experience being seen and seeing themselves in VCP, leading to the identification of both convergence and divergence specifically related to the phenomenon of interest, rather than extraneous factors. Demographic

characteristics such as gender were not deemed essential for homogeneity in this context. The participant pool consisted of five women and two men.

During the analysis process, I deliberated whether to include one participant's data due to their lack of English proficiency. Although the participant claimed proficiency and initial email exchanges suggested no issues, I struggled to understand parts of the interview, often needing clarification. This difficulty became more apparent during the analysis, where I could not achieve the same level of linguistic analysis as with other participants. Ultimately, I included the data because the transcript contained valuable analytical insights. Moreover, excluding the data felt ethically questionable, given the participant's investment of time (see Section 5.9 for further reflection).

Participants were encouraged to consider their well-being when considering participation, as outlined in the Information Sheet (see Appendix C), and to get in touch if they were uncertain about participating (see Appendix D for a list of questions I might have asked in such cases). In this way, I aimed to ensure a balance between protecting participants and respecting their agency and capacity to make decisions for themselves (BPS, 2021a). There were no other exclusion criteria in this study. To assess eligibility, the criteria were included in the recruitment materials (Appendices A-B) and the Information Sheet (Appendix C). Participants had to confirm that they met these criteria in the Participant Consent Form (Appendix E). Participation was entirely voluntary.

3.8 Recruitment

Participants were recruited on a first-come, first-served basis, provided they met the criteria. The initial recruitment strategy involved contacting charity organisations working with individuals experiencing BID, primarily focusing on the Body Dysmorphic Disorder Foundation (BDDF).

I had detailed conversations with a representative from the BDDF, during which I explained my role as a trainee CoP, outlined the purpose and aims of my research and described the recruitment and data collection processes. I assured them that the organisation's involvement would be limited to assisting with recruitment and made it clear that participants would be informed the BDDF was not

directly involved in the research itself. This ensured transparency and maintained the distinction between the organisation's role and the research process. Preliminary contact with the BDDF was promising, as the organisation expressed interest in supporting my research and had a history of assisting DPsych students. However, I managed to recruit only three participants. Consequently, I implemented a contingency plan to recruit via social media, specifically Facebook and Twitter. For ethical reasons, I aimed to set up separate research accounts rather than using my personal accounts to protect my privacy and professional integrity. Using a personal account could expose my personal information (e.g. photos and status updates) to potential participants. Additionally, participants could have been traced back to me, risking their anonymity (Kamp, 2019). However, I encountered issues setting up a dedicated Facebook account for the research because my phone number was already linked to my personal Facebook profile; using my university email did not resolve the issue. As a result, I pivoted to Twitter, where I do not have a personal account. I created a research-specific Twitter account to advertise the study, tagging BI-related organisations and using relevant hashtags to reach a broader audience. This strategy yielded two participants, but I still required more to meet my target. I contacted the BDDF again, requesting them to re-post my flyer with a note indicating that I needed two more participants. This final effort was successful, resulting in a total of seven participants for the study.

During the recruitment process, I initially received a high level of interest; however, a large number of potential participants declined to take part once I confirmed that no compensation would be provided. Following this, a BDDF representative suggested that offering remuneration might increase participation. Compensation is often advocated as a way to acknowledge participants' time and contributions (Grady, 2001). However, I also recognised potential ethical concerns, including the risk of participants engaging for financial gain rather than genuine interest or falsifying eligibility to qualify for compensation. I reflected on these considerations in supervision and decided against

offering remuneration to ensure voluntary participation and maintain consistency with the participants already recruited without compensation.

When recruiting through external organisations or charities, it is essential to consider their role as gatekeepers (Singh & Wassenaar, 2016). Potential participants were asked to contact me directly rather than via the organisation that advertised the study. It was also made clear to them that the organisation was not directly involved in the research, so any liability lay with me, and that in no way was the quality of service delivered by the charity affected by their participation or non-participation.

There are also ethical considerations when recruiting through social media, such as participants feeling forced to participate due to repeated recruitment messages or invitations from personal connections, privacy issues and over-recruitment (Gelinis et al., 2017). In the present study, I employed a passive recruitment strategy, which involved minimal risk since participants actively chose to participate. This passive recruitment involved the distribution of recruitment materials online (e.g. via posts and adverts; see Appendices A-B), aiming to attract volunteers to contact me for more information about participating. Privacy and researcher transparency were of particular importance (Gelinis et al., 2017), given the ease of access to personal information online. According to BPS's Ethics Guidelines for Internet-Mediated Research (2021b), specific consideration must be given to the public/private distinction to ensure the respect of participants' autonomy, privacy and dignity. On Twitter, individuals might expect to interact within a broader public domain. However, it was still crucial to ensure that the recruitment posts clearly indicated my identity as a trainee CoP and my purpose, thus avoiding any perception of intrusion or lack of transparency. This helped maintain participants' trust and ensured they were fully informed about the study before deciding to participate.

Participants were informed that individuals would be recruited on a first-come, first-served basis to minimise the impact of over-recruitment. Once I had enough participants, I updated my posts to say that I had finished recruitment for this study and that more information would follow when the findings were out. If more participants than needed had got in touch before I had time to edit the post, I

would have thanked them, explaining that I had reached the number of participants needed for this study and asking if they would like to be notified if more space became available at a later stage. I also informed people to follow the study's Twitter account for updates on the findings once they were available. Since Twitter has a wide reach, I might have received worldwide inquiries that I had to turn away. To mitigate this, I clarified in the inclusion criteria that participants must be UK-based.

There were chances of inadvertent confidentiality breaches on Twitter, e.g. participants replying in comments that they wanted to participate instead of directly messaging me. If this had happened, I would have replied to their comment, thanking them for their interest and encouraging them to contact me directly via email. It was also possible that individuals might share something personal about their struggles in the comments. To mitigate this risk, I posted a comment beneath the advert stating that if individuals do not want to participate but need help with these issues, they might want to contact the following organisations: their GP, Samaritans (116 123) or Beat (<https://www.beateatingdisorders.org.uk>; see Appendix B). If anyone had nevertheless verbalised signs of distress underneath the post, I would have replied to their comment, directing them to the above support organisations. Other than that, I did not interact with anyone unless they were coming forward to participate in my research, including refraining from giving "likes" to their comments.

The recruitment strategy was ultimately successful, resulting in a sufficient number of participants while addressing ethical considerations and maintaining participant confidentiality. None of the potential risks materialised during the process.

3.9 Participant Thumbnail Sketches

This section provides details for each participant to contextualise their experiences within their lifeworlds. All names are pseudonyms.

Ella. Ella was a White-British female in her early 30s. She had CBT via Microsoft Teams from April to October 2021. She had had telephone therapy before but never experienced PCP. Her BID involved fixations on various aspects of her appearance, particularly her face and upper body.

Charlotte. Charlotte was a White-British female in her late 30s. She had around 18 sessions of CBT via Zoom in 2021. She had had PCP four times prior to VCP. She experienced a complete dissatisfaction with herself that extended beyond appearance to feeling undeserving.

Dean. Dean was a White-British male in his late 20s. He had one session of guided self-help via Zoom in 2021 and a session of PCP a few years earlier. His BID was focused on various bodily aspects, particularly his weight and skin.

Yasmin. Yasmin was a Middle Eastern female in her late 20s. She had two sessions of CBT via Zoom in 2021 and never experienced PCP. Her BID pertained to her upper body, mainly her stomach.

Sarah. Sarah was an Eastern European female in her early 30s who had been undergoing schema therapy via Zoom and PCP for the past two years. Her BID pertained to her weight, height and face.

Kevin. Kevin was an Asian-British male in his early 30s. He had counselling, CBT and mindfulness therapy via Zoom in 2022 for four months, twice a week. Prior to that, he had one or two sessions of PCP. His BID pertained to his entire body, specifically a syndrome characterised by what he described as “abnormal body structure”.

Rachel. Rachel was an Asian-British female in her early 30s. She had four or five sessions of CBT in 2022. She had had 50-60 sessions of PCP prior to that. Her BID involved fixating on specific areas, including her face, thighs and shoulders.

3.10 Materials

All written materials used in the study (recruitment, information, consent, contact and demographics, interview, distress protocol and debrief materials) can be found in Appendices A-I. Further materials used in this study were a laptop with a camera function, Microsoft Teams, a backup recording device and my reflexive diary.

3.11 Procedure

Upon expressing interest in taking part in the study, potential participants were sent an Information Sheet (Appendix C) outlining the study's criteria, objectives, data anonymity and their right to withdraw from the study for up to two weeks after their interview without explanation. Participants were also informed about how their data would be processed and stored, given the chance to ask questions, asked to provide consent (Appendix E) and to complete the Contact Details and Demographics Questionnaire (Appendix F) via email. The interviews were conducted via Microsoft Teams, were audio-recorded and lasted 46-60 minutes. Participants were given the opportunity to ask questions at the end and were debriefed and thanked for their participation. After the interview, participants were given the chance to read over a PDF of the transcript and let me know if they wanted any corrections made for mistranscriptions, verify if the data had been anonymised to their satisfaction or request that any data be withdrawn or added. They had one week to request any changes. Four out of seven participants took up this offer, and I adjusted the transcripts accordingly. This approach was important for both practitioner and relational ethics – it promoted transparency and reassured participants that nothing was hidden in what they were submitting towards the research (see Section 3.13.3 for information on data processing throughout the study).

3.12 Interview Procedure

Data were collected via semi-structured interviews, in line with IPA's guiding principles (Smith et al., 2022). Interview questions and phrasings were derived from the literature review and methodological considerations, including a focus on self-perception and camera usage (see Appendix G). The questions were piloted with two DPsych colleagues to gather feedback on comprehensibility, appropriateness and interview style. Although these colleagues did not identify as having experienced BID, they were able to provide valuable insights into the phenomenon being investigated, as BI is a universally relatable topic; most individuals experience some level of dissatisfaction with their appearance at times in their lives (Cash & Smolak, 2011). Afterwards, I discussed the feedback with

my supervisors and made necessary adjustments, primarily focusing on presenting the interview as a discussion rather than a formal procedure and asking more open, curious questions.

Participants were introduced to the interview format at the outset. Although the interview schedule served as a guide, it was not followed rigidly, allowing for a more organic flow and for participants to address unanticipated aspects of their experiences spontaneously. The interview questions were memorised, but flexibility was maintained in their use. Open-ended exploratory questions were employed alongside probing questions to encourage participants to elaborate on their narratives, facilitating the elicitation of rich data.

Recognising that the research interviews might mirror participants' experiences of videoconferencing in psychotherapy, I invited them to reflect on and share any additional comments about their interview experience at the end. Participants had the option of pausing the interview if they appeared distressed. The interviews were conducted with the camera on, but participants were given the choice to turn the camera off if preferred; however, no participants chose to exercise this option. If any participants had chosen to turn the camera off, this would have been considered in the analysis and discussion, as they might have had different experiences due to this absence. Although this choice would have introduced some heterogeneity into the gathered data, a decision was made to prioritise ethics over methodology due to the potential for the camera to interact with the BID to distress participants.

To maintain the study's integrity, I kept a reflective diary throughout the research process. This practice helped me critically engage with my perspectives, emotional responses and evolving understandings of the participants' experiences. Supervision was crucial for enhancing the quality and rigour of the research, offering both support and a platform to address emerging issues. After the first interview, I checked in with my supervisors to discuss how it had gone and to explore any challenges or uncertainties encountered. Additionally, the first transcript was reviewed by my supervisors, who provided feedback on the data quality and the appropriateness of the interview technique.

3.13 Ethics and Risk

This study received ethical approval from the DPsych Ethics Committee at Regent's University London (see Appendix J). In line with the BPS Code of Human Research Ethics (2021a) and the Data Protection Act (DPA, 2018), I ensured participants' rights were respected, stakeholder interests were protected and the risk-to-benefit balance was carefully managed. Participants' anonymity and welfare were prioritised by obtaining informed consent, providing a debrief and offering information about psychological support organisations in case of distress during the interview (although no participants became distressed).

3.13.1 Anonymity. Personal identifying information that could reveal participants' identities, such as names, addresses and contact details, was not shared with anyone, including supervisors. Recordings and transcripts were saved using assigned pseudonyms to maintain anonymity. Participants provided consent for the use of direct quotes from the interviews in the written research thesis, as well as in any publications or conference talks, with quotes being attributed to pseudonyms to preserve anonymity (see Appendix E). Any other identifying information was carefully reviewed and altered to ensure anonymity.

3.13.2 Confidentiality. Data collected from the interviews (i.e. the substantive data) were shared on an anonymised basis with research supervisors, examiners and in the written thesis, and will remain anonymised in any future publications. If a participant had disclosed an immediate risk of harm to themselves or others, confidentiality would have been breached to arrange appropriate help, such as contacting emergency services. Participants were informed about the limits of confidentiality through the Participant Information Sheet (see Appendix C).

3.13.3 Data Protection. All materials were stored on a password-protected, cloud-based platform (OneDrive) linked to my university student account. Participants' personal data (e.g. name and contact details; that is, special category data) were stored separately from the anonymised interview transcripts, which were labelled with pseudonyms and saved in a password-protected folder.

Interviews were recorded using Microsoft Teams and an external recording device. After each interview, the recording was immediately transferred to the password-protected cloud-based platform and deleted from Microsoft Teams and the recording device.

Microsoft Teams complies with the UK General Data Protection Regulation (GDPR) and the DPA 2018 and does not retain personal information beyond what is necessary to facilitate online meetings, such as usernames (Microsoft, 2023). When inviting participants to join a Teams call, I informed them that they could join via the browser (rather than using a Microsoft Teams account) where they could enter a code or their initials instead of their name if they preferred not to use their real name. All categories of data were retained according to a data retention schedule determined by reference to the BPS (2018b) guidelines for academic research and publication. Participants were informed that their data would be retained until the thesis had been examined and any related publications had been completed, after which all recordings and transcripts would be deleted. Participants also had the right to withdraw their consent and request the deletion of their data for up to two weeks after their interview.

3.14 Mode of Analysis

I transcribed the audio-recorded interviews verbatim. This involved a process of active listening and re-listening to the audio data as well as reading and re-reading the transcribed material. I decided to transcribe the interviews manually as this meant I would spend a lot of time with the participants' voices and, as such, become intimately familiar with them. Additionally, concerns about confidentiality and GDPR compliance with many AI/cloud-based transcription tools made this manual method an ethically better choice. Laughter, pauses, expressions such as "uhmm" and any distinctive tone of voice were noted in the transcripts to stay as close to the original dialogue as possible.

The analysis consisted of (1) numerous close and detailed reflexive readings of the text to ensure the participant was the focus of the analysis, (2) in-depth exploratory noting with descriptive, linguistic and conceptual elements to systematise the reading of the data, (3) formulation and

organisation of patterns of experiential meaning called experiential statements (ES), (4) clustering/grouping ES to form personal experiential themes (PETs), (5) an iterative process of refining clusters and mapping the single case, (6) tabulating the final arrangement of PETs in a case level summary, (7) reviewing case level summaries looking for themes that cut across cases (“going cross-case”), (8) clustering PETs into group experiential themes (GETs) and (9) tabulating a master list of GETs. I completed the analysis of each interview (i.e. up to stage 7) before going back to stage 1 for the next interview. I then collectively completed stages 8 and 9 for all interviews (Smith et al., 2022; Smith & Niza, 2021).

All identifying information related to participants (e.g. names, locations, job information) was changed during transcription to preserve anonymity, considering the “cumulative effect” of information that could be potentially identifying (Braun & Clarke, 2013, p. 169). I kept a secure key, which linked participants to their corresponding pseudonyms, in a separate password-protected folder on my computer. This will be destroyed once the thesis has been examined and any related articles have been published.

3.15 Analytic Strategy

I formatted the transcripts in landscape orientation, with a wide margin on the right-hand side and a smaller margin on the left-hand side to provide space for notes. I numbered the lines and pages for ease of reference. Following IPA’s idiographic approach, I engaged with each transcript individually. The analysis involved an initial reading, exploratory noting, the identification of ES based on these notes, the clustering of ES by similarity and the creation of an individual table outlining PETs for that case (Smith & Nizza, 2021).

Initially, I read each transcript several times to immerse myself in the data and enter the participant’s world. I completed the first reading whilst listening to the audio recording, which I believe enhanced the analysis, as I could hear the participant talking in my head on subsequent readings of the text. In the right margin, I wrote down my initial thoughts about the transcript, parts of

the text that captured my interest, speculations and recollections from the interview process. This process had no particular structure; I gave myself “a license to be wrong, presumptive and wayward” (Larkin & Thompson, 2012, p. 106). I shared and discussed this free noting with my supervisors to help me with the process. The purpose of the free noting was to capture my initial thoughts, which allowed me to move forward with a more systematic and consistent focus later. It also helped me to identify and consider the impact of my preconceptions in terms of whether they were closing or opening up my interpretations of the data (Larkin & Thompson, 2012).

Next, I took a clean copy of the transcript and started a more systematic line-by-line reading of the data, focusing on the participant (whilst still noticing my reflexive responses and noting them in my reflexive diary). While there is no single way to make exploratory notes, distinguishing between descriptive, linguistic and conceptual notes helped me engage more deeply with the text, moving beyond the superficial readings I tend to rely on when encountering new information (Smith & Nizza, 2021). I recorded these notes in different colours on the right-hand side of the text. Descriptive notes (pink) captured the content, focusing on words, phrases and descriptions at face value without interpretation. The linguistic notes (blue) focused on the specific words used by the participants, their tone, pauses and emphasis, as well as what was not being said. The conceptual notes (purple) took the analysis from the descriptive and linguistic levels to a more interpretative and interrogative level. This consisted of questioning the underlying meaning behind the participants’ description of their experience, asking questions such as “What does this mean?” and “So what?” as well as looking for “similarities and differences, echoes, amplifications and contradictions” in the quote and entire transcript (Smith et al., 2022, p. 84). Here, I engaged deeply with the data, tentatively drawing on personal and professional experiences and knowledge while continually reflecting on my preconceptions to keep my commentary grounded in the transcript (Smith & Nizza, 2021). I noted any thoughts about methodological reflexivity in orange on the right-hand side of the text. This process is

demonstrated in an example of an annotated transcript in Appendix K. Again, I discussed and evaluated this noting in supervision to develop rigour and focus.

In the next stage, I transformed my exploratory notes into ES that captured what I understood about the meaning of the experience for the participant, aiming to produce approximately one ES for each turn of phrase (Smith & Nizza, 2021). During this process, I re-read the transcript multiple times to ensure that the ES remained grounded in the data, accurately reflecting the participant's narrative. These ES were then compiled into an Excel document with corresponding quotes and their location identifiers (page and line number). See Appendix L for illustration.

The next stage involved reviewing and refining the ES and grouping them coherently by asking, "What should go with what?" (Smith & Nizza, 2021, p. 43). I used an Excel sheet, applying different highlighting colours to group similar themes into distinct clusters (see Appendix M). Each cluster was then tentatively titled. These clusters, along with their respective ES, associated quotes and location identifiers, were copied into a new sheet as PETs. The PETs were further refined into subthemes, which were named, forming a comprehensive case-level summary (see Appendix N for an example). Throughout this process, I consistently cross-referenced the transcript to ensure the ES accurately reflected the participant's dialogue, maintaining fidelity to their words and experiences.

The case-level summary allowed each ES to be linked directly to its source in the transcript, streamlining the writing process. With all data easily accessible, I could efficiently revisit the transcript to review my linguistic and conceptual notes, aiding interpretation development. This organisation also facilitated independent audits by my supervisors, enhancing the credibility of the analysis (Smith et al., 2022). These audits included reviews of my interview technique, annotated transcripts and thesis drafts. Additionally, I conducted "hypothetical" audits, adopting the perspective of an external reviewer to ensure a coherent line of argument from raw data to the final write-up, maintaining transparency and rigour throughout.

Once I finished the case-level summary, I repeated this process for each subsequent transcript, following the same steps of initial reading, exploratory noting, constructing ES, clustering them into PETs and forming subthemes. It was crucial to approach each case independently, respecting its individuality and treating it as a distinct realm of inquiry, in keeping with IPA's idiographic commitment (Smith et al., 2022). However, as I progressed through subsequent transcripts, my interpretations were inevitably shaped by insights from earlier analyses – an inherent aspect of the hermeneutic circle, where understanding evolves with each encounter with new data. To ensure that each participant's unique experience was not overlooked, I remained aware of earlier insights and engaged with them reflexively while allowing myself to identify fresh ES that reflected the current narrative. I regularly questioned whether my analysis was genuinely informed by the present data, ensuring the integrity of each participant's story.

Upon completing the preliminary analysis, I reviewed each spreadsheet to ensure that the corresponding quotes accurately reflected the ES. My supervisors actively participated in this process, confirming coherence between the PETs, ES and the original transcripts.

The next phase involved comparing and contrasting PETs across participants to identify common patterns and distinctive differences within those patterns (i.e. discerning convergences and divergences) in order to form a set of GETs. This began with a "first pass review" of each participant's case-level summary. I then amalgamated all PETs, subthemes, ES and associated quotes relevant to the research question into a single Excel sheet, providing an expansive overview (see Appendix O). This approach facilitated a comprehensive examination of the entire dataset, allowing for the identification of connections, similarities and differences both within individual cases and across participants (Smith & Nizza, 2021).

I initially made comparisons at the PET level, as this approach provided me with a clear starting point. Once I identified a thematic synthesis at this level, I progressed to examining the subthemes, ES and eventually the corresponding quotes. This progression allowed me to conduct a

more nuanced, “finer grain” analysis that highlighted both similarities and differences among participants (Smith & Nizza, 2021). While shaping the GETs, I consistently revisited the exploratory notes and transcripts to ensure that the GETs remained firmly grounded in the empirical data.

The process of determining theme inclusion involved organising and reorganising PETs into thematic groups based on keywords. This process led me to identify three groups, which I tentatively labelled: (1) Realness, Bodily Presence and Visibility, (2) Uncertainty/Insecurity and Power/Control and (3) Mirror, Self-consciousness and Discomfort (see Appendix P). While I directly translated some PETs into themes within the GETs due to their prevalence or potency, I had to reconfigure others to better align with the overall dataset.

In the subsequent phase, I developed labels for the GETs and associated group-level subthemes, followed by systematically tabulating them (see Appendix Q for the initial master table). This table illustrated the overarching patterns evident across the group, showcasing how participants collectively experienced each theme while simultaneously highlighting the individual nuances within these shared patterns, showing how each participant navigated the themes in their own way. It provided a comprehensive mapping of the participants’ experiences and served as a foundation for the narrative account of the analysis. As I progressed with the written narrative account, I reworked and reorganised the GETs, selecting quotes that seemed to best capture the GETs. The table in Appendix R represents the refined, finalised GETs and quotations included in the analytic account.

The inclusion of a GET typically requires representation from at least half of the participants, although this is not an absolute rule (Smith et al., 2022). Following this guideline, I adopted a flexible approach, remaining open to including a GET that did not meet the 50% threshold. This openness stemmed from recognising that exceptionally intriguing, salient or illustrative data could compensate for not meeting the usual evidence density requirement (Smith, 2011). Nevertheless, all GETs in this research were supported by at least four of the seven participants.

Chapter 4: Findings

Findings from the analysis of participants’ interviews have been organised into three group experiential themes (GETs) and six subthemes, as shown in the table below.

Table 1

Group Experiential Themes and Subthemes

GET 1: Absence of the (Whole) Physical Body
Subtheme 1: Physical Co-Presence Versus Digital Distance
Subtheme 2: Challenges in Conveying BID in VCP
GET 2: Shifting Control in VCP
Subtheme 1: Curating the Body
Subtheme 2: Feeling Uncertain About Online Connections
GET 3: The Mirror of VCP
Subtheme 1: Digital Self-Scrutiny
Subtheme 2: The Therapist in the Virtual Mirror

GET 1 captures participants’ experiences of the absence of the (whole) physical body in VCP. Subtheme 1 reflects the tension between the sense of co-presence they imagined would be achieved in PCP and the distance they experienced in VCP. Subtheme 2 focuses on participants’ perspectives on the importance of being seen fully and the challenges they faced when communicating their BID to therapists due to the constrained visual field offered by the screen.

GET 2 reflects participants’ experiences of shifting control in VCP. Subtheme 1 depicts participants’ experiences of control as they curated their appearances by hiding areas they felt particularly self-conscious about and presenting more appealing versions of themselves. Subtheme 2 focuses on participants’ experiences of lack of control stemming from the unpredictability of the online therapeutic connection, specifically uncertainty about the therapist’s gaze and technical factors leading to misunderstandings.

In GET 3, participants liken their experiences of VCP to having therapy while looking in a mirror. Subtheme 1 explores how VCP enables extended self-examination through this virtual mirror,

with some participants embracing the opportunity and others intentionally avoiding it. Subtheme 2 focuses on the therapist's image within this virtual mirror. With both client and therapist simultaneously visible on-screen, VCP enhanced participants' natural tendency to compare themselves to others. While this allowed some to gain new insights, others saw it as a distraction from their therapeutic goals.

All seven participants' narratives converge and diverge to contribute to each of the six subthemes. For a detailed breakdown of prevalence, see Table 2. For a comprehensive compilation of themes with corresponding quotations, including those partially referenced below or not referenced due to word count constraints, see Appendices Q-R. For an explanation of the notations used in quotations, see Table 3 below.

Table 2

Prevalence Table

	Prevalence: Participants Represented in Subtheme	Extracts Provided in Support of Subtheme
GET 1		
Subtheme 1	Ella, Sarah, Yasmin, Charlotte, Rachel, Dean, Kevin (7/7)	Ella, Sarah, Yasmin
Subtheme 2	Ella, Dean, Kevin, Sarah (4/7)	Ella, Dean, Kevin
GET 2		
Subtheme 1	Yasmin, Sarah, Charlotte, Rachel, Dean (5/7)	Yasmin, Sarah, Rachel
Subtheme 2	Sarah, Dean, Rachel, Charlotte (4/7)	Sarah, Dean
GET 3		
Subtheme 1	Ella, Dean, Charlotte, Rachel, Kevin, Sarah, Yasmin (7/7)	Ella, Dean, Charlotte, Rachel, Kevin, Sarah, Yasmin
Subtheme 2	Ella, Yasmin, Charlotte, Sarah (4/7)	Ella, Yasmin, Charlotte

Table 3

Interview Transcript Key

Symbol	Meaning
[...]	Omitted content for brevity or relevance
[word]	

	Change in the original word for clarity or grammatical correctness
[laughs]	Non-verbal sounds or actions
[pause]	Pause
italicised text	Emphasis by the participant

4.1 GET 1: *Absence of the (Whole) Physical Body*

This GET captures participants' experiences of the absence of their (whole) physical body during VCP. Subtheme 1 explores the tension between the physical co-presence participants imagined would be achieved in PCP and the distance they experienced in VCP due to their bodies being physically absent. Most participants viewed the reduced physical co-presence in VCP as an obstacle to establishing deep connections; however, Yasmin saw it as a benefit, making the therapeutic process more approachable and less intimidating. Subtheme 2 focuses on the challenges participants encountered when communicating their struggles to their therapists due to limited bodily visibility in VCP. This issue seemed to stem from a belief that a person must be seen in their entirety to be understood.

4.1.1 Subtheme 1: Physical Co-Presence Versus Digital Distance. Participants spoke of VCP as lacking physical co-presence, which they imagined would have made the therapy more “tangib[le]” (Rachel, p. 48, line 8) and “real” (Yasmin, p. 22, line 16). Their language underscored a sense of distance in VCP and a belief that PCP would ensure a more immediate, embodied engagement. Ella's statement encapsulated this sentiment:

[...] personally, I feel like therapy would be more effective if you were sitting in the same room with that person in terms of making the connection with your therapist and them being able to convey empathy, you being able to feel it back, um, those kind of things. (Ella, p. 38, lines 10-14)

Since Ella had not yet engaged in PCP, her view of its superiority seemed rooted in speculation rather than personal experience, highlighted by her use of the second person (“if you were sitting”). Interestingly, when describing her lived experience of VCP, she said it was not inferior in terms of effectiveness: “Um, but I don't, I don't feel like, I don't feel like my therapy wasn't effective or was

less effective” (Ella, p. 39, lines 5-6). Nevertheless, her use of a double negative (“I don’t feel like [it] wasn’t effective”) suggested a somewhat cautious recognition of VCP’s effectiveness, as if she were leaving room for the possibility that PCP could still be superior. Towards the end of the interview, Ella revisited her earlier reflections, acknowledging a strong sense of closeness with her VCP therapist, noting she “felt very sort of close to her actually by the end of it” (Ella, p. 54, lines 13-14). Ella’s linguistic transitions between hypothetical scenarios of PCP and her lived experience of VCP suggest she was engaged in meaning-making in the moment. This interpretation aligns with Ella’s statement that she decided to participate in the study because she had reached a point where she felt eager to revisit and share her experiences. The interview seemed to have provided a space for Ella to reflect on her experiences, helping her articulate and process her thoughts about VCP.

Sarah also articulated the limitations of online interactions in terms of an absence of physical, bodily co-presence:

I don’t know if that is the right word, but somebody’s presence, their way of being, you can only see it when you meet with the person. Online it’s very restrictive, you’re limited to certain things. And not only because I see now only your face, even if you stand up and they see your body, it still would not be the same. (Sarah, p. 17, lines 6-10)

Sarah’s mention of “somebody’s presence, their way of being” suggested an elusive quality that is only fully apprehensible in physically co-present encounters, implying an inherent difficulty in fully grasping the other online. Her assertion that online interactions could only cover “certain things” carried a nuanced connotation, suggesting that only what is certain or tangible can be effectively addressed and understood. Her statement, “even if you stand up and they see your body, it still would not be the same”, reflected her attempt to make sense of the nature of the limitation, suggesting the experience of being seen by the other extended beyond visual appearance to include the embodied experience of being with the other. Moreover, the shift in pronouns (from “you can only see” to “they see your body”) suggested that the inability to capture the other’s way of being was intersubjective.

Concerning VCP specifically, Sarah's descriptions conveyed a sense of distance that transcended personal interactions, extending to the entire spatial dimension of the therapeutic encounter:

I think, uh, one thing that comes to my mind, uh, what is missing is the sense of a shared reality, shared space. I don't know where this person is. I don't know their surroundings and not that I'm paranoia, paranoid about who's around, but I don't know this as well. Uh, basically you are somewhere far away, and we are not sharing, we're not breathing the same air. We are not sharing the same space. We're not maybe even sharing being in the same country or in the same city. Um, it creates extra layer of a distance, I would say. And for me, uh, it's important to feel this proximity in order to feel this connection. (Sarah, p. 18, lines 3-11)

Sarah equated sharing physical space with sharing a broader reality, suggesting that being physically in the same room fostered a deeper sense of collective experience with her therapist compared to virtual encounters. When Sarah mentioned the importance of "breathing the same air", she did not seem to be merely expressing a personal preference but invoking a deeper, almost existential consideration of what constitutes co-presence and connection – a sense of immediacy and reality that comes with sharing physical space with someone.

The lack of physical proximity in VCP, combined with not knowing the therapist's surroundings or who might be around, introduced a layer of distance, hindering the establishment of a strong connection. Her words "this person" sounded almost disparaging, as if she was not talking about her therapist but rather an unknown being, further emphasising the distance that Sarah perceived in VCP. However, her words "extra layer of distance" suggested there was a level of distance in PCP, too, albeit smaller. Further, her acknowledgement that one can "definitely sit very close to a person and be totally disconnected" (Sarah, p. 19, lines 5-6), while still advocating for physical co-presence, introduced a nuanced layer to her narrative. This suggested that although she theoretically emphasised the importance of being in the same room, she recognised the practical limitations of this.

Yasmin also thought VCP was less "real" and tangible (touchable) than PCP; however, she anticipated that the physical proximity of her therapist in PCP would make her uncomfortable:

Oh, I think that's where the, um, in-person therapy, I would, it would make me very uncomfortable because I'm looking, like I can touch the person, I can look at them in the eye and be like, it just feels more real. (Yasmin, p. 22, lines 14-16)

The prompt to consider PCP as a reference point for describing her VCP experience possibly drew Yasmin to hypothetical thinking, as she had never experienced PCP. Nevertheless, her immediate discomfort with the idea of PCP stood out, demonstrating a firm stance rather than uncertainty. By expressing her anticipation of feeling “very uncomfortable” with the direct body-to-body interaction in PCP, Yasmin conveyed a strong conviction about its potential impact despite lacking first-hand experience.

Although Yasmin perceived VCP as less real, she found it more intimate. This intimacy arose from being “boxed” in a shared digital space, which she framed as “face-to-face, eye-to-eye” interaction: “It's more intimate because your whole space is in a box, you know? You're staring at another box as well [...] So that's why it's more intimate. It's like face-to-face, eye-to-eye, you know?” (Yasmin, p. 27, lines 1-2; 4-5).

The “box” seemed to metaphorically represent both isolation from the potential intrusions of the physical world and a focused connection, potentially fostering deeper understanding and intimacy than what might be possible in a more distracting physical environment. The connotation of a television screen also comes to mind, framing the interaction in a controlled, intimate space that feels both close and somewhat detached from reality. Yasmin's narrative suggests a renegotiation of what it means to be “face-to-face”, illustrating that meaningful emotional and relational engagement can indeed be achieved without physical proximity.

This contrasts with Ella and Sarah's discussion of the importance of physical co-presence, even though their lived experiences suggested they might have had an idealised notion of what being physically present could offer. Ella initially believed that physical co-presence would enhance the therapeutic connection and empathy. However, her actual experience with VCP led her to

acknowledge a strong bond with her therapist despite the lack of physical co-presence. Similarly, Sarah emphasised the value of sharing the same physical space to foster a deeper connection whilst recognising that, even in PCP, complete understanding is elusive. The divergence among participants underscores how their VCP experiences were shaped by individual beliefs, psychological needs and preferences.

4.1.2 Subtheme 2: Challenges in Conveying BID in VCP. This subtheme explores the difficulties participants had with conveying thoughts about their BID via VCP. Participants described perceptions that the restricted visual field in VCP, focusing primarily on the face and upper body, could limit therapists' ability to understand their comprehensive experiences of BID. This feeling seemed to be based on a belief that to be understood, people must be seen in their entirety, expressed by participants as a desire for a "360-degree view" (Kevin, p. 36, line 15) or to be perceived "in 3D" (Sarah, p. 17, line 2).

Kevin felt that VCP limited his therapist's ability to fully grasp the extent of his "abnormal body structure" (p. 4, lines 7-8), which was central to his BID, as he could only show certain parts of his body:

So video-wise, they, they're not seeing that the body is dysmorphic [...] Yeah. Um, partly, I, I did feel like that, uh, because, um, they can only see my face. Or I can only show my hands on these things, but my whole body I cannot show. And, uh, they cannot observe it. Also, they cannot feel uh, uh, what I am telling, what I am trying to say. Uh, but in person, even if I sit quietly, he can observe and he can, uh, you know, he can know, uh, what the [...] syndrome is like, what is, uh, what the body situation is like. (Kevin, p. 23-24, lines 7; 12-16 and 1-2)

Kevin's use of the phrase "what the body situation is like" emphasised the holistic, dynamic nature of his experience with "abnormal body structure", encompassing not just physical appearance but also the lived reality of his condition. His repeated use of "the body" rather than "my body" could be interpreted as a way for Kevin to distance his sense of self, his identity, from "the" body, which he perceived as a mechanical machine and not truly "him". Additionally, the repeated use of "they"

suggested a collective group of individuals Kevin perceived as ready and waiting to judge him for the body he wished to distance himself from.

What was particularly prominent in Kevin's narrative was a sense of being misunderstood and unable to effectively convey his inner experiences despite attempts to articulate them in words:

I told her that, Look, my body is like, uh, it's totally dysmorphic, and, uh, uh, due to that, um, uh, I don't have friends and I don't have a, uh, yes, I'm socially secluded because of these things. So video wise, she's unable to look and she's unable to see these things. So she said that, No, no, you're okay, you're totally, uh, fine. Uh, this is just your, uh, uh, presumption and you have prejudice in your mind, you are just prejudiced. (Kevin, p. 30, lines 8-14)

Kevin's description of his body as "totally dysmorphic" implied not just a superficial or aesthetic issue but an ontological concern (something deeply intertwined with his sense of being and existence) which he perceived to be the sole cause of his limited social interactions ("due to that [...]"). The stark contrast between this earnest expression of his lived experience and the therapist's dismissive response of "no, no" highlighted the disconnect in understanding and empathy within their therapeutic interaction. Longing for complete visibility in therapy, Kevin went on to suggest that it would be useful to have a 360-degree view of the client in VCP:

[...] maybe a 360-degree view, just like you have a Google view, uh, on the, you can take a 360-degree view of a street [...] So just like that, you can, you can take a 360-degree view of, uh, you know, the body structure, you know, the the body dysmorphia. Uh, you can just like, just to have a glance and just to have a picture of, uh, the patient of, uh, always, uh, how is, uh, how it is. Also in case of obese patients also, who are diagnosed with obesity, I think it would be helpful with them also. (Kevin, pp. 36-37, lines 15-16 and 2-7)

Kevin's analogy of a 360-degree view, like Google Street View, implied that he saw his body and the bodies of others as objects comparable to a location on a map. Just as Google Street View provides a comprehensive visual representation of physical environments, Kevin wished for a similar level of detail and visibility for therapists to understand body-related issues. This analogy underscored Kevin's desire for enhanced visibility and validation of his physical experiences in therapy, highlighting the limitations he perceived in the current digital format.

The quote evoked a sense that Kevin lacked compassion for himself. He seemed to believe that the faults he perceived in his body were indisputable facts, almost as though they could be proven in a court of law. Kevin appeared to be seeking validation from his therapist, hoping she would see those faults as he did and agree with him. This would confirm his certainty that his body – and, despite his attempts to distance himself, he himself – were wrong in some way. Furthermore, he extended this lack of compassion to other people whose bodies were, by his measure, flawed as well.

Similarly to Kevin, Ella highlighted the challenges of conveying physical nuances like “the odd spots” (Ella, p. 31, line 11) in VCP, leaving her feeling foolish. This limitation hindered her ability to communicate her BID to her therapist during sessions effectively:

I’d have like one [acne spot] here and one here, that’d be it. But it would, they would be the worst thing in the world to me at the time. Um, and I felt like I couldn’t really see [the odd spots] on Teams. So for me, I felt even sillier sitting there and telling my therapist that that’s what I was worrying about. (Ella, p. 31, lines 13-16)

This experience highlighted the disconnect between Ella’s lived bodily experience and the digital representation of her body, intensifying her feelings of triviality and possibly shame as she attempted to articulate concerns that felt so profound to her yet appeared insignificant or non-existent in VCP. While VCP may have alleviated some of Ella’s anxiety around physically co-present interactions, the digital barrier hindered her ability to convey the depth of her struggles:

Um, and I think where the difference would’ve been for me is it would’ve been more anxiety-provoking to sit face to face with the therapist, knowing that she could see my face in real life, and having to sort of go out, talk to reception and whoever else to get to that room...But I at least think I would’ve thought, or she can see my face, she can see how it properly is and she’s not gonna think I’m crazy. Whereas I really struggled throughout the whole time, to be honest, with her, me, me thinking that she thinks I’m imagining this stuff on my face. (Ella, p. 32, lines 1-5; 7-10)

Ella’s reflection underscored the personal hurdles she faced when sharing BI concerns in VCP and a tension between what is worse – appearing “crazy” or having something “properly” flawed with her face. However, it seemed that Ella was learning to trust others and accept herself:

Um, but in the end I think I just learned to accept it and have to trust that actually maybe there wasn't a lot there to begin with, you know? [...] So it then became more of a well, I'm, I'm still seeing people every day and day-to-day life, and they're not saying anything. And my boyfriend is constantly saying there's nothing on my face... My mom's telling me there's nothing there. So actually maybe even if she was face to face, she, she still might not be able to see anything. (Ella, p. 33, lines 9-11, 13-15; p. 34, lines 1-2)

Unlike Kevin, who felt misunderstood in his VCP experience, Ella's experience took a different course. Her boyfriend and mum initiated the process of acceptance by not validating her negative self-perceptions, and her therapist's lack of acknowledgement of her skin concerns in VCP further prompted her to reassess her BI concerns more positively. This seemed to have helped her accept and trust that perhaps her anxieties were unfounded.

Dean reflected on the peculiar sensation of being solely visible on a screen, expressing concern about his therapist's capacity to truly understand him:

Um, I guess it was, uh, just a bit of a, a strange feeling to be honest. 'Cause um, a part of me was thinking how are they, uh, really kind of getting to know me when it's just on a, a screen, if you know what I mean? (Dean, p. 32, lines 6-9)

His doubts about the extent of understanding possible through the screen highlighted a tension between the deeper, more meaningful process implied by "getting to know me" and the superficiality he associated with being "just on a screen". This transition suggested a loss of depth and intimacy inherent in VCP interaction. Dean was hesitant to share this uncertainty with his therapist which raised questions about the openness and trust within the therapeutic relationship. However, by voicing these thoughts in the virtual interview and seeking validation ("you know what I mean?"), he displayed a willingness or even a desire to go beyond the inadequate connection he experienced in VCP.

Earlier in his narrative, Dean reflected explicitly on the confined visibility in VCP:

And like video therapy, I, it might be a bit different these days with the better technology and stuff like that, you know, clearer cameras, but how are they really going to judge, um, sort of situations like that where they can only see a tiny portion of you, an odd box? (Dean, p. 20, lines 7-10)

Dean's reflection underscored a belief that being fully seen is crucial to being fully understood, thereby pointing to a potential limitation of VCP in capturing the entirety of his physicality. While for Yasmin, the "box" represented a space for focused connection and intimacy, Dean's reference to the "odd box" suggested that he saw the camera as something strange, abnormal or weird, potentially reflecting a sense of disconnection and a concern about the medium's ability to authentically convey personal experiences. This prompted him to overemphasise his concerns to the therapist:

[...] I guess I was trying to kind of make a point of it that almost, you know, like I was overemphasising a little bit and, um, I didn't really have the opportunity to discuss it, to be honest [...] Um, you know, I did mention about all of the issues that I had in relation to body, body image problems and all sorts [...] Um, and, um, I guess, you know [sighs], they didn't, it felt like I wasn't really being kind of listened to or acknowledged. (Dean, p. 41, lines 1-3; 5-6; 8-9)

Dean's reflection on his therapy session conveyed a sense of missed opportunities and unmet expectations. He expressed a desire to address his BID more fully but felt that his therapist did not create a space for him to do so. This suggested a perceived lack of engagement or understanding from the therapist's end, particularly regarding issues related to camera presence and self-perception, leaving him dissatisfied with the overall therapy experience. The sigh punctuating his words seemed to emphasise the emotional weight behind his sentiments, indicating disappointment or perhaps frustration. However, elsewhere in his narrative, Dean acknowledged that, even in his day-to-day life, people "would probably not agree in any way, shape or form" (p. 4, lines 4-5) with his perceived flaws, implying he would struggle to get them validated even if he could be seen in his entirety.

Dean also spoke about his PCP experience stating he felt unheard despite being seen fully: "even though it was in person [...], I didn't really feel like they were paying that much attention to what I was talking about" (Dean, p. 26, lines 14-15). This, combined with his willingness to try to be understood in the interview where he was not fully seen, raised questions about the extent to which the limited visibility in VCP was a serious issue, and whether his feelings of being misunderstood had more to do with the quality of the therapeutic relationship.

Kevin, Ella and Dean all wanted validation of their BID but felt that the limited visual scope in VCP hindered a full understanding of their bodily concerns. Kevin viewed this limitation negatively, feeling misunderstood and longing for complete visibility. In contrast, Ella's experience prompted a re-evaluation of her perceptions, leading her to consider that her concerns about BI might have been unfounded. Dean expressed concerns about the lack of full-body visibility but showed a willingness to strive for a deep understanding despite the limited visibility.

4.2 GET 2: *Shifting Control in VCP*

This theme captures participants' feelings of both control and lack of control at different times during their VCP experience. Subtheme 1 depicts participants' experiences of control over curating their appearances by hiding areas they felt particularly self-conscious about and showing what they thought were more appealing versions of themselves. Subtheme 2 focuses on participants' experiences of lack of control stemming from the unpredictability of the online therapeutic connection.

Specifically, uncertainty about the therapist's gaze and technical factors such as poor connection.

4.2.1 Subtheme 1: Curating the Body. Participants discussed various circumstances in which they felt in control of their online self-presentation. The camera and digital interface allowed them to hide areas they felt particularly self-conscious about and enabled them to show what they thought were more appealing versions of themselves. Yasmin's narrative underscored a strategic utilisation of the digital platform's features to curate her body, which gave her a sense of control:

[...] if I walked into like an office, I would have to shake their hands and touch them. And then also, um, I would feel they wouldn't see my, uh, they would see my stomach area. But if I'm in a, um, video call, I can always hide that, for example [laughs gently]. You can also add filters if you don't like the way that you look on videos, um, so, you know, I adjust the lighting, for instance. So you're in control when it's online. But when you go into an office, you're not in control. (Yasmin, p. 13, lines 8-15)

Here, Yasmin articulated the control she experienced online, not just by hiding aspects of her body that she wished to keep private but also by enhancing her visual presentation. Her reference to adjusting the lighting and adding filters reflected a curatorial practice where each choice was

deliberately made to shape how she was perceived, much like an artist or curator would arrange elements within a cultural exhibit. Linguistically, she seemed to own the act of adjusting the lighting (“I adjust the lighting”), but slightly distanced herself when it came to adding filters, as suggested by her use of the second person (“you can also add filters”). She may have perceived using filters as something she could be judged for, hence the distancing language as a protective measure. The sense of control Yasmin felt in VCP was further illustrated in the following quote:

...in virtual therapy, I’m just showing my face. But when you’re walking into in-person therapy, they see how you talk to other people, uh, how you, how you use your hands, uh, your body language, your full body. And like I said, they will see the flaw that I hate about myself, which is, uh, my stomach area. (Yasmin, p. 23, lines 12-16)

The phrase “I’m showing my face” reflected a sense of control in VCP that empowered Yasmin to dictate the boundaries of her visible presence. This control contrasted with the more expansive visibility in physical settings, where her entire body would be subject to observation and judgement. As such, Yasmin’s comments about control in VCP could be related to her insights in GET 1 Subtheme 1 about the digital medium fostering a helpful distance conducive to therapeutic intimacy. Yasmin’s cultural context might help us understand why control was important to her. Given the stigmatisation of therapy in her culture and her strong value of privacy – “privacy is an important matter to me. Where I originally come from, therapy is still very taboo” (Yasmin, p. 15, lines 5-6) – the ability to manage her visibility in VCP was crucial. The digital format, where she could decide the extent of her physical exposure, allowed Yasmin to engage in therapy in a manner that respected her need for confidentiality and aligned with her comfort levels, thereby making the process feel safer and more attuned to her individual needs.

Sarah also commented on her ability to curate her body through filters, which enabled her to present a “nicer” version of herself:

[...] Uh, it’s like a nicer version of myself, like a slightly, uh, smooth, smooth version with like a smooth skin. And, uh, I liked it. It was not my plan to do it, but when I saw it’s an option, I liked the idea of appearing better looking. (Sarah, p. 24, lines 10-13)

The phrase “It was not my plan to do it” suggested that Sarah discovered the option to use filters in VCP only after she began using the platform. The repeated use of the term “smooth” to describe her enhanced appearance was noteworthy. This choice of wording suggested not merely an aspiration to look more attractive but a deeper desire to eliminate or conceal aspects of her appearance that she found undesirable. The concept of smoothing over typically refers to efforts to mitigate or conceal something that provokes unease, displeasure or aversion, underscoring that the appeal of appearing “better looking” in VCP extended beyond aesthetics to the eradication of perceived flaws.

Like Yasmin and Sarah, Rachel also reflected on her sense of control within the therapeutic setting. However, she diverged from other participants as she felt it was PCP that afforded a greater degree of control over how she presented herself to her therapist, particularly through body language:

I think body language speaks a lot as well. Closed arms, sitting back, sitting forward, closed legs, cross armed, all these different things have an impact as well. And I could, I could do myself justice to appear smaller in person as well. So the, the therapist will then probably, I’ll probably communicate this to her definitely in the session in per, if it was in person, but I’ll tell her, Look, I’m now purposely closing myself or making myself appear smaller. Do I look smaller? I’ll probably ask that question to her, a rhetorical question: Do I appear smaller? [...] Um, obviously I don’t know what the answer would be to that, but you’ve got more, I guess, flexibility, fluidity, visibility, um, in changing and shaping who you are in that one given experience. When you’re doing an in-person therapy session, you can change and change up your body language a bit more. (Rachel, p. 47, lines 1-9; 11-15)

Rachel’s phrase “do myself justice to appear smaller” signified an intentional manipulation of her physicality and strategic use of her body as a communicative tool. It also suggested that she saw this “smaller” Rachel as the real her, the version of herself she believed she deserved to be – and this is the Rachel she could present to her therapist for her approval. This conscious shaping of her appearance and who she was as a person (“changing and shaping who you are”), akin to an actor’s deliberate performance, suggested she viewed her entire body as an instrument for crafting a specific narrative or impression within the therapeutic space. Her proactive questioning of the therapist (“Do I look smaller?”) underscored a heightened awareness and intentionality in how she used body language.

Unlike the perhaps more subconscious or instinctive uses of body language discussed by other participants, Rachel's actions seemed calculated and reflective, aimed at creating a particular impression – an impression she checked with the therapist to see if it was working. It seemed that she viewed the therapist as a mirror that answered back, suggesting a relationship where she sought external validation and approval for her constructed identity. Her narrative contrasted with those who described feeling in control in VCP through technical adjustments such as filters. Instead, she harnessed the full spectrum of her physical expression to dynamically shape the therapist's impressions of her. Her confidence in using body language to communicate complex emotional states positioned her as taking an active role in constructing and communicating her desired self-image in PCP, whereas in VCP, she felt she was “missing out on all those points” (Rachel, p. 48, line 15).

Participants in this subtheme described feeling in control of their appearances through curation. Yasmin and Sarah expressed a preference for the control VCP offered, utilising digital features like filters to manage their appearance and mitigate BI-related anxieties. Conversely, Rachel felt more control over how she was seen in PCP, where she could more actively use her body language to communicate information to her therapist, seeking and potentially receiving immediate feedback from her.

4.2.2 Subtheme 2: Feeling Uncertain About Online Connections. While participants

experienced a sense of control over their self-presentation, they expressed uncertainty about the quality of their online connections – both relational and technical. This uncertainty reflected a lack of control in establishing stable, secure client-therapist relationships in VCP. Sarah’s uncertainty was largely due to her inability to discern where the therapist was looking:

I think, uh, maybe because in real life we have eye contact and, on the screen, there is no eye contact so you don’t really, I don’t know where you look now, you probably try to look at my face, but it doesn’t, it doesn’t feel that way. We don’t know where we look. We try to get the eye contact through the video call. But we’re just staring at some dot on the screen, so it is not really eye contact. I feel like, uh, less intimidated, uh, when it is in person. Uh, it feels like this gaze, this stare, it’s diluted in real life. And through the video, it’s heavier, it’s this, like, you stare at me, I don’t even know where you stare, because there again, there is no eye contact, it’s just this, um, weird feeling of, um, somebody looking at you, but as if they’re looking through you [...] In real life, you can see exactly where, where is the gaze [...] Yeah, staring at your face. In, uh, in real life, it’s, uh, as I said, it’s diluted. It’s like a person, they would look in your eyes, but then they will probably look around as well. Maybe they will look aside, look at you again, and it comes in this natural way. So I find it less uncomfortable, less intimidating and more normal, if you like, more human. (Sarah, p. 20, lines 3-15; p. 21, lines 4-8).

Sarah’s shifting use of pronouns – moving from “we” to “I” and “you” – was noteworthy. Her use of “we” in “we don’t know where we look” suggested a momentary melding of herself and the therapist into a shared experience of uncertainty and disorientation. However, this very experience of not knowing where to look also highlighted the separation and disconnect between them.

The phrases “there is no eye contact” and “not really eye contact” prompted a deeper examination of what “real” eye contact entailed for Sarah. She seemed to suggest that looking directly into the other person’s eyes during a video call does not feel like eye contact to them. To make the other person feel like we are looking into their eyes, we must focus on the “dot” (the camera). However, this is just a simulation of eye contact – a simulation that feels less natural and more intimidating.

Sarah’s description of the gaze as both intense and insubstantial suggested a form of observation that felt penetrating yet lacked the authenticity and fluidity of “real” eye contact. She

appeared trapped in a dilemma where achieving eye contact was fraught with the discomfort of feeling observed too intensely, as if “they’re looking through you”, yet not achieving it left her yearning for more authentic engagement. This conundrum painted a picture of Sarah being in a difficult position with no apparent resolution. This paradox, where she could not win either way – unable to secure eye contact without feeling uncomfortably scrutinised – suggested a pervasive sense of lack of control. The medium intended to facilitate connection instead evoked feelings of disconnection and powerlessness.

Interestingly, Sarah’s use of the word “diluted” to describe interactions in the therapy room contrasted with the typical narrative of digital communication diluting “real-life” experiences. The term “diluted” usually implies a reduction in intensity or concentration, often used in contexts where something strong or pure is made weaker or less potent. In Sarah’s context, however, it suggested that the therapist’s gaze became more focused and concentrated, “diluting” everything else to intensify that core interaction. The heightened focus of the therapist’s gaze in VCP seemed to make the digital encounter feel more alien and less human, contributing to Sarah’s uncertainty about the authenticity and stability of the connection with her therapist.

Later, Sarah reflected on the perceived ephemeral nature of online connection, which seemed to create a further lack of control:

[...] I try to think more about it, um, it, when somebody can kind of get rid of you by just, uh, clicking like stop or leave the meeting, um, it’s not the same experience as somebody being next to you. It feels as if you can be dismissed easier [...] Not that my therapist ever did something like that, and I trust my therapist, but, um, the whole idea that, uh, um, like separating from you or getting rid of you is one click away. Um, it’s also not a very pleasant thought now when I’m reflecting on it. Um, and also, we rely on internet connection. It just doesn’t feel like as stable and safe as a face-to-face experience. (Sarah, p. 30, lines 6-16)

Sarah’s narrative conveyed a perception of being constrained by technology, which seemed to dictate the limits and possibilities of communication within VCP. It was as though VCP inherently altered the therapeutic interaction, introducing a sense of remoteness that she felt she could not control. The idea that the therapeutic connection could be severed at any moment, either intentionally by the

therapist or inadvertently due to technical issues, appeared to highlight her sense of uncertainty. The switch between pronouns (from “I” to “you” and “we”) could have indicated a strategy to distance herself from the discomfort of acknowledging this vulnerability. By framing her thoughts through “you” and “we”, she may have diluted the personal impact, making this a shared or universal concern rather than an isolated, individual anxiety.

The phrase “dismissed *easier*” implied an underlying anxiety about the stability of the therapeutic relationship that she felt even in PCP but was intensified in VCP due to the ease of ending the interaction with a single click. The word “dismissed” carried connotations of status and authority, reminiscent of a teacher dismissing a class – signifying a power dynamic where one party has the authority to end the interaction at will. This makes one wonder if, in this context, technology became a focal point of Sarah’s insecurity, acting as a metaphorical “scapegoat” for broader concerns about separation, powerlessness and being disposed of. Interestingly, the ease of dismissal in VCP, which was a source of discomfort for Sarah, was perceived positively by Rachel, who emphasised the advantage of accessing VCP via a click: “[...] it’s easily accessible by a click of a, you know, click of a mouse really, and having that therapist come to you as opposed to you going out of your own room or making that commute there” (Rachel, p. 3, lines 2-5).

Like Sarah, Dean’s account reflected a sense of uncertainty around relating to and connecting with his therapist. Technical issues necessitated him to speak louder, which led to an unintended self-presentation and fostered a fear of being misinterpreted:

Um, and there was a degree of frustration. And I think they even mentioned at one point, uh, You seem like you’re getting, um, you know, You seem, you are working yourself up. I’m like, No, I’m just trying to [laughs], trying to, trying to speak and I can’t. You’re not hearing what I’m saying. So that’s why I’m raising my voice. I’m not, I, I’m, you know, I’m not getting angry. I’m just trying to talk, trying to answer your question. Uh, so yeah, it was, uh, it was, it was strange, uh, to be honest. (Dean, p. 33, lines 5-11)

Dean’s recounting of the therapist’s perception of him “getting worked up” and his immediate correction, “No, I’m just trying to speak and I can’t”, illustrated a moment of disconnect fuelled by the

technical issues. Dean's subsequent laughter might be interpreted as disbelief at his predicament, serving as a coping mechanism to alleviate the discomfort he experienced while managing technical challenges and trying to express his frustration. His struggle to articulate these feelings of frustration – "I'm not, I, I'm, you know, I'm not getting angry" – could be seen as more than just verbal stumbling; this language seemed to act as a live demonstration of his panic over being potentially misinterpreted or misdiagnosed by his therapist. As Dean stated: "I was concerned that they were gonna make kind of like, almost like a false diagnosis, if you know what I mean [...] Um, uh, I wasn't there for, for, for anger issues or anything like that [...]" (Dean, p. 34, lines 3-4; 6). The fear of being seen as angry or agitated – when he was merely trying to be heard – underscored the lack of control Dean felt when technical issues interfered with his ability to communicate effectively.

This subtheme highlights participants' feelings of uncertainty and lack of control in VCP, although their experiences show divergent perspectives. Sarah's lack of control stemmed from her inability to discern where her therapist was looking, which led to her feeling uncomfortably scrutinised under an intense yet distant gaze. Additionally, she expressed concerns about the stability of the online connection and the possibility of being abruptly disconnected, introducing uncertainty about aspects of VCP that were beyond her control. In contrast, Dean's experience centred on communication barriers that led to fears of being incorrectly diagnosed with anger issues rather than being able to address his BID and depression – the primary reasons he sought therapy. He encountered technical issues that required him to speak louder, which he worried might lead his therapist to misinterpret his emotional state.

4.3 GET 3: *The Mirror of VCP*

All participants shared a common experience in which they felt their image was "being reflected back all the time" (Charlotte, p. 47, lines 5-6), akin to "having therapy with a mirror" (Sarah, p. 12, lines 4-5). Despite this shared experience, participants provided diverging accounts of how this unique visual experience influenced their sessions. Some engaged deeply in self-scrutiny while others

avoided it. Furthermore, the digital format of the therapy session, where both the participant's and therapist's images were visible simultaneously, seemed to amplify participants' natural tendency to compare themselves to others. For some, this comparison was helpful, enhancing their self-awareness; others viewed it as a distraction.

4.3.1 Subtheme 1: Digital Self-Scrutiny. This subtheme explores the varied experiences of participants when confronted with the chance to undertake in-depth self-scrutiny via the virtual mirror. Some participants embraced this opportunity, diving deep into self-examination, while others tried to avoid looking at their image. As someone who found herself looking at the self-view in VCP frequently, Ella likened this experience to an uncommon scenario in which another person (her therapist) unexpectedly holds up a mirror to her during moments of deep vulnerability:

It's not very often in real life that [...] somebody's holding up a mirror in front of you effectively whilst you are at your most vulnerable or doing your crying with your nose streaming and tears rolling down your face and you, you are all red and blotchy and whatever. Um, that's very unusual [laughs], you know what I mean? (Ella, p. 41, lines 9-14)

The mirror analogy underscored the intensity and intimacy of Ella seeing herself in states typically kept private or shared without the added layer of self-observation. Her laughter and the phrase "you know what I mean?" could have been a way of verifying her interpretation of this unusual experience, while the repeated use of "you" suggested a distancing technique. In the following extract, she wondered whether the act of seeing herself on video had prompted her to regain composure swiftly:

Um, I wonder whether I was maybe quicker to gather myself, get a tissue, sort my face out, having such an obvious visual thing in front of me of what I look like. So yes, I do feel like it was at times, yeah maybe a bit of a barrier in terms of being seen in that way. (Ella, p. 42, lines 9-13)

The phrase "a bit of a barrier" suggested that the visual element of VCP, where Ella could see herself, created some resistance to or difficulty in allowing herself to be fully exposed in a vulnerable state. The modifier "a bit" implied that this barrier, while present, did not completely obstruct her

therapeutic journey but was a noticeable factor in how she behaved and possibly processed her emotions.

Like Ella, Dean's experience with the self-view in VCP was that of a mirror that offered an unfamiliar and uncomfortable reflection. It brought to the fore aspects of self-perception and presentation that were typically unseen, meaning he felt prompted to alter his self-presentation in real-time:

[...] um, it sounds strange, but uh, I dunno, when you see yourself talking, um, 'cause obviously that's something you never really kind of see, you don't look in a mirror and kind of talk to yourself [...] Well, I don't anyway. And part of me is thinking, Oh God, is that, is that what I look like when I'm talking? Is that how my face goes when I'm, when I'm speaking? Um, and that led me kind of feeling even more sort of uncomfortable [...] And I guess that sort of ties in with the body dis, body image dissatisfaction, you know, I'm looking at strange aspects now, you know, going deeper. Um, you know, and then almost trying to alter how I'm, how I'm moving my mouth, in, in, in a sense. (Dean, pp. 35-36, lines 11-15 and 1-2; 4-7)

Dean's exclamation of "Oh God" suggested a moment of surprise or perhaps even shock upon confronting his speaking image, an image he did not commonly see when looking into a mirror. The VCP experience seemed to add new elements to his BID that were not there before. His use of the word "strange" to describe what he saw could imply that what he was witnessing was not only unexpected but also alien to his self-perception. It implied something mysterious that had not yet been classified and which, by extension, might have served as a softer, more digestible way of acknowledging that what he saw felt misaligned with his self-identity, without delving into a potentially more painful or critical territory of definitely labelling it. When Dean said, "And I guess that sort of ties in with the [BID]", it seemed as though he was integrating his experiences from the therapy process with his ongoing struggle with BID, which he "didn't really have the opportunity" to discuss with the therapist (Dean, p. 41, line 3). This reflection during the interview suggested a potentially missed opportunity in therapy, where discussing his real-time reactions and their impact on his self-perception could have enriched the therapeutic process and deepened his exploration of BID in the here and now.

Charlotte had a similar experience to Dean during one of her work calls, which she recorded and watched back for reference. She even used similar words, “oh my God, my face moves in a strange way” (Charlotte, p. 26, lines 4-5), highlighting a shared reaction of surprise or shock at seeing oneself on screen. However, she did not find looking at herself in the virtual mirror triggering:

Um, on the video calls, when I was doing it with my therapist, um, I initially found it quite hard if I was, yeah, I guess 'cause it's about me. But then I think when I get engrossed like I am now, I'm not really thinking about how I'm coming across to you cause I'm more interested in talking about what we're talking about [...] So I'm not constantly, I, I'm looking down a bit to see myself, but I'm not kind of, it's not triggering anything for me right now. Which is really, which is really good. (Charlotte, p. 28, lines 7-11; 13-15)

Charlotte's reflection suggested an evolution in her experience – from initial discomfort to not thinking about the self-view. However, the reference to “right now” implied a similar interaction could be triggering in the future. She further explained:

I guess it depends on who you're with as well and how relaxed you feel with that person [...] Like with my therapist, we always just felt, I always felt quite relaxed with her and um, so it always felt okay actually. Yeah. (Charlotte, p. 29, lines 3-4; 6-7).

This indicated that her comfort and relaxation with her therapist helped her overcome the initial discomfort of seeing herself on screen. As the relational context deepened and the conversation became more engaging, Charlotte's focus naturally moved away from self-monitoring. Charlotte's direct reference to our interview underscored the parallel between her therapy experience and the interview itself. Her evolving comfort during the interview mirrored the dynamics in therapy, suggesting that the relational context and her engrossment in the conversation played crucial roles in her comfort with self-observation.

Previously, Charlotte had been offered VCP but had refused, as it was hard for her to think about observing herself on the screen, a decision she now regrets. This suggested that although seeing herself was initially a barrier to therapy, it was not as challenging as she anticipated. Nevertheless, she added that she would “find it harder if it was recorded and [she] had to watch it back” (Charlotte, p.

52, line 14), highlighting her specific sensitivity to permanent visual records rather than live observation.

When asked to describe what it was like for her to see herself in VCP, Rachel said:

You know, people when they see themselves this is another way of mirror gazing you could say is, um, how you appear on video, you know. How you appear even on this photo here of me. Um, you know, I would always go out my way to find something negative or something that just doesn't sit right, and I fear that other people are seeing me in a different way or the lighting's not right. Um, or they notice something in, on my face or, um, on my shoulder, whatever it may be. Or, you know, Gosh, my, the width of my shoulders are the same width as that video box on Zoom, for example. It's like all these things that you think about [...] So you can say it is like mirror gazing, but would you maybe, I don't know, there's a term for it, but video self, video gazing, I don't know. Um, but it's like that. Yeah, it's real. It happens. (Rachel, p. 40-41, lines 9-16 and 1-2; 4-6)

Rachel's reflections brought a new dimension to the concept of self-observation, shifting from "traditional" mirror gazing to what she tentatively described as "video gazing". She explored how the video format framed her body, likening her physical presence to being contained within a video box: "Gosh, my, the width of my shoulders are the same width as that video box on Zoom". This comparison emphasised how the digital interface both constrained and defined her self-perception. Her use of phrases like "video self, video gazing, I don't know" indicated a search for language that accurately captured these experiences; nevertheless, she concluded with a definitive recognition of the reality of these experiences: "Yeah, it's real. It happens", affirming the significant, tangible impact of observing herself through the lens of video technology.

Sarah described a unique aspect of the virtual mirror – its manipulatable quality – which meant both she and her therapist appeared in different sizes at different times:

I remember that there was something off with the Zoom settings on a few occasions and instead of seeing the therapist big on the screen and myself like in the small window, for some reason I saw myself big and the therapist smaller. I remember something went off with the settings [...] And I said, uh, I remember at the start of the therapy, I said, Uh, I told my therapist, Wait, wait, I have to change it. Like I'm seeing my face big on the screen and it's really disturbing. And I think she did ask What, What is disturbing? And I just explained that I don't like to stare at a massive image of my face for one hour. But I believe that not only people with body image issues wouldn't like it. It's just like many people don't like hearing their voice recording or seeing themselves on the video. (Sarah, pp. 12-13, lines 13-15 and 1-10).

Like Rachel, Sarah also commented on the sizing and configuration of the video frames during her therapy sessions on Zoom. This setup, where her image unexpectedly became enlarged, was particularly disconcerting for her. In her recounting, she momentarily transported herself back to the unsettling experience, evidenced by her use of present tense, capturing the immediacy and emotional intensity of her reaction (“Wait, wait, I have to change it”, “it’s really disturbing”). Her comments such as “it’s a human reaction” and “not only people with [BI] issues wouldn’t like it” suggested she was trying to understand the extent to which other people would have been affected in the same situation, trying to place herself along an imagined spectrum from “normality” to “abnormality”.

Kevin’s comments suggested that he did not pay much attention to seeing himself in the self-view during VCP:

In therapy, um, in the little, I was, um, the focus was less on the little window [...] It was more on the, uh, on the therapy, uh, because, um, the main focus was just to get the treatment. Uh, you know, the focus was, the attention was on the other side, so, um, and also I didn’t want to look in this small window to lose focus and restrict myself. (Kevin, pp. 31-32, 13-1 and 1-4)

It seems that Kevin saw the focus on his image and the work of therapy as not being integrated, but instead as two opposing elements. By minimising engagement with the self-view, he ensured his therapeutic process remained uninterrupted by the potential distraction of self-scrutiny. Kevin’s experiences with the self-view during VCP diverged from those of Rachel and Sarah, who engaged in self-scrutiny, causing them discomfort. His experience also diverged from Charlotte’s, who described not looking at herself as something that naturally occurred because she felt relaxed with her therapist, whilst Kevin made an active choice to avoid the camera. Kevin’s experience could be understood in light of his approach to daily life, where he typically avoided looking in the mirror unless it served a practical purpose like shaving. This contrasts with Ella and Rachel, who both mentioned mirror-checking as one of the rituals they engaged in daily or had engaged in at some point to manage perceived flaws in their appearance.

Yasmin's approach to the self-view converged with that of Kevin, as she also made a conscious effort not to focus on self-scrutiny, albeit possibly for different reasons:

It's just in the beginning, I was staring at myself the whole time, but then when we got, you know, comfortable with each other and the conversation became more serious, then, you know, I, I was still looking at myself, but not as often as the beginning, you know? I was focusing on the actual material of the therapy 'cause I was benefiting from the exercise [...] And also it's, I'm paying for the, for the therapy. I have one hour. I can't be wasting the whole time just looking at myself. (Yasmin, pp. 18-19, lines 12-15 and 1-2; 4-5).

Yasmin's perspective demonstrated a conscious prioritisation of therapeutic goals over the inherent features of VCP that could detract from those goals. She articulated an understanding of the limitations of her money and time during sessions and made a deliberate effort to direct her attention away from self-scrutiny and towards more productive therapeutic engagement. This decision to redirect her attention away from self-scrutiny might have acted as a valuable life lesson in prioritisation, reinforcing that excessive self-scrutiny is "a waste of time" that could be spent on more meaningful pursuits and interactions.

VCP created a unique context for participants, transforming their screens into digital mirrors that offered continuous self-observation. Ella expressed discomfort due to seeing herself in states of high emotional vulnerability, which intensified her awareness of her appearance during therapy. Dean reported feeling shocked and unsettled by his visual appearance in VCP and seeing himself from this new perspective seemed to add layers to his existing BID. Although Charlotte experienced similar feelings of surprise during a recorded work call, she did not find the virtual mirror in VCP triggering due to her therapist's safe presence. Rachel and Sarah explored the more technical aspects of this self-scrutiny, focusing on how the video frame's sizing influenced their body perception. Conversely, Kevin and Yasmin chose to minimise their interaction with the self-view feature, concentrating instead on their therapists and the therapy itself, which they saw as separate and more meaningful than focusing on their image.

4.3.2 Subtheme 2: The Therapist in the Virtual Mirror. This subtheme explores

participants' experiences with the digital medium that presented an unusual view of the therapist within the virtual mirror. The online therapeutic space was seen as facilitating a comparison between the client's image and the therapist's image by allowing a certain amount of freedom to observe the therapist in a way that would not be otherwise possible.

Ella engaged in the same pattern of comparison in VCP, which she had previously reserved for social media, albeit with a newfound focus on her therapist. This act of comparison highlighted her capacity to scrutinise the therapist closely yet discreetly and speculate about the potential impact of her therapist's skin imperfections on their interaction:

[...] I would look at her skin a lot during the sessions [...] Um, and think like, she, she had a couple of imperfections I remember seeing on her skin. And I, I remember thinking, was that, how's that impacting on, like what she's feeling about what I'm saying. Is she looking at me thinking this, there's nothing wrong with this girl's skin. She's sitting there saying all this stuff and actually I do have imperfections on my skin. Um, but maybe what was different that I don't think I'd have been able to do as well in real life without looking like I'm staring at her all the time, is that I could look at her skin quite a bit and it wasn't obvious. (Ella, pp. 45-46, lines 11-12; 14-16 and 1-6)

Ella's covert observation of her therapist's skin might have had therapeutic value in the context of her BID. Perhaps focusing on her therapist's "imperfect" skin while contemplating her therapist's perspective allowed Ella to normalise her concerns by recognising that imperfections are universal and not solely a feature of her appearance. By closely observing her therapist's skin without her therapist knowing, she could engage in behaviour related to her BID that would be much harder to conceal in "real life". Her speculations about her therapist's potential judgement of her physical appearance ("there's nothing wrong with this girl's skin") might have helped her question her self-perceptions and reassess her assumptions about how others view her skin, a major focus of her BID.

Yasmin also engaged in comparison within the digital therapeutic environment. When asked what this was like for her, she said:

I think it's just, it's not because a therapist is more beautiful than me, or I'm more, it's not that someone is more beautiful than the other, it's just the attitude, you know, like, she's more confident in herself, you know? [...] So I would compare myself to every woman, to be honest with you, but in therapy, you know, you do compare, you compare yourself with another box because it's one box versus another box (Yasmin, p. 30, 5-8; 9-12)

Unlike Ella, whose comparisons focused more on physical traits, Yasmin's attention was drawn to confidence and demeanour. Furthermore, whilst Yasmin noted that she routinely compared herself to other women, it seemed that VCP made this a more formalised activity due to the structured layout of the video call interface, where each participant is distinctly framed in their separate box. Initially, the expression "one box versus another box" suggested a somewhat simplified and de-personalised interaction, potentially trivialising the depth of therapeutic connection. Yet, a more intricate interpretation can be offered when situated within Yasmin's overall positive reflections on VCP. It seemed that conceptualising the therapist and herself as separate "boxes" next to each other reduced the intensity of personal comparison. This digital "boxing" seemed to have modified the usual dynamics of intersubjectivity, creating a space where she could engage with her therapist more comfortably from the safety of her box, concentrating on the therapeutic exercises and conversation:

Um, just in the beginning I get distracted, like I don't really focus on the actual serious conversation, that she's trying to help me, but then the more exercises we do, the more like I feel like they are helpful, then I take the therapy more seriously and I stop saying that to myself. (Yasmin, p. 31, lines 5-8)

Yasmin saw the focus on comparison as a distraction from therapy. However, this gradually dissipated as she got more engaged in exercises, raising the question of what her experience would have been like if the therapy had not involved these exercises. Furthermore, her use of the present tense suggested the process was less resolved than Yasmin consciously realised.

Charlotte acknowledged a tendency to compare her image to her therapist's during sessions, but made a conscious effort to minimise its impact on her therapeutic experience:

I suppose I kind of would, there would be some comparative, like probably to like, thinking of how I look in relation to her, maybe? [...] Um, for negative or positive, I don't know. Um, so I,

I kind of would always be aware of it. Um, but I would try and not dwell on it cause I was conscious of the time and the cost and I just thought, I need to not, not keep, you know, looking at myself. I need to actually like, get something out of this for myself. (Charlotte, p. 43, lines 3-5; 7-11)

Charlotte's uncertainty, expressed with "for negative or positive, I don't know", suggested a moment of indecision and unresolved feelings regarding the implications of such comparisons. She remained conscious of this aspect but attempted to minimise its impact, acknowledging the constraints of time and cost and prioritising her therapeutic journey. Her awareness of "the time and the cost" suggested a pragmatic approach to the therapeutic space, where the potential for self-scrutiny and comparison with the therapist was recognised but intentionally minimised in favour of therapeutic gains, similar to Kevin and Yasmin choosing not to focus on the self-view. This indicated a level of self-regulation within the digital space, where the immediacy of visual feedback prompted a negotiation between introspection, self-evaluation and Charlotte's therapeutic goals.

This subtheme captures how the digital medium in VCP amplified participants' natural inclination to compare themselves to others by displaying their image alongside the therapists' within the virtual mirror. As the therapist's image became part of this digital reflection, Ella, Yasmin and Charlotte each experienced varying degrees of comparison, which they found differently helpful or distracting. Ella's act of "hidden" looking was beneficial, as she noted that even her therapist had imperfections, which normalised her concerns. In contrast, Yasmin and Charlotte found that observing the therapist in the mirror distracted them from engaging more fully with therapeutic exercises and goals.

4.4 Summary of Findings

The above analysis has presented the three GETs of (1) Absence of the (Whole) Physical Body, (2) Shifting Control in VCP and (3) The Mirror of VCP, highlighting both convergent and divergent perspectives among participants.

The first GET focused on the absence of the whole physical body in VCP, which most participants found hindered their ability to form deep therapeutic connections and fully convey their bodily struggles. However, one participant viewed this absence positively, feeling it increased approachability and reduced intimidation.

The second GET explored the dual aspects of control within the digital therapeutic environment. Participants experienced a sense of control when they could curate their appearance, yet faced uncertainties related to the stability of the online connection (relational and technical) and the direction of the therapist's gaze, impacting their sense of security in the therapeutic relationship.

The third GET focused on how the self-view function of video calls turned the screen into a virtual mirror. This led to varied responses, from intense self-scrutiny to avoidance of the self-view. The virtual mirror was unique as it showed the therapist at the same time as the client, offering participants a direct way to compare themselves to their therapists. However, like with the self-view, participants experienced this unique mirror differently – some engaged in comparing their image with their therapist's, whilst others made a conscious choice to focus on the therapy, which they saw as separate from their preoccupations with BI.

These findings collectively emphasise the nuanced and highly individual experiences of VCP among participants with BID. They highlight that participants' subjective experiences were shaped by a complex interplay of personal, relational and technological factors, where the challenges of BID, namely concern with physical appearance, heightened self-awareness and an ongoing struggle with self-criticism, intersect with the distinct features of VCP, particularly the absence of full physical co-presence, the use of filters and the self-view function.

Chapter 5: Discussion

In this chapter, I will interweave the current study's findings with relevant research and theoretical literature to validate the originality and significance of these insights and this field of study. I will consider the findings through the lenses of existential and psychodynamic theories, reflecting CoP's commitment to viewing phenomena through multiple theoretical perspectives (Milton, 2010). Additionally, I will critically analyse the implications of the findings for CoP, explore potential limitations and suggest directions for future research.

5.1 Interactions with Research Literature

In this section, I will focus on how the study's findings intersect with previous empirical literature. Although no authors have specifically addressed BID and VCP, one study has explored BI disturbance and VCP (Grignoli et al., 2021) and others have investigated the experiences of VCP among participants with EDs, who often also experience BID (e.g. Fernández-Aranda et al., 2020; Frayn et al., 2021; Murphy-Morgan et al., 2024; Simpson et al., 2005).

5.1.1 Research on VCP and BI Disturbance. In their qualitative study on experiences of VCP among individuals with BI disturbance, Grignoli et al. (2021) found that the self-view was so distressing for one participant that it inhibited their engagement in VCP. Similarly, in the present study, some participants initially hesitated to engage in VCP due to the idea of seeing themselves on screen. However, after participating in VCP, they expressed regret for not starting sooner, suggesting that their initial reluctance was driven more by assumptions about VCP rather than their actual experiences. Other participants reported significant discomfort with the self-view but noted that, over time, they gradually became accustomed to it, indicating that even deep-seated discomfort can be mitigated through continued exposure.

Grignoli et al. (2021) suggested that seeing the therapist's face in VCP could evoke associations with news reporting or police interrogations, making clients feeling more scrutinised. Although participants in this study did not explicitly make these connections, many described the

therapist's gaze as a stare which evoked an uncomfortable sense of intense scrutiny. Thus, the findings from this study both align with and diverge from those of Grignoli et al. (2021).

5.1.2 Studies of VCP Experiences Amongst Individuals with EDs. Many researchers have found that individuals with EDs experience VCP as more detached and impersonal than PCP (e.g. Frayn et al., 2021; Murphy-Morgan et al., 2024; Vuiller et al., 2021). Similarly, in the present study, participants experienced VCP as distant due to the absence of physical co-presence, with most seeing this distance as an obstacle to a deep empathic connection. This finding aligns with those from a recent mixed-methods study by Murphy-Morgan et al. (2024), where some individuals with EDs felt that the lack of physical proximity made it challenging to feel truly connected with their therapists. Some participants in that study (Murphy-Morgan et al., 2024) expressed a sense of loss over non-verbal forms of communication such as touch or the ability to offer or receive a comforting hug. The reference to hugging is interesting as it raises questions about how many therapists in PCP hug their clients. Similarly, in the current study, participants imagined what might have been in PCP (e.g. sharing a physical space would mean more empathy), highlighting a potential idealisation of physical co-presence over the actual benefits it provides.

In contrast to the majority, one participant in the present study appreciated the absence of physical co-presence in VCP, as this reduced her anxiety over her body being fully exposed. This aligns with findings from Frayn et al. (2021), who, in their qualitative study exploring the views of clients with EDs on VCP, reported that while most participants saw the physical distance of VCP as a barrier to connection, one cited it as an advantage as it reduced the anxiety of engaging with a therapist in person. The present study provides more specific reasons why one participant preferred the distant nature of VCP – she did not have to shake the therapist's hand and could avoid the cultural stigma associated with being seen seeking mental health support.

Authors of existing studies have discussed the theme of control in VCP. Simpson et al. (2005) reported that participants felt an increased sense of control in VCP due to the ability to leave the

session at any time. Moreover, psychoanalytic psychotherapist Ben-Salmon (2021) and psychodynamic psychotherapist Shaw (2020) have suggested that VCP allows clients living with EDs to exert a greater sense of control over how they are perceived by choosing which aspects of themselves they want their therapists to see. The current study builds on Ben-Salmon's (2021) and Shaw's (2020) informal observations by offering insights from clients' actual lived experiences. Participants in this study felt in control over how they were perceived by adjusting the camera angle to conceal areas of their bodies and using filters to smoothen their images.

In previous literature, the self-view in videoconferencing has been compared to a mirror (Grignoli et al., 2021; Pikoos et al., 2021). Participants in the present study made a similar analogy when discussing their experiences with the self-view, describing it as akin to having therapy with a mirror. The constant visibility of their physical appearance led to some participants becoming uncomfortably preoccupied with their appearance. Previous researchers (Fernández-Aranda et al., 2020; Grignoli et al., 2021; Murphy-Morgan et al., 2024; Simpson et al., 2005) have documented a range of discomfort among individuals with BI-related concerns when seeing themselves in VCP, from slight discomfort to severe distress. The current study builds on existing work by delving deeper into participants' nuanced experiences with the "mirror". For some, this led to discomfort and heightened awareness of their appearance during moments of emotional vulnerability. Others felt unsettled by seeing themselves from new perspectives, which seemed to add to their BID. Some participants focused on technical aspects, such as how the video frame influenced their body perception. In contrast, others chose to minimise their interaction with the self-view, instead concentrating on the therapeutic process, which they found more meaningful. These findings challenge the notion that the visual aspects of VCP are inherently distressing, suggesting instead that they can be managed or utilised differently depending on individual preferences, therapeutic goals and the specific nature of the individual's BID. As such, they build on preliminary findings by Datta et al. (2020) and Simpson & Slowey (2011), which suggested that the self-view can represent therapeutic opportunities.

Moreover, participants in the current study did not perceive the self-view as a typical mirror. Instead, they encountered a unique kind of mirror that reflected not only their image but also that of the therapist. This facilitated direct comparisons by the clients between themselves and the therapist, adding a layer of complexity to the self-view experience that goes beyond the traditional mirror analogy used by Grignoli et al. (2021) and Pikoos et al. (2021). The issue of comparisons has been anecdotally mentioned by Frayn et al. (2021), who warned about the potential for increased self-focus and social comparisons driven by the visibility of one's image during virtual consultations. Conversely, as part of their recommendations for enhancing VCP experiences for individuals with EDs, Cook-Cottone et al. (2024) suggested that because the camera only shows the therapist's face and shoulders rather than their whole body, this could mitigate unhelpful comparisons, thereby improving client concentration and engagement during sessions.

While Cook-Cottone et al. (2024) suggested that limited visual interaction could deter unhelpful comparisons, findings from the current study indicate that this might not apply to all individuals. For individuals whose BID pertains to their face, the digital focus on faces in VCP sessions might inadvertently facilitate rather than reduce comparisons. This highlights that the effect of VCP on self-comparison and therapy engagement is multifaceted. While VCP can help some clients avoid detrimental comparisons and focus on therapy, the same digital setting may intensify self-comparison for others. The contrast between these findings and those from Cook-Cottone et al. (2024) underscores the individuality of each client's experience, illustrating the need for a tailored approach in VCP that aligns with CoP's emphasis on seeing clients in their own terms (Woolfe, 2016).

5.2 Interactions with Psychoanalytic Theory

This section focuses on how the current study's findings intersect with existing psychoanalytic theory, specifically literature on the concept of the uncanny, mentalisation, pretend mode and the therapeutic relationship.

5.2.1 The Concept of the Uncanny. Findings from the current study demonstrate that the continuous presence of the self-view can add complexity to existing BI concerns rather than merely exacerbating them. The nature of that complexity seems to link with Freud's (1919/1971) concept of the uncanny, which is the unsettling sensation that arises when something familiar unexpectedly appears alien, triggering a sense of discomfort. Participants in the current study described how their familiar selves, typically perceived in a certain way, seemed unexpectedly foreign when seen on the screen. However, if they became engrossed in the conversation and felt relaxed with the therapist, self-viewing became more manageable. This evolution in perception can be linked to Japanese roboticist Mori's (1970/2005) theory of the uncanny valley, which describes people's discomfort with lifelike robots and similar experiences, including interactions mediated by technology. According to Mori, the uncanny valley represents a dip in our comfort level that occurs when something familiar becomes disturbingly alien. However, as we acclimate to new technology, the depth of this valley can change, meaning that what once seemed uncanny can become familiar over time (Mori, 1970/2005). This phenomenon seems to mirror the experience of some of the participants in the current study, where initial reluctance to engage in VCP due to the unsettling nature of the self-view feature was followed by the realisation that this was not as distressing as they had anticipated or that initial discomfort had been put into perspective as they ultimately prioritised other aspects of therapy, leading them to adapt to VCP more comfortably over time.

5.2.2 Mentalisation and Pretend Mode. "Pretend mode" is a state in which individuals disengage from their embodied experiences and present a facade to avoid confronting uncomfortable or painful realities (Bateman & Fonagy, 2016). This concept is rooted in mentalisation theory, which

examines how individuals make sense of their own and others' mental states (Bateman & Fonagy, 2010). Grignoli et al. (2021) hypothesised that individuals with BI disturbance may alter their self-presentation during VCP, engaging in a form of pretend mode. However, their exploration remained largely theoretical, without direct evidence from clients.

The findings from the present study closely align with the concept of pretend mode, as participants frequently curated their self-presentation during VCP by using filters or adjusting camera angles to conceal perceived flaws. While this behaviour provided temporary relief from the anxiety of exposing disliked features, it potentially perpetuated avoidance, as participants presented a modified version of themselves – one that aligned more with an idealised self or societal beauty standards – rather than confronting their true self-image. Participants even referred to this process as presenting an enhanced version of themselves that did not correspond to reality, further reinforcing the idea of disengaging from their authentic appearance. Unlike Grignoli et al. (2021), who offered theoretical speculation, the current research provides direct evidence of pretend mode in action, drawn from clients' experiences. However, the notion that this behaviour perpetuates avoidance remains speculative and requires further investigation.

5.2.3 The Therapeutic Relationship. The uncertainty described by participants in this study – such as not knowing where the therapist was looking or experiencing technical glitches that led to fears of being misunderstood – can be interpreted through the lens of psychoanalytic theory, particularly the concept of the therapeutic relationship (Sayers, 2021).

The therapeutic relationship is defined in several ways in theories and research relevant to psychotherapy (Cooper, 2008). From a psychoanalytic perspective, specifically that of attachment theory (Bowlby, 1969/1982, 1973), the therapeutic relationship serves as a secure base for clients, much like the parent-infant dynamic (Sayers, 2021). This secure base fosters relational safety, enabling clients to explore their difficulties. Unclear non-verbal cues – such as not being able to tell where the therapist is looking – and misinterpretations of vocal tone, like a client needing to shout due to a poor

connection, can threaten the perceived reliability of the relationship, ultimately weakening the secure base that underpins the therapeutic relationship (Sayers, 2021).

Participants' concerns about connection in VCP underscore the importance of the therapeutic relationship as a secure base. Clients with insecure attachment styles, such as anxious or ambivalent attachment, may be susceptible to perceived distance or disconnection (Holmes, 2014). Their need for reassurance and relational security can make them more vulnerable to the perceived instability of the virtual environment.

While I am not aiming to diagnose participants as having insecure attachment styles, their experiences highlight the centrality of a secure base in therapy since the less tangible, physically distanced nature of VCP may have amplified any existing attachment-related anxieties. As such, the technology may have become a focal point for these concerns, serving as a metaphorical "scapegoat" for broader concerns about connection and presence.

Nevertheless, researchers have argued that the issues participants experienced in VCP can be addressed with relatively simple adjustments, such as aligning the therapist's gaze with the camera or using physical gestures like leaning forward, to enhance the sense of co-presence (Dowell & Berman, 2013; Geller, 2020). Additionally, having contingency plans for technical difficulties – such as switching to a phone call or temporarily turning off the video to reduce internet load – can ease anxieties around potential disconnections (Geller, 2020). This suggests that although VCP presents certain inherent challenges, how therapists navigate and manage the virtual space plays a crucial role in shaping the quality of the therapeutic relationship and clients' overall experiences. It is worth noting that PCP also comes with its own set of challenges, such as the risk of clients encountering each other in waiting areas or environmental distractions. In both settings, therapists and clients can implement strategies to manage these issues, suggesting that VCP and PCP are not so different; they simply involve addressing different kinds of problems.

5.3 Interactions with Existential Theory

In this section, I focus on how the current study's findings intersect with existential-phenomenological theory, specifically literature on the concept of being-with, mirroring and being-in-space.

5.3.1 Being-With. “Being-with” is a concept introduced by Heidegger (1927/1962), referring to the inherent interconnectedness of human existence. Heidegger posited that human beings are always in relation to others; our existence is fundamentally social, and we are always in the world with others. Participants in this study seemed to strongly believe that being-with – or truly connecting in therapy – required physical co-presence. Dreyfus (2008), an existential-phenomenological philosopher, argued that sensing mood, feeling another's presence and grasping a genuine sense of reality online are nearly impossible, leading to ontological insecurity – a feeling of not having a firm grasp on one's own or others' reality.

Building on Dreyfus (2008), Spinelli (2007) reminded us that we can never fully be known by another person. Furthermore, he posited that therapists, much like Walt Disney's character Dumbo, who believed he could only fly with his “magic feathers”, often place undue faith in certain psychotherapeutic principles and assumptions that might be unnecessary or limiting (Spinelli, 2015). While Spinelli was referring to therapists' assumptions about what makes therapy work or not, one of the findings from the present study was that participants held similar beliefs, placing great importance on physical co-presence as essential for authentic connection. However, their reflections during interviews indicated a shift in their understanding. Over time, they realised that physical co-presence was not as central to building a meaningful connection as they had once assumed. In alignment with Spinelli (2007), they came to acknowledge that our ability to fully understand another person is inherently limited, even in PCP. This suggests that their initial assumptions about the necessity of physical co-presence were revised as they recognised that they could build strong therapeutic relationships online, contrasting with their earlier beliefs.

5.3.2 Mirroring the Body in VCP. Some participants felt that the reduced visibility of their bodies in VCP created a barrier to being fully understood. Spinelli (2001) used the metaphor of “mirroring” the client to describe the therapist’s role in existential-phenomenological therapy – the client’s words, emotions and body language are reflected back to them. This process invites clients to reconsider their perspectives, fostering deeper self-awareness and understanding (Spinelli, 2001). Participants in the current study seemed to believe that, since they were framed only from the shoulders up and the therapist could not see their entire bodies, this meant that the therapist could not fully understand them. Perhaps this intuitively reflects the participants’ understanding of the ability or need for the therapist to provide effective mirroring since, in VCP, non-verbal cues related to body language (e.g. leg positioning or hand movements) would not be available.

Moreover, participants seemed to believe that, because of the limited visibility, therapists could not see – and therefore could not validate – the perceived flaws that participants saw when they looked in the mirror. This lack of visibility meant they could not show the therapist the full extent of what they believed was wrong with their appearance, further deepening their sense of being misunderstood. However, this feeling of misunderstanding was intrinsic to how participants defined BID; that is, as flaws that only they could see. Even in physically co-present interactions, others often overlooked or dismissed these perceived flaws, telling participants that there was nothing wrong with them.

The shortcomings that participants in the current study attributed to VCP around conveying a complete sense of the body may reflect broader issues faced by individuals with BID rather than being an issue with the therapeutic medium per se. However, the lack of full visibility in VCP may have served as an explanation for experiences of not being fully understood that were more easily accessible to participants. Without the digital context, explaining why others fail to perceive what participants believed to be the “objective truth” about their appearance could become more abstract and complex. In line with these connections between being seen, being understood and the readily available attribution of deficiencies in understanding to VCP, participants’ desire for a “360-degree view” may

highlight a more profound need for empathy and understanding, rather than being solely a reflection of the limitations of VCP.

One could go even further and suggest that the decreased visibility of the body in VCP might actually be beneficial to therapy. As Spinelli (2005) noted, describing what one looks like rather than having the therapist see one's entire body may be a more accurate picture anyway: "Our image of our bodily self is not a reflection of what is truly there, in a physical sense, but is, more accurately, the reflection of what we believe to be there" (p. 77). This suggests that online work may enable therapists to bracket off their physical appraisals of their clients, allowing them to be fully open to receiving what the client is trying to explain about their beliefs about their appearances (Spinelli, 2005).

5.3.3 Being-in-Space. The existential concept of "being-in-space" (Adams, 1998, p. 2) refers to the mutual influence between individuals and their surroundings. According to existential theory, the self is intertwined with the environment, meaning both continuously shape one another. Thus, it is more precise to describe an individual as being spatial (or being-in-space) rather than a being in space (Kasket, 2003). In the present study, participants were being-in-the-virtual-space with the therapist, using filters and other videoconferencing features to alter their appearance, while simultaneously being-in-the-physical-space, surrounded by the furniture in their rooms and manipulating physical elements such as lighting. This dual presence highlights how participants navigated and shaped both their digital and physical environments to manage how they perceived themselves and were perceived by the therapist. At the same time, both the virtual environment (e.g. availability of filters) and the physical environment (e.g. available tools like lighting) influenced what and how much they could alter about their appearance.

5.4 Summary of Original Findings

This study is the first to specifically explore BID within the context of VCP. Some studies have examined the experiences of VCP among individuals with EDs, who often also experience BID, offering insights into clients' exposure to the self-view (e.g. Fernández-Aranda et al., 2020; Simpson et al., 2005). However, these studies often lack methodological rigour and do not fully capture the complexity of individuals' experiences. More rigorous studies exist (e.g. Frayn et al., 2021, Murphy-Morgan et al., 2024; Vuillier et al., 2021), but they focus primarily on the impact of the COVID-19 pandemic on individuals with EDs and their overall experiences with VCP, despite acknowledging the importance of exploring self-view experiences.

Grignoli et al. (2021) specifically explored BI disturbance and VCP, highlighting the discomfort that individuals with BI-related concerns experience when seeing themselves or being seen by their therapist. However, many of their conclusions are speculative and not based on direct client experiences.

What distinguishes the current study is its phenomenological approach, which delves deeply into the personal, lived experiences of individuals with BID as they navigate the dual processes of seeing themselves and being seen in VCP. This allows for a richer understanding of how these individuals make sense of visibility and perception within the online therapeutic context. Additionally, this is the only study written from a CoP perspective, providing practical recommendations for practitioners working in the field of BI and beyond.

5.5 Practical Implications for CoP Practice

Given this study's qualitative, idiographic nature, my aim is not to derive definitive guidelines (nomothetic principles) for practice. Instead, this section contains a set of applicable observations and principles for CoPs to suit specific situations and client needs.

The detailed analysis showed that participants' experiences of being seen/seeing themselves in VCP varied greatly. Furthermore, many participants did not discuss their thoughts about being

seen/seeing themselves with their therapist and expressed regret about this during the interviews. These observations underscore an existing aim of CoPs: creating a non-imposing, non-assumptive space for clients to discuss their concerns. By fostering an open and non-judgmental therapeutic environment, CoPs can better accommodate each client's unique needs and perspectives (Milton, 2010). They must strike the difficult balance between tailoring their approach to the client's comfort level and encouraging clients to work through their discomfort when it may benefit their therapeutic progress. Ultimately, such therapeutic decisions depend on the formulation and ongoing assessment of the client's needs and progress (Woolfe, 2016).

The first GET in the current study was the absence of the (whole) physical body in VCP. Linked to this, it is recommended that CoPs who are working with clients virtually remain alert to moments when clients discuss their experiences of being seen in the physical world, as these can be opportunities for exploring their feelings in the virtual setting. For example, if a client mentions what it feels like when others see their stomach, a CoP might make the following process intervention: "You're describing what it's like for you when people see your stomach. I'm aware that I'm not able to do that here. What's it like for you to talk to me about this, knowing that I can't do that?" This phenomenological process intervention involves describing an observation and then asking an open question without assuming what the client might be feeling or thinking. Phenomenology in practice allows therapists to remain open to the client's lived experience and understand the meaning of these experiences from the client's perspective, aligning with the core values of CoP that emphasise the exploration of subjective and intersubjective experiences (Finlay, 2011; Woolfe, 2016).

Biofeedback clinicians Rolnick and Ehrenreich (2020) have suggested "bringing the body back to the scene" (p. 20) by using special cameras that enable therapists using videoconferencing platforms to see the client's full body. However, it is worth reflecting on possible implications before practitioners make such changes. The recommendation that VCP should mimic PCP (by providing full bodily visibility) presupposes that PCP is inherently superior – an assumption not fully supported by

this study's findings. The case of a blind therapist further challenges these assumptions: what does this stance say about their ability to understand a client compared to sighted therapists? Recognising that therapy can take many forms and does not solely depend on visual perception is crucial for promoting a genuinely inclusive practice that aligns with CoP identity (Parritt, 2016).

GET 2 focused on participants' feelings of control, including control over appearance. When a client with BID uses a heavy filter during online sessions, practitioners have several options: not mention it, hope the client mentions it, ask for the filter to be turned off or acknowledge the filter and inquire about its meaning. Based on the current research and in alignment with CoP's commitment to unbridled curiosity, authenticity and an understanding of the human condition (Kasket, 2012b), I encourage CoPs to choose the last option. Just as they would address facial expressions or body language in PCP, engaging with the use of filters allows therapists to explore deeper meanings and foster an authentic dialogue that resonates with the client's lived experience (van Deurzen, 2010). One approach might be to say: "I'm noticing there's a filter on your video – tell me about that" or "What would it be like for you to appear without the filter?" Open questions such as these can lead to deeper insights into the client's BID. However, it is essential to consider the therapeutic relationship and the client's circumstances when using such questions, as some clients might find this direct approach too confrontational if they were hoping the filter was not noticeable. Online work is sometimes problematised because therapists cannot see how clients enter a room (Perry et al., 2020; Rees & Stone, 2005); however, using a filter can be seen as a way of "entering a room", analogous to a client coming to therapy wearing heavy make-up. Thus, filters not only provide cues about how the client wishes to be perceived but should be considered part of inclusive practice, in line with the profession's commitment to inclusivity (Parritt, 2016).

GET 3 illustrated that participants experienced VCP as a mirror. Linked to this, it is recommended that CoPs ask probing questions when clients discuss looking at themselves or mirror-checking in their daily lives. This will aid in understanding how this is playing out in therapy, e.g.

“How are you feeling about looking at yourself here?” Similarly, it might be helpful to ask clients about how they are using the video conferencing platform (e.g. whether they have the self-view on or off) to explore the function of digital choices for them and how these choices affect their experience.

In line with a pluralistic perspective on therapy which focuses on working collaboratively with clients to identify their goals and how to achieve them (Cooper & McLeod, 2010), CoPs could engage clients in discussions about whether they would prefer to keep the self-view on or off during sessions. If the client’s goal is to learn to accept themselves, they might decide to keep the self-view on despite initial discomfort. By collaboratively deciding to engage with the discomfort, CoPs can support clients in developing a more accepting relationship with themselves despite their BID.

If clients mention social comparisons, it may be useful to ask if the comparison shows up in all circumstances or just specific ones. If the client responds that they always show up, a follow-up question could be, “And what’s going on for you now?”. If a client expresses discomfort, such as an uncomfortable awareness or emotion, the CoP might ask a hypothetical question, such as: “If you had the power to arrange my image on the screen, how would you do that?” Asking curious questions like these allows for an exploration of clients’ experiences in terms of what they are aware of, what they do or want to do in response to this discomfort and any control they might attempt to exert by making particular digital choices.

5.6 Recommendations for Formal Guidance and Training

5.6.1. Recommendations for Formal Guidance. The above suggestions are practically achievable and focus on the individual practice level. However, broader strategies are needed to enhance competency and awareness across the field. The BPS has published various resources to support practitioners in delivering services via online platforms. For example, the BPS (n.d.) offers *Top Tips for Effective Therapy via Video*, which outlines best practices for conducting remote therapy sessions. This guidance highlights the importance of establishing “telepresence” – a sense of being fully present in the virtual space – by ensuring adequate lighting for the therapist’s face and

maximising sound quality with headsets or earbuds. The emphasis on telepresence aligns with the findings of the present study, which underscored the importance of co-presence in VCP – a sense of “being-with” irrespective of physical distance.

Despite the existence of various guidelines on VCP or online therapy more broadly, there remains a significant gap in formal guidance specifically addressing BID. While it may not be feasible to cover the implications of every presentation and its treatment in an online context, this research highlights BID’s status as a normative discontent and demonstrates its unique interaction with VCP. For example, clients’ preoccupation with their self-view and their experience of being seen can significantly influence the therapeutic process. To bridge this gap, formal guidance from organisations such as the BPS or the HCPC should incorporate BID-specific considerations. This would equip psychologists with practical strategies for addressing appearance-related anxieties in VCP, including managing clients’ self-view concerns, exploring their experiences of the gaze, and understanding the relational impact of appearance concerns. Embedding such content into official guidance would not only enhance psychologists’ ability to support clients with BID but also help meet the growing demand for VCP in a more inclusive and effective way.

5.6.2 Recommendations for Training. During the COVID-19 pandemic, DPsych programmes that were traditionally delivered in person had to transition rapidly to online teaching. This swift adaptation often required bringing in specialists and quickly assembling resources to meet the immediate needs of trainees. In response, the BPS (2022) developed supplementary guidance for accredited online, blended and distance learning programmes, aiming to enhance criteria within their accreditation standards. This guidance encourages institutions to reflect on and consider the unique aspects of delivering psychology education in digital formats. However, while it addresses educational delivery methods, it does not establish standards or curricula specifically dedicated to online therapy or VCP. Similarly, the HCPC (2023) provides broad guidelines for professional practice that can be extended to VCP but does not offer specific directives for it. In contrast, the British Association for

Counselling and Psychotherapy (BACP) has developed detailed frameworks, such as *the Online and Phone Therapy (OPT) Competence Framework (2021)* and *the OPT Training Curriculum (2021)*, to ensure that counselling courses adequately prepare practitioners for remote modalities. These frameworks address topics such as ethical considerations, managing technology and fostering therapeutic presence online.

Given these considerations and the increasing prevalence of VCP, it would be beneficial for the BPS to develop similar training-focused guidelines, which could also address the challenges of working with clients experiencing BID. Such frameworks could guide training programmes to address the nuances of appearance-related anxieties in VCP, including managing clients' preoccupation with their self-view, discussing their experiences of the gaze and exploring the relational impact of appearance concerns. Content about working with appearance-related anxieties in VCP could then be seamlessly integrated into existing CoP curricula without requiring extensive overhauls. For instance, it could be incorporated into existential-phenomenological modules, where the realms of existence (van Deurzen, 2010) offer a comprehensive framework for understanding appearance-related anxieties. Specifically, feelings around limited visibility of the body can be linked to the physical realm; the use of filters to curate one's appearance pertains to the social realm; while the personal realm encompasses thoughts and feelings around social comparisons (van Deurzen, 2010). By embedding such content into training programmes, psychologists would be better equipped to meet the growing demand for VCP and address the unique challenges faced by clients with BID.

Nonetheless, it is important to note that formal changes to training curricula and the development of comprehensive guidance often follow cyclical processes. The absence of specific guidelines at this time may reflect the natural progression of these cycles and it is possible that such guidance is currently under development or consideration.

5.7 Dissemination of Findings

To disseminate my findings, I plan to run a workshop at the BPS Division of Counselling Psychology Annual Conference 2025, sharing insights with CoP trainees, professionals and academics. Additionally, I plan to submit my research to BI and online psychotherapy conferences, such as the Association for Counselling and Psychotherapy Online (ACTO). I hope to publish my findings in UK-based journals for trainers and trainees, such as *Counselling Psychology Review* and the *BACP Research Journal*. I will also target high-impact international journals such as the *Journal of Counseling Psychology*, *Body Image* and the *International Journal of Eating Disorders*. I will actively seek possibilities to collaborate and build relationships with key stakeholders in the field, such as the BDDF and BEAT. Finally, I will share the findings with recruitment sources and participants who expressed interest.

5.8 Limitations and Suggestions for Future Research

The study's epistemological commitment to phenomenology and hermeneutics allowed for an in-depth, nuanced examination of personal lived experiences, focusing on the meanings these experiences hold for participants and how they make sense of them. The idiographic approach, emphasising depth over breadth, meant the study was conducted with a small, homogeneous sample. While this allowed for a detailed exploration of participants' individual experiences of being seen and seeing themselves in VCP and the identification of convergences and divergences within the specific group, it inherently prevented statistical generalisability of the findings (Smith et al., 2022). A quantitative or experimental study that focused on various dimensions of VCP could certainly be designed. For example, a controlled experimental study with different conditions (PCP vs. VCP, self-view on vs. self-view off, use of a filter vs. no filter) could be analysed statistically to assess the impact on variables such as self-consciousness, emotional disclosure or TA. This approach would allow researchers to systematically explore how these conditions influence the therapeutic process and outcomes, providing empirical evidence to guide best practices.

Whilst the findings from this study are not generalisable in the traditional sense, there is potential for theoretical generalisability, which involves the transferability of concepts, insights and understandings to other contexts and theoretical domains (Smith et al., 2022). For instance, the insights gained from the specific experiences of individuals in this study – such as the dynamics of self-view and therapist observation – could inform broader theories about BI and therapeutic practices beyond the specific group studied. This is especially relevant given that BID has been described as widespread human experience (Rodin et al., 1984). This study's insights also extend to other settings where BI and self-representation are significant concerns, such as social media, professional video conferencing and online education. This highlights the unique contribution of this research, which offers a nuanced understanding of visibility and perception in digital environments that is relevant to a wide range of contemporary contexts.

Participants were only included in this study if they had experienced VCP. Thus, the perspectives of individuals who might have opted out of VCP due to discomfort with the idea of being seen or seeing themselves virtually were not included. Future researchers should explore the experiences of these individuals to understand more about the perceived challenges and barriers associated with VCP. For instance, focus groups with individuals experiencing appearance-related anxieties could provide a platform for discussing concerns about VCP. Understanding the experiences of those who opted out of VCP due to strong beliefs about what was possible or desirable in VCP is crucial because therapeutic services are increasingly moving online, and these beliefs might significantly limit clients' opportunities for therapy.

While I did not set out to develop or advance theoretical frameworks, insights from the current study add to the literature that questions our assumptions about VCP vs. PCP (e.g. Clark & Green, 2018; Jiang et al., 2011) and suggest a fertile area for theory-building in future research. Given the disconnect between participants' apparently deeply ingrained beliefs about therapy and their actual experiences with VCP, future researchers could delve into how individuals reconcile their

preconceived notions of “effective” therapy with actual VCP experiences. This could involve longitudinal qualitative studies that track participants’ experiences over time, capturing the evolution of their beliefs and perceptions. Interviews could be conducted at different stages of the therapeutic process – such as before, during and after therapy. This method would capture participants’ preconceptions and expectations, as well as the processes of change and adaptation throughout their therapeutic journey. Additionally, engaging with participants on multiple occasions could help build a stronger rapport, making them more comfortable and potentially encouraging them to share deeper insights. This would allow for richer data collection and a more nuanced understanding of the issues discussed, ultimately enhancing the depth and quality of the research findings. There is a growing body of longitudinal IPA research (Farr & Nizza, 2019; Spiers et al., 2016), which might be an ideal methodology for such a study.

Grounded theorists could further explore the factors influencing shifts in perceptions about VCP. In-depth interviews with individuals who have experienced VCP could generate key themes and patterns, providing insights into the cognitive and emotional processes that drive these changes. Such research could delve into the mechanisms of change within the therapeutic context, offering valuable insights that inform practice by helping therapists understand how to better facilitate positive shifts in client perceptions and engagement with VCP.

5.9 Reflexivity

In this section, I will address both personal and methodological reflexivity. Personal reflexivity will focus on how my experiences, views and characteristics have shaped my approach, and how the research process has affected me personally and professionally. This contrasts with the initial reflexivity statement (Section 1.10), which offered a general overview of my position and motivations at the outset of the research. In the methodological reflexivity section, I will evaluate my execution of the IPA methodology, discussing any challenges and strategies used to overcome them.

5.9.1 Personal Reflexivity. As is typically the case with IPA, the data and meanings in this research were co-constructed through the dialogue between me and each participant, indicating that these interpretations are contextually bound to our interactions (Tuffour, 2017). I acknowledge that my participation in the dialogue inevitably influenced the phenomenon. For example, without my personal experience with VCP, my approach to designing the interview schedule might have differed. However, in IPA, these experiences are not seen as hindrances but as integral to the whole research process. IPA researchers value the co-construction of meaning between researcher and participant, recognising that understanding is inherently interpretative and contextual (Smith et al., 2022).

Someone who has not experienced VCP might have approached the research from a more naïve perspective. However, a naïve perspective does not necessarily imply a lack of assumptions. My experiences with VCP in personal therapy and clinical placements exposed me to contrasting experiences, which may have made me more curious and open to the nuances of participants' accounts than someone without VCP experience, who might assume, for instance, that it is inherently inferior to PCP. By acknowledging and reflecting on my preconceptions, I aimed to remain open to participants' experiences, allowing their narratives to guide the analysis.

As I immersed myself in participants' narratives and undertook the analysis, I could not help but think of my experiences with VCP. This required me to make a constant, conscious effort to maintain a clear boundary between their experiences and mine, resisting the temptation to draw comparisons with my encounters with VCP. I had to continually remind myself to prioritise the participants' stories, ensuring I did not inadvertently steer the conversation during interviews or overlook potentially important subtleties. Supervisory discussions helped me enhance the rigour of the research by ensuring that my interpretations remained closely tied to the data, maintaining their accuracy and transparency. For example, in the initial drafts of the write-up, I occasionally strayed too far into interpretation, rather than staying close to the content of the quotes. Supervision encouraged

reflexive practice which helped me distinguish between insights derived from the participants and those influenced by my own perspective as the researcher.

Participants seemed to engage in active meaning-making during the interactions, as evidenced by their spontaneous reflections, immediate reactions and the evolving nature of their responses. This realisation prompted me to reflect on my role in the construction of meaning, as meaning is the result of a collaborative process grounded in the intersubjective nature of researcher-participant interactions (Finlay, 2002a). I recognised that critical self-evaluation of the researcher's characteristics, including gender, age, origin, appearance and emotional responses to participants, was essential for the integrity of my research (Etherington, 2004). During the interviews, participants occasionally mentioned attributes such as slim body size and white ethnicity, which are also my attributes. For example, Yasmin's comments that she considered slim people with flat stomachs "more worthy" (Yasmin, p. 4, line 8) and Rachel's curiosity about what her VCP experience might have been like if the therapist had not been a "female white, Caucasian lady" but rather from "an ethnic minority background" (Rachel, p. 56, lines 4 and 8) heightened my awareness of these dynamics.

This reflection prompted me to consider whether, and how, the lifeworld presented in the interviews might have been different if my body size or ethnicity had been different. However, as these dynamics were not explored during the interviews, such thoughts remain speculative; it is not possible to determine the extent to which these characteristics of mine may have influenced the data. In the context of therapeutic practice, I might have directly explored these dynamics, but in the research setting, I felt constrained by the need to maintain a boundary between my roles as a therapist and a researcher. Additionally, I was aware that in IPA, the researcher's role is to facilitate participants' expression of their experiences without imposing interpretations or introducing dynamics that could shift the focus away from the participants' narratives (Smith et al., 2022). Therefore, while these reflections are important, they were not explicitly addressed during the interviews.

Another aspect of reflexivity involved examining my assumptions about the participants' experiences. While I reflected on my preconceptions before engaging with the participants (see Section 1.10), I only began recognising some of these assumptions during the analysis. I remembered often feeling surprised in the interviews, but it was not until the analysis that I realised why: I was surprised to discover that participants often did not discuss their feelings about VCP (e.g. anxieties about the self-view) with their therapists. This experience illustrates how deeply ingrained and implicit fore-understandings can remain dormant until challenged by conflicting data (Smith et al., 2007).

This realisation was particularly significant for me as a trainee CoP. My training emphasised the importance of creating a safe space for clients to discuss any concerns and encouraging them to provide feedback on how they feel during sessions. However, the lack of discussions about participants' feelings toward VCP in their therapy suggested that their therapists may not have actively encouraged this kind of openness and feedback or that participants did not feel comfortable enough to share their thoughts at the time. This realisation highlighted the diversity in therapeutic practices and the necessity of awareness of these differences when conducting research on individuals' experiences of therapy. Understanding that not all therapists work with the same assumptions as CoPs, and acknowledging the variety of training backgrounds, is crucial for interpreting the data accurately and comprehensively (Finlay, 2002a; Smith et al., 2022). At the same time, even when therapists strive to create a safe space for open discussions, this may not always be immediately achievable, regardless of the therapist's training background. In other words, being a CoP does not guarantee a strong and open therapeutic relationship, just as being a therapist from another discipline does not preclude the possibility of openly discussing in-the-moment experiences with clients.

5.9.2 Methodological Reflexivity. IPA has a set of quality criteria (Nizza et al., 2021; Smith et al., 2022) that I reflected on throughout my research to ensure that rigour and reliability were maintained. These criteria include demonstrating that the study has been conducted in a manner consistent with its epistemological position. Using IPA as a methodology requires approaching the

research process “with a purposeful phenomenological and hermeneutic orientation” (Eatough & Shaw, 2019, p. 51). This involves thinking, making decisions and carrying out those decisions in alignment with such perspective. One of the ways I endeavoured to be phenomenological towards the participants’ lived experiences was through careful selection of language throughout the research process. Rather than “interviewing” participants, I framed the data collection as a conversation about their experiences. Each participant was viewed as an expert on their experiences, while my role was to facilitate the description of that experience (Smith et al., 2022). Additionally, assigning pseudonyms to participants aimed to personify them, enhancing the reader’s connection with their individual experiences. This allowed for a more relatable presentation of findings, situating the data within participants’ unique lived experiences, rather than using impersonal identifiers like “Participant 1” (Eatough & Smith, 2017).

As mentioned in Chapter 3, the hermeneutic circle necessitates a continual oscillation between the parts and the whole (Finlay, 2011). For example, reading Yasmin’s phrase “you’re in control when it’s online” within its immediate context provided insight into her feelings about VCP. Examining this phrase within the broader context of her interactions provided deeper insights: PCP would require her to interact with others (e.g. a receptionist) and expose her (clothed) stomach area, which she was conscious of. Additionally, integrating other knowledge about Yasmin, such as the cultural stigma surrounding therapy in her community, further illuminated the phrase. The series of wholes illuminated the part, allowing its meaning to shine forth. Ambiguity in the part helped me see a broader issue in the whole; Yasmin’s preference for VCP was not just about managing her BID but also about navigating the cultural stigma associated with seeking mental health support.

The appeal of the hermeneutic circle lies in its ability to deepen interpretation; however, reaching a final interpretation can be elusive, as the process could theoretically continue indefinitely (Smith, 2007). I had to trust my judgement to determine when the interpretation was sufficient, which

was initially challenging. Over time, with practice and guidance from my supervisors, I became more confident in recognising when to step out of the circle and begin writing up the findings.

The topics I discussed with the participants had interesting parallels with the interview situation itself. This was not only due to the use of videoconferencing but also because the interaction involved sharing quite intimate experiences. It felt important to acknowledge this dynamic; hence, at the end of each interview, I asked participants: “What has it been like to talk about this here?” However, as I did not identify any meaningful themes from this question, I wonder if the experience might have been different had I asked a more specific question about their experience of being seen and seeing themselves during our video call. This reflection raises the possibility that asking participants more directly about this aspect could have yielded richer data more closely aligned with my research objectives.

Equally, it could be argued that the last two questions (“Have you ever had in-person therapy?” and “Is there anything else you would like to add?”) could have been either eliminated or reworded to make the interview schedule more methodologically consistent, as both were closed questions. Reflecting on this, I recognise that open-ended questions could have better captured the richness of participants’ experiences and aligned more closely with the principles of IPA. In practice, while a few participants had nothing more to add, others shared final thoughts or reiterated points mentioned earlier in the interview. In future studies, I would ask more open-ended questions at the end of the interview, such as: “We have spoken about your experience of VCP; what final thoughts would you like to share?” This could invite more reflective and detailed responses. Overall, this reflection highlights the need for ongoing critical evaluation of the interview process to ensure that the questions posed align with the methodological framework.

When recruiting participants, I trusted their self-assessment of English proficiency to allow individuals to determine their suitability for participation, promoting a more inclusive and respectful research environment. However, while conducting the preliminary analysis, I encountered challenges

relating to one participant's level of English proficiency. In transcripts of fluent English speakers, I could interpret repetitions or hesitations as meaningful indicators of their experience. However, with this particular participant, it was difficult to discern whether certain expressions were a result of the language barrier or reflections of their experience. This raised concerns about introducing heterogeneity in my analysis, as I could not treat that transcript with the same analytic strategy as others. IPA researchers focus on understanding how people make sense of their experiences, often requiring a deep engagement with participants' language use (Smith et al., 2022). Disparities in language fluency can complicate this analysis, as participants may struggle to express themselves fully, potentially leading to misinterpretations or uneven depth of insight (Noon, 2018).

Despite my efforts to confirm this participant's meaning during the interview, the language barrier still left room for misinterpretation, potentially leading to inaccuracies (e.g. identifying a pattern that may not have been present or missing an important subtlety). Furthermore, IPA seeks to make sense of the meanings individuals give to their experiences in "everyday language" (Tuffour, 2017, p. 2), and it seemed that English was not an everyday language for this participant. However, it did not feel ethical to exclude the participant simply because I could not achieve the same depth of linguistic analysis as with the other participants. The interview still provided valuable material for analysis, and I respected the participant's time and contribution. As a non-native English speaker myself, I found it especially complex to determine what counted as "proficient enough" English. Upon reflection, I realised that even sharing a native language does not guarantee mutual understanding. While language differences are more noticeable with participants like this one, they underscore the potential for misinterpretation with any participant. As such, variability among participants is inevitable, even in a linguistically homogeneous group. People will inherently express themselves differently, giving varying levels of detail and descriptiveness about their inner experiences. This variability means that achieving the same level of analytical depth across all transcripts is unattainable.

Analysis in IPA inherently requires a leap of faith, recognising the subjective nature of the researcher's role; thus, there is no definitive way to ensure entirely accurate interpretations (Smith et al., 2022). Although English proficiency was an inclusion criterion for this study, interpretations of proficiency can vary. Even if I had formally specified a requirement such as "Level 7", participants might have Googled the term and assumed they were proficient based on that description. To ensure linguistic homogeneity, I could have directed potential participants to a free online fluency test. However, such tests may not always accurately reflect a person's proficiency, as someone might perform well on a test but still struggle with conversational nuances. Additionally, requiring a test could discourage participation, resulting in a smaller, less diverse sample.

Before this research, my experience with research was limited to a quantitative study conducted during my MSc. Conducting the present study introduced me to the complexities of qualitative research and shifted my research approach significantly. I experienced a considerable challenge before transcribing the interviews: I worried that I had accidentally stopped the recording too early, asked questions that were not in line with the methodology or forgotten to ask something important. This anxiety caused delays, but eventually, I broke the task into manageable segments and followed a clear schedule, which helped me overcome the overwhelm. I plan to use this strategy from the outset in future projects.

The next difficulty I encountered was at the analytic stage, particularly during the formulation of the ES. This phase was crucial for consolidating and crystallising my thoughts, which had been somewhat disorganised and scattered until that point. Formulating the ES required a more structured and precise approach compared to the exploratory noting phase. I had to become more systematic, no longer allowing myself the freedom I had during exploratory noting. Having worked hard to preserve each word exactly as the participants had spoken it during transcription, I felt uncomfortable disrupting the flow of the interview. I also initially felt uneasy about moving from participants' exact words to incorporating more of my interpretations, as this shift increased my responsibility in making sense of

their experiences. At times, I doubted whether I was doing this correctly but reminded myself that I could always revise my work and that the subsequent PETs would develop through multiple passes of the transcript. Reflecting on my experience in my journal helped, and I found it useful to regularly revisit the original transcripts to ensure my interpretations remained grounded in the participants' voices.

In IPA, “[t]he researcher’s role is to be curious, open-minded and exploratory, and to avoid leading and directive questions” (Motta & Larkin, 2023, p. 58), enabling participants to express themselves freely. Despite this, there were moments when I veered away from phenomenological exploration. For instance, asking participants to compare PCP with VCP (“Can you think about in-person therapy and use that to better describe what is particular about the online situation?”) inadvertently led those without PCP experience to engage in theorising rather than reflecting on their lived experience. My intention was to keep the focus on VCP and use PCP as a comparative tool to surface more detail about VCP. However, the way I phrased the question was clumsy (as demonstrated by some participants asking for clarification) and epistemologically inconsistent (whilst no participants replied with a simple Yes or No, it was ultimately a closed question). The initial question, “Have you ever had in-person face-to-face therapy?”, was closed to determine context, but the follow-up could have been more open-ended. While these two questions yielded some interesting material, I wonder whether I could have delved more deeply into participants’ lived experiences with a more phenomenologically consistent approach, such as keeping contextual questions in the participant information questionnaire and rephrasing these interview questions to be more open-ended and exploratory. If I were to conduct another IPA study, I would aim to ensure that my questions were better aligned with these phenomenological practices.

5.10 Conclusion

While the global shift to online therapy is uneven and largely dependent on technological infrastructure, the trend is evident in many regions where access to mental health services via digital

means is gaining prevalence (Wind et al., 2020). Furthermore, BID continues to be recognised as a “normative discontent” (Rodin et al., 1984, p. 267), particularly in Western societies, where dissatisfaction with one’s body has become a common experience due to cultural and media influences (Grogan, 2021). In this context, it is increasingly important for CoPs to understand the dynamics at play when working with clients experiencing BID in VCP.

This study is the first to specifically explore BID within the context of VCP. While existing studies on BI-related concerns and VCP provide evidence for the effectiveness of VCP, client satisfaction and the therapeutic alliance, they offer limited insight into clients’ experiences with the self-view (Fernández-Aranda et al., 2020; Simpson et al., 2005; Simpson & Slowey, 2011). Despite the importance of this aspect of VCP – particularly for individuals with BID, who often have a complex relationship with their reflection – it has not been explored in detail. Many of these studies also lack methodological rigour, while higher quality studies primarily focus on the impact of COVID-19 and participants’ overall experiences with VCP rather than specifically investigating the self-view.

Moreover, with the exception of one study that hypothesises about its effects (Grignoli et al., 2021), existing research fails to explore the experience of being seen by the therapist – an important area, given that individuals with BID may be susceptible to the therapist’s gaze, especially when it is magnified in a close-up on the screen.

To fill this research gap, this research aimed to provide a detailed qualitative account of how individuals with BID subjectively experience being seen and seeing themselves in VCP. IPA was adopted due to its focus on lived experience and meaning-making, which aligns well with the emphasis on subjectivity and the exploration of personal experiences in CoP (Donati, 2016). Seven participants who self-identified as living with BID and were willing to discuss their experiences of being seen and seeing themselves in VCP took part. The key findings are as follows. Participants felt that VCP introduced a distance to connection and that PCP would foster a more immediate and “real” interaction. The lack of full-body visibility in VCP was perceived as hindering understanding.

However, even in physical settings, participants felt their flaws were not fully seen, indicating broader self-perception issues. Participants curated their appearances using filters and camera angles, which provided a sense of control; however, they also experienced uncertainty due to not knowing where the therapist was looking and technical glitches leading to misunderstandings. The video screen acted as a unique mirror, leading to varying levels of self-scrutiny and comparisons with the therapist's image, impacting the therapeutic process to different extents.

These findings broadly align with existing empirical literature that sheds light on the general acceptability and experiences of VCP and the potential effects of the self-view; however, they capture the nuances of these experiences and also explore what it is like for individuals living with BID to be seen by the therapist in this medium.

Relationality and pluralism are two values of CoP that are particularly relevant to the present study. However, building meaningful connections online and embracing a pluralistic ethos will be challenging if CoPs hold on to the belief that one modality (PCP) is more legitimate than another (VCP). The current study aims to provoke curiosity and encourage reflexive questioning, echoing Spinelli's (2015) concept of "un-knowing" (p. 116) – a stance of openness that challenges fixed assumptions and invites practitioners to engage with uncertainty in their practice. In line with Heidegger (1954/2003), rather than opposing technology due to its perceived power or unpredictability, this study encourages CoPs to cultivate curiosity about their and their clients' relationship with it to minimise its dangers and maximise its potential.

The implications of this study extend beyond CoP, as its emphasis on reflexivity and curiosity aligns with values central to other applied psychologies, such as health and clinical psychology, as well as in healthcare more broadly. For example, the HCPC (2023) emphasises the importance of reflexivity, maintaining professional skills and adapting to advances in technology to deliver safe and effective care (HCPC, 2023). Similarly, the NHS guidelines advocate for the ethical and effective use of digital platforms, ensuring that relational quality is preserved in virtual care settings (NHS England,

2023). By encouraging curiosity, openness and reflexivity in the use of VCP, the study supports applied psychologists and healthcare practitioners in leveraging technology to enhance accessibility and client care, while maintaining ethical and relational standards.

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Appendix A

Recruitment Flyer

HAVE YOU EVER EXPERIENCED PSYCHOTHERAPY ON VIDEO?

(ZOOM, SKYPE, FACETIME, WHATSAPP, OTHER PLATFORM)

More than ever before, psychotherapists and clients are meeting online, using video conferencing platforms and applications. Clients see their therapist on screen, are aware that they are being seen on screen, and may also be able to see themselves. There are many indications that it may remain common for some therapy to be provided online, beyond the pandemic.

I am conducting a research study about what online therapy on video platforms is like for a particular type of client, people who have experienced body image dissatisfaction (e.g. self-consciousness about and/or unhappiness with their appearance). This study is part of my doctoral training at Regent's University London.

If researchers and therapists understand more about the experience of clients in online therapy, we may be able to design online services that are maximally positive and helpful for clients in this new and developing area for psychotherapy.

Please consider participating if you can answer yes to all the questions below:

- I live in the UK.
- I am 25 or older.
- I have experienced video psychotherapy in the last two years.
- I would describe myself as often feeling dissatisfied with my body image.
- I can spare approximately one hour to have a confidential audio-recorded interview on Microsoft Teams (a videoconferencing software like Zoom or Skype)
- I am comfortable having a discussion about my experiences in English.

The DPsych Ethics Committee at Regent's University London has approved this study. However, you should always consider your own well-being when deciding whether to participate.

If you would like to participate, have questions, or are uncertain about whether participating in this study is right for you, please contact me at S18007279@regents.ac.uk.

Thank you so much!

Ema Exnerova
Counselling Psychologist in Training
Regent's University London

Date:

Appendix B

Social Media Advertisement

Have you ever had video #psychotherapy (e.g. via Zoom) and do you have #bodyimage dissatisfaction? If so, please see the image below for more information to join a #research study in this area, and contact me on S18007279@regents.ac.uk.

VIDEO PSYCHOTHERAPY FOR PEOPLE EXPERIENCING BODY IMAGE DISSATISFACTION

As part of my doctoral training at Regent's University London, I am conducting research about what video therapy is like for clients experiencing body image dissatisfaction (e.g. self-consciousness about and/or unhappiness with their appearance).

Please consider participating if you can answer yes to all the questions below:

- I live in the UK.
- I am 25+
- I have had video psychotherapy in the last 2 years.
- I often feel dissatisfied with my body image.
- I can spare approximately 1 hour for confidential audio-recorded interview on Microsoft Teams
- I am happy to conduct the interview in English

The DPsych Ethics Committee at Regent's University London has approved this study. However, you should always consider your own well-being when deciding whether to participate.

If you would like to participate, have questions, or are uncertain about whether participating in this study is right for you, please contact me at S18007279@regents.ac.uk.

Thank you so much!



Comment underneath the post:

For those who do not want to participate but are affected by these issues, you may wish to contact the following organisations:

- Your GP
- Samaritans - 116 123
- Beat - <https://www.beateatingdisorders.org.uk>

Appendix C

Participant Information Sheet

How do people with body image dissatisfaction experience being seen and seeing themselves in videoconferencing psychotherapy?

Researcher: Ema Exnerova

Director of Studies: Professor Isabel Henton

The research study

This study looks at the experiences of people with body image dissatisfaction who have had videoconferencing psychotherapy. In the last few years, more psychotherapy is happening online, with clients and therapists seeing each other on screen. If researchers and therapists understand more about the experience of clients in online therapy, we may be able to design better online services in a new and developing area for psychotherapy.

Who is being recruited to take part in this study

I am inviting you to participate in this study if you live in the UK; are 25 or over; have had video psychotherapy in the last two years; are proficient in English; and if you would describe yourself as often feeling dissatisfied with your body image.

Participation

You do not need to prepare for the interview, which will be on Microsoft Teams, and will last about one hour. Although you will join the meeting with your camera and microphone on, only the audio will be recorded. If you have a strong preference for disabling the video during the interview, let me know this at the beginning. I will not begin audio recording until you are comfortable that you understand the study and have had your questions answered.

During the interview, you may speak about many aspects of your experience with video psychotherapy. However, my questions will focus on what it is like to be seen and to see yourself on video calls.

After the interview, you will be given the opportunity to look over the transcript and let me know, within a week of receiving that transcript, if there are any inaccuracies or anything they would like to remove or add. I will also ask you if you would like me to share the results of the study after completion.

During the interview, and for up to two weeks afterwards, you can withdraw from the study if you wish, without having to give a reason. If you withdraw, all your information will be deleted, including the interview recording, and will not be used in the study.

Confidentiality

I will record your interview with both Microsoft Teams and an external device. After the interview, I will immediately transfer the recording to a password-protected area and then transcribe it. The recordings and transcripts will not be connected to any information that could identify you, such as your name, age, or contact details. I will use pseudonyms for any direct quotes from your interview that appear in the research.

After I have completed my doctoral thesis and published any other articles arising from this research, I will delete all recordings and transcripts.

I will only break confidentiality if you reveal that there is a clear, immediate risk to yourself or others. In that case, I will have to break confidentiality to arrange help.

Contacts for further information:

If you have any questions or concerns about your participation or would like to know more about the research, please contact me at S18007279@regents.ac.uk. Alternatively, you can contact my research supervisor Professor Isabel Henton at hentoni@regents.ac.uk.

Risks and benefits

By participating in this research, you will be contributing to the current knowledge on videoconferencing psychotherapy and providing valuable information as to how the practice of videoconferencing psychotherapy can be better tailored to people experiencing body image dissatisfaction. You should always consider your own well-being when deciding whether to participate. If you experience discomfort or distress during the interview, please let me know so that we can pause the interview and think about whether you would like to continue. After the interview, I will also email you with reminders of how to get in touch with me and where to find more support if you need it.

Ethics

The research is part of a Doctorate in Counselling Psychology (DPsych) at Regent's University London. This study has undergone ethical review and has received ethical approval from the Regent's DPsych University Ethics Committee.

Thank you for your time,

Ema Exnerova
Counselling Psychologist in Training
 S18007279@regents.ac.uk

Supervised by:
 Professor Isabel Henton
Director of Studies
 hentoni@regents.ac.uk

Appendix D

Questions for Uncertain Participants

Possible questions to ask:

1. What makes you uncertain about whether to participate?
2. What are you worried about if you do participate?
3. If you did want to participate, what would you find supportive and helpful?

Appendix E

Participant Consent Form

Psychotherapy via videoconferencing: An interpretive phenomenological analysis study among individuals with body image dissatisfaction

Please place your initials next to each statement below to demonstrate your agreement.

I have read and understood the Information Sheet provided. I meet the participation criteria and I have received a full explanation by the researcher of the nature, purpose, and likely duration of the study and of what I will be expected to do. I have been given the opportunity to ask questions.	
I agree to take part in the above study voluntarily.	
I understand that all personal data relating to participants is held and processed in the strictest confidence, and in accordance with the Data Protection Act (2018). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity will be preserved.	
I understand that direct quotes from my interview may be used in the research thesis, in published articles deriving from it or conference talks, and that these will be appropriately anonymised including the use of pseudonyms to protect my privacy.	
I understand that I am free to withdraw from the study at any time during the interview and up to two weeks after the interview without needing to justify my decision and without consequence, and that all my data will be destroyed if I do so.	
I confirm that I have read and understood the above and freely consent to participating in this study.	

Participant			
Name		Date	
Signature			
Researcher			
Name		Date	
Signature			

Appendix F

Contact Details and Demographics Questionnaire

Name:

Address at which the interview will take place:

Contact phone number:

Name of emergency contact available during or after the interview:

Contact phone number emergency contact available during or after the interview:

Age:

Gender:

Ethnic origin:

Employment status:

When did you have videoconferencing psychotherapy? For how long?

What kind of psychotherapy was it?

Which platform did you use to connect with your therapist?

Appendix G

Interview Schedule

1. What drew you to participate in this research project?
2. What does it mean for you to be dissatisfied with your body?
 - i. How does it manifest in your life?
 - ii. What is your experience of seeing yourself and being seen in everyday life?
3. You have been describing what it means for you to be dissatisfied with your body and now I'm curious – What did you seek online therapy for?
4. Tell me about your experience of having online conversations generally.
5. How would you describe your experience with videoconferencing psychotherapy?
 - i. How did it come about? (prompt)
 - ii. What was it like for you to be seen by your therapist through the camera? What did you notice? (prompt)
 - iii. What was it like for you to see yourself on the camera? What did you notice? (prompt)
6. Tell me about your experience of discussing or not discussing the presence of the camera with your therapist?
7. Have you ever had in-person face-to-face therapy? Can you think about in-person therapy and use that to better describe what is particular about the online situation?
8. Is there anything else you would like to add?
 - i. What has it been like to talk about this here? (prompt)

Appendix H

Distress Protocol

The following protocol has been adapted from Cocking (2008). Adaptations have been made to reflect the fact that interviews for the present project will take place over Microsoft Teams rather than face to face.

Steps taken prior to the interview process:

- 1) Participant's name and will be sought in order to facilitate contacting emergency services if required.
- 2) Emergency contact number will be obtained from participant. Participant will be informed that if researcher has significant concerns about the participant's or others' safety, and/or if the telephone conversation is terminated in the context of severe distress, the researcher may need to use this emergency contact.
- 3) Participants will be provided with a list of support organisations they may wish to contact in case of distress in the debriefing document.

Mild distress

Signs to look out for:

- 1) Tearfulness
- 2) Voice becomes choked with emotion/ difficulty speaking / tremulous voice
- 3) Statements such as "This is really hard for me to talk about," or "I didn't realise I would get so emotional"
- 4) Participant becomes distracted/ restless

Actions to take:

- 1) Ask participant if they are okay to continue
- 2) Offer them time to pause and compose themselves
- 3) Remind them they can stop at any time they wish if they become too distressed

Severe distress

Signs to look out for:

- 1) Uncontrolled crying/ wailing, heaving sobs, incoherent speech
- 2) Explicit statements that the participant feels unwell and is not sure whether they can continue the interview
- 3) Signs of high anxiety or panic attack, as heard/seen by researcher and/or as reported by participant, e.g. hyperventilation, shaking
- 4) Participant demonstrating extreme difficulties with concentration/ attention owing to 1) and 2)

Actions to take:

- 1) The researcher will intervene to terminate the interview.
- 2) The debrief will begin immediately
- 3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation
- 4) The researcher will acknowledge participants' distress, and normalise their reactions.

- 5) If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction.
- 6) Offer details of helpline services available to participants (see point 3 under “Steps taken prior to the interview process”, above).

Extreme distress

Signs to listen out for:

- 1) Severe agitation, lack of coherence, especially coupled with sudden termination of the video call.
- 2) Verbal indications of suicidality, especially coupled with sudden termination of the video call.

Action to take:

- 1) If termination of the video call has occurred, attempt to re-connect. If this is unsuccessful, and termination occurred *in the context of a level of agitation or emotionality that caused the researcher concern for the participant's or others' safety*, the researcher will break confidentiality to arrange for immediate help such as making a call to an emergency service based on having gathered the participant's address and contact details.
- 2) If the researcher has concerns for the participant's or others' safety and the participant is still online, she will inform them that she has a duty to inform the emergency contact provided and/or local emergency services.
- 3) If the researcher believes that either the participant or someone else is in immediate danger and the participant is still on the line, then researcher will suggest that they present themselves to nearest emergency room, and contacting the emergency contact may also be necessary.

Adapted from © Chris Cocking, London Metropolitan University Nov 2008

Appendix I

Participant Debriefing Document

An Interpretive Phenomenological Analysis study among individuals with body image dissatisfaction

Thank you very much for participating in this research study, which aims to explore how individuals with body image dissatisfaction experience being seen and seeing themselves in videoconferencing psychotherapy. I hope it has been an enjoyable and interesting experience.

If you have experienced any discomfort or distress as a result of your participation in this interview, you could consider seeking further support from the following organisations:

- Your GP
- Samaritans - 116 123
- Beat - <https://www.beateatingdisorders.org.uk>
- SANEline - 0300 304 7000
- Anxiety UK - 03444 775 774
- Campaign Against Living Miserably (CALM) - 0800 58 58 58

If you would like to ask any questions please get in touch via email. I can be contacted at S18007279@regents.ac.uk.

You are entitled to withdraw from the study up until my initiation of data analysis in two weeks. If you decide to withdraw from the study, all your data will be destroyed.

If you decide to take part, the data gathered in the interview will be used for research purposes and written up. If you would like to see the transcript in order to check for accuracy, anonymity or anything you would like to remove or add, please let me know. Once I send you the transcript, you will have one week to ask for any changes to be made.

If you have any concerns or complains related to the study, please contact my supervisor Prof Isabel Henton at Regent's University London. Prof Henton can be reached at hentoni@regents.ac.uk.

Thank you very much for participating in this study!

Appendix J

Ethical Letter of Approval



Regent's University London +44 (0)20 7487 7700
 Inner Circle regents.ac.uk
 Regent's Park
 London NW1 4NS

Professional Doctorate in Counselling Psychology (DPsych)
 Research Ethics Review Panel

13/10/2022

To whom it may concern

I can confirm that the following research proposal has been reviewed by the DPsych Ethics Review Panel that was held on 27/04/2022:

Doctoral researcher:	Ema Exnerova
Proposed title:	How do individuals with body image dissatisfaction experience being seen and seeing themselves in videoconferencing psychotherapy?
Director of Studies:	Professor Isabel Henton
Supervisor:	Dr Maria Kordowicz
Ethics panel members:	Professor Jo Lusher Professor Isabel Henton Dr Alice Kennedy Dr Nathan Faulkner Dr Sharon Cahill Dr Keren Cohen

The panel agreed that the proposed research was ethically sound and gave its approval for it to proceed as Level 8 doctoral research. This decision was noted at the Research Degrees Committee for the DPsych on 12th October 2022.

Ethical approval is granted under the condition that the researcher follows, at all times, the most recent guidance from the British Psychological Society and the Health and Care Professions Council.

The researcher must inform their supervisory team of any changes to the proposal. If the supervisory team believes these changes to be substantive, in that they could affect the ethical dimensions of the research, the supervisory team must consult with the Research Lead for the DPsych, and the researcher must then submit a revised proposal to the Ethics Panel if it is deemed necessary.

Yours faithfully

Professor Jo Lusher
 Chair of the Research Ethics Review Panel, Professional Doctorate in Counselling Psychology

Appendix K

Example of an Annotated Transcript – Sarah

EXPERIENTIAL STATEMENTS	SARAH	EXPLORATORY NOTES	Methodological reflexivity
	1 INT: Okay, so it's recording now. So as you know, this research is asking 2 about experiences of video therapy and body image dissatisfaction. So I 3 just wanted to start by asking what drew you to participate in this 4 research?	Descriptive Linguistic Conceptual	
Recounting her experience of BID and VCP in terms of number of years	5 P5: Um, I have been, <u>uh, struggling with, uh, body image and accepting</u> 6 <u>my appearance, uh, since very young age, maybe since being a teenager,</u> 7 and, <u>uh, uh</u>, I've been in therapy for a <u>number of years</u> and I've done a 8 <u>number of hours, uh</u>, of remote therapy, so I thought it would be helpful, 9 <i>hopefully</i> helpful for your research if I share my experience. 10 INT: Yeah, definitely. Thank you. Yeah, so you mentioned you've been 11 struggling ever since you were a teenager and you've also had video 12 therapy, so, um, you wanted to share your experience with me. 13 P5: Uh, yes. Uh, uh, so basically, <u>I've done a lot of face-to-face therapy,</u> 14 which comes with, uh, also <u>some difficulties</u>, uh, as, as any therapy does. 15 But then <u>a few years ago, maybe two years ago, my therapist suggested</u> 16 to do remote therapy because of, uh, Covid and, uh, it was difficult to, to	Has been struggling with BI and appearance acceptance since very young age Struggling (rather than simply “dealing with” or “facing”) implies a conflict, an ongoing battle with BID Has been in therapy for several years and has done many remote therapy sessions False starts “uh” – thinking about how to phrase her answer? Very young age – emphasising how young she was – indicates that BID has been a part of her life for a long time – maybe even part of her identity? A number of years – emphasising she has had a lot of therapy Using quite broad terms – “number of years”, “some difficulties”, “a few years ago” + repetition of “maybe” – does she find the details unimportant or does she struggle to express herself in more detail? Has done a lot of f2f therapy A lot of f2f - emphasising she has had a lot of experience with f2f prior to starting VCP	
It was her therapist's idea to switch to VCP			

Expected smooth transition to VCP

Experienced unexpected feelings of discomfort upon seeing herself on the screen

Filters make her feel more complete

Wondered how the therapist was experiencing VCP

Experiencing a difference in how she is seen online vs. in consulting room

1 see people face to face. And first I thought That's fine, that's not a

2 problem but once we got to do it, I realised that I'm not very comfortable

3 with seeing myself on the screen. I remember starting to use Zoom and

4 Zoom offers you to kind of alter your image a bit, filter it slightly to kind

5 of make your skin smoother. And I remember before the start of therapy,

6 I kind of adjusted it, so on every call I would be a bit, uh, filtered. It made

7 me feel better, especially when you log in from home, you sit there with

8 no makeup, with your home wear, it, it felt a bit, uh, better basically not

9 coming as you are, but in a more completed version. And then the

10 session started, and you would see yourself in this little screen and you

11 see the therapist on the big screen. And I started thinking, How is it for

12 the therapist on the other end? Because they see this big image and it's

13 quite intimidating, you can see all the traits and features. And you know,

14 in real life, when you go to the clinic, to the office of the therapist, they

15 see you in 3D and it's less staring in your face. It's more like looking all

2

Realised she was not very comfortable with seeing herself on screen

Uses a lot of adverbs, qualifiers and softening language like "not very comfortable", "kind of altered", "quite intimidating"

She begins to use softening or qualifying language when discussing her use of filters, possibly indicating a sense of distancing that could suggest feelings of shame or discomfort with the topic

"not very comfortable" – we know how she didn't feel but how did she feel?

Adjusting image before every call made her feel better

Shifting between "I" and "you" pronouns – shifting between owning the experience and trying to distance herself from it?

"More completed version" – does she consider herself incomplete without filters?

Little screen vs. big screen – seems conscious of the potential of the therapist's perception of her or the focus on her being different than if she were sitting with the therapist and the therapist had other things to be looking at in the room

Thought about how it was for the therapist

The phrase "in real life" might be a holdover phrase from a time when online interactions were more anonymous and detached. It's interesting that she continues to make this distinction (real vs. online) even though interacting through devices has become such an integrated part of our daily lives and sense of self. This suggests that, for her, there remains a significant difference between in-person and virtual experiences.

Staring – implies a strong and consistent gaze

Experiencing the therapist's gaze as constant

Finding the therapist's gaze to be anxiety-provoking and distracting

1 over the place. But here it felt like, um, yeah, for the whole duration of

2 the session, the therapist is looking at your face on the big screen.

3 INT: Mm-hmm.

4 P5: And it made me feel slightly uncomfortable.

5 INT: Yeah. Yeah. And so, uh, you mentioned the word uncomfortable. So

6 what did you, what did you notice? What was kind of happening, uh,

7 internally?

8 P5: Uh, it made me a bit cautious about my image. I thought, Oh, maybe

9 next time I should be wearing makeup or do my hair since, uh, my face is

10 so big on this screen, uh, it just, uh, uh, provoked a bit of anxiety, I would

11 say? Or provoked a bit of, uh, extra thoughts about how I look, extra

12 focus on my appearance.

13 INT: And so how did that impact the therapy if, if it did?

14 P5: Yeah, it's difficult to measure exactly how, but I would imagine,

15 retrospectively, it, uh, uh, maybe made me, distracted me from the

Feeling of scrutiny towards a particular body part – her face

Downgrades "staring" to "looking" – linguistic shift - did staring feel too strong?

Switches back to 1st person – owning the experience? Realising how it made her feel personally?

"Slightly uncomfortable", "a bit cautious" – again broad language and softening adverbs

Therapist looking at her face on the big screen during the whole session made her slightly uncomfortable and a bit cautious about her image

I would say? Implies uncertainty, perhaps she is seeking my confirmation?

Thought maybe next time she should wear makeup or do her hair

It provoked a bit of anxiety, extra thoughts about how she looked/ extra focus on appearance

Retrospectively – trying to remember the past

Maybe distracted her from therapy

3

Wondering if the therapist's gaze distracted her from other issues to BID	1	therapy process, from other issues and moved my thoughts, uh, uh,	Thoughts moved towards BI/ appearance issues
	2	towards the, uh, body image or appearance, uh, issues.	Many false starts compared to previous speech – is she finding it difficult to express this concept?
	3	INT: And, uh, okay. So you were kind of, is it correct to say that you were	
	4	focusing more on yourself and on your body image than the therapy	
	5	itself?	
	6	P5: Yes, and I have to say that, uh, my appearance was <u>totally not</u> the	Appearance not topic of the conversations during therapy
Not considering her BID to be the focus of her therapy	7	topic of the conversations during the sessions. I came to therapy with	Totally not – a strong way of saying not
	8	different issues, relational issues, family issues, and, uh, my own	Came to therapy with different issues
	9	appearance was never the focus in, uh, in those sessions.	
	10	INT: Mm-hmm.	
	11	P5: So it kind of maybe shifted my own, um... Yeah, my own focus. I	Therapist looking at her face on big screen maybe shifter her focus [to appearance]
	12	didn't bring it up in therapy sessions. I didn't talk about it with my	
Dealing with BID in therapy on her own	13	therapist, but I think it's <u>something that I was processing on, on my own,</u>	She was processing it on her own How was she processing it?
	14	<u>like an added layer of worries</u> , if you like. <u>As I mentioned</u> , I've um, I've	Interesting that she was keeping it to herself like a secret layer of worry and something that was not for presentation or consumption in the therapy situation (vs. she did bring up relational issues, etc.)
	15	<u>always struggled with accepting my appearance</u> and when I was younger,	
	16	I had anorexia, I had a lot of concerns about weight and height, until	As I mentioned – repeats the words struggling and accepting - reiterates the longevity of her BID by coming back to what she was saying at the beginning of our conversation
			Always struggled with accepting her appearance
	4		
Her BID has long and strong history	1	recent years <u>I would never leave the house without, uh, makeup or</u>	Struggling with accepting her appearance is something quite deeply rooted for her
	2	<u>wearing heels</u> , so it's, it's, uh, something quite <u>deeply rooted</u> for me.	
	3	INT: Yeah, yeah. And so, I mean, I know that people have kind of different	Deeply rooted – strong language to express origin/ history of her BID - implies it is not just something surface-level but rather something that is entrenched and has grown over time
	4	definitions of body image dissatisfaction or issues, whatever you want to	
	5	call it.	
	6	P5: Mm-hmm.	I would never leave the house without, uh, makeup or wearing heels – habitual behaviours related to her BID seem to further illustrate how embedded in her daily life these concerns are
Constantly worrying about her weight	7	INT: So, uh, how would you define it or how does it kind of manifest for	
	8	you? You've mentioned some examples, but if you could just say a bit	
	9	more.	
	10	P5: Yeah, of course. I, uh, uh, I'm always questioning if I am, uh, <u>fat</u> or not	
	11	[laughs]. Uh, so I <u>always have issues about my weight</u> . Um, I am <u>often</u>	Laughs after saying "fat" – is it because one some level she knows she is not/ knows how "ridiculous" it is to think that?
	12	<u>trying to diet or trying like new things for weight loss</u> . Uh, I mentioned I	
	13	<u>had anorexia for two years</u> and it was a very long time ago, over a decade	Always questions if she is fat or not Always has issues with her weight Often tries to diet or tries new things for weight loss
	14	ago.	
	15	INT: Mm-hmm.	Had anorexia for two years Second mention of anorexia – she is emphasising it, maybe because it is emotionally important or still unresolved
	5		

Cannot get too comfortable when it comes to weight	1	P5: Uh, but I still, uh, I still feel the, I think I'm in remission, but I still feel	Feels she is still in remission
	2	the, uh, issues around my weight and it's something that's <u>more or less</u>	Issues around weight are more or less always on her mind – always is an absolute thing, more or less is a relative thing – interesting choice of words
	3	<u>always on my mind</u> . And there are days when I feel good in my body, but	
	4	then there are many days when I feel, uh, that I have <u>extra weight</u> . Also,	Remission – medical term referring to temporary recovery - can't get too comfortable because there is always the possibility that it will reoccur, it implies she suffers from something that there is no absolute cure for
	5	I've always been <u>struggling with my height</u> , and I wanted to be taller and,	
	6	um, also with the, uh, <u>face</u> , like questioning my features or <u>trying to alter</u>	
Concerned about being pretty or not	7	<u>certain features by doing some treatments</u> and uh, <u>basically general</u>	Downgrades “fat” to “extra weight” but then follows by a cascade of things she struggles with – height, face, etc.
	8	<u>concerns about being pretty or not being pretty</u> .	
	9	INT: Mm hmm, mm hmm. But it kind of, it's, it sounds like it shows in	Has always been struggling with her height and face
Highlighting the extent of her BID	10	different areas like in terms of the height, the weight, you know, the face	Struggling – repeats this word again to highlight the ongoing fight with her BID?
	11	as well, so it's not one thing, really.	Tried to alter certain features by doing treatments
	12	P5: Yeah, it's a, it's <u>an ample combination of things</u> . Could be <u>really</u>	Concerns about being pretty or not
	13	<u>anything</u> , uh, from my hair to my skin, uh, everything appearance and	
	14	body related.	Ample combination of things - emphasising that her BID relates to many things
			“ample” – adjective historically used to apply to the physicality of women (e.g., ample breast) but can also refer to agriculture, e.g., ample harvest, meaning enough for everyone/ more than enough

6

Noticing an improvement in her BID over the years	1	INT: Mm hmm, mm hmm. And so in terms of your kind of day-to-day life,	
	2	how does it affect your you? You know, if, um, I don't know if that's a	
	3	clear question, but if you could try to say something about that.	
	4	P5: Um, I would say <u>that in the recent years it became better</u> . It was way	Better in recent years but still has days when she feels unattractive and overweight which affect her ability to socialise and interact with others
	5	<u>worse when I was younger</u> when I was a teenager or young adult. I was	
	6	really affected by those concerns and the issues with, um, self-confidence	Worse when she was younger
Experiencing BID as something powerful that impacts all of her life	7	around it. In the recent years, it became better, <u>but I still have days when</u>	
	8	<u>I feel unattractive, when I feel like I'm overweight</u> and, uh, um, on those	“Overweight” (previously “fat” followed by laughter) – did “fat” feel too harsh perhaps?
	9	days, it <u>affects my mood and my ability to socialise</u> , the way I, uh, interact	
	10	with other people, you know, basically <u>all the, all, all</u> spheres of my life.	The stuttering repetition (“all, all, all spheres of my life”) could suggest a moment of hesitation or self-correction. She might have started to list specific areas but then realised the list would be exhaustive, leading her to generalise by saying “all spheres of my life”
	11	INT: So it's, it's gotten better, but it's still there. And, uh, so, and what, so	
	12	what has it, um, what has made it better? Because you mentioned it's,	
	13	it's, uh, you know, if you compare it to when you started having these	
	14	issues to now, it's slightly better now.	
	15	P5: It's hard to say. <u>Maybe it is growing up</u> . Uh, I think the majority of	
	16	people overcome the, uh, youth or teenage years, uh, issues somehow.	

7

Various things contributed to her BID getting better	1	Maybe it's also a number of years of therapy that helped and, uh, maybe	Probably a combination of factors made it better (maybe growing up, life experiences or leaning to accepts things you cannot change).
	2	just life experiences or learning to accept things that you cannot change.	
	3	Probably a combination of factors.	Repetition of "maybe" – unsure?
	4	INT: And so, and so the things that kind of, uh, bother you about your	Reference to majority of people to minimise her achievements?
	5	body image. Um, it sounds like they don't come up just on video, but also	
	6	in like, you know, day-to-day, normal life.	
It was the format of the therapy that brought up thoughts around her appearance	7	P5: Yes, absolutely. They come up not just on video, but I happened to	[BID] comes up not just on video
	8	notice that in those remote sessions with the therapist, it, uh, it just came	But video therapy was when she noticed them
	9	to my mind probably because of the format.	
	10	INT: Mm hmm.	Seems like VCP highlighted some of her existing concerns
Feeling a general uneasiness around seeing herself on screen	11	P5: Because of, uh, uh, seeing your face big time on the screen and, uh, it	Big time – referring to the large size of the screen
	12	probably just highlighted for me that this issue is still there. I compare it	Seeing your face big time on the screen probably highlighted the issue is still there
	13	to my experience of other remote meetings, like work-related meetings	
	14	on Zoom and other platforms. And, um, I, I would say I still not, I don't	Doesn't feel "very comfortable" – another softening adjective – what does it feel like?
	15	feel very comfortable and don't like seeing myself on the screen, but it's	
	16	different from therapy because on those work meetings there would be a	Compares video therapy to her experience of other remote meetings

8

People in work calls don't focus exclusively on you	1	few people, and even if it is a one person, they're not focusing on you	Other experiences are different from therapy
	2	100 percent because it's just a different nature of a meeting. They focus	In work meetings people don't focusing on her 100%
	3	on the meeting agenda, on their own things. With a therapist, it's very	
	4	different because therapist is there to give you their full attention. And,	Therapist gives her their full attention – this is generally described as a good/beneficial thing in a therapist but in this situation it's a bit more complicated for her – she recognises it's part of their role, the very reason the therapist is there and yet it's something that bothers her
Experiencing the therapist's full attention as a hindrance in VCP	5	uh, it would be very unlikely the therapist would be sitting there looking	
	6	around or taking their own notes and doing whatever comes to them. So	
	7	I feel like in therapy sessions, it is exaggerated, this issue.	
	8	INT: Mm hmm.	In therapy sessions the issue is exaggerated
Not the centre of attention in work/personal calls	9	P5: In my work meetings, so personal meetings, uh, on Zoom, it's not,	100%, "exaggerated" - she is talking about degree or difference (not better or worse or more comfortable or less comfortable).
	10	um, it's not that prominent.	
	11	INT: Mm hmm. So there's, the focus is not so much on you in those work	In work/personal meetings it's not that prominent
	12	or, or personal calls?	
	13	P5: Yeah.	
	14	INT: Hmm. Hmm. And so that makes these calls...what?	

9

Seeing herself on the screen in work/personal calls is easier

1 P5: It makes it easier, I would say. It makes this issue of seeing myself on

2 the screen less prominent. I would lie if I said that I enjoy it, because I

3 don't, but, uh, uh, it's, uh, bothering me, uh, much less.

4 INT: Yeah, yeah. And what do, so, okay. And, um, I was gonna ask you,

5 what about, uh, other people looking at you? You know, like, noticing

6 that gaze. Um, how is that for you? Whether in therapy or, uh, in work

Finding other people looking at her intimidating in all video calls

7 meetings or personal meetings.

8 P5: Well, I find it intimidating and I start questioning at times, uh, How

9 they look at me, What do they think? Do they notice some issues? Do

10 they, uh, think that I don't look good? Do they notice if there is

11 something wrong with my face or makeup? Or if it's, if they can see more,

12 Do they notice something wrong with my body, my outfit? Um, I start

Getting carried away imagining what others are thinking of her

13 getting those ideas about other people's thoughts and opinions.

14 INT: Mm hmm.

15 P5: And maybe they don't have any opinions or any thoughts about it,

16 but I can't help thinking that they might and developing this fantasy that

That makes work/personal calls easier
The issue of seeing herself on the screen is less prominent

"less prominent", "bothering me less" – again it's about a difference in degree, not saying one is clearly better or worse

Finds noticing other people's gaze intimidating
Starts questioning how they look at her, what they think, what they notice
Intense self-consciousness and anxiety about how others perceive her

Starts getting ideas about other's thoughts and opinions

Can't help thinking they might have opinions

"Fantasy" implies a quality of thinking where someone is getting carried away, e.g., through the process of fantasising, an anxious thought becomes something that can feel very real
"Developing" – implies carrying away, building, elaborating nature
"Can't help" – feeling powerless?

10

1 they are maybe judging or maybe having some negative opinions about

2 myself.

3 INT: Mm hmm. So you kind of, you're thinking about what they're

4 thinking.

5 P5: Yeah.

6 INT: In therapy as well as in work calls?

Wondering what is visible to others and how they think of/judge her

7 P5: Uh, I think yes, uh, and I know that the therapist is not there to judge

8 me or to think anything about my appearance. And it's not that I don't

9 trust the therapist, but it's more my own, my issue. I start to fantasise:

10 What do they see? What do they notice? What do they think about me?

11 INT: Hmm. Hmm. Okay. And, um, I mean, I was, I was, uh, it was quite

12 interesting to hear that the therapy you had wasn't specifically for body

13 image issues, it was for something else. Um, but, um, they kind of, you

14 know, the fact that you moved online made you, okay, maybe drew more

15 attention to the body image issues.

She is attempting to engage with her therapist, but there's an internal process that interrupts this interaction. As she speaks with the therapist, her mind drifts into a cycle of self-doubt and questioning, leading her into an inner dialogue that she hasn't shared. This preoccupation with her appearance occurs in parallel to the conversation, potentially creating a barrier to fully being present in the therapeutic exchange.

Starts to fantasise about what other people see, notice and think

"I start to" implies that this is an ongoing or reoccurring pattern, not a one-time occurrence

11

- Lack of mirror in therapist's office means you can't see yourself
- Comparing VCT to therapy with a mirror
- Didn't think of discussing it with her therapist
- Conscious of the camera reflecting two differently sized images
- 1 P5: Uh, yes, because sitting in the, uh, office of the therapist, there is no
 - 2 mirror, so you don't really see yourself. You see the therapist, you see
 - 3 your surroundings, but, uh, remote therapy is very different. You would
 - 4 see yourself on the screen and this, uh, this is like having therapy with a
 - 5 mirror there.
 - 6 INT: It makes you more self cau, uh, cautious?
 - 7 P5: Yeah, yeah.
 - 8 INT: So, um, and so how did you discuss this with the therapist, you
 - 9 know, the presence of the "mirror" or just the fact that it's different than,
 - 10 um, uh, in person, if you discussed it?
 - 11 P5: I haven't discussed it with my therapist and probably I should have
 - 12 done it, but it didn't really cross my mind. Now that we are talking about
 - 13 it, I think I probably should. I remember that there was something off
 - 14 with the Zoom settings on a few occasions and instead of seeing the
 - 15 therapist big on the screen and myself like in the small window, for some

12

Doesn't see herself in the therapist's office (no mirror)

VCT is like having a therapy with mirror

"Mirror" implies that the act of seeing herself on the screen is akin to having a physical mirror present during the session, which continuously reflects her appearance back to her. She can see herself and also how the therapist sees her.

Has not discussed the "mirror" or the differences between the two mediums with the therapist but thinks she probably should have.

Repeats "probably should" – interesting because without the "probably" it would seem as though she has regrets about not talking about it but "probably" softens it and makes int more ambiguous

There was something wrong with the settings and she saw herself big and the therapist smaller
Page 12 and 13: Talking about who is big and who is small and how aversive it was to see herself big and the therapist smaller - this seemed to have disrupted the typical visual hierarchy she was accustomed in VCP.

- Seeing herself big on the screen (instead of therapist) was disturbing
- Having a dislike towards seeing oneself big is a shared experience
- 1 reason I saw myself big and the therapist smaller. I remember something
 - 2 went off with the settings.
 - 3 INT: Mm hmm.
 - 4 P5: And I said, uh, I remember at the start of the therapy, I said, Uh, I told
 - 5 my therapist, Wait, wait, I have to change it. Like I'm seeing my face big
 - 6 on the screen and it's really disturbing. And I think she did ask What,
 - 7 What is disturbing? And I just explained that I don't like to stare at a
 - 8 massive image of my face for one hour. But I believe that not only people
 - 9 with body image issues wouldn't like it. It's just like many people don't
 - 10 like hearing their voice recording or seeing themselves on the video.
 - 11 INT: Mm hmm.
 - 12 P5: I think it's a human reaction to feel a bit intimidated.
 - 13 INT: Hmm. Hmm. Yeah. So not, not just people with body image issues,
 - 14 but almost everyone.
 - 15 P5: Probably people with body image issues to a much bigger extent and
 - 16 probably as I mentioned those fantasies about what other people think

13

Told her therapist to wait because she had to change it as it was disturbing

She shifts from a vivid, immediate recollection of her experience in the moment – using present tense and direct speech ("Wait, wait, I have to change it...I'm seeing my face...and it's really disturbing"), to a more detached mode of thinking where she moves into explaining or generalising the experience ("I believe not only people", "I think it's a human reaction", "probably people with [BID] to a much greater extent..."). She seems to oscillate btwn reliving the phenomenological experience and stepping back to analyse or rationalise it from a more distant, cognitive perspective.

"really disturbing", "massive image", "one hour" (full therapy session) – implies a strong, intense experience
She is zooming in an out – she is situated in her own experience but then she is looking at the big picture in a theoretical kind of way which takes her away from some of the intensity of her own experience. So it goes from a more descriptive position into a more intellectualised position when she says "But I believe...", "I think..."

"Not just people with BID", "many people", "human reaction" – goes from her personal experience to saying how other people are feeling - Is she feeling shame and refers to others to normalise her experience? She is saying it isn't weird/unreasonable of her to be uncomfortable, it's a general truth.

It's a human reaction to feel a bit intimidated – something automatic, implies that we can't control it
Trying to figure to what extent it affects people with BID and trying to place herself along some imagined spectrum from abnormality to normality when she refers to those fantasies.

It's much more likely to happen to people with BID but most people would be uncomfortable – again she is estimating, theorising – very analytic and a bit more distanced

People with BID are more prone to feeling intimidated upon seeing themselves big on the screen

1 about me, **probably** this is much more likely to happen with people who

2 **struggle with accepting their appearance** and struggle with their body

3 image, but seeing themselves big on the screen, um, seeing your face in

4 front of you, **I think it would be uncomfortable for most people.**

5 INT: And if, **if you did share** it with your therapist, you know, for example,

6 what was happening for you at the beginning. What difference would

7 that make? If it would, what do you think?

8 **P5: I think it would probably give me a chance to explore my feelings in**

9 **the moment.** Uh, to explore what, uh, what exactly was uncomfortable

10 and why. So, uh, but it, **it's hard to imagine what it would open up.** But it

11 **probably** would be a chance to explore, uh, the issue as it is happening,

12 **because usually if I bring something to therapy, it's something that**

13 **happened in the past** or something that happened in my life. But rarely

14 something that is happening now in the moment.

15 INT: Hmm.

Wondering what could have been achieved if she shared her thoughts with the therapist

"I think", "I believe", "I think", "I'm actually thinking" – language that suggests a movement away from her immediate, lived experience toward a more analytical stance. This distancing can serve as a coping mechanism, allowing her to deal with challenging emotions by framing them within a more manageable, abstract framework.

"most people" – again reference to many people having the same experience

Repeats "probably" (p.13 and 14)

I go into a hypothetical place, taking her away from something she has experienced into how something might be if she did something different. She stays in this analytic zone but then talks re difficulty about getting outside her experience: "It's hard to imagine what it would open up."

Rather than asking her to speculate about an experience she hasn't had, a more phenomenological question might have been "You said earlier you feel you should have shared it with your therapist" and leave it there. Or add "Can you tell me about that feeling" Because that's something she is actually feeling. The way I asked her took her into a more distanced place.

Thinks that discussing this with her therapist would have allowed her to explore her feelings in the moment.

14

VCP allows people with BID to discuss their issues as they're happening

1 **P5: So it could have been a good opportunity. I'm actually thinking now**

2 that **for people who struggle** with self-esteem, with issues linked to their

3 appearance, uh, **it could be an interesting experience because they can**

4 **process things that are happening in the here and now.**

5 INT: Hmm, hmm, whilst they're happening.

6 **P5: Yeah.**

7 INT: And, um, so you mentioned that you were seeing this therapist in

8 person and then she suggested online because of COVID. So it's, uh, it

9 sounds like it was kind of her idea. It wasn't your idea to seek online

10 therapy. **It was just because of the therapist and what was happening in**

11 **the world at that time?**

12 **P5: Yes, it was not my idea and I'm still not a fan of online therapy. I still**

13 **have it sometimes for practical reasons**, both for me and the therapist,

14 because sometimes I can't travel to see the therapist and sometimes the

15 therapist is abroad or something else is happening. Um, so I still do it

16 because it's convenient, but **I don't like online therapy.** And **not only**

Experiencing a dislike towards online therapy

I'm actually thinking now – just realised something as we were talking

Talking about these issues in therapy would allow people with BID to process things in the here and now.

"For people who..." feels very distanced and ironic because she is not dealing with it here and now, she is doing what seems to be a distanced theorising

I follow here lead and go into a more closed question, and it sounds like I don't really know where to go based on what she was saying before.

Thankfully she doesn't just reply with a yes or no answer and goes into detail.

Still has therapy sometimes for practical reasons

Does not like online therapy because she can see herself on the screen and also finds face-to-face contact to be much more real

15

PCP is much more real	1 because I have to see myself on the screen, it's also a reason, but I, uh,	Does not like online therapy because she can see herself on the screen and also finds face-to-face contact to be much more real
	2 also find, uh, uh, face-to-face contact to be much more real.	Much more real – does that mean more genuine/authentic?
	3 INT: Hmm.	
Experiencing better therapist-client connection in PCP	4 P5: And, uh, my sense of the therapy, the therapy process, uh, it's just	Trying to unpack what the elements of “more real” are
	5 different in person. I feel like the connection between the therapist and	Client-therapist connection is better in f2f therapy
	6 the client is better. But in general, not only with the therapist, I would	
	7 prefer to see any doctor, any specialist, I would prefer to see my friends	Would prefer to see everyone in person (not just therapist)
	8 and family in person, not online. I feel like this is better. Online setting	
Experiencing VCP as lacking in human presence	9 removes the human, human presence from it.	Online setting removes human presence from the interactions
	10 INT: Yeah. I was actually going to ask you, what's your experience of kind	
	11 of like online conversations in general, you know, not necessarily in	
	12 therapy, but other practitioners or friends and family. So, there's this lack	
	13 of this lack of this human kind of presence, human factor, you said.	
Highlighting that VCP is not the same as PCP	14 P5: Yes, and I'm very grateful that we have an opportunity to meet	Grateful to be able to meet people online but it's not the same as f2f contact
	15 people online. It's so helpful for work, for personal life, it's great. Uh, but,	Grateful to be able to meet people online – quite a contrast to her criticism of online therapy above – does she feel like she was too critical above? Her language seems more formal here, as if she realised that she has not yet properly acknowledged the significance of the opportunity/ has forgotten to thank the academy
	16 uh, it's not the same as, uh, face-to-face contact. I think we just get so	Gets much more from seeing people f2f
	16	
	1 much more from seeing people face to face. It's the whole experience of	
	2 somebody's presence, their way of being, their, seeing somebody in 3D,	Cannot feel someone's energy from the screen
	3 you know, and uh, I, I don't know what we can call it. Maybe somebody's	
	4 energy? You cannot feel it from the screen.	
	5 INT: Yeah.	Can feel someone's presence and way of being only when you meet in person
VCP deprives you of the other person's presence	6 P5: I don't know if that is the right word, but somebody's presence, their	It seems that she keeps on trying to explain it or justify it – “not only because...”
	7 way of being, you can only see it when you meet with the person. Online	Online interaction is restrictive and limited (even if one can see the whole body)
	8 it's very restrictive, you're limited to certain things. And not only because	
	9 I see now only your face, even if you stand up and they see your body, it	
	10 still would not be the same.	
	11 INT: Hmm. And so can you think of an example, you know, in the online	This was an intervention intended to ground her in an example of an experience she has actually had
	12 therapy that you had in the video therapy of something that was missing	
	13 for you in terms of this kind of, um, this presence. Because I know you	
	14 had both experiences, so you can kind of compare, you know, how it feels	
	15 to be in the room with the therapist and then when you're both online, is	
	16 there something, I don't know, it might be difficult for you to think of an	

Experiencing a lack of shared reality online	1	example, but, um, yeah, an example where you were missing that	Misses a sense of a shared reality/shared space in VCP
	2	presence or where something was different.	Lack of information about the therapist and physical distance create a layer of distance
	3	P5: I think, uh, one thing that comes to my mind, uh, what is missing is	Not breathing the same air
	4	the sense of a shared reality, shared space. I don't know where this	Interesting how she is repeating "breathing the same air"
	5	person is. I don't know their surroundings and not that I'm paranoia,	
	6	paranoid about who's around, but I don't know this as well. Uh, basically	VCT creates an extra layer of distance
Finding physical proximity to be necessary for good connection	7	you are somewhere far away, and we are not sharing, we're not	
	8	breathing the same air. We are not sharing the same space. We're not	Physical proximity is important to feel connection
	9	maybe even sharing being in the same country or in the same city. Um, it	
	10	creates extra layer of a distance, I would say. And for me, uh, it's	
	11	important to feel this proximity in order to feel this connection.	Wants to feel physically close to any practitioners (not just therapists)
	12	INT: Yeah.	
	13	P5: Uh, especially with the therapist, but not only with the therapist, any	"in my mind" – acknowledgement that it might not be different for others but for her physical proximity makes a difference
	14	other doctor or medical practitioner, I would like to feel that they are	
	15	close to me, that they're in the same space. So, uh, it's probably, it	VCT creates an extra layer of distance, an obstacle to connection
	16	doesn't probably change something, but in my mind it does. It creates,	
18			
Lack of physical proximity makes connection more difficult	1	uh, it creates an extra layer of distance. It creates this obstacle on the	Repeats "extra layer of distance" – seems important – also implies that there is already a distance, the online setting just makes the difference larger/more prominent
	2	way to connection.	
	3	INT: And so what's the opposite of that then? So if, if you're in person,	
	4	then there is...? There is that extra, um, connection?	I was trying to clarify what additional aspects or benefits PCP offers compared to VCP, based on what she said was lacking in VCP
	5	P5: You can definitely sit very close to a person and be totally	
	6	disconnected, I'm aware of it, but I think it's an additional layer. If we are	Acknowledges that even in PCP one can feel totally disconnected
Sharing the same space is a factor in connection	7	sharing the same space and we can see each other in <i>full</i> experience and	
	8	we can <i>share</i> this, um, I don't know what can be, uh, a good description.	Breathing the same air helps create connection but it's not a guarantee
	9	If we are breathing the same air, it kind of helps a bit. It's not a guarantee	
	10	that we are going to connect, but it's a factor.	
	11	INT: Yeah, it helps the connection.	
	12	P5: Yeah.	
	13	INT: And, uh, I mean, you were talking about how in online therapy,	
	14	there's this mirror because you can see yourself in the little window,	
	15	which you don't get in when it's in person therapy. Um, but in, in both	
	16	kinds of therapies, you still have the therapist looking at you. So what's it	

- Lacking eye contact in VCP
- 1 like for the therapist to or what's it like for you to see the therapist
 - 2 looking at you online and in person?
 - 3 P5: I think, uh, maybe because in real life we have eye contact and, on
 - 4 the screen, **there is no eye contact**, so you don't really, I don't know
 - 5 where you look now, you probably try to look at my face, but it doesn't, it
 - 6 doesn't feel that way. **We** don't know where we look. **We** try to get the
 - 7 eye contact through the video call. But **we're** just **staring at some dot on**
 - 8 **the screen**, so it is **not really eye contact**. I feel like, uh, **less intimidated**,
 - 9 uh, when it is in person. Uh, it feels like this gaze, this stare, it's **diluted** in
 - 10 real life. And through the video, it's heavier, it's this, like, you stare at me,
 - 11 I don't even know where you stare, because there again, there is **no eye**
 - 12 **contact**, it's just this, um, weird feeling of, um, somebody looking at you,
 - 13 but **as if they're looking through you**.
 - 14 INT: Mm hmm.
 - 15 P5: **In real life, you can see exactly where, where is the gaze.**

20

There is no eye contact on the screen, just stating at some dot on the screen – denigrating it? Staring sounds intimidating. She moves from something personal and human (“eye contact”) to something impersonal/an object (“some dot”). By “dot”, does she mean the top of the screen or the pixelated eyes of the other person? Because if I stare at the top, I cannot see the person on the screen. Could it be a phrase that people use but not something they actually do?

Feels less intimidated in person

Gaze/stare is heavier through video

Lots of interesting paradoxes here – she is talking about the contact being too intense but not as real. Usually, we talk about real life being “diluted” online. But she is talking about a dilution that happens in the consulting room. Is she in description mode (her phenomenological lived experience) or explanation mode here? It sounds like a common script that doesn't necessarily stand out (e.g. “we don't know” - talking about a joint effort of trying to connect)

Someone is looking at you but as if they're looking through you

In real life you can see exactly where the gaze is – so online is not real?

The thing she talks about as trying for and needing and privileging is the same thing she is talking about as being uncomfortable. It's as though she can't win – can't get the eye contact and when she gets it, she feels like the therapist is looking through her. Sounds like she is in a rock and hard place where there is no fix for it other than a physically co-present meeting.

- Finding PCP less uncomfortable, less intimidating and more normal/ human
- 1 INT: Mm hmm. So, in real life you can tell where they're looking, but
 - 2 online you can't. And so, and then you said it feels like they're looking like
 - 3 literally through you.
 - 4 P5: Yeah, **staring at your face**. In, uh, **in real life**, it's, uh, as I said, **it's**
 - 5 **diluted**. It's like a person, they would look in your eyes, but then they will
 - 6 probably look around as well. Maybe they will look aside, look at you
 - 7 again, and it comes in this natural way. So I find it **less uncomfortable**,
 - 8 **less intimidating and more normal, if you like, more human**.
 - 9 INT: Mm hmm.
 - 10 P5: Because **all this remote business**, it's only happening in the recent
 - 11 years and **it's not something that we are naturally as human beings used**
 - 12 **to**. **All those video conferences**, it's the modern invention and a great
 - 13 invention, but **it removes this human connection**. It removes eye contact,
 - 14 and it feels less, uh, less comfortable and less something that we are
 - 15 accustomed to.
 - 16 INT: Yeah.
- Lacking human connection in VCP

21

In real life the gaze is diluted – people look at other things too
Repeats that gaze is more diluted in PCP

Staring at your face – repeats “staring” but says “face” instead of “dot” – feels more personal
It's less uncomfortable, less intimidating, more normal, and more human.

I'm curious if her impression is accurate of her own lived experience because most people still do look around even in online interactions. Does her therapist look into the camera for the whole time and not look anywhere else? Is so, that seems to be an unusual dynamic.

“all this remote business” – techno phobic language?

It's not something we as human beings are used to

Remote business removes human connection

She seems to be low on PROI (Clark and Green's concept of perceived reality of online interactions; the extent to which a person views online interactions as suitable for the maintenance and formation of close relationships). She is basically saying that certain kinds of connections are not achievable via these means.

Online is different and uncomfortable	1	P5: If I think about my whole life growing up, um, seeing somebody	Being online is different and sometimes uncomfortable
	2	online was not part of life. It's a different experience and sometimes it's	
	3	uncomfortable.	
	4	INT: Yeah, yeah. And you mentioned the word human, like more or less	
Connecting online is less natural	5	human, and more or less natural, and more or less normal. So, yeah, so it	Online conversations are less emotionally comfortable and less natural
	6	sounds like, um, this is just something new that came up, but it's not	
	7	really natural. It's, it's not the way it's supposed to be?	
	8	P5: It's less comfortable, at least for me, with a lot of, uh, it's convenient,	
	9	but in terms of, uh, emotional comfort, it's less comfortable, and less	
	10	something natural. I'm not saying it's unnatural or terrible, but it's less	
	11	natural than the connections that we are all used to from the	
	12	communication that we are used to have outside of the video	
	13	conferencing life.	
	14	INT: Yeah. And that's both, um, in therapy, but also in other contexts like	
	15	work and personal calls.	

22

Not so bothered about the quality of connection on work calls	1	P5: Yes, absolutely. But with work I care less. You know, if I don't have a	Cares less about work connections – as long as work is done it's OK
	2	great connection and contact with my colleagues, as long as we can have	
	3	our businesses done and we achieve what we need to achieve, we	
	4	discuss what we need to discuss, that is totally fine. But the expectation	
Desires and expects to connect with her therapist	5	from therapy is different.	With therapist she wants to connect
	6	INT: Mm hmm.	
	7	P5: With a therapist, I want to connect. I don't need to connect with 10	
	8	colleagues to discuss the agenda of the day.	
Online connection does not measure up to physical connection	9	INT: Yeah.	She is emphasising her point in various ways, invoking all sorts of broader phenomena to back up how she feels. Does this mean she feels uncomfortable and is invoking a lot of things to justify/validate her feelings?
	10	P5: Uh, we could, we could even discuss it over the phone with no video	
	11	at all, or we could send each other an email as well, and that's fine. But	
	12	when you strive to get this connection, when you strive to be fully heard,	
	13	seen and understood, then it's important, the quality of work, of	
	14	communication, and I think the quality of communication online,	Feels like a self-fulfilling prophecy – one's experience of deep and valuable online work is depending on to a large extent one's ability to be open to the potential of online connection and on the other person's as well. Without being willing to allow for that the connection won't happen because the belief system will be an obstacle. But she is speaking about the obstacles as something that exists in the world, as something that just is, not as something that mediates online connection. It's an ontological reality, an existential given that the presence of the machinery is going to have this impact/ is going to mean that this kind of connection is impossible. She seems to be leaning heavily on assumed ontological givens, saying her experience is determined by some external things over which she doesn't have control and furthermore it's probably the same for most people as well. But it's not a given, it's ontic. Some phenomenological methods are designed to pick out the universal or the fundamental structure of an experience, like the descriptive phenomenological approach. IPA looks at the range of experiences that are around a particular phenomenon. But Sarah seems to believe that her experience is part of the fundamental inescapable structure of online therapy (she is talking about that experience being imposed on her)
	15	remotely, is not the same as in person.	

23

Filters allow her to present a nicer version of herself	1	INT: Hmm. Hmm. And, uh, I just want to go back, um, to what you said	Seems that my question brought her back to her phenomenological experience.
	2	about the filters. Um, so you mentioned that before, even before your	
	3	first therapy session, you decided to put on a filter, right? And is that	
	4	something, um, that you used to do even before that? Or was it just	Zoom suggested that she could use a filter every time she joined
	5	specifically for the video therapy?	
	6	P5: Well, I didn't use Zoom much and I also, I didn't know there is an	
	7	option to put this filter on. Zoom suggested it when, when I was setting	She saw a nicer, smoother version of her and liked the idea of looking better Quotes what was going on in her head at that time – she is right in the moment
	8	up the camera for the call, it suggested that you can set it on a, like, you	
	9	can set up a certain way that your filter will always appear. And then I	
	10	looked and, Uh, it's like a nicer version of myself, like a slightly, uh,	
	11	smooth, smooth version with like a smooth skin. And, uh, I liked it. It was	
	12	not my plan to do it, but when I saw it's an option, I liked the idea of	
	13	appearing better looking.	
	14	INT: And so how was, how did that make you feel? Because, uh, am I	
	15	correct to assume that when you used online, uh, communication before,	

24

Feels prettier with a filter on	1	like for work, for example, there was not this option, so you only	
	2	discovered it when you were installing Zoom for the therapy?	
	3	P5: I think I used Teams before, and Teams don't offer you this. And then	
	4	my therapist suggested using Zoom, if I remember correctly. Um, How it	The filter made her feel better and prettier. Present tense – still right in the experience.
	5	made me feel? It made me feel better. I liked it. I felt like, Oh, I appear	
	6	prettier, this is good.	
Filters photos to change herself	7	INT: Mm hmm.	It was a no brainer.
	8	P5: Uh, and, uh, I went for it. It was a no brainer. But if I can look prettier,	Filters all her social media photos.
	9	then I would look prettier. It's just like with, uh, social media and the	
	10	photos that I would use. I filter all my photos, so... And filter much more	
	11	than Zoom would allow you, so I properly filter them, like adding hair	Likes altering her image, it makes her feel better.
	12	volume and putting face filters and making myself look slimmer. So I like	
	13	the, the alternating the image and I know it's silly in a way because it's	
	14	not you, but it makes, uh, makes me feel better about myself.	"it's not you" – why the switch to 2 nd person? Would 1 st person be too exposing? Maybe it's difficult for her to accept that that's her experience/behaviour.
	15	INT: Yeah, and, uh, and this was even though the therapist knew you	
	16	from before because you've met in person, so she knew exactly what you	

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Presents a better version of herself to therapist when in consulting room	1 looked like. Um, but yeah, you were still more comfortable with the filter, 2 which was kind of smoothing you out. 3 P5: Yes, I was more comfortable with it, and although she saw me before, 4 but she also saw me in the clinic, usually with makeup and better 5 dressed. So since I was sitting at home kind of with my lounge wear and, 6 uh, uh, hair not washed for a few days, so I thought it would help me to 7 at least have a bit of filter on my face [laughs].	Therapist had seen her in person but she had make up then and was better dressed. Thought it would help to have a bit of filter online. Difference between the person she presents outside vs. at home and how online therapy challenged that
Covid-19 was challenging due to inability to keep up her hair	8 INT: Okay. So there is something about lockdown and the whole thing of, 9 you know, everyone being at home kind of in their comfortable clothes. 10 P5: Yeah. It was a very difficult period of time because when the 11 hairdresser is closed, you can't go do your nails, you can't go to your 12 beautician. Uh, it's, it was difficult for a person who is already careful 13 with how they look and, uh, conscious about it. It was difficult. I couldn't 14 colour my hair, I started to get like long dark roots, uh, and it's, uh, it's 15 very unpleasant. So this triggered quite a bit of, uh, thoughts about, uh, 16 my appearance.	My sentence could have moved her to talking about other people but thankfully she stays with her phenomenological experience. For a person – why the personalisation? Could have been because of my intervention above... Lockdown was difficult for a person who is already conscious about their looks

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Seeing herself on camera during Covid-19 added to an already difficult experience of not having her hair coloured	1 INT: Yeah. 2 P5: And then in this image on the screen, um, not the best experience. 3 INT: Yeah, I can imagine. So that was a particularly difficult period in your 4 life because of your kind of general like worries around or feelings around 5 your body image and then not being able to do these things that you 6 probably normally do, go to the hairdresser and and things like that.	Not the best experience – again says what it wasn't but not what it was, feels like a softening adjective (e.g., not a good experience would sound like it was worse). I can see her coming into the specific phenomenological experience and then there is some kind of judgment or evaluation or something that causes her to need to lean on some "it is what it is" or what other people do ("many people struggled" in this case).
Describing collective experience of struggling with BID during lockdown	7 P5: Yes, absolutely. And, uh, uh, I think many people struggled. I 8 definitely struggled. You know, the gym closed, the hairdresser closed, 9 you sit at home and, uh, feel uncomfortable about yourself. 10 INT: Yeah. Okay. And, uh, but you mentioned the therapy was never kind 11 of about that. 12 P5: No, but maybe it should have been, but it was not. When the, years 13 ago when I had anorexia, I received therapy, and this was about the 14 weight, the body image. But, uh, in the past few years with the, uh, 15 therapist I'm currently seeing, uh, no, it's, uh, it's not about that.	"You know", "you sit at home", "feel uncomfortable about yourself" – using 2nd person to push the experience away from her? Many people struggled in lockdown. Maybe her BID should have been a topic of her online therapy.

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Still struggling with her weight	1	INT: And how did the anorexia link to your body image issues? Do you	
	2	think, cause you mentioned that that was something you had in the past.	
	3	P5: I think I'm still struggling with the weight . I very often feel like I need	Seems to be in constant fear/lives in fear of putting on weight.
	4	to lose weight, and I think it's the aftermath of this experience. I'm	
	5	always, um, careful with, um, what I eat and always a bit scared to put on	Makes it clear that she does not have anorexia so does not want to be given that label but still fears becoming overweight.
	6	weight.	
Fears gaining weight	7	INT: Mm-hmm. So it's, uh, it's still kind of there or you still	
	8	P5: I don't have anorexia now and my weight has been stable for, for over	Still has fear of being overweight and issues around body acceptance in a lighter format.
	9	a decade, but the fear of being overweight is still there . And the issues	
	10	around accepting my body, they're still there. In a lighter format, but still	
	11	there.	
	12	INT: Still there, yeah. Okay, okay. I'm just looking at the questions that I	
	13	wanted to ask you. Um... I think we've gone through pretty much	
	14	everything, really. Um, I just wanted to ask you... I mean, we already	
	15	compared the, you know, in-person experience and the online situation,	
	16	um, I can ask you one more time. Is there something about in person	

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Feels greater sense of safety and comfort in PCP	1	therapy, um, that you could think about and use that to better describe	
	2	the online experience.	
	3	P5: Uh, would you, would you please explain what you mean? Something	
	4	about in-person therapy?	
	5	INT: Yeah, if there's like one particular thing that, uh, would help you, you	Feels safer and more comfortable when in the same room with the therapist.
	6	know, something maybe characteristic of the in-person therapy that	T's physical presence + predictability of T's enviro is important to her in creating a sense of safety and comfort in therapy and may contribute to building trust and rapport, which is challenged in an online setting.
	7	would then help you describe the online therapy or the video therapy.	"not knowing," "who is behind the door," and "what's going on around them" indicates a sense of mystery and lack of control and the language conveys a feeling of uncertainty and perhaps a hint of anxiety or discomfort.
	8	You, you already mentioned the connection, for example, you know, that	I think it adds a tiny bit of insecurity" – speculative/hypothetical language an attempt to rationalise or make sense of her feelings, perhaps pointing to an ongoing internal dialogue about her comfort with the therapy format?
	9	you feel, um, that it's easier to establish connection in person, so that	Not knowing where the therapist is and who is around adds a tiny bit of insecurity - refers to feeling insecure in her attachment to her T
	10	was one thing. Is there anything else or was this mainly the, was this the	Worried about her privacy (who else is listening, who else can see), control and the unknown aspects of online communication? Suggests a need for a contained, predictable therapeutic space.
	11	main thing?	
	12	P5: I think it's also the feeling of, uh, safety, uh, when I'm in the same	
	13	room with the therapist, I feel, um, uh, I feel more safe and comfortable .	
	14	I am not particularly paranoid about who can overhear the conversations,	
	15	but I would say that to a small extent not knowing where this person is	

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Inability to see therapist's surroundings online feels a bit uneasy

Online therapy allows for quick dismissal

Possibility of sudden dismissal in VCP feels unpleasant, unstable and unsafe

- 1 and who is behind the door and what's going on around them, I think it
- 2 adds a tiny bit of insecurity to, to the whole, the whole process.
- 3 INT: Mm-hmm.
- 4 P5: And I think, uh, being, sitting there face to face feels safer as well if
- 5 we compare it to online experiences. And, uh, it also feels now, now that
- 6 I try to think more about it, um, it, when somebody can kind of get rid of
- 7 you by just, uh, clicking like stop or leave the meeting, um, it's not the
- 8 same experience as somebody being next to you. It feels as if you can be
- 9 dismissed easier.
- 10 INT: Mm-hmm.
- 11 P5: Not that my therapist ever did something like that, and I trust my
- 12 therapist, but, um, the whole idea that, uh, um, like separating from you
- 13 or getting rid of you is one click away. Um, it's also not a very pleasant
- 14 thought now when I'm reflecting on it. Um, and also, we rely on internet
- 15 connection. It just doesn't feel like as stable and safe as a face-to-face
- 16 experience.

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Can get dismissed by just clicking the stop button or leaving the meeting

The words "dismissed easier" and "one click away" have a sense of immediacy and simplicity, possibly implying that ending a VCP session feels abrupt and lacks the gradual process present in PCP.

"dismissed easier" – what does that say re her feeling re the relationship? Easier: - already there is sth about insecurity in the relationship that's being exacerbated w technology and the ease of being dismissed.

The idea of getting rid of you in one click is not pleasant.

Describes the perceived ephemeral nature of online connection, which seems to create a sense of vulnerability and lack of permanence.

Doesn't feel as "stable and safe" – concerned about the stability and reliability of tech in facilitating a meaningful therapeutic connection?

Being "one click away" from termination implies a perceived fragility in the therapist-client relationship in an online setting; it suggests a conceptual understanding that the physical effort and process required to end a session in PCP are replaced by a simple, almost effortless digital action, which might perhaps feel less substantial or committed Internet connection is not as stable and safe as f2f experience.

Repeatedly switches between "I", "you" and "we". Utilising "you" and "we" to talk freely about difficult and uncomfortable things? Who is she including in her groupings?

"not a very pleasant thought" - an emotional response to the perceived ease of dismissal – she feels uncomfortable and uneasy

Fillers ("uh", "um", "you know") might indicate hesitation or her attempt to carefully articulate her feelings – could suggest a deeper, possibly unexplored emotional landscape related to her experience.

- 1 INT: Yeah. So more safety, cause you know what's around you versus
- 2 online you're not really sure, you know, if someone can hear or, you
- 3 know, where the therapist is exactly. And also, um, uh, yeah, the fact that
- 4 they can literally just click on something and then you're gone.
- 5 P5: Yeah. It feels like, uh, again, going back to the connection, I guess, it
- 6 feels like it's more solid and secure when you're face to face with the
- 7 person also, you know, in a real-life therapy, when you are about to say
- 8 goodbye and you grab your coat and your bag, you have an opportunity
- 9 to say, like, Have a good weekend while you're slowly exiting the room,
- 10 uh, it's a little thing and it's not crucial, you can have therapy, I believe,
- 11 without it. But it's as if a part of the experience is missing when you are
- 12 remote.
- 13 INT: Hmm, yeah, because it's not there, right? This kind of small talk, or
- 14 whatever you want to call it.
- 15 P5: The small talk and the experience of entering and exiting and saying
- 16 something and looking around. Uh, those tiny little things, the one by

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F2f feels more solid and secure and you are able to say grab your stuff and say Have a good weekend.

"real-life therapy" – what's VCP then?

Loss of small interpersonal moment and rituals that contribute to her therapeutic experience

Gradually acclimating/accepting/easing her way out of the end of the session – describing the separation from her T when you say Goodbye – in the office she is able to acclimate more gradually to separation from the T – in terms of Bowlby and Ainsworth's attachment style, this is feeling like insecure attachment

It's as if a part of the experience is missing when you are remote.

It's the remoteness that's determining the quality of the connection but even the content (can't say Have a good weekend) insecurity around being cut off by T or internet connection - either at the hands of the T or the internet connection you can suddenly just be severed

Those tiny little things don't mean much but form the whole experience.

Experiencing a loss of small interpersonal moments

PCP is
superior in
quality

1 one, they don't mean much, but it's the *whole* experience. And I just feel
2 like the experience of *face-to-face interactions has more quality in it.*

F2f has more quality

3 INT: Hmm, hmm, because there is more of this, more of these kind of
4 things.

5 P5: Yes.

6 INT: Hmm. And, um, yeah, I think, I think that's it. I have one more tiny
7 question, but first I'm going to ask you if there's anything that you would
8 like to add anything, you know, that you, about anything that we spoke
9 about, or if, if there's something, um, else you think might be relevant.

It would be a good idea for therapist to bring up this
topic in remote therapy.

10 P5: Well as we were talking today, I thought *that it would be a good idea*

Has not
spoken re in-
the-moment
VCP
experience
with
therapist

11 *for therapists to bring this topic up when they work remotely, because*

"the little square"— sounds impersonal

12 *my therapist has never asked me how do I feel to see myself in the little*

Therapist never asked her how she feels looking at
herself. She has also not said anything even though it
seems she was able to form a good therapeutic
relationship with the therapist – does this mean it
wasn't a real concern for her then, but it is now that
she is reflecting back?

13 *square on the screen.* And again, yes, body image issues were not the

14 topic of our discussions, but I think it might be relevant in general

15 INT: Hmm.

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Retrospecti
vely
realised she
might not
feel
comfortabl
e seeing
herself in
VCP

1 P5: To just ask a little question, because I didn't think about it until you
2 asked me about it today. But *when you did ask me and I started to reflect*
3 *on it, it just came to my mind that yes, maybe I don't feel comfortable.*

Maybe she doesn't feel comfortable and there are
issues she needs to talk through

4 *Maybe there are issues that I need to talk through.*

A sentence to please me/something she thinks should
be said at the end of a discussion or is she actually
going to talk through this with her therapist?

5 INT: Hmm. Hmm. And you, you also mentioned previously that you think

6 it would be good for anyone really to, um, you know, to maybe think

7 about these things because it's... You know, there's something about, um,

8 I mean, you said, you know, maybe not natural or less human that

9 perhaps other people would have issues with as well, not necessarily just

10 people who have kind of body image dissatisfaction or body image issues.

Recommen
ds that
every VCP
client is
asked how
they feel
about VCP

11 P5: I think so. I think *every client who goes for some remote therapy*

Every client in remote therapy should be asked how
they feel about being online.

12 *probably should be asked those questions* and *if they don't feel like*

13 developing this topic, then be it, but maybe something interesting might

14 come up for them.

15 INT: Yeah. Yeah. Yeah, it's a great idea. And so lastly what has it been like

16 for you to talk with me, you know on video about video therapy?

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Feels more uncomfortable about VCP than expected	1	P5: Well, it was a thought provoking because I haven't really given a lot of	Talking to me was thought provoking and made her realise that she might be more uncomfortable with online therapy than she previously thought More uncomfortable – quite a broad term – previously used stronger expressions (e.g., that she doesn't like online therapy) and was more specific (e.g., that she finds it intimidating).
	2	thoughts to this topic and it made me realise that I'm maybe more	
	3	uncomfortable with online therapy than I thought previously, and there	
	4	are some things to reflect on. And also as we talked about being	
	5	uncomfortable to see yourself on the screen, as I see myself on the	
Looking at her image during our chat felt intimidating	6	screen, so I've been looking at my image in the corner now and thinking,	"My image in the corner" – previously referred to the same thing as "the little square, the small window, the little screen – less distant/closer relationship to the self-view?" "Now" – she is right in her experience
	7	um, uh, Well, this is, uh, this is a bit intimidating. You know, as you talk	
	8	about it and it's happening, you talk about the process that is happening	Talking about the process in the here and now made her more attuned to the issue
	9	right now, it makes you maybe more attuned to the issue?	
	10	INT: Yeah, yeah, so it sounds like you were feeling a little bit more of, or	Question mark – unsure about the word "attuned" or seeking my confirmation? I try to summarise what she was saying without telling her how she felt ("you were feeling a little bit more of..."), leaving her to fill in the blanks
	11	you were feeling what you were talking about.	
	12	P5: Yes, I felt connected to the topic that we were discussing.	
	13	INT: Yeah. Yeah. Well, that's great. But you know, if, if there is anything	Felt connected to the topic – more confident about the word here ("connected")
	14	that kind of comes up for you after the interview, I'll send you, um, um,	
	15	like this list of places that you can contact if you need any support, or you	
	16	can let me know if you, you know, if you have any questions about that	

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- 1 or about the research or anything that would make you feel kind of more
- 2 reassured or yeah, anything you need.
- 3 **P5:** Thank you.
- 4 **INT:** Yeah, you're welcome. Well, thank you so much. I'm just going to
- 5 turn off the recording now before we say the final goodbye, so let me just
- 6 do that now.

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Appendix L

Example of an Excel Sheet with ES and Corresponding Quotes – Sarah

Experiential Statements (ES) - Sarah		
Experiential statement	Location	Quote
Recounting her experience of BID and VCT in terms of number of years	P1, 5-8	Um, I have been, uh, struggling with, uh, body image and accepting my appearance, uh, since very young age, maybe since being a teenager, and, uh, uh, I've been in therapy for a number of years and I've done a number of hours, uh, of remote therapy
It was her therapist's idea to switch to VCP	P1, 15-16	A few years ago, maybe two years ago, my therapist suggested to do remote therapy because of, uh, Covid
Expected smooth transition to VCP	P2, 1-2	And first I thought That's fine, that's not a problem
Experienced unexpected feelings of discomfort upon seeing herself on the screen	P2, 2-3	I realised that I'm not very comfortable with seeing myself on the screen
Filters make her feel more complete	P2, 6-9	on every call I would be a bit, uh, filtered. It made me feel better, especially when you log in from home, you sit there with no makeup, with your homeware, it, it felt a bit, uh, better basically not coming as you are, but in a more completed version.
Wondered how the therapist was experiencing VCP	P2, 11-13	And I started thinking, How is it for the therapist on the other end? Because they see this big image and it's quite intimidating, you can see all the traits and features.
Experiencing a difference in how she is seen online vs. in consulting room	P2, 14-15-P3, 1-2	in real life, when you go to the clinic, to the office of the therapist, they see you in 3D and it's less staring in your face. It's more like looking all over the place. But here it felt like, um, yeah, for the whole duration of the session, the therapist is looking at your face on the big screen.
Experiencing the therapist's gaze as constant	P3, 1-2	it felt like, um, yeah, for the whole duration of the session, the therapist is looking at your face on the big screen.
Finding the therapist's gaze to be anxiety-provoking and distracting	P3, 10-12	it just, uh, uh, provoked a bit of anxiety; it, uh, uh, maybe made me, distracted me from the therapy process
Wondering if the therapist's gaze distracted her from other issues to BID	P3, 15-P4, 1-2	it, uh, uh, maybe made me, distracted me from the therapy process, from other issues and moved my thoughts, uh, uh, towards the, uh, body image or appearance, uh, issues.
Not considering her BID to be the focus of her therapy	P4, 8-9	my own appearance was never the focus in, uh, in those sessions.
Dealing with BID in therapy on her own	P4, 13	I think it's something that I was processing on, on my own
Her BID has long and strong history	P5, 2	it's, uh, something quite deeply rooted for me
Constantly worrying about her weight	P5, 11	I always have issues about my weight
Cannot get too comfortable when it comes to weight	P6, 1-3	I think I'm in remission, but I still feel the, uh, issues around my weight and it's something that's more or less always on my mind.
Concerned about being pretty or not	P6, 5-8	I've always been struggling with my height, and I wanted to be taller and, um, also with the, uh, face, like questioning my features or trying to alter certain features by doing some treatments and uh, basically general concerns about being pretty or not being pretty.
Highlighting the extent of her BID	P6, 12	it's an ample combination of things
Noticing an improvement in her BID over the years	P7, 4	I would say that in the recent years it became better
Experiencing BID as something powerful hat impact all of her life	P7, 9-10	it affects my mood and my ability to socialise, the way I, uh, interact with other people, you know, basically all the, all, all spheres of my life.
Various things contributed to her BID getting better	P8, 1-3	Maybe it's also a number of years of therapy that helped and, uh, maybe just life experiences or learning to accept things that you cannot change. Probably a combination of factors.
It was the format of the therapy that brought up thoughts around her	P8, 7-9	They come up not just on video, but I happened to notice that in those remote sessions with the therapist, it, uh, it just came to my mind probably because of the format.
Feeling a general uneasiness around seeing herself on screen	P8, 14-15	I don't feel very comfortable and don't like seeing myself on the screen
People in work calls don't focus exclusively on you	P8, 16-P9-1-2	on those work meetings there would be a few people, and even if it is a one person, they're not focusing on you 100 percent
Experiencing the therapist's full attention as a hindrance in VCP	P9, 3-7	With a therapist, it's very different because therapist is there to give you their full attention. And, uh, it would be very unlikely the therapist would be sitting there looking around or taking their own notes and doing whatever comes to them. So I feel like in therapy sessions, it is exaggerated, this issue.
Not the centre of attention in work/personal calls	P9, 9-10	In my work meetings, so personal meetings, uh, on Zoom, it's not, um, it's not that prominent.
Seeing herself on the screen in work/personal calls is easier	P10, 1-2	It makes this issue of seeing myself on the screen less prominent
Finding other people looking at her intimidating in all video calls	P10, 8	I find it intimidating
Getting carried away imagining what others are thinking of her	P10, 15-6-P11, 1-2	maybe they don't have any opinions or any thoughts about it, but I can't help thinking that they might and developing this fantasy that they are maybe judging or maybe having some negative opinions about myself.
Wondering what is visible to others and how they think of/judge her	P11, 8-9	I start to fantasise: What do they see? What do they notice? What do they think about me?
Lack of mirror in therapist's office means you can't see yourself	P12, 1-2	in the, uh, office of the therapist, there is no mirror, so you don't really see yourself
Comparing VCT to therapy with a mirror	P12, 4-5	this is like having therapy with a mirror there.
Didn't think of discussing it with her therapist	P12, 11-12	I haven't discussed it with my therapist and probably I should have done it, but it didn't really cross my mind.
Conscious of the camera reflecting two differently sized images	P12, 14-15-P13, 1	instead of seeing the therapist big on the screen and myself like in the small window, for some reason I saw myself big and the therapist smaller.
Seeing herself (instead of therapist) big on the screen was disturbing	P13, 5-6	Like I'm seeing my face big on the screen and it's really disturbing.
Having a dislike towards seeing oneself big is a shared experience	P13, 8-9	But I believe that not only people with body image issues wouldn't like it.
People with BID are more prone to feeling intimidated upon seeing themselves big on the screen	P14, 1-3	probably this is much more likely to happen with people who struggle with accepting their appearance and struggle with their body image

39	Wondering what could have been achieved if she shared her thoughts with the therapist	P14, 8-11	I think it would probably give me a chance to explore my feelings in the moment. Uh, to explore what, uh, what exactly was uncomfortable and why. So, uh, but it, it's hard to imagine what it would open up. But it probably would be a chance to explore, uh, the issue as it is happening
40	VCP allows people with BID to discuss their issues as they're happenin	P15-2-4	for people who struggle with self-esteem, with issues linked to their appearance, uh, it could be an interesting experience because they can process things that are happening in the here and now.
41	Experiencing a dislike towards online therapy	P15, 16	I <i>don't</i> like online therapy
42	PCP is much more real	P16, 1-2	I, uh, also find, uh, uh, face-to-face contact to be much more real.
43	Experiencing better therapist-client connection	P16, 5-6	I feel like the connection between the therapist and the client is better.
44	Experiencing VCP as lacking in human presence	P16, 8-9	Online setting removes the human, human presence from it.
45	Highlighting that VCP is not the same as PCP	P16, 16	it's not the same as, uh, face-to-face contact.
	VCP deprives you of the other person's presence	P17, 1-8	It's the whole experience of somebody's presence, their way of being, their, seeing somebody in 3D, you know, and uh, I, I don't know what we can call it. Maybe somebody's energy? You cannot feel it from the screen... I don't know if that is the right word, but somebody's presence, their way of being, you can only see it when you meet with the person. Online it's very restrictive, you're limited to certain things.
46	Experiencing a lack of shared reality online	P18, 3-4	what is missing is the sense of a <i>shared</i> reality, <i>shared</i> space.
47	Finding physical proximity to be necessary for good connection	P18, 10-11	for me, uh, it's important to feel this proximity in order to feel this connection.
48	Lack of physical proximity makes connection more difficult	P19, 1-2	it creates an extra layer of distance. It creates this obstacle on the way to connection.
49	Sharing space ≠ connection but it's a factor	P19, 5-10	You can definitely sit very close to a person and be totally disconnected, I'm aware of it, but I think it's an additional layer. If we are sharing the same space and we can see each other in <i>full</i> experience and we can <i>share</i> this, um, I don't know what can be, uh, a good description. If we are breathing the same air, it kind of helps a bit. It's not a guarantee that we are going to connect, but it's a factor.
50	Lacking eye contact in VCP	P20, 3-8	on the screen, there is no eye contact; we're just staring at some dot on the screen, so it is on the screen, there is no eye contact, so you don't really, I don't know where you look now, you probably try to look at my face, but it doesn't, it doesn't feel that way. We don't know where we look. We try to get the eye contact through the video call. But we're just staring at some dot on the screen, so it is not really eye contact.
51	Experiencing VCP as more intense but less real	P20, 11-13	there is no eye contact, it's just this, um, weird feeling of, um, somebody looking at you, but as if they're looking through you.
52	Finding PCP less uncomfortable, less intimidating and more normal/human.	P21, 7-8	I find it less uncomfortable, less intimidating and more normal, if you like, more human.
53	Lacking human connection in VCP	P21, 13	it removes this human connection
54	Online is different and uncomfortable	P22, 1-3	um, seeing somebody online was not part of life. It's a different experience and sometimes it's uncomfortable.
55			
56	Connecting online is less natural	P22, 8-13	it's less comfortable, and less something natural. I'm not saying it's unnatural or terrible, but it's less natural than the connections that we are all used to from the communication that we are used to have outside of the video conferencing life.
57	Not so bothered about the quality of connection on work calls	P23, 1-4	with work I care less. You know, if I don't have a great connection and contact with my colleagues, as long as we can have our businesses done and we achieve what we need to achieve, we discuss what we need to discuss, that is totally fine.
58	Desires and expects to connect with her therapist	P23, 7	With a therapist, I <i>want</i> to connect.
59	Online connection does not measure up to physical connection	P23, 12-15	when you strive to be fully heard, seen and understood, then it's important, the quality of work, of communication, and I think the quality of communication online, remotely, <u>is</u> not the same as in person.
60	Filters allow her to present a nicer version of herself	P24, 10-3	it's like a nicer version of myself, like a slightly, uh, smooth, smooth version with like a smooth skin. And, uh, I liked it. It was not my plan to do it, but when I saw it's an option, I liked the idea of appearing better looking.
61	Feels prettier with a filter on	P25, 5-6	I felt like, Oh, I appear prettier, this is good.
62	Filters photos to change herself	P25, 10-14	I filter all my photos, so... And filter much more than Zoom would allow you, so I properly filter them, like adding hair volume and putting face filters and making myself look slimmer. So I like the, the alternating the image and I know it's silly in a way because it's not you, but it makes, uh, makes me feel better about myself.
63	Presents a better version of herself to therapist when in consulting room	P26, 3-5	she also saw me in the clinic, usually with makeup and better dressed
64	Covid-19 was challenging due to inability to keep up her hair	P26, 13-15	It was difficult. I couldn't colour my hair, I started to get like long dark roots, uh, and it's, uh, it's very unpleasant.
65	Seeing herself on camera during Covid-19 added to an already difficult experience of not having her hair coloured	P27, 2	And then in this image on the screen, um, not the best experience.
66	Describing collective experience of struggling during lockdown	P27, 7-9	I think many people struggled. I definitely struggled. You know, the gym closed, the hairdresser closed, you sit at home and, uh, feel uncomfortable about yourself.
67	Still struggling with her weight	P28, 3	I think I'm still struggling with the weight.
68	Fears gaining weight	P28, 9	the <i>fear</i> of being overweight is still there.
69	Feels greater sense of safety and comfort in PCP	P29, 12-13	when I'm in the same room with the therapist, I feel, um, uh, I feel more safe and comfortable.
70	Inability to see therapist's surroundings online feels a bit uneasy	P29, 15-30, 1-2	not knowing where this person is and who is behind the door and what's going on around them, I think it adds a tiny bit of insecurity to, to the whole, the whole process.
71	Online therapy allows for quick dismissal	P30, 8-9	It feels as if you can be dismissed easier.

72	Possibility of sudden dismissal in VCP feels unpleasant, unstable and unsafe	P30, 12-16	the whole idea that, uh, um, like separating from you or getting rid of you is one click away. Um, it's also not a very pleasant thought now when I'm reflecting on it. Um, and also, we rely on internet connection. It just doesn't feel like as stable and safe as a face-to-face experience.
73	Experiencing a loss of small interpersonal moments and rituals	P31, 7-12	in a real-life therapy, when you are about to say goodbye and you grab your coat and your bag, you have an opportunity to say, like, Have a good weekend while you're slowly exiting the room, uh, it's a little thing and it's not crucial, you can have therapy, I believe, without it. But it's as if a part of the experience is missing when you are remote.
74	PCP is superior in quality	P32, 2	the experience of face-to-face interactions has more quality in it.
75	Has not spoken re in-the-moment VCP experience with therapist	P32, 10-13	...I thought that it would be a good idea for therapists to bring this topic up when they work remotely, because my therapist has never asked me how do I feel to see myself in the little square on the screen.
76	Retrospectively realised she might not feel comfortable with VCP	33, 1-3	I didn't think about it until you asked me about it today. But when you did ask me and I started to reflect on it, it just came to my mind that yes, maybe I don't feel comfortable.
77	Recommends that every VCP client is asked how they feel about VCP	P33, 11-12	I think every client who goes for some remote therapy probably should be asked those questions
78	Feels more uncomfortable about VCP than expected	P34, 2-3	it made me realise that I'm maybe more uncomfortable with online therapy than I thought previously
79	Looking at her image during our chat felt intimidating	P34, 6-7	so I've been looking at my image in the corner now and thinking, um, uh, Well, this is, uh, this is a bit intimidating.

Appendix M

Example of Clustering – Sarah

Clustering - Sarah			
Experiential statement	Location	Quote	
Feels prettier with a filter on	P25, 5-6	I felt like, Oh, I appear prettier, this is good.	PET 1
Filters allow her to present a nicer version of herself	P24, 10-3	it's like a nicer version of myself, like a slightly, uh, smooth, smooth version with like a smooth skin. And, uh, I liked it. It was not my plan to do it, but when I saw it's an option, I liked the idea of appearing better looking.	natural vs. filtered Sarah
Filters photos to change herself	P25, 10-14	I filter all my photos, so... And filter much more than Zoom would allow you, so I properly filter them, like adding hair volume and putting face filters and making myself look slimmer. So I like the, the alternating the image and I know it's silly in a way because it's not <u>you</u> , but it makes, uh, makes me feel better about myself.	
Filters make her feel more complete	P2, 6-9	on every call I would be a bit, uh, filtered. It made me feel better, especially when you log in from home, you sit there with no makeup, with your homeware, it, it felt a bit, uh, better basically not coming as you are, but in a more completed version.	
Finding other people looking at her intimidating in all video calls	P10, 8	I find it intimidating	PET 4
People in work calls don't focus exclusively on you	P8,16-P9-1-2	on those work meetings there would be a few people, and even if it is a one person, they're not focusing on you 100 percent	constant gaze
Experiencing a difference in how she is seen online vs. in consulting room	P2, 14-15-P3,1-2	in real life, when you go to the clinic, to the office of the therapist, they see you in 3D and it's less staring in your face. It's more like looking all over the place. But here it felt like, um, yeah, for the whole duration of the session, the therapist is looking at your face on the big screen.	
Finding the therapist's gaze to be anxiety-provoking and distracting	P3, 10-12	it just, uh, uh, provoked a bit of anxiety; it, uh, uh, maybe made me, distracted me from the therapy process	
Experiencing the therapist's gaze as constant	P3, 1-2	it felt like, um, yeah, for the whole duration of the session, the therapist is looking at your face on the big screen.	
Getting carried away imagining what others are thinking of her	P10, 15-6-P11, 1-2	maybe they don't have any opinions or any thoughts about it, but I can't help thinking that they might and developing this fantasy that they are maybe judging or maybe having some negative opinions about myself.	
Experiencing the therapist's full attention as a hindrance in VCP	P9, 3-7	With a therapist, it's very different because therapist is there to give you their full attention. And, uh, it would be very unlikely the therapist would be sitting there looking around or taking their own notes and doing whatever comes to them. So I feel like in therapy sessions, it is exaggerated, this issue.	
Wondering what is visible to others and how they think of/judge her	P11, 8-9	I start to fantasise: What do they see? What do they notice? What do they think about me?	
Wondering if the therapist's gaze distracted her from other issues to BID	P3,15-P4, 1-2	it, uh, uh, maybe made me, distracted me from the therapy process, from other issues and moved my thoughts, uh, uh, towards the, uh, body image or appearance, uh, issues.	
Describing collective experience of struggling with BID during lockdown	P27, 7-9	I think many people struggled. I definitely struggled. You know, the gym closed, the hairdresser closed, you sit at home and, uh, feel uncomfortable about yourself.	PET2
Presents a better version of herself to therapist when in consulting room	P26, 3-5	she also saw me in the clinic, usually with makeup and better dressed	therapy with mirror
Having a dislike towards seeing oneself big is a shared experience	P13, 8-9	But I believe that not only people with body image issues wouldn't like it.	
Experienced unexpected feelings of discomfort upon seeing herself on the screen	P2, 2-3	I realised that I'm not very comfortable with seeing myself on the screen	
People with BID are more prone to feeling intimidated upon seeing themselves big on the screen	P14, 1-3	probably this is much more likely to happen with people who struggle with accepting their appearance and struggle with their body image	
Covid-19 was challenging due to inability to keep up her hair	P26, 13-15	It was difficult. I couldn't colour my hair, I started to get like long dark roots, uh, and it's, uh, it's very unpleasant.	
Seeing herself on camera during Covid-19 added to an already difficult experience of not having her hair coloured	P27, 2	And then in this image on the screen, um, not the best experience.	
Feeling a general uneasiness around seeing herself on screen	P8, 14-15	I don't feel very comfortable and don't like seeing myself on the screen	
Lack of mirror in therapist's office means you can't see yourself	P12, 1-2	in the, uh, office of the therapist, there is no mirror, so you don't really see yourself	
Seeing herself (instead of therapist) big on the screen was disturbing	P13, 5-6	Like I'm seeing my face big on the screen and it's really disturbing.	
Looking at her image during our chat felt intimidating	P34, 2-3	so I've been looking at my image in the corner now and thinking, um, uh, Well, this is, uh, this is a bit intimidating.	
Retrospectively realised she might not feel comfortable with VCP	33, 1-3	I didn't think about it until you asked me about it today. But when you did ask me and I started to reflect on it, it just came to my mind that yes, maybe I don't feel comfortable.	
Comparing VCT to therapy with a mirror	P12, 4-5	this is like having therapy with a mirror there.	
Seeing herself on the screen in work/personal calls is easier	P10, 1-2	It makes this issue of seeing myself on the screen less prominent	
Conscious of the camera reflecting two differently sized images	P12, 14-15-P13, 1	instead of seeing the therapist big on the screen and myself like in the small window, for some reason I saw myself big and the therapist smaller.	

31	Didn't think of discussing it with her therapist	P12, 11-12	I haven't discussed it with my therapist and probably I should have done it, but it didn't really cross my mind.	PET 3
32	VCP allows people with BID to discuss their issues as they're h	P15-2-4	for people who struggle with self-esteem, with issues linked to their appearance, uh, it could be an interesting experience because they can process things that are happening in the here and now.	priate struggles
33	Wondering what could have been achieved if she shared her thoughts with the therapist	P14, 8-11	I think it would probably give me a chance to explore my feelings in the moment. Uh, to explore what, uh, what exactly was uncomfortable and why. So, uh, but it, it's hard to imagine what it would open up. But it probably would be a chance to explore, uh, the issue as it is happening	
34	Not considering her BID to be the focus of her therapy	P4, 8-9	my own appearance was never the focus in, uh, in those sessions.	
35	Dealing with BID in therapy on her own	P4, 13	I think it's something that I was processing on, on my own	
36	Wondered how the therapist was experiencing VCP	P2, 11-13	And I started thinking, How is it for the therapist on the other end? Because they see this big image and it's quite intimidating, you can see all the traits and features.	
37	Recommends that every VCP client is asked how they feel	P33, 11-	I think every client who goes for some remote therapy probably should be asked those questions	
38	Has not spoken re in-the-moment VCP experience with therapist	P32, 10-13	...I thought that it would be a good idea for therapists to bring this topic up when they work remotely, because my therapist has never asked me how do I feel to see myself in the little square on the screen.	
39	Noticing an improvement in her BID over the years	P7, 4	I would say that in the recent years it became better	PET 6
40	Various things contributed to her BID getting better	P8, 1-3	Maybe it's also a number of years of therapy that helped and, uh, maybe just life experiences or learning to accept things that you cannot change. Probably a combination of factors.	never-ending BID
41	Experiencing BID as something powerful that impacts all of	P7, 9-10	it affects my mood and my ability to socialise, the way I, uh, interact with other people, you know,	
42	Still struggling with her weight	P28, 3	I think I'm still struggling with the weight.	
43	Fears gaining weight	P28, 9	the fear of being overweight is still there.	
44	Her BID has long and strong history	P5, 2	it's, uh, something quite deeply rooted for me	
45	Constantly worrying about her weight	P5, 10-13	I'm always questioning if I am, uh, fat or not [laughs]. Uh, so I always have issues about my weight. Um, I am often trying to diet or trying like new things for weight loss. Uh, I mentioned I had anorexia for two years	
46	Cannot get too comfortable when it comes to weight	P6, 1-3	I think I'm in remission, but I still feel the, uh, issues around my weight and it's something that's more or less always on my mind.	
47	Concerned about being pretty or not	P6, 5-8	I've always been struggling with my height, and I wanted to be taller and, um, also with the, uh, face, like questioning my features or trying to alter certain features by doing some treatments and uh, basically general concerns about being pretty or not being pretty.	
48	Highlighting the extent of her BID	P6, 12	it's an ample combination of things	
49	Recounting her experience of BID and VCT in terms of number of years	P1, 5-8	Um, I have been, uh, struggling with, uh, body image and accepting my appearance, uh, since very young age, maybe since being a teenager, and, uh, uh, I've been in therapy for a number of years and I've done a number of hours, uh, of remote therapy.	

50	Expected smooth transition to VCP	P2, 1-2	And first I thought That's fine, that's not a problem	PET 4
51	It was her therapist's idea to switch to VCP	P1, 15-16	A few years ago, maybe two years ago, my therapist suggested to do remote therapy because of, uh, Covid.	more intense, less real
52	PCP is much more real	P16, 1-2	I, uh, also find, uh, uh, face-to-face contact to be much more real.	
53	Experiencing better therapist-client connection in PCP	P16, 5-6	I feel like the connection between the therapist and the client is better.	
54	Experiencing VCP as lacking in human presence	P16, 8-9	Online setting removes the human, human presence from it.	
55	VCP deprives you of the other person's presence	P17, 1-8	It's the whole experience of somebody's presence, their way of being, their, seeing somebody in 3D, you know, and uh, I, I don't know what we can call it. Maybe somebody's energy? You cannot feel it from the screen... I don't know if that is the right word, but somebody's presence, their way of being, you can only what is missing is the sense of a <i>shared</i> reality, <i>shared</i> space.	
56	Experiencing a lack of shared reality online	P18, 3-4	for me, uh, it's important to feel this proximity in order to feel this connection.	
57	Finding physical proximity to be necessary for good connection	P18, 10-11	it creates an extra layer of distance. It creates this obstacle on the way to connection.	
58	Lack of physical proximity makes connection more difficult	P19, 1-2	You can definitely sit very close to a person and be totally disconnected, I'm aware of it, but I think it's an additional layer. If we are sharing the same space and we can see each other in <i>full</i> experience and we	
59	Sharing space ≠ connection but it's a factor	P19, 5-10	on the screen, there is no eye contact, so you don't really, I don't know where you look now, you probably try to look at my face, but it doesn't, it doesn't feel that way. We don't know where we look. We try to get the eye contact through the video call. But we're just staring at some dot on the screen, so it is not really eye contact.	
60	Lacking eye contact in VCP	P20, 3-8	there is no eye contact, it's just this, um, weird feeling of, um, somebody looking at you, but as if they're looking through you.	
61	Experiencing VCP as more intense but less real	P20, 11-13	I find it less uncomfortable, less intimidating and more normal, if you like, more human.	
62	Finding PCP less uncomfortable, less intimidating and more normal/ human.	P21, 7-8	it removes this human connection	
63	Lacking human connection in VCP	P21, 13	um, seeing somebody online was not part of life. It's a different experience and sometimes it's	
64	Online is different and uncomfortable	P22, 1-3	it's less comfortable, and less something natural. I'm not saying it's unnatural or terrible, but it's less natural than the connections that we are all used to from the communication that we are used to have	
65	Connecting online is less natural	P22, 8-13	outside of the video conferencing life.	

66	Not the centre of attention in work/personal calls	P9, 9-10	In my work meetings, so personal meetings, uh, on Zoom, it's not, um, it's not that prominent.	
67	Not so bothered about the quality of connection on work calls	P23, 1-4	with work I care less. You know, if I don't have a great connection and contact with my colleagues, as long as we can have our businesses done and we achieve what we need to achieve, we discuss what we need to discuss, that is totally fine.	
68	Desires and expects to connect with her therapist	P23, 7	With a therapist, I <i>want</i> to connect.	
69	Online connection does not measure up to physical connection	P23, 12-15	when you strive to be fully heard, seen and understood, then it's important, the quality of work, of communication, and I think the quality of communication online, remotely, <u>is</u> not the same as in person.	
70	Feels more uncomfortable about VCP than expected	P34, 2-3	it made me realise that I'm maybe more uncomfortable with online therapy than I thought previously	
71	Experiencing a dislike towards online therapy	P15, 16	I <i>don't</i> like online therapy	
72	Online therapy allows for quick dismissal	P30, 8-9	It feels as if you can be dismissed easier.	PET 5
73	Possibility of sudden dismissal in VCP feels unpleasant, unstable and unsafe	P30, 12-16	the whole idea that, uh, um, like separating from you or getting rid of you is one click away. Um, it's also not a very pleasant thought now when I'm reflecting on it. Um, and also, we rely on internet connection. It just doesn't feel like as stable and safe as a face-to-face experience.	feeling insecure
74	Experiencing a loss of small interpersonal moments and rituals	P31, 7-12	in a real-life therapy, when you are about to say goodbye and you grab your coat and your bag, you have an opportunity to say, like, Have a good weekend while you're slowly exiting the room, uh, it's a little thing and it's not crucial, you can have therapy, I believe, without it. But it's as if a part of the experience is missing when you are remote.	
75	Feels greater sense of safety and comfort in PCP	P29, 12-13	when I'm in the same room with the therapist, I feel, um, uh, I feel more safe and comfortable.	
76	Inability to see therapist's surroundings online feels a bit uneasy	P29, 15-30, 1-2	not knowing where this person is and who is behind the door and what's going on around them, I think it adds a tiny bit of insecurity to, to the whole, the whole process.	
77	It was the format of the therapy that brought up thoughts about	P8, 7-9	They come up not just on video, but I happened to notice that in those remote sessions with the therapist, it, uh, it just came to my mind probably because of the format.	
78	PCP is superior in quality	P32, 2	the experience of face-to-face interactions has more quality in it.	
79	Highlighting that VCP is not the same as PCP	P16, 16	it's not the same as, uh, face-to-face contact.	

Appendix N

Example of a Case Level Summary – Sarah

1	Case level summary - Sarah		
2	PET 1: Disparity between natural and altered image		
3	Feels prettier with a filter on	P25, 5-6	I felt like, Oh, I appear prettier, this is good.
4	Filters allow her to present a nicer version of herself	P24, 10-3	it's like a nicer version of myself, like a slightly, uh, smooth, smooth version with like a smooth skin. And, uh, I liked it. It was not my plan to do it, but when I saw it's an option, I liked the idea of appearing better looking.
5	Filters photos to change herself	P25, 10-14	I filter all my photos, so... And filter much more than Zoom would allow you, so I properly filter them, like adding hair volume and putting face filters and making myself look slimmer. So I like the, the alternating the image and I know it's silly in a way because it's not <u>you</u> , but it makes, uh, makes me feel better about myself.
6	Filters make her feel more complete	P2, 6-9	on every call I would be a bit, uh, filtered. It made me feel better, especially when you log in from home, you sit there with no makeup, with your homeware, it, it felt a bit, uh, better basically not coming as you are, but in a more completed version.
7	PET 2: VCP is like therapy with a mirror		
8	Describing collective experience of struggling with BID during lockdown	P27, 7-9	I think many people struggled. I definitely struggled. You know, the gym closed, the hairdresser closed, you sit at home and, uh, feel uncomfortable about yourself.
9	Presents a better version of herself to therapist when in consulting room	P26, 3-5	she also saw me in the clinic, usually with makeup and better dressed
10	Having a dislike towards seeing oneself big is a shared experience	P13, 8-9	But I believe that not only people with body image issues wouldn't like it.
11	Experienced unexpected feelings of discomfort upon seeing herself on the screen	P2, 2-3	I realised that I'm not very comfortable with seeing myself on the screen
12	People with BID are more prone to feeling intimidated upon seeing themselves big on the screen	P14, 1-3	probably this is much more likely to happen with people who struggle with accepting their appearance and struggle with their body image
13	Covid-19 was challenging due to inability to keep up her hair	P26, 13-15	It was difficult. I couldn't colour my hair, I started to get like long dark roots, uh, and it's, uh, it's very unpleasant.
14	Seeing herself on camera during Covid-19 added to an already difficult experience of not having her hair coloured	P27, 2	And then in this image on the screen, um, not the best experience.
15	Feeling a general uneasiness around seeing herself on screen	P8, 14-15	I don't feel very comfortable and don't like seeing myself on the screen
16	Lack of mirror in therapist's office means you can't see yourself	P12, 1-2	in the, uh, office of the therapist, there is no mirror, so you don't really see yourself
17	Seeing herself (instead of therapist) big on the screen was disturbing	P13, 5-6	Like I'm seeing my face big on the screen and it's really disturbing.
18	Looking at her image during our chat felt intimidating	P34, 2-3	so I've been looking at my image in the corner now and thinking, um, uh, Well, this is, uh, this is a bit intimidating.
19	Retrospectively realised she might not feel comfortable with VCP	33, 1-3	I didn't think about it until you asked me about it today. But when you did ask me and I started to reflect on it, it just came to my mind that yes, maybe I don't feel comfortable.
20	Comparing VCT to therapy with a mirror	P12, 4-5	this is like having therapy with a mirror there.
21	Seeing herself on the screen in work/personal calls is easier	P10, 1-2	It makes this issue of seeing myself on the screen less prominent
22	Conscious of the camera reflecting two differently sized images	P12, 14-15-P13, 1	instead of seeing the therapist big on the screen and myself like in the small window, for some reason I saw myself big and the therapist smaller.

23	PET 3: Unspoken troubles - private processing of discomfort in VCP		
24	Didn't think of discussing it with her therapist	P12, 11-12	I haven't discussed it with my therapist and probably I should have done it, but it didn't really cross my mind.
25	VCP allows people with BID to discuss their issues as they're happening	P15-2-4	for people who struggle with self-esteem, with issues linked to their appearance, uh, it could be an interesting experience because they can process things that are happening in the here and now.
26	Wondering what could have been achieved if she shared her thoughts with the therapist	P14, 8-11	I think it would probably give me a chance to explore my feelings in the moment. Uh, to explore what, uh, what exactly was uncomfortable and why. So, uh, but it, <i>it's hard to imagine what it would open up</i> . But it probably would be a chance to explore, uh, the issue as it is happening
27	Not considering her BID to be the focus of her therapy	P4, 8-9	my own appearance was never the focus in, uh, in those sessions.
28	Dealing with BID in therapy on her own	P4, 13	I think it's something that I was processing on, on my own
29	Wondered how the therapist was experiencing VCP	P2, 11-13	And I started thinking, How is it for the therapist on the other end? Because they see this big image and it's quite intimidating, you can see all the traits and features.
30	Has not spoken re in-the-moment VCP experience with therapist	P32, 10-13	...I thought that it would be a good idea for therapists to bring this topic up when they work remotely, because my therapist has never asked me how do I feel to see myself in the little square on the screen.
31	Recommends that every VCP client is asked how they feel about VCP	P33, 11-12	I think every client who goes for some remote therapy probably should be asked those questions
32	PET 4: More intense stare but less real connection		
33	All focus on her - feeling the pressure of the gaze		
34	Finding other people looking at her intimidating in all video calls	P10, 8	I find it intimidating
35	People in work calls don't focus exclusively on you	P8,16-P9-1-2	on those work meetings there would be a few people, and even if it is a one person, they're not focusing on you 100 percent
36	Experiencing a difference in how she is seen online vs. in consulting room	P2, 14-15-P3,1-2	in real life, when you go to the clinic, to the office of the therapist, they see you in 3D and it's less staring in your face. It's more like looking all over the place. But here it felt like, um, yeah, for the whole duration of the session, the therapist is looking at your face on the big screen.
37	Finding the therapist's gaze to be anxiety-provoking and distracting	P3, 10-12	it just, uh, uh, provoked a bit of anxiety; it, uh, uh, maybe made me, distracted me from the therapy process
38	Experiencing the therapist's gaze as constant	P3, 1-2	it felt like, um, yeah, for the whole duration of the session, the therapist is looking at your face on the big screen.
39	People in work calls don't focus exclusively on you	P8,16-P9-1-2	on those work meetings there would be a few people, and even if it is a one person, they're not focusing on you 100 percent
40	Getting carried away imagining what others are thinking of her	P10, 15-6-P11, 1-2	maybe they don't have any opinions or any thoughts about it, but I can't help thinking that they might and developing this fantasy that they are maybe judging or maybe having some negative opinions about myself.
41	Experiencing the therapist's full attention as a hindrance in VCP	P9, 4-7	With a therapist, it's very different because therapist is there to give you their full attention. And, uh, it would be very unlikely the therapist would be sitting there looking around or taking their own notes and doing whatever comes to them. So I feel like in therapy sessions, it is exaggerated, this issue.
42	Wondering what is visible to others and how they think of/judge her	P11, 8-9	I start to fantasise: What do they see? What do they notice? What do they think about me?
43	Wondering if the therapist's gaze distracted her from other issues to BID	P3,15-P4, 1-2	it, uh, uh, maybe made me, distracted me from the therapy process, from other issues and moved my thoughts, uh, uh, towards the, uh, body image or appearance, uh, issues.
44	Not the centre of attention in work/personal calls	P9, 9-10	In my work meetings, so personal meetings, uh, on Zoom, it's not, um, it's not that prominent.
45	VCP is less real, less normal, less human		
46	Experiencing VCP as more intense but less real	P20, 11-13	there is no eye contact, it's just this, um, weird feeling of, um, somebody looking at you, but as if they're looking through you.
47	Expected smooth transition to VCP	P2, 1-2	And first I thought That's fine, that's not a problem
48	It was her therapist's idea to switch to VCP	P1, 15-16	A few years ago, maybe two years ago, my therapist suggested to do remote therapy because of, uh, Covid.
49	PCP is much more real	P16, 1-2	I, uh, also find, uh, uh, face-to-face contact to be much more real.
50	Experiencing better therapist-client connection in PCP	P16, 5-6	I feel like the connection between the therapist and the client is better.
51	Experiencing VCP as lacking in human presence	P16, 8-9	Online setting removes the human, human presence from it.
52	VCP deprives you of the other person's presence	P17, 1-8	It's the whole experience of somebody's presence, their way of being, their, seeing somebody in 3D, you know, and uh, I, I don't know what we can call it. Maybe somebody's energy? You cannot feel it from the screen... I don't know if that is the right word, but somebody's presence, their way of being, you can only see it when you meet with the person. Online it's very restrictive, you're limited to certain things.
53	Experiencing a lack of shared reality online	P18, 3-4	what is missing is the sense of a <i>shared</i> reality, <i>shared</i> space.
54	Finding physical proximity to be necessary for good connection	P18, 10-11	for me, uh, it's important to feel this proximity in order to feel this connection.
55	Lack of physical proximity makes connection more difficult	P19, 1-2	it creates an extra layer of distance. It creates this obstacle on the way to connection.
56	Sharing space ≠ connection but it's a factor	P19, 5-10	You can definitely sit very close to a person and be totally disconnected, I'm aware of it, but I think it's an additional layer. If we are sharing the same space and we can see each other in <i>full</i> experience and we can <i>share</i> this, um, I don't know what can be, uh, a good description. If we are breathing the same air, it kind of helps a bit. It's not a guarantee that we are going to connect, but it's a factor.
57	Lacking eye contact in VCP	P20, 3-8	on the screen, there is no eye contact, so you don't really, I don't know where you look now, you probably try to look at my face, but it doesn't, it doesn't feel that way. We don't know where we look. We try to get the eye contact through the video call. But we're just staring at some dot on the screen, so it is not really eye contact.
58	Finding PCP less uncomfortable, less intimidating and more normal/ human	P21, 7-8	I find it less uncomfortable, less intimidating and more normal, if you like, more human.
59	Lacking human connection in VCP	P21, 13	it removes this human connection
60	Online is different and uncomfortable	P22, 1-3	um, seeing somebody online was not part of life. It's a different experience and sometimes it's uncomfortable.

61	Connecting online is less natural	P22, 8-13	it's less comfortable, and less something natural. I'm not saying it's unnatural or terrible, but it's less natural than the connections that we are all used to from the communication that we are used to have outside of the video conferencing life.
62	Not so bothered about the quality of connection on work calls	P23, 1-4	with work I care less. You know, if I don't have a great connection and contact with my colleagues, as long as we can have our businesses done and we achieve what we need to achieve, we discuss what we need to discuss, that is totally fine.
63	Desires and expects to connect with her therapist	P23, 7	With a therapist, I <i>want</i> to connect.
64	Online connection does not measure up to physical connection	P23, 12-15	when you strive to be fully heard, seen and understood, then it's important, the quality of work, of communication, and I think the quality of communication online, remotely, <u>is</u> not the same as in person.
65	Feels more uncomfortable about VCP than expected	P34, 2-3	it made me realise that I'm maybe more uncomfortable with online therapy than I thought
66	Experiencing a dislike towards online therapy	P15, 16	I <i>don't</i> like online therapy
67	PET 5: Feeling less secure in the online relationship		
68	Online therapy allows for quick dismissal	P30, 8-9	It feels as if you can be dismissed easier.
69	Possibility of sudden dismissal in VCP feels unpleasant, unstable and unsafe	P30, 12-16	the whole idea that, uh, um, like separating from you or getting rid of you is one click away. Um, it's also not a very pleasant thought now when I'm reflecting on it. Um, and also, we rely on internet connection. It just doesn't feel like as stable and safe as a face-to-face experience.
70	Experiencing a loss of small interpersonal moments and rituals	P31, 7-12	in a real-life therapy, when you are about to say goodbye and you grab your coat and your bag, you have an opportunity to say, like, Have a good weekend while you're slowly exiting the room, uh, it's a little thing and it's not crucial, you can have therapy, I believe, without it. But it's as if a part of the experience is missing when you are remote.
71	Feels greater sense of safety and comfort in PCP	P29, 12-13	when I'm in the same room with the therapist, I feel, um, uh, I feel more safe and comfortable.
72	Inability to see therapist's surroundings online feels a bit uneasy	P29, 15-30, 1-2	not knowing where this person is and who is behind the door and what's going on around them, I think it adds a tiny bit of insecurity to, to the whole, the whole process.
73	It was the format of the therapy that brought up thoughts	P8, 7-9	They come up not just on video, but I happened to notice that in those remote sessions with the therapist, it, uh, it just came to my mind probably because of the format.
74	PCP is superior in quality	P32, 2	the experience of face-to-face interactions has more quality in it.
75	Highlighting that VCP is not the same as PCP	P16, 16	it's not the same as, uh, face-to-face contact.
76	PET 6: Never-ending BID		
77	Noticing an improvement in her BID over the years	P7, 4	I would say that in the recent years it became better
78	Various things contributed to her BID getting better	P8, 1-3	Maybe it's also a number of years of therapy that helped and, uh, maybe just life experiences or learning to accept things that you cannot change. Probably a combination of factors.
79	Experiencing BID as something powerful that impacts all of her life	P7, 9-10	it affects my mood and my ability to socialise, the way I, uh, interact with other people, you know, basically all the, all, all spheres of my life.
80	Still struggling with her weight	P28, 3	I think I'm still struggling with the weight.
81	Fears gaining weight	P28, 9	the fear of being overweight is still there.
82	Her BID has long and strong history	P5, 2	it's, uh, something quite deeply rooted for me
83	Constantly worrying about her weight	P5, 10-13	I'm always questioning if I am, uh, fat or not [laughs]. Uh, so I always have issues about my weight. Um, I am often trying to diet or trying like new things for weight loss. Uh, I mentioned I had anorexia for two years
84	Cannot get too comfortable when it comes to weight	P6, 1-3	I think I'm in remission, but I still feel the, uh, issues around my weight and it's something that's more or less always on my mind.
85	Concerned about being pretty or not	P6, 5-8	I've always been struggling with my height, and I wanted to be taller and, um, also with the, uh, face, like questioning my features or trying to alter certain features by doing some treatments and uh, basically general concerns about being pretty or not being pretty.
86	Highlighting the extent of her BID	P6, 12	it's an ample combination of things
87	Recounting her experience of BID and VCT in terms of number of years	P1, 5-8	Um, I have been, uh, struggling with, uh, body image and accepting my appearance, uh, since very young age, maybe since being a teenager, and, uh, uh, I've been in therapy for a number of years and I've done a number of hours, uh, of remote therapy.

Appendix O

All PETs Relevant to the Research Question, Including Subthemes, ES and Associated Quotes

1	RQ PETs, sub-themes and quotes		
2	ELLA		
3	PET 3: Unseen struggles - the quest for visibility and validation in VCP		
4	Lacking validation of inner struggles		
5	Feeling silly discussing invisible imperfections	P31, 14-16; P32, 1	Um, and I felt like I couldn't really see [the odd spots] on Teams. So for me, I felt even sillier sitting there and telling my therapist that that's what I was worrying about.
6	Struggling to be honest in therapy due to the perceived insignificance of her concerns	P35, 9-14	And she couldn't [see her issues], and it made me think, it, it made it even harder to be like, honest about how much I was struggling and how much I was, you know, what my behaviours were like at the time. Um, because like I said before, only a couple of weeks before, really, I'd not even myself recognised that that was a problem, let alone ever told anybody. Um, that I was worrying about something that in my mind was just so silly.
7	Fear of being perceived as imagining facial imperfections	P32, 7-10	But I at least think I would've thought, or she can see my face, she can see how it properly is and she's not gonna think I'm crazy. Whereas I really struggled throughout the whole time, to be honest, with her, me, me thinking that she thinks I'm imagining this stuff
8	Wanting validation in therapy	P35, 5-7	Um, whereas, yeah, I think with therapy it was that, it was that I almost didn't, in the beginning, I wanted her to be able to see what I was talking about.
9	Forced to accept that maybe there are no imperfections		
10	Video forcing her to assume T doesn't see her imperfections	P33, 1-5	I think it maybe helped the therapy in a way, because I had to work off the basis that the work we are doing, I'm like, she, she doesn't think there's anything on my face. So she really thinks that I must be completely like away with the fairies [laughs].
11	Evolving self-perception	P33, 7-11	sometimes I've come off the call and think, Yeah, but she can't see, like if I look in this light at this reflection, I can see these bumps or this line. Um, but in the end I think I just learned to accept it and have to trust that actually maybe there wasn't a lot there to begin with, you know?
12	More self-assured through everyday interactions and therapy	P33, 13-15; P34, 1-2	So it then became more of a well, I'm, I'm still seeing people every day and day-to-day life, and they're not saying anything. And my boyfriend is constantly saying there's nothing on my face...My mum's telling me there's nothing there. So actually maybe even if she was face to face, she, she still might not be able to see anything.
13	Managing appearances at work meetings/unable to check the mirror in video calls	P24, 14-16; P35, 1-3	at work, I'm just work [Ella]. I'm pretending everything's fine [laughs] and nobody's got an idea. So I just sit on my call and pretend I'm fine and do it and run up to the toilet afterwards to have a look in the mirror. Um, that would just be the, that was probably the only thing that was annoying is that I was stuck to the computer and I couldn't go
14	PET 4: Striving for authenticity in a new normal		
15	Accepting VCP as the only option		
16	Accepting video as the sole option	P36, 7-8	So I don't think, um, we really did [have a choice] because it was during Covid.
17	Acknowledging T's preference for visual contact and limited PCP options during Covid	P36, 11-13	I think with therapists' preference, I'm sure they probably feel they need to at least see you. Um, yeah. There wasn't the option to do it face-to-face at the time, so Teams was the only option.
18	Recognising the importance of establishing a connection	P36, 15-16	And, you know, I think having studied counselling myself, I, I can understand that they need to be able to make some sort of connection.
19	Understanding lack of choice re. therapy format during Covid	P37, 2-3	I don't think I had the choice. I do not remember being given them the choice.
20	Academically believes in PCP's bigger effectiveness	P37, 7-9	Oh, um, I think with my sort of academic hat on, I, I'd have to say face-to-face, knowing that that would probably be more effective.
21	PCP being more effective (real life)	P37, 15-16	Um, I think having a, holding a space with somebody sort of sitting in, in real life with them.
22	Unable to convey some things via video	P38, 2-3	I think there's things that you can't necessarily convey across a Teams call.
23	Values physical presence in therapy for better empathy and connection	P38, 10-14	personally, I feel like therapy would be more effective if you were sitting in the same room with that person in terms of making the connection with your therapist and them being able to convey empathy, you being able to feel it back, um, those kind of things.
24	Potential challenge in building a strong therapeutic connection in VCP	P39, 8-9	maybe we just had to work a little bit harder at making that connection between the two of us and um, it's difficult to say without
25	Awareness of being observed on VCP affected her ability to be authentic	P40, 12-14	I did find that sometimes it took away a little bit of me being able to do that, to be like fully, um, authentic.
26	Not experiencing VCP as any less effective than PCP		
27	Never had PCP	P39, 3	I've never experienced it.
28	Doesn't feel her VCP was any less effective	P39, 5-6	I don't, I don't feel like, I don't feel like my therapy wasn't effective or was less effective.
29	PCP feels daunting	P37, 11	But, um, it feels quite daunting. That in itself.
30	PET 5: Mirror of vulnerability		
31	Uncomfortable vulnerability		
32	Having a preference for minimising visibility	P30, 5-6	I still felt like a bit seen. Um, and I would turn my camera off if it was kind of socially acceptable to in work meetings.
33	Avoids looking at her own face during these calls	P30, 12-14	initially I just wouldn't look at my face [laughs]. Um, and I, I try not to now still, I do find that I'm very quick to start negatively, like criticising myself
34	Engages in negative self-talk when looking at herself on video	P31, 1-3	I can see things that like, I think, Oh, my mouth is funny when I'm talking. Or my lips are a bit like, or my chins or like, it's very easy for me to negatively criticise myself.
35	Self-criticism focused on minor facial details	P31, 10-11	it was to do with lines and texture and, um, I never really had acne, but like spots, just like the odd spot.
36	Confronting emotions with a visual reminder	P41, 1-2; 4	you've got like a reminder right in front of your face...As to what you look like when you're doing that [i.e., crying]
37	Feeling vulnerable during "ugliest crying"	P41, 5-7	So to then think like, My counsellor's looking at me right now and I'm doing my ugliest crying for years.
38	Unusual vulnerability: facing herself in the virtual mirror	P41, 9-14	It's not very often in real life that you are hold somebody's holding up a mirror in front of you effectively whilst you are at your most vulnerable or doing your crying with your nose streaming and tears rolling down your face and you, you are all red and blotchy and whatever. Um, that's very unusual [laughs], you know what I mean?
39	Quick self-composure hindering complete vulnerability	P42, 5-7	but I think I was probably quite quick to gather myself and perhaps it might have prevented me from being fully vulnerable, um, in those situations, which is sometimes what is needed.
40	Seeing herself = barrier to necessary vulnerability	P42, 9-14	Um, I wonder whether I was maybe quicker to gather myself, get a tissue, sort my face out, having such an obvious visual thing in front of me of what I look like. So yes, I do feel like it was at times, yeah maybe a bit of a barrier in terms of being seen in that way.
41	Expressing intense emotions so visually and externally is unusual	P43, 12-14	Um, so it's very, it's a very unusual situation in itself to sit there in front of somebody like that and show those kinds of emotions so visually, um, also externally, let's say.
42	Anxious about both being seen and seeing herself	P23, 10-12	Um, yeah, no, I think it is a, it is probably a combination of the two. I'm not sure I could say which one sort of weighs in more heavily. I definitely don't like seeing myself

43	Difficulty separating experiences of being seen and seeing herself	P25, 13	I'd say it is quite, it's quite difficult to separate the two out for me.
44	Immediate bodily reaction to being seen	P16, 5-6	It's interesting cuz even just as you asked that question and said the words was about being seen, like my stomach did a bit of a flip.
45	Existential "nausea" in response to being seen	P16, 8-9	Really the idea of being seen to me is, um, yeah, it makes me feel quite nauseous.
46	Adapting to video calls		
47	Got used to seeing herself through prior experience with online work calls	P29, 13-15	luckily I think I was doing quite a bit already online for work, so I started to get used to having to see my face while I was doing calls.
48	OK with video calls due to lower camera quality	P30, 1-3	Um, for me it wasn't necessarily too bad because it didn't feel like the quality of the cameras is that good. So I didn't feel like I was really under much scrutiny.
49	Managing self-criticism well	P31, 5	Um, so that does happen, but I manage it quite well.
50	PET 6: VCP allowing for hidden looking		
51	Focused on what T looked like	P44, 7-8	I remember actually, um, focusing quite a bit on what she looked like as well.
52	Looking at other people's skin and making comparisons	P45, 1-2	I was also looking at other people's and doing like comparisons.
53	Analysing her therapist's skin	P45, 10-12	I was constantly looking at other people's skin and I would look at her skin a lot during the sessions.
54	Covertly observing T's skin/hidden looking	P46, 3-6	I don't think I'd have been able to do as well in real life without looking like I'm staring at her all the time, is that I could look at her skin quite a bit and it wasn't obvious.
55	VCP allowed for socially inappropriate looking	P46, 12-14	in real life, I, I knew at the time that I couldn't just stare at people and look at their skin as much as I wanted to, cuz it would, it would look weird.
56	Looking at T was distracting	P47, 3	Um, potentially distracting?
57	Concerned about the therapist's judgments re her skin	P47, 11-14	Uh, another thing would've been, like I was saying, you know, Is she judging what I'm saying based on how her skin is and how that's making her feel? Or is it making her think that I'm more delusional than, you know?
58	VCP enables looking at yourself in a way PCP doesn't	P48, 11-12	you definitely can't do the first one in real life unless you are, you can find reflections and things.
59	PET 7: Achieving connection despite therapy being on video		
60	Experienced challenges building therapeutic connection online		
61	Initially struggled to connect with therapist	P51, 8-13	she was pushing, um, for me to do things that were challenging myself outside of the sessions. So again, I don't know whether maybe I'd have connected more with her in a real open environment. It, it did feel difficult to make a connection at first, but there could be so many other factors influenced in that. Um, but I definitely struggled with feeling like she really understood me.
62	Prior knowledge of psychology influenced her engagement	P50, 16- P51, 1-2	I think I was more engaged than maybe somebody else would've been who didn't have that kind of background.
63	Experienced resistance and discomfort when T pushed boundaries	P52, 1-3	then there was that point where she kind of pushed me and I was a bit like, Oh. I remember closing my laptop that day and thinking, I'm not sure I like you [laughs].
64	Unhappiness in therapy balanced by recognition of its necessity	P52, 5-7	I was really not very happy [when the therapist pushed her]. Um, but as I said, like that other part of me knew, Actually this is probably what you need to do and this is probably what's gonna work.
65	Developed a strong therapeutic bond online		
66	Initial difficulty in therapy followed by a positive breakthrough	P52, 9-11	then there was kind of like a bit of a breakthrough time where I, between say sessions 10 and 15
67	Transition to a stronger therapeutic connection	P53 4-6	And then, then I did feel quite connected with her and she, I think for her as well, there was probably a part of her that was sort of going, whew, I have done something that that actually did help this person.
68	CBT exceeding initial expectations, delving deeper	P53, 14-15- P54, 1-2	I had this idea that CBT is like, You're scared of birds, go and walk outside and go to a bird show. Whereas actually there was so much more um, empathy and exploration of things than I'd initially expected there to be.
69	Progress and self-reflection in the second half of therapy	P54, 4-8	a lot of [healing] like again, would say happened in that second half of things. Um, maybe where there was less like work to do because I was starting to really make a lot of progress. Um, but I was in a, I was probably in a better mental space and able to like really sort of reflect on where things had come from and what had happened in my background.
70	Bonded with therapist by end of therapy	P54, 13-16	I felt very sort of close to her actually by the end of it. I felt very much like we had that unique sort of shared bond that you would only get with a therapist.
71	Apprehension associated with saying goodbye to therapy.	P55, 2	it was quite sort of scary to say goodbye and to, to, to chill.
72	Reaffirmation of a positive and helpful therapy experience	P55, 4-5; 7	I think I've still had a very positive, helpful experience...Um, regardless of it being a video connection.
73	Achieved connection despite it being VCP	P55, 9	We still were able to like, achieve that, but it did take a little while.
74	Emphasis on trust, unlearning, and realistic expectations in therapy	P55, 15-16	I did have to put quite a bit of trust in her to, you know, cuz that was like my, that was my coping mechanism at the time. Um, and I hadn't realised that I'd gone on for so long with my life doing things like that and subsequently feeling safe as a result of those behaviours. So it was a lot of like unlearning to do.
75	Finding invaluable benefits in therapy	P57, 1-2	Yeah, invaluable things that I gained from, from that experience.
76	PET 8: The real progress happens beyond therapy		
77	Taking her mental health in her own hands		
78	Real progress happened outside of therapy	P50, 2-5	although the conversations with your therapist took part, took place virtually, everything else that you then did outside the session, which is where we know the, the work really happens, that was all still in the real world, you know?
79	Therapy is like passing your driving test	P56, 5-6; 8- 11	And then you're out on your own type thing a little bit like driving, passing your driving test...You, you do the lessons and you never really, you're not an expert driver by the time you, you pass, but you get out there in the real world and you have to, um, yeah, you have to fend for yourself really, don't you?
80	Not discussing the camera with T	P44, 7	I don't think it was really ever like touched on at all.
81	Applying what she learned in therapy in everyday life		
82	VCP = hugely beneficial and challenging experience	P49, 11-16	Um, it was definitely one of the best things that I've ever done, still. You know, I look back on it as a really, really positive thing. Um, and it was still very challenging in the way that you would expect therapy to be challenging, um, like emotionally, but also with overcoming things in your, in your day-to-day life, sort of the homework that you do outside of therapy. I would say it was still really
83	Actively seeking challenges in daily life	P17, 3-6	So I know that I almost see it as like an empowering thing now when I go out and I just might be, I'm, I'm always trying to push myself continuously, like coming outta therapy with something that challenges me.

84	Committed to ongoing self-challenge	P19, 13-15	And I know that I have to keep challenging myself and doing the, the types of things that I learned to do during therapy, um, just to remind myself.
85	Recognition of the potential for regression	P20, 1	I think it would be very easy for me to not do that work and slip back.
86	Need for ongoing effort to manage and prevent the resurgence of self-	P20, 6; 8	I have to still work at it...To keep it at bay.
87	Therapy continues to support her well-being	P56, 13-14	I think a lot of what I still do now, well actually most of it that helps me now I've learned in therapy from that.
88	CHARLOTTE		
89	PET 3: From not feeling secure in the digital environment to safe therapy alternative		
90	Anxiety developed from work calls: lack of control and distraction		
91	Feels lack of control in videos	P26, 13-15-27, 1	I just felt this, really kind of lack of control and like, I wish I could sort of, I wish I could just zone it out, really tune it out...I just like, I feel like I just don't know how I'm coming across and all these things just feed into it.
92	Feels very differently on online work calls vs VCP	P45, 10-11	there is a definite distinction between how I feel on work calls and how I feel on, um, therapy calls.
93	Online work calls are harder than VCP	P45, 13-16	Um, I think I find the work calls maybe harder. Maybe there's more expectation and maybe 'cause it's not a safe space, probably it's not a space where I could, you know, it's a, it's a hidden thing for me, how I feel. I'm just in my head and I'm alone with it.
94	Video calls were detrimental to her MH	P24, 16-25, 1	I definitely think that that amount of video calls probably was detrimental to my mental health [laughs] 'cause it was not helping anyway.
95	Video calls showed her everything she didn't want to see	P25, 9-10	I don't think it helped, um, because it's just everything you don't want to see, like, seeing yourself.
96	Monitoring appearance is distracting	P24, 12-15	Cause it's just distracting and you can't do your job properly if you're, if you're trying to listen to a client and like [laughs], and then you are just constantly kind of monitoring your how you think you look or you'll just get distracted in your own image and stuff.
97	Less conscious in work calls when not leading	P27, 8-10	I think if I'm not focused, say on a work call, say I'm on a call with lots of colleagues, um, and I'm not leading a meeting, that would be fine, I think.
98	Looking at how other people look	P27, 15-16	'Cause that's the other thing I would be looking at - how other people look on video as well.
99	Compares herself to others	P28, 2-3	And that will play into, oh, they look better than me, oh, I look awful. You know [laughs], so there's that comparative thing.
100	Had most online work calls after VCP	P45, 3-4	my intensive period of work calls has been this year. After I finished the therapy.
101	Digital doubts: approaching VCP with scepticism		
102	Has had PCP 4x for different issues	P38, 4-5	And I've had it, I think three, I've had it four times actually. Cause I've had different things.
103	Found PCP helpful	P38, 12-13	I still suffer [various mental health problems] occasionally, but I'm definitely better than I was. So, I don't know. I think they, they did help. I dunno.
104	Seeing VCP as a brave option	P19, 11-13	guess I kind of thought I need to be a bit brave here and actually, 'cause part of it is the difficulty of seeing yourself, you know, it's not easy to have this little box with your face in it [laughs nervously]
105	Found a BDD therapist and took a chance	P20, 1-3	so I just needed to do the BDD therapy, and I saw that it was one of her areas of expertise, and so I thought, well, let's give it a go, really.
106	Approaching VCP with an exit plan	P20, 5-7	see how I get on and if it was really awful but no, I managed about, I think I said in the notes, I had 18 sessions in the end.
107	Initial hesitation about VCP	P21, 5-6	I think before starting that it was, it was pretty hard to think about doing it online.
108	Therapist was only offering VCP	P35, 3-4	she was only offering online, and I just thought, well, I like her. Let's see.
109	First therapy offered in person but switched to VCP due to Covid	P23, 1-3	I think it was offered in person, but I think because Covid happened, everything shut down. I think they switched all their services to online.
110	Camera = initially a barrier to therapy	P52, 1-3	it was definitely, for such a long time, a block, a barrier in my head for, for, um, for, for therapy, for seeking therapy.
111	Refused VCP due to fear of seeing herself	P22, 3-4	I thought, no, I can't do it if it's online cause I can't see myself when I'm doing it, and it won't, it won't work for me.
112	Chose therapist based on proximity and expertise	P34, 9-10; 12-13	I didn't go in with the intention of seeking online therapy...It was, um, Who is in close proximity to where I live, who can I get to? And this woman seemed really well qualified in everything.
113	VCP was not as bad as anticipated		
114	VCP is convenient	P35, 6-7	It's probably quite convenient. It means I don't have to drive to her or whatever, so.
115	Imagining the other person is actually in the room	P40, 5-8	I'm imagining you are not, you are actually there and I feel a bit more relaxed because I'm imagining you're actually in the room and I'm talking to you rather than looking at you.
116	VCP was not as bad as anticipated/ depends on content of discussion	P40, 12-14	it was probably not as bad as I was anticipating. Um, yeah, I think depended on what I, what we were talking about, I think, and how, how hard it was for me.
117	VCP offered a private, cathartic space	P42, 4-6	it was really nice to have that time, that space to talk to someone privately who wasn't in my family. And I found that really cathartic and very helpful.
118	Felt relaxed with her therapist	P29, 6-7	I always felt quite relaxed with her and um, so it always felt okay actually.
119	Regrets refusing first VCP	P23, 9-11	I do slightly regret that [laughs] 'cause I, I would've liked to have maybe started my treatment a bit earlier than I did and yeah, not be so costly
120	Navigating video calls with a mix of empowerment and uncertainty	P29, 1-4	I know I can do it [laughs] and I know it's not always, um, gonna make me feel awful, but it's just the unknowing, so I just don't know sometimes. I guess it depends on who you're with as well and how relaxed you feel with that person.
121	VCP as an alternative to "normal" therapy		
122	Future therapy: online or PCP?	P37, 2-6	I'm considering having therapy again, but I'm thinking, do I go on, so now this will be of interest maybe to you with your research, do I look for, do I try online again or do I go, No, that didn't work for me, um, I'm gonna go in person and, and actually that would help me.
123	Curious about whether she would feel safer or better in PCP	P47, 13-16-48, 1-4; 6	it's an interesting one 'cause you, you could argue that when you're in person, the therapist, you could think that the therapist is judging you then and you're feeling exposed then. Um, but for some reason, I don't know, it'd be interesting for me to have, uh, therapy for BDD in person and to compare how I feel. Um, if I were to, you know, whether I would feel safer or like yeah better or worse doing that. Um, yeah, 'cause it wasn't. You're not comparing like with the like cause the therapy I had in person was for different...Different conditions.
124	Seeking normalcy in VCP	P40, 2-3	it's not a substitute for being with the person, but it can feel normal, I guess, maybe.
125	Dissatisfied with VCP/PCP might have been better	P35, 10-12	I feel a bit dissatisfied with the therapy. Um, I don't feel like I've got out of it as much as I wanted to, and I'm wondering whether having, if I had gone in person, whether I would feel differently to that.
126	VCP unleashed problems, not solved	P20, 11-12	I think it's unleashed more than it's actually solved, but maybe I had to start somewhere.
127	Differences in the nature of the therapy received	P48, 3-4; 6-8	You're not comparing like with the like cause the therapy I had in person was for different...Different conditions. Um, but I remember, yeah, it not being a thing back then, but then I wasn't trying to treat that, so I wasn't thinking about BDD.

128	PET 4: Virtual mirror - self-perception in the lens of VCP		
129	From initial self-consciousness and comparisons to focus on content		
130	Aware of how she was coming across	P42, 1-2	I was aware every time of, you know, How I'm, how am I coming across to her?
131	Shift in attention from self-consciousness to the content of the conversation	P28, 7-11	I initially found it quite hard if I was, yeah, I guess 'cause it's about me. But then I think when I get engrossed like I am now, I'm not really thinking about how I'm coming across to you cause I'm more interested in talking about what we're talking about.
132	Self-view: initial shock and emotional moments	P39, 3-8	Um, the first time I think it was probably a bit of a, a bit difficult, a bit of a shock. I'm just trying to think back. Um, the first call was like a consultation. Um, and I'm just trying to remember whether I had it on or I switched the video off. I did have it on, I did have it on, um, I remember now. Um, but I got quite, I got quite emotional at times. Um, and I may have switched it off then, I'm not sure. Can't say
133	Focusing on the green dot/ evaluating phone therapy vs. VCP	P39, 13-16	if I'm sort of focusing more on the green dot at the top and talking to you as if you are there, then um, then it's better. Um, but yeah, it is a bit of a distraction. It's probably better just to have a. I dunno, is it better to have a phone call? I dunno, I'm not sure [laughs].
134	Awareness of time and cost = less fixation on appearance	P43, 8-11	I would try and not dwell on it cause I was conscious of the time and the cost and I just thought, I need to not, not keep, you know, looking at myself. I need to actually like, get something out of this for myself.
135	Being seen is easier than confronting own image (ALSO see P15, 3-4: "I am better with that than with the camera thing")	P16, 14-16- P17, 1-4	I used to find it hard to do the school drop off, um, like without wearing make-up and stuff. But now I think I'm kind of like, Hi, I can nod to a mom or dad at the school gate, and it won't send me in the spiralling quite the same way. But if I was at an event, you know, like a school play, and someone was, had a camera and they, I, not that they take a picture of me because, but if I was in the audience I would be like trying to avoid it.
136	Seeing herself/being seen is less scary now	P44, 11-13	I'm feeling obviously a lot more able to, cause I've done more exposure to this, so it's less scary for me now. Whereas I think maybe, I'm trying to think back. It's quite hard to remember. Mm. Um, yeah.
137	Video screen is like a mirror	P47, 5-6	Online you are being reflected back all the time. I guess the video screen is a bit like a mirror, really.
138	Comparing herself to therapist	P43, 3-5	I suppose I kind of would, there would be some comparative, like probably to like, thinking of how I look in relation to her, maybe?
139	In VCP you see both parties; in PCP just T	P47, 9-11	we're talking about when you can see yourself not just seeing the therapist, right? So you, you have to see both, both parties, don't you?
140	Not dwelling on what T might be thinking about her	P41, 11-14	Um, maybe in passing and thinking that she might be thinking things about me, but then telling myself, realising that she was professional and that that's not what they, she was there to do. Um, so yeah, I didn't really dwell on that.
141	Looking at herself currently does not trigger her	P28, 13-14	I'm looking down a bit to see myself, but I'm not kind of, it's not triggering anything for me right now.
142	Her perspective now may not fully align with initial experiences	P44, 3-9	but I think I'm telling you this with, you know, hindsight. So obviously I did this, um, I started in September 2021, I think, and then I finished in May this year. So I think probably the, the early stages of that, especially, I probably wouldn't have necessarily felt the same. There might be a bit that looking back on it now as I'm talking to you now, I'm probably feeling okay about it or as we are talking. So there might be a little bit of that misremembering as well.
143	Absence of spiralling thoughts post sessions	42, 10; 12	I never came out and had a spiral. Um, I don't think I did. No...So that's positive. Yeah.
144	Emphasises the value of addressing this aspect in therapy	P54, 9-11	I think to definitely acknowledge it is a really healthy thing to do and to keep keep that in check, really.
145	Highlights the importance of acknowledging the camera	P55, 12-14	I think the big thing actually is acknowledging the presence of the the camera and how that kind of plays into the recovery of someone or how that person feels they're progressing, really.
146	Ensuring clients don't feel isolated	P56, 1-4	I'd say keeping that in check and that person not feeling like they're suffering, like on their own with it. Um, cause that would be quite scary to feel like you're having therapy, but actually it's making things worse for you.
147	Highlights the importance of respecting clients' preferences	P56, 10-14	Um, I think it's about just giving people sort of the space to sort of make their own choices about things, I suppose at the end. And clear parameters being certain, just basic common courtesy and respect to, to that process, really.
148	If it's not recorded, it didn't happen		
149	Recorded video calls are worse	P25, 12-13	What's worse, um, is like video interviews that are recorded.
150	Watching recorded sessions would be more challenging	P52, 14	I'd find it harder if it was recorded and I had to watch it back.
151	If it's not recorded it never happened	P53, 1-4	I think as long as it's not recorded, not, not talking about now, but like, you know, the sessions weren't recorded, so it was like just meeting someone, it was just in, it's in the ether. It's forgotten, it happens. It's, there's no evidence of it happening.
152	Reluctant to confront her recorded image	P53, 8-10	I hate having things, my image pinned down because, yeah, that's your reality. You have to confront it. So yeah, so I guess just, yeah, not dwelling on it probably was quite good.
153	Feeling safe without smartphones	P16, 1-2	Um, so I think just generally, if I know that there's no phones around, then I'm, I'm, I'm okay.
154	Embodied response to smartphones	P15, 12-14	I know that I will freeze up, clam up, you know, if I see anyone with, take their phone out of their pocket.
155	Pictures differ from videos in self-perception	P26, 3-10	I recorded the Zoom call and watched that back and that was a big, big mistake [laughs]. Cause you know, you're like, oh my God, my face moves in a strange way and stuff. Really bizarre. I think it all comes down to just not being here. Like, I don't know what I look like, really, if that makes sense. 'Cause you sort of get a sense of what you look like from your, from pictures of yourself. But pictures are quite different to, you know, I can't step outside myself and, you know, see myself how other people see me.
156	PET 5: Online therapy's casual pitfall		
157	Preferring PCP's more formal structure		
158	PCP felt more formal	P48, 15	Um, uh, well, a bit more formal, maybe?
159	Open to VCP but considering PCP for a more intensive experience	P57, 5-9	Part of me does still want to go into like the [Priori] and just have like a really good 12 sessions and like kill this thing once and for all. But, um, yeah, in, in the absence of that, um, yeah, I wouldn't rule out doing online therapy again for this.
160	Prefers a structured and assertive therapy for accountability and progress in healing	P49, 9-12	I think actually when you're in therapy, you kind of, well for me, I'm, I like to have that more rigid structure and to be, someone to be a bit tougher with me because, you know, you try and get out of doing the work, don't you?
161	Would take PCP more seriously	P50, 8-11	I think you take it more serious. One takes it more seriously, I think. Um, I think I would take it more seriously and I would do the work, you know? Um, because I would, I wouldn't dream of turning up not having done the work because it would be a complete waste of my time.
162	Finding VCP's flexibility to be unhelpful		
163	Likes the informality of VCP but thinks it's unhelpful	P49, 5-7	I kind of like the informality of online, but at the same time I think it's unhelpful 'cause it's a bit too casual.
164	Needed her VCP therapist to be tougher	P50, 2-4	I think I needed someone to be a bit tougher with me and to go look, you know, these are the exercise you need to do. But I don't know, maybe I, I'm not sure.
165	Less committed to VCP than PCP	P50, 14-16- P51, 1-4	but I didn't go away and do as much practicing. I would sort of, I, I probably wiggled out from doing some of the tasks and stuff a bit more, um, gloss over stuff. Like I'd probably do stuff but not really very rigorously. Um, I think probably looking back what, 'cause what helped me was, say that the eating disorder, was kind of doing workbooks, writing down thoughts and stuff as well.
166	VCP lacked in seriousness, consistency and commitment	P35, 14-16- P36, 3-6	maybe there's something about online being too casual and like we would change meetings or I would like change meetings or I didn't have that consistency and I sh cause I was like, Oh, I'll just do it whenever I can...I probably maybe didn't take it seriously enough 'cause I know when I've had per like in-person therapy, I've had exercises, I've gone away, and I've done a lot of support work that I think has really helped me to recover
167	Experienced a lack of framework in VCP	P36, 9-10	maybe there was a lack of a framework there either maybe that came from her or from me.

168	DEAN		
169	PET 2: Ease in familiarity: the comforting embrace of VCP		
170	Feeling free of anxiety pre VCP	P30, 3-6	it was a bit, just a link that I had to follow when I was kind of ready, essentially. So I didn't have any uncomfortable, um, thoughts, any anxiety or nervousness going into it.
171	Doing therapy from home is a benefit of VCP	P28, 10-11	Um, I feel one benefit of the, um, the video therapy is that you're in the comfort of your own home.
172	Uncomfortable in hospital/clinical settings	P29, 1-3	if I have to go to the hospital or something like that, that's very uncomfortable for me.
173	Uncomfortable with therapy in university setting	P29, 5-6	And it was the same at the university, sort of just sat in a room waiting to go in and see this person. I guess you build up a bit of anxiety.
174	Comparing PCP waiting room to waiting in hospital for results	P29, 8-13	Um, I guess, um, you're just kind of thinking about what is going to happen. You know, the same as if you were to go for a check-up or something like that at a hospital, you know, or you're waiting for a result, something like that, you know. It's this sort of just feeling of like, Oh God, what, what could happen? You know, you, you end up thinking about the worst-case scenario.
175	Excessive worry diverting focus from therapy	P29, 15-16	And that can often take your mind off of, uh, the actual purpose of why you are there. Um, from my experience anyway.
176	Recognising the detrimental impact of overthinking on effective communication	P31, 14-15	It's almost like, you know, you're mentally preparing yourself while waiting to be seen and, um, yeah, you kind of just get a bit lost with it.
177	Comfort of home fostering openness	P30, 9-11	being in a comfortable environment, um, might allow them to open up a bit more. And, uh, at first it did with me.
178	Change of setting causing nervousness	P31, 5-6	With the university situation, I think just the un, the nervousness of being, um, somewhere else, you know, a different environment.
179	Uncomfortable feelings of being in the waiting room eventually pass	P45, 16-46, 1	being in the waiting room, building up that sort of anxiety, you get used to that.
180	Forgetting intended thoughts during therapy	P31, 6-9; 11-12	I guess you kind of naturally feel like you have a bit of an expectation and therefore you end up forgetting a lot of the things that you kind of intended to say...Which I think happened to me as well. Um, you know, I was sort of just thinking too much.
182	Drowning in trying to adjust details		
183	Trying to manage presentation by adjusting appearance to present himself in a favourable light	P35, 1-2	And the whole time this is going on, I'm still kind of looking at the camera, trying to find the right angle [laughs gently].
184	Surprised at his own appearance when speaking	P35, 11-15-36, 1-2	I dunno, when you see yourself talking, um, 'cause obviously that's something you never really kind of see, you don't look in a mirror and kind of talk to yourself ... Well, I don't anyway. And part of me is thinking, Oh God, is that, is that what I look like when I'm talking? Is that how my face goes when I'm, when I'm speaking? Um, and that led me kind of feeling even more sort of uncomfortable.
185	Actively changing appearance	P36, 6-7	Um, you know, and then almost trying to alter how I'm, how I'm moving my mouth, in, in, in a sense.
186	Whilst correcting himself, the constant movement might draw more attention than the perceived flaws	P39, 9-11; 13-14	What they're gonna pick up on is the fact that I am constantly moving around and correcting myself...Not how I'm, while I'm stationary, which is what, yeah. It's almost like a bit of a double-edged sword, really.
187	Feels uncomfortable when questioned re corrective behaviour	P40, 1; 3-4	I dunno, it's, it's a, it's quite uncomfortable, really...Especially if there's more people and they're kind of curious as to what I'm doing.
188	Justifies behaviour by referring to restlessness	P40, 9-11	I'll just be like, Oh, you know, like, Excuse me, I'm just quite fidgety. I just say, oh, I can never still, I can never sit, sit still, I'm sorry, you know?
189	Constantly adjusting appearance during video calls	P17, 15-16-P18,	And I guess the video call thing, uh, you probably notice now as well, you know, I'm kind of changing myself, always correcting myself.
190	Checking behaviour was especially noticeable/pronounced in VCP	P18, 6-7	And, uh, that was obviously, that was very prominent when I did the video therapy.
191	Experience dictated by where he is trying to direct his attention (discomfort is variable/not constant)		
192	Overly conscious of various bodily aspects in VCP	P36, 10-12	And then there's just suddenly a lot going on. So everything from my position, my posture, the lighting to the way my mouth moves, and what my eyebrows do.
193	Distracted by heightened self-scrutiny	P37, 1-2	And, and suddenly it's way too much to, um, to really sort of answer the, the question or think about what you're meaning to say.
194	Preference for video to be off	P37, 5-6	Yeah, I mean, um, if I had the opportunity to, I would probably turn the camera off if I didn't, if it wasn't necessary.
195	Considers visibility to be crucial in certain contexts	P37, 8-12; 14	But, uh, I guess it does just depend on the circumstances, depend on the situation. Um, you know, if it's a work-related thing where I obviously have to be seen, um, you know, someone needs to, you know, uh, I did do this thing for a small acting role once, um, where it was essentially an audition...So, you know, they need to see every aspect.
196	Pressure to be seen working in his favour	P38, 1-4	And, uh, for me, the pressure of that actually worked in my favour. 'Cause I knew I needed to get myself in a position where I had to come across as comfortable. I couldn't seem sort of fidgety and trying to kind of constantly correct myself. I just had to kind of be focused.
197	Excessively self-monitoring even in casual situations	P38, 6-9	Um, if it's, uh, a situation where like, um, a job interview or something a bit more casual, I guess I will just kind of not take any, I'll try not to take notice, but I will always be looking and, you know, and I'll sort of keep changing my position and stuff like that.
198	Expressing strong dissatisfaction with how he looks on camera (self-view)	P39, 1-2	Uh, and you know, Oh God, you know, I don't, I don't look great. This lighting makes me look terrible. This camera makes me look terrible.
199	Wanting to look better for others	P39, 5; 7	I guess trying to make myself look better...Look better in terms of others, I guess.
200	Acknowledging others might not care	P39, 7-9	Not that anyone would care, that's the thing. I know that deep down, I always think that after I've kind of, you know, it's like no one's gonna really pick up on this.
201	Not looking great is distracting but only in formal situations	P20, 4-11	if I have to join a meeting and I see myself not looking great, not looking in the sort of, you know, like I'm in the right lighting or this and that, not wearing the right outfit, this outfit doesn't look good on camera. Um, I guess that can often distract from what I'm actually kind of there for.
202	Self-examines when he sees a mirror	P17, 9-11	I guess, uh, I'm one of these guys that's similar to sort of, um, you know, I, I'll walk past a mirror or a reflection and I'll, you know, I'll, I'll sort of check myself out in a sense.
203	Constantly focusing on the little window	P22, 7-9	So, you know, 'cause I'm just constantly looking rather than, uh, you know, looking at the screen as a whole, just looking down in the corner of my little box.
204	Not knowing what T is thinking	P22, 15-16-23, 1-2	I don't, don't, don't know what they're thinking and frankly, realistically, they probably don't care about how I'm necessarily looking, um, just due to the nature of the situation being on a small screen or whatever.
205	Discomfort around being seen on a bigger display	P23, 3-5; 7-8	I'm up on a bigger display. They're not seeing what I'm seeing here. They're seeing a lot more and a lot closer up... And I sort get a bit of a discomfort from that if I'm not happy with how I'm looking.
206	Deliberately trying to detach himself from his own image/ better tech = less dissatisfaction	P48, 8-10	Um, I guess, uh, I've been trying not to pay attention to the little box, uh, with me in it. Um, but, uh, it's a very clear image. Um, you know, I think the best technology definitely helps.
207	Experiences discomfort upon seeing himself on camera despite being OK in normal conversations	P19, 3-6	having all these issues and then suddenly, you know, finally being in a position where I'm kind of okay with myself. And then you're in a position where you're sort of on this funny little camera and you think, Oh God, I don't look good.
208	Shifting mentality depending on the formality of the situation	P19, 8-10	It's just a, I dunno, it's different mentality that takes over when it's a more kind of informal sort of situation.

209	PET 4: Seeking connection, facing dissatisfaction		
210	Striving for connection and understanding		
211	VCP being the only option	P25, 13	the only kind of therapy that I was able to get was, was video therapy.
212	Consciously accentuating certain aspects to test/gauge the therapist's response	P18, 13-15	I guess the video therapy, um, maybe in my head I was trying to kind of emphasise certain things to see if the, uh, therapist would pick up on it.
213	Exaggerating behaviour to convey meaning	P21, 15-22, 1-2	after I had the session, it was sort of like, I kind of realised it was almost like that was a, it was for a purpose, you know? I wanted them to know what I was sort of dealing with.
214	Overemphasising issues	P41, 1-2	Um, well that's, um, 'cause I guess I was trying to kind of make a point of it that almost, you know, like I was overemphasising a little bit
215	Desiring empathy and understanding	P44, 1-2	Um, you know, I felt like what I needed was someone to talk to and someone to actually listen and understand.
216	Hypothetically open to VCP	P44, 12	I feel like I would've given it, um, another chance.
217	Didn't experience any issues during our call	P48, 12-14	Um, I, I felt like, um, you know, this was, this was comfortable. Um, you know, I felt like I was able to kind of open up, um. Yeah, I've felt I haven't really had any, uh, any issue with this.
218	Challenges and dissatisfaction in therapy regardless of format		
219	Feeling isolated in his self-criticism	P4, 3-6	it's that little voice in the back of my head. Um, you know, and anyone that would see me would probably not agree in any way, shape, or form. But, you know, it's only me that can kind of notices it, you know?
220	Comparing VCP to an uncomfortable job interview	P24, 3-4	I was, I was opening up quite a lot and it almost seemed like, uh, an uncomfortable job interview.
221	Doubting the therapist's engagement	P24, 13-14	And I, it's the, um, is the therapist as involved here as I am? Uh, are they really listening?
222	Feeling disappointed as expectations not met	P30, 13-14	Um, it was just throughout the session where I started to think, Ah, this is not really what I expected it to be.
223	Not achieving what he sought from VCP	P24, 1-2	Um, frankly, I wasn't happy. Um, I don't feel like I got what I wanted from it.
224	Having a strong preference for PCP	P26, 6	Oh, definitely in person.
225	Not having space or opportunity to discuss concerns	P41, 3	um, I didn't really have the opportunity to discuss it, to be honest.
226	Emotionally disengaged from the therapy sessions	P42, 1-6	the antidepressant thing that sort of, that kind of hit the, the nail on the head for me, really. I was just like, okay. After that I'd almost checked out a little bit. And I thought, This isn't gonna help me. So I kind of stopped caring for the rest of it. And I just kind of like snubbed down and just kind of stayed a bit stationary and didn't really pay that much attention.
227	Emphasises the limitation of a single one-hour session	P42 10-13	I believe that you, it takes a lot to actually understand somebody and one-hour long session, frankly, I don't think that's gonna cut it. Um, you know, like you see most people that have therapy, well, they'll have multiple sessions.
228	Acknowledging shared responsibility in sessions	P43, 2-3	but, uh, I guess I never gave myself that opportunity, but the therapist didn't necessarily give me the opportunity.
229	Feeling unheard and possibly dismissed	P41, 8-9	Um, and, um, I guess, you know [sighs], they didn't, it felt like I wasn't really being kind of listened to or acknowledged.
230	Discontent with the therapist's approach/missed chance to delve into his concerns further	P43, 5-6	You know, I felt like that was wrong on their part to, uh, to mention that.
231	Strongly opposed to antidepressants	P43, 9	it's something that I'm quite strongly against.
232	Acknowledging the efficacy of antidepressants for others	P43, 11-14	Um, just, you know, obviously what these things, antidepressants, stuff like that, they work for people, but I just don't think that's something that I want in any way, shape, or form, really. I don't think it's necessary for me.
233	Struggling with the approach/ handling of the session rather than the format itself	P44, 16-45, 1-2	I dunno, maybe it would've been different if it was face-to-face as well. I felt like I would've reacted the same if it wasn't for that. You know, if, if I had been given the same suggestion [antidepressants]
234	Current convo feeling more attentive and engaged/ highlighting the importance of active listening and genuine interest from therapist	P49, 1-4	But I guess a big part of it is, is you, you are paying attention, or you can, I can tell that you are interested in what I'm, what I'm saying, and not sort of with your head down taking notes, which was what was kind of happening in my previous session.
235	Dissatisfied with all therapeutic experiences	P27, 15-28, 1-2	those two experiences, the university experience as well as the video therapy experience - not great.
236	Didn't feel heard even in PCP	P26, 11-15	I had a, well just one therapy session, um, with the university therapist, uh, and, um, again, very like, dissatisfied. Um, I felt like, um, again, they just seemed like even though it was in person, it was face-to-face, um, I didn't really feel like they were paying that much attention to what I was talking about.
237	Determined to manage depression independently	P27, 4-7	You know, I do have tendency to get depressed, but I kind of pick myself up. I deal with this, and I don't really want to be drugged, you know, that it's never really been a viable option for me.
238	Experienced communicative challenges even in PCP	P27, 1-3	It was just very one-word answers, one-word responses. And then eventually it led to, uh, them asking if I ever thought about, um, taking any kind of antidepressants.
239	PET 5: Clarity and presence: the foundations of understanding and perception in VCP		
240	Visibility for verity: the need for physical presence to foster understanding in therapy		
241	Believes PCP leads to deeper level of connection and understanding	P46, 7-8	I feel like the therapist is able to, uh, understand someone a lot more personally, um, with actual sort of face-to-face interaction.
242	PCP allows for body language to be picked up on	P21, 3-5	I guess a lot of, I'm assuming, I guess in therapy sessions, the therapist would be, um, picking up on body language.
243	Doubtful about how well T could understand him through a screen	P32, 6-9	Um, I guess it was, uh, just a bit of a, a strange feeling to be honest. 'Cause um, a part of me was thinking how are they, uh, really kind of getting to know me when it's just on a, a screen, if you know what I mean?
244	Concerned about accurate communication and understanding in VCP	P21, 7-10	And like video therapy, I, it might be a bit different these days with the better technology and stuff like that, you know, clearer cameras, but how are they really going to judge, um, sort of situations like that where they can only see a tiny portion of you, an odd box?
245	Finding VCP atypical for personal conversations	P24, 9-11	I guess the lack of face-to-face interaction, you know, you can't really look someone in the eye. Um, it's, uh, it's just a strange way of having a very, very personal conversation.
246	Lack of eye contact creates mental block in communication	P46, 13-16, 47, 1-2	and the sort of lack of eye contact, you know, that's always an interesting one. Uh, it's, yeah, it's just a bit strange. Um, you feel like you're not, either not being listened to or, um, I dunno, just you're not sort of, I guess you're kind of putting a bit of a mental block on what you're actually trying to say in a sense.
247	Distorted signals: the impact of technical issues on perception in VCP		
248	Technical issues affecting quality of interaction	P32, 11-12; 14-16	I think they were using quite a dated, um, system. Um, so it was a very unclear image as well...Um, it seemed very pixelated. Um, the service didn't seem too great. It was probably something to do with my internet, but, um, yeah. You know, it wasn't the best connection
249	Worried about potential misinterpretations of his emotional state	P32, 16-33, 1-3	I was having to, um, to, to kind of speak quite loudly as well, which I was kind of worried that that was gonna make me come across as quite a short-tempered person or something like that. 'Cause I kept having to repeat myself.
250	Feeling frustrated by tech issues	P33, 5-8	Um, and there was a degree of frustration. And I think they even mentioned at one point, uh, You seem like you're getting, um, you know, You seem, you are working yourself up. I'm like, No, I'm just trying to [laughs], trying to, trying to speak and I can't.
251	Concerned re being misjudged/misdiagnosed due to tech issues	P34, 3-4; 6-10	I was concerned that they were gonna make kind of like, almost like a false diagnosis, if you know what I mean...Um, uh, I wasn't there for, for, for anger issues or anything like that, and I was kind of paranoid like, Oh, how am I coming across? Are they, they're seeing me getting a bit worked up and they're gonna think that I'm a very stressed out, anxious person, which is gonna affect how this is gonna

252	YASMIN		
253	PET 2: VCP - mastering control with flexible approach		
254	Convenience and flexibility of VCP		
	Convenience, intimacy, and comfort = factors in choosing VCP	P14, 8-14	Um, I had video therapy because like for, like I mentioned, you know, I have a busy schedule and I don't really have the time to go to the office. And also it's, it's can be just instant, like I can just call the therapist and she would be also flexible because she wouldn't have to go to her own office as well. She can be also at home, or he, but for my therapist it was a she. Um, so, and also like I said, and it's more intimate, you know, I'm in my own safe space as well. I'm more comfortable.
255	VCP is flexible for herself as well as T	P14, 10-12	I can just call the therapist and she would be also flexible because she wouldn't have to go to her own office as well
256	Liked VCP's flexibility and therapist's adaptability	P12, 5-10	my experience with video was amazing because like I mentioned I work a lot and I don't really have that much time, like my, my work is from nine to six officially, those are the official timings, but sometimes I have to work till like midnight. So, uh, I was happy to have a video call because it was flexible, and the therapist was very accommodating of that.
257	Feeling control over her appearance in VCP		
258	Lack of control in physical spaces vs. control and customisation afforded by online platforms	P13, 8-15	if I walked into like an office, I would have to shake their hands and touch them. And then also, um, I would feel they wouldn't see my, uh, they would see my stomach area. But if I'm in a, um, video call, I can always hide that, for example [laughs gently]. You can also add filters if you don't like the way that you look on videos, um, so, you know, I adjust, the lighting, for instance. So you're in control when it's online. But when you go into an office, you're not in control.
259	Feels control in all video conversations	P14, 4	Yeah, I have the same one. Yeah.
260	Managing insecurity by controlling visibility	P16, 8-11	[felt insecure] in the beginning, but that's just the norm. Like I do that with a lot of people. I'd rather have that than...You know, going into her actual office and her seeing my whole body, for instance, you know, at least I can think, I can be in control.
261	VCP gives her control over how much she shows	P23, 8-9	they might, you know, look at your whole body rather than just one section that you're choosing, for sure.
262	Prefers VCP despite looking bigger because can hide her stomach	P29, 7-8	Yeah, I'm, I'm hiding my stomach, you know. I'm, I'm in my own safe area. And, um, it's, it's more convenient for my busy schedule.
263	PCP reveals her stomach and body lang	P23, 12-16	in virtual therapy, I'm just showing my face. But when you're walking into in-person therapy, they see how you talk to other people, uh, how you, how you use your hands, uh, your body language, your full body. And like I said, they will see the flaw that I hate about myself, which is, uh, my stomach area.
264	Feels comfort and ease during video conversations	P13, 4-6	So for example, in a job interview, I would feel more comfortable because I'm in my own home, I'm in my own safe space. I'm not in unfamiliar place, so it's more comfortable for me.
265	PET 3: Virtual curtains - VCP allowing for privacy and concealment		
266	Feels less seen in VCP		
267	Feels more exposed or uncomfortable being seen if she were to attend a therapist's office physically	P15, 2-3	I don't want people to see me if I go into a, a therapist's office. It's more private
268	Privacy is important to her for cultural reasons	P15, 5-6	Um, and privacy is an important matter to me. Where I originally come from, therapy is still very taboo.
269	Concerned about consequences of disclosing therapy attendance	P15, 8-9	Even, even though UK is, it's a big country, but, um, you never know, you know, like you don't wanna take any risks.
270	Being in a safe place helped her feel more comfortable	P16, 4-5	And because I was in my safe space, um, that, that was very helpful.
271	Got comfortable through understanding and soothing tone	P17, 6-8	so I, I got...I got to know her and her tone of voice was very like soft and she seemed very understanding. She had like experience of dealing with people like me. So I felt like I got more comfortable.
272	Personal processing of BID struggles		
273	Didn't discuss camera with therapist	P20, 11-12	Uh, to be honest with you, I never really discussed the camera with my therapist.
274	Concerned re being judged if she told therapist re self-scrutiny	P21, 4	I didn't want her to judge me
275	Worried that self-scrutiny might be perceived as rude	P21, 10-13	she would think it's rude if I was staring at myself the whole time, instead of, you know, staring at her and listening to her conversation, she would think that I would be distracted and not taking it seriously.
276	PET 4: From self-consciousness to full engagement in therapy		
277	VCP: a dual lens of self-scrutiny and comparative analysis		
278	Hyper-focused on flaws and imagining how T might view her	P17, 11-15	Seeing myself, um, in, in the camera, um, I was staring at myself the whole time. Um, I just, I wouldn't stop staring at myself. I was trying to focus on any flaw in my face and I was imagining how she would perceive me as well. Uh, so it's, I wasn't, I wasn't, uh, looking at the best part of my face. I was looking at the worst parts of my face.
279	From self-observation to active engagement and confidence-building	P18, 4-9	Uh, it just, I think in the beginning, but the more I got into the therapy, uh, the more I forgot about myself and I just, you know, focused on the actual, uh, substantive, uh, conversation that we're having 'cause I was benefiting from it. And we were doing exercises and, and it's, and, you know, I was feeling more confident the more exercises we did with each other.
280	Growing comfort and benefit from the session's content	P18, 12-15- P19, 1-2	in the beginning, I was staring at myself the whole time, but then when we got, you know, comfortable with each other and the conversation became more serious, then, you know, I, I was still looking at myself, but not as often as the beginning, you know? I was focusing on the actual material of the therapy 'cause I was benefiting from the exercise.
281	Comparisons distract her only at the beginning	P31, 1-3	Um, well, in the beginning it only affects it, but then I get more comfortable and, you know. It's, uh, it gets better, you know, I forget that, you know, in a virtual experience.
282	Compares herself with T	P29, 12-13	Sometimes I do also compare myself with my therapist. Especially if she's a woman, you know? I do compare myself, yeah.
283	Confidence gap, not about looks	P30, 4-8	So it's, it's because, you know, they, they seem confident to, the therapist, because, you know, and, and I'm coming in for help. I think it's just, it's not because a therapist is more beautiful than me, or I'm more, it's not that someone is more beautiful than the other, it's just the attitude, you know, like, she's more confident in herself, you know?
284	Projecting perceived shortcomings onto how others view her	P27, 8-10	Um, so I thought, when I look at myself in a box, I just try to look at the flaw that is in my face rather than the best part of my face. And then I just imagine that this is how people look at me, you know
285	Doubt over virtual reflection	P28, 10-11	I just imagine Okay, this is how I look like in real life, I guess, you know?
286	Evolving comfort in VCP		
287	Initial discomfort gradually eased	P15, 15-16- P16, 1-2	So, I felt a bit insecure in the beginning, but the more I spoke to her, I felt more comfortable. She put me at ease. Uh, especially when we did the exercise of listing the qualities that I liked about myself. It made me feel a bit confident in myself.
288	Initial concerns about appearance fading as conversation progressed	P16, 14-15- P17, 1-2	I was feeling like, um, or is she looking at, um, the, the pimple that I have on my face? Is she, is, is my stomach showing? And I was trying to adjust the camera. Um, so that was just in the beginning, but then it was, uh, it was very, uh, at ease when, when the more we spoke.
289	Initial distraction gives way to therapy's helpfulness	P31, 5-8	Um, just in the beginning I get distracted, like I don't really focus on the actual serious conversation, that she's trying to help me, but then the more exercises we do, the more like I feel like they are helpful, then I take the therapy more seriously and I stop saying that to myself.
290	Shift from self-focus to content of interview	P34, 10-13	Well, like my, like in my previous therapies, um, I would say that at the beginning I was looking at myself, but then the more the conversations became serious, the more, um, I forgot that I was even in a virtual interview with you, a virtual therapy. Yeah.
291	Prioritising therapy's purpose over self-scrutiny due to time	P19, 4-5	I'm paying for the, for the therapy. I have one hour. I can't be wasting the whole time just looking at myself.
292	Shifts focus from self to others in all online conversations	P20, 5-8	I always look at myself in the beginning, but then slowly, slowly, I start looking at the other person. I would still look at myself, but not as much as before because then, you know, I get into the conversations.
293			

294	PET 5: Boxed intimacy: connection without physical reality		
295	Sense of intimacy fostered by the confined space of a video call		
296	PCP is more real due to tangible/sensory experiences	P26, 5-9	So the difference is for me, like, and the, in the real word it's like you can touch people, and I look at them in their eyes, like the eyes are more visible, and you can see, you can like, you can see like their real skin colours, like their veins, you know, like their real person, you know, but you can't see that in a virtual interview call.
297	VCP is more intimate but less real	P26, 13-14	So, so even though, uh, like virtual interviews calls are more intimate it doesn't feel as real as, you know, when you go to an in-person therapy.
298	Sense of intimacy created by the enclosed digital space	P27, 1-2; 4-5	It's more intimate because your whole space is in a box, you know? You're staring at another box as well...So that's why it's more intimate. It's like face-to-face, eye-to-eye, you know?
299	VCP is just you and T	P27, 9-13	it's only you and that person, you know, like no one else is, uh, there. But maybe if you go to an in-person therapy, you can hear sounds, um, you can, you have to enter, like, for example, the reception before you go into the actual, uh, therapy room and you have to interact with the receptionist.
300	Feels closeness in all online calls	P20, 3-4	Um, and, and it's the same thing that they're both intimate. You're both looking at people's faces in a box.
301	VCP was more intimate	P12, 12	it felt more intimate as well.
302	The sensory richness and perceived authenticity of PCP		
303	PCP is more real, hence more uncomfortable	P22, 14-16	Oh, I think that's where the, um, in-person therapy, I would, it would make me very uncomfortable because I'm looking, like I can touch the person, I can look at them in the eye and be like, it just feels more real.
304	VCP feels like La La Land/ not real world	P23, 1-6	it's like everyone is in La La Land, you know, like you're, you're in your own comfort. It doesn't feel like it's the real world, to be honest with you. It just feels different. It's, it's more intimidating when it's in-person, you know, because they can also see your hand gestures, your, your, um, your, uh, how to say body, um, language, body language.
305	(Compares) 1 box vs. another box	P30, 10-12	So I would compare myself to every woman, to be honest with you, but in therapy, you know, you do compare, you compare yourself with another box because it's one box versus another box.
306	Face looks bigger in the "box"	P29, 2-4	I just feel like, um, I don't know, like, my, my face looks bigger maybe in a, in a box, but when you look at yourself in a mirror, like, it looks smaller, your, your face looks smaller.
307	Open to PCP	P22, 4-5	No, I've never had, no. But I'm willing to, I'm willing to give it a shot to just compare
308	PET 6: Embracing therapy		
309	Had online therapy for BID when struggling a lot	P10, 8-11	I had the online therapy in, uh, in, in London, uh, two, uh, two years ago. And, um, I went a few times and it was mostly because of my body image, because I was just really struggling a lot and I needed to find a solution.
310	Therapist helped her shift perspective	P11, 2-10	So basically I went to the therapy and a therapist and she told me to list down like stuff that I like about my body. So I said I like my arms, that they're skinny, um, I like that my, about my legs, that they're are skinny, that I don't have big thighs, um, that I like my face and I have a good personality and I'm funny. So I'm deserving of, for example, that amazing spouse. And, um, it's, and if I have an issue with my stomach, then I should just, you know, use all of that energy to work out rather than, you know, just hide in my room or like not dress the way that I would want.
311	Advocating self-kindness despite imperfections	P31, 13-16	Um, I think we should be more kind to ourselves because no one is perfect, um, and everyone has flaws.
312	Encourages therapy if one has issues	P32, 10-11	if it's an issue that's affecting your life, then you should go for it.
313	Interview contributing to self-reflection and personal growth	P34, 1-6	Um, it's, it's been amazing. I feel like it's a learning experience because I have never done an interview for research. Um, it's, it's and telling my story is a bit like self-discovery. Um, it just, it's healing, you know, and, uh, it's great speaking to someone who is compassionate and who listens. So, um, I really enjoyed the session interview, to be honest with you.
314	SARAH		
315	PET 1: Disparity between natural and altered image		
316	Feels prettier with a filter on	P25, 5-6	I felt like, Oh, I appear prettier, this is good.
317	Filters allow her to present a nicer version of herself	P24, 10-3	it's like a nicer version of myself, like a slightly, uh, smooth, smooth version with like a smooth skin. And, uh, I liked it. It was not my plan to do it, but when I saw it's an option, I liked the idea of appearing better looking.
318	Filters photos to change herself	P25, 10-14	I filter all my photos, so... And filter much more than Zoom would allow you, so I properly filter them, like adding hair volume and putting face filters and making myself look slimmer. So I like the, the alternating the image and I know it's silly in a way because it's not <u>you</u> , but it makes, uh, makes me feel better about myself.
319	Filters make her feel more complete	P2, 6-9	on every call I would be a bit, uh, filtered. It made me feel better, especially when you log in from home, you sit there with no makeup, with your homeware, it, it felt a bit, uh, better basically not coming as you are, but in a more completed version.
320	PET 2: VCP is like therapy with a mirror		
321	Describing collective experience of struggling with BID during lockdown	P27, 7-9	I think many people struggled. I definitely struggled. You know, the gym closed, the hairdresser closed, you sit at home and, uh, feel uncomfortable about yourself.
322	Presents a better version of herself to therapist when in consulting room	P26, 3-5	she also saw me in the clinic, usually with makeup and better dressed
323	Having a dislike towards seeing oneself big is a shared experience	P13, 8-9	But I believe that not only people with body image issues wouldn't like it.
324	Experienced unexpected feelings of discomfort upon seeing herself on the screen	P2, 2-3	I realised that I'm not very comfortable with seeing myself on the screen
325	People with BID are more prone to feeling intimidated upon seeing themselves big on the screen	P14, 1-3	probably this is much more likely to happen with people who struggle with accepting their appearance and struggle with their body image
326	Covid-19 was challenging due to inability to keep up her hair	P26, 13-15	It was difficult. I couldn't colour my hair, I started to get like long dark roots, uh, and it's, uh, it's very unpleasant.
327	Seeing herself on camera during Covid-19 added to an already difficult experience of not having her hair coloured	P27, 2	And then in this image on the screen, um, not the best experience.
328	Feeling a general uneasiness around seeing herself on screen	P8, 14-15	I don't feel very comfortable and don't like seeing myself on the screen
329	Lack of mirror in therapist's office means you can't see yourself	P12, 1-2	in the, uh, office of the therapist, there is no mirror, so you don't really see yourself
330	Seeing herself (instead of therapist) big on the screen was disturbing	P13, 5-6	Like I'm seeing my face big on the screen and it's really disturbing.
331	Looking at her image during our chat felt intimidating	P34, 2-3	so I've been looking at my image in the corner now and thinking, um, uh, Well, this is, uh, this is a bit intimidating.
332	Retrospectively realised she might not feel comfortable with VCP	33, 1-3	I didn't think about it until you asked me about it today. But when you did ask me and I started to reflect on it, it just came to my mind that yes, maybe I don't feel comfortable.
333	Comparing VCT to therapy with a mirror	P12, 4-5	this is like having therapy with a mirror there.
334	Seeing herself on the screen in work/personal calls is easier	P10, 1-2	It makes this issue of seeing myself on the screen less prominent
335	Conscious of the camera reflecting two differently sized images	P12, 14-15; P13, 1	instead of seeing the therapist big on the screen and myself like in the small window, for some reason I saw myself big and the therapist smaller.

336	PET 3: Unspoken troubles - private processing in VCP		
337	Didn't think of discussing it with her therapist	P12, 11-12	I haven't discussed it with my therapist and probably I should have done it, but it didn't really cross my mind.
338	VCP allows people with BID to discuss their issues as they're happening	P15-2-4	for people who struggle with self-esteem, with issues linked to their appearance, uh, it could be an interesting experience because they can process things that are happening in the here and now.
339	Wondering what could have been achieved if she shared her thoughts with the therapist	P14, 8-11	I think it would probably give me a chance to explore my feelings in the moment. Uh, to explore what, uh, what exactly was uncomfortable and why. So, uh, but it, <i>it's hard to imagine what it would open up</i> . But it probably would be a chance to explore, uh, the issue as it is happening
340	Not considering her BID to be the focus of her therapy	P4, 8-9	my own appearance was never the focus in, uh, in those sessions.
341	Dealing with BID in therapy on her own	P4, 13	I think it's something that I was processing on, on my own
342	Wondered how the therapist was experiencing VCP	P2, 11-13	And I started thinking, How is it for the therapist on the other end? Because they see this big image and it's quite intimidating, you can see all the traits and features.
343	Has not spoken re in-the-moment VCP experience with therapist	P32, 10-13	...I thought that it would be a good idea for therapists to bring this topic up when they work remotely, because my therapist has never asked me how do I feel to see myself in the little square on the screen.
344	Recommends that every VCP client is asked how they feel about VCP	P33, 11-12	I think every client who goes for some remote therapy probably should be asked those questions
345	PET 4: More intense stare but less real connection		
346	All focus on her - feeling the pressure of the gaze		
347	Finding other people looking at her intimidating in all video calls	P10, 8	I find it intimidating
348	People in work calls don't focus exclusively on you	P8,16-P9-1-2	on those work meetings there would be a few people, and even if it is a one person, they're not focusing on you 100 percent
349	Experiencing a difference in how she is seen online vs. in consulting room	P2, 14-15-P3,1-2	in real life, when you go to the clinic, to the office of the therapist, they see you in 3D and it's less staring in your face. It's more like looking all over the place. But here it felt like, um, yeah, for the whole duration of the session, the therapist is looking at your face on the big screen.
350	Finding the therapist's gaze to be anxiety-provoking and distracting	P3, 10-12	it just, uh, uh, provoked a bit of anxiety; it, uh, uh, maybe made me, distracted me from the therapy process
351	Experiencing the therapist's gaze as	P3, 1-2	it felt like, um, yeah, for the whole duration of the session, the therapist is looking at your face on the big screen.
352	People in work calls don't focus exclusively on you	P8,16-P9-1-2	on those work meetings there would be a few people, and even if it is a one person, they're not focusing on you 100 percent
353	Getting carried away imagining what others are thinking of her	P10, 15-6-P11, 1-2	maybe they don't have any opinions or any thoughts about it, but I can't help thinking that they might and developing this fantasy that they are maybe judging or maybe having some negative opinions about myself.
354	Experiencing the therapist's full attention as a hindrance in VCP	P9, 4-7	With a therapist, it's very different because therapist is there to give you their full attention. And, uh, it would be very unlikely the therapist would be sitting there looking around or taking their own notes and doing whatever comes to them. So I feel like in therapy sessions, it is exaggerated, this issue.
355	Wondering what is visible to others and how they think of/judge her	P11, 8-9	I start to fantasise: What do they see? What do they notice? What do they think about me?
356	Wondering if the therapist's gaze distracted her from other issues to BID	P3,15-P4, 1-2	it, uh, uh, maybe made me, distracted me from the therapy process, from other issues and moved my thoughts, uh, uh, towards the, uh, body image or appearance, uh, issues.
357	Not the centre of attention in work/personal calls	P9, 9-10	In my work meetings, so personal meetings, uh, on Zoom, it's not, um, it's not that prominent.
358	VCP is less real, less normal, less human		
359	Experiencing VCP as more intense but less real	P20, 11-13	there is no eye contact, it's just this, um, weird feeling of, um, somebody looking at you, but as if they're looking through you.
360	Expected smooth transition to VCP	P2, 1-2	And first I thought That's fine, that's not a problem
361	It was her therapist's idea to switch to VCP	P1, 15-16	A few years ago, maybe two years ago, my therapist suggested to do remote therapy because of, uh, Covid.
362	PCP is much more real	P16, 1-2	I, uh, also find, uh, uh, face-to-face contact to be much more real.
363	Experiencing better therapist-client connection in PCP	P16, 5-6	I feel like the connection between the therapist and the client is better.
364	Experiencing VCP as lacking in human presence	P16, 8-9	Online setting removes the human, human presence from it.
365	VCP deprives you of the other person's presence	P17, 1-8	It's the whole experience of somebody's presence, their way of being, their, seeing somebody in 3D, you know, and uh, I, I don't know what we can call it. Maybe somebody's energy? You cannot feel it from the screen... I don't know if that is the right word, but somebody's presence, their way of being, you can only see it when you meet with the person. Online it's very restrictive, you're limited to certain things.
366	Experiencing a lack of shared reality online	P18, 3-4	what is missing is the sense of a <i>shared</i> reality, <i>shared</i> space.
367	Finding physical proximity to be necessary for good connection	P18, 10-11	for me, uh, it's important to feel this proximity in order to feel this connection.
368	Lack of physical proximity makes connection more difficult	P19, 1-2	it creates an extra layer of distance. It creates this obstacle on the way to connection.
369	Sharing space ≠ connection but it's a factor	P19, 5-10	You can definitely sit very close to a person and be totally disconnected, I'm aware of it, but I think it's an additional layer. If we are sharing the same space and we can see each other in <i>full</i> experience and we can <i>share</i> this, um, I don't know what can be, uh, a good description. If we are breathing the same air, it kind of helps a bit. It's not a guarantee that we are going to connect, but it's a factor.
370	Lacking eye contact in VCP	P20, 3-8	on the screen, there is no eye contact, so you don't really, I don't know where you look now, you probably try to look at my face, but it doesn't, it doesn't feel that way. We don't know where we look. We try to get the eye contact through the video call. But we're just staring at some dot on the screen, so it is not really eye contact.
371	Finding PCP less uncomfortable, less intimidating and more normal/ human	P21, 4-8	I find it less uncomfortable, less intimidating and more normal, if you like, more human.
372	Lacking human connection in VCP	P21, 13	it removes this human connection
373	Online is different and uncomfortable	P22, 1-3	um, seeing somebody online was not part of life. It's a different experience and sometimes it's uncomfortable.
374	Connecting online is less natural	P22, 8-13	it's less comfortable, and less something natural. I'm not saying it's unnatural or terrible, but it's less natural than the connections that we are all used to from the communication that we are used to have outside of the video conferencing life.
375	Not so bothered about the quality of connection on work calls	P23, 1-4	with work I care less. You know, if I don't have a great connection and contact with my colleagues, as long as we can have our businesses done and we achieve what we need to achieve, we discuss what we need to discuss, that is totally fine.
376	Desires and expects to connect with her therapist	P23, 7	With a therapist, I <i>want</i> to connect.

380	PET 5: Feeling less secure in the online relationship		
381	Online therapy allows for quick dismissal	P30, 8-9	It feels as if you can be dismissed easier.
382	Possibility of sudden dismissal in VCP feels unpleasant, unstable and unsafe	P30, 12-16	the whole idea that, uh, um, like separating from you or getting rid of you is one click away. Um, it's also not a very pleasant thought now when I'm reflecting on it. Um, and also, we rely on internet connection. It just doesn't feel like as stable and safe as a face-to-face experience.
383	Experiencing a loss of small interpersonal moments and rituals	P31, 7-12	in a real-life therapy, when you are about to say goodbye and you grab your coat and your bag, you have an opportunity to say, like, Have a good weekend while you're slowly exiting the room, uh, it's a little thing and it's not crucial, you can have therapy, I believe, without it. But it's as if a part of the experience is missing when you are remote.
384	Feels greater sense of safety and comfort in PCP	P29, 12-13	when I'm in the same room with the therapist, I feel, um, uh, I feel more safe and comfortable.
385	Inability to see therapist's surroundings online feels a bit uneasy	P29, 15-30, 1-2	not knowing where this person is and who is behind the door and what's going on around them, I think it adds a tiny bit of insecurity to, to the whole, the whole process.
386	It was the format of the therapy that brought up thoughts around her appearance	P8, 7-9	They come up not just on video, but I happened to notice that in those remote sessions with the therapist, it, uh, it just came to my mind probably because of the format.
387	PCP is superior in quality	P32, 2	the experience of face-to-face interactions has more quality in it.
388	Highlighting that VCP is not the same as PCP	P16, 16	it's not the same as, uh, face-to-face contact.
389	KEVIN		
390	PET 2: The paradox of presence and absence in VCP		
391	VCP enabling face-to-face interaction despite geographical separation		
392	Values VCP's reach but sees limits	P20, 15-16; P21, 1-2	Video therapy, I do think that, uh, it's good for, um, uh, for for a person who is, uh, uh, accessing from a remote place or, uh, who does not have access to, uh, a psychologist in a hospital. But I do feel that it, it has limitations, uh, on their part.
393	Misses personal connection in video VCP	P21, 4-6	the feel and the, the personalisation and the, uh, you know, the one-to-one contact you have, uh, personally, uh, I don't feel on, uh, videos.
394	VCP and BDD both require customised, personalised approach	P37, 9-10	video therapy, I do think that, uh, it's good for, um, uh, for for a person who is, uh, uh, accessing from a remote place or, uh, who does not have access to, uh, a psychologist in a hospital. But I do feel that it, it has limitations, uh, on their part.
395	Highlights the need for individualised treatment for different BDD "symptoms"	P38, 7-8; 10-11	both are suffering from body dysmorphic disorders.
396	VCP is comparable to PCP in content and length	P33, 10-14	Um, it was, uh, uh, not very different from, uh, from in person, uh, discussions. Uh, the sessions were one-hour long sessions. So I have to discuss everything and even she has to say whatever she has to say, uh, in that period. So length wise, it was not different from, uh, from in-person.
397	Accepts VCP's practicality and utility	P25, 10-13; P26, 1-3	[not seeing her in-person was] okay because, uh, she was in a different city and it was, uh, not practical for me to go every now and then. So, uh, I, um, you know, counselling and, um, uh, mindfulness and these things can be, can be done online also. But some things are, some things, some things and some assessments and evaluations are done in, in person only. And, uh, so, um, that, um, those things, uh, cannot be done online, I think.
398	Values VCP for convenience, comfort and savings	P26, 13-15	Online I think, convenience is one thing, convenience is the biggest benefit of this thing. And, uh, comfort, uh, comfort level, comfort from a home. And, uh, it's cost and time saving.
399	Sees value in combining VCP and PCP	P21, 8-9	I think, um, both can go hand in hand also, um, uh, with the same person.
400	Appreciates VCP's improved accessibility	P27, 1-3	it's very accessible and, uh, today it's very easy to access. So these things have felt better. These things.
401	Lack of holistic visibility in VCP = lack of understanding		
402	PCP offers deeper observational insights	P22, 4-6	Uh, [the therapist] can observe you much closer and much deeper and, um, get a better understand, better understanding of you.
403	Proposes 360-degree view for comprehensive body assessment in therapy	P36, 15-16; P37, 2-7	maybe a 360-degree view, just like you have a Google view, uh, on the, you can take a 360-degree view of a streets...So just like that, you can, you can take a 360-degree view of, uh, you know, the body structure, you know, the the body dysmorphia. Uh, you can just like, just to have a glance and just to have a picture of, uh, the patient of, uh, always, uh, how is, uh, how it is. Also in case of obese patients also, who are diagnosed with obesity, I think it would be helpful with them also.
404	Sees VCP as potentially less substantial	P22, 12-13	But video wise, you know, they will be, or they will be, you know, uh, like, um, camera will, will not be, uh, good or, uh, it can be, it can be very formal...And it can be, um, not very, uh, you can say, uh, it can be not be very concrete, uh, in that respect.
405	VCP limits physical assessment accuracy	P23, 1-5	For in, uh, for body structure, uh, it may be because, uh, they're observing, uh, like, uh, uh, what is the patient, uh, telling, uh, what he feels or what he just said, uh, they don't know if it's just an illusion or just, uh, you know, just their imagination and, uh, you know, uh, they need a concrete evidence also.
406	VCP overlooks physical aspects of dysmorphia	P23, 7	So video wise, they, they're not seeing that the body is dysmorphic.
407	VCP lacks comprehensive physical observation	P23, 12-16; 24, 1-2	partly, I, I did feel like that, uh, because, um, they can only see my face. Or I can only show my hands on these things, but my whole body I cannot show. And, uh, they cannot observe it. Also, they cannot feel uh, uh, what I am telling, what I am trying to say. Uh, but in person, even if I sit quietly, he can observe and he can, uh, you know, he can know, uh, what the Marfan syndrome is like, what is, uh, what the body situation is like.
408	VCP offers partial treatment and accessibility	P28, 1-3	From, uh, doctor perspective, the doctor is getting partial information, from patient perspective, the patient is also getting a partial treatment.
409	Views communication/treatment limits as VCP's major flaw	P28, 5-6	So I think in terms of video, uh, video calls, I really feel like, uh, [the insufficient information and insufficient treatment] was the biggest drawback.
410	Sees need for detailed understanding in long-term therapy	P28, 13-15	you need a detailed one and very, uh, comprehensive, uh, thing if you're going for a long, long, uh, therapy sessions.
411	Emphasises the need for detailed observation in long-term therapy	P29, 3-5	You need to have a comprehensive look and comprehensive, uh, um, information. And if you have, if you want to, uh, you want to have a good gaze about that.
412	PET 3: Digitally disconnected - the unbridged gap between the therapist's perception and the participant's lived experience		
413	Online VCP misaligned with expectations and needs	P29, 9-11	I did feel that, um, it was not on the right course and, um, I feel, I felt that, uh, you know, it's getting, it's not on the line, not what I, I wanted and, uh, what I felt that it should be.
414	Misalignment and communication issues in VCP	P29, 13-15	we were not on the same page. Uh, so I thought that maybe there is a, a misinterpretation or misinformation or miscommunication.
415	Didn't receive the expected treatment in VCP	P30, 1-4	so that, uh, [the miscommunication] affected it a lot. Uh, and so, uh, there was, uh, not very, uh, I, I felt that, uh, it's not very, um, not what I wanted and not what that, uh, it is not, I'm not getting a treatment that, uh, that would benefit me.
416	Felt dismissed/misunderstood in VCP	P30, 8-14	I told her that, Look, my body is like, uh, it's totally dysmorphic, and, uh, uh, due to that, um, uh, I don't have friends and I don't have a, uh, yes, I'm socially secluded because of these things. So video wise, she's unable to look and she's unable to see these things. So she said that, No, no, you're okay, you're totally, uh, fine. Uh, this is just your, uh, uh, presumption and you have prejudice in your mind, you are just prejudiced.
417	Experienced communication gap with therapist	P31, 1-4	I felt that maybe she is not, uh, understanding or maybe there's some miscommunication or, uh, what I'm trying to say for her to be able to understand this. Uh, so, so what I was trying to convey to her, she was not, uh, receptive, receptive to that.

418	PET 4: Digital panopticon of VCP - scrutiny, support and evasion strategies		
419	Contrasting gazes: from the critical audience to the compassionate therapist		
420	Feels ashamed when looking at himself	P18, 1-3	Sometimes I do feel ashamed and, uh, I feel, um, you know, uh, little embarrassed, uh, seeing my body in that small window that because so much, so many people are watching you.
421	Highly conscious and aware of body and others' perceptions in work video calls	P18, 5-6; 8-9	I do feel very body conscious, body consciousness is very much present for me... So I'm, I become very conscious, very much about how am I looking, how they may, uh, you know, judge me or perceive me.
422	Boosted confidence and reduced self-consciousness in VCP	P18, 11-13; 15-16	but, uh, in the [therapy] sessions it is not like that, because I know that the other person is, uh, understanding, is, he has, uh, he is very much there to help me...so the body consciousness level, uh, you can say, uh, body, um, confidence level is, uh, high from that
423	High self-consciousness in work calls	P19, 6	My body conscious is, yeah, body consciousness is high in work calls.
424	Camera amplifies concerns about appearance and reactions (both work and VCP calls)	P19, 14-16; P20, 1-3	I look at both because, uh, in the small window I see how, how am I looking, how I, uh, if I'm not, I'm not looking too ugly, if I'm not looking too big. And uh, other people, yeah, I look at them. Uh, but um, I look at their reactions and they look at their, uh, their, um, you know, the emotions that they're showing, um, how they're perceiving me. I look at that also.
425	Not much focus on the little window in VCP	P31, 13-14	In therapy, um, in the little, I was, um, the focus was less on the little window.
426	Chose to focus on therapy content, not video	P32, 1-4	It was more on the, uh, on the therapy, uh, because, um, the main focus was just to get the treatment. Uh, you know, the focus was, the attention was on the other side, so, um, and also I didn't want to look in this small window to lose focus and restrict myself.
427	Heightened body consciousness video in work calls due to audience	P32, 14-16	more in work calls because other people are looking, a lot of people start, uh, looking at you when on the call, a lot of unknown people are looking at you.
428	Familiarity with therapist eases VCP	P33, 4-6	With the therapist, because I've seen the, I've seen them for a long period of time, so I just feel like it, just like it is, uh, familiar uh, um, you can say familiar. So it becomes easy for me.
429	Trust in therapy/ist enhanced openness in VCP	P16, 13-14	Because it has happened for a long period of time, the trust level is there so I have opened up a little bit.
430	Comfortably discussing history of BDD in therapy	P17, 5-8	Uh, yeah, talk about [body image] And, um, uh, you know, and also whatever questions they pose, I would be able to answer them. Uh, even if they want to ask some background questions, the history about that, I become comfortable opening about that.
431	Discussed camera concerns, advised to refocus	P34, 5-7	Um, I did, I did once I did uh, I had taken this, uh, issue to her once also, but, um, yeah, um, she was just, her main, her main advice was: Just distract yourself and refocus yourself.
432	Advised to ignore camera and focus on conversation	P34, 9-14	Focus on what you're trying to say and focus on, uh, to whom you're speaking. Don't look at yourself and don't look and don't perceive and don't be judgmental, uh, about how others are looking at you, how others are judging you. These were the tips, and these were the things she was trying to tell me when, uh, while uh, I was telling her about the camera related issues, the camera related body
433	Minimising the little window's intrusion		
434	Advice on managing camera was somewhat helpful	P35, 6-9	Yeah, it was okay. But, um, but I tried, um, uh, I particularly tried to distract myself and it helped me but, you know, you cannot hundred percent totally defocus and distract yourself. You have to see the other person and when you do that, you also see the small window.
435	Aware of digital format's practical	P35, 11-12	So because it's a, it is a digital thing. You have to, uh, otherwise it'll not work practically.
436	Positive experience in initial PCP	P24, 14-16; 25, 1-3	because I had one or two in person, so, and that therapist was very, uh, um, knowledgeable and he was very, uh, focused and very, uh, uh, patient-oriented, they got through what I was saying and what problem I had, and he, uh, yeah, I had a good, good time, uh, for one or two sessions. Then for, uh, uh, the rest sessions, the rest of the sessions was held online.
437	RACHEL		
438	PET 3: Uncertainty and unpredictability of VCP		
439	VCP being the only option then	P40, 3	Um, at that point, if I recall, I think that was the only option.
440	Unpredictability of support groups	P44, 7-8	Um, but you just don't know when one, when, when one's going to kind of slip through the net and trigger you, you just don't know.
441	Being able to divert one's gaze	P46, 11-14	So you can, you know, you can gaze off to the left or right, or either side of you, like you can move your eye, um, so you're not totally focused on that person or vice versa. So there's not much of that sort of head-on, face-to-face interaction? In person.
442	Consciously managing her physical presence in PCP	P47, 1-4	I think body language speaks a lot as well. Closed arms, sitting back, sitting forward, closed legs, cross armed, all these different things have an impact as well. And I could, I could do myself justice to appear smaller in person as well.
443	Unpredictability of impact of group advice	P43, 2-3	you don't know how that's gonna trigger you or if it's gonna be a trigger.
444	Unable to predict other's video behaviours	P61, 12-14	Um, but you never know you that obviously that's not an effective method because you don't know when everyone's gonna turn on their cameras [laughs].
445	Valuing adaptivity and control in PCP	P47, 12-15	you've got more, I guess, flexibility, fluidity, visibility, um, in changing and shaping who you are in that one given experience. When you're doing an in-person therapy session, you can change and change up your body language a bit more.
446	Technical issues are a huge distraction	P49, 10-12; 15	You know, um, and I also think the whole, you know, technical, like we are having now, but technical issues as well...Can, um, be a huge distraction for when one's having therapy.
447	Finds VCP distracting	P36, 12-13	it's one of those things where you get distracted as well when you're video conferencing
448	Difficulties maintaining focus and avoiding distractions	P50, 5-10	So having technical issues just longs that process, um, and interrupts that flow. So whereas when you are in person, you have that natural flow. If a bird noise comes in, you sort of laugh it off and continue. Um, you don't need to kind of come out and then go back into Teams. Like from a technical admin point of view, logistic point of view, it is a bit of a foe.
449	PET 4: Too much self-scrutiny and not enough intimacy in VCP		
450	Video gazing: the reflective intricacies of VCP		
451	Seeing herself on camera = mirror gazing	P40, 9-10; P41, 4-6	this is another way of mirror gazing you could say; So you can say it is like mirror gazing, but would you maybe, I don't know, there's a term for it, but video self, video gazing, I don't know. Um, but it's like that.
452	Contemplating what the therapist might be thinking about her appearance	P45, 7-11	what is she thinking about me and how I look and my appearance? Can she see a spot, oh no, she's seeing a spot. But then when I look into the mirror, the spot is not there or it's something else, or it's something bigger or the spot is there. So it is just ruminating of what other people think of me.
453	PCP is less confronting and less intense	P46, 7-8	just the position of chairs is important, you know, and having that not sort of, not that face-to-face, um, seating arrangement
454	Feeling the gaze of others	P60, 11	They're looking at me.
455	Heightened awareness of being scrutinised	P60, 15-16; P61, 1-2	So when you are the odd one out, when you're switching on later on in the call, that's when you feel it the most. You're thinking, Okay, I've just switched it on. They're now looking at me. I've now filled up that mosaic square
456	Highlighting the importance of body language and interactive tools in therapy	P48, 1-6	You can say a lot through your body language and the positioning of the cheers and your eye contact and gaze as well shifts. Um, and you've got other things to look at or worksheets, hard copy worksheets to look through together. You could be doing an exercise, a, um, a card game or something, um, that explores your BDD, that together, you know, there's lots of collaboration as well, which I like.
457	VCP lacking in intimacy		
458	PCT creates an intimate, one-on-one atmosphere	P46, 1-4	Um, if I think back to my in-person video, sorry, in person, um, therapy, you are on sofas. It is a quiet environment, you are in a room, door is closed. You are just, it's just you and therapist in front of you.
459	Highlighting the tactile and sensory aspects present in PCP	P48, 8-10	you've got that tangibility to things. Um, you've got that first-hand experience of tone and how that person's coming across and vice versa.
460	Feeling the limits of VCP	P49, 1-5	Um, the seating arrangement, um, you know, that one-to-one, um, Let's go through this worksheet together side by side, I'm right here, seated next to you. Um, let's play this game 'cause it will help with X, Y, and Z. Um, so video conferencing can only take you so far, or video therapy can only take you so, so far.
461	Highlighting VCP's easy accessibility	P3, 2-5	and how it's easily accessible by a click of a, you know, click of a mouse really, and having that therapist come to you as opposed to you going out of your own room or making that commute there.
462	VCP helps with managing BDD	P3, 9-11	Um, that social anxiety of just not wanting to leave or cannot leave your house for X and Y reasons. So, video conferencing has a lot of pros.
463	Reflecting on the novelty of VCP as a medium	P2, 11-12	the whole concept of video conferencing and doing therapy over video conferencing - it's a new medium for most.

464	PET 5: Looking for the "perfect" therapy		
465	Wishing for a personalised approach		
466	Experiencing distractions in VCP	P37, 10-13	Um, being online here. Um, yeah, mainly work calls, meetings, emails, notifications, popping up. Um, tabs being open, all these different behind the scenes, technical computer noises and things like that.
467	VCP having both pros and cons	P51, 1	it has, definitely has its pros and cons.
468	Supporting personalised approach		It could be something that could be a part or formulate part of the in-person, you know, subject to the person's needs. And it all goes down to the person's needs at the end of the day, right? You know, what do they prefer?
469	Preference for a hybrid approach	P4, 9-11	for me personally, I would love, say 80% of my the therapy to be in person, but then the rest supported through a means of Teams, video calls, and phone calls. You know, mixed mediums.
470	Needing a specialist	P55, 7-8	I don't want someone that's a jack of all trades. I really needed a specialist in, um, eating disorders and, um, BDD
471	Desiring a therapist who could relate to her background	P56, 5-9	In hindsight, I'm thinking maybe this might be something that for me to explore separately. But whether there would've been much benefit is it, if the individual looked like me. So from an ethnic minority background or understood my culture and identity and where I'm coming from.
472	Encouraging open discussion with therapist	P62, 16-63, 1-3	It's good to then, it is good to mention that, you know, to your therapist and, and say that to them, um, from the onset. Definitely. And say that obviously this is a, this is the area that I want to work on together with you
473	Desiring to have therapy with a specialist	P35, 1-2 & 4	there wasn't a specialist BDD therapist that I saw...This is something that I want to pursue now
474	Still searching for that "perfect" specialist	P36, 6-7	And still to this day, I guess I'm still trying to find that therapist.
475	Regretting not vocalising her needs	P38, 2-4	I feel as if I should have, um, voiced it as well in terms of taking ownership of what exactly, exactly do I really want to truthfully benefit from this.
476	Anticipating similarities between the VCP and prior experiences of CBT	P38, 8-11	I thought I've had CBT so many times, is it gonna be the same? And I had a bit of that experience with her, and I thought this sounds like it's gonna be the same. So it is just that, even that commitment.
477	Needing to vocalise her expectations for a beneficial therapeutic outcome	P38, 13-14	holding yourself accountable for that experience as well if it's not sitting right to vocalise it earlier on
478	Questioning her own motives	P56, 13-15	And I always question: Am I making excuses? Is it even down to that? Do I want to be helped? You know, I always, again, question myself.
479	Less committed to VCP but seeing it as a useful point of contact		
480	Having a preference for PCP	P36, 8-9	I still prefer the in-person contact
481	Functionality of VCP	P49, 7-9	It's still definitely a check-in, um, you know, a port of core, a point of, you know, contact with an individual
482	Putting in more effort for PCP	P36, 14-15	when you go to in-person therapy, you make that effort to commute, to make your way there.
483	Feeling a difference in commitment and effort	P37, 1-2	There's not that much of that self-drive and that self-commitment to it.
484	VCP not meeting her therapeutic needs or expectations	P37, 7	Um, it just didn't work for me, really.
485	Not investing 100% in VCP	P37, 16-P38, 1	I didn't give it a hundred percent commitment that it deserved
486	Feeling a lack of commitment on her part	P55, 4-5	I wasn't giving it justice. I wasn't committing myself fully, in all honesty.
487	PET 6: External expectations and internal hesitations in video calls		
488	External pressure to be seen		
489	Feeling slightly pressured to be seen in work calls	P58, 11-13	But with work-related meetings, you do have some pressure on you to have your camera switched on.
490	Feeling a gentle push to have camera on during training sessions	P59, 1-3	Um, even with sort of our training, um, and development sort of courses that we do as well, they encourage you, that's a word they use, <i>encourage</i> you to have your videos on.
491	Expectation to turn camera on when everyone else does	P59, 7-10	they say it's encouraged, but when you see the whole wide world in that room, you do feel that pressure on you to switch on. You do, um, without no fault of their own, you do feel that pressure inside you that, let me just hover over that camera icon and put myself on.
492	Grappling with the professional demand for visibility vs. personal preference/comfort	P60, 2-7	I work in a law firm, so there is that, uh, that, that pressure of, um, being, being seen, being heard and things like that, so it's that pressure. But then sometimes I think, No, I'm not going to switch it on. Like on one given day, it'll be like, for, for example, Friday afternoon, I'll be like, No, I don't really feel like switching my video on, you know.
493	Feeling relieved when others switch their cameras on simultaneously	P61, 8-10	It helps, like I said, when everybody else switches on at the same time, because then you're not alone. Everyone's in the same boat. Everyone's done it to a timed way [laughs gently].
494	Acknowledging the importance of visibility in VCP	P62, 9-11	to build up that relationship, if it's gonna be long-term psychotherapy, whatever it is, they need to see you, they need to see you, who you are as a person
495	Changing behaviour based on context	P57, 6-5, 9-11	I think with the video in general, it depends on the purpose of having yourself on video...So take for example, work: in a work capacity, [Rachel] at work will have different video behaviour to say [Rachel] not in a non-work capacity.
496	Depends on reasons for having camera on	P58, 1-3	So I guess it really depends on the context - the person, the people in the room, virtual room, the per, um, the, the reason as to why we should have our cameras on, um, yeah.
497	Internal response to being seen		
498	Fixating on external judgment	P45, 10-13	it is just ruminating of what other people think of me. Like I would hold their opinions and thoughts much more important, importantly, and they are of value to me as opposed to my own.
499	Heightened sensitivity to physical features and their perception	P41, 1-2	Gosh, my, the width of my shoulders are the same width as that video box on Zoom, for example.
500	Desire to look more presentable	P64, 13-15-65, 1	I was thinking maybe we could have scheduled in the call tomorrow because I'll be in the office tomorrow and I will appear a little bit more, um, how can I say this a little bit more, um, you know, with makeup and a little bit more fresh, shall I, shall I say?
501	Putting more effort into her appearance at work	P65, 8-9	obviously when you're in the office you put more effort in how you look like outfit and things like that [laughs].
502	Meticalous about capturing a favourable image	P19, 5-6	Certain angles have to always take a lot of photos to get the right one eventually. And always checking, uh, when other people are taking photos of me, to check in to see myself there.

Appendix P

Translating PETs into GETs

1	Table of PETs - no quotes		
2	ELLA		
3	PET 3: Unseen struggles - the quest for visibility and validation in VCP		
4	Lacking validation of inner struggles		
5	Forced to accept that maybe there are no imperfections		
6	PET 4: Striving for authenticity in a new normal		
7	Accepting VCP as the only option		
8	Not experiencing VCP as any less effective than PCP		
9	PET 5: Mirror of vulnerability		
10	Uncomfortable vulnerability		
11	Adapting to video calls		
12	PET 6: VCP allowing for hidden looking		
13	PET 7: Achieving connection despite therapy being on video		
14	Experienced challenges building therapeutic connection online		
15	Developed a strong therapeutic bond online		
16	PET 8: The real progress happens beyond therapy		
17	Taking her mental health in her own hands		
18	Applying what she learned in therapy in everyday life		
20	CHARLOTTE		
21	PET 3: From not feeling secure in the digital environment to safe therapy alternative		
22	Anxiety developed from work calls: lack of control and distraction		
23	Digital doubts: approaching VCP with scepticism		
24	VCP was not as bad as anticipated		
25	VCP as an alternative to "normal" therapy		
26	PET 4: Virtual mirror - self-perception in the lens of VCP		
27	From initial self-consciousness and comparisons to focus on content		
28	If it's not recorded, it didn't happen		
29	PET 5: Online therapy's casual pitfall		
30	Preferring PCP's more formal structure		
31	Finding VCP's flexibility to be unhelpful		

33	DEAN
34	PET 2: Ease in familiarity: the comforting embrace of VCP
35	PET 3: Reflected discomfort
36	Drowning in trying to adjust details
37	Experience dictated by where he is trying to direct his attention (discomfort is variable/not constant)
38	PET 4: Seeking connection, facing dissatisfaction
39	Striving for connection and understanding
40	Challenges and dissatisfaction in therapy regardless of format
41	PET 5: Clarity and presence: the foundations of understanding and perception in VCP
42	Visibility for verity: the need for physical presence to foster understanding in therapy
43	Distorted signals: the impact of technical Issues on perception in VCP
45	YASMIN
46	PET 2: VCP - mastering control with flexible approach
47	Convenience and flexibility of VCP
48	Feeling control over her appearance in VCP
49	PET 3: Virtual curtains - VCP allowing for privacy and concealment
50	Feels less seen in VCP
51	Personal processing of BID struggles
52	PET 4: From self-consciousness to full engagement in therapy
53	VCP: a dual lens of self-scrutiny and comparative analysis
54	Evolving comfort in VCP
55	PET 5: Boxed intimacy: connection without physical reality
56	Sense of intimacy fostered by the confined space of a video call
57	The sensory richness and perceived authenticity of PCP
58	PET 6: Embracing therapy

60	SARAH
61	PET 1: Disparity between natural and altered image
62	PET 2: VCP is like therapy with a mirror
63	PET 3: Unspoken troubles - private processing of discomfort in VCP
64	PET 4: More intense stare but less real connection
65	All focus on her - feeling the pressure of the gaze
66	VCP is less real, less normal, less human
67	PET 5: Feeling less secure in the online relationship
69	KEVIN
70	PET 2: The paradox of presence and absence in VCP
71	VCP enabling face-to-face interaction despite geographical separation
72	Lack of holistic visibility in VCP = lack of understanding
	PET 3: Digitally disconnected - the unbridged gap between the therapist's perception and the
73	participant's lived experience
74	PET 4: Digital panopticon of VCP - scrutiny, support and evasion strategies
75	Contrasting gazes: from the critical audience to the compassionate therapist
76	Minimising the little window's intrusion
78	RACHEL
79	PET 3: Uncertainty and unpredictability of VCP
80	PET 4: Too much self-scrutiny and not enough intimacy in VCP
81	Video gazing: the reflective intricacies of VCP
82	VCP lacking in intimacy
83	PET 5: Looking for the "perfect" therapy
84	Wishing for a personalised approach
85	Less committed to VCP but seeing it as a useful point of contact
86	PET 6: External expectations and internal hesitations in video calls
87	External pressure to be seen
88	Internal response to being seen

PET 3: Unseen struggles - the quest for visibility and validation in VCP	Keywords: realness, bodily presence, visibility
PET 4: Striving for authenticity in a new normal	GET 1: Digital embodiment is not real embodiment/ VCP is more intense and intimate but less real
PET 7: Achieving connection despite therapy being on video	
PET 3: From not feeling secure in the digital environment to safe therapy alternative	
PET 4: Seeking connection, facing dissatisfaction	
PET 5: Clarity and presence: the foundations of understanding and perception in VCP	
PET 5: Boxed intimacy: connection without physical reality	
PET 1: Disparity between natural and altered image	
PET 4: More intense stare but less real connection	
PET 2: The paradox of presence and absence in VCP	
PET 3: Digitally disconnected - the unbridged gap between the therapist's perception and the participant's lived experience	
PET 5: Looking for the "perfect" therapy	
PET 4: Too much self-scrutiny and not enough intimacy in VCP	
PET 3: From not feeling secure in the digital environment to safe therapy alternative	Keywords: uncertainty/insecurity and power/control
PET 6: VCP allowing for hidden looking	GET 2: Control vs. uncertainty
PET 2: Ease in familiarity: the comforting embrace of VCP	
PET 2: VCP - mastering control with flexible approach	
PET 3: Virtual curtains - VCP allowing for privacy and concealment	
PET 5: Feeling less secure in the online relationship	
PET 3: Uncertainty and unpredictability of VCP	
PET 5: Mirror of vulnerability	Keywords: mirror, self-consciousness and discomfort
PET 3: From not feeling secure in the digital environment to safe therapy alternative	GET 3: Reflective discomfort
PET 3: Reflected discomfort	
PET 4: From self-consciousness to full engagement in therapy	
PET 2: VCP is like therapy with a mirror	
PET 4: Digital panopticon of VCP - scrutiny, support and evasion strategies	
PET 4: Too much self-scrutiny and not enough intimacy in VCP	
*PET 3: From not feeling secure in the digital environment to safe therapy alternative - renamed as: From camera anxiety to safe therapy alternative	

Appendix Q

Initial Master Table of GETs

1	Master Table of GETs - First Draft	
2	GET 1: Digital embodiment is not real embodiment/ VCP is more intense and intimate but less real	
3	PET 3 Ella: Unseen struggles - the quest for visibility and validation in VCP	"I'd have like one [spot] here and one here, that'd be it. But it would, they would be the worst thing in the world to me at the time. Um, and I felt like I couldn't really see [the odd spots] on Teams. So for me, I felt even sillier sitting there and telling my therapist that that's what I was worrying about." (Ella, P31, 13-16)
4		"Um, whereas, yeah, I think with therapy it was that, it was that I almost didn't, in the beginning, I wanted her to be able to see what I was talking about." (Ella, P35, 5-7)
5		"But I at least think I would've thought, or she can see my face, she can see how it properly is and she's not gonna think I'm crazy. Whereas I really struggled throughout the whole time, to be honest, with her, me, me thinking that she thinks I'm imagining this stuff on my face." (Ella, P32, 7-10)
6		"Um, but in the end I think I just learned to accept it and have to trust that actually maybe there wasn't a lot there to begin with, you know?... So it then became more of a well, I'm, I'm still seeing people every day and day-to-day life, and they're not saying anything. And my boyfriend is constantly saying there's nothing on my face... My mum's telling me there's nothing there. So actually maybe even if she was face to face, she, she still might not be able to see anything." Ella, P33, 9-11; 13-15; P34, 1-2)
7	PET 4 Ella: Striving for authenticity in a new normal	"personally, I feel like therapy would be more effective if you were sitting in the same room with that person in terms of making the connection with your therapist and them being able to convey empathy, you being able to feel it back, um, those kind of things." (Ella, P38, 10-14)
8		"I don't, I don't feel like, I don't feel like my therapy wasn't effective or was less effective." (Ella, P39, 5-6)
9	PET 3 Charlotte: From camera anxiety to safe therapy alternative	"[VCP is] not a substitute for being with the person, but it can feel normal, I guess, maybe." (Charlotte, P40, 2-3)
10		"I'm imagining you are not, you are actually there and I feel a bit more relaxed because I'm imagining you're actually in the room and I'm talking to you rather than looking at you." (Charlotte, P40, 5-8)
11	PET 4 Dean: Seeking connection, facing dissatisfaction	"it's that little voice in the back of my head. Um, you know, and anyone that would see me would probably not agree in any way, shape, or form. But, you know, it's only me that can kind of notices it, you know?" (Dean, P4, 3-6)
12		"I guess the video therapy, um, maybe in my head I was trying to kind of emphasise certain things to see if the, uh, therapist would pick up on it." (Dean, P18, 13-15)
13		"Um, well that's, um, 'cause I guess I was trying to kind of make a point of it that almost, you know, like I was overemphasising a little bit and, um, I didn't really have the opportunity to discuss it, to be honest." (Dean, P41, 1-3).
14		"I had a, well just one therapy session, um, with the university therapist, uh, and, um, again, very like, dissatisfied. Um, I felt like, um, again, they just seemed like even though it was in person, it was face-to-face, um, I didn't really feel like they were paying that much attention to what I was talking about." (Dean, P26, 11-15)
15	PET 5 Dean: Clarity and presence: the foundations of understanding and perception in VCP	"I feel like the therapist is able to, uh, understand someone a lot more personally, um, with actual sort of face-to-face interaction." (Dean, P46, 7-8)
16		"I guess, 'cause it's not in person, um, you know, I guess a lot of, I'm assuming, I guess in therapy sessions, the therapist would be, um, picking up on body language...And like video therapy, I, it might be a bit different these days with the better technology and stuff like that, you know, clearer cameras, but how are they really going to judge, um, sort of situations like that where they can only see a tiny portion of you, an odd box?" (Dean, P20, 3-5; 7-10)
17		"Um, I guess it was, uh, just a bit of a, a strange feeling to be honest. 'Cause um, a part of me was thinking how are they, uh, really kind of getting to know me when it's just on a, a screen, if you know what I mean? (Dean, P32, 6-9)."
18		"and the sort of lack of eye contact, you know, that's always an interesting one. Uh, it's, yeah, it's just a bit strange. Um, you feel like you're not, either not being listened to or, um, I dunno, just you're not sort of, I guess you're kind of putting a bit of a mental block on what you're actually trying to say in a sense." (Dean, P46, 13-16-P47, 1-2)

19		"...I guess the lack of face-to-face interaction, you know, you can't really look someone in the eye. Um, it's, uh, it's just a strange way of having a very, very personal conversation." (Dean, P24, 9-11)
20		"Um, and there was a degree of frustration. And I think they even mentioned at one point, uh, You seem like you're getting, um, you know, You seem, you are working yourself up. I'm like, No, I'm just trying to [laughs], trying to, trying to speak and I can't." (Dean, P33, 5-8).
21		"I was concerned that they were gonna make kind of like, almost like a false diagnosis, if you know what I mean... Um, uh, I wasn't there for, for, for anger issues or anything like that, and I was kind of paranoid like, Oh, how am I coming across? Are they, they're seeing me getting a bit worked up and they're gonna think that I'm a very stressed out, anxious person, which is gonna affect how this is gonna conclude." (Dean, P34, 3-4; 6-10).
22	PET 5 Yasmin: Boxed intimacy: connection without physical reality	Oh, I think that's where the, um, in-person therapy, I would, it would make me very uncomfortable because I'm looking, like I can touch the person, I can look at them in the eye and be like, it just feels more real." (Yasmin, P22, 14-16)
23		"So the difference is for me, like, and the, in the real word it's like you can touch people, and I look at them in their eyes, like the eyes are more visible, and you can see, you can like, you can see like their real skin colours, like their veins, you know, like their real person, you know, but you can't see that in a virtual interview call." (Yasmin, P26, 5-9)
24		"So, so even though, uh, like virtual interviews calls are more intimate it doesn't feel as real as, you know, when you go to an in-person therapy." (Yasmin, P26, 13-14).
25		"So I would compare myself to every woman, to be honest with you, but in therapy, you know, you do compare, you compare yourself with another box because it's one box versus another box." (Yasmin, P30, 10-12)
26		"It's more intimate because your whole space is in a box, you know? You're staring at another box as well... So that's why it's more intimate. It's like face-to-face, eye-to-eye, you know?." (Yasmin, P27, 1-2; 4-5)
27	PET 1 Sarah: Disparity between natural and altered image	"it's like a nicer version of myself, like a slightly, uh, smooth, smooth version with like a smooth skin. And, uh, I liked it. It was not my plan to do it, but when I saw it's an option, I liked the idea of appearing better looking." (Sarah, P24, 7-10)
28	PET 4 Sarah: More intense stare but less real connection	"I think, uh, one thing that comes to my mind, uh, what is missing is the sense of a shared reality, shared space. I don't know where this person is. I don't know their surroundings and not that I'm paranoia, paranoid about who's around, but I don't know this as well. Uh, basically you are somewhere far away, and we are not sharing, we're not breathing the same air. We are not sharing the same space. We're not maybe even sharing being in the same country or in the same city. Um, it creates extra layer of a distance, I would say. And for me, uh, it's important to feel this proximity in order to feel this connection." (Sarah, P18, 3-11)
29		"You can definitely sit very close to a person and be totally disconnected, I'm aware of it, but I think it's an additional layer. If we are sharing the same space and we can see each other in full experience and we can share this, um, I don't know what can be, uh, a good description. If we are breathing the same air, it kind of helps a bit. It's not a guarantee that we are going to connect, but it's a factor." (Sarah, P19, 5-10)
30		"the experience of face-to-face interactions has more quality in it." (Sarah, P32, 2)
31		[lack of physical proximity] creates an extra layer of distance. It creates this obstacle on the way to connection. (Sarah, P19, 1-2)
32		"...when you strive to get this connection, when you strive to be fully heard, seen and understood, then it's important, the quality of work, of communication, and I think the quality of communication online, remotely, is not the same as in person (Sarah, P23, 12-15)
33		"With a therapist, it's very different because therapist is there to give you their full attention. And, uh, it would be very unlikely the therapist would be sitting there looking around or taking their own notes and doing whatever comes to them. So I feel like in therapy sessions, it is exaggerated, this issue." (Sarah, P9, 3-7)
34		"And you know, in real life, when you go to the clinic, to the office of the therapist, they see you in 3D and it's less staring in your face." (Sarah, P2, 13-15)
35		"It's the whole experience of somebody's presence, their way of being, their, seeing somebody in 3D, you know, and uh, I, I don't know what we can call it. Maybe somebody's energy? You cannot feel it from the screen... I don't know if that is the right word, but somebody's presence, their way of being, you can only see it when you meet with the person. Online it's very restrictive, you're limited to certain things." (Sarah, P17, 1-8)
36		"there is no eye contact, it's just this, um, weird feeling of, um, somebody looking at you, but as if they're looking through you." (Sarah, P20, 11-13)
37		"on the screen, there is no eye contact, so you don't really, I don't know where you look now, you probably try to look at my face, but it doesn't, it doesn't feel that way. We don't know where we look. We try to get the eye contact through the video call. But we're just staring at some dot on the screen, so it is not really eye contact." (Sarah, P20, 3-8).
38		"I find it less uncomfortable, less intimidating and more normal, if you like, more human." (Sarah, P21, 4-8).

39	PET 4 Rachel: Too much self-scrutiny and not enough intimacy in VCP	"You can say a lot through your body language and the positioning of the cheers and your eye contact and gaze as well shifts. Um, and you've got other things to look at or worksheets, hard copy worksheets to look through together. You could be doing an exercise, a, um, a card game or something, um, that explores your BDD, that together, you know, there's lots of collaboration as well, which I like." (Rachel, P48, 1-6)
40		"you've got that tangibility to things. Um, you've got that first-hand experience of tone and how that person's coming across and vice versa. From a video perspective, you don't, you don't get all of that." (Rachel, P48, 8-11)
41		"But I think video is good, but you are missing out on all those points that I've mentioned, um, isn't it? You are missing out on that, that just that seat direction. Um, the seating arrangement, um, you know, that one-to-one, um, Let's go through this worksheet together side by side, I'm right here, seated next to you. Um, let's play this game 'cause it will help with X, Y, and Z. Um, so video conferencing can only take you so far, or video therapy can only take you so, so far." (Rachel P48, 15-16-P49, 1-5)
42		"and how it's easily accessible by a click of a, you know, click of a mouse really, and having that therapist come to you as opposed to you going out of your own room or making that commute there" (Rachel, P3, 2-5)
43	PET 5 Rachel: Looking for the "perfect" therapy	"And I always question: Am I making excuses? Is it even down to that? Do I want to be helped? You know, I always, again, question myself." (Rachel, P42, 7-9)
44	PET 2 Kevin: The paradox of presence and absence in VCP	"Video therapy, I do think that, uh, it's good for, um, uh, for for a person who is, uh, uh, accessing from a remote place or, uh, who does not have access to, uh, a psychologist in a hospital. But I do feel that it, it has limitations, uh, on their part" (Kevin, P20, 15-16-P21, 1-2).
45		"the feel and the, the personalisation and the, uh, you know, the one-to-one contact you have, uh, personally, uh, I don't feel on, uh, videos" (Kevin, P21, 4-6).
46		"So video wise, they, they're not seeing that the body is dysmorphic." (Kevin, P23, 7).
47		"...you know, uh, the therapist can see you, uh, he can observe you, uh, in person. In person, I'm talking about. He can observe you and he can, uh, see your emotions and he can see your, uh, body language, your face. Uh, he can observe you much closer and much deeper and, um, get a better understand, better understanding of you." (Kevin, P22, 1-6)
48		"maybe a 360-degree view, just like you have a Google view, uh, on the, you can take a 360-degree view of a streets...So just like that, you can, you can take a 360-degree view of, uh, you know, the body structure, you know, the the body dysmorphia. Uh, you can just like, just to have a glance and just to have a picture of, uh, the patient of, uh, always, uh, how is, uh, how it is. Also in case of obese patients also, who are diagnosed with obesity, I think it
49	PET 7 Ella: Achieving connection despite therapy being on video	"it was quite sort of scary to say goodbye and to, to chill." (Ella, P55, 2)
50		"I felt very sort of close to her actually by the end of it. I felt very much like we had that unique sort of shared bond that you would only get with a therapist." (Ella, P54, 13-16)
51	PET 3 Kevin: Digitally disconnected - the unbridged gap between the therapist's perception and the participant's lived experience	"I told her that, Look, my body is like, uh, it's totally dysmorphic, and, uh, uh, due to that, um, uh, I don't have friends and I don't have a, uh, yes, I'm socially secluded because of these things. So video wise, she's unable to look and she's unable to see these things. So she said that, No, no, you're okay, you're totally, uh, fine. Uh, this is just your, uh, uh, presumption and you have prejudice in your mind, you are just prejudiced." (P30, 8-14)

GET 2: Control vs. uncertainty		
52	PET 3 Charlotte: From camera anxiety to safe therapy alternative	"...I definitely think that that amount of video calls probably was detrimental to my mental health [laughs] 'cause it was not helping anyway." (Charlotte, P24, 16-P25, 1)
53		"I just felt this, really kind of lack of control and like, I wish I could sort of, I wish I could just zone it out, really tune it out...I just like, I feel like I just don't know how I'm coming across and all these things just feed into it." (Charlotte, P26, 13-15-P27, 1)
54		Um, I think I find the work calls maybe harder. Maybe there's more expectation and maybe 'cause it's not a safe space, probably it's not a space where I could, you know, it's a, it's a hidden thing for me, how I feel. I'm just in my head and I'm alone with it. (Charlotte, 45, 13-16)
55		"...I know I can do it* [laughs] and I know it's not always, um, gonna make me feel awful, but it's just the unknowing, so I just don't know sometimes. I guess it depends on who you're with as well and how relaxed you feel with that person." (Charlotte, P29, 1-4) *VCP
56		"... I recorded the Zoom call and watched that back and that was a big, big mistake [laughs]. Cause you know, you're like, oh my God, my face moves in a strange way and stuff. Really bizarre. I think it all comes down to just not being here. Like, I don't know what I look like, really, if that makes sense. 'Cause you sort of get a sense of what you look like from your, from pictures of yourself. But pictures are quite different to, you know, I can't step outside myself and, you know, see myself how other people see me." (Charlotte, P26, 3-10).
57	PET 6 Ella: VCP allowing for hidden looking	"...I don't think I'd have been able to do as well in real life without looking like I'm staring at her all the time, is that I could look at her skin quite a bit and it wasn't obvious." (Ella, P46, 3-6)
58		"Um, so yes, since that was something else that, like, in real life, I, I knew at the time that I couldn't just stare at people and look at their skin as much as I wanted to, cuz it would, it would look weird." (Ella, P46, 12-14)
59		"I remember actually, um, focusing quite a bit on what she looked like as well" (Ella, P44, 7-8)
60		"So anyway, I was constantly looking at other people's skin and I would look at her skin a lot during the sessions..." (Ella, P45, 10-12)
61	PET 2 Dean: Ease in familiarity: the comforting embrace of VCP	"Um, potentially distracting?... Yeah. Quite distracting. Quite like it in, it instantly, um, puts you in the space of, I'm like, that was a form of me preoccupying about my skin" (Ella, P47, 3; 5-7).
62		"Um, I guess, um, you're just kind of thinking about what is going to happen. You know, the same as if you were to go for a check-up or something like that at a hospital, you know, or you're waiting for a result, something like that, you know. It's this sort of just feeling of like, Oh God, what, what could happen? You know, you, you end up thinking about the worst-case scenario." (Dean, P29, 8-13)
63	PET 2 Yasmin: VCP - mastering control with flexible approach	"if I walked into like an office, I would have to shake their hands and touch them. And then also, um, I would feel they wouldn't see my, uh, they would see my stomach area. But if I'm in a, um, video call, I can always hide that, for example [laughs gently]. You can also add filters if you don't like the way that you look on videos, um, so, you know, I adjust, the lighting, for instance. So you're in control when it's online. But when you go into an office, you're not in control." (Yasmin, P13, 8-15)
64		"they might, you know, look at your whole body rather than just one section that you're choosing, for sure." (Yasmin, P23, 8-9)
65		"[I felt insecure] in the beginning [when the therapist was looking at me], but that's just the norm. Like I do that with a lot of people. I'd rather have that than...You know, going into her actual office and her seeing my whole body, for instance, you know, at least I can think, I can be in control." (Yasmin, P16, 8-11)
66		Yeah, I'm, I'm hiding my stomach, you know. I'm, I'm in my own safe area." (Yasmin 29, 7-8)
67		
68	PET 3 Yasmin: Virtual curtains - VCP allowing for privacy and concealment	"Yeah, because in virtual therapy, I'm just showing my face. But when you're walking into in-person therapy, they see how you talk to other people, uh, how you, how you use your hands, uh, your body language, your full body. And like I said, they will see the flaw that I hate about myself, which is, uh, my stomach area." (Yasmin, P23, 12-16)
69		"...I don't want people to see me if I go into a, a therapist's office. It's more private." (Yasmin, P15, 2-3)
70	PET 5 Sarah: Feeling less secure in the online relationship	"I don't want her to think that, you know, I'm staring at myself in the mirror and I'm not paying attention, not the mirror, I mean the camera, the box, looking at myself and not focusing on the conversation, she would think it's rude if I was staring at myself the whole time" (Yasmin, P21, 7-11)
71		"...privacy is an important matter to me. Where I originally come from, therapy is still very taboo" (Yasmin, P15, 5-6)
72		"...I try to think more about it, um, it, when somebody can kind of get rid of you by just, uh, clicking like stop or leave the meeting, um, it's not the same experience as somebody being next to you. It feels as if you can be dismissed easier...Not that my therapist ever did something like that, and I trust my therapist, but, um, the whole idea that, uh, um, like separating from you or getting rid of you is one click away. Um, it's also not a very pleasant thought now when I'm reflecting on it. Um, and also, we rely on internet connection. It just doesn't feel like as stable and safe as a face-to-face experience." (Sarah, P30, 6-16)
73	PET 3 Rachel: Uncertainty and unpredictability of VCP	"I think body language speaks a lot as well. Closed arms, sitting back, sitting forward, closed legs, cross armed, all these different things have an impact as well. And I could, I could do myself justice to appear smaller in person as well. So the, the therapist will then probably, I'll probably communicate this to her definitely in the session in per, if it was in person, but I'll tell her, Look, I'm now purposely closing myself or making myself appear smaller. Do I look smaller? I'll probably ask that question to her, a rhetorical question: Do I appear smaller?...Um, obviously I don't know what the answer would be to that, but you've got more, I guess, flexibility, fluidity, visibility, um, in changing and shaping who you are in that one given experience. When you're doing an in-person therapy session, you can change and change up your body language a bit more." (Rachel, P47, 1-9; 11-15).
74		"You know, um, and I also think the whole, you know, technical, like we are having now, but technical issues as well...Can, um, be a huge distraction for when one's having therapy." (Rachel, P49, 10-12; 15)
75		"So having technical issues just longs that process, um, and interrupts that flow. So whereas when you are in person, you have that natural flow. If a bird noise comes in, you sort of laugh it off and continue. Um, you don't need to kind of come out and then go back into Teams. Like from a technical admin point of view, logistic point of view, it is a bit of a foe." (Rachel, P50, 5-10)

GET 3: Reflective discomfort		
76	PET 5 Ella: Mirror of vulnerability	"It's not very often in real life that you are hold somebody's holding up a mirror in front of you effectively whilst you are at your most vulnerable or doing your crying with your nose streaming and tears rolling down your face and you, you are all red and blotchy and whatever. Um, that's very unusual [laughs], you know what I mean?"
77		"It's interesting cuz even just as you asked that question and said the words was about being seen, like my stomach did a bit of a flip." (Ella, P16, 5-6)
78		"Um, and when I was sort of free just going into therapy really, um, I was checking so often that it was quite strange to then sort of explain to my therapist that I also hate looking at my reflection [laughs]." (Ella, 23, 14-16)
79		"...it was to do with lines and texture and, um, I never really had acne, but like spots, just like the odd spot." (Ella, P31, 10-11)
80		"Um, I wonder whether I was maybe quicker to gather myself, get a tissue, sort my face out, having such an obvious visual thing in front of me of what I look like. So yes, I do feel like it was at times, yeah maybe a bit of a barrier in terms of being seen in that way." (Ella, P42, 9-14).
81	PET 4 Charlotte: Virtual mirror - self-perception in the lens of VCP	"Online you are being reflected back all the time. I guess the video screen is a bit like a mirror, really." (Charlotte, P47, 5-6)
82		"I suppose I kind of would, there would be some comparative, like probably to like, thinking of how I look in relation to her, maybe?" (Charlotte, P43, 3-5).
83		"I'm looking down a bit to see myself, but I'm not kind of, it's not triggering anything for me right now." (Charlotte, P28, 13-14)
84		"I'd find it harder if it was recorded and I had to watch it back." (Charlotte, P52, 14)
85	PET 3 Charlotte: From camera anxiety to safe therapy alternative	"...I thought, no, I can't do it if it's online cause I can't see myself when I'm doing it, and it won't, it won't work for me." (Charlotte, P22, 3-4)
86		"I always felt quite relaxed with her and um, so it always felt okay actually." (Charlotte, P29, 6-7)
87	PET 3 Dean: Reflected discomfort	"Um, no, I mean I kept kind of, um, it sounds strange, but uh, I dunno, when you see yourself talking, um, 'cause obviously that's something you never really kind of see, you don't look in a mirror and kind of talk to yourself ... Well, I don't anyway. And part of me is thinking, Oh God, is that, is that what I look like when I'm talking? Is that how my face goes when I'm, when I'm speaking? Um, and that led me kind of feeling even more sort of uncomfortable...And I guess that sort of ties in with the body dis, body image dissatisfaction, you know, I'm looking at strange aspects now, you know, going deeper. Um, you know, and then almost trying to alter how I'm, how I'm moving my mouth, in, in, in a sense" (Dean, P35, 11-15-P36, 1-2; P36, 4-7)
88		"And, and suddenly it's way too much to, um, to really sort of answer the, the question or think about what you're meaning to say...Yeah, I mean, um, if I had the opportunity to, I would probably turn the camera off if I didn't, if it wasn't necessary." (Dean, P37, 1-2; 5-6)
89		
90	PET 4 Yasmin: From self-consciousness to full engagement in therapy	"Um, so I thought, when I look at myself in a box, I just try to look at the flaw that is in my face rather than the best part of my face. And then I just imagine that this is how people look at me, you know, I just imagine Okay, this is how I look like in real life, I guess, you know?" (Yasmin, P28, 8-11)
91		"I just feel like, um, I don't know, like, my, my face looks bigger maybe in a, in a box, but when you look at yourself in a mirror, like, it looks smaller, your, your face looks smaller." (Yasmin, P29, 2-4)
92	PET 3: Unspoken troubles - private processing of discomfort in VCP	"I'm paying for the, for the therapy. I have one hour. I can't be wasting the whole time just looking at myself" (Yasmin, P19, 4-5)
93		"Um, just in the beginning I get distracted, like I don't really focus on the actual serious conversation, that she's trying to help me, but then the more exercises we do, the more like I feel like they are helpful, then I take the therapy more seriously and I stop saying that to myself." (Yasmin, P31, 5-8)
94		"And I started thinking, How is it for the therapist on the other end? Because they see this big image and it's quite intimidating, you can see all the traits and features." (Sarah, P2, 11-13).
95	PET 2 Sarah: VCP is like therapy with a mirror	"You would see yourself on the screen and this, uh, this is like having therapy with a mirror there." (Sarah, P12, 3-4)
96		"...instead of seeing the therapist big on the screen and myself like in the small window, for some reason I saw myself big and the therapist smaller." (Sarah, P12, 14-15-P13, 1)
97	PET 4: Digital panopticon of VCP - scrutiny, support and evasion strategies	"In therapy, um, in the little, I was, um, the focus was less on the little window." (Kevin, P31, 13-14).
98	PET 4 Rachel: VCP is either too much or too little VCP	"Ah yes, that is a good point. Um, that's another thing, um, to add into the mix [laughs gently]. You know, people when they see themselves this is another way of mirror gazing you could say is, um, how you appear on video, you know. How you appear even on this photo here of me. Um, you know, I would always go out my way to find something negative or something that just doesn't sit right, and I fear that other people are seeing me in a different way or the lighting's not right. Um, or they notice something in, on my face or, um, on my shoulder, whatever it may be. Or, you know, Gosh, my, the width of my shoulders are the same width as that video box on Zoom, for example. It's like all these things that you think about (P40, 8-16-P41, 1-2)... So you can say it is like mirror gazing, but would you maybe, I don't know, there's a term for it, but video self, video gazing, I don't know. Um, but it's like that. Yeah, it's real. It happens" (Rachel, P41, 4-6)

Appendix R

Final Master Table of GETs

1	Master Table of GETs
2	GET 1: Absence of the (Whole) Physical Body
3	Sub-theme 2: Physical Presence vs. Digital Distance
4	"you've got that tangibility to things. Um, you've got that first-hand experience of tone and how that person's coming across and vice versa. From a video perspective, you don't, you don't get all of that." (Rachel, P48, 8-11)
5	"Oh, I think that's where the, um, in-person therapy, I would, it would make me very uncomfortable because I'm looking, like I can touch the person, I can look at them in the eye and be like, it just feels more real. (Yasmin, P22, 14-16)
6	"personally, I feel like therapy would be more effective if you were sitting in the same room with that person in terms of making the connection with your therapist and them being able to convey empathy, you being able to feel it back, um, those kind of things." (Ella, P38, 10-14)
7	"Um, but I don't, I don't feel like, I don't feel like my therapy wasn't effective or was less effective." (Ella, P39, 5-6)
8	"I felt very sort of close to her actually by the end of it. I felt very much like we had that unique sort of shared bond that you would only get with a therapist." (Ella, P54, 13-16)
9	"I don't know if that is the right word, but somebody's presence, their way of being, you can only see it when you meet with the person. Online it's very restrictive, you're limited to certain things. And not only because I see now only your face, even if you stand up and they see your body, it still would not be the same." (Sarah, P17, 6-10)
10	"I think, uh, one thing that comes to my mind, uh, what is missing is the sense of a shared reality, shared space. I don't know where this person is. I don't know their surroundings and not that I'm paranoia, paranoid about who's around, but I don't know this as well. Uh, basically you are somewhere far away, and we are not sharing, we're not breathing the same air. We are not sharing the same space. We're not maybe even sharing being in the same country or in the same city. Um, it creates extra layer of a distance, I would say. And for me, uh, it's important to feel this proximity in order to feel this connection." (Sarah, P18, 3-11)
11	"You can definitely sit very close to a person and be totally disconnected, I'm aware of it, but I think it's an additional layer. If we are sharing the same space and we can see each other in full experience and we can share this, um, I don't know what can be, uh, a good description. If we are breathing the same air, it kind of helps a bit. It's not a guarantee that we are going to connect, but it's a factor." (Sarah, P19, 5-10)
12	Oh, I think that's where the, um, in-person therapy, I would, it would make me very uncomfortable because I'm looking, like I can touch the person, I can look at them in the eye and be like, it just feels more real. (Yasmin, P22, 14-16)
13	It's more intimate because your whole space is in a box, you know? You're staring at another box as well...So that's why it's more intimate. It's like face-to-face, eye-to-eye, you know? (Yasmin, P27, 1-2; 4-5)

14	Sub-theme 2: Challenges in Conveying BID in VCP
15	"maybe a 360-degree view, just like you have a Google view, uh, on the, you can take a 360-degree view of a streets...So just like that, you can, you can take a 360-degree view of, uh, you know, the body structure, you know, the the body dysmorphia. Uh, you can just like, just to have a glance and just to have a picture of, uh, the patient of, uh, always, uh, how is, uh, how it is. Also in case of obese patients also, who are diagnosed with obesity, I think it would be helpful with them also" (Kevin, P36, 15-16; P37, 2-7)
16	"And you know, in real life, when you go to the clinic, to the office of the therapist, they see you in 3D and it's less staring in your face." (Sarah, P2, 13-15)
17	"So video wise, they, they're not seeing that the body is dysmorphic...Yeah. Um, partly, I, I did feel like that, uh, because, um, they can only see my face. Or I can only show my hands on these things, but my whole body I cannot show. And, uh, they cannot observe it. Also, they cannot feel uh, uh, what I am telling, what I am trying to say. Uh, but in person, even if I sit quietly, he can observe and he can, uh, you know, he can know, uh, what the [...] syndrome is like, what is, uh, what the body situation is like." (Kevin, P23, 7; 12-16-P24, 1-2)
18	"I told her that, Look, my body is like, uh, it's totally dysmorphic, and, uh, uh, due to that, um, uh, I don't have friends and I don't have a, uh, yes, I'm socially secluded because of these things. So video wise, she's unable to look and she's unable to see these things. So she said that, No, no, you're okay, you're totally, uh, fine. Uh, this is just your, uh, uh, presumption and you have prejudice in your mind, you are just prejudiced." (Kevin, P30, 8-14)
19	"It's the whole experience of somebody's presence, their way of being, their, seeing somebody in 3D, you know, and uh, I, I don't know what we can call it. Maybe somebody's energy? You cannot feel it from the screen." (Sarah, P17, 1-4)
20	"...it was to do with lines and texture and, um, I never really had acne, but like spots, just like the odd spot." (Ella, P31, 10-11)
21	"I'd have like one [acne spot] here and one here, that'd be it. But it would, they would be the worst thing in the world to me at the time. Um, and I felt like I couldn't really see [the odd spots] on Teams. So for me, I felt even sillier sitting there and telling my therapist that that's what I was worrying about." (Ella, P31, 13-16)
22	"Um, and I think where the difference would've been for me is it would've been more anxiety provoking to sit face to face with the therapist, knowing that she could see my face in real life, and having to sort of go out, talk to receipt reception and whoever else to get to that room...But I at least think I would've thought, or she can see my face, she can see how it properly is and she's not gonna think I'm crazy. Whereas I really struggled throughout the whole time, to be honest, with her, me, me thinking that she thinks I'm imagining this stuff on my face." (Ella, P32, 1-5; 7-10)
23	"Um, but in the end I think I just learned to accept it and have to trust that actually maybe there wasn't a lot there to begin with, you know?... So it then became more of a well, I'm, I'm still seeing people every day and day-to-day life, and they're not saying anything. And my boyfriend is constantly saying there's nothing on my face... My mom's telling me there's nothing there. So actually maybe even if she was face to face, she, she still might not be able to see anything. (Ella, P33, 9-11; 13-15; P34, 1-2)"
24	"Um, I guess it was, uh, just a bit of a, a strange feeling to be honest. 'Cause um, a part of me was thinking how are they, uh, really kind of getting to know me when it's just on a, a screen, if you know what I mean? (Dean, P32, 6-9)." "And like video therapy, I, it might be a bit different these days with the better technology and stuff like that, you know, clearer cameras, but how are they really going to judge, um, sort of situations like that where they can only see a tiny portion of you, an odd box?" (Dean, P20, 7-10)
25	"...I guess I was trying to kind of make a point of it that almost, you know, like I was overemphasising a little bit and, um, I didn't really have the opportunity to discuss it, to be honest... Um, you know, I did mention about all of the issues that I had in relation to body, body image problems and all sorts... Um, and, um, I guess, you know [sighs], they didn't, it felt like I wasn't really being kind of listened to or acknowledged." (Dean, P41, 1-3; 5-6; 8-9)
26	"I guess it's that little voice in the back of my head. Um, you know, and anyone that would see me would probably not agree in any way, shape, or form. But, you know, it's only me that can kind of notices it, you know?" (Dean, P4, 3-6).
27	"I had a, well just one therapy session, um, with the university therapist, uh, and, um, again, very like, dissatisfied. Um, I felt like, um, again, they just seemed like even though it was in person, it was face-to-face, um, I didn't really feel like they were paying that much attention to what I was talking about." (Dean, P26, 11-15)
28	

29 GET 2: Shifting Control in VCP

30 Sub-theme 1: Curating the Body

31 "Yeah, that's how I feel because if I walked into like an office, I would have to shake their hands and touch them. And then also, um, I would feel they wouldn't see my, uh, they would see my stomach area. But if I'm in a, um, video call, I can always hide that, for example [laughs gently]. You can also add filters if you don't like the way that you look on videos, um, so, you know, I adjust, the lighting, for instance. So you're in control when it's online. But when you go into an office, you're not in control." (Yasmin, P13, 8-15)

32 "Yeah, because in virtual therapy, I'm just showing my face. But when you're walking into in-person therapy, they see how you talk to other people, uh, how you, how you use your hands, uh, your body language, your full body. And like I said, they will see the flaw that I hate about myself, which is, uh, my stomach area." (Yasmin, P23, 12-16)

33 "...privacy is an important matter to me. Where I originally come from, therapy is still very taboo" (Yasmin, P15, lines 5-6)

34 "It's like a nicer version of myself, like a slightly, uh, smooth, smooth version with like a smooth skin. And, uh, I liked it. It was not my plan to do it, but when I saw it's an option, I liked the idea of appearing better looking." (Sarah, P24, 7-10)

35 "I think body language speaks a lot as well. Closed arms, sitting back, sitting forward, closed legs, cross armed, all these different things have an impact as well. And I could, I could do myself justice to appear smaller in person as well. So the, the therapist will then probably, I'll probably communicate this to her definitely in the session in per, if it was in person, but I'll tell her, Look, I'm now purposely closing myself or making myself appear smaller. Do I look smaller? I'll probably ask that question to her, a rhetorical question: Do I appear smaller?...Um, obviously I don't know what the answer would be to that, but you've got more, I guess, flexibility, fluidity, visibility, um, in changing and shaping who you are in that one given experience. When you're doing an in-person therapy session, you can change and change up your body language a bit more." (Rachel, P47, 1-9; 11-15).

36 "But I think video is good, but you are missing out on all those points that I've mentioned, um, isn't it? You are missing out on that, that just that seat direction. Um, the seating arrangement, um, you know, that one-to-one, um, Let's go through this worksheet together side by side, I'm right here, seated next to you. Um, let's play this game 'cause it will help with X, Y, and Z. Um, so video conferencing can only take you so far, or video therapy can only take you so, so far." (Rachel P48, 15-16-P49, 1-5)

37 Sub-theme 2: Feeling Uncertain About Online Connections

38 "I think, uh, maybe because in real life we have eye contact and, on the screen, there is no eye contact, so you don't really, I don't know where you look now, you probably try to look at my face, but it doesn't, it doesn't feel that way. We don't know where we look. We try to get the eye contact through the video call. But we're just staring at some dot on the screen, so it is not really eye contact. I feel like, uh, less intimidated, uh, when it is in person. Uh, it feels like this gaze, this stare, it's diluted in real life. And through the video, it's heavier, it's this, like, you stare at me, I don't even know where you stare, because there again, there is no eye contact, it's just this, um, weird feeling of, um, somebody looking at you, but as if they're looking through you...In real life, you can see exactly where, where is the gaze." (Sarah, P20, 3-15)

39 "Yeah, staring at your face. In, uh, in real life, it's, uh, as I said, it's diluted. It's like a person, they would look in your eyes, but then they will probably look around as well. Maybe they will look aside, look at you again, and it comes in this natural way. So I find it less uncomfortable, less intimidating and more normal, if you like, more human" (Sarah, P21, 4-8).

40 "I try to think more about it, um, it, when somebody can kind of get rid of you by just, uh, clicking like stop or leave the meeting, um, it's not the same experience as somebody being next to you. It feels as if you can be dismissed easier...Not that my therapist ever did something like that, and I trust my therapist, but, um, the whole idea that, uh, um, like separating from you or getting rid of you is one click away. Um, it's also not a very pleasant thought now when I'm reflecting on it. Um, and also, we rely on internet connection. It just doesn't feel like as stable and safe as a face-to-face experience." (Sarah, P30, 1-4; 6-11)

41 "and how it's easily accessible by a click of a, you know, click of a mouse really, and having that therapist come to you as opposed to you going out of your own room or making that commute there" (Rachel, P3, 2-5)

42 "Um, and there was a degree of frustration. And I think they even mentioned at one point, uh, You seem like you're getting, um, you know, You seem, you are working yourself up. I'm like, No, I'm just trying to [laughs], trying to, trying to speak and I can't. You're not hearing what I'm saying. So that's why I'm raising my voice. I'm not, I, I'm, you know, I'm not getting angry. I'm just trying to talk, trying to answer your question. Uh, so yeah, it was, uh, it was, it was strange, uh, to be honest." (Dean, P33, 5-11)

43 "I was concerned that they were gonna make kind of like, almost like a false diagnosis, if you know what I mean." (Dean, P34, 3-4)

44 "Um, uh, I wasn't there for, for, for anger issues or anything like that, and I was kind of paranoid like, Oh, how am I coming across? Are they, they're seeing me getting a bit worked up and they're gonna think that I'm a very stressed out, anxious person, which is gonna affect how this is gonna conclude." (Dean, P34, 6-10)

45	GET 3: The Mirror of VCP
46	Sub-theme 1: Digital Self-Scrutiny
47	"Online you are being reflected back all the time. I guess the video screen is a bit like a mirror, really." (Charlotte, P47, 5-6)
48	"You would see yourself on the screen and this, uh, this is like having therapy with a mirror there." (Sarah, P12, 3-5).
49	"It's not very often in real life that you are hold somebody's holding up a mirror in front of you effectively whilst you are at your most vulnerable or doing your crying with your nose streaming and tears rolling down your face and you, you are all red and blotchy and whatever. Um, that's very unusual [laughs], you know what I mean?" (Ella, P41, 9-14)
50	"Um, I wonder whether I was maybe quicker to gather myself, get a tissue, sort my face out, having such an obvious visual thing in front of me of what I look like. So yes, I do feel like it was at times, yeah maybe a bit of a barrier in terms" (Ella, P42, 9-13)
51	"Um, no, I mean I kept kind of, um, it sounds strange, but uh, I dunno, when you see yourself talking, um, 'cause obviously that's something you never really kind of see, you don't look in a mirror and kind of talk to yourself ... Well, I don't anyway. And part of me is thinking, Oh God, is that, is that what I look like when I'm talking? Is that how my face goes when I'm, when I'm speaking? Um, and that led me kind of feeling even more sort of uncomfortable...And I guess that sort of ties in with the body dis, body image dissatisfaction, you know, I'm looking at strange aspects now, you know, going deeper. Um, you know, and then almost trying to alter how I'm, how I'm moving my mouth, in, in, in a sense" (Dean, P35, 11-15-P36, 1-2; P36, 4-7)
52	"didn't really have the opportunity to discuss [the presence of the self-view with his therapist]" (Dean, P41, line 3).
53	"... I recorded the Zoom call and watched that back and that was a big, big mistake [laughs]. Cause you know, you're like, oh my God, my face moves in a strange way and stuff. Really bizarre. I think it all comes down to just not being here. Like, I don't know what I look like, really, if that makes sense. 'Cause you sort of get a sense of what you look like from your, from pictures of yourself. But pictures are quite different to, you know, I can't step outside myself and, you know, see myself how other people see me." (Charlotte, P26, 3-10).
54	"Um, on the video calls, when I was doing it with my therapist, um, I initially found it quite hard if I was, yeah, I guess 'cause it's about me. But then I think when I get engrossed like I am now, I'm not really thinking about how I'm coming across to you cause I'm more interested in talking about what we're talking about... So I'm not constantly, I, I'm looking down a bit to see myself, but I'm not kind of, it's not triggering anything for me right now. Which is really, which is really good." (Charlotte, P28, 7-11; 13-15)
55	"I guess it depends on who you're with as well and how relaxed you feel with that person...Like with my therapist, we always just felt, I always felt quite relaxed with her and um, so it always felt okay actually. Yeah."" (Charlotte, P29, 3-4; 6-7).
56	"I'd find it harder if it was recorded and I had to watch it back." (Charlotte, P52, 14)
57	"Ah yes, that is a good point. Um, that's another thing, um, to add into the mix [laughs gently]. You know, people when they see themselves this is another way of mirror gazing you could say is, um, how you appear on video, you know. How you appear even on this photo here of me. Um, you know, I would always go out my way to find something negative or something that just doesn't sit right, and I fear that other people are seeing me in a different way or the lighting's not right. Um, or they notice something in, on my face or, um, on my shoulder, whatever it may be. Or, you know, Gosh, my, the width of my shoulders are the same width as that video box on Zoom, for example. It's like all these things that you think about (P40, 8-16-P41, 1-2)... So you can say it is like mirror gazing, but would you maybe, I don't know, there's a term for it, but video self, video gazing, I don't know. Um, but it's like that. Yeah, it's real. It happens" (Rachel, P41, 4-6)
58	"I remember that there was something off with the Zoom settings on a few occasions and instead of seeing the therapist big on the screen and myself like in the small window, for some reason I saw myself big and the therapist smaller. I remember something went off with the settings...And I said, uh, I remember at the start of the therapy, I said, Uh, I told my therapist, Wait, wait, I have to change it. Like I'm seeing my face big on the screen and it's really disturbing. And I think she did ask What, What is disturbing? And I just explained that I don't like to stare at a massive image of my face for one hour. But I believe that not only people with body image issues wouldn't like it. It's just like many people don't like hearing their voice recording or seeing themselves on the video." (Sarah, P12, 13-15; P13, 1-10).
59	"In therapy, um, in the little, I was, um, the focus was less on the little window...It was more on the, uh, on the therapy, uh, because, um, the main focus was just to get the treatment. Uh, you know, the focus was, the attention was on the other side, so, um, and also I didn't want to look in this small window to lose focus and restrict myself." (Kevin, P31, 13-1; P32, 1-4)
60	"It's just in the beginning, I was staring at myself the whole time, but then when we got, you know, comfortable with each other and the conversation became more serious, then, you know, I, I was still looking at myself, but not as often as the beginning, you know? I was focusing on the actual material of the therapy 'cause I was benefiting from the exercise...And also it's, I'm paying for the, for the therapy. I have one hour. I can't be wasting the whole time just looking at myself." (Yasmin, P18, 12-15-P19, 1-2; 4-5).

61	Sub-theme 2: The Therapist in the Virtual Mirror
62	"So anyway, I was constantly looking at other people's skin and I would look at her skin a lot during the sessions..." (Ella, P45, 10-12)
63	"Um, and think like, she, she had a couple of imperfections I remember seeing on her skin. And I, I remember thinking, was that, how's that impacting on, like what she's feeling about what I'm saying. Is she looking at me thinking this, there's nothing wrong with this girl skin. She's sitting there saying all this stuff and actually I do have imperfections on my skin. Um, but maybe what was different that I don't think I'd have been able to do as well in real life without looking like I'm staring at her all the time, is that I could look at her skin quite a bit and it wasn't obvious. (Ella, P45, 14-16-P46, 1-6).
64	"I think it's just, it's not because a therapist is more beautiful than me, or I'm more, it's not that someone is more beautiful than the other, it's just the attitude, you know, like, she's more confident in herself, you know?...So I would compare myself to every woman, to be honest with you, but in therapy, you know, you do compare, you compare yourself with another box because it's one box versus another box." (Yasmin, P30, 5-8; 9-12)
65	"Um, just in the beginning I get distracted, like I don't really focus on the actual serious conversation, that she's trying to help me, but then the more exercises we do, the more like I feel like they are helpful, then I take the therapy more seriously and I stop saying that to myself." (Yasmin, P31, 5-8)
66	"I suppose I kind of would, there would be some comparative, like probably to like, thinking of how I look in relation to her, maybe?...Um, for negative or positive, I don't know. Um, so I, I kind of would always be aware of it. Um, but I would try and not dwell on it cause I was conscious of the time and the cost and I just thought, I need to not, not keep, you know, looking at myself. I need to actually like, get something out of this for myself." (Charlotte, P43, 3-5; 7-11)