


Therapist training in video chat technology for use in an adaptive digital mental health intervention: Challenges, facilitators and implications for training models

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Abstract

Objective: This qualitative study investigated therapist training experiences, elements of skill acquisition, and barriers and facilitators associated with conducting assessments, and the delivery of low- and high-intensity therapist assistance delivered via video chat technology, adjunctive to a transdiagnostic digital mental health intervention programme for anxiety and depression.

Methodology: In total, 34 semistructured interviews were conducted with 20 therapists. Twenty interviews explored experiences of training to administer a clinical assessment tool, and 14 additional interviews explored training experiences of delivering low- and high-intensity therapist assistance via video chat technology.

Results: Reflexive thematic analysis identified three themes: video chat skill acquisition, competencies transferrable to video chat and video chat service quality. Training and supervision were identified as important to scaffold skill development, and therapists described surprise that their skill set was transferrable to video chat. The most cited barrier to the adoption of video chat was the management of risk and distress, along with environmental suitability. Frequently cited facilitators to the adoption of video chat included stable Internet connection, protocols and resources.

Conclusion: The benefits of video chat technology and digital mental health interventions can be maximised through the expansion and integration of training into existing teaching curricula. If therapists are familiarised and competent to deliver mental health services via the Internet, as well as in person, the future adoption of blended and stepped-care models is likely to be increased.

KEYWORDS

digital mental health interventions, qualitative methods, therapist experiences, therapist training, video chat

Trial registration: Australian and New Zealand Clinical Trials Registry (ANZCTR): ACTRN: 12620000422921, Date Registered 30/03/2020.

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1 | INTRODUCTION

The COVID-19 pandemic required a rapid transition to the digital delivery of mental healthcare services (De Witte et al., 2021). Digital therapy, or telehealth, includes the use of video chat technology, which involves the remote delivery of therapy via a secure video link enabling a therapist and client to communicate over the Internet in real time (Muir et al., 2020; Norwood et al., 2018). Video chat therapy is a mental health service delivery model that involves synchronous face-to-face interactions that closely resemble the traditional in-person therapy model (Muir et al., 2020). The need for therapists to receive training to transfer their clinical skills, traditionally developed for face-to-face therapeutic contexts, to a digital environment had been identified as critical long before COVID-19 (Hadjistavropoulos et al., 2012; Pierce et al., 2020). Historically, however, slow progression and uptake have been reported (Anthony, 2014; Shandley et al., 2011). The pandemic, therefore, created an opportunity to re-evaluate therapist training models to ensure therapists adapt their skills to provide effective mental healthcare services via the Internet. Consequently, an additional opportunity arose to evaluate therapist training focussed on the utilisation of key skills adjunctive to a digital mental health (dMH) intervention. Such research can help to maximise the resources of mental healthcare professionals and improve the scalability and benefits of stepped-care models.

Digital mental health (dMH) interventions have slowly been paving the way for the adaptation of standard face-to-face treatment protocols into a computerised format, which have been disseminated with or without therapist assistance (Topooco et al., 2017). Therapist assistance within dMH interventions has been delivered via email, telephone, instant message and video chat technology, with the investigation into the latter an evolving field of research. The provision of therapist assistance in conjunction with a dMH intervention programme serves to enhance the effectiveness of the intervention by offering personalised guidance, feedback and support to participants. The level of therapist assistance can vary depending on the intensity of the intervention and the needs of participants. Low-intensity therapist assistance generally involves shorter sessions with a focus on encouragement, basic guidance and reinforcement of intervention strategies. High-intensity therapist assistance provides a longer, more tailored treatment experience, providing specific feedback and time to complete strategies collaboratively while addressing barriers to generalisability. As dMH interventions are typically based on manualised treatment protocols, they allow for the effective training of therapists in evidence-based practice with high fidelity, as well as the opportunity to provide a larger-scale training model for expanding the mental health workforce (Newby et al., 2020; Schneider et al., 2016).

Given the increased use of video chat telehealth, it is particularly important to investigate factors associated with the adoption and sustained use of video chat so that the benefits of this modality can be maximised beyond the COVID-19 pandemic. The research conducted before COVID-19 highlights that therapists can identify both benefits and challenges offered by dMH interventions (Gellatly

Implications for Practice

- Therapist skills are transferrable to the modality of video chat, with training programmes presenting an opportunity to positively influence the next generation of therapists' adoption of video chat technology into practice.
- The COVID-19 pandemic has seen a significant and rapid impact on the uptake of telehealth services; however, the dissemination and required use during periods of social distancing requirements has potentially reinforced the message of video chat telehealth as an available substitute, rather than an acceptable equal modality.
- If clinicians are trained to effectively deliver therapist assistance adjunctive to a digital mental health intervention, as was the case in the current study, the opportunities of stepped-care models can be maximised.

et al., 2017), with training and support consistently identified as key facilitators of therapist implementation (Gellatly et al., 2017; Maciag et al., 2022). Systematic reviews (Connolly et al., 2019; Etzelmueller et al., 2020; Konttila et al., 2019) and qualitative studies (Gilmore & Ward-Ciesielski, 2019; Richards et al., 2020) have identified that therapist attitudes towards video chat vary according to years of user experience, with more positive attitudes and confidence to deliver service identified among users with more video chat experience (Aafjies-van Doorn et al., 2021). Therapists with more experience were also less likely to report issues in using technology, developing therapeutic alliances digitally and managing high-risk situations (Connolly et al., 2019; Gilmore & Ward-Ciesielski, 2019).

Findings derived from researchers who have investigated dMH interventions also highlight the importance of therapist training (Titov et al., 2019). Titov et al. (2019) present 10 lessons learnt in dMH intervention research, one of which relates to the importance of therapists receiving specialised training and supervision in the delivery of dMH interventions. Titov et al. (2019) highlight the need for a training framework not only for the development of skills but also to ensure therapists are not unconsciously communicating any untested assumptions or beliefs about the effectiveness of dMH interventions to clients. The authors explained that while therapists can develop the knowledge competency of the effectiveness of dMH interventions, it is often not until they obtain the necessary experience in implementation that they can test any expectations held (e.g., that dMH interventions may produce poorer outcomes than traditional in-person services). Titov et al. suggested that a supported training programme is, therefore, imperative.

The research conducted throughout the COVID-19 pandemic similarly highlights the importance of adequate training and support as facilitative of therapist adoption of telehealth into practice. Aafjies-van Doorn et al. (2021) investigated how 141 therapists prepared to transition to providing services online during the COVID-19

pandemic. Results highlight that, overwhelmingly, therapists began using video chat during the pandemic without accessing training or support. Of the sample, 66% of therapists spoke to colleagues, 48.9% read guidelines, 37.6% prepared consent forms, 33.3% attended webinars on how to conduct video chat therapy, and 29.8% spoke to a supervisor. De Witte et al. (2021) similarly found that only 11% of a total of 2082 mental healthcare professionals accessed any form of training to prepare for telehealth delivery during the COVID-19 pandemic.

Aafjies-van Doorn et al. (2021) found that therapist preparedness to deliver services via video chat telehealth was associated with positive therapist attitudes and lower levels of professional self-doubt and anxiety. Therapists generally felt less competent and confident about transitioning their skills in digital environments, with anxiety levels assessed as moderate. Higher anxiety was associated with being female, being younger, having less clinical experience, having no previous experience with video chat therapy, as well as not yet achieving full registration status (Aafjies-van Doorn et al., 2021). The survey data highlight that prior experience of video chat therapy and positive perceptions of their clients' experience were associated with therapists' reported future adoption and use of video chat technology (Aafjies-van Doorn et al., 2021), findings that are consistently reported across other studies (i.e., De Witte et al., 2021; Muir et al., 2020; Poletti et al., 2021; Thew, 2020).

In a thorough review of current evidence, Thew (2020) found that therapists held five beliefs that presented as barriers to therapist adoption of dMH interventions in practice. Specifically, the beliefs were that: Internet-based therapies do not have a strong evidence base; they are less effective than in-person therapy; there is a decreased ability to develop a strong therapeutic alliance digitally; dMH interventions are not suitable for severe mental health problems; and Internet-based therapies will fail to meet clients' expectations of therapy. Thew (2020) concluded that further research evaluating therapist training in the delivery of dMH interventions is needed. Specifically, factors contributing to these beliefs need to be examined as they are consistently presented in the literature but are incongruent with the extensive research demonstrating the effectiveness of dMH interventions.

The research conducted to date suggests that therapist perceptions of video chat use within dMH interventions tend to become more positive with experience and are predictive of future adoption into practice (Aafjies-van Doorn et al., 2021; Connolly et al., 2019; Gerton et al., 2022; Poletti et al., 2021; Reilly et al., 2022). With experience, therapists come to view video chat telehealth as effective and comparable to face-to-face services. Experience provides therapists with the opportunity to reassess their beliefs and recognise that they can adapt and transfer their skills online, which appears to increase their self-efficacy and planned future adoption of video chat telehealth. To further the field of dMH interventions, it is therefore essential to investigate trainee therapists' experiences of acquiring competency through a training programme focussed on delivering therapist assistance via video chat technology adjunctive to a dMH intervention programme. Specifically, qualitative

research will provide insight into barriers and facilitators in the use of video chat technology to deliver both low- and high-intensity therapist assistance adjunctive to a dMH intervention programme. This knowledge will assist in enhancing our understanding of therapist perceptions and can be used to increase the adoption of video chat technology and the use of stepped-care models in practice. Qualitative evaluation of therapists' training and implementation experiences can also help inform training models aimed at enabling therapists to effectively deliver and integrate dMH interventions into their practice.

1.1 | Objectives

The purpose of the current study was to qualitatively investigate trainee therapists' experiences of training in the delivery and implementation of clinical assessments, and low- and high-intensity therapist assistance via video chat within an adaptive transdiagnostic dMH intervention programme for anxiety and depression. This study aimed to explore training experiences, identify elements of skill acquisition and barriers and facilitators associated with the integration of video chat technology post-trial to advance the field of video chat as a suitable mode of service delivery beyond the COVID-19 pandemic, maximising the benefits of therapist assistance delivered via video chat technology within dMH interventions. This study investigated the following research questions:

1. What was the therapists' experience of training to use video chat to conduct clinical assessments and deliver therapist assistance adjunctive to a dMH intervention programme for anxiety and depression in an adaptive clinical trial?
2. What are the self-identified therapist characteristics and skills required for effective video chat assessment and therapist assistance adjunctive to a dMH intervention programme?
3. What are the implementation barriers and facilitators to therapists' intended adoption of video chat technology beyond a clinical trial?

2 | METHOD

2.1 | Design

This qualitative study forms part of a larger adaptive clinical trial that investigated various support intensities of a transdiagnostic dMH intervention programme, called Life Flex, for anxiety and depression. The clinical trial was conducted digitally in Australia, between November 2020 and March 2022. More information about the adaptive clinical trial is included in Andrews et al. (In press). The adaptive trial was registered with the Australian and New Zealand Clinical Trials Registry (ANZCTR; ACTRN: 12620000422921), and ethics approval was obtained from Federation University Australia's Human Research Ethics Committee (Approval ID: A19-095).

In the adaptive clinical trial, eligible participants were given access to the Life Flex programme and had their symptoms of anxiety and/or depression evaluated on Day 15 to assess whether they met the criteria to have the self-help programme augmented with therapist assistance. The stepped-care rules applied where participants had not read up to the end of Module 1 of the dMH intervention programme; had symptoms of anxiety and/or depression that had deteriorated by more than five points (as assessed by comparison of their baseline depression [Patient Health Questionnaire; Kroenke et al., 2001] and anxiety [Generalised Anxiety Disorder Scale; Spitzer et al., 2006] scores against their Week 3 scores); showed symptom improvement but their scores remained in a severe range; or were yet to complete the Week 3 questionnaire.

When participants met the stepped-care rules at Week 3, they were randomised to receive seven sessions of either low- (i.e., 10 min) or high-intensity (i.e., 50 min) therapist assistance delivered via video chat technology to assist with the Life Flex programme. More information about the Life Flex programme can be accessed via Klein et al. (In press). The qualitative component of the adaptive clinical trial that forms the focus of this paper involved the completion of semistructured interviews, which sought to evaluate therapist training experiences in the administration of clinical assessments and delivery of low- and high-intensity therapist assistance via video chat technology adjunctive to a dMH intervention programme.

2.2 | Participants and procedure

The therapists who participated in the clinical trial were provisionally and generally registered psychologists with the Psychology Board of the Australian Health Practitioner Regulation Agency (AHPRA), undertaking a clinical placement in a community mental health service in Victoria, Australia.

Therapists were eligible to participate in the qualitative aspect of the clinical trial if they had administered a clinical assessment (Mini International Neuropsychiatric Interview; M.I.N.I. 7.0.2; Sheehan et al., 1998) via video chat at any time point in the trial (preintervention, postintervention or three-month follow-up) or had delivered a minimum of two sessions of either low- or high-intensity therapist assistance via video chat to participants in the clinical trial. Each therapist had no therapeutic involvement with participants in a treatment condition that they may have assessed at one of the assessment time points.

All therapists were asked to consent and agree to participate in this study by clicking a button on the digital platform, after having been presented with and reading the Plain Language Information Statement. In total, 20 therapists participated in semistructured interviews conducted over video chat technology, producing 20 assessment interviews and 14 therapist-assistance interviews, with each therapist interview containing a total of 22 questions. All interviews were conducted and recorded with a handheld audio device by the first author, who is a registered clinical psychologist with a Master of Clinical Psychology and has been working in the

TABLE 1 Sample therapist interview questions.

1. What therapist skills do you see to be important in conducting diagnostic assessment interviews effectively via video chat in clinical trials?
2. What therapist qualities do you think are important in fostering effective assessments via video chat in clinical trials?
3. Would you consider integrating the use of conducting assessments via video chat into your practice beyond the Life Flex adaptive treatment trial?
4. If so, what would you see as implementation facilitators for continuing to conduct clinical assessments via video chat after the clinical trial?
5. If not, why would you not consider using video chat for conducting assessments after the clinical trial?
6. What can you identify as the specific barriers to nonuse of video chat for assessments postclinical trial?

mental health field since 2006. The interviews ranged between 18 and 60 min ($M=34.38$, $SD=13.31$) and were transcribed verbatim and de-identified by the first author. There were two distinct parts to the interview schedule. A part of the interview schedule asked therapists questions about their expectations of video chat technology and their impressions about the impact of video chat on communication and the development of therapeutic relationships. These therapist views are presented in a separate paper, along with participant views of video chat within the adaptive clinical trial (Andrews et al., In press). Another part of the interview schedule asked therapists about their prior experiences of using video chat technology and the process of training and delivery. Questions also explored therapist perceptions of the skills and characteristics needed for conducting assessments and delivering therapeutic assistance via video chat, and exploration of implementation barriers and facilitators beyond the clinical trial. Sample interview questions from the therapist interviews utilised in the current study are presented in Table 1.

Therapists completed a demographic questionnaire where they were asked to provide their age, gender, indicate if they were in their 5th or 6th year of training and outline their years of previous experience in delivering counselling and/or psychological treatment, as well as experience in the delivery of telehealth or dMH interventions. Therapists were also asked to identify their preferred therapeutic orientation for context. Table 2 provides the demographic details of therapists.

2.2.1 | Therapist training

Prior to the commencement of the clinical trial, the therapists were required to complete and obtain competency in a purposively developed 14-hr, 5-module online training programme. The programme included an introduction to dMH interventions (specifically video chat technology and key ethical considerations), diagnostic assessments, qualitative interviewing techniques and transdiagnostic cognitive behavioural therapy (CBT) principles that underpin the dMH intervention programme. Therapists were required to obtain a minimum score of 80% on a 40-item multiple-choice competency

assessment. The training programme also contained a pre and postevaluation survey designed to assess therapists' knowledge and confidence in the use of dMH interventions before and upon completion of the training programme, along with training programme satisfaction ratings. In total, 27 therapists completed the therapist training programme, of which 22 participated in the adaptive clinical trial and 20 in the semistructured interviews that form the focus of this paper. Table 3 provides the therapist competency scores, the pre and postsurvey results and satisfaction ratings with the training programme for all 27 therapists.

Therapists were provided with an account on the digital health platform that housed the dMH intervention programme, the therapist training programme, and access to the therapist repository of resources. This repository contained a training manual that documented all processes, procedures, templates and questionnaires of the adaptive clinical trial, video chat procedures, risk assessment templates, case note templates for assessments and all treatment sessions, as well as an administration, scoring and interpretation

TABLE 2 Therapist demographics.

Variable	Clinical assessment interviews (n = 20)	Therapist-assistance interviews (n = 14)
Age, M (SD)	27.5 (5.4)	27.6 (5.9)
Gender, n (%)		
Female	16 (80%)	10 (71%)
Male	4 (20%)	4 (29%)
Number of years' experience, M (SD)	1.5 (1.5)	1.7 (1.6)
Number of years' experience in video chat/dMH, M (SD)	0.3 (0.7)	0.3 (0.8)
Preferred therapeutic orientation, n (%)		
Cognitive behaviour therapy	–	8 (57%)
Dialectical behaviour therapy	–	0 (0%)
Acceptance and commitment therapy	–	0 (0%)
Psychodynamic/psychoanalytic	–	0 (0%)
Narrative therapy	–	0 (0%)
Integrative/eclectic	–	2 (14%)
Not sure	–	4 (29%)
Number of video chat assessments, M (SD)	7.25 (4.9)	–
Number of video chat treatment sessions, M (SD)	–	13.07 (6.8)

Variable	Score (n = 27)
Competency quiz scores	35/40 (SD = 1.81)
Pretraining knowledge and confidence to use dMH	45/100 (SD = 15.5)
Post-training knowledge and confidence to use dMH	76/100 (SD = 13)
Satisfaction ratings with the therapist training programme	8.9/10 (SD = 1.1)

guide for using the M.I.N.I. (M.I.N.I. 7.0.2; Sheehan et al., 1998). Prior to participation in the adaptive clinical trial, all therapists were required to submit a video demonstrating administration of the M.I.N.I., which was reviewed by the first author with written feedback provided to ensure competency to administer the assessment tool. Therapists were provided with daily access to individual clinical supervision and attended weekly group supervision sessions to build upon knowledge obtained in the therapist training programme. They engaged in role-play activities with peers, case discussion and therapist presentations on the module content of the dMH intervention programme to ensure familiarity with the treatment content prior to interacting with participants in the adaptive clinical trial.

2.2.2 | Therapist roles

The role of the therapist in the low-intensity therapist-assisted condition was to support the participants' engagement with the dMH intervention programme by specifically checking on participant progress with modules, task reinforcement, clarification where required, encouragement of reading and skill practice, as well as ensuring that participants were clear on their between-session module tasks assigned for completion. The role of the therapist in the high-intensity therapist-assisted condition involved the same support provided in low intensity, with the added roles of tailoring programme content, support in generalising skills learnt to daily life, questionnaire feedback and engagement in problem-solving where required.

Fidelity and adherence to the study protocol was maintained throughout the trial by the first author in consultation with the second author. Random checking of audio and/or video recordings of clinical assessments and treatment sessions was completed to ensure that adherence to administration and the therapist role was maintained. Adapted versions of the Internet Delivered Cognitive Behaviour Therapy–Therapist Rating Scale (iCBT-TRS; Hadjistavropoulos et al., 2018) and Cognitive Therapy Rating Scale (CTRS; Young & Beck, 1980) were used by the first author in the review process to ensure treatment fidelity in both the low- and high-intensity therapist-assisted conditions.

2.3 | Qualitative analysis

Data analysis was completed in line with Braun and Clarke's (Braun & Clarke, 2019, 2022) six phases of inductive reflexive thematic analysis. This data analysis methodology was chosen as it recognises the researcher's active role in data coding and values

TABLE 3 Therapist training programme survey scores.

exploration of participants' experiences and perspectives (Braun & Clarke, 2022), which aligns with the aims and research questions of the current study. The approach of reflexive thematic analysis contains procedures of code and theme development that reflect important aspects of the data and emphasise the researcher's active role in coding and theme generation (Braun & Clarke, 2019). Drawing on their extensive experience as a clinical psychologist who has worked with clients both in person and online, the first author critically and analytically read all of the text transcripts, which enabled codes to be mapped onto themes as patterns in the data emerged, which were reviewed by the co-authors. The prior experience was invaluable in shaping the reflexive thematic analysis process, enabling the first author to discern and scrutinise key patterns in the data, enabling a more nuanced and comprehensive analysis.

All data were stored and managed within the computer software package NVivo, and a reflexivity journal was documented within a Microsoft Excel spreadsheet. As the first author holds a favourable view of video chat, they were mindful of potential biases during the reflexive analysis process. Care was taken to avoid overlooking any challenges or limitations that may exist and ensure that the analysis remained firmly grounded in the data. To further minimise any potential biases influencing the data, the co-authors conducted multiple comprehensive reviews of the analysis, during which they collaborated on refining the themes. The themes that were generated from the analysis included direct quotes from the therapist interviews to highlight the thematic findings.

The thematic findings reflect the therapists' experiences of training and delivery of clinical assessments and therapist assistance adjunctive to a DMH intervention programme. The therapist interviews identified three themes: video chat skill acquisition; competencies transferrable to video chat; and video chat service quality. The subthemes are depicted in Figure 1.

3 | FINDINGS

3.1 | Theme 1: Video chat skill acquisition

3.1.1 | Knowledge and skill development

A training programme plays a critical role in developing self-efficacy and facilitating knowledge and skill acquisition among therapists. The training programme was found to ease concerns over using video chat technology. Despite prior knowledge of the effectiveness of video chat for therapeutic purposes, some therapists initially expressed scepticism towards its use. However, once therapists started using video chat technology, the majority reported a preference for the comfort offered by the video chat screen, as well as increased access to resources during sessions (e.g., preparation notes and DMH intervention programme). This aided their skill development and confidence.

I think I was more comfortable doing them [sessions] through technology rather than in person [laughs] ... so I think doing it via telehealth. It just made me more confident.

(therapist #36, 25-year-old female)

Therapists expressed satisfaction with the protocols and processes provided in their training. They reported that these resources helped them know how to respond in the event of a technology challenge, risk issue or participant distress. For some therapists, these resources appeared to decrease anxiety about potential risks and distress. However, other therapists remained apprehensive until they had obtained more experience.

So I guess so I've learnt a lot of skills... now I make a conscious effort of, you know, of course, checking risk, you know, where they are located, I don't think I did that before Life Flex, so yeah, I've learnt things around risk.

(therapist #22, 22-year-old female)

3.1.2 | Scaffolding and supervision

Scaffolded skill development was identified as very important to minimise challenges related to split attention and cognitive load in trainee therapists (i.e., learning the assessment and treatment model and then learning the technology), which seemed to minimise overall stress levels. The availability and access to supervision were also identified as essential in helping therapists to feel comfortable and prepared to offer services via video chat technology. Many therapists reported feeling apprehensive and nervous due to a lack of experience in specific therapeutic tasks, which, combined with concerns about video chat technology, resulted in increased cognitive load. In particular, some therapists reported feeling more distracted via video chat.

Learning the M.I.N.I and then, you know, balancing everything else and looking at the camera and listening, um, yeah, and then I think if a tech issue came up, that was just kinda like another difficulty.

(therapist #25, 26-year-old female)

3.2 | Theme 2: Competencies transferrable to video chat

3.2.1 | Concerns unfounded

Therapists frequently indicated initially feeling concerned about interacting with participants over video chat. Upon further exploration, therapists tended to attribute their concerns to a lack of experience in the role of a psychologist, rather than using video chat technology. In general, therapists expressed concerns related to learning a new assessment tool, conducting risk assessments and safety planning

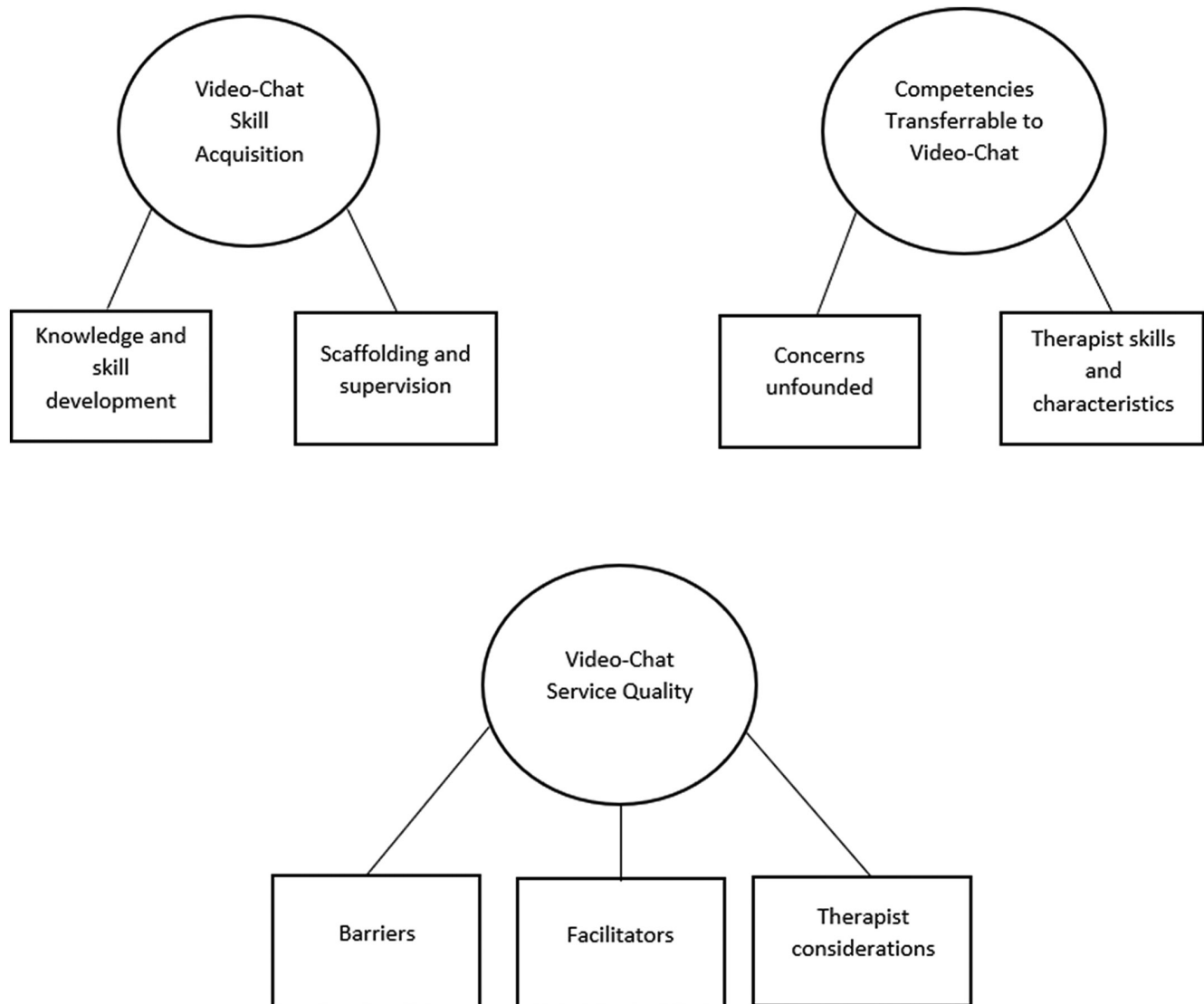


FIGURE 1 Final thematic map.

digitally, navigating technology issues with distressed participants and developing a therapeutic relationship online. These concerns were found to be common, irrespective of the therapist's previous use of video chat for work and personal use. Despite these initial concerns, the majority of therapists stated that they were pleasantly surprised to discover that their skills were transferrable and adaptable to the modality of video chat.

I originally thought that there would be a lot of technical difficulties and that my lack of knowledge might have hindered the process as well, but I actually found it really easy to just get going, really easy to use.

(therapist #27, 23-year-old female)

3.2.2 | Therapist skills and characteristics

Therapists identified using the same skills over video chat sessions as they do in person. The most cited skills required to deliver

effective services over video chat included conveying empathy through a screen, strong verbal and nonverbal communication, problem-solving, self-regulation, rapport and relationship-building skills, risk assessment and safety planning, observational skills, multitasking and boundary setting. In addition, therapists frequently highlighted the importance of being flexible, patient and persistent with technology, displaying warmth and unconditional positive regard, being present and collaborative and engaging in self-reflection (e.g., therapists emphasised the need to be aware of how they present themselves on the screen, the facial expressions they display, and the background environment).

Empathy, uh, good communication and listening skills and clarifying skills.

(therapist #36, 25-year-old female)

Therapists found that the skills and characteristics required for clinical assessments overlapped with those needed for delivering both low- and high-intensity therapist-assisted interventions. Therapists

delivering therapeutic assistance noted the importance of being able to motivate and enhance self-efficacy, as well as use motivational interviewing skills to keep participants engaged with a dMH intervention programme. The ability to tailor and deliver individualised assistance was also highlighted as essential, and the therapists reported striving to achieve this during the clinical trial.

I guess motivational interviewing core skills is another skill as well, and it can be a bit of an issue as well, and I guess this is an issue that I didn't mention earlier, but trying to get clients to participate in the Life Flex program and engage with the modules themselves.

(therapist #21, 23-year-old female)

Therapists reported an increased self-awareness and a heightened consciousness of their skill set due to providing services via video chat. They appreciated the ability to adjust their facial expressions in real time and spent time carefully considering how to engage with each participant. The process of self-reflection enhanced their experience and created more consciousness of their overall competency development. As therapists gained more experience, they reported being able to attune and be present with their participants via video chat, which alleviated common concerns about limited behavioural observations during video chat consultations.

Being able to see myself, I'm quite mindful of my facial expressions, you know, of my posture, um, and I think that also gives me a little bit of insight into what the client can see, which typically in face to face I don't have that opportunity.

(therapist #24, 25-year-old female)

3.3 | Theme 3: Video chat service quality

3.3.1 | Barriers

Therapists identified several barriers to using video chat technology for service provision. The most identified barrier included challenges related to risk and participant distress management, followed by concerns about the suitability of the environment in which the participant was located during the appointment, and questions regarding the suitability of the person to receive service via video chat technology. Some therapists perceived that video chat technology offered a lower quality service compared with in-person services. Disruptions to Internet connectivity were identified as a significant issue that could interrupt service provision. Therapists also reported feeling fatigued with technology during the COVID-19 pandemic.

You just don't know if there is going to be a power outage or, you know, just little things like that, again,

that are out of our control, as you do rely heavily on a secure internet, a secure platform.

(therapist #22, 26-year-old female)

3.3.2 | Facilitators

Therapists identified several facilitators for the use of video chat technology. These included having a stable Internet connection, good quality technology such as a camera, headphones, computer and a secure video chat platform. Access to literature about the evidence base for video chat therapy was also important, as were participant preferences and suitability for video chat. Additionally, having a professional working space that is private, confidential and comfortable for both the therapist and the participant was seen as crucial. Finally, developed risk management protocols, protocols for handling technology disruptions, access to good supervision and alternative video chat platforms in the event of technology issues were also featured as facilitators.

I suppose knowing what the platforms are, knowing where to sort of find them and access them, um as well as staying up to date.

(therapist #40, 24-year-old female)

3.3.3 | Therapist considerations

Therapists reported several factors that influenced their adoption of video chat beyond the clinical trial. These included participant suitability, therapist preferences, belief in technology and stage of training. Therapists who preferred video chat over in-person interactions and perceived utility in video chat were more likely to report future adoption of the technology into their practice. However, some therapists felt they needed to continue offering services via video chat (in addition to in person) to remain competitive in the marketplace, regardless of personal preference.

It's just going to be really difficult if you are a psychologist that doesn't know how to navigate video-chat technology because that's where the opportunities for jobs are as well, you know.

(therapist #38, 36-year-old male)

4 | DISCUSSION

This study aimed to qualitatively investigate trainee therapists' experiences of training in the administration of clinical assessments, and delivery of low- and high-intensity therapist assistance via video chat adjunctive to an adaptive transdiagnostic dMH intervention programme for anxiety and depression. Ensuring that therapists are effectively trained and competent to deliver low- and high-intensity

therapist-assisted dMH interventions via video chat technology is imperative to further advance the field of dMH, with the identification of therapist barriers and facilitators of future adoption of video chat helpful in progressing the field of video chat technology beyond the COVID-19 pandemic.

The results of the reflexive thematic analysis highlight the importance of formal training and supervision support to the development of therapist confidence and competence to deliver dMH interventions via video chat technology. It appears that a scaffolded training programme with supervisory support not only reduces the cognitive load for trainee therapists but also contributes to knowledge development and skill acquisition. During skill acquisition, many therapists described a preference to develop their skills via video chat technology in addition to in person, stating that they liked the distance offered by the screen and increased access to resources when in session. Some therapists reported increased presence via video chat, perhaps due to feeling more comfortable via the screen. Other therapists, however, reported feeling more distracted. Future research could explore the unique factors that may account for these therapist differences to further understand how to potentially overcome these challenges and assess therapist suitability for the modality of video chat.

Therapists also initially described what appears to be reflective of expected uncertainty that can be experienced when in training. Therefore, it is plausible that some of the initial discomfort experienced by therapists in the current study is attributable to an overall lack of experience in the role of a therapist, as natural uncertainties can arise in learning a new assessment or new intervention beyond dMH skill development. With experience, trainee therapists were able to adapt their skills to effectively interact with their participants over video chat. Trainee therapists' confidence to manage any issues of risk or distress reportedly increased by the application of pre-existing knowledge learnt in training and the use of study protocols. As therapists reported access to resources as helpful in preparing for and navigating video chat technology, governing bodies must continue to provide access to evidence-based guidelines, templates and protocols to increase therapist adoption of video chat technology in practice.

Despite their training and developed protocols, the number one barrier to the future use of video chat identified by therapists was concern about risk management. The training protocols and supervision provided therapists with knowledge of how to manage risk and respond appropriately to distress. Nonetheless, therapists had limited practical opportunities before and during their participation in the clinical trial to practice and use their risk assessment and safety planning skills via video chat. Given the screening and exclusion criteria of the trial (i.e., suicidality), therapists potentially remained cautious about their ability to manage risk effectively via video chat due to a lack of practical experience. Therefore, the current therapist training programme (as well as future training programmes) could be enhanced by the addition of specific experiential opportunities for therapists to role-play their risk management skills via video chat technology before use.

According to therapists, effective delivery of support to participants through video chat required a strong foundation in therapeutic communication skills like empathy, warmth and unconditional positive regard. Of equal importance was knowing that these skills were transferable to the video chat context, with minor adaptations needed around managing the technology interface. It appears that therapists ensured the foundational components of therapeutic work were present and remained within awareness despite the potential distance created by the screen. Therapists also appeared to actively utilise self-reflection skills, reporting self-regulation and cultivation of presence to be important, along with the need for therapists to be flexible and proficient in observation, communication and problem-solving skills in a novel context. Therapists consider increasing motivation and self-efficacy, as well as using motivational interviewing skills, as crucial for keeping participants engaged in dMH intervention programmes. Therefore, future therapist training programmes should continue to include these skills to adequately prepare therapists for the role of providing therapist assistance adjunctive to a dMH intervention.

Therapists were also mindful of multitasking, as their role involved managing video chat technology and the development of a therapeutic relationship to facilitate effective therapeutic outcomes. The level of self-awareness required may partly account for the increased cognitive load reported. While it may be beneficial for therapists to be able to self-adjust in real time via video chat, this may mean they are preoccupied with their skill development and presentation at the expense of attention to their participants. A practical suggestion here might be that therapists minimise their image on screen. Future research could then evaluate how much of this potential distraction is attributable to the video chat modality (e.g., research comparing therapists who can see their image on the screen versus those who cannot) versus stage of training and experience level.

Despite all therapists undertaking a purposively developed dMH training programme that outlined the effectiveness research of dMH, scepticism towards video chat was still widespread in the therapist interviews. Therapists had acquired knowledge and skills, but it was not until they had the opportunity to experience the clinical trial that they realised that their initial concerns were unfounded and that their therapist skills were able to be adapted and transferred to an online environment. This scepticism is further evidence of the concerns expressed by Titov et al. (2019), who concluded that a supported training programme is necessary to decrease the likelihood of therapists unconsciously communicating untested beliefs or assumptions held of dMH effectiveness to clients.

While it appears that a training programme is important and may reduce the occurrence of unconscious projections, future research should seek to identify factors that contribute to the perpetuation of such therapists' beliefs in the presence of specific dMH training. Such beliefs may be symptomatic of a broader issue that continues to portray telehealth services as a poor substitute for in-person support, rather than normalising video chat as an equally acceptable option for service delivery. The COVID-19 pandemic has seen

a significant and rapid impact on the uptake of telehealth services; however, the dissemination and required use during periods of social distancing has potentially reinforced the message of video chat telehealth as merely an available substitute, rather than an acceptable equal modality.

Postgraduate training programmes in psychology, therefore, present an opportunity for normalising video chat telehealth as one modality in which mental health services can be delivered. Some postgraduate training programmes in Australia have started integrating training in both in-person and video chat telehealth modalities (i.e., Swinburne University of Technology and University of South Australia; Simpson et al., 2014, 2015). Given the increased need for therapist competency in technology and the demand for mental health services, this training framework must be adopted more widely in the Australian postgraduate psychology curriculum.

It may be helpful if training programmes integrate the effectiveness research into the teaching curricula and ensure skills are developed for use in both the telehealth and in-person contexts. Previously, training in dMH as a separate or necessary modality has been presented as an acceptable mode of service only for those living in rural and remote areas, or, more recently, during the COVID-19 pandemic. For the therapists who participated in the current study, the knowledge and skills learnt in their postgraduate training programme had to quickly be adapted for delivery via telehealth during the COVID-19 pandemic. It appears that the dMH therapist training programme completed by therapists prior to participation in the clinical trial scaffolded competency development and significantly increased knowledge and confidence to use dMH, as reflected in the therapists' change scores (i.e., improved by 31/100) after completing the training programme.

Training and familiarisation with the role of providing therapist assistance adjunctive to a dMH intervention was novel for the therapists in the current study. Before they participated in the clinical trial, the average amount of therapists' previous experience with telehealth or dMH interventions was 3 months. This is, unfortunately, not unique to the current study, and research providing a comprehensive overview for clinicians to integrate dMH into practice has been provided (Newby et al., 2020). The research of Newby et al. (2020) presents the advantages of therapists adopting dMH into practice, such as increasing the mental health workforce and access to evidence-based services.

While the current study presents several implications for training therapists in the use of delivering dMH interventions via video chat technology, this study is not without limitations. The views reflect therapists who consented to participate in the adaptive clinical trial delivering dMH interventions during the global COVID-19 pandemic. Therefore, it is somewhat difficult to discern what is attributable to the stage of training and competency development and the impact of the pandemic on therapist training and overall experience. All therapists were undertaking postgraduate training in psychology with various levels of prior clinical experience, which may present a methodological limitation. As a qualitative study, the data rely on the self-report accounts of therapists, with the potential for bias in

the investigator conducting the research. The first author conducted all semistructured interviews, transcribed and interpreted the data. The reflexive thematic analysis approach was chosen, however, as it values the active role of the researcher in coding and theme generation, in consultation with co-authors, as well as the subjectivity of experiences and perspectives reflected in the interview data (Braun & Clarke, 2022).

In conclusion, the current study provides valuable insights that can advance the field of video chat training in low- and high-intensity therapist-assisted dMH interventions. The qualitative findings present an opportunity for re-evaluation of training therapists to ensure specialised support is provided to equip therapists with the necessary skills and competency in dMH interventions, particularly in conducting assessments and delivering both low- and high-intensity therapeutic assistance via video chat technology. This study highlights the importance of integrating such training into existing models. Such training can maximise the benefits of therapist assistance adjunctive to a dMH intervention programme. This study presents therapists' perspectives on the adoption of video chat technology, including their perceived barriers and facilitators. By providing effective training and support, therapists can acquire the skills needed to deliver high-quality dMH interventions through video chat, which has significant benefits for scalability and therapists being better equipped to meet the evolving needs of their clients in clinical practice. The reflections of therapists presented in this paper highlight the transferability of therapist skills, as well as the opportunity for training programmes to positively influence the next generation of therapists' adoption of video chat technology and dMH interventions.

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CONFLICT OF INTEREST STATEMENT

BK was one of the primary creators of the Life Flex digital mental health programme. BK receives no personal income from the Life Flex programme.

DATA AVAILABILITY STATEMENT

Research data are not shared due to privacy and ethical restrictions.

ETHICS STATEMENT

This study received ethics approval from Federation University Australia (Approval ID: A19-095). Participation in this study was voluntary, and participants and therapists provided informed consent

by way of agreeing to the Plain Language Information Statement on the study's website.

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