Online Therapy Across the Lifespan: An Exploration into the Perspectives of Clients and Clinicians

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Chapter 1

Exploring Experiences of Online Therapy in a Post-Pandemic Context: A Systematic Review of Perspectives from Children, Young People, and their Clinicians

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Abstract

Children and young people's mental health is a longstanding public health concern, one which has been further exacerbated by the disruption from the Covid-19 pandemic. Although research into the effectiveness of online therapy has advanced considerably in recent years through increased use of the platform, less is known about its acceptability for this population. Even less is known about the experiences of clinicians delivering online therapy to children and young people. This systematic review aims to synthesise qualitative research exploring these experiences, specifically capturing data from the start of the pandemic onwards. A comprehensive search was conducted across EBSCOhost (APA PsycINFO, Child Development & Adolescent Studies, CINAHL, MEDLINE, Psychology and Behavioral Sciences Collection), EMBASE, and ProQuest, covering literature published between March 2020 and March 2025. Seven studies met the inclusion criteria, and quality was appraised using the CASP checklist. Thematic synthesis resulted in two overarching themes: (1) *Shifts in therapeutic dynamics impacting depth of connection*, and (2) *One size does not fit all*. These themes contain subthemes that reflect the impact of altered experiences in the therapeutic relationship between the young people and their clinicians, alongside the perceived benefits and limitations of the online platform. The insights discussed underscore the importance of tailoring online therapeutic interventions to the needs of the young person, while also considering the views of the clinicians. To the author's knowledge, this review is the first to integrate perspectives from children, young people, and clinicians, offering a greater understanding of the ethical, practical, and therapeutic considerations associated with online therapy in a post-pandemic landscape.

Keywords: children and young people, online therapy, clinician perspectives, mental health

Introduction

Research Context

Children and young people's mental health has been a longstanding concern for the Scottish Government, with significant attention placed on improving access to effective digital mental health care, as outlined in the NHS Recovery Plan (The Scottish Government, 2021). Even prior to the COVID-19 pandemic, Child and Adolescent Mental Health Services (CAMHS) were under increasing pressure due to high demand and long waiting times (The Scottish Government, 2018). The pandemic introduced further disruption, compounding existing challenges through prolonged school closures, social isolation, and reduced access to in-person support systems. Emerging evidence indicates that these disruptions have led to a deterioration in young people's mental health, with risks of enduring psychological difficulties (de Oliveira et al., 2022). Poor mental health in childhood has well-documented long-term consequences. Longitudinal studies have shown that mental health problems in early life are strongly associated with poorer educational attainment and lower employment rates (Minh et al. 2023), as well as an increased likelihood of experiencing mental health concerns persisting into adulthood (Mulraney et al. 2021). On a global scale, children's mental health continues to decline, carrying with it implications felt not just at the individual level, but on a societal level as well (World Health Organisation, 2025). As such, ensuring timely and accessible mental health support in childhood is not only a clinical priority, but also a social and economic one.

In response to the pandemic, mental health services rapidly pivoted to online delivery. For the purposes of this review, *online therapy* refers specifically to real-time, video-based psychological interventions delivered by a trained therapist, rather than asynchronous modalities such as text messaging or self-guided programs. While the transition to online therapy occurred out of necessity, it has since prompted sustained changes to service delivery. The Scottish Government continues to invest heavily in the use of technology in mental health care, with key strategies to improve equality and access to digital mental health care outlined the Care in the Digital Age: Delivery Plan 2025-2026 (The Scottish Government, 2025). These initiatives have involved expanding on existing digital mental wellbeing resources, widening the hours that patients can access online services, encouraging self-referrals, and investing in the evaluation of digital services. This investment highlights that online therapy is likely to remain a permanent fixture in the Scottish Government's action plan to improving mental health outcomes for the population. Alongside operational benefits such as reduced waiting

times and improved accessibility (National Institute for Health and Care Excellence; NICE, 2024), these gains, however, must be weighed against the lived experiences of those delivering and receiving care through the online platform. Fonagy et. al. (2022) highlight some important implications for providing online therapy to children and young people. These include concerns around the accessibility of online therapy for children who may be victims of abuse within their family home and lack the privacy to engage safely, and families impacted by digital poverty and unable to purchase the required data or technology to access online appointments.

Evidence-base for the use of online therapeutic interventions

There is a growing evidence base supporting the clinical effectiveness of online mental health interventions. A comprehensive systematic review and meta-analysis conducted by Fischer-Grote et al. (2024) explored the effectiveness of digital mental health interventions for children and young people with a range of emotional disorders. The results included mainly randomized-controlled trials, and reported various positive effects on the improvements in symptoms of depression, anxiety and overall mental wellbeing, with moderate to large effect sizes. However, the results highlight some risk of bias owing to the use of self-report measures. Furthermore, similar improvements in mental health outcome measures have been found in Potts et al. (2025), although these results are primarily based on mental health interventions delivered via app and asynchronous web-based platforms such as chat bots. The authors draw attention to the lack of generalisability within the results, particularly in relation to marginalised groups. Although these findings suggest the effectiveness of the online delivery platforms for mental health interventions, less is known about the acceptability and subjective experiences of the online platform. Acceptability is a key determinant of therapeutic engagement and retention, particularly for younger populations (Bear et al. 2024). Recent literature has begun to illuminate the complex and sometimes contradictory experiences of children and young people engaging in online therapy. A survey by the Scottish Government (2023) identified key barriers such as lack of access to devices, poor internet connectivity, and concerns around privacy, particularly within crowded or unsafe home environments. Despite these barriers, a qualitative study conducted by Hagyari-Donaldson and Scott (2024) has identified young people as “digital natives” suggesting that they are more comfortable with the online platform. However, the authors also highlighted the important issue of digital poverty, and how any findings about the usability of the online platform cannot be fairly generalisable to this population as a whole.

Clinicians' experiences are equally nuanced. A study conducted by Busch et al. (2025) explored clinicians' perceptions of providing online therapy to children and adolescents with problematic behaviours related to online media use. Although not generalisable to specific mental health conditions, the findings were that clinicians had less favourable views towards the online platform, due to issues with technical challenges, lack of infrastructure, and concerns around the therapeutic relationship. However, these results were based on survey data, therefore perhaps limiting the true depth of the clinicians' experiences, as well as the risk of bias introduced through convenience sampling. Furthermore, a study conducted by Pomales-Ramos et al. (2023) highlights the complexities associated with delivering online therapeutic interventions with children who are on the autistic spectrum. Issues relating to effectively engaging children in the online platform, and how best to utilise parent and carer involvement were among some of the key insights. Importantly, the authors noted that the data collection took place during the height of the pandemic at a time of increased disruption and challenges. The results may therefore have been biased because of this, highlighting the need for future research into the experiences of online therapy as society adapts to the digital delivery platforms becoming more 'normal' in the years following the pandemic.

Aims and Rationale

This review aims to use thematic synthesis to explore the qualitative experiences of children, young people, and their clinicians regarding their perceptions of online therapy from the emergence of the pandemic and beyond. With improvements in technology infrastructure and training opportunities, pre-pandemic data may reflect outdated concerns or barriers and therefore result in less generalisable findings. Focusing on post-pandemic data allows for an exploration of experiences in the context of more stable, intentional, and potentially sustainable service delivery models. With five years having passed since the onset of the pandemic, this review offers a timely opportunity to evaluate the extent to which online therapy is perceived as a viable and acceptable modality in a post-pandemic landscape. To the author's knowledge, no previous review has brought together both clinician and young person perspectives in this way, despite the central role both groups play in shaping the effectiveness of therapeutic outcomes. While the review originally aimed to synthesise data from post-pandemic studies where online therapy was more established, this was not possible due to the lack of published research. Furthermore, as the review includes international studies taking place in different parts of the world, the end of the pandemic was difficult to define. Therefore the decision to

include studies that also collected data during the height of the pandemic was made. This was also based on the premise that studies conducted during the first-wave of the pandemic still reflect real-world experiences of online therapy and are conceptually relevant, although the limitations of this have been explored in the discussion.

Research Questions

(1) What are the experiences of children, young people, and their clinicians regarding online therapy since the emergence of the Covid-19 pandemic?
(2) What are the benefits and/or costs of online therapy, from both the child and the clinician's perspective?

Methodology

Search strategy

This systematic review has been developed in accordance with the PRISMA reporting guidelines in order to uphold the transparency and quality of the research (Appendix 1, pg. 86). The review has been registered on PROSPERO (registration number: CRD42025645991). An initial scoping search of Google Scholar, and PsycINFO was conducted to ensure that there were no existing systematic reviews exploring the experiences of online therapy with children and young people, and their clinicians using post-pandemic data. The search strategy was structured using the Sample, Phenomenon, Interest, Design, Evaluation, Research type (SPIDER) framework due to its application with qualitative research (Cooke et al. 2012). Search terms were developed in collaboration with a librarian at the University of Glasgow. The following databases were searched: EBSCOhost (APA PsycINFO, Child Development & Adolescent Studies, CINAHL, MEDLINE, Psychology and Behavioral Sciences Collection), EMBASE, and ProQuest to identify grey literature and dissertation theses. Searches were limited to full-text articles and English language, with publication dates set between March 2020-March 2025 to capture post-pandemic data. Searches were conducted on 4th March 2025.

Eligibility Criteria

Table 1 (Appendix 1.1, pg. 87) provides details of the specific inclusion and exclusion criteria applied to the articles selected for this review, alongside the exact search terms used.

The search was designed to identify qualitative studies that explored the experiences of therapists delivering real-time, video-based online therapy to children and young people up to the age of 25 years old, alongside the experience of children and young people receiving online therapy. Studies were included if they used a qualitative method to investigate barriers and facilitators of online therapy. Exclusions applied to studies solely using carer or family responses, non-mental-health clinicians, family or parenting interventions, blended approaches (in-person sessions supplemented with online therapy), and asynchronous interventions using apps, text, or chatbots. The review specifically excluded survey responses, quantitative research, and studies focused only on intervention efficacy rather than lived experiences.

Given the vast heterogeneity surrounding the concept of 'online therapy', this review uses the term to refer to any therapeutic intervention that is aimed at improving the mental health of children and young people that is comparable to any face-to-face therapy in its style and content, but delivered online using a video-based platform. For example, a cognitive behavioural therapy intervention that has been delivered over video-conferencing rather than in-person. The rationale for including studies that only use synchronous (real-time) video-based interventions is to allow for the thorough exploration of the experiences of this type of online therapy, and not have this diluted by other methods of remote delivery, such as telephone, text-based, or computerised-CBT interventions that do not involve real-time input from a therapist. Many online platforms are available for the delivery of online video-conferencing therapy. As a result, where reference to 'the platform' is made, this will refer to all online video-conferencing delivery systems such as Zoom, Microsoft Teams, Attend Anywhere.

Furthermore, this review does not aim to explore the outcomes of specific therapeutic interventions, rather to encapsulate the experiences of receiving or delivering online video therapy instead of face-to-face therapy. The term 'clinician' has been used to refer to any therapeutic practitioner who is involved in delivering a therapeutic intervention aimed at improving children and young people's mental health. In order to increase the richness of data and add depth to the analysis, the review excludes studies which only utilise survey responses as their data collection method. Survey responses, even those using open-ended questions, do not allow for researchers to offer prompts for participants to elaborate (Braun and Clarke, 2021), and as the current review is solely interested in experiences, it was deemed appropriate to exclude studies using this data collection method. The results of the database searches were imported into AI-based software, Rayyan, for the removal of duplicates and to assist with the screening process against the inclusion/exclusion criteria.

Data Collection Process

Following screening of study title, abstract, and full-text against the eligibility criteria, the subsequent data were collected: author, date published, aims, setting, context relative to pandemic, data collection method, participant demographics, mental health conditions being treated, type of therapy being provided, qualitative method used, and main results. In instances

where the required information was not clearly reported in the original studies, this has been acknowledged to ensure transparency.

Quality Appraisal – Risk of Bias

The Critical Appraisal Skills Programme (CASP, 2023) developed a checklist to assess the quality of qualitative research articles for systematic reviews. This tool was selected for the review due to its endorsement from the Cochrane Qualitative and Implementation Methods Group (Noyes et al. 2018), and is the most consistently used quality appraisal tool in health and social care research (Dalton et al. 2017).

Data Synthesis

Thematic synthesis was the chosen method of analysis for several reasons. The researcher chose to take an interpretative and inductive stance towards the review, in order to generate concepts that were grounded in the findings of the included studies, rather than introducing a priori themes regarding experiences of online therapy. This was in order to ensure subtle nuances within the included articles were not excluded. According to Boland et al. (2017), thematic synthesis is well suited to reviews investigating acceptability and appropriateness of health interventions. Also, due to the small number of included articles, and the largely descriptive nature of the data, thematic synthesis was considered an appropriate integrative approach, while also allowing for an interpretative stance.

Researcher Positionality

The researcher has experience of delivering online psychological therapy within their current role as Trainee Clinical Psychologist in the NHS. They also have an awareness of how delivering therapy online can significantly improve waitlists and make efficient use of therapists' time. Therefore, it is important to note that these prior experiences and thoughts may have introduced some bias into the interpretation of the results. In addition, due to the researcher's prior knowledge of factors impacting the acceptability of online therapy in the adult population, it was possible that this could also introduce bias into the results of the review. Therefore, a constructivist lens was taken to interpretation of the data to stay grounded in the experiences detailed in the articles, with data being coded in the categories reported in each

article. A reflexive log served as a useful tool in order to record any concerns regarding bias emerging, as well as improving the transparency of the decision process within the data analysis. As an example, the decision to exclude studies relying solely on survey data was informed by the researcher's prior experience with qualitative interviewing, and a recognition of the richness and depth of data obtained by this method. It was decided that due to the lack of opportunity for participants to expand on subtle nuances within survey responses, this method was considered insufficiently detailed for the purposes of this review. A sample of the reflective log detailing further decision making processes is located in Appendix 3 on page 89.

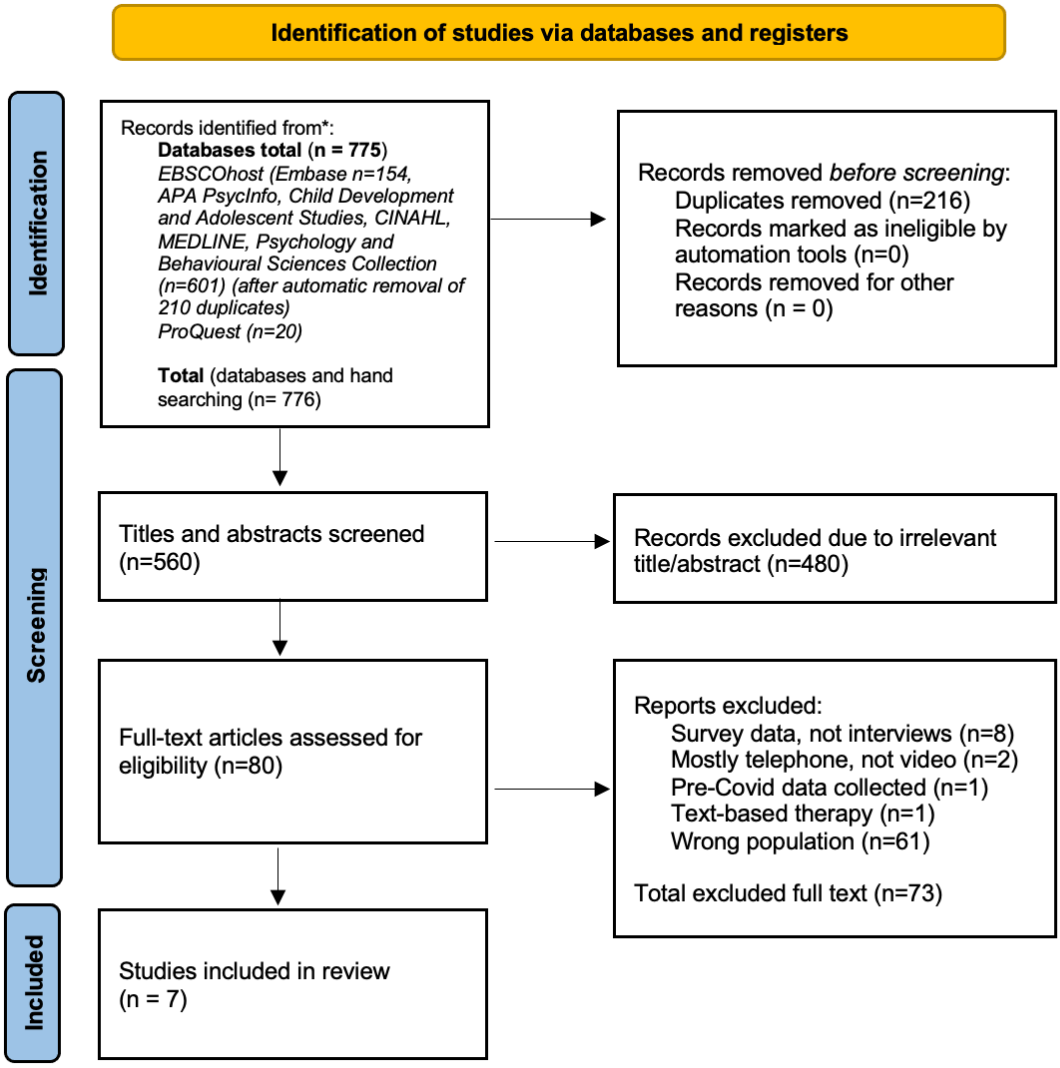
Results

Study selection

Figure 1 represents the search strategy from the databases that revealed a total of 776 articles. These were imported into Rayyan for the deduplication, and resulted in 216 duplicates being removed. The titles and abstracts of 560 articles were then screened which resulted in 480 articles being excluded. Full-text screening was then carried out on the remaining 80 articles against the inclusion criteria, with the subsequent removal of 73 articles that did not meet the inclusion criteria. Reasons for excluding articles at this stage related to studies that had used adult participants; collected data prior to the emergence of the pandemic; blended telephone interventions alongside video platforms; survey data; or text-based therapy. This resulted in a total of 7 articles included in the review. To improve the rigour of the process, a second researcher independently screened 70 articles from the initial search at the title and abstract stage, and 7 articles at the full-text stage. Any discrepancies between author decisions were discussed and resolved.

Figure 1

PRISMA Flow Diagram of the Search Process



Data Extraction

Details of the study characteristics have been extracted and are summarised in Table 1.

Table 1

Study Characteristics

Author and Year	**Primary Aims / Research Questions**	**Setting, Context and Data collection method**	**Participant Demographics**	**Mental health conditions being treated / therapies provided**	**Qualitative Method and Results**
1. Benzel & Graneist (2023)	Experiences of online therapy from the perspectives of child and adolescent psychotherapists and adolescent patients.	Semi-structured interview questions, an outpatient setting in Germany, in the first wave of the Covid-19 pandemic.	24 psychodynamic child and youth therapists, and 11 patients, aged 15–23 years (mean age =18).	Depression, psychosomatic disorders, or (social) anxieties.	Therapists: Qualitative Content. Adolescents: Sequence Analysis and Scenic Understanding. Four combined themes: (1) Altered conditions of time and space; (2) Altered conditions of closeness and distance; (3) Altered conditions of transitions; (4) Altered conditions of corporeality and body awareness

Author and Year	Primary Aims / Research Questions	Setting, Context and Data collection method	Participant Demographics	Mental health conditions being treated / therapies provided	Qualitative Method and Results
2. Castro et al. (2023) * Parent responses were not reported as this was beyond the scope of the review.	Feasibility, perceived strengths and limitations of telehealth-delivered cognitive behavioural therapy (CBT) for paediatric anxiety from the perspective of therapist, youth, and their parents.	Community Mental Health setting in California USA with Lantinx population in the first wave of the pandemic in early 2020.	Three focus groups were conducted: one with 13 youth (aged 8–17); one with 4 mental health providers; and the third with parents of the youth*,	Anxiety. No information was on the therapeutic approaches offered.	Grounded Theory Seven main themes: (1) privacy and confidentiality; (2) limitations with telehealth; (3) comfort with telehealth; (4) therapeutic relationship; (5) perceived strengths of telehealth; (6) safety; (7) advice for therapists starting telehealth.
3. Cohen and Gindi (2023)	Experiences of child therapists transitioning to online therapy with children during the Covid-19 pandemic.	Interviews took place during the first wave of the Covid-19 pandemic in 2020 in an outpatient mental health service for children and youth in Israel.	20 female therapists working with children under the age of 12.	No data provided on the types of mental health conditions being treated. Therapists were psychologists or art therapists providing integrative, humanistic, and psychodynamic therapy.	Thematic analysis Two main themes: (1) Online psychological therapy as a transformative (2) The limitations of online psychotherapy

Author and Year	Primary Aims / Research Questions	Setting, Context and Data collection method	Participant Demographics	Mental health conditions being treated / therapies provided	Qualitative Method and Results
4. Erlandsson et al. (2022)	Experiences of child and adolescent therapists on the transition from face-to-face to video-mediated psychotherapy during the COVID-19 pandemic.	Semi-structured interviews with 16 therapists in child and adolescent mental health services across various locations in Sweden between August 2021-Jan 2022.	Participants were therapists working with children and adolescents providing psychotherapy. No details on types of mental health conditions treated were provided.	Therapists did not report their therapeutic orientation and no details provided for mental health conditions being treated.	Inductive thematic analysis Five main themes: (1) Issues with patient safety (2) Restricted therapeutic repertoire (3) High demands on the patient (4) Pros and cons of the new normal (5) Possibilities and limitations of communication technology
5. Krane et al. (2023)	How do young people receiving Child Welfare Services (CWS) experience video conferencing (VC) in mental health treatment? How do young people receiving CWS experience the therapeutic relationship in VC treatment?	Semin-structured interviews in a Child and Adolescent Mental Health Service in between 2021-2022.	10 care-experienced young people aged 15–19 years (mean age =17)	Anxiety, depression, eating disorders, PTSD, borderline personality disorder.	Thematic Analysis Three main themes: (1) Video consultations can be OK, but it's not like real treatment; (2) You can escape video consultations when it's too demanding; (3) Video consultations can be timesaving but can also be really messy.

Author and Year	Primary Aims / Research Questions	Setting, Context and Data collection method	Participant Demographics	Mental health conditions being treated / therapies provided	Qualitative Method and Results
6. Usluoglu & Balık (2024)	Psychotherapists' experiences and views of videoconferencing psychotherapy (VCP) conducted with children - 1) What are child psychologists' experiences of VCP? 2) What are child psychologists' views about the suitability of VCP in psychological disorders?	Open ended interviews with therapists working across several Education and Psychological Counselling Centres in Turkey between January and March 2022.	7 female therapists.	Cognitive Behaviour Therapy (CBT), play therapy, Eye Movement Desensitisation and Reprocessing (EMDR) and 'eclectic' therapy. No details provided for mental health conditions being treated.	Inductive Content Analysis Two Main themes and subthemes: (1) Benefits and possibilities (2) Difficulties and limitations
7. Van Rooij, Weeland & Thonies (2023)	How youth care professionals and adolescent clients experienced the sudden transition to telehealth during the early waves of the COVID pandemic.	Two interview studies: (1) with therapists during the first wave of COVID pandemic working in an outpatient mental health care setting in the Netherlands; (2) Adolescents who used mental health care support during the second wave of the COVID pandemic in the Netherlands (2020).	20 Child and Adolescent Therapists were interviewed on their experiences Fourteen adolescents aged between 12 and 22 years old (mean age =17.5)	Depressive disorders, mood disorder, post-traumatic stress disorder, suicidal thoughts or attempts, anxiety disorders, autism spectrum disorder, eating disorders, attachment problems, attention deficit disorder, sensory overload, emotion regulation problems, signs of Borderline Personality Disorder.	Constant Comparative Method Eight main themes and subthemes: (1) General changes regarding client situation (2) General experience with transitioning to telehealth (3) Tools (4) *Privacy* (5) Alliance (6) Content and working Methods (7) Perceived effectiveness (8) Telehealth in the future

Quality Appraisal

The results of the quality appraisal using the CASP (2023) tool concluded that of the seven included articles, all but Castro et al. (2023) provided a clear statement of aims and appropriately used a qualitative design, though three articles lacked sufficient justification for their chosen method. Recruitment strategies were generally well described, except in Usluoglu and Balik (2024), and Benzel and Graneist (2023) which provided limited detail on data collection. Only Van Rooij, Weeland and Thonies (2023) and Erlandsson et al. (2022) reported transparency on the relationship between researcher and participants, raising potential bias concerns. Ethical procedures appeared sound across all articles. Krane et al. (2023) and Cohen and Gindi (2023) lacked detail on epistemological positions in data analysis, and Cohen and Gindi (2023) did not clearly present findings. Overall there was evidence of sound methodological rigour amongst the majority of the articles particularly in recruitment, data collection, and analysis, with notable strength in Usluoglu and Balik (2024), Van Rooij, Weeland and Thonies (2023), and Erlandsson et al. (2022). The main limitations across the articles were insufficient justification of methodological choices, and limited researcher reflexivity. See Appendix 2 on page 87 for further details regarding the decisions around quality rating.

To provide increased confidence in the quality appraisal, a second researcher with experience of qualitative research applied the CASP tool to three of the included articles. Only one discrepancy was reported from this with regards to the reporting of the results of one of the studies, and a discussion took place to ensure a consensus was reached in the quality appraisal.

Table 2

CASP Ratings

First author	Krane (2023)	Benzel (2023)	Usluoglu (2024)	Castro (2023)	Cohen (2023)	Van Rooij (2023)	Erlandsson (2022)
Are the results valid?							
1. Was there a clear statement of the aims of the research?	Yes	Yes	Yes	No	Yes	Yes	Yes
2. Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3. Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Can't tell
4. Was the recruitment strategy appropriate to the aims of the research?	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes
5. Was the data collected in a way that addressed the research issue?	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes
6. Has the relationship between researcher and participants been adequately considered?	No	No	Can't tell	Can't tell	No	Yes	Yes
What are the results?							
7. Have ethical issues been taken into consideration?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8. Was the data analysis sufficiently rigorous?	No	Yes	Yes	Yes	No	Yes	Yes
9. Is there a clear statement of findings?	Yes	Yes	Yes	Yes	No	Yes	Yes
Will the results help locally?							
10. How valuable is the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Data Analysis

The data analysis has been conducted following the procedures laid out by Thomas and Harden (2008). A more detailed description of the analysis can be found in Appendix 4 on page 91 and provides full transparency of this process, along with the number of studies contributing to the final analytical themes. First, the results sections of all the included articles were uploaded into Nvivo (a qualitative data analysis software tool) to assist with the management of the data. Then, line-by-line coding of the articles specifically from the children and young people's experiences took place without a priori themes being considered, in a process known as free-coding. Author interpretations, alongside direct quotes from participants were coded in this way. The process of 'free coding' allowed for the translation of concepts between the included studies, and resulted in an initial 14 main codes with sub-categories identified at this stage (see Table 1 in Appendix 4 (pg. 91) for the initial codes. These initial codes from the children and young people's perspectives were then used as a template to code the data from the articles exploring the clinician's experiences, while allowing for any additional codes that were unique to the clinicians to be identified. The final codes from this process were then grouped together into broader descriptive themes that summarised and combined the main findings of the included studies across the children, young people, and clinicians' experiences. See Table 5 in Appendix 4 (pg. 91) for summary of descriptive themes. From here, the final analytical themes were developed through a more in-depth interpretation of the descriptive themes. This was completed by identifying the relationships between, and patterns within the data, alongside consultation with a Clinical Psychologist experienced in qualitative research. Analytical themes were then brought into the context of real-world implications to provide answers to the research questions of the review.

Study and Participant Characteristics

The synthesis was conducted on seven studies with the results representing the experiences of 139 participants in total (48 children and young people aged between 12 and 22 years, and 91 clinicians). A diverse range of mental health conditions were treated, including: anxiety; depression; eating disorders; Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD), Borderline Personality Disorder, and

emotion regulation difficulties. Where stated, the types of therapies being delivered were: Cognitive Behaviour Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR), play therapy and psychodynamic therapy. These studies took place across a range of clinical, and cultural settings, including Norway, Sweden, Germany, Israel, Turkey, the United States of America and the Netherlands. Of the seven included articles, six represent clinician's experiences and four represent children and young people's experiences.

The synthesis resulted in the arrival of two main themes, and four subthemes:

Table 3

Themes and Subthemes

Themes	**Subthemes**
Theme 1 - *Shifts in therapeutic dynamics impacting depth of connection*	*Perceived control over therapeutic environment* *Varied Experiences of Therapeutic Connection*
Theme 2 – *One size does not fit all*	*Therapeutic opportunities and obstacles - A double-edged platform* *Individual preferences - a necessary compromise in times of disruption*

An explanation of each theme and subtheme will now be presented in line with the research questions relating to the general perceptions of online therapy, alongside costs and benefits of the online platform.

Shifts in therapeutic dynamics impacting depth of connection

This theme captures how the therapeutic experience of children, young people and clinicians is altered in the online setting. This is particularly in relation to the changes in perceived control over the therapeutic environment, which appears to result in shifts within the therapeutic relationship, therefore impacting the depth of therapeutic connections.

Perceived control of the therapeutic environment

Clinicians described their sense of unease when delivering online therapy to children and young people, with an evident theme of discomfort around the shift in perceived control over the therapeutic environment. An author quote from Benzel and Graneist (2023) captures the essence of their discomfort arising from the shift in therapeutic dynamics brought about by the online platform;

> "*So, instead of the patients visiting their therapists' treatment rooms, the therapists now visit their patients' rooms which, in the experience of the therapists, turns the relationship upside down."*

Clinicians appeared to struggle with the lack of control over ensuring a safe therapeutic space from which to provide therapy, and found that it hindered their ability to reach the therapeutic depths with their patients, with one clinician from Cohen and Gindi (2023) expressing;

> *"In the clinic, the room was her safe space . . . Every time we met on Zoom she went out into the street. There is no control over the setting … it was complicated for me to be in this place where everything flows out."*

Furthermore, clinicians expressed how they noticed that their young clients struggled with the lost sense of privacy in the online setting, which impacted what they brought to their sessions. One clinician from Benzel and Graneist (2023) expressed how their young clients *"turned to the door over and over again to check that no one was coming in"* which made it incredibly hard for both clinician and client to talk about substantial topics

and reach the necessary therapeutic depth of connection required for meaningful interventions.

However, some clinicians noticed that the shift in perceived control as a result of young people attending therapy from their own safe and familiar environment allowed some young people to reach greater depths of therapeutic connection, as evidenced by this clinician's quote from Benzel and Graneist (2023);

> *"It has even intensified some conversations where I thought, this is something like a protective space, to sit in one's own capsule, maybe also with the fantasy of being able to press the button at any time. So, you can, to speak simply, click yourself away."*

Furthermore, one young person from Krane et al. (2023) highlights how the online space created an opportunity for escape, something that perhaps feels harder to achieve when attending therapy in a clinic room;

> *"It was kind of OK, because I just hung up when I didn't want to talk anymore.*"

It appears that the online platform can be both an unsettling environment for therapists who want to ensure the safety of their young clients, coupled with a newfound opportunity to achieve greater depths within therapy sessions when young people perceived that they have more control over their treatment, or at least a quick escape.

Varied experiences of therapeutic connection

A consistent theme across all of the included articles was a mutual expression of therapeutic disconnection, and a sense of tangible distance between clinicians and young people when engaging in online therapy. This sense of disconnection was uncomfortable for the clinicians, with one from Benzel and Graneist (2023) describing;

> *"When dramatic things are told or so, then you feel so far away and it's somehow harder to contain because you have the feeling that you're so separated."*

Despite these challenges, one young person from Castro et al (2023) described how the online platform resulted in the development of a different kind of connection;

> *"You can get to know what kind of stuff your therapist likes through their screen and that can help with relating to them and forming a good connection."*.

This was felt similarly from the clinician's perspective in Cohen and Gindi (2023);

> "*Suddenly the exposure to the client's world. I saw the room. The girl was engaged in art, and she could show me all the artwork she had made; there was a possibility to see the room and her world."*

It can be considered that although the online platform creates a physical barrier between the young person and their therapist, the unspoken barriers related to the power dynamics appear to shift through the online platform, allowing the young people, and therapists, to see more of who they truly are, and potentially laying the foundations for a different, but in some ways, deeper therapeutic connection.

One size does not fit all

This main theme captures the complex and, at times, contradictory experiences of children, young people and clinicians engaging with online therapy. It represents the many perceived benefits and costs of the online platform, alongside the appreciation that ultimately, the delivery format itself is not inherently positive or negative, but mediated by individual preferences, interpersonal, and contextual factors.

Therapeutic opportunities and obstacles – a double edged platform

This subtheme examines the dual nature of online therapy, recognising the valuable opportunities and benefits it offers, alongside the barriers and limitations perceived by both clinicians and young people. Online therapy introduced a range of tangible benefits across the young people and the clinician's experiences, such as; continuity of care, improved flexibility, accessibility, and helpful shifts in power dynamics. One clinician from Van Rooij, Weeland and Thonies (2023) highlighted the benefit of flexibility and

adaptability that the online platform brings, particularly for working with children and young people who perhaps struggle to engage and attend therapy;

> "*We don't really have a very appointment-loyal target group and sometimes they were too late. Then I usually just moved the appointment to the next week or so, but now I think: I can also make a video call right away."*

This quote highlights how the flexibility of remote working can help to avoid otherwise non-attended appointments, and support in the continuity of care for young people. However, these advantages were coupled with significant challenges, particularly if the young people were experiencing more severe and complex mental health conditions. Clinicians highlighted important issues regarding the suitability of certain therapies being delivered online for this reason. There was a general sense of fear and lack of confidence, coupled with frustration expressed by clinicians in several studies regarding the difficulties posed by delivering therapy online, with one clinician from Cohen and Gindi (2023) highlighting;

> *"I am powerless in this place . . . . I want to see the "whites of their eyes", and it does not go over well. Having a real human being with you, feeling his warmth, his tears, if necessary, is essential for treating depression."*

This quote highlights the real challenges of providing online therapy to children and young people, and suggests the sense of distress and unease that clinicians expressed with their confidence in treating more complex mental health conditions.

Individual preferences – a necessary compromise in times of disruption

This subtheme captures the individual preferences that determine whether or not the online platform is acceptable for clinicians and young people, with the recognition that online therapy is better than no therapy at all. Across the included articles, it did appear that young people and clinicians favoured in-person therapy over online therapy, but for different reasons. For the clinicians, it appeared that their experience of the online platform was marred by insecurities and concerns likely emanating from the novelty of

the online platform. One clinician from Van Rooij, Weeland and Thonies (2023) highlighted;

> *""I'm worried, did I handle this properly, what would you do?" And that is also lost when you're at home alone behind your laptop. I also think that this makes work a bit heavy. That consultation with colleagues is not a matter of course."*

There was an undertone of aloneness in the online platform, particularly for the clinicians who had been used to working closely with one another. This was perhaps symptomatic of the rapid transition from in-person to online therapy, without the necessary training. Frustrations were also felt with the distractibility of the platform, particularly when working with younger children, as one clinician from Cohen and Gindi (2023) articulates;

> *"Stimuli always pop up on the computer . . . it creates an experience of distraction. You must constantly compete with it, try to generate interest, and keep the child focused. It creates a lot of frustration."*

While technology concerns arose frequently among the clinicians' experiences, children and young people did not appear to be disturbed by internet glitches, or issues managing the technology, which is perhaps symbolic of the generational differences in technology acceptability. The young people appeared to be more troubled by the loss of a separate space to explore their feelings, as one young person from Benzel and Graneistt (2023) said;

> *"I thought about my problems (...) in my bed (...) I went to my desk, talked about my problems, but then I just went back to my bed and lay there again and thought about my problems, so (...) it just (...) didn't really, it (...) wasn't as relieving as I just (...) knew when I talked about it in person."*

Fundamentally, acceptability comes down to personal preferences, and it is clear to see from the included studies that online therapy in the early days after the pandemic was not a panacea. Many clinicians and young people alike recognised that online therapy was a temporary solution, but not something that should be a default. One clinician from Cohen and Gindi (2023) summarises this;

> *"I switched to online psychotherapy thinking that it was better than not meeting at all and interrupting the therapeutic continuity. To this day, I think the priority is face-to-face."*

These experiences highlight the importance of choice in the platform, and recognise that individual preferences are an important factor in the acceptability of online therapy.

In summary, children, young people, and clinicians experience online therapy to be an amalgamation of altered experiences. For some, there was a diminished sense of therapeutic depth, yet for others, a greater sense of empowerment contributed to feelings of increased safety that enhanced the therapeutic experience. These themes bring together the diverse and often contradictory experiences of the online platform.

Discussion

This review provides a comprehensive thematic synthesis of seven qualitative studies exploring the combined experiences of children, young people, and their clinicians of online therapy from the start of the pandemic onwards. The synthesis resulted in two main themes: (1) Shifts in therapeutic dynamics impacting depth of connection; and (2) One size does not fit all. These themes remain largely aligned with the original themes from the seven included studies, such as addressing the changes to therapeutic relationships, and the benefits and costs of online therapy. However, by bringing together children, young people, and clinicians' experiences, this has allowed for greater understanding and novel interpretation of these shared experiences that add to the existing evidence base.

In response to the first research question about the experiences of online therapy for children, young people, and their clinicians, the first theme captures a similar sense of altered therapeutic dynamics that has previously been found in the literature. A systematic review conducted by McCoyd et al. (2022) explores clinicians perceptions of providing online therapy with an adult client group, and reports similar experiences of distance and disconnection, coupled with an additional sense of safety that their clients appeared to experience from being in their own home. The authors also recognised the additional effort required on the therapist's part in building a strong therapeutic alliance,

which supports the findings of the current review that depth can be maintained or even enhanced, but requires deliberate effort from the therapist to compensate for changes in therapeutic dynamics.

In relation to the benefits of online therapy, the findings of improved accessibility and continuity of care are also echoed in previous research (Stewart et al. 2021). However, the sense that online therapy enhances depth through an opportunity to quickly end contact with a therapist appears to be an addition to the evidence base. This finding can be contextualised within Erikson's Psychosocial Stage Theory of Development (Erikson, 1968). According to Erikson, adolescents seek autonomy and agency in the 'identity versus role confusion' stage of the model. When young people perceive greater control over how they interact with their therapist, such as being able to end a therapy session from the click of a button, the online platform may support this developmental need for autonomy, and suggests a theoretical base for why the online platform may contribute positively to building deeper therapeutic relationships.

Furthermore, the power dynamics between a clinician and a young person in an in-person therapeutic relationship can often be perceived as imbalanced, with the adolescent aware that the clinician holds the authority (Cook and Monk, 2020). In the online platform, the shifts in therapeutic dynamics and power create an opportunity for the young people to feel more in control, but perhaps at a compromise to the clinicians' sense of control. Although this highlights important considerations for how to support young people who may struggle to attend in-person settings in engaging with online therapy as a more manageable alternative, it is important that clinicians also feel comfortable with the change in dynamics as well. The findings from the current review align with previous research suggesting that careful consideration is needed when delivering therapy online, particularly in relation to the type of mental health condition being treated. More severe and enduring difficulties, especially those linked to trauma, may be less suited to the online format (Hagyari-Donaldson & Scott, 2024).

The finding that young people and clinicians appreciated being able to see into each other's worlds during therapy sessions offers valuable insight into how the platform may be perceived as less intimidating, and more personable for some young people and clinicians. However, this benefit is highly subjective, as although some may find it

improves therapeutic alliance, others may perceive it to blur the boundaries between private and professional lives (Benzel and Graneist, 2023). Additionally, clinicians in several studies expressed discomfort when delivering therapy to young people in environments that appeared unsafe. Carleton (2016) discusses the role of discomfort in the face of the unknown, and the concept of Intolerance of Uncertainty. For clinicians with lower tolerances for uncertainty, it is arguable that this discomfort may not reflect resistance to delivering online therapy in principle, but rather it is the psychological response to reduced feelings of certainty that they are able to deliver therapy in a safe way. These concerns underscore the need for clear ethical guidance when providing therapy remotely. It is likely that such guidelines were not well established at the time of data collection for the included studies due to the sudden emergence of the pandemic. However, more recent guidance set out by the Health and Care Professions Council (HCPC, 2024), emphasises the importance of assessing the suitability of remote delivery on an individual basis, particularly in relation to managing risk and maintaining confidentiality. While such guidelines are undoubtedly helpful, the reality is that providing online therapy with children and young people often involves unpredictable challenges that require clinicians to respond flexibly in the moment. These complexities can understandably lead to uncertainty and stress for clinicians, reinforcing the broader findings that online therapy cannot a ‘one size fits all’ approach.

Strengths and Limitations

A key strength of this review is the integration of perspectives from both children, young people, and their clinicians. By synthesising these experiences, the review offers a more holistic understanding of the therapeutic process in how online therapy is experienced on both sides of the relationship. This integrated approach allows for the identification of the differences between experiences, highlighting where clinicians' perspectives align or contrast with young people's experiences. Such insights are valuable for improving the delivery of online therapy, as they inform more responsive, collaborative, and person-centred approaches. These are key insights that may be lost if each group were studied in isolation.

Another strength of this research is the transparency of the synthesis process, through the use of Nvivo software to code the data, and the second rater for the screening process

and the critical appraisal of individual studies. These approaches helped to reduce the risk of bias. However, the review could have been improved through the use of an additional research team to assist with the initial coding of the data, in order to ensure consensus amongst the decisions made in the earlier stages of the review.

Furthermore, due to the limited evidence base in this fast-evolving topic, no articles were excluded on the basis of the quality assessment through the CASP assessment tool. While the majority of studies demonstrated sufficiently rigorous data analysis, others, notably Krane et al (2023) and Cohen and Gindi (2023) were rated as less robust in this domain. Reflexivity, including discussion of the researcher's epistemological stance, was frequently under-addressed, indicating a risk of researcher bias across the included studies. Despite this, some of the articles that were rated more methodically sound (Van Rooij, Weeland and Thonies (2023) and Erlandsson et al (2022) did not report adequate depth in their participant quotes, therefore quotes from less high-quality studies have been reported throughout this review, and caution must be taken with regards to the risk of bias amongst the findings.

A further point to discuss relates to the proximity of data collection to the emergence of the pandemic amongst the included studies, and the resulting small number of included studies in the review. It was initially anticipated that this review would be able to separate participants' experiences related to the sudden emergence of online therapy from the more planned use of the platform, and therefore identify the experiences outwith the context of the disruption caused by the pandemic. However, only three of the included studies (Krane et al. (2023), Usluglu and Balik (2024), and Erlandsson et al. (2022)) can be considered to have collected their data at a time when government-mandated lockdowns had eased. Therefore these results can only be considered as partly representative of service provision going forward, and future research would benefit from repeating this review in several years to fully capture the experiences of children, young people, and clinicians of online therapy when it is a clear choice, rather than a necessity.

Service improvements and future research

With the results of this review generally suggesting that children, young people, and their clinicians appear to find online therapy an acceptable temporary solution, many participants did not view the online platform as a sustainable option. This brings with it implications for how to ensure service provision continues to meet the needs of its users. Key insights from the work of Fonagy et al. (2020) suggest that in order to provide effective mental health support using the online platform, therapists are encouraged to adopt a mentalising stance by staying curious and attuned to the inner world of the client, especially in the absence of non-verbal cues. These findings highlight the importance of ensuring adequate training is provided to therapists who work across online and face-to-face platforms, as different therapeutic skills may be required depending on the delivery platform.

Only one of the included studies, Castro et al. (2023) was representative of under-resourced young people, which highlights the ongoing issue that research into digital therapy is often not generalisable to people of a lower socioeconomic status. While online therapy has significantly expanded access to mental health services, the issue of digital exclusion cannot be overlooked. It will be critical for service providers and stakeholders to be aware of these issues in order to prevent the risk of exacerbating existing inequalities. Aisbitt, Nolte, and Fonagy (2023) offer several practical recommendations to address these challenges, including: social prescribing of phone contacts, schools loaning out devices to young people engaging in therapy, as well as prioritising families from low socioeconomic backgrounds for face-to-face therapy. These measures may help to bridge the digital divide and ensure that increased availability does not come at the cost of accessibility, with the aim of future research being more representative of the experiences across diverse socioeconomic statuses.

Furthermore, the findings of this review emphasised the importance of having a safe and private space from which to engage in therapy, and this is something that many children and young people do not have. Fundamentally, the importance of flexibility and choice in the provision of therapy for children, young people, and the clinicians delivering it is evident. All of the included articles in this review demonstrated that the acceptability of online therapy was dependent on individual preferences, clinical presentations, and

environmental factors. Furthermore, since the acceptability of digital platforms is closely linked to engagement, Lau et al. (2024) emphasise the need for the use of validated and consistent outcome measures for assessing acceptability in effectiveness studies. This would help to ensure that research into mental health remains person-centred.

The varied and contrasting experiences articulated across the participants make it difficult to offer concrete recommendations on whether online therapy is more or less acceptable compared to in-person therapy, but these important insights from the children, young people, and clinicians across the articles ultimately underscore the need for personalised and flexible approaches to service provision, where the therapeutic delivery platform can take into account the personal needs and preferences of the client, offering informed choice and adaptability where possible.

Conclusion

In conclusion, this review aimed to explore the experiences of children, young people, and their clinicians in relation to online therapy from the emergence of the pandemic onwards. The two main themes found relate to the shifts in therapeutic dynamics impacting the depth of connections, and the sense that online therapy is not a 'one size fits all' approach. The associated costs and benefits of engaging with the online platform have also been discussed within the subthemes identified. By bringing together these experiences, it has been possible to understand the perspectives from both sides of the therapeutic relationship. The insights discussed in this review underscore the importance of tailoring online therapeutic interventions to the needs of the young person, while also considering the views of the clinicians. Although limited by the small number of included studies, the review provides novel findings to add to the research base in this fast-evolving subject area. As the use of the digital platform in mental health services continues to advance, this review emphasises how services must be developed and delivered in ways that are ethically sound, while ultimately holding the young people and the clinicians at the centre.

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Chapter 2

Patients' Perspectives and Experiences of Digitally-Delivered Psychological Therapy Groups in an Adult Mental Health Setting

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Plain Language Summary

Title: Patients' Perspectives and Experiences of Digitally-Delivered Psychological Therapy Groups in an Adult Mental Health Setting

Background: The Covid-19 pandemic caused a sudden change in how mental health treatment is delivered, moving from in-person appointments towards 'digitally delivered' online therapy, through the use of video appointments. There are some benefits to online therapy, such as reduced travel costs and easier access to treatments. However, there are also worries about privacy, and difficulties accessing the technology needed to attend an online appointment. The use of digital therapy is predicted to increase, particularly in the form of group therapy, as this helps services improve access to psychological therapy and cope with the increasing numbers of people needing mental health support. It is therefore important to understand patients' experiences of digital group therapy. If this is something that patients do not feel comfortable with, it is important to understand why so that psychological services can make changes that result in the right support for everyone.

Aims: The study aims to learn about patients' experiences of accessing psychological therapy in a digital group format, and to understand the reasons why some patients decide to stop attending digital group therapy.

Research Question: What benefits and costs do participants perceive there to be for digitally-delivered psychological therapy groups?

Methods: Participants were recruited from NHS Greater Glasgow & Clyde (GG&C) Psychological Therapies Group Service (PTGS). This service provides online (video) group-based psychological therapy to patients who have been referred for support from their Community Mental Health Team (CMHT) within NHS Greater Glasgow & Clyde. Patients who are still under the care of their CMHT, and aged between 18-65 years were able to participate. All types of mental health conditions and intellectual abilities were included. For the recruitment, clinicians working in the PTGS gave information about the study to potential participants, and then informed the researchers of which participants wanted to take part. This study followed a qualitative design. Semi-

structured interviews were completed with 13 participants between the ages of 19 and 52 years old. Interview questions were designed to explore participants' experiences of the group they attended. Framework analysis was used to explore the themes that came out of the participants' experiences of attending their group.

Main Findings and Conclusions: Four main themes were found, and these were used to help provide an answer to the research question relating to participants' experiences of attending online group therapy. These themes were: Expectations, Engagement, Therapeutic Relationships, and Attendance, each with several related subthemes. Within each theme there were factors which can be considered a benefit of attending online group therapy, and factors which highlight some of the barriers of the online group setting. These findings have helped to provide some information for services, particularly with regards to the importance of choice in how mental health treatments are provided.

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Abstract

The Covid-19 pandemic necessitated a rapid transition from in-person to digitally-delivered psychological therapy. While emerging evidence points to a range of benefits and challenges associated with online therapy, research specifically exploring patients' experiences of digitally-delivered group therapy remains limited. In the context of the Scottish Government's aim to improve access and reduce waiting times for psychological services, online group therapy has become an increasingly utilised intervention. This qualitative study explored the experiences of 13 patients (12 of whom attended, and one who dropped out) of an online group therapy intervention through an NHS Adult Mental Health Service. Semi-structured interviews were conducted, and the data was analysed using Framework Analysis. The final framework identified four interrelated themes: Expectations, Engagement, Therapeutic Relationships, and Attendance, with each theme containing subthemes exploring facilitators and barriers to participation. These themes offer insight into the acceptability, benefits, and challenges of online group therapy from the patient's perspective. Implications for the design and delivery of future digital mental health services are discussed in the context of the findings.

Keywords: Digitally-delivered group therapy, Adult mental health, Patient experiences, Framework Analysis, Facilitators and Barriers

Introduction

The Covid-19 pandemic forced a rapid uptake in the implementation of digitally-delivered psychological interventions (Scottish Government, 2021). Such interventions encompass a wide range of formats. These include smartphone apps, online self-help tools, and therapist-guided support via text, telephone and video conferencing software, often using a range of online platforms such as Microsoft Teams, Zoom, and Attend Anywhere. Hereafter, the term 'platform' will refer to any of these online delivery platforms. The increase in the use of group-based online psychological interventions is also expanding. However, there are concerns that psychological therapy moved online without the adequate research to explore best-practice guidelines (Skegg et al. 2021). Now in the years after the pandemic, it is important to investigate patients' experiences of online group psychological therapy in order to understand what factors make the online setting a more or less acceptable platform from which to receive mental health interventions.

Current evidence base for digital interventions

There was a marked increase in research exploring the acceptability of digital psychological interventions during the Covid-19 pandemic. Borghouts et al. (2021) conducted a comprehensive systematic review investigating the barriers and facilitators of engagement with digital mental health interventions across 208 individual studies. User characteristics, such as severity of mental health issues; participants' experience of the content of the intervention, such as perceived utility; and the technology and implementation environment were all found to be important factors in the acceptability of digital interventions. A lack of personalisation within the interventions was noted as a barrier to engagement. The review included both qualitative and quantitative studies which adds to the depth of information obtained. However, the majority of the studies included in the review were based on 1:1 digital interventions, rather than group therapies, and a blend of synchronous and asynchronous interventions. Of the 10 studies that did include some aspect of group therapy, such as focus groups, several of these studies incorporated blended approaches which augmented face-to-face groups with individually accessed app or web-based resources. Given the large number of studies included, some notable limitations in the methodology of this review include the

heterogeneity within the types of interventions offered, the methodology, and presenting mental health conditions. This makes it difficult to generalise these findings to specific population groups or mental health conditions. Additionally, the authors note that the review was conducted prior to the pandemic, indicating that there may be unique factors that influence engagement levels which might only be revealed in future studies.

At a service level, the benefits of online group-based psychological interventions in mental health services are well established. These include reducing waiting times for patients accessing psychological care, and increasing clinicians' capacity to offer interventions to a larger number of patients, both of which are targets of the Scottish Government (2021) NHS Recovery Plan. On a personal level, the evidence-base is more nuanced, and captures a range of factors impacting individual experiences of online group therapy interventions.

Factors impacting the acceptability of online group therapy

A systematic review on the experiences of online group psychotherapy, conducted by Andrews et al. (2024), found several themes that add to the existing research on the factors that make online group therapy more acceptable. The review highlights novel concepts such as issues related to 'boundary breakdowns' which refer to the relaxation of appearance and presentation by online members compared to in-person groups. However, many of the studies included in this review had recruited participants either prior to the pandemic, or during the pandemic, which makes it more difficult to understand the acceptability of the online platform before life had returned to 'normal'. Furthermore, the heterogeneity of the interventions used in the individual studies, and the limited detail provided regarding whether the interventions were conducted in real-time, or using asynchronous technology such as email, and text-messaging software limits the conclusions that can be drawn from this review.

A sense of empowerment was identified as an important facilitator to engagement with digital mental health interventions in a study conducted by Norwood et al. (2018). It refers to the idea that a client may feel more empowered in their treatment when accessing therapy remotely due to a sense of perceived control, from factors such as being in their own environment and using their own technology. However, Pipkin et al. (2022) found

that group members can feel uncomfortable, as though they are intruding on other group member's personal space when they attend remote therapy from their bedroom.

Therapeutic alliance, which refers to the quality of the relationship between the client and the therapist, is strongly associated with the effectiveness and acceptability of psychological interventions (Lederman and D'Alfonso, 2021). Evidence indicating whether the therapeutic alliance is maintained during online group psychological therapy is mixed, with some studies suggesting therapeutic alliance is as strong in online settings as it is in face-to-face settings (Lopez et al. 2020), and others suggesting that therapeutic alliance is significantly stronger in face-to-face settings (Gentry et al. 2019).

Related to the concept of therapeutic alliance is group cohesion, or a sense of 'togetherness' which has been found to be an important concept with regards to the acceptability of online group therapy. Weinberg (2021) suggests several factors that may influence group cohesion in an online therapeutic setting. These include practical issues such as glitches in internet connection and only one person being able to speak at a time, which can force an unnaturally linear group narrative. Furthermore, Weinberg (2021) reports that the tendency to dissociate may be intensified in an online group therapeutic setting. Other factors such as the lack of small talk before and after a group can also impact group cohesion, and thus the acceptability of the platform (Weinberg, 2021).

A practical concern regarding the advances in digital therapy is the equity of the platform. A qualitative study by Kaihlanen et al. (2022) explored the experiences of vulnerable individuals accessing digital therapies. These included older adults, migrants, high-frequency users of health services and unemployed people. The common themes emerging from this study were that access to digital platforms was limited, either by lack of support to use the technology or by the technology itself. Participants shared that they feared the technology, and did not trust it to be secure. These are issues that are also considered in the World Health Organisation (WHO, 2021) Global Strategy on Digital Health 2020-2025 report which outlines the vision for improving global health through the integration of digital technologies.

Rationale

To summarise, there is a wealth of factors influencing the acceptability and experiences of online group therapy. However, the existing data appears to utilise participants from a broad heterogeneity of populations, and is primarily focused on 1:1 rather than group interventions. Therefore, it is not clear whether patient experiences are transferrable in a moderate-to-severe adult mental health population in an online group setting.

Importantly, the majority of the existing research in this area took place prior to the Covid-19 pandemic. The rapid implementation of digitally-delivered psychological interventions in the early stages of the pandemic did not allow for thorough consideration of whether this modality would be appropriate for all of the people who were likely use it. This creates a distinctive gap in the literature regarding what the fundamental experiences of digital delivery in a post-pandemic society might be, particularly when digital therapy could be a choice, rather than a necessity. It is important to mitigate the 'Covid-19 effect' which relates to how during the height of the pandemic clients may have felt more willing to engage in remote therapy due to the lack of alternative options, compared to post-pandemic when society has reopened and life has returned to 'normal'. Furthermore, The Scottish Government (2021) developed the NHS Transition and Recovery Plan which advocates for increased use of digital intervention. This represents a seismic shift in how services may continue to operate. With this development, it is important to ensure that people are appropriately matched to the delivery platform in order to maximise the efficiency of psychological services. This research presents a unique and timely opportunity to identify the perceived barriers and facilitators of digital group therapy.

Aims and Research Question

Aims: The primary aim was to develop an understanding of patients' perspectives and experiences of digitally-delivered group-based psychological therapy for patients accessing adult mental health services in NHS Greater Glasgow and Clyde (GG&C). A secondary aim was to understand why patients chose to complete, or not to complete their intervention.

Research Question: What facilitators and barriers do participants perceive there to be for digitally-delivered psychological therapy groups?

Methods

Design

This study employed a qualitative design and followed the Framework Analysis method (Ritchie & Spencer, 2002) to analyse and interpret the data. According to Srivastava & Thomson (2009), Framework Analysis is considered to be well adapted for research that utilises specific questions, has a limited time frame, a pre-designed sample, and a priori issues, such as an awareness of the barriers and facilitators associated with digitally-delivered therapy. Although alternative qualitative methods were considered, such as Grounded Theory, and Interpretative Phenomenological Analysis, these were decided against due to their reliance on smaller sample sizes, and need for highly detailed accounts involving lived experiences. As this empirical study aimed to explore a breadth of experiences from a larger sample, it was agreed that those methodologies would be too detailed for the level of depth expected from participants experiences of their online psychological group. The study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007, Appendix 5 pg. 92).

A literature search was carried out to identify existing frameworks related to engagement with online therapy that may have been appropriate to use as the framework for the current research. One framework initially considered was The Technology, People, Organizations, and Macroenvironmental (TPOM) framework developed by Cresswell,

Williams & Sheikh (2020). This framework was developed to assess Health Information Technology implementations, and appeared to link well with identifying attitudes and expectations around the online therapeutic group. However, the TPOM framework was heavily centred around macroenvironmental factors that were considered to be less relevant in relation to participants experiences, such as issues related to economic pressures, data governance, and legal considerations. The TPOM framework also deviated from the clinical experiences shared by the PTGS during early discussions about the research project, rendering it inappropriate for use in the current research.

Another theoretical model explored for suitability as an initial structure for the framework was the Zech et al. (2023) Integrative Engagement Model of Digital Psychotherapy, which described engagement with an asynchronous digital messaging platform. The model draws heavily on concepts from behaviour change frameworks, such as the Health Action Process Approach (Zhang et al. 2019) which has a strong grounding in social cognitive theory (Bandura, 1986) and the Theory of Reasoned Action (Hale, Householder, & Greene, 2002). Although the current research is concerned with synchronous digital group therapy, a few of the concepts of the Zech et al. (2023) model aligned with the existing research base regarding the general experiences of online therapy. These included clients' expectations of how effective online therapy can be, alongside concerns about therapeutic alliance, and helped to shape the development of the framework for this study. However, several of the concepts of the model did not appear to be as relevant for this study, such as factors affecting the choice of the platform, and the concept of managing therapeutic ruptures. In order for the research to remain closely aligned with participant's experiences, it was agreed that a new framework would be developed, informed primarily by participants experiences, as well as the existing evidence-base, insights shared from the PTGS clinicians, and discussions from the PPIE group.

Setting

Psychological Therapies Groups Service

The study took place within NHS GG&C Psychological Therapies Group Service (PTGS) which provides structured psychological therapy in a digitally-delivered group format for people experiencing a range of moderate to severe mental health conditions. The PTGS is connected to 18 Community Mental Health Teams (CMHT) within GG&C. For clients to be able to take part in a psychological therapy group run by the PTGS, they are referred by their keyworker (e.g., Community Psychiatric Nurse, Psychiatrist, Psychologist, Occupational Therapist) within their CMHT. A screening appointment is then offered from a mental health clinician working within the PTGS to discuss suitability for attending a psychological group.

Participants

Inclusion and exclusion criteria

Participants were recruited from the PTGS. Participants were eligible if they were open to their local Community Mental Health Team at the point of recruitment and had accessed a PTGS group between October 2024 and February 2025. Participants were included if they were over the age of 18, and had completed or dropped out of a PTGS psychological therapy group. Due to the nature of the PTGS, participants were all individuals who experienced moderate to severe mental health concerns. No limits were placed on the type of mental health condition experienced, or intellectual functioning, as the focus was on participants' experiences of the digital groups and not their demographics, mental health conditions, or the specific groups attended. This was also to reduce any potential cohort effects that might confound the findings. Data on client demographics were gathered, such as gender, age, and name of the referring community mental health team. See Appendix 6 (pg. 96) for demographics questionnaire.

Ethical approval and sponsorship

Ethical approval was granted by the NHS Health Research Authority Seasonal REC (reference 24/LO/0623). See appendix 7 (pg. 97) for approval letter. All participants provided verbal consent at the start of the interview process, and returned a signed copy of the consent form (Appendix 8 pg. 99) to the Principal Researcher via email. The project was sponsored by the University of Glasgow.

Procedure

Recruitment Process

The Field Researcher first discussed the research proposal with clinicians who work in the PTGS. During the PTGS initial screening process for attending a group, clinicians were asked to read from a script (Appendix 9, pg. 100) to inform patients that a study exploring the experiences of digitally-delivered psychological groups was taking place, and determine whether any patients would be interested in taking part. PTGS clinicians were asked to make it clear to patients that their decision to take part, or not, would have no impact on their NHS treatment. When a group was completed, PTGS clinicians were asked to remind the patients about the study. When a patient expressed an interest in taking part, the PTGS clinicians then shared the contact details of potential participants with the Principal Investigator. At that point, the Principal Investigator had permission to contact the participants directly to further explain the study. Only participants who were open to their local CMHT at that point were contacted to take part. This was due to the importance of having mental health support available through the CMHT if the participant experienced any distress during the interview process.

The Principal Investigator initially contacted 23 participants via telephone after they had expressed interest in taking part in the study. One participant appeared in distress during the initial telephone call, and was subsequently put in touch with her local CMHT for support, and did not participate in the study. Six of the participants did not answer the initial telephone call to learn more about the study, and were emailed with a brief reason for the telephone call. Three participants responded to this email with interest in participating. Participants were then asked if they would prefer an interview online over

Microsoft Teams, or in-person at the University of Glasgow Clarice Pears Building. Following this initial telephone call, participants were sent the Participant Information Sheet (Appendix 10, pg. 101), Privacy Notice (Appendix 11, pg. 102), and Consent Form by email. The details of the interview were also contained in this email. A further four participants who had agreed to an interview did not attend on their interview date. 12 interviews then took place, all of which were participants who had completed their online group. Informed consent was discussed at the beginning of each interview and participants were encouraged to sign and return their consent forms to the Principal Investigator. Following the interviews, participants were emailed a Debrief form (Appendix 12, pg. 103) and compensated for their time with a £10 Love to Shop voucher.

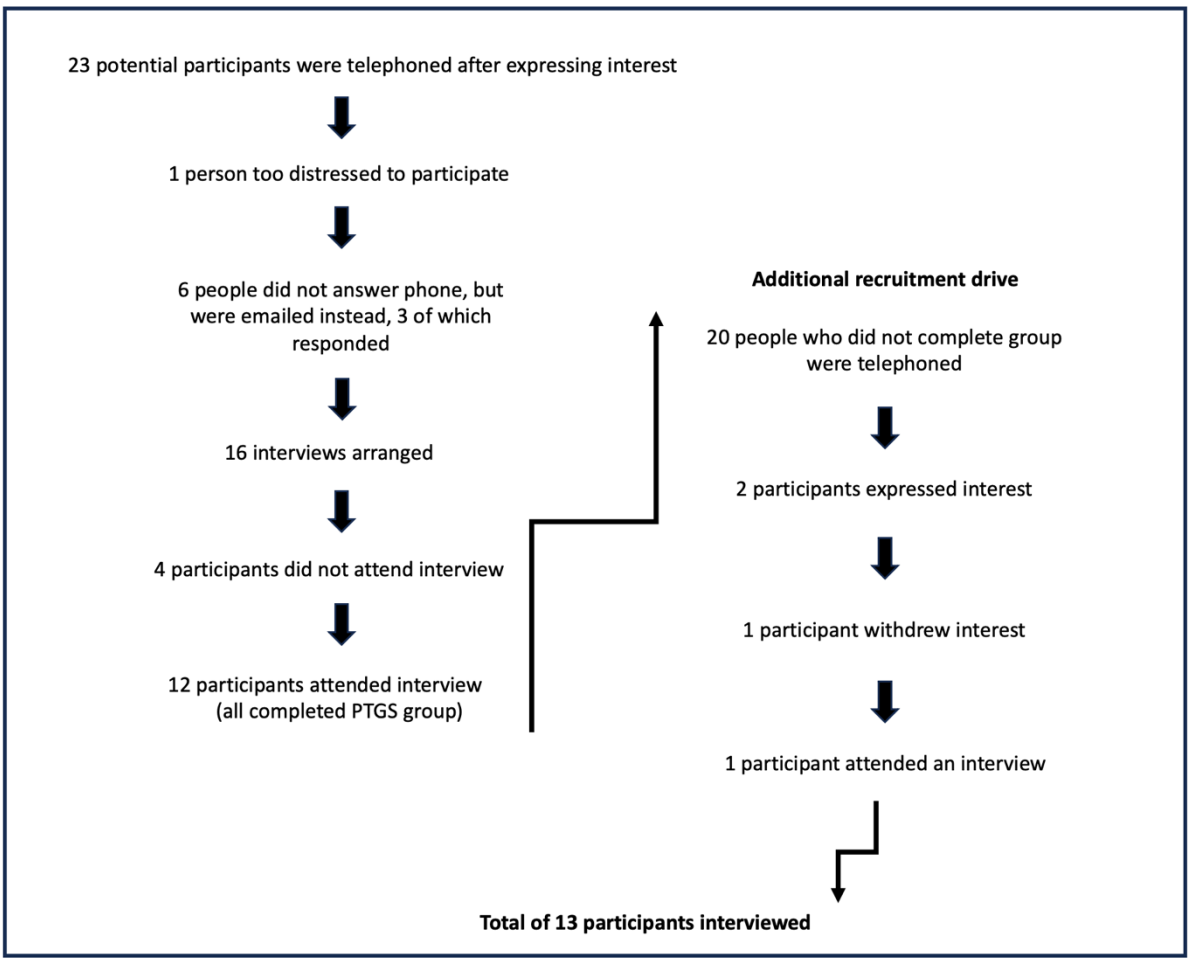
Additional recruitment drive

As the current research was also interested in finding out why patients chose not to complete their group, the Field Supervisor in the PTGS made direct contact with a further 20 participants who had dropped out of their PTGS group. This resulted in two people registering their interest in taking part. However, one of these participants withdrew their interest during the Principal Investigator's initial phone call, due to time constraints, resulting in only one person taking part in an interview. Two Clinical Psychologists from two separate CMHT's were also asked to discuss the research with any patients who had dropped out of the PTGS. However, this did not result in any further participants.

The final sample consists of 13 participants who attended an interview, 12 of whom had completed their PTGS group, and one had dropped out of their group. See Figure 2 for diagram of the two streams of recruitment.

Figure 2

Recruitment Process



Materials

Interview Schedule

The interview schedule (Appendix 13, pg. 104) was created in alignment with the aims and specific research questions of the study. Interview questions were developed following an exploration of the extant literature, and discussions with people who have lived experience of mental health issues, including the Patient and Public Involvement and Engagement (PPIE) Research Group at the University of Glasgow. Interview questions were also discussed with the wider research team directly involved in the project. Care was taken to include open-ended questions and prompts in order to promote rich data from the participant's' experiences.

Interview questions were developed to explore participants' experiences of attending a digitally-delivered psychological therapy group and what might have influenced a participant's decision to attend or stop attending a digital group. This process involved the same set of interview questions regardless of whether the participants completed their intervention, or chose to disengage after initially attending a digital session. However, prompts and follow-up questions differed slightly depending on responses to individual questions. Interviews have been transcribed and anonymised by assigning numbers to each participant's file.

Interviews

A total of 13 interviews were completed, 12 of which took place over video on Microsoft Teams, and one which interview took place in-person at the University of Glasgow Clarice Pears Building. The interviews were audio recorded using a Dictaphone, and transcription and recording software within Microsoft Teams was also used, with participant permission. Interview questions were supplemented with further questions to clarify and encourage participants to expand upon their reflections. Where there was any concern for a participant during the interview, participants were asked if they knew where to access further support, and sent a debrief sheet with further advice on contacting their GP or CMHT for further support if necessary. A reflexive log (Appendix 14, pg. 105) was kept by the Principal Investigator to keep note of any thoughts that arose which may have impacted the direction the interview took.

Sample size

With regards to the decision around sample size, this has been determined using the concept of Information Power developed by Malterud et al. (2016) and was informed by Braun and Clarke's (2021) concept that data saturation may not be achievable, and that data sufficiency and information power are more useful concepts for determining sample size. Information power suggests that rather than relying on a predetermined sample size, the extent to which a sample provides rich and relevant data in relation to the research aims is considered to be more meaningful. Malterud et al. (2016) put forward five considerations which help determine adequate sample size, and suggest that larger samples are required for studies that have broader aims, use participants with more varied

experiences, have a limited existing theoretical base to draw upon, have limited depth in the interview dialogue, and studies that use a cross-case analysis method. These factors suggest that the more information a sample holds, the fewer participants are needed. In relation to this study, given the aims, variety of experiences of mental health conditions and group attended, the novel area of online group therapy, and concerns about the depth of data available in interviews, information power would advise a larger sample size. Taken together, these factors present justification for the use of Framework Analysis as a methodology that was suitable for larger data sets. For the current study, in order to ensure the richness of the data, and meet sufficient information power, the decision to recruit 15-20 participants was planned with a split between those who completed their group and those who did not. However, there were significant issues with recruiting participants who had not completed their PTGS group. The additional recruitment drive to recruit participants who did not complete their group only resulted in one participant. Therefore the decision to interview more participants who had completed their group was made, and the sample of 13 participants in total was considered to meet information power.

Data analysis

Framework Analysis, developed by Ritchie & Spencer (2002), is a systematic and thematic approach to organising and interpreting qualitative data. There are seven stages involved in the Framework Analysis method, outlined in Gale et al. (2013). The first and second stages relate to data familiarisation through transcribing the interviews, and re-listening to the audio recordings while noting down any recurring themes. The third stage involved coding a sample of the transcripts in a process known as 'free coding'.

The fourth stage of Framework Analysis involved the creation of the initial framework. This initially began as a deductive process. A literature search was carried out to identify whether existing frameworks regarding engagement with online therapy could help inform the framework for the current research. The aforementioned Integrative Engagement Model developed by Zech et al. (2023) incorporates several domains that appear to fit well with the initial themes that emerged in data familiarisation stage. These included the significance of how engagement in digital mental health interventions was influenced by the user's expectations of the intervention, and also their perceived level

of need for the intervention. The Integrative Engagement Model also includes therapeutic alliance as a domain, which was another similarity within the themes emerging in the data. These a priori framework domains, taken together with the themes that had helped shape the interview schedule from discussions with the PPIE group, helped to influence the initial framework for the current research. It then became apparent that a more inductive approach would be needed in order to capture the subtle nuances and novel themes that were emerging from the interviews. From this point, an inductive approach was taken to complete the initial framework that would then be used to code the remainder of the transcripts.

The fifth step involved systematically completing line-by-line coding across all of the transcripts and indexing the codes into the relevant domains of the framework. The process of applying the data to the framework was entirely iterative, and the re-coding and reworking of the framework continued until all of the data relevant to the framework domains had been coded and applied. The process of charting the data into the framework matrix was the sixth stage, and involved succinctly summarising the data across the themes, while retaining participants' original meaning. The seventh and final stage of Framework Analysis was the interpretation of the data by comparing and analysing the data across the main themes and within each participant in the matrix.

Researcher positionality and epistemological stance

The Principal Investigator is a Trainee Clinical Psychologist undertaking this research project in the context of clinical experience delivering individual and group online therapy across adult and child mental health services. It is therefore possible that some bias has been introduced into the results due to the researcher's existing beliefs about the facilitators and barriers of the online platform. In order to mitigate this bias and encourage reflexivity as recommended by Gale et al. (2013), notes on the researcher's impressions and thoughts about the analysis of the data have been recorded, which have supported the bottom-up approach to analysis. In addition, bracketing was used to avoid any further researcher bias by keeping notes of preconceptions that the researcher may have about the data as they arose.

To further reduce the risk of bias and support transparency in interpretation, this research adopts a critical realist ontological stance (Robson, 2002). This perspective assumes that a reality exists independently of individual perceptions, while recognising that participants' experiences are shaped by individual, relational, and contextual factors. In line with this, an interpretivist epistemological stance was also taken, acknowledging participants as experts in their own experiences and valuing their accounts as meaningful sources of knowledge. At the same time, this stance allows for the exploration of underlying patterns and potential explanations for why certain experiences may occur. The use of framework analysis aligns with these positions, as it offers a structured yet flexible approach, supporting both close engagement with the original data and the development of broader thematic interpretations that may extend beyond the surface of individual accounts.

Results

Participant characteristics

A total of 13 participants were interviewed for the study (10 female and three male). The age range was between 19 and 52 years, with an average age of 33. Twelve participants had completed the online group, and one participant had dropped out of the online group. The interviews ranged between 17 minutes to 93 minutes, with an average length of 37 minutes. Participants have been given pseudonyms to maintain anonymity. See Table 4 below.

Table 4

Participant Demographics

Participant	Gender	Age	Group Attended	Group Completed?
1 – James	Male	43	Living Well with Health Conditions	Yes
2 – Frances	Female	50	Emotional Coping Skills	Yes
3 – George	Male	52	Living Well with Health Conditions	Yes
4 – Corinna	Female	21	Emotional Coping Skills	Yes
5 – Elodie	Female	27	Emotional Coping Skills	Yes
6 – Isla	Female	26	Emotional Coping Skills	Yes
7 – Ava	Female	24	Survive and Thrive	Yes
8 – Karen	Female	31	Survive and Thrive	Yes
9 – Susan	Female	35	Survive and Thrive	Yes
10 – Rachel	Female	44	Survive and Thrive	Yes
11 – Louise	Female	41	Living Well with Health Conditions	Yes
12 – Peter	Male	23	Survive and Thrive	Yes
13 - Stephanie	Female	19	Emotional Coping Skills	No - attended 2-3 sessions before stopping

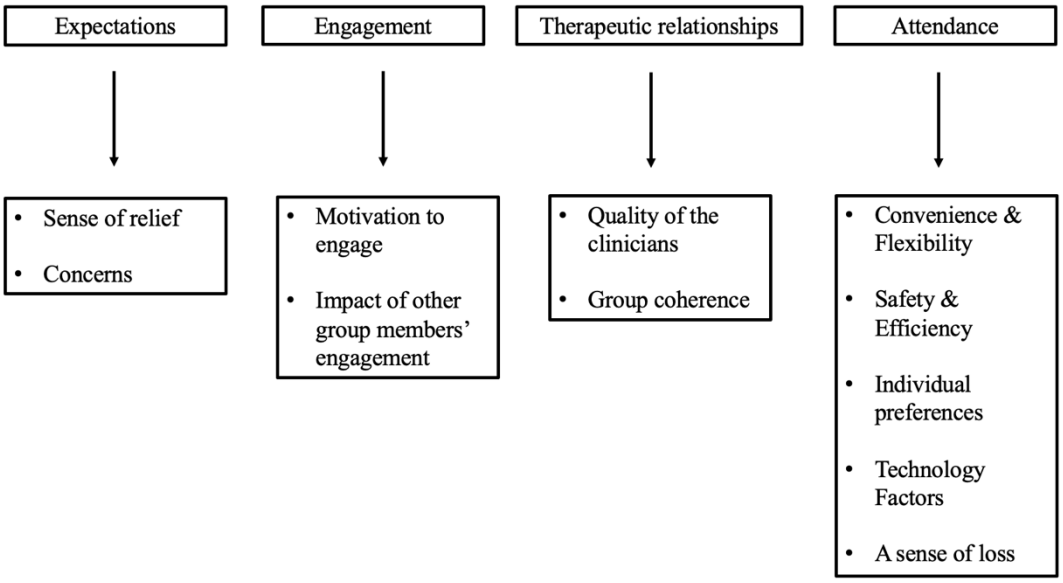
Development of the framework

To enhance transparency, a comprehensive description of each stage of the framework analysis process can be found in a detailed data analysis plan in Appendix 15 (pg. 108). After the familiarisation stage (Appendix 16, pg. 109), an initial framework of 11 main themes was used to code the interview transcripts (Appendix 17, pg. 114). A sample of the coding process of one transcript has been provided in Appendix 18 (pg. 115). To ensure the reliability of the coding process, one transcript was coded by the Chief Investigator which resulted in the clarification of one of the subthemes into the framework. Following this, the framework was further revised and reduced to 5 main themes and subthemes in line with the research questions of the current study. These themes were then used to chart the data into the framework matrix (Appendix 19, pg.

116). The framework matrix was then refined further during the mapping and interpretation stage to represent participants' experiences of online group therapy across four main themes and 11 subthemes as represented in the diagram below.

Figure 3

Final Themes and Subthemes



A description and analysis of each theme and subtheme will now be presented. See Appendix 20 (pg. 117) for the number of participants contributing to each subtheme.

Expectations

This theme discusses the initial expectations that participants had when they learned their group would be taking place online rather than in-person. This theme contains two subthemes: (1) a *sense of relief*, due to a variety of physical and mental health reasons, and (2) *concerns*, that contributed to generally low expectations of the online group.

Sense of Relief

A strong sense of relief about the group taking place online was expressed by several participants, making the online platform a clear facilitator for some of the more anxious participants. One participant admitted they would not have even considered attending the group if it had taken place face-to-face due to high levels of anxiety:

> *Ava (24 years) - "I don't like people very much, I struggle with like group settings. So the fact it was all over the phone [video] actually helped a wee bit. I liked it. […] I don't think I would have done it if it was in person."*

Relief was also expressed by participants living with physical health conditions that limited their ability to leave the house, or those experiencing physical injuries that would have prevented them from being able to attend in-person support, with one participant expressing:

> *Louise (41 years) – "I wouldn't have been able to drive, so I wouldn't have been able to go. So the fact that it was online at home, I was rested up with a broken foot and could still attend."*

The online format appeared to provide some reassurance for group members with mental and physical health issues in ways that would not have been possible if the group had taken place in-person.

Concerns

Participants also expressed concerns about the online nature of the group, and communicated how these concerns contributed to a general sense of low expectations, alongside a belief that in-person group therapy would be 'better'. Almost all of the participants discussed feeling some initial hesitation about the online platform, most drawing comparisons with positive past experiences of face-to-face group therapy, or negative past experiences of individual online therapy. In addition, a few participants anticipated concerns around managing the technology, as well as concerns around privacy, and a worry about being overheard by neighbours. Participants spoke about their apprehension around whether they would be able to develop effective therapeutic relationships online, as expressed in the following quote:

> *Karen (31 years) – "So I've done some in person group stuff before with a charity. So I knew it was going to be different. At first I was like, oh, kinda,. not disappointed, but a little bit like, oh, this will be different because the group that I worked with before, we all ended up really close friends and we're still friends."*

Furthermore, participants mentioned fears specifically relating to the idea of having to speak about personal feelings in the online group setting, and general worries about not knowing what to expect from the online setting:

> *Corinna (21 years) – "It was just quite nerve wracking for me just because I just didn't know what to expect I think, and I was like, what if… I don't even know what I was scared of. You know, it's just one of those things where it's like it's brand new, it's a bit daunting."*

However, despite the participants' concerns, most reflected on how their initial fears and worries did not materialise, which highlights important insights into whether low initial expectations of online group therapy may actually prevent some from accessing the service.

Engagement

The second theme relates to participants' overall experiences of engaging with the online group. These experiences are understood within two subthemes: (1) *motivation to engage*, and (2) the *impact of other group members' engagement*.

Motivation to engage

Many participants spoke passionately about their own intrinsic motivation to engage with the online group, highlighting that being in the right frame of mind to engage with the online platform could be an important factor in how likely they were to engage in the group platform:

> *James (42 years) – "They're offering you something. Even if it sounds bonkers, they're offering you it for a reason. So, I'm duty bound to give them the respect of attending, you know, and trying my best 'cause I want to be better, you know".*

It was clear amongst the participants that their motivation to engage was also facilitated and enhanced by how engaging they found the content of the group:

> *Louise (41 years) - "the very first group meeting we ever had, they showed us a video and it was about making your life bigger because that blew my mind, that was it for me, that first ever… and I'm thinking how are they going to do that […] So that concept that first day like I was like intrigued, so I wanted to go back. I wanted to know more."*

Impact of other group members' engagement

The impact of other group members' engagement levels appeared to influence participants' own experiences as well. Several participants spoke about enjoying a platform to give and receive help, but found it much more beneficial when they perceived high levels of engagement from their fellow group members:

Corinna (21 years) – "There was like a couple of, like, particular members of the sort of group that I was in that were, like, really keen on contributing and like really quite like open and I just, like I definitely found a lot of like admiration from them from that and it, like encouraged me to do the same. So it was, it worked out really well. Yeah. So as long as we've got some, you know, the sort of people like that in the group its like, definitely seems to be a good thing."

This quote highlights the possibility that engagement levels are perhaps somewhat dependent on the other group members attitudes and engagement. While most participants experience of other group members was positive, another participant's experience was different. This participant expressed that the online nature of the group may have contributed to a lack of commitment, and he felt discouraged and frustrated that other group members didn't appear to be taking the online group seriously:

James (43 years) – "There was people who just could come and go as they pleased […] They would come to the next one and nothing was said, and they would miss another one. Nothing was said. Then they'd pop up for one and then away for two. So that that got to me a little bit because…I am wanting to be helped. I want to learn new strategies and these people are just wandering in and out, you know, as if this service is... I don't know, just a little giant waste of time."

Among these difficulties, other participants mentioned frustrations with group members attending from inappropriate locations, or under the influence of substances, which may have been picked up on more easily at an in-person setting, and ultimately impacted on their experience of engagement with the online platform, However, participants shared how these issues were dealt with promptly by the clinicians leading the group.

Therapeutic Relationships

The third theme relates to the therapeutic relationships that were developed with the clinicians leading the group, as well the relationships between the group members. There

were two subthemes identified for this theme: (1) *quality of clinicians*, and (2) *group coherence*.

Quality of clinicians

Many of the participants recognised that the skill and professionalism of the clinicians leading the group helped them feel safe and listened to, and facilitated the creation of strong therapeutic relationships in a relaxed and non-judgemental environment:

> *James (43) – "It was lovely. They were very softly spoken. They weren't overpowering, and they had this amazing ability to listen. And not, it wasn't just by their ears, you know, they were picking up on so many other aspects of listening. You know, the way people were talking, the facial expressions, etcetera, the body language. I could see what they were doing and they could adapt their questioning or approach to the individuals to try and offer more encouragement, which I felt was exceptional. I can't speak highly enough about what I've seen from them."*

This quote is an example of the therapeutic warmth that many of the participants resonated with. It appears that the altered expression of body language cues in the online setting were not lost on the clinicians, or at least the clinicians delivering the group were highly trained in adapting their therapeutic skills for the online setting to nurture the therapeutic alliance.

Group coherence

The therapeutic relationships among the group members have been captured in this subtheme related to a sense of togetherness. Almost all of the participants discussed feeling able to connect with others online, with some expressing surprise that a strong sense of group coherence and therapeutic bonds were possible to achieve online:

> *Louise (41) – "It was so nice that we all bonded. There was like… it didn't feel any different. It kind of felt still face-to-face which I found strange like…. I don't*

think as a person that I missed that contact. I did not miss it. I felt very connected to everybody there."

It seems that a sense of group coherence was possible to feel in the online group setting. However, some participants described feelings of discomfort and worry for their fellow group members, and wondered whether that sense of togetherness was not as easy to manufacture online as it would be if physically in a room with group members:

Frances (50) – "You know, if you've actually got somebody in front of you, you can read their body language and you can see all these different things…. But I suppose I, you know, I wonder if it might... whether it gives a true representation of how somebody appears."

Several participants talked about feeling sadness regarding the abruptness in the ending of the final session of the online group, and expressed how they missed the informal chitchat that contributes to building therapeutic connections. They described how there was no natural way to continue the bonds that had been made with other members, unlike in a face-to-face group setting:

Susan (35) – "It was quite sad in the end actually, I was like, I'll miss my wee group because we kinda bonded quite well, but obviously you're sort of anonymous to an extent so you don't really, there's nothing.. you know.. sort of mechanism to carry on meeting up… Once the call ended, it was kind of like, oh, that's that, that's it. It was just.. it was really like abrupt. Or it felt really abrupt, it wasn't obviously, but it was kind of like, OK that's that done…Yeah and then you're just sitting by yourself in the living room."

It is apparent that many of the participants did experience feelings of warmth and connectedness with their group leaders, and fellow group members, although some did express a sense of aloneness created from the sudden end to the therapeutic connections, with no opportunity to maintain these once the group had finished.

Attendance

Attendance is the third theme and primarily relates to the facilitators and barriers of attending the online group. This theme explores the factors that make the online group an attractive option for receiving therapy, as well as factors which hinder the acceptance of the online platform. Five subthemes were identified: (1) *convenience and flexibility*, (2) *safety and efficiency*, (3) *technology*, (4) *individual preferences*, and (5) *sense of loss*.

Convenience and Flexibility

All participants highlighted various practical benefits that made engaging with online group therapy much more convenient and accessible, such as the flexibility of not having to travel and fitting therapy in with work and family life. The following two quotes are from participants who disclosed that they had children with additional support needs at home, and therefore the convenience and flexibility provided by the online group was a strong facilitator for them.

> *Rachel (44 years) - "I found it really good and actually not having to travel somewhere […] It could be the other side of the city for like an hour to come back and sort of fitting that in with work as well because I work full time."*

> *Frances (50 years) – "It just meant that instead of like working and then having to go to a clinic or whatever, you know it was just like I could say to the kids, I'm just upstairs and then when we had a break, I could go down and make sure they were OK. So it just fitted into… kind of like my work and my home life… managing to fit it in."*

It appears that the online platform provides tangible benefits for participants working hard to strike a balance between family and work commitments, while trying to prioritise their own mental health needs as well.

Safety and Efficiency

An important subtheme of safety was identified, with many participants highlighting how they felt safer, and more able to engage with therapy from the comfort and safety of their own home, as it allowed them space to process their emotions without distractions:

> *Karen (31 years) – "Being in an environment where I feel most comfortable and the safest made it so much easier for me to… to… take everything on board and sort of take my time with things and take the time to understand"*

Participants also shared that the online platform helped to provide a protective barrier from experiencing the intensity of other people's emotions, as well as helping to prevent some participants from going into 'helper' mode, something that they felt could often happen in face-to-face group settings:

> *Elodie (27 years) – "I think in person, you've got more chance to... like before and after the group and maybe during the break to communicate and talk to people. And I can't help but want to help people either, so I'm very like I would... aw they are no worse than me, but they are struggling. So I should help them. Rather than like… for me."*

Participants reflected on how efficient the group felt with regards to being able to get through the material because of feeling slightly removed from other group members' distress. Another factor contributing to the efficiency were the rules encouraging participants not to share too much personal information. There was a recognition amongst several of the participants that the online group platform worked well *because* it was not an in-depth personal exploration, and that it may be useful to have an in-person setting if there were expectations to share more personal information:

> *Frances (50 years) - "It wasn't particularly…you know, like provoking trauma or anything but so I think maybe with something that was maybe a bit more intense, it might be quite good to have somewhere where you could go and then leave."*

This subtheme of safety and efficiency demonstrates some of the facilitators of the online platform in relation to how participants felt they were able to maximise the usefulness of the content they were receiving from the online group, due to how the online platform provided a safe and non-distracting space, supported by clear rules and expectations of how to engage with other people in the group.

Technology

Regarding some factors that made attending the online group a less attractive option, several participants noted that their concentration was impacted by the online setting, while others reported being slightly bothered by technology glitches, as it interrupted the flow of the therapy. One participant did not have access to a laptop, and struggled to focus using her smartphone, and reported that she was not the only one in her group having to join the session using her smartphone:

> *Elodie (27 years) – But on the phone, it's just the way that the wee screens all popped up and you need to… I think part of the group rules is everybody's cameras have to be on. So you need to see everybody as well. But it's some people's cameras can go off and your feed goes off. It's can be a bit distracting."*

This participant quote highlights an important point about the risks of digital exclusion with the online platform, particularly if having to join group therapy sessions from a smartphone where the screen size represents a clear barrier for usability.

Individual Preferences

This subtheme captures the varied experiences across the participants attending the online group, and highlights their preferences regarding the delivery platform. In general, there was an overall sense that the online group was a positive experience, with some participants describing how their expectations of the online group were thoroughly exceeded, as evidenced in the following quote:

> *Louise (41 years) – "The only way you know that a service is good is its impact it's had on the person who's been involved in it. And I feel that it's definitely... like I'm saying it has totally changed my life. If I didn't start that group when I started it, and if I didn't take away from it what I have, I don't know where I'd be […] I'm waiting for counselling and one of the things I asked for was in-person counselling, which means the waiting lists are a wee bit longer. But I'm actually... I've actually contacted them to say that I would do the online now."*

Although this suggests that many participants were impressed with the online group platform, a few of the participants expressed how they would still prefer in-person therapy after their experiences of the group. The following quote is from the only participant who did not complete her online group and explained that the online platform may not be as acceptable for people who perhaps struggle with group settings in general, regardless of the delivery platform. She discussed challenges associated with neurodivergence, such as finding it hard to follow the conversation and finding her home environment quite distracting;

> *Stephanie (19 years) - "People were coming from it from different points and I didn't really understand, and it was incredibly heavy going because it felt like you had eight individual people on a call, but all expected to like, follow the same thing […] people were interpreting it in different ways and I was trying to work my head around that."*

Individual preferences are understandably a significant factor with regards to the acceptability of the platform, which carries with it the importance of choice in delivery format.

Sense of loss

In this subtheme, participants reported feeling that something was lost in the online platform of the group. Participants discussed feeling the loss of a 'personal touch' and generally missed connecting with people face-to-face. A few participants articulated that their motivation to look after their physical appearance was taken away by the online platform, and saw this as a missed opportunity to improve their low mood:

James (43 years) – "You're sitting in the house all by yourself all day, every day. You know, it's, it becomes incredibly difficult with mobility issues and stuff. When I do have my appointments, it's nice. You know, I like, I like to get out because I get myself up, I get myself cleaned. I get myself dressed and I'm, you know, you make the effort to go places and do things. So that's definitely a big advantage. Whereas online, I could have sat here in my pyjamas and you would never have known, you know."

Another participant highlighted that the online platform prevented an opportunity for them to confront their fears of engaging with others in a face-to-face group setting and reflected on the impact this could have had on their confidence:

Corinna (21 years) – "The only thing I can think of off the top of my head is maybe just like getting a bit more confident being in person to be honest….. I don't really deal with much social anxiety anymore, at least not to the point that I did. But I definitely am like very, very self-conscious a lot of the time just being in any sort of public or social space and like I think it might like, I don't know, build some sort of like self-confidence or self-assurance like by being in person and talking about difficult things."

In summary, the theme of attendance identified several facilitators of attending online group therapy, such as experiences of convenience and safety, coupled with barriers such as concentration issues, and challenges associated with the loss of having an opportunity to physically leave the house or face their social anxiety head on. Ultimately, the acceptance of the online group platform is mediated by unique and personal individual preferences.

Table 5 represents these themes and subthemes as distinct barriers and facilitators of online group therapy. Note that some subthemes are represented as both a facilitator and a barrier, depending on participants' experiences.

Table 5

Facilitators and barriers of online group therapy

Main theme	Subthemes as facilitators	Subthemes as barriers
Expectations	Sense of relief	Concerns
Engagement	Motivation to engage Impact of other group members' engagement	Impact of other group members' engagement
Therapeutic relationships	Quality of the clinicians Group coherence	Group coherence
Attendance	Convenience & Flexibility Safety & Efficiency Individual preferences	Individual preferences Technology Factors A sense of loss

Discussion

The current study has utilised the method of framework analysis to present a comprehensive investigation into participants' perceptions and experiences of online group therapy. The four main themes identified relate to factors affecting the acceptability of attending an online therapy group. These include: Expectations, Engagement, Therapeutic Relationships, and Attendance, with each containing subthemes contributing to the facilitators and barriers of the online platform. The secondary aim of the study was related to what factors influenced a participant's decision to complete or not complete their group. The findings of this study can only partially answer this question, through the facilitators and barriers already described. Without adequate data from participants who chose to stop attending their online group, it is not possible to provide a more comprehensive answer as to why participants made that

decision. The only participant interviewed who did not complete their group cited reasons associated with a dislike of the group setting in general, regardless of whether it was online or in-person.

Within the *Expectations* theme, while factors such as a sense of relief about the group being delivered online were expressed by the particularly anxious participants and those experiencing physical health issues, the theme also highlighted participant's concerns. These related to the worry about their ability to form meaningful therapeutic relationships with their group members and leaders, as well as worries about privacy and managing the technology, which were often based on prior negative experiences. Despite participants' generally low expectations of the online group, many discussed how their expectations were exceeded on completion of the group. The perspectives explored within the *Engagement* theme present some hypotheses as to why participants continued to attend their group, despite low initial expectations. Participants spoke proudly about their own intrinsic motivation to engage with the online group, with high levels of desire to engage being seen as a strong facilitator for the platform. As in previous research, motivation and willingness to improve one's own mental health is a significant factor in engagement with online therapy (Zech et al. 2023).

Self-determination Theory (Ryan & Deci, 2000) provides a theoretical lens from which to contextualise the findings of this study, particularly with regards to participants' high levels of motivation to complete their group despite initial concerns. Self-determination theory suggests that intrinsic motivation is built upon three needs being met: autonomy, competence, and relatedness. Participants spoke about enjoying the flexibility of attending the group remotely, and appreciated being able to contribute as much or as little as they liked, which may have fostered a natural sense of autonomy.

With regards to the *Therapeutic Relationships* theme, the current study offers a contrasting perspective to previous research about group cohesion in online therapy. Weinberg (2021) identified that a tendency to dissociate was a common challenge within online group therapy settings. In contrast, participants in the current study did not report such difficulties. One possible explanation is that participants were influenced by the active engagement of fellow group members, which may have supported their own involvement. This highlights the significance of group dynamics in shaping individuals'

acceptance of the online platform; when group interaction is limited, disengagement or dissociation may be more likely. These findings also reinforce the central role of the clinician in cultivating an engaging and structured therapeutic environment. Skilled facilitation with clear rules, boundaries, and a didactic approach may be key in reducing the risk of dissociation and enhancing the overall therapeutic experience.

These findings again link in with Self-determination Theory (Ryan & Deci, 2000), particularly the concepts of competence and relatedness. Participants spoke highly of the exceptional skill of the clinicians leading the group. Such level of skill may naturally have built a sense of competence in the participants, and helped them to feel that they were not only gaining something useful from the group, but also contributing positively to others' experiences. Furthermore, the finding that strong therapeutic relationships were formed between the participants and clinicians links with the concept of relatedness. Shared experiences, and mutual support appeared to enhance participant's feelings of connection and belonging, and ultimately contributed to participants motivation to continue their group.

Within the *Attendance* theme, the subthemes relating to some of the facilitators of online group therapy, such as the safety, efficiency and convenience of the online platform, echo previous research (Borghouts et al. 2021). However, the findings relating to a *sense of loss*, particularly the missed opportunities for self-care and the exposure to feared social situations, offers novel insights into some of the factors hindering the acceptance of the online group therapy platform. These reflections suggest that for some individuals, the physical setting of in-person therapy contributes meaningfully to their therapeutic experience. Furthermore, there is a general consensus within the existing literature that younger people are more comfortable with technology (Hagyari-Donaldson and Scott, 2024). However, within the current study, it was several of the younger participants who expressed that they did not feel at ease with technology, therefore challenging this assumption. Ultimately, such findings reinforce the broader conclusion of this study, that acceptability of online group therapy is a highly individual experience, and what is beneficial for some may feel limiting or less effective for others.

Limitations

One limitation of this research is that socio-economic information was not collected for the sample of participants used in the study. This has meant that it has not been possible to draw more comprehensive conclusions about groups that may be less represented in the existing research base, such as individuals from lower socio-economic backgrounds and minority groups. However, the study reinforces existing concerns about the digital divide. For instance, one participant described her difficulty with seeing other group members' faces on her phone screen, highlighting how limited access to appropriate technology (a laptop or tablet) can affect the ability to fully engage in online group therapy. These barriers underscore the importance of considering digital accessibility when designing and delivering online interventions.

Additionally, the gender distribution of participants suggests that the results may be more reflective of women's experiences, with 10 female participants compared to only three male participants. However, the sample does align to some extent with the demographic profile of PTGS referrals. According to the PTGS data from 2024, 76% of referrals were women, 22% were men, and 2% identified as other or did not disclose their gender. Therefore, while these qualitative findings are context-specific, they may offer transferability of insights to similar settings.

Given the nature and format of the online groups, focus groups could have been used as an alternative method of data collection. Focus groups can be an efficient method of data collection compared to arranging individual interviews (Zech et al. 2023). However, the decision to conduct individual interviews in the present study may have facilitated the exploration of more sensitive or personal experiences. For example, participants feeling protected from absorbing others' emotions, or their reflections on the less positive engagement of other group members. Such nuanced and potentially delicate insights may have been less likely to emerge in a focus group setting, where social dynamics may have influenced openness and disclosure.

Finally, the sample in the current study may be skewed towards participants who had more positive experiences of the online group, as evidenced by the difficulty in recruiting individuals who did not complete their group. With only one non-completer included, it

is challenging to fully explore the factors that may contribute to disengagement from online group therapy. Additionally, the study does not account for individuals who were offered an online group but chose not to attend. Gaining qualitative insights from these individuals could offer a more comprehensive understanding of the barriers to engagement and attendance. Such insights would be valuable in helping online services better identify and support those who are harder to engage.

Recommendations for Services

The findings from the *Expectations* theme, particularly participants' initial concerns about attending the group, carry important implications for service development. Many participants began the group with low expectations, highlighting an opportunity for services to improve how they communicate with potential patients. One strategy could involve including positive quotes or testimonials from previous participants in the information materials sent to prospective group members, in order to foster more realistic and hopeful expectations. Notably, one participant reflected that the way the group was initially communicated to him contributed directly to his low expectations. In addition, several participants expressed sadness at being unable to maintain the connections they had formed during the group. One participant suggested a creative solution, drawing a parallel with online dating platforms and proposed a system in which group members could indicate mutual interest in staying in touch, thereby maintaining connections. This reflects the strong value participants placed on sustaining their relationships beyond the therapy setting, something that can be more natural in in-person settings.

Conclusion

In conclusion, this qualitative study aimed to explore patients' experiences of online group therapy. Framework analysis identified four main themes that encapsulate these experiences: expectations, engagement, therapeutic relationships, and attendance. Within these themes, insights such as the level of other group members' engagement, facilitated by highly skilled and nurturing clinicians, were among some of the factors influencing the acceptability of the online group. Furthermore, novel insights such as the loss of motivation for self-care, and an opportunity to face one's own anxieties about meeting other group members in person were identified as some of the barriers. The findings

support the growing evidence-base which emphasises the importance of choice within the delivery platform of mental health interventions, ensuring that the individual remains central in the decisions around their care.

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Appendices

Appendix 1: PRISMA Reporting Guidelines

Available online at:
https://systematicreviewsjournal.biomedcentral.com/articles/10.1186/s13643-021-01626-4/tables/2

Appendix 2.1: Search Strategy and Eligibility Criteria

Table 1: Search Strategy and Eligibility Criteria

SPIDER	Concepts	Inclusion/Exclusion	Search Terms
Sample	Clinicians	**Include**: Experiences of mental health clinicians (including counsellors, psychologists, mental health practitioners) who are involved in delivering online (video) therapy for mental health conditions (anxiety, depression, eating disorders, personality disorders.) **Exclude**: Other types of therapists e.g. Occupational Therapists, Physiotherapists, Medical Doctors, Speech and Language Therapists not specifically providing mental health therapy.	Child* OR "Young people" OR "Young person" OR Adolescen* OR Youth OR Teen* OR Juvenile OR Student* OR Young adult* OR Clinician* OR "Clinical Psychologist*" OR Therapist* OR "Mental health professional" OR "Mental health practitioner" OR Psychologist OR Counsellor OR Psychotherapist
	Children and young people	**Include**: Experiences of children and young people up to the age of 25 years old. **Exclude**: Participants over the age of 25 years old, parent, sibling, or carer responses.	
Phenomenon of interest	Online therapy	**Include**: All types of mental health conditions experienced by children and young people, all types of therapies, all length and intensity of interventions, no limits on therapist's prior experience of online therapy. Include group interventions as well as 1:1 interventions. Include studies where telephone therapy is mentioned amongst mainly online therapy. **Exclude**: Any solely app-based, text-based, telephone, Artificial Intelligence, chatbot, anything that does not involve	"Digital therapy" OR Tele-therapy OR Ehealth OR Telehealth OR Telemedicine OR "Internet delivered" OR "digital* delivered" OR "digital intervention" OR e-therapy OR "internet counsel*" OR "internet mental health" OR "internet psychotherapy" OR "internet therap*" OR "online

		real time video therapy as the main platform for intervention. **Exclude**: Family therapy excluded due to existing research on this. Blended forms of therapy to be excluded e.g. face to face therapy complementing online therapy. Exclude parenting interventions, and if data does not differentiate between medical and mental health clinicians. Exclude studies that are evaluating the transition of a specific intervention programme from F2F to online.	counsel*" OR "online mental health" OR "online therap*" OR "online psychotherap*" OR "remote counsel*" OR "remote mental health" OR "remote therap*" OR "remote psych*" OR "videoconferencing mental health" OR "videoconferencing counsel*" OR "videoconferencing psychotherapy" OR "videoconferencing therap*" OR "digital CBT" OR "computerised CBT" OR Ccbt OR "telehealth mental health" OR "telehealth counsel*" OR "telehealth psychotherapy" OR "telehealth therap*" OR "telemedicine mental health" OR "telemedicine counsel*" OR "telemedicine psychotherapy" OR "telemedicine therap*" OR "video therapy" OR "synchronous online therapy" OR cybercounselling OR "e-mental health"
Design	Data collection procedure	**Include:** Interviews Focus groups **Exclude**: Case studies, Observations, Surveys, Questionnaires, Quantitative data	

Evaluation	Barriers or facilitators	**Include:** studies that explore the qualitative experience of the platform of online therapy. **Exclude:** studies that are only looking at efficacy, effectiveness, or outcomes of specific interventions rather than qualitative experiences .	Barrier* OR Facilitator* OR Experience* OR Attitude* OR View* OR Opinion* OR Perception* OR Belief* OR Challenge* OR Driver* OR Limitation* OR Opportunities OR Benefit* OR Advantage* OR Perceive* OR Disadvantage* OR Obstacle* OR Feasibility OR Accessibility
Research type	Qualitative or mixed method	**Include**: Mixed method studies will be considered if there is qualitative data from interviews or focus groups that is relevant to the research questions. **Exclude**: Reviews will not be included.	Qualitative OR mixed method*

Appendix 3: Additional information from CASP quality assessment

Article	Positive/Methodologically sound	Negative/Relatively poor methodology
Krane et al. (2023)	Recruitment process was appropriately wide with helpful detail on participant demographics Clear description of themes being derived from the data	No consideration of relationship between researcher and participants, or evidence of any reflexivity - the researcher did not critically examine their own role, potential bias and influence during analysis and selection of data for presentation No clear description of analysis process regarding how themes were achieved
Benzel & Graneist (2023)	Good use of blinding in the participants when therapists and their patients both participated Detailed interview process Clear description and relevance of results put forward	No justification for the different analysis methods for the therapists and the child participants No comment on authors epistemological stance The setting of the study is not explicitly stated
Usluoglu & Balık (2024)	Clear aims of research with background evidence Methodological approach clear and well-explained with thematic process explored Limitations and future research goals clear	Would benefit from exploration of relationship between researcher and participant in interview process Not explained why Instagram was chosen as a recruitment process. However, some explanation given regarding type of therapeutic modality, training and experience and rationale behind exclusion of participants. The role of the researcher (past experience etc) was discussed. However, how this influences the relationship between researcher and participant was not discussed.
Castro et al. (2023)	Excellent detail in the data analysis process Good discussion on how consensus was reached	Aims are not clearly set out No description on researcher positionality Generally not clear when recruitment took place, although it was post-pandemic based on the context of the study
Cohen and Gindi (2023)	Linked well to previous research and explored rationale well Findings section linked to discussion section well with exploration of results in relation to current literature	The researchers used thematic analysis to analyse their data and outlined this process clearly. They did not explain their epistemological or ontological standpoint which is integral to this analytic process. Did not explore their own views The researchers explained their roles and the Israeli context in which the study was being

	Good strengths, limitations and implication for future research section.	conducted but did not include potential bias etc. There was some evidence of integration of the process in data analysis although difficult to replicate based on the information provided. There was not a clear statement of the findings although the findings were outlined in table format.
Van Rooij, Weeland & Thonies (2023)	Excellent description of the data analysis steps and the attempt to reduce bias by discussing coding with other researchers to reach consensus. Very detailed descriptions of results section	It was not explicitly discussed how they decided to choose their research design No description of researcher's epistemological stance
Erlandsson et al. (2022)	Good description of recruitment strategy Really clear description of the analysis process	Not clear what the epistemological stance was or justification of the research design

Appendix 4: Sample of reflexive log

Ideas and themes emerging from the initial reading of the included studies:
Want to consider the adolescence developmental stage and how this may create feelings of being confronted with one's own face in therapy, this is something that was raised in paper 2.

Wondering what type of mental health conditions the online setting may be most useful for e.g. certain therapies, certain types of people? Wondering if this may form part of my analytical themes.

I am completing this process after nearly completing my major research project in a similar topic area, and I am noticing that I don't want there to be an overlap of themes, if I am already biased by looking for such themes in the data. However, it is understandable that there may be some overlap.

Reasons for excluding a paper 8 after full text – it was only briefly mentioned in the results that the study did not involve synchronous video therapy, but a web-based asynchronous therapy. The paper otherwise reads as very relevant. May be useful to explore for discussion and future research ideas.

Coding

Study 1 – coding – noticing my Major Research Project theme of 'something missing' emerging, is this my bias?

During coding I am noticing that the same theme can either be a positive or a negative e.g. online feels demanding (good and bad), and this is maybe going to form part of the interpretation stage that ultimately there are pros and cons and it is an individual preference thing, but then can try to link it to certain types of people perhaps.

Study 1 – was just children/young people's views – and all liked in-person best - need to see how close to start of the pandemic this was because this is perhaps not representative of online therapy in a post-pandemic landscape.

Study 2 – again highlights the lockdown effect that will likely be part of my limitations – some of the studies included will have taken place during the lockdown so will not be an accurate reflection of children and clinician's usual thoughts and feelings.

Study 4 – also noticing a theme of pandemic stress in this and how the therapists may have been at heightened stress levels

Wondering if I should generate main themes for the children and young people and then match those to the Clinician's experiences, with room for additional ones if necessary – discussed in supervision and agreed this is sensible.

This is my process - Primary codes (the 14 original codes) → descriptive themes → analytical themes

Lack of depth needs to be represented in the analytical themes – it feels central to so many parts of online therapy

Discussion in research supervision – awareness that completing two pieces of qualitative work simultaneously requires careful separation. Going to explore Thematic Synthesis research articles to understand the processes further and how it differences from Framework.

Removing subtheme of institutional care, blending it into preferences because it was only represented once.

Removing 'impact of lockdown' as a subtheme because it's not actually that informative and I can talk about it in the discussion more generally, and how my review can no longer be considered 'post pandemic' since so many papers were actually during the pandemic.

Decisions around the themes (see detailed analysis plan for more information on decision process)

Appendix 5: Detailed analysis (for systematic review)

Open Science Framework link - https://osf.io/kgjs6

Appendix 6: COREQ checklist

The research study followed the consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups (Tong et al., 2007).

No	Item	Guide questions/description
Domain 1: Research team and reflexivity		
Personal Characteristics		
1.	Interviewer/facilitator	Which author/s conducted the interview or focus group?
2.	Credentials	What were the researcher's credentials? *E.g. PhD, MD*
3.	Occupation	What was their occupation at the time of the study?
4.	Gender	Was the researcher male or female?
5.	Experience and training	What experience or training did the researcher have?
Relationship with participants		
6.	Relationship established	Was a relationship established prior to study commencement?
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? e.*g. personal goals, reasons for doing the research*
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. *Bias,*

No	Item	Guide questions/description
		assumptions, reasons and interests in the research topic
Domain 2: study design		
Theoretical framework		
9.	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? *e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis*
Participant selection		
10.	Sampling	How were participants selected? *e.g. purposive, convenience, consecutive, snowball*
11.	Method of approach	How were participants approached? e.*g. face-to-face, telephone, mail, email*
12.	Sample size	How many participants were in the study?
13.	Non-participation	How many people refused to participate or dropped out? Reasons?
Setting		
14.	Setting of data collection	Where was the data collected? e.*g. home, clinic, workplace*
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?

No	Item	Guide questions/description
16.	Description of sample	What are the important characteristics of the sample? *e.g. demographic data, date*
Data collection		
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?
20.	Field notes	Were field notes made during and/or after the interview or focus group?
21.	Duration	What was the duration of the interviews or focus group?
22.	Data saturation	Was data saturation discussed?
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?
Domain 3: analysis and findings		
Data analysis		
24.	Number of data coders	How many data coders coded the data?
25.	Description of the coding tree	Did authors provide a description of the coding tree?

No	Item	Guide questions/description
26.	Derivation of themes	Were themes identified in advance or derived from the data?
27.	Software	What software, if applicable, was used to manage the data?
28.	Participant checking	Did participants provide feedback on the findings?
Reporting		
29.	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.*g. participant number*
30.	Data and findings consistent	Was there consistency between the data presented and the findings?
31.	Clarity of major themes	Were major themes clearly presented in the findings?
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?

Appendix 7: Demographics questionnaire

Open Science Framework link: https://osf.io/6g489

Appendix 8: Ethics approval letter

Research & Innovation
Dykebar Hospital, Ward 11
Grahamston Road
Paisley, PA2 7DE
Scotland, UK

04/10/2024

NHS GG&C Board Approval

Dear Ms Rumney

Study Title:	Patients Perspectives and Experiences of Digitally-Delivered Psychological Therapy Groups in an Adult Mental Health Setting
Principal Investigator:	Heather Rumney
GG&C HB site	Psychological Therapies Groups Service or virtual
Sponsor	University of Glasgow
R&I reference:	UGN24MH035
REC reference:	24/LO/0623
Protocol no: (including version and date)	V3 – 06.08.2024

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

Conditions of Approval

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004
   a. During the life span of the study GGHB requires the following information relating to this site
      i. Notification of any potential serious breaches.
      ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy (www.nhsggc.org.uk/content/default.asp?page=s1411), evidence of such training to be filed in the site file. Researchers must follow NHS GG&C local policies, including incident reporting.

2. **For all studies** the following information is required during their lifespan.
   a. First study participant should be recruited within 30 days of approval date.
   b. Recruitment Numbers on a monthly basis
   c. Any change to local research team staff should be notified to R&I team

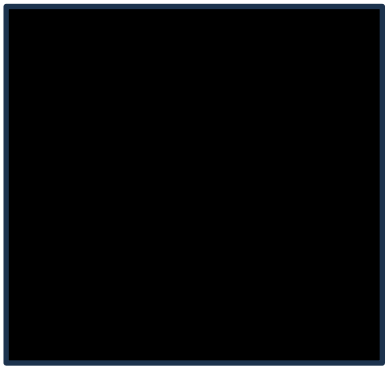
d. Any amendments – Substantial or Non Substantial
e. Notification of Trial/study end including final recruitment figures
f. Final Report & Copies of Publications/Abstracts
g. You must work in accordance with the current NHS GG&C COVID19 guidelines and principles.

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Your personal information will be held on a secure national web-based NHS database.

I wish you every success with this research study

Yours sincerely,



Appendix 9: Consent form

Open Science Framework link - https://osf.io/unyht

Appendix 10: Recruitment script

Open Science Framework link - https://osf.io/z9y28

Appendix 11: Participant information sheet

Open Science Framework link - https://osf.io/dpkry

Appendix 12: Privacy notice

Open Science Framework link - https://osf.io/qwm7z

Appendix 13: Debrief form

Open Science Framework link - https://osf.io/gsyqw

Appendix 14: Interview schedule

Open Science Framework link - https://osf.io/cmkq6

Appendix 15: Sample of MRP reflexive log

Sample:

Reflections during the process of interviewing, transcribing, coding, and developing the framework

Reflections from Participant 2 – 13/12/24 – felt like I kept cutting her off, I felt quite frustrated with myself listening back to this. Must have been an internet delay. Worried I am being a bit leading with my questions and perhaps asking closed questions. During coding I am noticing how this participant is saying that she would prefer in person therapy if she was doing it 1:1 due to the therapeutic relationship being a concern otherwise, but she liked the nature of the online group because it was less personal and maybe the therapeutic relationship was less important in that context

Reflections from Participant 3 – noticing a theme of not liking it when people drop out, this will perhaps fit nicely into a theme that suggests the more effort and engagement people put into the group, the more beneficial they will find it.

Participant 4 – potential theme of readiness for therapy being important. I asked a question I wish I'd thought to ask other people about - is there anything you think that you would gain from being an in-person group compared to online. Theme of about how online can possibly reach those who are more anxious, but also maintain anxiety for those anxious people due to lack of exposure.

Participant 7 – wouldn't have done the group otherwise, if it had been in-person – sense of support from other group members, influence of alcohol being more obvious if in person. I'm now wondering about having a theme of feedback, or how to make sure the feedback from these participants doesn't get lost in the online aspect of it. Realise this may not be in line with my current research questions, but definitely areas for future discussion, and can share with the PTGS at the end.

Participant 9 – in person interview – Felt more informal since we had had a chat beforehand coming into the room. Noticing a theme of abrupt endings and loss of connection that is otherwise felt in in-person settings. Noticing this interview brought a lot of subtle themes about a sense of something missing in an online setting, and interesting that this was my only F2F interview.

Participant 11 – Some good comparisons with difference between face-to-face and in-person settings here e.g. how do you know someone wants to talk in a F2F when online they can put their hand up more easily. Good point about quality of clinicians, as well as the engagement of the group members being an important facilitating factor, noticing themes of therapeutic relationships coming through

Participant 13 – wonder if I have been a bit biased, or been putting words in this participants mouth to try get her to say what I have noticed about reasons why online group therapy doesn't work for everyone – conscious not to overwhelm her, and conscious of how she disclosed neurodivergence, and therefore my wording of questions.

Awareness that I am wanting to find novel information to make this research stand out, so I'm conscious of this to avoid being too leading in my follow up questions.

General observations after completing interviews and coding stages

Overarching themes emerging – Something about expectations of what the group would be. Perception that the group's aim is about learning techniques and not necessarily about personal connection helped knowing it was online. Perception that online works well with for this type of therapy where it is not too personal – coming up in Participant 2, Participant 8.

Group was restarted due to low group numbers – happened for 2 people I think – but perhaps not relevant to research questions. Will create a top-level code for important info not related to research questions.

Idea for discussion - Changing people's expectations of online therapy may help waitlists as many people have said they would now consider online therapy when given the choice.

Wondering if I need to separate the theme of the 'amazing clinicians' and have a theme to do with the organisation and running of the group, and therapeutic skill of the facilitators?

Idea - Did it work well because people had low expectations?

Content of the PTGS sessions – important part of why a group is acceptable or not

Real sense that across the groups, it was generally encouraged not to go into too much personal detail. Which is why this platform may have worked well.

Getting close to deadline, noticing that I'm struggling with coding and need to pace myself now.

Reflections following discussion in supervision

Discussions regarding framework analysis – framework is currently too large, decision to remove the domains (themes) that are not as relevant to research questions. Discussed decisions on how to present the data in a matrix. Initially began doing this per participant regarding each theme. Perhaps thinking of doing a more meaningful way with barriers/facilitators as my main themes. See notes in paper sheets about other topics discussed for writing up methods. Interesting concept to explore – what were the facilitators that kept people attending the group?

May need to recode the 'perceptions after' back into barriers and facilitators. Need to check I haven't lost any barriers/facilitators after removing several domains.

Noticing that my barriers/benefits of online therapy are really just linked to engagement with online therapy. Need to see if this theme needs tweaked next.

Wondering if I should add participants experiences of past therapy into demographics section. On second thoughts, this would potentially impact ethics so have not done this. Just wondered whether it would have impacted expectations.

Reflections from research supervision

Wondering if engagement as a distinct domain doesn't make sense, or needs redefined because it's hard to put it into the matrix – should it maybe be motivation for engagement which fits with the other model of a framework I had been looking at. Thinking that engagement codes often related to own personal motivation to engage, as well as comments about the impact of other people's level of participation and engagement. Which is very different from reasons for engagement (facilitators) and reasons against engagement (barriers). Discussions then led to thinking about changing facilitators/barriers of attending the online group to 'Attendance'.

Mapping and Interpretation stages

I will start by comparing data over a theme e.g. (engagement across all participants) and within a case (e.g. participant 3 across all themes). Try to link the type of people with the type of themes that come up.

Made big leaps today – need to make sure my quotes are relating to the right themes now due to all the changes I've made. – reworked the final framework and now added Attendance

Remember to perhaps add into the results the number of people who would do online group therapy again, or who couldn't decide, or who wouldn't do it again, see white notepad for rough notes. Add in point that people like to know why others dropped out. Could also do a word cloud to show frequency of main themes mentioned? May want to discuss the implications of the findings in the results section for future intervention development? The Thomas and Harden thematic synthesis paper talks so nicely about how to go a step further in interpretation and into analytical interpretation, look at this paper again if struggling to add to interpretation.

Appendix 16: Detailed data analysis plan

Open Science Framework link - https://osf.io/ahndy

Appendix 17: Familiarisation stage

Participant	Key themes
Participant 1	Initial hesitation, past experience of group F2F therapy + online group therapy, worries about confidentiality, frustration at group members lack of engagement, disappointment with CPN access, lack of follow up support, comfort in being able to support others, sense of togetherness, ideas for improvement, great quality of clinicians. Strong personal motivation to complete, tech issues, Interesting/helpful content of group sessions, smaller group numbers more productive the group is not the cure-all, Abruptness of ending Organisation/running/delivery of the group Put off by strict rules/ written communication sent before the group, You get what you put into it
Participant 2	Low initial expectations, past experience of group F2F therapy worry about losing non-verbal communication, worry about quality of therapeutic relationship if more in depth therapy were to be online, great quality of clinicians, fits in well with family needs, Interesting/helpful content of group sessions, comfort of own home. Attention not just on me (good thing) Organisation/running/delivery of the group Exceeded expectations Online can work well for less personal group therapy (as in the case of the PTGS)
Participant 3	Initial relief about not having to leave the house, worries around technology, worries around interacting with strangers in the group, past experience of 1:1 F2F therapy, no pressure to talk, big advantage being able to attend from home due to anxiety, disappointment/worry for group members lack of engagement/dropping out, interesting content, comfort in being able to support others, sense of togetherness, online way more accessible due to anxiety, platform to help other people, overall good experience
Participant 4	Relief that it was online, anxious group setting, fear of unknown, more accessible online due to poor mental health and getting out the house, individual therapy previously, sense of togetherness, engaged group members really helped own engagement, worry about tech issues coming up, but not as big an issue as anticipated, worry about showing face if having bad day, flexibility, convenience - one less barrier to engaging, if slept in still able to attend, not possible in F2F. Comfort of own home Great quality of clinicians, strong personal motivation to complete. In person would give opportunity to face fears, rather than hide behind screen.
Participant 5	Initial hesitation, exceeded expectations, no worries about Practical accessibility benefits – transport, appearance, online+group fear of (unknown), worries about tech initially, this therapy worked well in group setting, hearing others viewpoints helpful, easily accessible,

	helpful to be online due to high anxiety, works around family's needs, size of the group too large initially, best to join with laptop, leaders on top of tech issues and privacy issues, mental health nearly impacted stopping, but strong personal motivation to complete, sense of togetherness, not alone. Enjoyed the lack of small talk, avoided distractions Online creates a helpful distance from experiencing others trauma overall good experience. Suggestions for improvements, lack of individual support during the sessions, the group is not the cure-all, abruptness of ending,
Participant 6	Initial hesitation due to anxiety, fear of unknown, Comfort of own home, Attention not just on me (good thing), Interesting/helpful content of group sessions, Practical accessibility benefits – transport, cost (time commitments). Quality of clinicians, reduced stigma (no waiting room to be judged in), being in own space to process thoughts, shared responsibility to have to engage, overall positive experience, Engagement from other group members - bonded
Participant 7	Pleased about it being online, Comfort of own home Personal anxiety had impacted F2F attendance before, positive engagement from other group members, Sense of togetherness, not alone, Practical accessibility benefits (health), group member under influence of alcohol, overall positive experience, Suggestions for improvements, Quality of clinicians, Group was restarted due to low group numbers, Strong personal motivation to complete, Usefulness of the chat function on Teams Interesting/helpful content of group sessions, Organisation/running/delivery of the group
Participant 8	Past positive experience of in-person group work, initial hesitation this wouldn't be as good, fear of unknown, camera having to be on. Comfort & safety of own home, Personal anxiety may have impacted attendance in person. Noticed much less anxiety in online group compared to F2F group. Perhaps more personal connection in F2F than online. being in own space to process thoughts, Sense of togetherness, not alone. Not as personal as F2F group but connection still there. Practical accessibility benefits – (transport) encouraged consistent attending from everyone. Online creates a helpful distance from experiencing others trauma - still had enough personal connection but not to the point of being too intense Usefulness of the chat function on Teams Engagement from other group members was helpful, Strong personal motivation to complete, more pragmatic than in-person, but in a helpful way, nice to have a variety of people ages/stages, Interesting/helpful content of group sessions Online can work well for less personal group therapy (as in the case of the PTGS) Exceeded expectations. Overall positive experience, huge benefit

Participant 9	Initial hesitation, feel that in-person usually better, Fits in well with work/family needs, Sense of togetherness, not alone, Engagement from other group members – experienced closeness, Practical accessibility benefits – (flexible, no need to travel), Comfort & safety of own home, being in own space to process thoughts, Organisation/running/delivery of the group, rules to keep safe Quality of clinicians, wouldn't have been able to attend in person due to moving between cities. Frustration with tech issues – chat function not working, hand up not working work commitments, group did bring up difficult emotions, Strong personal motivation to complete, Missing the chit chat – not being able to reach out to support others so easily , Abruptness of ending, lack of intimacy online, missing being able to gauge body language, unsure when to speak, Felt seen – in the letter Suggestions for improvements
Participant 10	Lots of initial hesitation, about rapport, sitting at home, not feeling personal, thought it might be too clinical/sterile/lecture-like set up worrying about being overheard initially but exceeded expectations, Practical accessibility benefits – (travel, time), Fits in well with work/family needs. Comfort & safety of own home. Felt more able to be open online, liked not seeing body language - Online creates a helpful distance from experiencing others trauma, easier to remain focused online, still able to build bonds and gel with people, being online strips away initial awkwardness, liked being able to get right into things Online can work well for less personal group therapy (as in the case of the PTGS)* helpful that employer was supportive of attendance, Quality of clinicians, body language cues not able to be picked up (over speaking), Size of the group too small initially, didn't gel, Heterogeneity of the group – positive/negative – felt ancient, Put off by strict rules/ written communication sent before the group, Engagement from other group members really helpful. Overall positive experience
Participant 11	Lots of initial hesitation, past experience of running therapeutic groups in-person, belief that it would need to be in person to be able to gel, but not the case. Exceeded expectations. Practical accessibility benefits– (travel, traffic, much more relaxed leading up to it, less pressure, couldn't drive due to broken foot), so much more accessible, never had to cancel. Fits in well with work/family needs, Comfort & safety of own home, great online if anxious, Engagement from other group members – bonded so well, but worried about them and missed them when they dropped out Sense of togetherness, not alone, Strong personal motivation to complete, real sense of pride for giving it everything You get what you put into it, Quality of clinicians (person centred, really cared about us, softly

	spoken, reassuring, genuinely cared) Interesting/helpful content of group sessions, basic but so well delivered became emotional discussing such a positive impact it has had. Felt seen – in the letter , easier to stick to time, Organisation/running/delivery of the group, rules to keep safe, no negatives, taking turns to speak using hand up function, helped prevent over-talking, visual clock, strong preference for online work after the group. Referral came quickly, at the right time. didn't feel like they weren't in the same room, didn't feel different, felt very connected to group members and clinicians. Not going to be one shoe fits all
Participant 12	Sceptical because always preferred in-person, wasn't sure if able to connect with others in same way, Sense of togetherness, not alone, goes to F2F group as a comparison, still prefer in person, found it hard to be vulnerable online, safety of own home, vulnerable to share in person too, Organisation/running/delivery of the group – efficient, online helped not miss it if he slept in, online easier, not having to travel - Practical accessibility benefits, being in own space to process thoughts, wouldn't be put off anymore or as nervous, exceeded expectations, Interesting/helpful content of group sessions, Engagement from other group members – positive, Quality of clinicians, Predictability and routine of the group
Participant 13	Initial feelings hesitation - Completed 2 full sessions, but then left after 10 mins on the next 2 sessions before stopping group. Practical accessibility benefits – travel – more convenient, lives in remote location. Would have preferred face to face if formal. No past experience of groups. previous therapy 1:1 which went well, neurodiverse – struggle to understand other people's points, heavy going with large group size, struggle to follow the content, felt not enough time to go through content, different interpretations of what people were saying, felt very uncomfortable, Heterogeneity of the group – positive/negative - felt very draining, very distracting being in own home, different ages/genders, different experiences of MH difficulties – Size of the group – too large (8) – half the size - Difficult with other group members – 8, Frustration at lack of explanation from CPN about the group, Reasons thought about stopping, or stopped the group- didn't like watching a video, prefers to be in a room with full attention on each other 1:1. Felt the group wasn't taking into consideration everyone's individual needs. Scared to say no to the group for fear of being discharged from CMHT Frustration at lack of follow up – feels shut down by CMHT- knowing that might be discharged after group finished was of putting as well. Group setting

	appears to have been main issue, although still would prefer F2F therapy even 1:1. Everything is better face-to-face. Sense of clock watching during the break which might not happen in person. Missing the chit chat – went straight into the content of the session

Key for Initial themes

Initial feelings – (hesitation or relief) – Exceeded expectations, fear of unknown, past experiences shaping beliefs about this
Lack of individual support, or follow up – inconsistent for people
Sense of togetherness, not alone
Privacy and confidentiality
Quality of clinicians
Worries about tech issues
Strong personal motivation to complete
Suggestions for improvements
Engagement from other group members – positive and negative
Fits in well with work/family needs – flexibility
Interesting/helpful content of group sessions – having access to paper materials
Organisation/running/delivery of the group, rules to keep safe
Personal anxiety may have impacted attendance in person
Size of the group
Enjoyed platform to help others
non-verbal communication, body language & therapeutic relationship
Comfort & safety of own home
Attention not just on me (good thing) – (shared responsibility to have to engage)
Practical accessibility benefits – (transport, cost, time commitments, physical health)
reduced stigma - (no waiting room to be judged in)
being in own space to process thoughts,
Online creates a helpful distance from experiencing others trauma nice to be removed from this
Usefulness of the chat function on Teams
Put off by strict rules/ written communication sent before the group
Online can work well for less personal group therapy (as in the case of the PTGS)*
Abruptness of ending
Missing the chit chat
Felt seen – in the letter
You get what you put into it
Timing of group needs to be right
Predictability and routine of the group
Heterogeneity of the group – positive/negative
Reasons thought about stopping, or stopped the group
Neurodiversity – does not meet individuals needs

Appendix 18: Initial framework

Open Science Framework link - https://osf.io/vdfqz

Appendix 19: Sample of a coded transcript

Open Science Framework link - https://osf.io/yzpvn

Appendix 20: Framework matrix

Open Science Framework link - https://osf.io/7yefz

Appendix 21: Number of participants contributing to subtheme

Theme	**Initial Expectations**		**Engagement**		**Therapeutic Relationships**		**Attendance**				
Subtheme	Relief	Concerns	Motivation to engage	Impact of other group member's engagement	Quality of Clinicians	Group coherence	Convenience & Flexibility	Safety & Efficiency	Technology Factors	Sense of Loss	Individual Preferences
Number of participants contributing to subtheme	4	12	6	8	9	10	13	9	4	6	9 preferred online, 1 preferred F2F, and 2 undecided

Appendix 22: Data availability statement

What are the plans for data sharing and access? • Who is expected to use the completed dataset(s) and for what purpose? • How will the data be developed with future users in mind? e.g. use of widely-used or open source file formats • How will you make the data available? e.g. deposit in a data repository; forward copies on request; create website
A plain language summary will be written for the participants who would like to understand how their data was used. Recordings and transcriptions will be destroyed following the appropriate waiting period as set out in the University of Glasgow data protection guidelines. The final project will aim to be published online in the University of Glasgow thesis publication website via Enlighten and further publication will also be considered in the journal – *Current Psychology*. The Principal Investigator intends to hold a meeting within the Psychological Therapies Groups Service (the service in which the study was conducted) to share the findings of the research study, alongside additional information participants wanted to share with the service for suggested improvements and general feedback, that was beyond the scope of the initial research questions.

Appendix 23: Final approved proposal

Open Science Framework link - https://osf.io/9e6u5