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WORKING THERAPEUTICALLY BY VIDEO CALL WITH COUPLES, FAMILIES AND GROUPS: A DIFFERENT WORLD?

Section A:
Beyond the Digital Dyad: A Systematic Review of Experiences of Therapists Working by Video Call with Multiple Clients

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Section B:
Adapting to a Digital Culture: Experiences of Family Interventions for Psychosis by Video Call

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Acknowledgements

The title page of this report shows one name, yet there are so many people whose contributions were essential: I am so grateful to the participants who took time to talk about their experiences of family interventions for psychosis; I am indebted to the many researchers whose work I have reviewed; and I am deeply thankful for those who have supported me, including Dr Edwin Ashong-Boateng for his encouragement, my principal supervisor Dr Maria Griffiths for her incredible wisdom and understanding, and my partner and family, not least my father, who died last year, to whom the project is dedicated.

Summary of the MRP

This project is concerned with therapy by video call with two or more clients. The first part is a systematic review: qualitative studies of clinicians' experiences of any therapeutic intervention with two or more clients were synthesised to address the question, *How are the attitudes and beliefs of therapists revealed by ways in which they report their experiences of working by video call with multiple clients?* Results suggested individual differences in clinicians' attitudes and beliefs. This is discussed in the context of training, guidance and organisational support. The second part is a qualitative study of experiences of family interventions for psychosis by video call. Service users, family members and practitioners, were invited to participate, but recruitment challenges meant that two family members and 11 practitioners were interviewed. Two overarching themes were identified: 'The digital demand', encompassing experiences of culture shock as the therapy moved online in the pandemic, and 'Flows and blocks in the human connection online', describing participants' differing experiences of connecting with each other via the screen. Family members especially testified to the consequences of that connection not working. Overall, this project highlights complex challenges of video work with two or more clients and the importance of learning to do it well.

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SECTION A

BEYOND THE DIGITAL DYAD: A SYSTEMATIC REVIEW OF EXPERIENCES OF THERAPISTS WORKING BY VIDEO CALL WITH MULTIPLE CLIENTS

Word Count: 7,347

Abstract

Reviews of dyadic contexts suggest that negative therapist attitudes towards video call may affect outcomes. However, attitudes of clinicians working by video with couples, families and groups, as revealed by accounts of their beliefs and experiences, are yet to be reviewed. Systematic searches of three electronic databases (PsycInfo, CINAHL and Web of Science) and hand-searching were conducted to identify qualitative studies of beliefs and experiences of clinicians delivering any psychological intervention to multiple clients via video call. Thematic synthesis methodology was used to draw interpretative themes from the included study reports. Initially, 1,215 articles were found. Duplicates were removed and remaining reports screened for eligibility, with 15 studies included in the final sample. Three overarching themes describing therapist attitudes were identified, '*A rewarding experience*', '*Working at it*', and '*Feeling generally negative*'. The influences clinicians may bring to the video context are discussed as a focus for further research.

Until the arrival of the coronavirus disease of 2019 (COVID-19), therapy by video call (VC) was something of a niche field. Despite 20 years of literature suggesting that dyadic therapy by VC has similar outcomes and acceptability to in-person work (for a review, see Thomas et al., 2021), and despite consistent national drivers towards digital health delivery since the Five Year Forward View (NHS England, 2014) was produced, use of remote therapy in the UK remained low (Vaitheswaran et al., 2012; Castle-Clarke, 2018). Barriers to implementation have been found to include concerns among clinicians naïve to the medium about its effectiveness and safety, as well as the feasibility of forming good therapeutic relationships (Cowan et al., 2019; Muir et al., 2020). A negative bias towards VC was noted in an early study by Rees and Stone (2005), in which psychologists who watched an identical therapy session, conducted either face-to-face or by video call, rated the therapeutic alliance lower in the video condition. Cowan et al. (2019) suggested that clinicians may perform a gatekeeping role that leads to negative beliefs about VC restricting its implementation. It is also somewhat ironic that negative attitudes held by therapists towards working by video call have been associated with reductions in the quality of the therapeutic relationship (Simpson & Reid, 2014).

As a consequence of the social isolation measures imposed during the COVID-19 pandemic, psychological therapy by VC exploded into the mainstream. In accordance with the findings of Muir et al. (2020), clinicians' beliefs about VC changed in response to this exposure: for example, Dowling et al. (2022) found that clinicians' experiences of delivering CBT by VC within an Improving Access to Psychological Therapies context exceeded their negative expectations. Interestingly, psychotherapists in Mitchell's (2020) study were able to work at a deep relational level, despite the visual limitations of the screen, although this was

noted to be easier for those who had been practising by video before the pandemic. While Mitchell (2020) reasonably argues that this demonstrates a need for training for therapists working online, we should also remember that those embarking on video work for the first time were doing so in the extraordinary and stressful context of the COVID-19 pandemic, which affected the wellbeing of healthcare workers as well as people with existing psychological difficulties (Moreno et al., 2020).

Research into therapeutic work with two or more clients (hereafter 'multiple clients') has also reported positive outcomes. A systematic review by de Boer et al. (2021) concluded that couples and family therapy by video call was effective, feasible and acceptable for clients, and that the additional difficulties of working with multiple clients were minor ones, for example the challenge of working with children who become distressed. Studies of couples and family therapy most often focus on work with two people, such as a child and a parent (Helps & Le Coyte Grinney, 2021). However, the findings of de Boer et al. (2021) are similar to those of Gentry et al. (2018), who reviewed studies of group interventions in any modality by video call, including some with large group sizes, and found them also to be feasible and acceptable with generally positive outcomes. However, the almost exclusively quantitative studies included gave little insight into the experiences and concerns of the clinicians involved.

An indication of the issues that might be of concern for clinicians can be found in professional guidance for working online with multiple clients. One such is the need to manage potential issues of conflict and risk remotely with multiple clients, a common theme in guidance across couples', family or group work. Thus, the British Psychological Society (BPS) guidelines on online family interventions for psychosis (Griffiths et al., 2021) share an emphasis on setting boundaries and ground rules with the BPS guidance for digital group interventions (BPS, 2021), as well as the Association of Family Therapy and Systemic

Practice (AFT) *Remote working guidance* (AFT, 2020). The AFT guidance, covering both couples' therapy and family work, warns of the risk of missing subtle interactions, and stipulates that members should complete a recognised course of training before starting. This implicitly acknowledges that core training for most therapists has only prepared them for a face-to-face work context (Anthony, 2015). Nevertheless, in the NHS, guidance from the Psychology Professions Network (2020), also published around the time of the first COVID-19 lockdown in the UK, documents a move for all therapists from a pre-COVID culture concerned with competencies, data security and risks to clients, to a pandemic culture of relative flexibility and pragmaticism aimed at facilitating much-needed care to continue, where many clinicians found themselves working online for the first time with little time to prepare.

This complex backdrop frames a question of how clinicians have experienced working via VC with multiple clients. This is particularly relevant now, as psychological services gradually adjust to a post-COVID-19 world and make decisions about the extent to which they continue to offer therapies by video call. If, as has been concluded in dyadic contexts, clinicians act as gatekeepers for the implementation of services, their experiences and the conclusions they draw from them are likely to shape future services. To the current author's knowledge, there has to date been no review of literature describing those experiences.

This paper reports a systematic review of qualitative studies of the experiences of therapists working in any modality with multiple clients by video call. In the planning stages of this review, scoping searches were conducted using Google Scholar. These indicated a relatively young literature with insufficient studies to justify a research question focusing exclusively on either couples' therapy, family therapy or group work. Given also the overlap in practice issues indicated by the guidance, it was decided to include all qualitative research

where more than two clients joined a video call. Qualitative evidence was privileged in order to develop a richer picture of the experiences that might reveal therapists' beliefs about the video context. Specifically, the review aims to answer the following question: How are the attitudes and beliefs of therapists revealed by ways in which they report their experiences of working by video call with multiple clients?

Method

The conduct and reporting of this review was guided by the Enhancing Transparency in Reporting the Synthesis of Qualitative Research statement (ENTREQ; Tong et al., 2012).

Synthesis Methodology and Search Strategy

Scoping searches suggested a methodologically heterogeneous body of literature. Examination of a small sample of studies with qualitative or mixed designs found during these searches revealed that some did not clearly report their epistemological position or methodology, raising questions about the potential reliability of conclusions that would be drawn by authors of the papers that would result from a systematic search. Thematic synthesis (Thomas & Harden, 2008) was therefore selected as a method for the 'translation of concepts between studies' (p. 5), as it requires line by line coding of participants' reported experiences, as close to the raw data as possible, rather than relying on higher level interpretations. This was to mitigate, at least to some degree, the triple hermeneutic 'interpretation of an interpretation of an interpretation', warned of by Ring et al. (2011; p.4). The procedure of thematic synthesis involves three principal steps: first, line by line coding of sections of study reports relevant to the research question; second, identifying descriptive themes from these codes; and third, drawing interpretative themes from those descriptive themes (Thomas & Harden, 2008). This presented a good fit with the research aim of interpreting clinician attitudes and beliefs through their reported experiences.

Inclusion criteria

Empirical studies using a qualitative or mixed methodology were included that investigated therapist experiences of using synchronous videoconferencing (that is, in real time) with more than one client simultaneously. Studies of any psychotherapeutic intervention with any client group were included. Due to lack of resources for translation, only studies published in English were included.

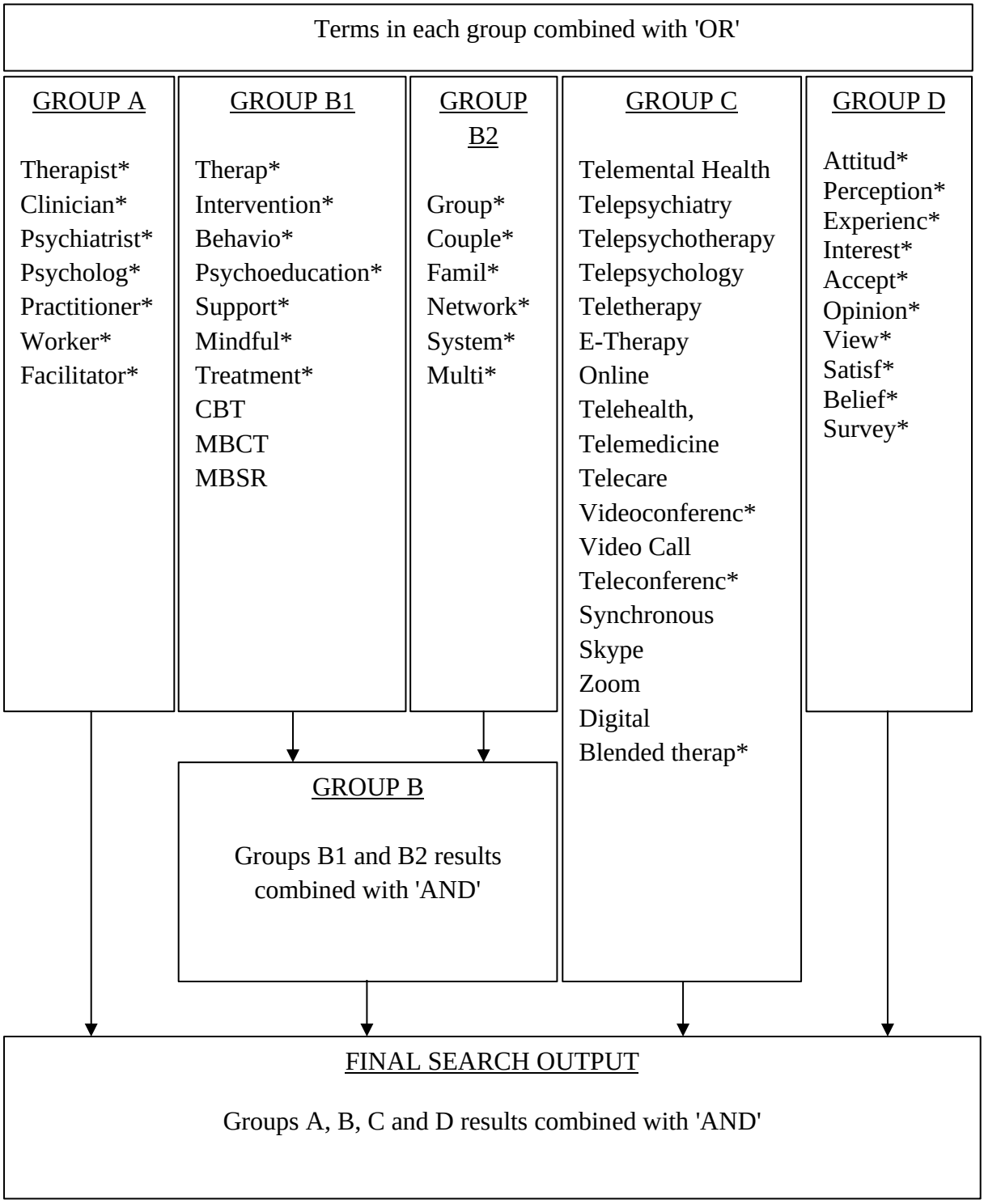
Exclusion criteria were: 1) the study was not empirical; 2) there was no qualitative report of therapist experience; 3) There was no psychotherapeutic intervention; 4) clients were individuals, rather than couples, families or groups; 5) synchronous videoconferencing was not used for at least 50% of the intervention; 6) studies published before 1994, when the first personal computer webcam became commercially available (Devaney, n.d.).

Data sources

The search was conducted on 2nd April 2022 using three electronic databases: PsycInfo, covering psychology journals; CINAHL, covering nursing and allied health professionals, since these clinicians commonly deliver psychologically informed interventions; and Web of Science, covering broader disciplines. The search terms used are presented in Figure 1. Filters were applied to limit searches to title and abstract in peer reviewed journals for studies from 1994. Hand searches were carried out using the reference lists of relevant studies.

Figure 1.

Search Terms and Combinations



Screening

After removing duplicates, search results were screened by title and abstract to exclude those which were clearly not relevant. The reports of remaining studies were obtained and screened on full text to obtain the final sample (see figure 2).

Quality appraisal

The studies for inclusion were assessed for quality and methodological rigour using the Critical Appraisal Skills Programme (CASP) tool for qualitative studies (CASP, 2018), following Noyes et al. (2018). Given that the present synthesis does not rely on the reported interpretations of the included studies, the purpose of appraisal was not to exclude but to give context to the synthesis.

Data extraction and synthesis

Data extraction was in two parts. First, a data extraction form was adapted for purpose from the form published by Cochrane Effective Practice and Organisation of Care (EPOC; 2017), with findings of particular relevance to the present research question given special emphasis. data extraction forms were used to inform reporting of the characteristics of the included studies and their findings as reported by their authors (Appendix A1). For the purposes of the thematic synthesis, following Thomas and Harden (2008), data was defined as text from each study report that represented the experiences of participants, either by description or direct quotation. Interpretative themes identified by study authors and text from Discussion sections were not included. The data was entered into NVivo software (version 12; QSR international) and coded line by line. Following Thomas and Harden (2008), codes derived from all studies were organised into descriptive themes, staying close to the data, and a process of identifying interpretative themes was conducted, using visual mapping. Finally, the interpretative themes were organised into higher level themes.

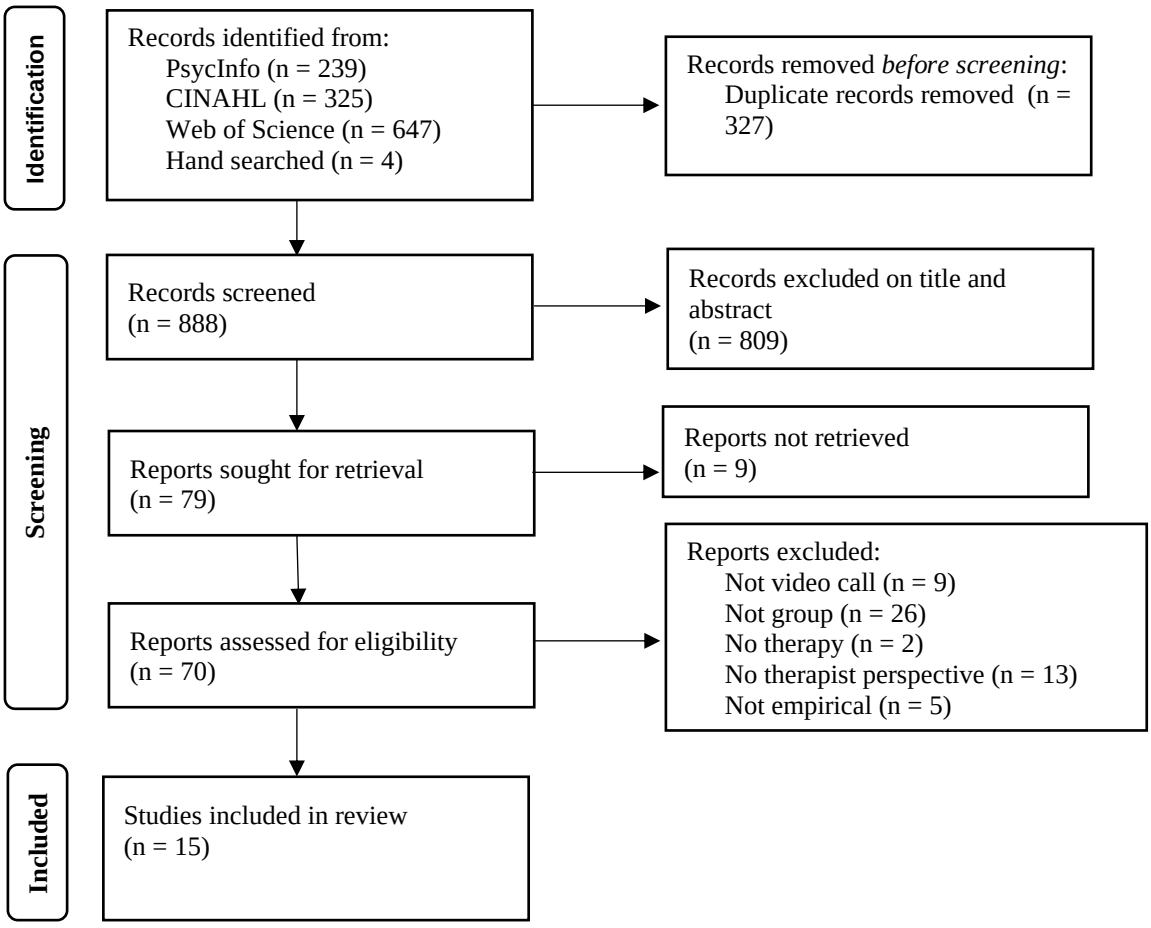
Results

Search Results

Electronic searches revealed 1,211 studies, with hand searches contributing a further four (total 1,215 studies). After removing duplicates and screening on title and abstract, 75 study reports were sought, of which nine were unavailable. After checking the full articles for eligibility, the final sample consisted of fifteen studies. Following ENTREQ recommendations (Tong et al., 2012), a flowchart showing the process of identification of studies for inclusion is presented in Figure 2, using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses 2020 (PRISMA 2020; Page et al., 2021) format.

Figure 2.

PRISMA 2020 Flow Diagram Showing Identification of Included Studies



Study characteristics

Characteristics of the included studies are summarised in Table 1. The included studies were published between 2011 and 2021; all but two of them (Rayner et al., 2016; Wade et al., 2011) were published between 2019 and 2021. The move to video work due to COVID-19 social distancing measures was the rationale for ten of them, with the remaining five conducted prior to the pandemic. Seven studies reported whether clinicians had previous experience of working by video call (Campbell et al., 2021; Glass & Bickler, 2021; Hardy et al. 2021; Heiden-Rootes et al., 2021; Sasangohar et al., 2020; Wade et al., 2011; Wade et al., 2019), and three reported training in the online intervention delivery as part of the study (Burek et al., 2021; Wade et al., 2011; Wade et al., 2019). Most were conducted in North America, either USA (*n* = 7) or Canada (*n* = 3). The others took place in Australia (*n* = 2), UK (*n* = 2) and India (*n* = 1). The contexts for nine of the studies were couples or family therapy, including studies of parenting interventions and surveys of general couples or family practice. Six studies focused on groups, including two which investigated art or music therapy by video call. Study designs varied: seven used purely qualitative designs, while the remaining eight incorporated a qualitative element into a mixed methods design. As will be seen in the thematic synthesis section below, the extent of the qualitative elements in study designs varied markedly.

The reported findings related to research questions concerning the feasibility or the advantages and disadvantages of video call with multiple clients, experiences of adapting to video call, and relational experiences in this context. These findings are summarised in Table 1; however, since it became clear that many of the reported findings were related to the VC context generally, rather than the multiple client context specifically, the latter are differentiated in italics. The report texts will be analysed in detail in the thematic synthesis below. In their conclusions, however, authors most commonly drew attention to therapists'

overall satisfaction with the video call medium, the challenges they felt it presented, and the demand on them to find adaptations to overcome those challenges.

Table 1 shows that relatively few of the reported findings in the included studies elucidated specifically the experience of working with more than one client by VC in ways that might differentiate it from dyadic work. Six studies reported that clinicians found it helpful to work with families in their home environment, for example, by working *in vivo* with their interactions and coping strategies (Burek et al., 2021; Glass & Bickler, 2021; Hardy et al., 2021; Heiden-Rootes et al., 2021; McKenny et al., 2021; Wade et al., 2011). A further six reported that clinicians found it harder to pick up non-verbal communications by VC, particularly when there were more people online (Fogler et al., 2020; Heiden-Rootes et al., 2021; McKenny et al., 2021; Rayner et al., 2016; Shah et al., 2019; Wade et al., 2019). Only Heiden-Rootes et al. (2021) noted specifically that having the device placed further away from multiple clients made it harder to pick up on subtle communications, due to the camera's restricted field of view and the change in audio quality. There were no reports of differences between family members on individual devices or joining together on a single device. McKenny et al. (2021) reported one clinician encouraging family members to check in with each other verbally when noticing body language that might otherwise be missed. By contrast, Wade et al. (2011) reported that non-verbal communication was clear, providing that the internet connection was good. The issue of disruption due to one or more clients having technical problems was recorded in three studies (Rayner et al., 2016; Sasangohar et al., 2020; Shah et al., 2019). In their feasibility study of Acceptance and Commitment therapy groups, Rayner et al. (2016) concluded that it is desirable to provide participants with standard equipment, software and data plans, and to have two facilitators, with one attending to non-verbal communications and the other troubleshooting technical problems.

Table 1.

Characteristics of Included Studies.

Study and *title*	Participants and context	Intervention/Area of practice studied	Data collection/analysis	Key findings and reported themes **Specific to multiple client therapy by VC*
Burek et al (2021). *Transdiagnostic feasibility trial of internet-based parenting intervention to reduce child behavioural difficulties associated with congenital and neonatal neurodevelopmental risk*	Canadian trainee therapists working at the SickKids Hospital, Toronto (*N* not reported)	Internet-based parenting intervention to reduce child behavioural difficulties associated with congenital and neonatal neurodevelopmental risk 7 self-guided online modules, followed by 60 minute session with parent and child by video call	Qualitative data collected as part of mixed-methods study. Semi-structured interviews gathered therapist views on acceptability of intervention Data analysed using Thematic Analysis	• Increased accessibility • Increased flexibility of scheduling • More rescheduling • Technical issues most frequent challenge • Technical challenges easy to overcome • Increased accessibility, effectiveness and generalisability of intervention materials • **Seeing family at home highlighted challenges and strategies used at home, empowering families to be own problem-solvers* • Flexibility to individual need possible
Campbell et al (2021). *Role and process change and satisfaction with*	One educational and developmental psychologist, 6 managers and 4 rural MDT members at BUSHkids, (rural	Routine psychology sessions, majority by video call with families joining from rural clinic	Qualitative design: Session observation notes from all participants, semi-structured interviews with psychologist and managers and	Theme 1: Extending therapeutic role, e.g., **Parents as co-therapists* Theme 2: Processes to maintain therapist presence, e.g., **adapted ways to engage young children in family work* Theme 3: Increased routines and documentation

Study and *title*	Participants and context	Intervention/Area of practice studied	Data collection/analysis	Key findings and reported themes **Specific to multiple client therapy by VC*
an educational and developmental psychologist telehealth service for rural children	allied health and education service in Queensland, Australia. Data collection pre-COVID-19	Interventions ranged from 3 – 13 sessions of between approximately 45 – 60 minutes each (120 minutes for assessments)	satisfaction surveys completed by psychologist and MDT members Thematic analysis	
Fogler et al (2020). *Implementing Group Parent Training in Telepsychology: Lessons Learned During the COVID-19 Pandemic*	USA Psychologists and trainees (*N* = 3) and observers (*N* = 3) in quality improvement study of an intervention moved online due to COVID-19	*Bootcamp for ADHD*, a 4-week group intervention delivered by video call to caregivers of 20 children in 3 groups. Sessions were 90 minutes, shortened to 60 minutes as part of the quality improvement process.	Feedback collected from psychologists and trainees as part of mixed methods study. Method for collecting data reported as varied. Not clear how clinician qualitative data was analysed.	• Families engaged and shared experiences • Facilitating sharing took 'intentional effort' • Materials distributed by email and screen sharing • Challenge to collect homework and questionnaires • Many distractions for families • **Extra effort to monitor, engage and connect all families in group*
Glass and Bickler (2021). *Cultivating the Therapeutic Alliance in a Telemental Health Setting*	Marital and Family therapists in the USA (N = 23). Private practice during COVID-19. Specialisms included trauma and substance misuse.	General practice in marital and family therapy	Qualitative design: Online questionnaire with open questions. Interpretative/construct-ionist phenomenological methodology, using thematic analysis	Theme 1: Doing telemental health is similar, but different, than in-person therapy, e.g., **Families share more with safety of being at home behind a screen* Theme 2: Adapting to telemental health is worthwhile Theme 3: Validating clients' voices and experiences is fundamental to building connectivity in telemental health therapies

Study and *title*	Participants and context	Intervention/Area of practice studied	Data collection/analysis	Key findings and reported themes **Specific to multiple client therapy by VC*
Hardy et al (2021). *Couple teletherapy in the era of COVID-19: Experiences and recommendations*	Couples therapists, most working in the USA (*N* = 58)	General couples therapy by video call	Qualitative data collected as part of mixed-methods study. Online survey including 12 open-ended questions to explore couple therapists' experiences. Inductive thematic analysis	Theme 1: Flexibility and convenience Theme 2: Enhanced connection Theme 3: Client discomfort Theme 4: Technology connection, e.g., **difficulty reading body language; touch and trust exercises harder* Theme 5: Clinician fatigue Theme 6: Ethical dilemmas Theme 7: Clarification Theme 8: Infrastructure, e.g. having reliable internet connection Theme 9: Focus, e.g. a different kind of attention required
Heiden-Rootes et al (2021). *Relational teletherapy experiences of couple and family therapy trainees: "Reading the room," exhaustion, and the comforts of home*	Clinically active trainee couples and marriage therapists in USA who transitioned from in-person to teletherapy due to COVID-19	General trainee clinical practice in couples and marriage therapy with couples and families	Qualitative design: Web survey including 4 questions inviting free text responses Hermeneutic phenomenological methodology, using thematic analysis	Theme 1: The dys-appearing body in teletherapy, e.g., **Inability to direct body language towards an individual - using names instead; difficulty picking up subtle communications, especially when device further away from multiple clients; difficulty managing conflict between clients* Theme 2: Relational and flexible engagement of children and adolescents, e.g., **harder to engage children; parents as co-therapists*
Lecomte et al (2021) *Group therapy via videoconferencing*	2 co-therapists working in an early intervention in	24 week group CBT for psychosis, delivered twice	Qualitative data collected as part of mixed-methods study.	• Lending iPads to participants with phone only (screen too small for group) • Therapist's work computer not adequate

Study and *title*	Participants and context	Intervention/Area of practice studied	Data collection/analysis	Key findings and reported themes **Specific to multiple client therapy by VC*
for individuals with early psychosis: A pilot study	psychosis service in Canada during COVID-19.	weekly by video call. 3 groups with a total of 17 people.	Semi-structured interviews with the 2 therapists Data analysis technique not described	• More accessible for people with social anxiety or not local • **Group members benefited from sharing experiences* • Fewer sessions missed
McKenny et al (2021). *'Living in a Zoom World': Survey mapping how COVID-19 is changing family therapy practice in the UK*	UK-based AFT members (N = 312), including qualified family and systemic therapists, supervisors, and those on the pathway to qualification. Private practice, NHS adult and child & adolescent mental health, public, third and educational sectors, trainers and students.	General practice of AFT members	Qualitative data collected as part of mixed-methods study. Online survey including open questions. Thematic analysis	Positive themes: • Positive clinical outcomes • Therapist satisfaction • Learning new technology skills • Increased access to resources • Improved therapeutic relationship and open communication • **Reflective conversations can still occur* • Clients feel more at ease • **Insight into how families 'operate'* • Overcoming geographical distance • More flexibility and convenience Negative themes • ** Enacting and mapping more difficult* • **Managing conflict harder with multiple clients* • Concerns about risk management • Difficulties assuring confidentiality • Therapist dissatisfaction • Difficulties creating boundaries/managing conflict and emotions • Difficulties with the therapeutic relationship

Study and *title*	Participants and context	Intervention/Area of practice studied	Data collection/analysis	Key findings and reported themes **Specific to multiple client therapy by VC*
				• **Difficulties picking up on body language, facial expressions and feelings* • **Flow of dialogue disrupted by glitches/delays* • Support and training needs
Power et al (2021). *'Reflecting or frozen?' The impact of Covid-19 on art therapists working with people with a learning disability*	Members of the Art Therapy and Learning Disability Professional Support Group of the British Association of Art Therapists (N = 105) Contexts: charity sector, education, forensic services, NHS, private care homes, self-employed, young people's specialist services, and trainees.	Art therapy practice during COVID-19 with people with a learning disability.	Qualitative design: Notes taken during six, 1-hour data collection sessions, including live art-making and reflective practice, held by Zoom. Reflexive thematic analysis	Theme A: the pandemic as leveller • Slowing down life and practice • Crisis response by therapists • Organisational response Theme B: the joy and jeopardy of working online • Barriers to online working • Facilitators to online working, e.g., **group routine to transition into and out of sessions* • Emerging best practice for online working Theme C: art after the eclipse • Loss of art • Discovering the capacity to make art online • Making art aids active self-exploration Theme D: function of the professional support group • Emotional expression • Inclusive community • Melting pot of learning Theme E: insight and understanding to meet client diversity • Frustrated endings • Adapting the therapeutic frame

Study and *title*	Participants and context	Intervention/Area of practice studied	Data collection/analysis	Key findings and reported themes **Specific to multiple client therapy by VC*
				• Shifting of power
Rayner et al (2016). *Participating From the Comfort of Your Living Room: Feasibility of a Group Videoconferencing Intervention to Reduce Distress in Parents of Children With a Serious Illness or Injury*	4 psychologists delivering an acceptance and commitment therapy (ACT) intervention at the Royal Children's Hospital in Melbourne, Australia	5-session ACT group intervention via videoconferencing, to groups of 4–6 parents and partners participating from home. Four sessions delivered weekly with a 5th booster session 1 month later.	Part of mixed methods study. Data were session records of clinicians' experiences and reflections Records were reviewed by two study clinicians at the end of the study to identify challenges and strategies for managing them with a final review by the clinical team	Adaptations for groups by video call: • Reduce sessions content • Use more visual content • **Replace small group activities with individual experiential exercises* • **Provide standard equipment, software and data plans* 'Essential' strategies for facilitators: • Pre-first session 1:1 technical checks • Prepare visual materials for content • Allow extra time for all activities • Shorten sessions due to screen fatigue • **Initially, two facilitators to observe body language and troubleshoot technical difficulties* • **Develop rules on turn-taking and opting in/out of discussions* • Identify ways to manage distractions • Consider implications of therapist and participant backgrounds
Sasangohar et al (2020). *Adapting an Outpatient Psychiatric Clinic to Telehealth During*	Psychiatric outpatient clinic at Houston Methodist Hospital, USA.	Art and music therapy groups delivered by VC	Case study exploring feasibility of online art and music therapy groups	• Have a backup plan if technology fails • Allow for time spent on technology issues • Managing interruptions • Patients as receptive and well-engaged • Setting the home therapeutic space

Study and *title*	Participants and context	Intervention/Area of practice studied	Data collection/analysis	Key findings and reported themes **Specific to multiple client therapy by VC*
the COVID-19 Pandemic:A Practice Perspective				• Challenge of access to art/music materials • **Challenge of group's technical limitations* • Balancing limitations and opportunities of creating music online • Opportunities to use new resources, e.g. music composition software • Starting a piece in-session to work on between sessions well-received • **Online groups appreciated as giving structure to the day and springboard to accessing other online support groups* • Time lags make live shared music difficult
Shah et al (2019). *Participating from homes and offices: Proof-of-concept study of multi-point videoconferencing to deliver group parent training intervention for attention-deficit/ hyperactivity disorder*	Clinicians (N not reported) at the Telepsychiatry Centre of the Department of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigarh, India	Group parent training intervention for parents of a child with ADHD. 10 sessions, each of 90 min, held weekly, delivered by Zoom.	Mixed methods design. Clinician records while conducting the groups. Data analysis not reported.	• **Some participants had slow connection* • Disturbance from other family • **Body language harder to read* • Parents more comfortable and relaxed • **Clinicians unable to conduct small group exercises, e.g. role play*
Tang et al (2021). *Transitioning a home-based, motivational*	3 health educators in children's obesity prevention	Motivational Interviewing via video call and telephone.	Qualitative design: Focus group made up of 3 health educators.	• More non-attenders • Fewer cancellations • Challenge of families' unfamiliarity with video platform and security concerns

Study and *title*	Participants and context	Intervention/Area of practice studied	Data collection/analysis	Key findings and reported themes **Specific to multiple client therapy by VC*
interviewing intervention among families to remote delivery during the COVID-19 pandemic: Key lessons learned	service in Guelph, Canada. Health educators are registered dietitians who completed a two-day Motivational Interviewing training before the study began and advanced follow-up training once each year.	Families had 4 sessions with a HE, plus emails and resources	Data analysed using thematic analysis	• Video delivery satisfying when in-person not possible • Satisfying to learn new skills • Family appreciation satisfying • Scheduling easier than in-person • **Need to involve children in rapport-building*
Wade et al (2011). *Live Coaching of Parenting Skills Using the Internet: Implications for Clinical Practice*	Six therapists (3 psychologists and 3 trainees) in USA delivering coaching for parents of children with traumatic brain injury Therapists' levels of knowledge and experience of using technology varied.	Parenting skills intervention with psychoeducation about cognitive/behavioural consequences of traumatic brain injury. Initial home visit followed by 10–14 self-guided web sessions and 10–14 coaching sessions	Qualitative element was small part of mixed design study. Qualitative data collection and analysis not clearly reported.	• Online work beneficial, irrespective of technology experience • **More discussion about boundaries and ground rules* • **Greater insight into everyday family behaviours* • Attention to session environment at family end • High therapeutic alliance estimates • Need to plan to limit distractions • **Non-verbal communications were clear if the internet connection was good enough*

Study and *title*	Participants and context	Intervention/Area of practice studied	Data collection/analysis	Key findings and reported themes **Specific to multiple client therapy by VC*
Wade et al (2019). *Clinician Perspectives Delivering Telehealth Interventions to Children/Families Impacted by Pediatric Traumatic Brain Injury*	Psychologists, psychology fellows and doctoral students (N = 14) at 6 large tertiary care hospitals in Colorado, Minnesota and Ohio, USA	Telepsychology interventions to children/adolescents and families affected by traumatic brain injury, as part of a series of eight clinical trials	Mixed design. Qualitative data collection via: 1) Spaces for comment as part of survey with forced-choice responses 2) Focus groups (total 9 participants) 3) 5 semi-structured interviews using same protocol as focus groups. Data was analysed using content analysis	Advantages: • Easily accessible, convenient • Cost-effective • Less stigmatizing/more comfortable for families • **Insight into family dynamics at home* • Can problem-solve/practice immediately in vivo • Easier to schedule/fit into family's day • **Greater involvement of both parents (in two caregiver homes)* Disadvantages: • Requires knowledge of technology • Technological difficulties • Need to address anxieties with technology • Harder for clinician to control environment • **Hard to see all family members/read cues* • **Harder to engage children* • Harder to establish boundaries/set limits

Quality Appraisal

Following appraisal using the CASP (2018) tool, four studies (Hardy et al., 2020; Heiden-Rootes et al., 2020; McKenny et al., 2021; Power et al., 2021) were rated as strong; four were rated as satisfactory (Campbell et al., 2021; Glass & Bickler, 2021; Tang et al., 2021; Wade et al., 2019); the remainder were rated as poor. Six of the seven studies rated as poor had mixed methods designs in which the qualitative enquiry into therapist experiences was a relatively small element. The seventh (Sasangohar et al., 2020) was a case study as part of a broader report of a clinic's transition to telepsychiatry. A summary of the quality appraisal focusing on methodology and analysis is presented in Table 2. An example of a completed quality appraisal form has been added as Appendix A2. Common omissions in the studies rated as poor were a lack of attention to the methodology and its implications for the knowledge claims made, and a lack of reflexivity to illuminate the researchers' impact on the conduct and findings of the work.

This quality appraisal information has particular relevance for the results reported above in the study characteristics section. The lack of methodological information given in some studies means that it is not possible to judge with confidence how those results were arrived at. While a 'poor' rating on the CASP (2018) tool means that those reported results should be treated with caution, it is not a basis for dismissing them entirely. For the purposes of the thematic synthesis at the centre of the present review, care was taken to extract data from the included articles that either described or directly quoted participants' accounts of their experiences. Themes and other interpretations drawn by study authors were not included.

Table 2.

Summary of Quality Appraisal

Study	Methodology description	Analysis and Reporting	Overall rating
Burek et al. (2021)	Epistemological position for use of thematic analysis not described	No clear themes. Unclear how findings were derived from data	Poor
Campbell et al. (2021)	Case study design use described and justified.	Themes and quotations reported. No divergent cases reported	Satisfactory
Fogler et al. (2020)	Qualitative methodology not clearly reported	Unclear how findings were derived from data	Poor
Glass and Bickler (2021)	Basis for phenomenological design clearly described and justified	Findings clearly presented. Analysis remains at descriptive level	Satisfactory
Hardy et al. (2020)	Inductive thematic analysis clearly described. Reflexive diary	Themes clearly presented	Strong
Heiden-Rootes et al. (2020)	Hermeneutic phenom-enological methodology described and justified	Themes clearly laid out with illustrative quotes	Strong
Lecomte et al. (2020)	Methodology for qualitative part of study not described	Cursory report of findings. Analysis not described	Poor
McKenny et al. (2020)	Inductive thematic analysis described in detail	Themes clearly presented	Strong
Power et al. (2021)	Critical realist thematic analysis described	Diagram of themes with illustrative quotes	Strong
Rayner et al. (2016)	Methodology for qualitative aspect of design not described	Not clear how qualitative data informed the recommendations	Poor
Sasangohar et al. (2020)	Case study from team perspective: methodology not described	Analysis not reported. Findings presented as recommendations	Poor
Shah et al. (2019)	Methodology not reported	Not reported how findings were derived.	Poor

Study	Methodology description	Analysis and Reporting	Overall rating
Tang et al. (2021)	Use of thematic analysis clear but epistemological position not addressed	Analysis and findings clearly reported	Satisfactory
Wade et al. (2011)	Methodology not clearly described	Not always clear whose voice is being reported	Poor
Wade et al. (2019)	Methodology described but limited to qualification of quantitative results	Findings clearly presented	Satisfactory

Thematic synthesis

The relevant data extracted from each study ranged in size from 100 words (Fogler et al., 2020) to 3,016 words (Glass & Bickler, 2021), with a median of 1,494 words. In total, 576 codes were derived from the data; these were organised into 38 descriptive clusters which were themselves grouped into 14 descriptive themes, for example 'Adapting', 'Group Processes' and 'Technology'. The full list is presented in Appendix A3. However, as Thomas and Harden (2008) predicted, these descriptive themes served only to summarise the findings of the studies from which they were drawn. It also became clear that individual descriptive themes commonly incorporated divergent experiences of concepts relevant to the present research questions. For example, the theme 'Beliefs and assumptions' covered views of video call that were 'generally negative', 'generally positive' and 'better than expected'. To identify interpretative themes, therefore, the descriptive clusters were copied into an NVivo Concept Map (Appendix A4) and an interactive process of visual mapping and referring to the meanings in the original data was used. These interpretative themes carried meanings concerning clinicians' beliefs and experiences. Three overarching themes were identified, representing different approaches to the online medium interpreted from the clusters of experience. A total of eight underlying themes were also identified. The theme structure and illustrative quotations are presented in Table 3 and discussed below.

Table 3.

Thematic Synthesis: Theme Structure and Illustrative Quotes

Overarching Themes	Underlying Themes	Illustrative Quotations
1. A rewarding experience	1.1 Embracing the New	*HEs [Health Educators] described the transition to remote visits during the pandemic as a rewarding experience* (Tang et al., 2021) *'Pushing boundaries… new ways of working… [it's] exciting'* (Participant quote; Power et al., 2021)
	1.2 Feeling the Connection.	*'The virtual setting creates less vulnerability, therefore, (they are) willing to open those doors.'* (Participant quote; Glass & Bickler, 2021) *The patients seemed grateful to have the groups as a way to create structure in their days and to connect with others* (Sasangohar et al., 2020)
	1.3 Celebrating advantages.	*Accessibility was highly regarded in some way by all participants* (Glass & Bickler, 2021) *Increased flexibility and accessibility in terms of scheduling for both themselves and families* (Burek et al., 2021)
2. Working at it	2.1 Adapting Skills	*The EDP [Education and Developmental Psychologist] also made a conscious effort to look directly into the web camera to maintain eye contact.* (Campbell et al, 2021) *Agreement was reached by the group that the therapist should support the client(s) to: 'do something practical to transition in and out' of each session* (Power et al., 2021)
	2.2 Trying So Hard	*'Doing teletherapy requires a different type of focus that was tiring at first'* (Participant quote; Hardy et al., 2021) *Videoconference boundary ambiguity prompted more discussions with families about boundaries and ground rules than would occur in traditional therapy* (Wade et al., 2011)

3. Feeling Generally Negative	3.1 It's Not the Same	*'I do not believe you can fully replicate face to face family therapy work online'* (Participant quote; McKenny et al., 2020) *The clinicians also reported not being able to conduct small group activities like role play amongst parents* (Shah et al., 2019)
	3.2 Barriers to Online Work	*These difficulties were attributed to limits of technology to process multiple speakers and a client's camera position for including all family members in the video* (Heiden-Rootes et al., 2020) *Specific groups might be excluded, such as older people and particular religious communities who, for different reasons, may not adopt particular technologies* (McKenny et al., 2020)
	3.3 Safety Concerns	*Respondents expressed a general concern with assuring client safety* (McKenny et al., 2020) *Several participants noted how conflict would erupt on the other side of the screen and they felt unprepared for how to intervene* (Heiden-Rootes et al., 2020)

Theme 1. 'A Rewarding Experience'

The first overarching theme brought together experiences and beliefs that were characterised by a sense that working by video call could be positive and something to be embraced, for example: *'most (all but two) respondents noted they felt pleased in the transition and found the ease of the switch to telemental health was more rewarding than they would have anticipated'* (Glass & Bickler, 2021). Clinicians felt they were still able to use their strengths to build therapeutic relationships, and that the remote context offered unique advantages, such as, *'Fathers' increased attendance'* (McKenny et al., 2020). Three underlying themes were identified: 'Embracing the New', 'Celebrating Advantages' and 'Feeling the Connection.'

1.1 Embracing the New. This theme encompasses a sense of enthusiasm about working by video call. A participant in one study said, 'I seem more comfortable with clients

in teletherapy' (Hardy et al., 2021). Several studies reported that clinicians felt positive about learning new skills, and that some had embraced new digital tools, such as free music production software for use in music therapy (Sasangohar et al., 2020) and a digital whiteboard for group art making (Power et al., 2021). Some clinicians expressed satisfaction or pride at learning new skills. Other clinicians were reported to have found working by video call better than they expected: 'I thought the loss of “atmosphere” and emotion in the room would hinder but that has not really proven to be the case’ (McKenny et al, 2020).

1.2 Feeling the Connection. There were many accounts of clinicians feeling positive about working with group process online. In the context of art therapy, for example, '*[It] felt like a group. Absorbed in making, then noticing others on screen'* (Power et al., 2021), while in family therapy, *'Reflective conversations can still occur'* (McKenny et al., 2020). There was a sense that video call could help people to connect for whom attending in person might have been a barrier: *'It breaks down the walls of the walled-off, so to speak'* (Glass & Bickler, 2021). Therapists used to seeing families in clinic found that being invited into the home via video call gave them more insight into family life (e.g., Wade et al., 2011; Heiden-Rootes et al., 2020). They felt that families were more relaxed at home and interacted in a more natural way. Some also thought that this helped to deepen the therapeutic relationship: *'I think being in the client’s environment is really connecting, seeing their families, their pets, the décor'* (Glass & Bickler, 2021).

1.3 Celebrating advantages. Clinicians reported advantages of the video call context for their clients, for themselves and for the conduct of the work. Participants in four studies felt that working by video increased the accessibility of therapies, for example:

> *'Accessibility included clients being more comfortable in their own settings due to mental health or physical health barriers, clients who could make telemental health sessions more easily due to time demands or childcare issues, clients that*

> *prefer the convenience (e.g., less travel time, scheduling flexibility), and meeting the needs of rural clients who may not have sought services otherwise'* (Glass & Bickler, 2021).

Some clinicians also felt that the power dynamics changed, for example, citing the control individuals had over their device, whether they chose to appear on screen, or whether they decided to end the call. This was seen as an advantage, for example, when clients with a learning disability used this control with a sense of *'playfulness'* (Power et al., 2021). Some therapists working from home reported a better work-life balance and found it easier to arrange professional meetings by video. Other reported advantages of video work included easier scheduling (e.g., Burek et al. 2021; Tang et al., 2021) and fewer clients arriving late (Hardy et al., 2021).

Theme 2. Working at it.

The second overarching theme captures therapists' beliefs and experiences of working by video call that were concerned with extra work or adaptation. Clinicians described changes to their roles and ways in which this impacted them. They felt that working online was characterized by increased effort, and this could be experienced as a burden, for example, *'The EDP reported an increased cognitive load associated with managing these new routines'* (Campbell et al., 2021). Two underlying themes were identified: 'Adapting Skills' and 'Trying So Hard'.

2.1 Adapting Skills. Clinicians reported being flexible in adapting their work to be sensitive to individual needs, such as offering session times for parents when their children were in childcare (Glass & Bickler, 2021) or developing routines for clients with learning disabilities to transition in and out of sessions (Power et al., 2021). Changes in communication skills were frequently reported. In terms of body language, for example, one participant in McKenny et al., (2020) spoke of using *'my hands and face and vocal tone to*

express interest and engagement.' Some used more active verbal communication to compensate for body language that could not be seen on screen (e.g. McKenny et al., 2020), while others focused their attention differently to convey presence and build therapeutic relationships, for example: *'I am tuned into the clients' eyes and changes in voice'* (Glass & Bickler, 2021). Others described using therapeutic qualities such as validation to promote deeper therapeutic relationships, including validating clients' challenges with working by video call (Glass & Bickler, 2021).

Being adaptable to taking extra time where needed was thought to be helpful (Glass & Bickler, 2021), as was the ability to address distractions arising for their clients: *'clinicians reported that they needed to feel comfortable checking-in with families about distractions in the home that may be impacting the session'* (Wade et al., 2019). Adaptations to content varied widely. Some clinicians felt their practice was largely the same as in-person work (Campbell et al., 2021), others reduced the amount of content in sessions (Rayner et al., 2016), while still others either increased or decreased the amount of structure in their work (Glass & Bickler, 2021).

Adapting to online risk management was a common task for clinicians. Some reported having to adapt to new routines and protocols (e.g., Campbell et al., 2021; Hardy et al., 2021), although others complained of a lack of guidance (McKenny et al., 2020). Contracting was raised by some clinicians as a way of promoting safety, for example: *'Agreeing a contract frames new therapeutic boundaries'* (Power et al., 2021). The need to update informed consent procedures for video call was also mentioned (Hardy et al., 2021). Generally, there was a sense that working online required extra safety planning, especially for people identified as at increased risk (Sasangohar et al., 2020). However, the availability of authoritative support helped some clinicians: *'In the NHS, local expertise diffused organisational anxiety regarding online working risk'* (Power et al., 2021).

2.2 Trying So Hard. Clinicians reflected on additions to their roles, not least being a technology trouble shooter for clients (e.g. Sasangohar et al., 2020). McKenny et al. (2020) stated that *'many respondents reported that working online fatigued and stressed them more than working face-to-face.'* Some clinicians felt that group activities and discussions took more time online than in-person (Rayner et al., 2016). Others spent more time in preparing sessions (Campbell et al., 2021) and in setting up their online environment: *'one or two drew attention to the hassles of 'getting set up well.i.e. headphones! lighting!"* (McKenny et al., 2020). For some, having to deal with distractions in clients' homes was another thing to contend with: *'another process to comment on and understand'* (Heiden-Rootes et al., 2020). For Sasangohar et al (2020), it became another thing to plan for when doing meditation interventions. The burden of troubleshooting technology may have been heavier for some, as therapists were reported to vary in their technological ability (Wade et al., 2011). Some found it easy: *'therapists unanimously reported on the ease and value of overcoming these barriers'* (Burek et al., 2021)

Theme 3. Feeling Generally Negative

The final theme concerns clinicians' experiences of video work as negative, problematic or concerning, for example, *'A small number of respondents felt generally negative about practicing online'* (McKenny et al., 2020). Clinicians felt that there were barriers to working by video call and had concerns about safety. Three underlying themes were identified: 'It's Not the Same', 'Barriers to Online Work' and 'Safety Concerns'.

3.1 It's Not the Same. Some clinicians felt that working in person was better than by video call. One study participant said simply, *'face-to-face therapy is [a] better experience'* (McKenny et al., 2020). Therapists expressed reservations about the possibility of relating at deeper levels with families by video (Campbell et al., 2021). A variety of difficulties were raised, for example, some felt that engagement was especially difficult when working with

young children (Glass & Bickler et al., 2021) or children with a cognitive impairment (Wade et al., 2019), and others identified that families were less likely to attend online sessions (Tang et al., 2021). One therapist reported that *'a client abruptly ended a session'* after a rupture in the relationship (Hardy et al., 2021). The convenience of video call sessions, noted elsewhere as an advantage, was felt by a participant in one study as having the potential to mask a family's lack of motivation to engage (McKenny et al., 2020). Similarly, whereas we have seen that some clinicians saw distractions and disruptions during sessions as something extra to work with, others saw them more negatively: *'The greatest disadvantage clinicians reported of telepsychology relative to face-to-face interventions was [the] amount of disruptions during session'* (Wade et al., 2019).

3.2 Barriers to Online Work. The feeling shared by some clinicians that there was a barrier to non-verbal communication by video was expressed strongly by some trainee couples and family therapists: *'The therapist's body was identified as an intervention tool that was now rendered useless and dependent on technology'* (Heiden-Rootes et al., 2020). Others complained of a barrier to reading body language (e.g. Shah et al., 2019; Rayner et al., 2016), and felt that attending to process with several people on screen was challenging (McKenny et al., 2020). This was particularly seen as a problem by one clinician when relationships were difficult*: 'I think it's harder with multiple people in Zoom especially if it is a high conflict family or couple, it is difficult to interrupt and help them de-escalate virtually'* (Heiden-Rootes et al., 2020). These barriers were often expressed in terms of loss, for example*: 'one participant described the loss of non-verbal communication which would usually inform clinical formulation and therapist response'* (Power et al., 2021).

Technology problems were also commonly cited as a challenge, especially with more people in the family or group (Heiden-Rootes et al., 2020). Issues of delayed or absent video or audio were reported as a problem, for example, *'inability to read facial cues because of*

delays' (Hardy et al., 2021). The quality of the internet connection was recognised as a factor: *'some respondents bemoaned their (and clients) poor wifi connections'* (McKenny et al., 2020).

Participants in the study by Glass & Bickler (2021) identified historical challenges that made a heightened emotional backdrop to online work for people from minoritised cultures, which could be a barrier to therapy if not handled with sensitivity. These historical challenges included the murder of George Floyd and the disproportionate impact of COVID-19 on people from Black and Minority Ethnic backgrounds:

> *'During the time of this research, there were two difficult historical challenges that clients were experiencing. These challenges included isolation, fatigue, unknown future around the virus, and life shifts that were occurring in the midst of the COVID-19 pandemic. The other was the intensity of social climates in response to George Floyd's death while in police custody.'* (Glass & Bickler, 2021).

People on low incomes were also identified as at risk of exclusion from video therapy (McKenny et al., 2020), as were people who are not comfortable with using technology (Glass & Bickler, 2021).

3.3 Safety Concerns. Concerns and uncertainties about keeping clients safe online were expressed by some clinicians. Risk assessment was seen as more difficult by video call, including ongoing assessment: *'Harder to 'sniff out' possible abuse or other such 'secrets''* (Hardy et al., 2021). Some worried about their ability to support distressed or anxious clients at a distance, especially in initial appointments (McKenny et al., 2020). One clinician's concerns were cited by Hardy et al. (2021): *'Hasn't happened to me, but what if you have a suicidal client, or one who is becoming psychotic?'*

Privacy and confidentiality were a particular concern for some clinicians, referring to the risks of clients being overheard or of the call being hacked (Hardy et al., 2021). Similarly, the issue of boundaries was raised, for example the blurring of boundaries that might occur with the informal culture of video call (Sasangohar et al., 2020). However, an art therapist working with people with learning disabilities appreciated the client playing with the boundaries: *'client had a snack bar - playing, taunting - fun'* (Power et al., 2021).

Discussion

The present review set out to synthesise findings relating to clinicians' beliefs and experiences of working by video call with multiple clients. A thematic synthesis of 15 studies resulted in three overarching themes relating to ways in which video call was experienced as rewarding, as demanding extra work and adaptations, and as generally negative. These themes were identified in a process to find meaning from the divergent responses of clinicians to the same aspects of video call work. These individual differences could be for a number of reasons, including differences in the contexts in which clinicians were working, differences in clinician background experiences, for example whether or not they had training in VC work, or perhaps differences in attitudes towards therapy by VC, which Simpson and Reid (2014) noted as a variable affecting the therapeutic relationship in dyadic work by VC. For the sake of brevity, these individual factors will be referred to as a 'reflexive relationship' which describes the potential for clinicians' individual differences to affect their experience of the video context. This represents a new direction in thinking when compared to the findings of the original studies, as it recognises a broader context to the evaluation of video call as a mode of delivering interventions. While the reported findings of the included studies are helpful in revealing the benefits and challenges of VC with multiple clients and some adaptations that can be made for that context, it must be equally important to consider what clinician factors might be facilitative, including perhaps prior experience and training.

The individual differences termed here a reflexive relationship between clinicians and their experiences of the video context were captured most strongly within the themes 'A rewarding experience' and 'Feeling generally negative'. Contrasting experiences were seen even within the same study, for example, 'working online could be more focused, direct and ‘intimate’' and 'A small number of respondents felt generally negative about practicing online' (McKenny et al., 2020). Again, the design of the present review precludes drawing any conclusions about possible causes or effects of this reflexive relationship on working with multiple clients by video call. However, it is in accord with evidence from a study of dyadic psychotherapy by Boldrini et al (2020), which suggested that therapist satisfaction may be negatively affected by lack of prior experience of video therapy and their beliefs about the incompatibility of therapy modality with video call. Other evidence of therapists' reflexive relationship with their work context in dyadic work has been reviewed above, for example Simpson and Reid's (2014) review associating negative therapist views about video call with a poorer therapeutic relationship. Outside the video context, a review by Waller and Turner (2016) gathered evidence that the quality of therapy delivery may be negatively affected by clinicians' knowledge, beliefs and attitudes, emotions and work cultures.

Nine of the 15 included studies were conducted during the COVID-19 pandemic, a time of increased work-related pressure and stress within mental health services (Byrne et al., 2021). The second theme identified in the present review, 'Working at it', incorporates a sense of the burden experienced by all clinicians at that time who were adapting to meet the needs of their clients in a new social landscape, and especially those who were also having to adjust to working by video call for the first time. There was a sense also that this burden could be experienced differently depending on the circumstances; for example, art therapists in the study by Power et al. (2020) particularly felt the loss of the tactile nature of making art together in person. It would have been interesting to hear more from the included studies

about ways in which therapists' experiences may have related to the contexts in which they worked. A study Bekes and Aafjes-van Doorn (2020) suggested that dyadic psychotherapists' attitudes towards remote delivery were affected by contextual factors including therapeutic modality, clinical experience and the quality of the transition experience.

One difficult aspect of the transition experience raised by many clinicians in the included studies was the question of risk and safety management. Concerns ranged from the specific, such as the limits to risk information gathering afforded by the camera, to the more general, such as the feeling that 'confidentiality, safety cannot be guaranteed' (Hardy et al., 2021). While guidance is available for safety management when working with multiple clients remotely (e.g., Burbach & Helps, 2022), it is an area that has attracted little empirical research. Working with people at risk has been recognised as one of the most challenging aspects of a therapist's role (McGarry & Reeves, 2020), and something that, even in the familiar in-person context, can expose gaps in competence (see Overholser & Fine (1990) for a discussion of case examples). Given the understandable anxieties of some clinicians in the included studies as they negotiated risk management in the video context, it seems likely that providing support in this area would be protective both for clinicians and their clients. Indeed, among adaptations for online risk management described in the included studies were compliance with guidance, using supervision and organisational support, notably in one case the presence of a senior team member with expertise in online work.

Technological problems were regarded as a source of extra work and as a generally negative feature of working by video call. Previous reviews of couples and family therapy by videoconferencing have noted issues of connection disruptions (de Boer et al., 2020) and the need to support therapists to learn and use video call systems (Muir et al., 2020). However, the results of the present review have shown that clinicians' perceptions of technological challenges vary, with some finding them easy to overcome and others feeling they are more

of a barrier. There are many possible explanations for these differences. For example, the private couples' therapists working from home in Hardy et al.'s (2021) study may have felt less supported than the psychologist videoing in to a remote rural clinic with stable technology, where families were helped by a multidisciplinary team (Campbell et al., 2021). Similarly, it might be supposed that clinicians would have differing technical knowledge and experience, and that both they and their clients would have differing qualities of equipment and connection. Certainly, Muir et al. (2020) reported evidence that video work was facilitated by having a dedicated team of motivated clinicians with prior experience and training, and with specialist technical support. Comparing this ideal with the situation of a lone therapist with little knowledge and no experience of video call taking their first steps in the context of a pandemic, it is easy to see why it might feel burdensome, at the very least.

Limitations

The present review was limited to empirical studies with a qualitative design, either wholly or in part. Grey literature was excluded as it would have been beyond the resources of a single reviewer to source and analyse it. This strategy was also intended to ensure that the reports forming the data of the present synthesis would have been prepared with methodological rigour, although, as the quality appraisal results showed, some of the included studies did not live up to this expectation. Furthermore, deriving data from the descriptions of participant contributions and direct quotes included in study reports inevitably reflected the authors' selections from their raw data. While higher level themes identified in those studies were excluded from the current review to limit the impact of the authors' interpretations on the review results, those themes might also have been more broadly representative of the whole data sets for each included study.

Despite the limitations of the inclusion criteria, the studies represented a diverse range of settings, client groups and therapeutic modalities. This gave the current review a breadth

of perspectives, although it precluded a depth of information from any one context. It is important to emphasise therefore that the review results can only be a starting point for future research on ways in which therapists' experiences of working by video call with multiple clients might inform their training and support needs in different contexts.

Nine of the 15 included studies were focused on the COVID-19 context. This was a clear priority for research at the time, as academics and clinicians sought to find ways to deal with the pandemic crisis. However, as we turn to a future in which a mix of face-to-face and video call therapy seems likely, the experiences of clinicians who faced having to translate their practice online with little warning, when both they and their clients were dealing with the significant psycho-social effects of a pandemic, may need to be contextualised. There is an opportunity here for researchers to investigate how clinicians who choose to embrace digital working without the pressure of a global pandemic might usefully prepare themselves.

Implications for practice and future research

The findings of the present review have implications for training, professional guidance and clinical practice from organisational and practitioner perspectives. The theme of VC being experienced as burdensome, and the contrasts in clinicians' responses to the medium, suggest that training is likely to support clinician well-being and good practice. For example, given the ongoing NHS commitment to digital healthcare, doctoral training courses for clinical psychologists need to incorporate working by VC and other digital means into their cultures to prepare psychologists for their roles as therapists, supervisors and future leaders. The British Psychological Society-sponsored e-learning 'Developing competencies for digital clinical practice' is one such excellent example https://dclinpsy.psychologyresearch.co.uk/e-learning/. Similarly, organisational and individual qualified clinician choices about continuing professional development need to reflect increased use of VC since COVID-19. Training of all kinds will need to prepare

clinicians systematically for the complexities of the medium, including knowledge of digital tools to facilitate interventions, managing safety, risk and safeguarding remotely, and working with process with multiple clients. Future research should support this increased attention to the complexities of VC work with multiple clients by focusing on outcomes which have until now been neglected, but which the present review has shown are concerns for clinicians, for example online group process, and risk and safety.

Problems with technology arose as a theme in the present review, and are commonly noted elsewhere in the literature. This has implications for the NHS and other organisations offering digital mental health care which extend beyond ensuring that clinicians have good equipment and secure internet connections, as important as those things are. Where interventions for multiple clients by VC might be an option, assessment protocols should capture any barriers to clients' access, such as a lack of technical resources or skills, or the availability of a private and confidential space. Information about these barriers could be important data for research looking at ways to overcome them. NHS Digital's (2019) *Digital inclusion guide for health and social care* may be a helpful framework to guide such research initiatives.

In addition to taking up available training, clinicians have a responsibility to know and follow professional guidance. In response to the upsurge in use of VC with multiple clients during the COVID-19 pandemic, professional bodies such as the BPS and the AFT produced guidance for their members, although the evidence base on which they are founded is acknowledged as small (e.g., Griffiths et al., 2021). Professional bodies could helpfully inform and guide a research agenda aimed at filling this evidence gap in order to update guidance for a future in which digital work seems set to stay.

Finally, the results of this review suggest that clinicians working with multiple clients by VC might usefully reflect on ways in which their approach to practice may be affected by

past experiences and their feelings and beliefs about the context. Supervision is likely to be a helpful setting to support such reflections. Further research into clinicians' perceptions of how professional and/or personal experiences have prepared them for working with multiple clients is likely a helpful follow-up to the present review.

Conclusion

Individually, the studies of clinicians' experiences included in the present review focused their conclusions on the feasibility or the advantages and disadvantages of working with multiple clients by VC. However, taking the studies together, the thematic synthesis conducted in the present review identified a picture of individual differences in clinician experiences, with overarching themes concerning ways in which VC was embraced, ways in which it was experienced as generally negative, and ways it felt like extra work. This suggested a possibility that clinicians may bring their own influence to the experience of the video context, perhaps for example through their prior training or experience with technology, a notion described in the present review as a reflexive relationship between clinician and context. Further research is recommended into clinician factors which may influence this reflexive relationship. Keeping in mind broader systems which might inform this relationship, a role has been identified for organisations including training providers and professional bodies in supporting clinicians through the complexities of working with multiple clients by VC. Ultimately clinicians act as significant gatekeepers to services, and if clients are to continue to have the choice of how they attend psychological therapy after the pandemic, then clinician beliefs will need to be seriously addressed in training curricula, supervision and in service policies. After the sudden and wholesale shift to video work in response to the pandemic, there has to be a period of reflection and adjustment in which clinicians, organisations and researchers work together towards the future of digital healthcare.

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SECTION B

ADAPTING TO A DIGITAL CULTURE: EXPERIENCES OF FAMILY INTERVENTIONS FOR PSYCHOSIS BY VIDEO CALL

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Abstract

Family interventions are recommended in NICE guidelines for people diagnosed with psychosis; however, implementation is recognised as poor. Delivery by video call has been suggested to improve implementation rates, but has been little researched. This study aimed to explore experiences of service users, family members and practitioners of family interventions for psychosis by video call, using a qualitative research design. Recruitment challenges limited participation to 11 practitioners and two family members. Transcripts of semi-structured interviews were analysed using template analysis. Two overarching themes were identified: first, 'The digital demand', covering experiences of culture shock, extra work, learning by trial and error, and managing risk and safety online; second, 'Flows and blocks in the human connection online', covered experiences of feeling connected or disconnected online, empowerment and disempowerment of families, and the relational impact of technology problems. Results are discussed with reference to existing literature and recommendations for further research made.

Keywords: Family interventions, psychosis, videoconferencing, family psychoeducation; systemic family therapy

There is longstanding debate about how we should understand and treat the unusual and sometimes distressing experiences known as psychosis. These experiences may include hearing voices, seeing things others do not, and having unusual beliefs (World Health Organisation, 2022). When these experiences are distressing for the person, it is also likely to affect the people close to them, often their family. Since the 1980s, one area of treatment has proved successful in helping people and their close networks through the challenges. Family interventions for psychosis (FIp) helps families to share understandings of what psychosis is, to address communication challenges between family members and to solve problems co-operatively (Burbach, 2018).

Evidence of favourable outcomes from FIp has resulted in it being recommended as a first-line treatment by the National Institute for Health Care Excellence (NICE, 2014). However, implementation has consistently fallen short of recommended levels (Ince et al., 2016). Remote delivery by video call (VC) has been suggested as a means of improving implementation of psychological therapies in general (Rees & Maclaine, 2015) and FIp specifically (Absalom-Hornby, 2012), but there is a dearth of empirical research into FIp by VC. This, and the sudden increase in its use due to the coronavirus disease of 2019 (COVID-19), form the contexts for the current study.

Family Interventions for Psychosis

The development of FIp was heavily influenced by research findings that rates of relapse of psychosis correlated with levels of expressed emotion in the individual's family, in particular expressed criticism, emotional over-involvement and hostility (Brown et al., 1972). An array of psychosocial family interventions grew from these findings, variously incorporating brief educational packages about psychosis, family problem-solving strategies, multi-family interventions and systemic therapy, some including the individual diagnosed with psychosis and some not (Lam, 1991). 'Family interventions' remains an umbrella term

for this range of approaches. NICE (2014) states that a family intervention should have a 'specific supportive, educational or treatment function' (p.257), while acknowledging that family interventions can be complex and lengthy, and that therapists are likely to draw on their own theoretical backgrounds, whether cognitive behavioural, systemic or psychodynamic. In practice, there has been an increasing trend towards integrated ways of working (Burbach, 2018). However, there are also distinct, structured models of FIp, notably behavioural family therapy (BFT; Falloon, 1987) and cognitive behavioural family interventions (CBFI; Barrowclough & Tarrier, 1992).

One unifying concern in FIp has been to move away from early inferences that high expressed emotion in families might be a cause rather than just a correlate of relapse in the symptoms of psychosis (see, for example, Leff et al., 1982), which risked families being blamed for their relative's distress (Kanter et al., 1987). Burbach (2018) provided a set of basic guidelines for family interventions, from any tradition, which caution the practitioner against viewing the family as 'toxic or dysfunctional' (p.226). Practitioners need to be able engage families through core therapeutic qualities such as authenticity and presence (James et al., 2006) and a systematic review of the process elements of family interventions emphasised the importance of the therapeutic alliance (Grácio et al., 2016).

Despite the complexities of defining FIp, the evidence base for its effectiveness is consistently strong. A review of meta-analyses by Lincoln and Pederson (2019) concluded that, true to its origins, FIp was effective in reducing relapse and admissions to hospital. Benefits of FIp to family carers have been found to include improved knowledge of mental health and less negative perceptions of caregiving (Sin et al. 2017). FIp has been a first-line treatment in NICE guidelines since 2002 but, as we will see, implementation remains a problem.

Implementation

NICE (2014) recommends that FIp should be offered to every family in close contact with a family member diagnosed with psychosis or schizophrenia. However, a systematic review by Ince and colleagues (2016) found that reported implementation rates varied widely, with between 0% and 53% of eligible families receiving FIp. Even accepting the highest estimate shows implementation rates well below recommendations. Geographical inequalities are problematic. The National Audit of Schizophrenia (Royal College of Psychiatrists, 2014) found the rates varied between 44% and 1% of families being offered of FIp between Trusts. Reviewing implementation barriers, Bucci et al. (2016) suggested that organisations did not prioritise FIp in their use of resources, which tended to be used for crisis management instead. This is despite NICE guidelines selecting interventions based on their cost-effectiveness as well as favourable treatment outcomes (NICE, 2012).

The study of factors which may influence the adoption of evidence-based practice is the concern of implementation science (Bauer et al., 2015). In the case of FIp, one such factor, delivery by video call (FIp by VC), has long been suggested as a means of increasing its accessibility (Absalom-Hornby et al., 2011). This is consistent with national drivers towards digital healthcare as a means of increasing access to care while freeing up staff resources (Topol, 2019). However, implementation science suggests that the adoption of FIp by VC would require a concerted and integrated change of organisational focus (Fixsen et al., 2009). The complexities of implementing such a change within organisational cultures have been discussed by Blase et al. (2015), who pointed out that 'changes in people's beliefs, habits, and loyalties is a messy process' (p. 6). The arrival of the COVID-19 pandemic overturned long-established beliefs and accelerated the implementation agenda far faster than the slow and painful process that implementation scientists predicted. Within a matter of months, everything changed because it had to. Many FIp practitioners suddenly turned to VC

as the only way of continuing, despite social isolation measures. It was against these most challenging circumstances that the opportunity arose to study responses to FIp by VC.

Family Interventions by Video Call

There is a growing evidence base for the feasibility, acceptability and effectiveness of delivering psychological interventions by VC. A systematic review and meta-analysis by Norwood and colleagues (2018) found that outcomes in dyadic psychotherapy by VC were non-inferior to face-to-face comparators, and that a strong working alliance was reported across all of their included studies. Good outcomes have been reported in studies of dyadic therapeutic interventions by video call with people diagnosed with schizophrenia-spectrum disorders (Santesteban-Echarri et al., 2018). The literature on group interventions by video call, while relatively small, is also promising. For example, a systematic review found good outcomes and acceptability in group mindfulness by video call (Moulton-Perkins et al., 2020), and respondents to an online survey of systemic family therapists by McKenny et al (2021) were generally positive about working online during the pandemic, albeit more for its practical advantages than for the experience of the technique of therapy and the therapeutic relationship. In FIp by VC specifically, a case study involving a mix of video call and face-to-face work in a forensic setting (Absalom-Hornby et al., 2012) concluded that this format was feasible and could deliver good outcomes. Overall, however, there has been a dearth of empirical study of FIp by VC (Burbach & Helps, 2022) that might inform its potential for wider adoption.

The Current Study

The current study takes a step towards filling the knowledge gap by exploring the experiences of practitioners and families who have engaged in FIp by VC. The aim was to understand how people taking part experienced FIp by VC, with the hope of informing future

research by hypothesising how FIp might helpfully be adapted for VC and what implications participants' experiences might have for its wider adoption.

There were four specific research questions:

1. How do service users, family members and practitioners experience video call as a means of engaging in FIp?
2. What are participants' views about how the experience of FIp is affected by the video call context?
3. What are participants' views about how the process and content of FIp are affected by the video call context?
4. What adaptations to FIp practice in the video call context are suggested by participants' experiences?

Method

Design and Methodology

A qualitative design was chosen to explore the experiences of participants. A critical realist epistemological position (Archer et al., 2016) was taken, allowing a position of 'judgemental rationality' (p.1) between, on the one hand, the realist position of the existing FIp literature and frameworks, which have shaped the way FIp is delivered, and on the other hand, the inevitably interpretive nature of participants' accounts of their experience and the researcher's role in mediating, analysing and presenting those accounts. This position informed two key aspects of the study design: first, themes from the existing literature on FIp delivered face-to-face were derived as a departure point for analysing data from the current study; and second, a reflexive diary was used to inform a reflexive account of the research process.

Data was collected through semi-structured interviews, allowing the researcher to respond flexibly to participants' accounts (Smith & Osborn, 2015). Interviews lasting about one hour were conducted by video call and subsequently transcribed by the researcher. Template analysis (King, 1998) was chosen as an analytic approach appropriate to the research methodology in two ways: first, it permitted the use of *a priori* themes, developed in this case from the existing FIp literature, to be used as a starting point in the analysis (Brooks et al., 2015); second, it is adaptable to both inductive and deductive methodologies (Brooks et al., 2015), rather than a methodological framework in the sense of, for example, interpretative phenomenological analysis or grounded theory. For the purposes of the current study, this flexibility allowed an element of deductive analysis, in that the *a priori* template was used as a lens through which to organise participants' data, and an element of inductive analysis, in that new learning from the data was used to modify the template. This process recalls Peirce's (1974) notion of abduction, in which gaps in existing knowledge are exposed by surprising data, leading to the formation of new hypotheses (Kennedy & Thornberg, 2018).

The analysis was conducted using NVivo software (version 12; QSR International) though none of the software's automatic coding functions were used. Following Brooks et al. (2015), an *a priori* set of themes, known as a 'template', was created. A systematic review of the process of FIp by Grácio et al (2016) was selected to create the *a priori* template because it offered richer detail than reviews of effectiveness. This template was applied to codes from a subset of interview transcriptions and modified accordingly. The process was then repeated using codes from the remaining data. The resulting template was refined in a process of mapping themes visually and going back to the raw data to check original meanings. Following Yardley (2015), participants' responses to an accessible summary of the final template of themes were sought and reported as a validity assessment.

Expert by Experience Involvement

An expert by experience panel convened by one of the participating Trusts was consulted for advice on the study concept and accessibility of the participant information sheet. Only one of the six panel members had previously engaged in FIp, the remainder being unaware of this form of therapy. Several changes were made to the participant information sheet following the panel's advice.

Participants

Participants were FIp practitioners working in three NHS Trusts, two in the South of England and one in the North. Local investigators facilitated recruitment by disseminating research flyers to practitioners and inviting the researcher to attend team meetings. Practitioners passed information about the project to service users and their family members about the project. A full participant information sheet (Appendix B1) was sent to practitioners and family members who consented to be contacted. A consent form (Appendix B2) was shared and used to guide informed consent. Although a project of this type using thematic analysis would typically involve between six and fifteen participants (Clarke et al., 2015), the aim was to recruit between six and nine each of practitioners, service users and family members.

The principal inclusion criteria were, 1) practitioners with at least five days' training in FIp and experience of at least five sessions by VC; and 2) adult service users under the care of the participating team, and/or their family members, who had been offered FIp by VC, whether or not this was completed. The principal exclusion criteria were, 1) people under the age of 18; 2) those assessed by their clinical team as at risk from participation; 3) those not engaging in FIp by VC within the last two years; 4) anyone lacking capacity to consent.

Interview Schedules

Separate interview schedules for practitioners and service users or family members (Appendix 3a and 3b) were designed to explore participants' experiences by VC of key elements of FIp, including engagement, the therapeutic relationship, risk management, process issues and aspects of the content of interventions, such as communication skills and problem-solving (Grácio et al., 2016). The interviews also covered experiences particular to the video call context, including internet connection and using technology hardware and applications. Brief demographic data was collected as context for the analysis.

Ethics

Ethical approval for the current study was given by the Health Research Authority (ID no. 291306) and letters of access were granted by the three participating NHS Trusts (Appendix B4). As they were conducted by video call, interviews started with a safety discussion, including checking privacy and agreeing a procedure if the call ended unexpectedly. These are laid out in the interview schedules (Appendix 3).

Reflexive Statement: Study Design

Following Yardley (2015), this statement is designed to offer transparency about my approach to the study design. I approached this study with a positive attitude towards digital therapy having co-authored a systematic review of mindfulness-based group interventions by video (Moulton-Perkins et al., 2020). In March 2020, I started remote clinical work as a trainee clinical psychologist and felt comfortable in the video context. I have no training in, or previous experience of, FIp.

Having become interested in the subject of including geographically distant family members in FIp by VC through discussions with the principal supervisor, a highly experienced FIp practitioner and trainer, I moved the focus of the study towards the

experience of the video context itself in FIp. Reflecting on this, I brought an intention of setting aside my prejudices to designing the interview schedules and preparing for the interviews themselves. A reflexive account of the data collection and analysis process is included in the results.

Results

Participant Characteristics

Recruitment among service users and family members proved challenging. Eleven practitioners, no service users and two family members took part. Four clinicians and both family members came from one NHS Trust in the South of England, four clinicians came from the other southern Trust, and the remaining two came from the northern Trust. The family members were both mothers of an adult using services. One identified as White British, the other as White Other. Five clinicians identified as White British, one as Black British, and the remainder as from various European countries. Years of experience of family work ranged from 4 to 20 years, and all but two started working by video during the COVID-19 pandemic. Three clinicians identified as systemic practitioners, two as using BFT and/or CBFI, and the remaining six as working integratively.

A Priori Themes

The *a priori* template of themes produced from the systematic review by Grácio et al. (2016) is presented in Table 1. Grácio et al. (2016) reviewed 22 empirical studies of process elements of FIp, concluding that the most important aspects of process were the therapeutic alliance, education about psychosis and coping skills training. Following detailed examination of their paper, three overarching themes were identified. The first, 'Process', described aspects of the therapeutic relationship within the room; the second, 'Content', covered elements of content that had process implications, for example, narratives being

heard and coping strategies being understood; and the third, 'Power', related to aspects of the relationship processes outside the room, namely relationships with mental health services.

Table 1.

A priori themes and defining elements derived from Grácio et al. (2016)

Overarching themes	Themes	Defining elements
Process	Common therapeutic factors	Good therapeutic alliance; empathy, warmth, listening skills and support; containing emotion and conflict and maintaining focus
	Engagement processes	Trust in therapist competence established; needs are heard and met in planning; therapy is helpful
	Human connection in the intervention	Participants feel supported; belonging, hope and motivation are fostered
	Recognising strengths	Negative emotions and experiences in relation to 'illness' balanced with recognition and bolstering of individual and network resources
	Cultural sensitivity	Adaptations sensitive to background and culture of participants
Content	Sharing narratives	Narratives shared and heard; negative impact of 'illness' recognised; roles in broader contexts acknowledged
	Education and reframing attributions	Negative attributions of 'illness' shared; education given to assist reframing
	Needs-based interventions	Stepped care approach; needs-focused, rather than a rigid formula.
	Coping strategies	Strategies understood and engaged in; individual and shared problem-solving
Power	Relationships with mental health services	Frustrations managed and better relationships facilitated

Developing the Template of Themes

Codes were applied to the *a priori* template from a subset of data consisting of the first four interview transcripts, all coincidentally from interviews with clinicians. The overarching themes of 'process', 'content' and 'power' were partial fits for participants' experiences of connecting with families by VC. Under 'process', participants described mixed

experiences of engaging with families and forming good therapeutic relationships remotely. For example, the first practitioner (P1) commented 'the therapeutic relationship still grew, still blossomed, the working alliance was still there' (P1), whereas another felt there was a 'dumbing down' (P3) of the interpersonal connection. In terms of the theme 'content', there were again mixed experiences: participants noted difficulties in doing creative interventions, such as sculpting and genograms, while recognising new possibilities for sharing psychoeducational materials, for example, by sharing their screens to play videos. Finally, within the 'power' theme, all four participants recognised that the video format enabled access to FIp for more family members and that it was an additional choice to offer families. However, there were many aspects of the data which did not fit well with the *a priori* theme template. One such was participants' accounts of starting FIp by VC in the context of the pandemic. Thus, all spoke of having to learn a new way of adapting their skills very quickly in stressful circumstances, with feelings of anxiety and scepticism about the video context described. Risk management, including the ability to contain conflict and distress, was another common topic in the data, as was the experience of technical problems.

The *a priori* template was adapted by dividing each theme into two new themes in an attempt to capture more fully the complexity in the data. Thus, the theme 'process' was divided into 'pulling out the same therapeutic skills', to encompass risk management and planning as well as engagement and working with process, and 'learning to live with the machine', to encompass learning processes and participants' responses to the new context. Similarly, the *a priori* theme 'content' was divided into 'doing FI differently', to cover differences in how interventions were done, and 'problem tech', to cover ways in which aspects of technology affected the interventions. Finally, 'power' was divided into 'empowering and enabling families', to capture the effects of video call on families' access to FIp, and 'option rather than default', to capture participants' reflections on how video should

be offered as a choice. This amended template was used to inform the coding of the remaining transcripts, including those of the two family members. Despite the practitioner focus in the development of the template to this point, the family data was found to fit well with the template, and was conceived of as a commentary on the practitioner data. The results were arranged into a concept map (Appendix B5b).

While this template was a fit for the content of the data, it was felt to be less successful in clarifying the underlying meanings and too complex to offer a helpful narrative. The themes were tabulated (Appendix B5c), printed and cut into individual clusters. The themes were then refined through an iterative process of arranging the clusters manually (Appendix B5d), while also re-visiting the data to produce a final template of themes, which will now be explored.

The Final Template

The final template of themes is detailed in Table 2 with illustrative quotations. Quotations from practitioners are attributed to study identifiers P1, P2, and so on, whereas family member quotations are identified as F1 or F2. The following is a narrative summary of the themes identified in the data.

1. The Digital Demand: Being 'Thrown Into' FIp by Video Call

This first overarching theme conveys the experiences of participants immersed by COVID-19 in a digital environment which most had not previously contemplated. There was a sense of culture shock as skills learned and practiced face-to-face were transferred to the video context. One practitioner commented, 'we never did it before and never dreamed of doing it' (P1). The four themes within this overarching theme are: 1) The digital culture shock; 2) 'A little bit more effort': Adapting to the digital workplace; 3) 'Trial and error': Learning FIp by video; and 4) Managing risk and safety online. These themes and their sub-themes will be elaborated below.

Table 2

Final Template of Themes with Illustrative Quotes

Overarching theme 1. The digital demand: Being 'thrown into' FIp by video call		
Themes	Subthemes	Illustrative quotations
1.1. The digital culture shock	1.1.1. COVID-19: A challenging context	*I found myself thrown into it by the pandemic* (P1) *It wasn't just FI online it was everything online... I wasn't quite sure how it would go, and I wasn't sure how I felt about it* (P8) *I think initially when we first started it, everyone was a bit, oh this strange new world that we're in, isn't this awful* (P5)
	1.1.2. Hung jury: verdicts on video	*There's been mixed experiences - but on the whole I would say it's been quite well received* (P8) *I would say, yeah, go for it. We did that and it was fine, and see how you feel about it.* (F1) *We still were doing the work, and we were still getting results* (P1) *I feel so strongly that the online family therapy is... I feel it was a disaster* (F2) *I think my real worry... about digital ways of working is an assumption that this is equivalent to meeting people in person - I really don't believe that is the case* (P4) *I think that's probably changed over time, I think I would feel comfortable working with someone always... online, if that was needed* (P6) *I kind of, try to be really reflective and reflexive about how I offer it, because I know I've slipped back into offering it with a bias, expecting families to not want it* (P7)

Overarching theme 1. The digital demand: Being 'thrown into' FIp by video call		
Themes	Subthemes	Illustrative quotations
	1.1.3. The digital offer	*We'll try and combine things so we'll see them face-to-face sometimes, and then do it remotely again* (P10)
		There's the risk of kind of defaulting to it when we don't need to (P12)
		It's no longer, you know, a possible offer, it is an offer, and people have an absolute choice to whether they want to meet online or not (P5)
		I know my supervisor in particular wants us to be seeing more people face-to-face again, erm, but then I've got the dilemma that if we offer the choice, most people will opt for online (P9)
1.2. 'A little bit more effort': Adapting to the digital workplace	1.2.1. Planning and planning	*We sent out invites, families and clients would get our e-mail address, and so as part of that you might get an awful lot more e-mail correspondence than you would normally have got... and I think there's pros and cons to that* (P4)
		You have to do a little bit more thinking and prepping... I feel there is a little bit more extra work to do things online (P6)
		There's more preparation in terms of making sure the facilities are working (P10)
	1.2.2. Facilitating and adapting to video work	*I just noticed that I can access more materials practically, and I can show them and they can show me things* (P1)
		There was a tendency more to perhaps do more psycho-educational stuff (P3)
		The BFT approach, again that feels a little bit slower and more considered (P10)
		The therapists I think were leading it and they chose who was allowed to speak when (F2)
		We had a Word version of all the symptoms, and I would share that online and ask the family to pick a different highlighter pen so we could record their individual observations (P9)

Overarching theme 1. The digital demand: Being 'thrown into' FIp by video call		
Themes	Subthemes	Illustrative quotations
	1.2.3. Challenges of online FIp	*You and your co-worker are just the same person on an online screen... equal to everyone else and if you want to talk to your coworker you have to do it kind of publicly in front of everyone else* (P3) *For the communication skills I think it is much more beneficial if people are face-to-face* (P9) *Being online to some extent limits... being able to do more creative interventions, or challenges it in different ways* (P6) *It's really helpful to... just draw stuff down and… Harder to do that [online], and again that's not because it can't be done, it's just that I'm not proficient at it, and certainly the trainees and the assistant psychologists, you know, whip through that* (P5)
1.3. 'Trial and error': Learning FIp by video	1.3.1. Experiential and informal learning	*Flying by the seat of your pants when trying to acclimatise to using a screen... Initially!* (P1) *Peer support, 'cause we went online as colleagues and played about with it, experiential learning* (P7) *My supervisor... is in exactly the same boat as me, having not done online therapy before* (P9)
	1.3.2. Desire for practical training	*It's more the written than the hands-on training so a lot of it's been kind of learning on the job... just simple things like how to do a chat comment and that kind of thing* (P10) *I suppose we're working in organisations where they expect us to have certain IT skills* (P10) *Some specific training about delivering FI online, in case there are other bits that we should be thinking about, could potentially be useful* (P8) *It's really pushing my IT skills..., and it's like, let's not- let's not do this* (P5)

Overarching theme 1. The digital demand: Being 'thrown into' FIp by video call		
Themes	Subthemes	Illustrative quotations
1.4. Managing risk and safety online	1.4.1. Differences in risk and safety online	*He would walk off screen and be arguing in the background with her, so those early sessions were challenging* (P2) *You do feel more separate which, on the one hand you know you are ... putting the ownership on that person to contain themselves* (P3) *I don't know if they're negatives, they're just things that you really have to pay attention to, I think, in order to make sure it's safe* (P7) *Touch wood, I haven't had, you know, a nightmare to date* (P1) *They were in houses of multiple occupancy and actually privacy was something that really wasn't guaranteed* (P4)
	1.4.2. Skills for managing safety	*I think ground rules really helped* (P2) *This is how I work full stop as a psychologist... I do not walk into the room of therapy without having done very thorough assessments first of the individuals I'm going to be working with* (P1) *I might have to kind of put my hand up you know if somebody is sort of struggling to stop... you have to be a bit sort of interventive somehow, which again is different if you've got your body to use in a room* (P6) *It's still pulling out the same psychotherapeutic skills, whether you're in the room, or whether you're online* (P1)

Overarching theme 2. Flows and blocks in the human connection online		
Themes	Subthemes	Illustrative quotations
2.1. (Dis)connecting with families by video	2.1.1. Connecting in a different way	*I think people have a particular script about going to a building and having an appointment, or about somebody coming to their home who's a professional, that is different to video* (P2) *I think sometimes it can be quite helpful because the picture's not very clear... it gives us the opportunity to check in with that person and say, oh, you know, I can't quite see you clearly today, how are you feeling about that... actually, it kind of enables us to be less direct, in a way that can be quite helpful* (P9) *I guess you're having to verbalise body language sometimes, or... perhaps things that would happen more organically in a face-to-face situation* (P6)
	2.1.2. Making the human connection	*I have been able to sense, loud and clear, unspoken subtexts* (P1) *Generally I think engagement has been going ok, people seem to be very familiar with online meetings now* (P9) *Once they're engaged in the therapy... I don't think the engagement online is, as I said, hugely different to being face-to-face* (P5) *I could feel that interventions that invited some kind of proximity, even in a very gentle, playful way, I could sense even on screen that was triggering anxiety in the female* (P1) *I've experienced enough of kind of good therapeutic relationship and connection and change* (P6) *I think there's something about people working online... particularly if they're not in the same room together and you're all on screens you're looking at a screen you're working and so the idea of, Hang on, what are we doing here, we need to stop that and sort of say what's happening* (P3)
	2.1.3. Losing the human connection	*You just don't get those cues at the same- at the same level* (P3) *When you're meeting a family in person, you're much more able to pick up on physiological feedback in a way I'm just unable to manage over the screen* (P4)

Overarching theme 2. Flows and blocks in the human connection online		
Themes	Subthemes	Illustrative quotations
		At the end of the session, when it all closes down, you're on your own, and thinking, what did I say? What did I do? How is everybody, and how am I? And you're just like lost, really (F2)
		I feel like with online therapy in general, sort of emotional temperature can be turned down a bit, and I think that that can be an advantage and a disadvantage (P12)
		A couple of times I might have cried... I don't think anyone focused on it or commented on it (F1)
	2.1.4. Distractions in the video environment	*It's just like you're hanging on the end of a phone, it's like you're on hold* (P2)
		He gets really distracted, so he'll go off camera, he might even just like wander off... overall, we've found that he wasn't engaging that much better now, than he did last time [face-to-face] (F1)
		There's the interference of doorbells ringing, and you know dogs jumping up and cats walking in front of the camera, and all sorts of things that don't happen in the therapy room (P5)
		As a therapist you either need to get rid of it or... cope with... seeing yourself and I think that's the same for families as well (P3)
2.2. Video (dis)empowering families	2.2.1. Power and choice	*If they can be changing in (?) that setting in that way, then it's more likely to be more lasting, and actually your role as an external person, there's something very representative of your real role in life, you know, as being on the screen, being... separate from them* (P3)
		Once people learn the technology, you know, we shouldn't underestimate even older people... actually I've seen people come off the acute ward and continue to use it (P1)
		You don't have to travel to places and it really saves time, it means you can do a lot more meetings and, you know, so from that point of view it's convenient (F1)
		It opens up so much, so many more families, and so many more people joining the sessions, so that's great (P12)
	2.2.2. Language and SES as barriers	*The data thing's a big issue, but- and I did have somebody who, I was on the phone for that reason, cause she didn't really have access* (P7)

Overarching theme 2. Flows and blocks in the human connection online		
Themes	Subthemes	Illustrative quotations
		For families where English isn't the first language it's a lot more unwieldy doing online sessions with an interpreter (P9)
	2.2.3. Offering resources and support	*Make sure you have some kind of teaching or training facility in place to help older people to use the technology, because they can if they can learn, and it's a shame for them to miss out on it really* (P1)
		The person who was experiencing psychosis was supported to log on to the session (P3)
		It's not that kind of level of support that they would do...Other housing places might, I don't know (F1)
2.3. You've frozen! The technology interface	2.3.1. The disrupting lens	*When you've just got this big [indicates size of video window with hands] you can't really see what's happening* (P2)
		I think particularly more challenging when there's somebody who's got a much quieter voice, because I think it's much easier to include somebody with eye contact and... wait for them to be a little bit more ready, whereas when you're on a screen, you can't (P7)
	2.3.2. Connectivity and IT skills matter	*There's a couple of families that we saw that were on particularly older, sort of, like Chromebooks, and they were blobs* (P4)
		Sometimes it just takes ages to connect and it's kind of buffering (F1)
		I think it's getting better, but only Tuesday evening I was doing a session and it was- it was hopeless again, so it just varies (P10)
		A dad was really struggling to like log on and everyone else is sort of sitting there and... he was perhaps in a more- slightly disadvantaged position in the family (P3)
		Where it's worked well is when people have good connection (P3)
	2.3.3. Platform and medium differences	*I'm sure they said, do you know how to use Teams, are you ok with that... I think we would have just said, yeah* (F1)
		I think we tried [Trust platform] for a while, and it just wasn't stable enough... and then we moved to Zoom and that was a bit better (P2)

Overarching theme 2. Flows and blocks in the human connection online		
Themes	Subthemes	Illustrative quotations
	2.3.4. Who's on which device?	*This feeling of disconnection I have when I'm- it gets magnified by the family being together but me not being with them, whereas in fact it's very possible that that's better because they're more connected with each other and they can speak directly to one another when they- when they are communicating* (P12) *It's been more common that people have joined on their own device, and that seems to have worked quite well* (P8) *It wasn't really possible to have choices over who was in each room* (F2) *In that case, there will always be a one and a two, or the three together, but we'd sometimes try and switch around who the two would be* (P9)

Abbreviations: (F*n*) refers to participant number for family members; (P*n*) refers to participant number for practitioners.

Theme 1.1. The Digital Culture Shock. Nearly all practitioners started video work during the COVID-19 pandemic and found it stressful. Seven described initial anxiety and scepticism at the move to video, for example: *'in the early stages there was a lot of anxiety for me, associated with, oh, you know, doing it right, and learning how to do it properly, and making it run smoothly so it doesn't feel kind of jarring*,' (P8). This newness was acknowledged by one of the family members: *'it was something that was new to* [therapist name] *and* [co-therapist name] *and everyone really*' (F2).

Verdicts on the new medium were more divided. Eight practitioners noted that FIp by video seems to work, for example: '*we are still doing therapy*' (P5). Others felt the video context was problematic, one stressing that it was not equivalent to in-person work. Four wondered about how their assumptions might influence their experience of the video culture, with one identifying as a '*dinosaur*' (P2). The two family members' views also differed: one said, '*it's about their experience as a therapist, knowing your circumstances... it's not about if they're actually in a room with you or not*'; the other felt very differently: '*there's something wrong with the situation and that's why I feel so strongly that the online family therapy is- I feel it was a disaster*.'

Despite these different verdicts, ten practitioners favoured keeping the choice for families between face-to-face or video, particularly in terms of increasing access. One spoke of it as a right: '*I think it needs to part of a service now... I think the NHS has cottoned on to that*' (P5). However, six also emphasised that video should be '*an option, rather than a default*' (P8). The potential for bias in the offer was recognised by some: '*it's an ethical thing that I need to offer it as a choice and not offer it from that position of my own personal bias*' (P7).

Theme 1.2. '*A Little Bit More Effort*': Adapting to the Digital Workplace. The video context brought demands of new, often unfamiliar tasks. For many practitioners, this

meant extra planning and preparation. Three noticed that the volume of emails increased. Four reported doing extra session preparation, for example: '*I'm very conscious of making sure that I have all the information that's required so that I can share onscreen*' (P10). Eight described taking time to plan video work with families, for example through pre-therapy meetings or pre-session connection checks.

Another extra task involved adapting session content to the video context. Eight practitioners reported sharing their screens to show resources, a new skill for some. Others experimented with adding check-ins, turning cameras on and off during communication exercises, and recording sessions to play back as part of an intervention. Three practitioners felt they were more directive online, increasing psychoeducation content and, having '*a tighter leash on things*' (P12) when working on communication. One family member also noticed this: '*the therapists I think were leading it and they chose who was allowed to speak when*' (F2).

Some practitioners found it challenging to adapt to video call. Three found communication with co-therapists more difficult. One missed families' immediate responses to a reflecting team as cameras were turned off. A family member found the reflecting team difficult for different reasons: '*I didn't actually mind them being there, just some of their suggestions were... in a different world completely from what's actually happening here*' (F1). Practitioners found more structured, psychoeducational models, such as BFT, easier to adapt than systemic-influenced work. For example, one practitioner used the six-stage problem-solving model in BFT, commenting '*I haven't really noticed any barriers, doing that online*' (P9), whereas another commented on enactment work online: '*you can't quite play in the same way*' (P1).

Theme 1.3. '*Trial and Error*': Learning FIp by Video. Practitioners described having to learn through experience, with attitudes exemplified by, '*just make the most of what*

you can and go for it' (P2). Conversations with colleagues and supervisors who were '*in the same boat*' (P9) were a commonly reported mode of learning. Most consulted written guidance but only one practitioner described practical training, which was in using the video platform, and '*far too technical for us... I think the poor chap was bewildered at our lack of skills and ability*' (P10). Five practitioners commented that practical training in adapting family interventions for video would be desirable, while four felt put off by the idea of learning more techniques, for example: '*I'm not awful but I'm certainly not the best, and… want to try and learn but we also have a slight sort of avoidance to it*' (P6).

Theme 1.4. Managing Risk and Safety Online. Managing risk and safety by video was a common concern for practitioners. Six reported anxieties around people leaving the call during or after a difficult session. Five worried about containing conflict or distress, for example: '*you're putting the ownership on that person to contain themselves*' (P3). Concern was also expressed about working with people in unsafe relationships or home environments. However, no serious risk incidents were reported and neither of the family members felt risk had been a concern. Nevertheless, five practitioners described intervening to protect privacy and confidentiality, for example, when a family member joined from an internet café.

Planning for risks when agreeing ground rules was a common strategy, although one practitioner noted the need to remain flexible as situations change. Other practitioners described using more assertive techniques to manage risk, such as checking in verbally more often during sessions and making follow-up calls after difficult sessions. Reflecting on risk management, one practitioner described '*a different way of being attuned to it*' (P10), giving the example of listening out for noises off-camera. Three practitioners spoke about using traditional therapeutic skills to contain risk, for example sitting with distress: '*if somebody's experiencing something you can't just stop it, can you… sometimes you have to be able to sit with that*' (P10).

2. Flows and Blocks in the Human Connection Online

This second overarching theme captures participants' experiences of the human connection during FIp by VC. While some participants described forming good relationships online, others felt that there was less of a connection. Video call was seen as both an enabler and a barrier for families. Many practitioners described technical barriers to relating, including the limited view of the camera or video platform, the technical skill of participants and the quality of the internet connection.

The three underlying themes that were identified are: 1) (Dis)connecting with Families by Video; 2) Video (Dis)empowering Families; and 3) You've Frozen! The Technology Interface. These themes and their sub-themes will now be elaborated.

Theme 2.1. (Dis)connecting with Families by Video. Some practitioners sensed differences in rapport, even if they were hard to define. One commented, '*Does it affect the therapeutic relationship? I'm sure it must do, but I'm not sure in what way*' (P5). Nine practitioners had made adaptations to facilitate engagement, including adjusting lighting and camera position and using body language that will be visible on screen. There was a sense in practitioners' accounts that body language was less immediate by VC. Seven described relying more on verbal expression, for example: '*you're having to verbalise body language sometimes*' (P6).

Seven practitioners reported building good therapeutic relationships with families. One practitioner remembered that video call facilitated engagement with a client who was '*answering my questions with a thumbs up or a thumbs down. So she was out of shot, she put her arm in. And we moved on from that quite quick, but… it gave her the choice*' (P7). A family member felt the lack of formality was helpful: '*It is sort of less formal, because, you know, if you're comparing it to some people coming to your house, and they're sitting there, it's sort of like having visitors*' (F1). The ability to notice and work with process by VC was

also noted by five practitioners, for example: '*Body language: It goes 'boom' on the screen!*' (P1).

By contrast, some participants felt something was missing in the human connection online. For example, one family member commented, '*Obviously, you don't have that feeling in the room*' (F1), and the other said, '*the normal body signals that you pick up when you're in the room with someone weren't there*' (F2). Seven practitioners also experienced that it was harder to pick up subtle family communications. Four sensed that families brought less emotion to sessions, and that there was more emotional distance. Two practitioners missed the opportunities for informal conversation with families before and after face-to-face sessions, and four participants reported that endings could feel abrupt.

Theme 2.2. Video (Dis)empowering Families. Participants' accounts suggested that families may be variously empowered and disempowered by the video context. Two practitioners felt it offered families agency, for example in controlling their device: '*they can turn it off, you know, and sometimes do!*' (P3). All participants - practitioners and family members - said that VC enabled family members to join who might otherwise have been excluded due to distance, work or caring commitments, health, etc. One family member said, '*it was lovely to be able to see the whole family together*' (F2).

Practitioners reported cultural barriers to video which might disempower families. Six said that people from less well-resourced backgrounds may lack access to good internet and equipment that may even exclude them, for example: '*the data thing's a big issue, but- and I did have somebody who, I was on the phone for that reason, 'cause she didn't really have access*' (P7). Three practitioners commented that working with an interpreter was more difficult by VC.

Practitioners empowered family members and service users, where appropriate, by supporting them to use technology. Five described various support methods, from sending

links for explanatory YouTube videos to more intensive support: '*Click this, click that, can you see- what can you see on the screen, talk me through. It's like the IT department really*' (P1). Four participants reported that service users' access may depend on the support available. One practitioner commented, '*there was not one person that I engaged with that couldn't engage, even with quite profound psychosis if, you know, as long as the screen and the work was done for them*' (P1). One family member confirmed that her son would not have been supported to join independently at his supported accommodation.

Theme 2.3. You've Frozen! The Technology Interface. Participants reported ways in which technology directly impacted the work, whether due to the nature of the camera, the connection, the skills of participants, or the platforms and devices used.

The camera's limited field of view was mentioned by three practitioners as limiting the information available to them. One commented, '*you've only got the screen so you don't know what's happening elsewhere*' (P3). Limitations on eye gaze as communication were noted by three practitioners. One, for example, missed using eye gaze to invite people to speak.

The type of device was noted by seven participants as affecting the experience of FIp by VC. Five found a phone less successful for video calls, for example, '*you've less of a picture*' (P4); a family member agreed: '*I find the laptop is easier generally*' (F1). Advantages and disadvantages of families joining from one device or separately were raised by nine participants. A family joining on one phone was described by one practitioner as '*just a problem*' (P9), while another experienced that family communication may benefit from them joining together, although at the expense of the practitioner's sense of disconnection, which '*gets magnified by the family being together but me not being with them*' (P12). One family member reflected that sharing a device can feel '*closed up*' (F1), however.

Poor quality internet was cited by eight practitioners as a challenge, although with differences in the degree of disruption: '*it's varied – markedly so – some work has been absolutely fine… there are little interruptions, others have been very difficult*' (P10). Variations in IT skills among family members were also noted by practitioners. One, for example, spoke of being impressed by some clients' abilities while feeling that others may have struggled. Choice of video platform was dictated by NHS Trusts for the nine participants who commented on it. One family member using Microsoft Teams remembered being '*ok with that*' (F1), whereas five practitioners said they would have preferred Zoom.

Reflexive Statement: Analysis

Having reflected on my positive bias towards video call, I noticed and did my best to set aside some disappointment with accounts of challenging experiences. Perhaps my efforts to contextualise these accounts influenced the identification of the first overarching theme of 'The Digital Demand', as practitioners skilled in working face-to-face had suddenly to acquire complex and perhaps unlooked-for digital skills in the stressful pandemic context. Spending time with the data, I sensed a fundamental motivation to connect in the accounts of practitioners and family members. Where the technology interfered with that connection, it was named, understandably, but I saw that those who remained sceptical of the medium also named where the connection had been possible. This, I believe was an influence behind the second overarching theme, 'Flows and blocks in the human connection online', with its focus on how the technology could be both facilitator and barrier.

Discussion

In this study of experiences of FIp by video call, two overarching themes were identified. The first, 'The digital demand: being 'thrown into' FIp by video call,' represented responses to the move to VC delivery in the context of COVID-19. Underlying themes

included a sense of culture shock with mixed feelings about the digital world, the extra work involved, the largely experiential learning environment, and differences in managing risk and safety. The second overarching theme, 'Flows and blocks in the human connection online,' represented the facilitators and barriers participants experienced in relating by VC. Underlying themes included mixed experiences of forming therapeutic relationships and attending to process by video, video as empowering or disempowering for families, and experiences of the quality of technological equipment and connectivity impacting interpersonal aspects of the work. These themes will be discussed in relation to the research questions and the wider literature.

Experiences and Views of FIp by Video call

The findings of the current study suggest that practitioners' experiences of using VC for FIp were affected by the pandemic context, especially the new and unexpected 'digital demand'. The vast majority had no previous experience of FIp by VC and there was a lack of formal training. Practitioners reported feeling anxious and uncertain, and references to doing extra work suggest that it may have felt burdensome. Jones and Stokes (2009) noted that even experienced therapists may feel deskilled when starting to work online, and that training can be helpful in managing this. Practitioners in the present study were pragmatic in learning from written guidance, from experience and from each other in challenging circumstances. Nevertheless, their wish for training should be noted. The Topol Review (Topol, 2019) encouraged a 'culture of learning' (P.74) for healthcare professionals towards technical proficiency and openness towards digital healthcare technologies.

It is perhaps unsurprising that there was some scepticism among practitioners new to video work and some concerns that endured with experience. These should not be dismissed: after all, one family member was clear in blaming VC for her difficult experience of FIp. There is an obvious need to address these concerns to minimise the risk of such negative

outcomes. Furthermore, research has associated negative attitudes of practitioners towards online interventions with reduced therapeutic presence (Rathenau et al., 2022). The emphasis placed on choice for families by participants in the present study is likely to be helpful, however. A meta-analysis of 53 studies of individual psychotherapy found that client choice was associated with lower rates of drop-out and more positive outcomes (Swift et al., 2018).

Many participants in the current study reported having concerns about managing risk and safety remotely. Some valued a process of screening out people who may find it hard to cope with distress by VC. However, this may be problematic as alternatives would need to be available to avoid excluding people from services (Sansom-Daly et al., 2015). The literature on therapy by VC has tended to focus on effectiveness or the therapeutic relationship as outcomes, rather than safety (e.g., Backhaus et al., 2012; Berryhill et al., 2019; Cataldo et al., 2021). Indeed, De Boer et al (2021) pointed out that participants presenting with risk are often excluded from studies. Research on safety would be helpful, as current guidance on safe practice is largely based on reviews of case studies and opinion pieces, rather than robust empirical evidence (Burbach & Helps, 2022).

The current study collected data from practitioners and family members. While it was not designed to make group comparisons, differences in the experiences between the groups may be observed, even if such observations should be treated with caution. Under the theme 'The digital demand', the data suggested that the responsibilities of adapting in-person practice may have negatively affected practitioners' inital responses to VC, whereas the two family members did not report any initial concerns, having become used to communicating with family by VC during the COVID-19 lockdown. By contrast, under the theme 'Flows and blocks in the human connection online', the family members' views appeared understandably to be focused on their very personal experiences of the process, for example one finding that the reflecting team's suggestions were alien to their situation and the other feeling

misunderstood and voiceless, whereas practitioners' views were often reflective of multiple experiences and perhaps less immediate as a result, for example comments about having experienced enough good therapeutic relationships.

Perceived Effects of Video Call on Process and Content of FIp

There were interesting contrasts in participants' accounts of process in FIp by VC. While some practitioners felt they could be sensitive to the subtle communications of families remotely, others felt less connected and worried about missing important information. Both family member participants reported a different feeling to VC sessions compared to face-to-face, although they differed in their experience of the impact. One mediating factor for this sense of connection may be the number of family members on each device: accounts varied between the feeling of being in ‘close-up’ with people on individual devices and, at the other extreme, the 'problematic' (P9) experience of a whole family trying to be seen on a single mobile phone. Studies of individual therapy by VC strengthen the argument that process is clearer on individual devices: a qualitative study by Mitchell (2020) noted 'a sense of magnification' on screen (p. 126), and Dowling et al's (2022) quantitative survey of 55 practitioners found that 84% agreed or strongly agreed they could pick up their client's emotions. In FIp, however, this attention to individual process comes at the expense of seeing and working with the way the family interacts when they are face-to-face. Furthermore, choices about who joins from which device may be limited by family resources, geographical location, the quality of family relationships, and so on. No wonder, perhaps, that some practitioners looked forward to technological developments that might improve the view.

It is notable in the current study that themes were identified which contextualised the experiences of interacting by VC, rather than describing commonalities in the experiences themselves. For example, themes related to the quality and accessibility of technology and the number of people on each device, rather than describing experiences of time lag on calls

or the partial view of participants' bodies. This decision during the analysis was informed by contrasts in the reported experiences of video exchanges and an attempt to capture the complexity of those experiences revealed by the data. Thus, data coding relating to the onscreen view included, for example, 'whole family on one phone is problematic', 'connectivity affected by device type and where people live' and 'sensing online that woman was triggered by proximity intervention'.

Findings in the current study relating to accessibility for people with a diagnosis of psychosis were generally positive. Practitioners described supporting service users to engage where necessary. For service users with good IT skills, helping family members could be empowering. Engage selectively by turning the camera on and off and joining from home were viewed as empowering. These findings echo results from a systematic review by Sharp et al (2011) supporting the accessibility of telepsychiatry for people with a diagnosis of psychosis, including people with unusual beliefs. However, contrasting accounts in the current study, including a practitioner who spent significant time with a service user to prepare for video sessions and a family member who reported that her son had struggled to engage in both VC and face-to-face work, remind us of the importance of adapting to individual needs.

Reports in the current study of adapting the content of FIp for VC were understandably more positive for family psychoeducation than for systemic-oriented interventions. Education and support groups by VC have been reported as feasible for participants and facilitators without specialised IT skills (Banbury et al., 2018), whereas digital guidance for systemic practitioners suggests using digital whiteboards, breakout rooms and other, more specialised tools (Burbach & Helps, 2022), a digital immersion of which some practitioners in the current study were wary. Interestingly, the only interventions reported in a recent review of couple and family psychotherapy by VC (Helps & Le Coyte

Grinney, 2021) were psychoeducation with 'often minimal... synchronous therapeutic or coaching input' (p.205); core systemic interventions, such as genograms or sculpting, were not mentioned. The current findings that practitioners found mapping and enacting interventions challenging online are mirrored in a survey of family therapists' experiences during COVID-19 (McKenny et al., 2021). It is hard to disagree with their conclusion that family work is lagging behind some other modalities in embracing digital therapy innovations.

Adaptations to FIp practice in the video call context

Adaptations to FIp by VC reported in the current study were made in the context of a rapid learning process, guided by trial and error, mutual support and some written guidance. It might be unreasonable to expect practitioners in these circumstances to do more than find relatively straightforward ways of translating their usual practice into the video context. Beyond obvious adaptations like screen-sharing, however, there were some more creative adaptations, such as facilitating engagement by agreeing that the client would initially be off-camera with only her hand gestures visible as communication. Where practitioners in the current study expressed a wish for practical training, the benefit could go beyond learning techniques: with greater comfort in working digitally, practitioners may bring their experience and creativity to develop a digital culture offering more than a translation of face-to-face work.

Among the key elements of in-person FIp identified by Grácio et al. (2016), is that narratives are shared and understood. This was not always experienced as successful in the current study, as one family member felt strongly that her voice was not heard and that she was misunderstood. Some practitioners reported adapting session management by becoming more directive, for example in controlling turn-taking, while others slowed the session pace to allow different perspectives to be heard. Burbach and Helps (2022) noted that

conversations in systemic therapy by VC tend to proceed more slowly as 'sequential monologues' (p. 248), advising practitioners to be active in managing turn-taking. However, there may be other possibilities for sharing narratives in a video session. For example, as one practitioner reported playing back recordings for families to reflect on: perhaps family members struggling to be heard might be invited to record a brief 'diary room' video in advance for others to hear in session. The possibilities for exploiting digital means of communication are many and varied.

Implications for Implementation

Participants' experiences of increased accessibility in FI by VC give some support to the suggestion from Absalom-Hornby et al. (2011) that video call delivery may help in the implementation of FIp. The benefit of video call in overcoming geographical distance has been well documented in studies of rural populations, for example in the Veterans Administration in the USA (e.g. Moreau et al., 2018). However, results of the present study show broader issues of accessibility, including the helpfulness of increased client control in facilitating engagement. Nevertheless, the mixed responses of practitioners and family members to the digital culture are a reminder that the implementation of VC interventions requires buy-in from the people concerned (Muir et al., 2020) and that implementation science sees working with organisational cultures as a key process in introducing new practice (Fixsen et a., 2009). The British Psychological Society (BPS) guidelines for FIp (BPS, 2021) advise a multi-level approach to implementation involving families, practitioners and service leads. It is notable that practitioners in the current study reported largely supporting each other to learn to practice by VC with very little training, and while that must be seen in the context of the COVID-19 crisis, there was nevertheless little sense of the joined-up effort called for by the BPS.

Participants' Reflections

All practitioners and family members consented to receive summaries of the study findings (Appendix B6) and were invited to comment as a form of validity assessment Yardley, 2015). Responses were received from only two practitioners, both of whom noted the complex and contrasting nature of participants' subjective experiences.

Limitations

It was disappointing that recruitment challenges meant that no service users and only two family members participated, resulting in the practitioner perspective inevitably being privileged. However, while a wider range of perspectives would have been desirable, the contributions of those who did take part offer detailed insights into the practical and cultural factors influencing FIp by VC. So detailed were the accounts that it might have been helpful to narrow the study focus to a specific aspect of FIp, for example process, in order to represent them more fully. Finally, the experiences presented in this study were clearly shaped by the COVID-19 context. Practitioners found themselves immersed unexpectedly in a new medium, and may well have been affected in other ways by the pandemic. Some commented on the stress experienced by families and especially service users, which may go some way to explain the difficulty of recruiting from those groups for this study. Indeed, it should be noted that the voices of those who contributed to this study were heard via video call, with the concomitant risk of a self-selecting sample.

Implications for practice and further research

A clear implication of the current study is the need to support practitioners in the use of technology. Practitioner participants described a marked lack of experiences of appropriate training being provided and few expressed confidence in their technology skills. The skills

gap which emerged from this study suggests that practitioners and their professional bodies could helpfully press digital training needs with provider organisations.

Most participants felt that VC has the potential to increase access to FIp. However, many practitioner participants also noted inequalities in access to fast broadband and suitable devices. This not only implies inequalities in people's ability to access FIp by VC but also in the quality of their experience, given that the number of people on each device and the types of device used were perceived to affect the ability to pick up on process, amongst other factors. Services may need to consider ways of providing access to technology for less well-off families, for example through device loan schemes, to overcome these inequalities.

Several areas for further research arise from the present study. Most obviously, a wider range of voices needs to be heard. Since the voices of service users and family members were poorly represented due to the recruitment difficulties experienced in the current study, a starting point might be a survey of routine therapy evaluations collected from service users by individual services. In addition, given the whole organisation approach favoured by implementation science, service leads and commissioners might provide useful insights into the barriers from their perspectives to implementing FIp by VC.

The issue of risk and safety management by video call was a common concern raised in the current study, and one that has attracted little empirical research. A first step could be to conduct a survey of risk incidents in services offering a digital FIp choice to gauge the extent to which practitioners' concerns represent a real-world difference.

In terms of the process and content of FIp, there was a strong suggestion in the present study that variations on family members joining from individual or shared devices may influence participants' ability to pick up subtle communications and may be manipulated by practitioners as an intervention, where practically possible. It was beyond the scope of the

present study to investigate this in more detail, but it may be a valuable subject for future research.

Conclusion

This study has reported on experiences of practitioners and family members of FIp by video. The signs are that practitioners found the transition to video challenging, and that some at least remained sceptical of embracing it more fully. Practitioners and family members reported a different feeling of human connection by video, although the level of challenge this presented seems to have varied. Certainly, the experience of not being heard and understood was distressing for one family member. Specifics of the mode of connection available to or chosen by participants appear to be important: the number of people on each device, the device type and quality, and the speed of the internet connection were all reported as affecting the experience, as did the skill levels of practitioners, service users and family members in using technology. Practitioners appear to have adapted by emphasising family psychoeducation over systemic interventions and by becoming more directive. Although some creative adaptations for individual needs were reported, the use of digital tools seems to have been limited. Nevertheless, there was broad agreement that video call enables greater access to FIp. All these experiences are likely to have been affected by the COVID-19 context, including the suddenness of the transition to video call delivery.

There was a powerful sense of FIp by video call as a different culture from that in which practitioners trained and in which all participants are used to communicate. It seemed like another country, where things are done differently, and a new language must be learned. Little wonder, then, that it has been experienced by participants in the current study as a challenge. Perhaps it may also prove enriching for those willing to embrace it.

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SECTION C:

APPENDICES

Appendix A1. Data extraction form example: Burek et al., 2021

General Information	
Report Title	Transdiagnostic feasibility trial of internet-based parenting intervention to reduce child behavioural difficulties associated with congenital and neonatal neurodevelopmental risk: introducing IInTERACT-North
Reference	Brittany Burek, Meghan K. Ford, Marie Hooper, Rivka Green, Sara Ahola Kohut, Brendan F. Andrade, Monidipa Ravi, Renee Sananes, Mary Desrocher, Steven P. Miller, Shari L. Wade & Tricia S. Williams (2021) Transdiagnostic feasibility trial of internet-based parenting intervention to reduce child behavioural difficulties associated with congenital and neonatal neurodevelopmental risk: introducing I-InTERACT-North, The Clinical Neuropsychologist, 35:5, 1030-1052, DOI: 10.1080/13854046.2020.1829071
Extraction date	14.02.22
Authors and affiliations, as reported	Brittany Bureka,b , Meghan K. Forda, Marie Hoopera,c, Rivka Greena,c, Sara Ahola Kohuta, Brendan F. Andradee,f, Monidipa Ravia,f, Renee Sananesa, Mary Desrocherc, Steven P. Millera,d, Shari L. Wadeg,h and Tricia S. Williamsa,d,f aDepartment of Psychology, Division of Neurology, The Hospital for Sick Children, Toronto, Canada; bDepartment of Applied Psychology and Human Development, The University of Toronto, Toronto, Canada; cDepartment of Psychology, York University, Toronto, Canada; dDepartment of Pediatrics, The University of Toronto, Toronto, Canada; eMargaret and Wallace McCain Centre for Child Youth and Family Mental Health, Child Youth and Emerging Adult Program, Centre for Addiction and Mental Health, Toronto, Canada; fDepartment of Psychiatry, The University of Toronto, Toronto, Canada; gDepartment of Pediatrics, Cincinnati Children's Hospital Medical Center, Cincinnati, OH, USA; hUniversity of Cincinnati College of Medicine, Cincinnati, OH, USA
Authors' professional discipline	Psychology

Notes	

Eligibility	
Empirical?	Y
Peer reviewed?	Y
Report of psychological therapy with more than one client?	a parent-child intervention for children at risk for poor neurodevelopment
Practitioner beliefs or experience reported?	Therapists took part in semi-structured interviews to gather their perspectives on the acceptability of the program
Synchronous video call?	After completing each online module, parents met with their therapist virtually (60 minutes long) to review the content using videoconference technology (Zoom)
Eligible?	Yes

Study characteristics & methods	
Study design	Qualitative data from parent interviews were examined through a cross-case thematic analysis for themes related to program acceptability (Braun & Clarke, 2006). Data were analyzed by the second and third authors based on Braun and Clarke (2006) six thematic analysis phases. Information on therapist experience delivering the program was also collected and similarly coded for program acceptability.
Research questions as reported	To investigate parents' acceptability of the program and online coaching sessions
Epistemological assumptions (stated or interpreteted)	Realist (interpreted)
Methodology	Thematic analysis
Data collection method	Therapists took part in semi-structured interviews to gather their perspectives on the acceptability of the program
Context for data collection	Participants were recruited between July 2019 and February 2020 from SickKids, a large pediatric hospital in Toronto, Canada. Families were eligible to participate if they met the following criteria: a) child between the age of 3-

(e.g., nature of service)	8 years, b) child was being followed at our institution given their diagnosis of neonatal stroke, HIE, CHD, or preterm birth (32 weeks), c) parent or clinician concerns regarding child behaviour/mental health
Description of participants, including reported diversity characteristics	Canadian therapist-trainees, and the previously trained senior therapist/supervisor (TW), gathered on-site at SickKids to receive didactic and interactive training from the I-InTERACT program developer (SW) and her American team via videoconference. Therapist-trainees practiced delivering the program within- and across-sites during three four-hour sessions.
Number of participants	Number of therapists interviewed not stated
Data analysis technique	Thematic analysis
Notes	Therapist interviews formed a small part of the overall design. Themes not clearly delineated.

Table 2. Family demographics by completion status.

	Completer (n = 19)	Non-completer (n = 3)
Parent who Participated in Program*		
Mother	10 (53%)	2 (67%)
Father	0 (0%)	1 (33%)
Mother and Father together	9 (47%)	0 (0%)
Parent Current age *M(SD)*		
Mother	37y 4m (5y 3m)	31y 6m (4y 1m)
Father	41 4m (10y 1m)	32y 6m (6y 3m)
Total Social Risk Score		
Low Risk (%)	15 (79%)	2 (67%)
High Risk (%)	4 (21%)	1 (33%)
Mother's age $\geq$ 21yr at Childbirth	18 (95%)	2 (67%)
Parent Education**		
High school diploma or less	3(16%)	0(0%)
Two years of college or more	16 (84%)	3 (100%)
Full-time Employment Status**		
Full-time	17 (89%)	3 (100%)
Part-time	2 (11%)	0 (0%)
Not currently employed	0 (0%)	0 (0%)
Marital Status		
Married/living with someone	17 (89%)	2 (67%)
Not living with someone	2 (11%)	1 (33%)
English as Primary Language	18 (95%)	3 (100%)
Other Languages Spoken at Home***	3 (16%)	1 (33%)
Age of Child *M(SD)*	5y 4m (1y 6m)	4y 9m (0y 9m)
Gender of Child – males	13 (68%)	2 (67%)
Child Condition's		
Hypoxic Ischemic Encephalopathy (HIE)	8 (42%)	2 (67%)
Neonatal Stroke	7 (37%)	0 (0%)
Congenital Heart Disease (CHD)	4 (21%)	1 (33%)
Preterm	2 (10%)	0 (0%)
Congenital Infection	2 (10%)	0 (0%)
Epilepsy	5 (26%)	0 (0%)

Note.
*All parents were biological parents.

Intervention	
Psychological intervention studied	Families completed seven online educational modules (in a fixed order) with corresponding videoconference sessions with the same therapist (Wade et al., 2017). The online modules (approximately 30 minutes long) were self-guided and included content to help parents further develop their parenting skills such as specific praise, use of behavioural contingencies, and parent stress management strategies; alongside psychoeducation about common challenges associated with brain injury for both children and their families
Nature of client group (couple, family, group)	Parent(s) and child
Were individual therapy experiences also studied? How were these experiences distinguished?	No
Timing of intervention (when, how often, how long)	Families completed seven online educational modules (in a fixed order) with corresponding videoconference sessions with the same therapist (Wade et al., 2017). The online modules (approximately 30 minutes long)… After completing each online module, parents met with their therapist virtually (60 minutes long)
Proportion of intervention delivered by video call	67%
How were other aspects of the intervention delivered?	N/A
Details of video call technology used (equipment, platform, etc)	Zoom – families participated from home. Exclusion criteria included lack of access to the internet.
Previous participant experience of Video call delivery	Not reported
Notes	1 family out of 47 excluded by lack of technology. No unemployed in sample Privileged therpists (as doctoral/post-doctoral students) and families Therapist data collection and analysis not rigorously described/validated

Findings	
Key themes emerging from the study ** Points of particular interest to work with multpile clients by VC*	Increased accessibility Increased flexibility of scheduling More rescheduling Technical issues most frequent challenge Technical challenges easy to overcome Increased accessibility, effectiveness and generalisability of intervention materials **Seeing family at home highlighted challenges and strategies used at home, empowering families to be own problem-solvers* Flexibility to individual need possible

Review author reflexivity notes
Reviewer's responses to study during data extraction: Reporting of therapist data collection and analysis feels cursory and peripheral. I found myself wondering about researcher reflexivity and how in-depth the process was. The themes, such as they are, seem shallow. Perhaps I am judgemental because of what I need from the paper – a solid contribution to doctoral work.

Appendix A2: Quality Appraisal Form example

Study quality appraisal (using CASP tool, following Noyes et al., 2018)	
Validity	
Was there a clear statement of the aims of the research? HINT: Consider • what was the goal of the research • why it was thought important • its relevance	Y/N/CT: Y Comments: This was an exploratory study designed to gain a preliminary understanding of shifts in EDP, multidisciplinary team and parent roles and processes when moving from an in-person to a telehealth modality in a real practice setting. We particularly wanted to understand whether EDP, team and parent roles shifted in a major or minor way, and whether telehealth involved the addition of new work processes, or rather the subtraction or deletion of processes when compared to in-person practice. We also wanted to understand whether the telehealth service was generally acceptable to the EDP, multidisciplinary team, and parents, and attempt to get a preliminary understanding of whether changed roles and processes may be linked to satisfaction.
Is a qualitative methodology appropriate? HINT: Consider • If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants • Is qualitative research the right methodology for addressing the research goal	Y/N/CT: Y Comments: Study aimed to understand EDP work in a particular setting within a particular time period. However, Clinical Implications risk drawing conclusions for general practice and do not adequately acknowledge limitations of qualitative research
Was the research design appropriate to address the aims of the research? HINT: Consider • if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)	Y/N/CT: Y Comments: Case study design is appropriate when describing a case bounded by time or place that can inform a problem (Creswell et al., 2007).
Was the recruitment strategy appropriate to the aims of the research? HINT: Consider • If the researcher has explained how the participants were selected • If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study • If there are any discussions around recruitment (e.g. why some people chose not to take part)	Y/N/CT: Y Comments: Convenience sample of EDP patients in that setting at that time.

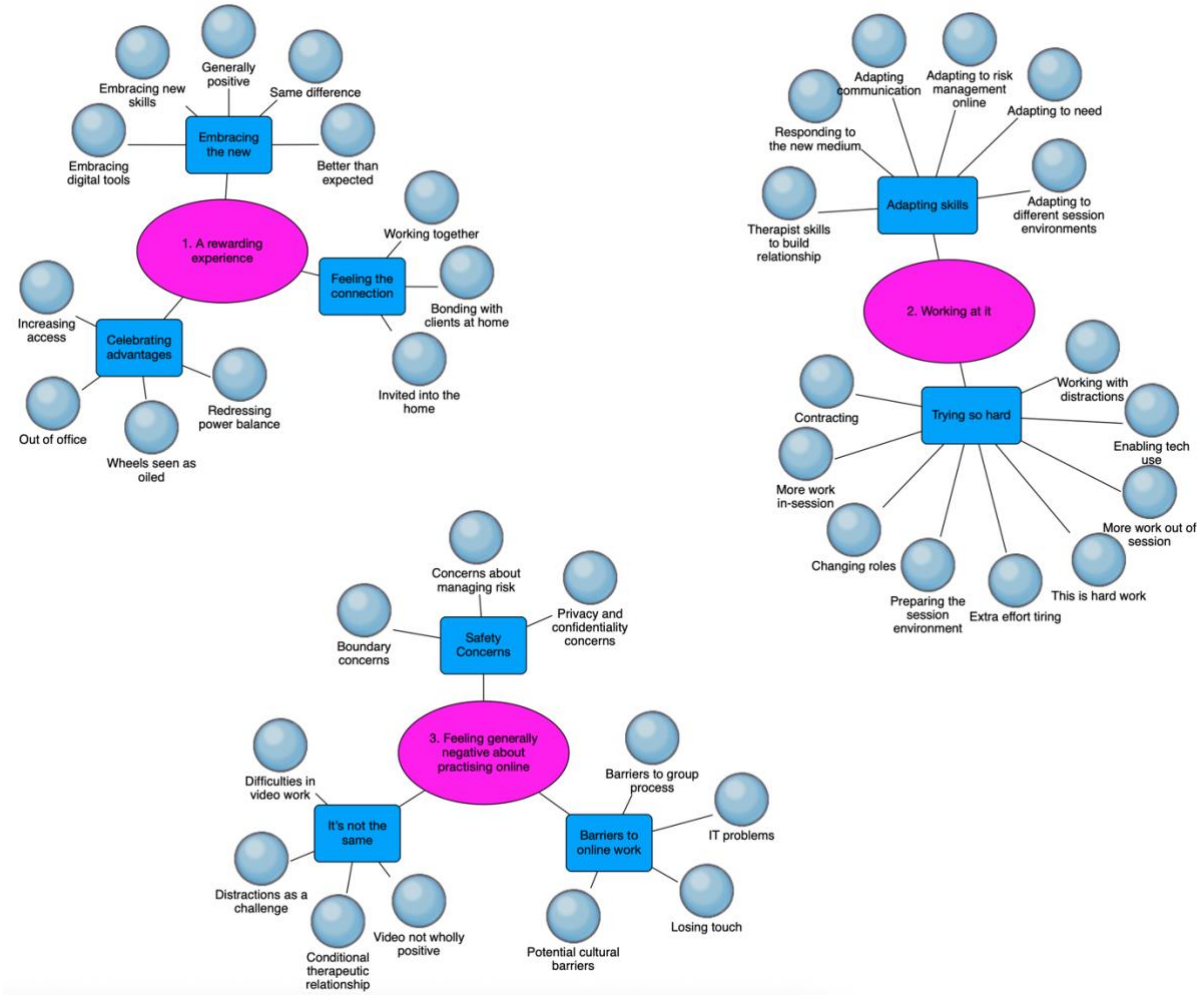
Was the data collected in a way that addressed the research issue? HINT: Consider • If the setting for the data collection was justified • If it is clear how data were collected (e.g. focus group, semi-structured interview etc.) • If the researcher has justified the methods chosen • If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide) • If methods were modified during the study. If so, has the researcher explained how and why • If the form of data is clear (e.g. tape recordings, video material, notes etc.) • If the researcher has discussed saturation of data	Y/N/CT:Y Comments: Methods clearly described Multiple data collection methods used and different perspectives sought
Has the relationship between researcher and participants been adequately considered? HINT: Consider • If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location • How the researcher responded to events during the study and whether they considered the implications of any changes in the research design	Y/N/CT: CT Comments: Connection of researchers with setting and response to participants not discussed
What are the results?	
Have ethical issues been taken into consideration? HINT: Consider • If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained • If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study) • If approval has been sought from the ethics committee	Y/N/CT: Y Comments: Ethical approval for this study was obtained from the University of Queensland Human Research Ethics Committee B (2017001829).

Was the data analysis sufficiently rigorous? HINT: Consider • If there is an in-depth description of the analysis process • If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data • Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process • If sufficient data are presented to support the findings • To what extent contradictory data are taken into account • Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation	Y/N/CT: Y Comments: Exemplars given to illustrate themes Triangulation process described However, only main themes reported and exceptions not discussed This study did not include analysis of minor themes or divergent cases, although we have attempted to balance the presence of negative and positive perceptions of telehealth in our findings
Is there a clear statement of findings? HINT: Consider whether • If the findings are explicit • If there is adequate discussion of the evidence both for and against the researcher's arguments • If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst) • If the findings are discussed in relation to the original research question	Y/N/CT: Y Comments: Findings related consistently to aims
Will the results help locally?	
How valuable is the research? HINT: Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used	Comments: Practice recommendations made in light of experience in a single setting Blurred boundary between this organisation and "organisations" in recommendations, e.g. Organisations adopting telehealth should acknowledge the critical role of team members and include them as members of the "telehealth team".
Overall assessment of quality and reasons	Strong/satisfactory/poor: Satisfactory Comments: Generally strong but left out minor themes and discrepancies – latter important in demonstrating quality (Yardley)

Appendix A3. Descriptive Themes and Clusters

Descriptive themes	Descriptive Clusters
Adapting	Adapting to need
	Changing roles
	Embracing video call
	Responding to new medium
Additional work	More work in-session
	More work out of session
Beliefs & assumptions	Better than expected
	Generally negative
	Generally positive
Barriers and facilitators	Cultural contexts
	Increasing access
	Same difference
	Spanners in works
	Oiled wheels
Distractions	Client distractions
	Responses to distractions
Group processes	This is hard work
	This is not working
	Working together
Impact on therapist	Burdens and challenges
	Embracing new medium
	Out of office
Non-verbals	Adapting communication
	Loss of non-verbals
Power	Redressing power balance
Safety & risk	Adapting risk management
	Barriers to risk management
	Boundaries
	Privacy and confidentiality
Session setting	Forms of session environment
	Invited into the home
Setting up	Contracting
	Preparing environment
Technology	Enabling technology use
	Technology problems
Therapeutic relationship	Bonding with clients at home
	Mixed experiences of rapport
	Skills to build rapport

Appendix A4: Concept Map of Interpretative Themes



Appendix B1. Participant Information Sheet

B1a Participant Information Sheet for Service Users and Family Members

IRAS no: 291306 Version number: 2 Date: 19.11.2021

Participant Information Sheet

A Study of Family Interventions for Psychosis by Video Call

Thank you for your interest in this research study. My name is [REDACTED]. I am the "chief investigator" for this research study, which forms part of my doctoral studies. I am a trainee clinical psychologist at Salomons Institute for Applied Psychology, part of Canterbury Christ Church University.

This information is to help you decide if you would like to take part in this research study. Please read it carefully. If you have any questions, you are welcome to contact me. My details are at the end of this sheet. You are also free to ask others about the study if you wish.

If you decide you want to take part, you can find out what to do at the end of this sheet.

What is the research about?
I would like to learn from people who have taken part in a family intervention for psychosis by video call.

- I will interview service users and family members
- I will also interview therapists
- The aim of the research is to learn more about family interventions for psychosis by video call
- I hope to find out what works well and what could be improved.

What would you do?

- You would take part in a recorded interview lasting approximately one hour.
- You would be able to choose to do the interview by video call from home or by phone.
- I would ask you questions about what it was like to take part in a family intervention by video call.
- You would not have to answer all the questions, for example if you think it might be upsetting.
- I would welcome anything you wish to say about your experience, whether good or bad.

How would your interview recording be used?
I would transcribe (write out) your interview recording. I would then look for themes in what you and other participants say. This will help me learn about what family interventions are like by video call. If you want, you can choose to receive a summary of the results. I would welcome any comments on the summary you might wish to make.

Do you have to take part?

- You do not have to take part in this study.
- If you choose not to take part, your access to care will not be affected.
- If you do take part, you can choose to withdraw afterwards.
- If you choose to withdraw, your access to care would not be affected.
- Please note that you will not be able to withdraw once the research report is written.
- You can choose to be informed when the report has been written.

What might be the benefits of taking part?
You might find it interesting to talk about your experiences of the family intervention. I hope that the research will lead to improvements in the way family interventions for psychosis are done by

1

video call. This may benefit others having treatment in the future. It may also benefit you, if you have family interventions by video call again.

What are the risks of taking part?
I will not ask you about personal things you discussed in therapy. However, talking about your experience may be upsetting. At the start of the interview, I will talk to you about how to get help in case you are affected.

Will you be paid?
I will not pay you a fee or expenses for taking part in this research. However, you can choose to receive a £10 'thank you' voucher. You can choose either an Amazon voucher or a VEX voucher, which can be exchanged at a variety of outlets.

To process your voucher request, I would need to share your email address with the research administrator and finance department at Canterbury Christ Church University. If you accept the voucher, it will not affect your right to withdraw from the study.

How will we use your information?
I will need to use information from you for this research project. This information will include your:

- Name
- Address
- Email address
- Phone number

People will use this information to do the research or to check your records to make sure that the research is being done properly. Only people who **need** to know who you are will be able to see your name or contact details. Your interview data will have a code number instead.

We will keep all information about you safe and secure. Once the study is finished, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but I will keep information about you that I already have
- I need to manage your records in specific ways for the research to be reliable. This means that I won't be able to let you see or change the data I hold about you
- You can choose to be offered the opportunity to participate in future research studies

How would your confidentiality be protected?
As lead researcher, I would be responsible for keeping personal information confidential. I will be supervised by two highly experienced clinicians, [REDACTED] and [REDACTED].

- I would record the interview on an encrypted voice recorder.
- The recording would be transferred at the first opportunity to a password protected CD, and the recording deleted from the voice recorder
- The personal information you give me (e.g. name or email address) will be stored securely, separate from the CDs
- I will use a code number on the CD so that no unauthorised person could identify you from the CD
- When I transcribe the interviews, I will remove names and anything else that might identify you

- The study supervisors, [REDACTED] and [REDACTED], will have access to the transcripts
- The information we collect for this research will be kept securely for 10 years. After this time, it will be destroyed
- **Important.** In special circumstances, I may have to share your information with a third party. This could be if there is a risk to your safety or the safety of others. It might also be in special legal circumstances

Where can you find out more about how your information is used?
You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/ and www.hra.nhs.uk/patientdataandresearch
- by sending an email to [REDACTED]
- by ringing 01227 927070 and leaving a message for [REDACTED]

What if there is a problem?
If you take part in the study and have a problem or complaint, I would welcome you telling me about it. My email address is at the end of this sheet. I will do my best to resolve the problem to your satisfaction. If you prefer to speak to someone else, you can contact the Research Director at the Salomons Institute, Dr Fergal Jones: fergal.jones@canterbury.ac.uk, or tel. 01227 927070.

Who is organising and funding the research?
This research study was organised by me, as lead researcher, in collaboration with the principal supervisor, [REDACTED] and second supervisor, [REDACTED]. The study is funded by Canterbury Christ Church University.

Who has reviewed the study?
The study has been reviewed and approved by Canterbury Christ Church University. An official organisation called the Health Research Authority will have checked that the study is ethical before anyone takes part. The local NHS Trust research and development authority will also have approved the study before work commences.

What will happen to the results of the research study?
The written report will be submitted to Canterbury Christ Church University as part of my doctoral degree. It will also be submitted for publication in an academic journal so that therapists, researchers and other professionals can read it. If you would like to see the written report of the research when it is completed, please contact me using the details below.

What do I do if I want to take part?
If you have not already spoken to me ([REDACTED], the chief investigator), please contact me using the email address or phone number below. I will then reply to talk you through the next steps.

Further information and contact details
If you have any questions about the research or your participation, please email the chief investigator, [REDACTED]: [REDACTED] If you would like to speak to me, you can leave a message on a 24-hour voicemail phone line, 01227 927070. Please say the message is for [REDACTED] and leave a contact number so I can call you.

If you would like to speak to the principal supervisor for this study, who is very experienced in this field of research, please contact [REDACTED]: [REDACTED]

B1b: Participant Information Sheet for Practitioners

IRAS no: 291306 Version number: 2 Date: 19.11.2021

Participant Information Sheet (practitioners)

A Study of Family Interventions for Psychosis by Video Call

Thank you for your interest in this research study. My name is [REDACTED], and I am a trainee clinical psychologist at Salomons Institute for Applied Psychology, part of Canterbury Christ Church University. I am the chief investigator for this research study, which forms part of my doctoral studies.

This information is to help you decide if you would like to take part in this research study. Please read it carefully. If you have any questions, you are welcome to contact me. My details are at the end of this sheet. You are also free to ask others about the study if you wish.

What is the research about?
I would like to learn from practitioners who have delivered family interventions for psychosis (FIp) by video call. The aim of the research is to increase our understanding of family interventions in this context.

What would you do?
You would be asked to take part in a recorded interview, lasting approximately one hour. The interview will be conducted by video call or by telephone.

I would ask you questions about the process of conducting FIp by video call. You will not be asked about the personal information disclosed by your clients.

How would your interview recording be used?
I would transcribe your interview recording. I would then look for themes in what you and other participants say. This will help me learn about what family interventions are like by video call. If you want, you can choose to receive a summary of the results. I would welcome any comments on the summary you might wish to make.

What might be the benefits of taking part?
You might find it interesting to reflect on what it is like to deliver FIp by video call. I hope that the research will lead to improvements in the way family interventions for psychosis are done by video call.

How would my interview recording be used?
We would transcribe the interview recordings made with you and other participants. We would then analyse what everyone has said to see what we can learn about family interventions by video call.

Do I have to take part?
You can choose not to take part in this study or to withdraw afterwards without penalty. Please note that withdrawal will not be possible once the research report is written.

Will I be paid?
There is no payment for taking part in this research. The interview would take place within work time.

How will we use information about you?
We will need to use information from you for this research project. This information will include your:

- Name
- Work address
- Work email address
- Phone number

People will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.
- Participants can choose to be offered the opportunity to participate in future research studies

Where can you find out more about how your information is used?
You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/ and www.hra.nhs.uk/patientdataandresearch
- by sending an email to [REDACTED]
- by ringing us on 01227 927070

How would my confidentiality be protected?
We would record the interview on an encrypted voice recorder. This would be transferred at the first opportunity to a password protected CD, and the recording deleted from the voice recorder. The transcribed recording would also be kept on the CD.

The personal identifying information you give us (e.g. name or email address) will be stored securely, separate from the CDs. We will use a coding system so that no unauthorised person could identify you from the CD.

As lead researcher, I will be responsible for keeping your information confidential. The study is supervised by [REDACTED]and [REDACTED]. They will also be able to see your information.

It will not be possible for anyone to identify you in the written report of this research.

Important: in special circumstances, we may be legally obliged to share your information with a third party. This might be if there is a concern about risk to your safety or the safety of others. It might also be if we are required to do so by a court of law.

The information we collect for this research will be kept securely for 10 years. After this time, it will be destroyed.

What if there is a problem?
If you take part in the study and have a complaint, I hope you will feel able to raise it with me first. My email address is at the end of this sheet. If you are not satisfied and wish to make a formal complaint, you can contact the Research Director at the Salomons Institute, Dr Fergal Jones: fergal.jones@canterbury.ac.uk, or tel. 01227 927070.

Who is organising and funding the research?
This research study was organised by me, as lead researcher, in collaboration with the principal supervisor, [REDACTED]and second supervisor, [REDACTED]. The study is funded by Canterbury Christ Church University.

Who has reviewed the study?
The study proposal has been reviewed and approved by Canterbury Christ Church University. Application will be made to the Health Research Authority for ethical approval, and permission will be sought from the relevant Trust research and development authorities, before the work commences.

What will happen to the results of the research study?
The written report will be submitted to Canterbury Christ Church University as part of the lead researcher's doctoral degree. It will also be submitted for publication in an academic journal.

If you would like to see the written report of the research when it is completed, please email me at the address below.

Further information and contact details
If you have any questions about the research or your participation, please email the principal investigator, [REDACTED]: [REDACTED]If you would like to speak to me, you can leave a message on a 24-hour voicemail phone line, 01227 927070. Please say the message is for [REDACTED]and leave a contact number so I can call you.

If you would like to speak to the principal supervisor for this study, who is very experienced in this field of research, please contact [REDACTED]: [REDACTED]

Appendix B2. Consent Form

IRAS no: 291306 Version number: 2 Date: 19.11.2021

CONSENT FORM

Title of Project: **A Study of Family Interventions for Psychosis by Video Call**
Name of Researcher: [redacted]
Participant Identification number for this study:

Please initial box

1. I confirm that I have read and understand the information sheet dated 11.11.2021 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my access to services being affected	☐
3. I agree to my interview being recorded and transcribed for analysis. I understand that the recording and transcript will be stored securely and anonymously.	☐
4. I understand that data collected during the study may be reviewed by the supervisors, [redacted] and [redacted]. I give permission for these 2 people to have access to my data.	☐
5. I agree that anonymous quotes from my interview and other anonymous data may be used in published reports of the study findings	☐
6. I am interested in future research opportunities and agree to have my name and email address retained in order that I may be contacted YES/NO (*please delete as appropriate*).	☐
7. I confirm that I have been able to ask any questions I may have about the research and that these have been answered.	☐
8. I agree to take part in the above study.	☐

Name of Participant: _____

Signature _____ Date: _____

Name of Person taking consent: _____

Signature _____ Date: _____

Appendix B3. Interview Schedules

B3a: Interview Schedule for Service Users and Family Members

INTERVIEW SCHEDULE FOR SERVICE USERS AND FAMILY MEMBERS

Date: 16.10.2021
Version no.: 1

- *Bullet points indicate possible follow-up questions*

Preamble
If there is a good reason under the Mental Capacity Act (2004) to believe that the participant may lack capacity to consent, conduct a capacity assessment by checking the participant's understanding of what the interview is about and their ability to weigh the information and communicate their decision.

Remind participants about the risks of taking part:

1. Emotive material, and choice of whether to answer question or not
2. Ensuring participant privacy, and plan if participant's privacy is interrupted (including agreed stop phrase, if appropriate)
3. What to do if the call is cut off (for remote interviews)
4. What action the participant would like the interviewer to take if they choose to terminate the call unexpectedly
5. Limits of confidentiality and right to withdraw

Demographics

1. What is your age?
2. What is your family relationship to the person receiving mental health care?
3. How would you describe your ethnic background?
4. When (approximately) did you start your family work? (if not obtained from referrer)
5. And how long did it go on for? (if not obtained from referrer)
6. Approximately how many sessions did you have? (if not obtained from referrer)
7. Who in your family / social network attended the sessions?
8. Have you received any other psychological intervention as a family or individually? (Relevant if previous experiences relate to engagement or usefulness of FI)

General
Overall, how would you describe your experience of participating in the family intervention for psychosis [find out how the service refers to them] sessions?

- *What did you find helpful or interesting?*
- *What did you find unhelpful or difficult?*
- *What surprised you?*

Engagement

Thinking back to when the sessions were first offered: how did you find the process of setting up the sessions?

- *What was it like when the sessions were offered?*
- *What were your hopes and fears before the sessions started?*
- *And which things you hoped or worried about happened during the sessions?*
- *What choices were you given about how the sessions were planned?*

What was your experience of the professional(s) during the work?

- *How did the professional involve you in the way the sessions were run?*
- *How did you feel about the way the professional listened to you in the sessions?*
- *If there were times of conflict or emotion, how were these managed?*
- *If the professional were here now, what advice would you give them?*

Process & Content

What do you remember about the kinds of things that were discussed in the sessions?

- *Did the video call context help or hinder you in talking about different things?*
- *How did the sessions change your understanding of psychosis? … And how was information about psychosis given to you?*
- *How were you helped to talk with each other in the family?*
- *What do you remember about working on how your family solves problems together?*
- *What did you learn about dealing with strong emotions or conflicts in the family?*
- *If the subject of loss or bereavement came up, how did you experience talking about it in the sessions?*

Still thinking about the content of the sessions, what stands out as being helpful? …And what stands out as being unhelpful?

- *What would you change about the content of the sessions?*
- *Is there anything you would have liked to do that wasn't done?*

What was your experience of any between-session tasks set by the professional?

- *In what ways were the tasks helpful or unhelpful?*
- *What affected your ability to complete the between-session tasks?*

What was it like communicating with your family member(s) during the sessions?

- *How was this helped or hindered by the video call context?*
- *How was this different from when you have communicated in the past?*
- *What aspects of the sessions might have made communicating with your family more difficult?*

Video Call

How did you feel about having the sessions by video call?

- *Was there anything about using video that made the family sessions easier?*

- *What was unhelpful about using video for the sessions?*
- *What was your experience of talking with others in the sessions by video?*
- *What would have improved the video call sessions?*

How well do you think the content of the sessions worked by video call?

- *What was it like to talk with your family member(s) by video call?*
- *How did the video call affect your ability to work on problems together?*
- *What was it like dealing with strong emotions during the video call?*
- *What would you change if you had sessions by video call again?*

How did you find using the technology during the video calls?

- *What prior experience did you have of video calls?*
- *What help were you given to set up the technology?*
- *What problems with technology did you experience during the sessions?*
    - *Equipment?*
    - *Reliable internet connection?*
    - *Problems with platform?*
    - *Audio quality?*
- *What help was available if there were technology problems?*
- *Generally, what more help would you have liked with technology?*

How did you feel about the safety of having the sessions by video call?

- *How did you feel about your privacy during the calls?*
- *What emotional support was available if the video call failed at a difficult moment?*
- *Did you have any other concerns about your safety during the video calls?*

Summing Up

Thinking about your experience of having family sessions: if a friend told you they were thinking about doing it, what would you say to them?

What do you feel your family has got out of participating in the sessions?

- What is different now?
- What resources were you given?

Is there anything about your experience of taking part in the family intervention sessions which we haven't covered but which you'd like to speak about?

B3b: Interview Schedule for Practitioners

Interview Schedule for FIp practitioners

Version: 1 Date: 16.10.2021

- *Bullet points indicate possible follow-up questions*

Preamble
Remind participants about the risks of taking part:

1. Ensuring participant privacy
2. What to do if the call is cut off (for remote interviews)
3. Limits to confidentiality and right to withdraw
4. Check participant consents to continuing the interview

Background

1. What is your age?
2. How would you describe your ethnic background?
3. What is your professional role?
4. Please describe your training in family interventions.
5. Approximately how long have you been delivering FIp in general, and how long online?

General
As a practitioner, how would you describe your experience of delivering family interventions for psychosis by videoconferencing?

- *What do you find works well?*
- *What did you find works less well?*

Engagement
How do you find that the video context affects the way you plan the sessions with a family?

- *What works well in planning?*
- *What have you found that doesn't work so well in planning?*
- *In what ways are you able to involve service-users and family members in the planning?*
- *What choices are you able to offer service-users and family members in how the sessions are planned?*

What are your experiences of building helping relationships with service users and family members by VC?

- *What has helped engagement?*
- *What has hindered engagement or resulted in families disengaging?*
- *What is your experience of service user/family members' feelings about the intervention being offered by video call?*

Process & Content
How has the content of the FIp sessions you deliver been affected by the video call context?

- *How do you deliver information by video call?*

- *What is your experience of how VC affects working on family communication?*
- *How do you address family problem-solving online?*

How have the video call context affected your experience of managing strong emotions or conflicts in the family?

- What has helped you to do this?
- What would you wish to be different?
- How have you experienced dealing with issues of loss and bereavement?

How has the way you set between-session tasks been affected by the video call context?

- *What adaptations have you made for the online context?*
- *What is your experience of clients' engagement with between-session tasks in the video call context?*

If you have also delivered FIp face-to-face, what is your experience of how the process in the sessions is different by video call?

- *If not, what are the reasons for this?*
- *How do the sessions feel different to working in-person?*
- *How are things communicated differently?*
- *How do participants relate to each other that is different to other contexts?*

Video Call

What are your feelings about delivering FIp sessions by video call?

- *What is helpful about using video calls to deliver FIp?*
- *What is unhelpful about using video calls?*
- *What adaptations have you made to the way you deliver FIp for delivery by video call?*
- *How do you feel about the training and support you have received to deliver FIp by video call?*

How well do you think the content of the sessions works by video call?

- *What elements of FIp work best by video call?*
- *What elements of FIp work less well?*
- *What is your experience of the way participants respond to the content of FIp when delivered by video call?*

How do you find using the technology during the video calls?

- *What training and support you have received to use the technology? How helpful has it been?*
- *What problems with technology have you experienced in sessions?*
    - *Equipment?*
    - *Reliable internet connection?*
    - *Problems with platform?*
    - *Audio quality?*
- *What aspects of the technology would you change, if you could?*

How do you feel about risk and safety in video call session?

- *What helps or hinders your ability to manage risk during sessions by video?*
- *How do you find that using video call affects issues of privacy and confidentiality?*

- *What other ethical issues are important to you in relation to delivering FIp by video call?*

Summing Up

If you were put in charge, what would you change about how your service delivers FIp by VC?

Is there anything about your experience of delivering FIp by VC which we haven't covered but which you'd like to speak about?

Appendix B4. Ethical Approval

B4a: HRA Approval Letter

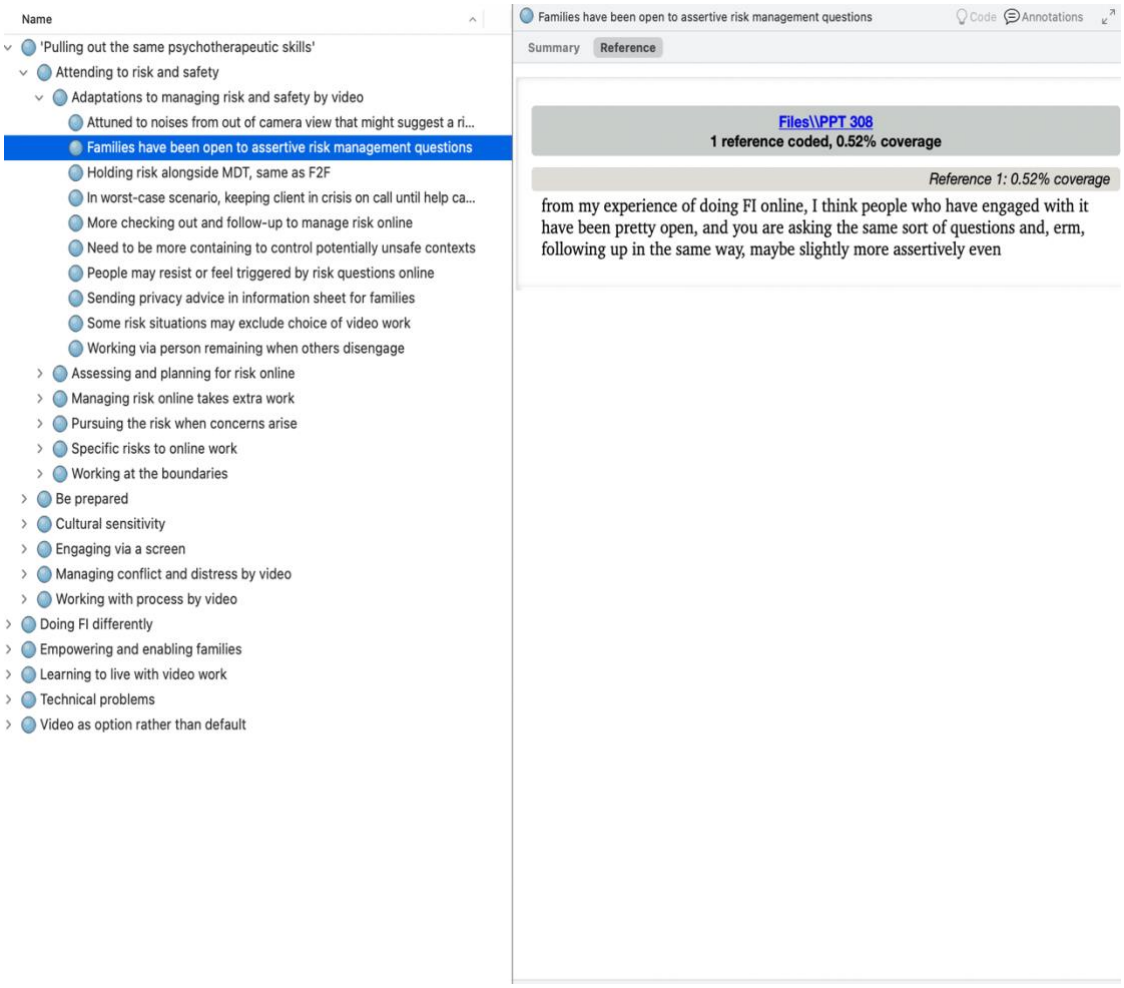
This has been removed from the electronic copy

B4b: Letters of Access

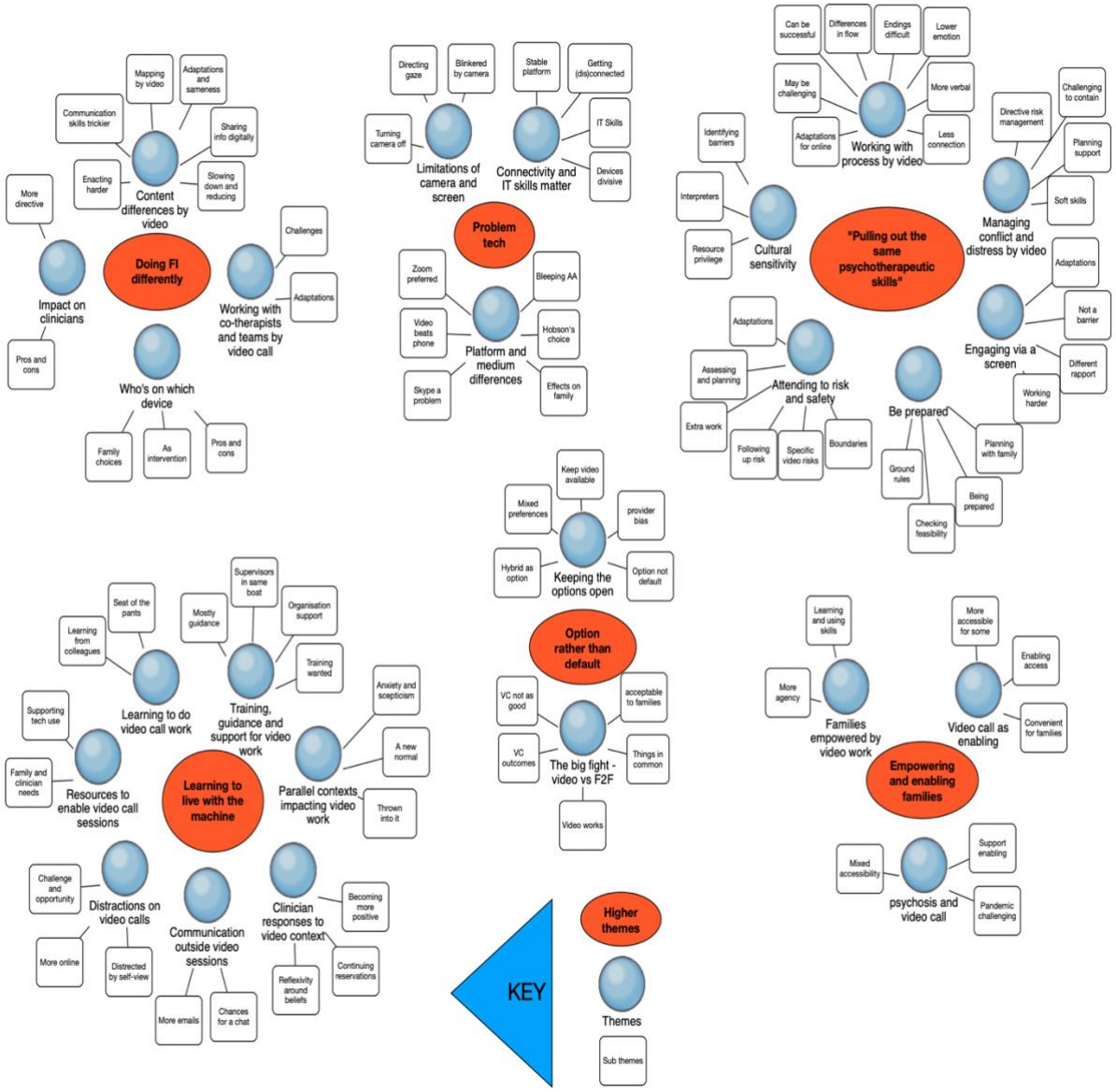
These have been removed from the electronic copy

Appendix B5. Coding processes

B5a: Coding raw data



B5b: Working with NVivo Concept Map



B5c: Themes tabulated

Higher Theme 1: '**Pulling out the same psychotherapeutic skills**'. Describes use of generic therapy skills in FIp by video		
Theme	Clusters	Codes
Attending to risk and safety	Adaptations to managing risk and safety by video	Attuned to noises from out of camera view that might suggest a risk issue
		Families have been open to assertive risk management questions
		Holding risk alongside MDT, same as F2F
		In worst-case scenario, keeping client in crisis on call until help can arrive
		More checking out and follow-up to manage risk online
		Need to be more containing to control potentially unsafe contexts
		People may resist or feel triggered by risk questions online
		Sending privacy advice in information sheet for families
		Some risk situations may exclude choice of video work
		Working via person remaining when others disengage
	Assessing and planning for risk online	Assessing risk and planning same as F2F
		Formulating risk thoroughly in advance, same as F2F
		Planning what to do if family member drops out
		Taking time and care over setting up risk management
		Video sessions generally don't feel more risky
		Working online helps manage risk when F2F not possible
	Managing risk online takes extra work	More work and anxiety to managing risk online
		More work to manage risk online but acceptable
		Need to pay extra attention to safeguarding issues makes video harder
	Pursuing the risk when concerns arise	Challenge of client moving off-screen during conflict
		Challenge of managing risk if client drops out while distressed or dissociating
		Challenge of negotiating follow up after session when someone becomes distressed
		Concern about clients after call ends
		Following up risk concerns may be more assertive in video work

Higher Theme 1: **'Pulling out the same psychotherapeutic skills'.** Describes use of generic therapy skills in FIp by video		
Theme	Clusters	Codes
		More follow-up phone calls initially might have been clinician anxiety
	Specific risks to online work	Dissociation more risky by video
		Increased risk to clients joining from hostel accommodation
		Reliance on information given by family to monitor privacy
		Risk of offering devices to people with substance abuse problems who might sell them
		Risk of unsafe relationships in home environment
		Uncertainties about risk when client disconnects during difficult conversations
	Working at the boundaries	Acceptance of changing boundaries among colleagues
		Addressing privacy and confidentiality boundary issues arising in the work
		Attending to clinician's boundaries of privacy and confidentiality
		Attending to privacy boundary for client when setting up online work
		Boundaries of privacy and confidentiality online need more thinking and attention
		Boundary issues when videoing into family homes
		Challenges to privacy boundaries for clients in houses of multiple occupancy
		Clinician reassessing boundaries of video from home
		Concern over boundaries of privacy and confidentiality for family members
		Conversations with families to maintain privacy and confidentiality boundaries
		Holding privacy and confidentiality boundaries vs 'can do' approach
		Interest in clinician's blurred background spurs conversation about privacy boundary
		Raising session boundaries at the start
Be Prepared	Agreeing ground rules for safety in video work	Addressing people joining from their car in ground rules
		Benefit of setting ground rules
		Clarifying reduced ability to follow up distress post-session in ground rules
		Including agreement to keep cameras on in ground rules
		Including how to manage conflict and distress in ground rules

Higher Theme 1: **'Pulling out the same psychotherapeutic skills'.** Describes use of generic therapy skills in FIp by video		
Theme	Clusters	Codes
		Including in ground rules need to inform clinicians if leaving the room
		Need to be flexible sometimes when no ground rules workaround possible
		Revisiting ground rules when arrangement to manage risk proved unworkable
	Checking the feasibility of video with family	Checking older family members able to access technology
		Checking out family feelings about video but less about connectivity
		Checking what devices people have to ensure video accessible
		Checking whether families are using mobile data
		More preparation needed to ensure video working and settings appropriate
		Pre-session connection checks with family helpful
		Pre-session technical checks may be difficult for person with psychosis
		Supporting people by phone to log on at start
	Clinician being prepared for video sessions	Experience guiding session preparation
		Extra thinking and preparation required for video work
		Learning family names in advance of video session but not F2F
		More preparation needed to feel in control of things by video
		Solid preparation of clinical issues before seeing family by video
	Planning video work with families	Attention to trauma and loss in planning with preference for F2F
		BFT screening as test of preference for video or F2F
		BFT structure makes planning easier with family
		Creating information sheet about online working helpful
		Families did not raise many worries about working online
		Having test call to work through technical issues
		Individual meetings before FI work included discussing feelings about working online
		Planning to avoid whole family on one phone if possible
		Preference for meeting people F2F before video work

Higher Theme 1: **'Pulling out the same psychotherapeutic skills'.** Describes use of generic therapy skills in FIp by video		
Theme	Clusters	Codes
		Preparing family for video work interfered with getting to know each other
		Warming the context by discussing choices around video work
Cultural sensitivity	Identifying potential cultural barriers	Main potential cultural barrier resources
		No obvious barrier to video work with people from Afro-Caribbean and African backgrounds
	Privilege of resources	Digital poverty as limitation of video work
		Does family member have access to a device
		Ethical concern that people able to take up video offer are better resourced
		Families without IT access may be excluded from FI online
		Family members with no technical background may need a lot of support
		Holding awareness of potential cultural barriers including SES
		Ideal to have solutions to reduce barriers for people with limited IT access
		Older adults may not have suitable device for video
		Platforms needing more data affect less well-off families
		Risk of family member being excluded by inability to access IT
		Working by phone with person without internet access
	Working with interpreters 'a lot more unwieldy' online	Concerns over feasibility of working with interpreter online
		Working with interpreter better F2F
Engaging via a screen	Adaptations and flexibility towards engagement	Building rapport by phone before video work
		Building trust with service user alone by video first
		Checking all family members have same view mode
		Checking what people can see at start of session
		Clinician adapting own set-up to be fully engaged
		Clinician perhaps more conscious of birthdays for rapport online
		Engaging with families through dealing with tech issues
		Flexibility helped engagement for anxious family member

Higher Theme 1: **'Pulling out the same psychotherapeutic skills'.** Describes use of generic therapy skills in FIp by video		
Theme	Clusters	Codes
		IT support allows people with psychosis to engage
		People learning to engage with gentle graded teaching and practice
		Starting relationship F2F before video work
		Trying any way possible to engage
		Using check-in to promote engagement
		Video enabling engagement by offering communication choices
	Quality of engagement is not a barrier	Building rapport by video fine with most families
		Building rapport in same way as F2F
		Building relationship online with person with poor attachment history
		Engagement by video going ok due to familiarity with online meetings
		Good therapeutic relationship experienced online
		No difference in family engagement noticed after moving to F2F work from video
		No difference in video engagment, once established
		No experience of families disengaging
		Therapeutic relationship possible by video
		Uncertainty about how online therapeutic relationship is different
		Unsure about how video affects therapeutic relationship
		Feeling that extensive check-in not necessary for people to be comfortable
	Sense of difference in rapport	Anticipation of meeting family F2F after video work like going on a date
		Being welcomed to family home might explain better engagement F2F
		Client scripts different for video call than F2F session
		Engagement different for clinician and maybe for clients
		Feeling of connection with people more abstract online
		Feeling of not having met families when online
		Mixed experiences of establishing rapport
		Sense that video affects relationship but don't know how

Higher Theme 1: **'Pulling out the same psychotherapeutic skills'.** Describes use of generic therapy skills in FIp by video		
Theme	Clusters	Codes
		Lots of checking out with people their experience of the work online
		More difficult for clinician to attend to more than a couple of people on screen
		Need to take time at start of work to build rapport
		Reviewing family experience of online work regularly
		Sense of working harder to communicate by video
		Working harder to engage may not be necessary
Managing conflict and distress by video	Being more directive to manage risk	Being more interventive to manage escalating process
		Intervening strategically to manage family arguing
		Intervening verbally when things are escalating
		Inviting someone to turn their camera off and listen to manage conflict
		More directive in managing conflict due to uncertainty about risk
	Finding conflict and distress challenging online	Conflict easier to manage in-person
		Difficult to manage volatile relationships online
		Easier to manage dynamics around distress when F2F
		Family has more responsibility to contain themselves
		Feeling of being less skilled at working with loss remotely
		Harder to attend to emotional distress by video
		Harder to intervene in open argument by video
		People may leave during conflict whether video or F2F
		Sitting with distress F2F does not work by video
		Strong expressed emotion arousing anxiety in clinician
		Unable to offer direct support when somebody is upset
		Unclear who has responsibility to manage distress
	Planning how to support distress	Planning how to support distress remotely
		Preparing how to support distress when setting up work

Higher Theme 1: **'Pulling out the same psychotherapeutic skills'.** Describes use of generic therapy skills in FIp by video		
Theme	Clusters	Codes
	Using soft skills to manage conflict and distress	Balancing empathy and gentle pushing
		Containing by acknowledging and validating distress
		Containing distress online by acknowledging, validating and reframing
		Enlisting husband's help to contain distress online
		Managing a lot of distress online by being containing
		Naming and reflecting on low-level conflict easy
		Need to be able to sit with difficult emotion arising online
		Pacing session sensitively to promote safety
		Using same psychotherapeutic skills to manage distress as F2F
		Working very gently to contain fears
Working with process by video	Adaptations to work with process online	Advising people to take time to process before and after video sessions
		Closeness to camera increasing sensitivity to process
		Contacting family member after session where unsure about their process
		Easier to work with process when family joins from separate devices
		Lively family conversation style easier to manage when on separate devices
		Seeing client emotion build up and working with family to support
		Slower process helps attending to feelings in session and reduce follow-up calls
		Slowing down the process of FI online for clarity
		Slowing down to allow people to experience emotions online and attend to them
		Slowing the pace of systemic FI with more checking out understanding
		Suggesting move to F2F when issues of loss arise
		Using body language visible on camera
	Attending to process may be challenging...	Attention feels different online
		Call quality affects ability to pick up on process
		Camera positioning and lighting affect sensitivity to process
		Clients on video at home may assume clinician has seen things they have not

Higher Theme 1: **'Pulling out the same psychotherapeutic skills'.** Describes use of generic therapy skills in FIp by video		
Theme	Clusters	Codes
		Clinician uncertainty about process by video
		Emotional attunement harder by video
		Family turning cameras off makes reading process much harder
		Harder for clinician to notice emotion developing with more than one person on screen
		Harder to pick up family body language by video
		Intuition - picking up on different forms of communication in room - more difficult online
		Limited process information by video makes clinician less active
		Missing process information when family on one phone
		More obvious F2F than online that family member was being sidelined
		Process can take longer to show itself in video sessions
		Suspicion of missing process online
		Taking longer to notice strong emotions arising
		Therapeutic relationship may be affected by clinician taking longer to identify process by video
	Attending to process may be successful too	Ability to observe dynamic of family on one screen
		Able to read body language of overwhelmed client
		Easier for clinician to pause and comment on unhelpful communications
		Sensing online that woman was triggered by proximity intervention
		Sensitivity to process possible by video
		Similar process issues maybe online as F2F
		Video call process may be similar to home visits F2F
		Working with process of father reprimanding adult daughter
	Differences in flow of therapy by video	Privacy violations in residential placement impact process of therapy
		Sense of less continuity between sessions by video call
		Silences in digital work may be harder for families
		Video context limits natural flow of conversation

Higher Theme 1: **'Pulling out the same psychotherapeutic skills'.** Describes use of generic therapy skills in FIp by video		
Theme	Clusters	Codes
	Endings may be difficult online	Clinician's ending cues may not be understood, especially by people with psychosis
		Endings feel less human by video call
		Endings preferred F2F
		Inventing ritual to overcome struggle with ending video sessions
		Video session endings can feel very abrupt
	Lower emotional temperature by video	Clinician holding back from difficult conversations due to safety fears
		Emotions may be less likely to escalate online
		In hybrid working, stronger feelings come out F2F
		Lack of in-person response may explain low emotional temperature online
		Lower emotional temperature can be advantage and disadvantage
		Lower emotional temperature online can enable therapist to be more direct and less distracted
		Lower emotional temperature online may help processing difficult things
		Online work as barrier to bringing highly emotive material
		People more lilkely to talk about strong emotion F2F than video
		Safer subjects talked about with family after move to video from F2F
		Sensitive subjects may be harder to talk about by video
		Strong emotion less intense by video and easier to cut off from
		Uncertainty about whether video context responsible for avoiding difficult conversations with family
	More verbal expression than body language	Alluding to unclear picture as way into enquiring about process
		Checking out who's agreeing with whom online
		Clinician able to offer emotional containment verbally but not through presence by video
		Commenting on limitations of view to warm context for process observation
		Families body language responses vary but less noticeable
		Greater reliance on verbal responses to understand emotion

Higher Theme 1: **'Pulling out the same psychotherapeutic skills'.** Describes use of generic therapy skills in FIp by video		
Theme	Clusters	Codes
		Harder to manage talkative person with non-verbal cues
		Need for questions to check perception of emotions
		Need to use verbal communication by video in place of body language
		Self-disclosure as way of encouraging families to verbalise process on video call
		Verbalising body language to make up for more organic F2F process
		Working more directly with process by video may be helpful or confronting
	Sense of less emotional connection by video	Clinician adapting to emotional exchange by video but easier to cut off
		Clinician feeling greater separation when family all on one device
		Emotional connection with family reduced by video
		Emotional distance between family members on video helpful for difficult relationships
		Emotional distance of video enabling for both very involved and uninvolved parents
		Family unable to give physical comfort to each other when on separate devices
		Feeling like being on hold when distractions arise on video call
		Human contact different online and affects recognition
		interpersonal connection that happens F2F missing on video
		Loss of felt sense on video similar to PPE F2F
		Meeting family F2F after video felt different

Higher Theme 2: **Doing FI differently.** Describes differences in how FI is done when delivered by VC		
Theme	Sub-themes	Codes
Content differences by video	Adaptations and business as usual	Adaptations for video interventions require more effort
		Adapting BFT sessions online by adding check-ins
		Adapting flash card exercise in Word for online relapse prevention work
		Between session tasks same online as F2F
		Between-session tasks in BFT same online as F2F
		CBT-FI good for encouraging equal voices by video
		CBT-FI work going well despite initial worries
		Hard to judge relative effectiveness of intervention with pros and cons of video
		No obvious differences in between-session tasks online
		Similar techniques online as F2F for making role-plays more comfortable
		Six-stage problem-solving model works as well online as F2F
	Communication skills work can be tricky	Cameras on and off for communication skills with family on separate screens
		Can't do direct communication work with people on separate devices
		Checking in explicitly with quieter voices to promote equailty
		Communication skills exercises online lack feeling of connection
		Communication skills work trickier online
		Communication work in BFT and CBT-FI less impactful online
		Families needed less help than expected with practising communication skills online
		Sense that communication skills work may be harder for more reticient families
	Enactment by video is hard to do	Action based interventions limited or impossible
		Challenge of sculpting online
		Challenges of using space by video leading to more information-giving
		Changing combinations of people and devices as intervention
		Discussions about re-positioning family online not effective
		Families amenable to positioning changes if space allows

Higher Theme 2: **Doing FI differently.** Describes differences in how FI is done when delivered by VC		
Theme	Sub-themes	Codes
		Families focusing on screen rather than each other in enactment work
		Limited abiity to teach communication skills by positioning people
		Online sculpting workaround effective at starting conversation but less powerful
		Physical positioning change in room revealed process not apparent by video
		Seating arrangements can be difficult to manage online
		Two chair work depends on family environment
		Using positioning online to work with relationships
		Working with positioning online lacks 3-dimensionality
	Mapping online harder and needs IT skills	Being in this box hinders creativity
		Challenge of creating genograms by video call
		Clinician being more directive when doing genogram online may be less comfortable for people
		Creative interventions limited by video
		Creative possibilities depend on IT skills
		Difficulty of using digital tools to draw genogram
		Hesitancy to do genograms online maybe related to IT skills
		Mapping and genograms harder by video
		Sculpting alternatives for video may be challenging for people with psychosis
		Using digital tools perhaps easier for younger professionals
		Using Excel for genograms
		Using finger puppets on a felt tray as a sculpting workaround
		Using flipchart for creative work online feels like teaching
		Video as less spontaneous, relies on talking
		Video work less visual
		Workaround for genogram
		You can't play in the same way
		Collating information on screen helped service user with memory challenges

Higher Theme 2: **Doing FI differently.** Describes differences in how FI is done when delivered by VC		
Theme	Sub-themes	Codes
	Sharing information digitally in session	Emailing resources alongside video work to empower families
		Families more open to recording sessions by video
		Family accepted using flipchart online for creative work
		Family less willing to comment on information video when played online
		Recording families as information in sessions
		Screen-sharing prompt sheet to facilitate communication skills exercise
		Screen-sharing videos and slide shows main digital tools used
		Setting between-session tasks by sharing electronic resources and asking families to write things down
		Setting between-session tasks feels less formal and substantial without pieces of paper and physical diary
		Sharing information websites through screen share, email or family screenshots
		Sharing screen and web resources in online FI
		Sharing screen flexibly helpful for psycho-education
		Sharing screen to facilitate BFT interventions
		Sharing videos in online work helpful
		Showing video of recorded FI helpful
		Video helpful for monitoring difficulties at home such as hoarding
	Slow down and carry on	Check-ins in early appointments help build rapport
		Check-ins introduced for video sessions took up a lot of time
		Slower pace of BFT online with fewer interventions
		Spending longer warming context for interventions online
		Using conversation to warm context for BFT interventions
		Video work takes longer than F2F
Impact on clinicians	Clinicians more directive by video	Being a more instructive professional on video
		Being more instructive when session feels chaotic
		Easier online to gently interrupt people in CBT-FI

Higher Theme 2: **Doing FI differently.** Describes differences in how FI is done when delivered by VC		
Theme	Sub-themes	Codes
		Interrupting in CBT-FI feels less rude online
		Taking ownership of problem-solving online
		Tendency to do more psycho-education online
		Video facilitates clinician being more directive in CBT-FI
		Video may set up expectation of clinician being instructional
	Pros and cons of video work for clinicians	Little oversight of impact of working from home
		Sculpting skills rusty after all-video work
		Students training digitally lack F2F experience
		Training in CBT-FI all currently online
		Training in video work perceived as evangelising
		Video aids clinician time management
Who's on which device	How do families choose how to join	Deciding who joins from which devices in initial appointments
		Family choices about who joins on which device mostly practical
		Family joining on one device due to lack of space or only having one device
		Family members often choosing separate devices
		Negotiating who joins from which device to help acceptability
		Parents often on one device
	Manipulating people and devices as intervention	Changing combinations of people and devices as a process intervention
		Mixing up who joins from where
		Swapping people between devices can be helpful intervention
		Using multiple screens as adaptation to facilitate enactment work dependent on family economic resources
	Pros and cons of who joins where	Anxious family member on own device facilitated engagement
		Clinician feeling frustrated sometimes when family working on communication on one device
		Clinician feeling greater separation when family all on one device
		Easier to work with process when family joins from separate devices
		Family members and clinicians all on separate devices feels more like level playing field

Higher Theme 2: **Doing FI differently.** Describes differences in how FI is done when delivered by VC		
Theme	Sub-themes	Codes
		Family sharing one laptop with unhelpful seating arrangement
		Feeling of separation vs better family connection when on one device
		Greater clinician control of dynamic when family on separate devices
		Lively family dynamics easier to manage when on separate devices
		Missing interactions in skills work when family on one phone
		Most people join from separate devices which works well
		People on same camera not necessarily facing each other
		Using own device gave choice of how to engage
		Whole family on one phone is problematic
Working with co-therapists and teams by video call	Adaptations for working online with co-therapists and reflecting teams	Adaptations aimed at making reflecting team acceptable online
		Following systemic tradition of reflecting team on video relay
		Important to be able to turn sound and video off when working with reflecting teams online
		Planning sessions more consciously with colleagues for video session
		Preparing a reflecting team for working by video
	Challenges of working with co-therapists and reflecting teams online	Clinician loses visual sense of family response to reflecting team when videos turned off
		Lead practitioner as co-therapist was distracting
		Video inhibits co-therapists' opportunities to develop relationship
		Video inhibits consultation between co-therapists
		Working with co-therapist less spontaneous online

Higher Theme 3: **Empowering and enabling families.** Describes how families and service users may be empowered or enabled through FIp by VC		
Theme	Sub-themes	Codes
Families empowered by video work	Families have more agency	Client controls their device
		Families more proactive when online
		Family control of session environment
		Need to consult service users about digital services
		Separation of video representative of family agency in change
		Video sessions in people's homes may be less intrusive than F2F
		Video work flattening hierarchies between 2 therapists and family
	Learn and using video skills	Families more relaxed by video
		Families with younger members more adaptable to using IT
		Older adults can learn to use technology
		Positive role for service user supporting parents with tech
		Some families better with technology than clinicians
Psychosis and video call	Mixed picture of access to video for people with psychosis	Ability of people with psychosis to access video may vary
		Recovery journey as context for ability to engage online
		Video call tolerated by client with paranoid beliefs
		Video from home may be more comfortable for service users
		Video sessions may be challenging for someone with paranoid beliefs
	Pandemic was challenging for many service users	Harder to reach service user after transition to video in lockdown
		Psychosis began in lockdown or attributed to it
	Supporting people with psychosis to access video sessions	Arranging support for vulnerable people to enable access to video sessions
		Engaging people with profound psychosis with IT support
		Gentle and graded support for client to use IT
		Lack of support to connect may be barrier to access for person with psychosis
		Need to prepare someone very unwell for online FI
		Nurses on ward supported clients with IT
		Person with psychosis supported to log on

Higher Theme 3: **Empowering and enabling families.** Describes how families and service users may be empowered or enabled through FIp by VC		
Theme	Sub-themes	Codes
		Relying on support to join session limits service user independence
		Supporting service user to connect to video session at clinic site
Video call as enabling	Enabling access to FI for people who could not attend F2F	Benefit of more family being able to attend balances the difficulties
		Enabling access to FIp for people unable to leave house
		Enabling children to engage who might not want to come to F2F sessions
		Enabling inclusion of both parents makes a massive difference
		Enabling inclusion of client in forensic hospital or under section
		Enabling inclusion of distant family member
		Enabling inclusion of family elsewhere in country
		Enabling inclusion of family members abroad
		Enabling inclusion of person who feels unable to use technology
		Enabling working family members to engage
		Increased access to FIp for older adults
		Video as positive experience making FI feasible for more families
		Video enabling work with families who would not accept home visits
		Video opens FI up to more families with many more family members able to join
	Video convenient for families	Convenience of video call for families
		Convenience of video for getting people together
		Video context enabling a 9am start
	Video more accessible for some people	Video enabling work with neurodiverse family members
		Video work more accessible for family member with hearing impairment
		Video work reduces travel costs

Higher Theme 4: **Learning to live with video work.** Describes experiences of learning to deliver and accept FIp by VC		
Theme	Sub-themes	Codes
Clinician responses to video context	Becoming more positive about video work	Assumption that families would prefer all F2F post-covid proved wrong
		Belief that experience of video sessions will improve as technology gets better
		Experience of video challenged assumption it would not be possible
		Feeling more comfortable working online with time
		Future technology may be more enabling
		Idea of a chemical exchange in-person less salient with experience of video
		Making the most of video call
		Strong rapport with families online was surprising
	Continuing reservations about working online	Clinician feeling less engaged in video calls to plan FI work
		Clinician feeling less engaged with interactions by video
		Concern of losing F2F skill set which is different to online
		Fatigue and boundary blurring with working online from home
		IT skills being pushed was aversive
	Reflexivity concerning beliefs	Awareness of own assumptions and biases
		Awareness that responses to video may differ from families'
		Identifying as a 'dinosaur' compared to some others
		May be difficult to distinguish assumptions from experience
		Reflecting on bias towards F2F
		View that people being happier with video is sad indictment of life may be biased
		Worry about person storming out may be based on assumptions
Communication outside video sessions	Informal chats less straightforward by video	Informal conversation more forced in video sessions
		Lack of chat before and after may be helpful or unhelpful for families
		Replicating informal conversation time pre and post sessions
	More emails	Contracting about limits of ability to respond to emails between sessions
		Emailing information not too far in advance

Higher Theme 4: **Learning to live with video work.** Describes experiences of learning to deliver and accept FIp by VC		
Theme	Sub-themes	Codes
		Emailing links may result in more correspondence
		Emailing resources more labour intensive
		Families may not have read leaflets emailed in advance
		Ground rules more fomalised when typed up and emailed
		Pros and cons to increased email contact
		Using email more for appointments and information
Distractions on video calls	Distractions present challenge and opportunity	Discussing how to manage distractions like phone calls in ground rules
		Distractions in home environment as means of procrastination
		Distractions make work unpredictable
		Distractions when clinician home working embarrassing initially
		Rolling with distractions on video call
		Shared experiences of bad internet and distractions humanise the context
	More distractions online	Children as distraction in home environment
		Many possible distractions in video session
		More distractions in pandemic
		More distractions on video than at clinic
		Video limits clinican ability to control session environment
	Self-view as distraction	Clinician witnessing self on screen as unpleasant
		Helpful to witness own facial expression of sympathy
		People on video feeling witnessed and on best behaviour
		Self-view distracting for people with body image problems
		Shared experience of clinician and family coping with witnessing selves on video
		Some people don't want to see themselves on screen
Learning to do video call work	Flying by the seat of your pants	Everyone initially trying to work it out
		Initially earning by trial and error
		Initially flying by the seat of your pants
		Learning as we went along

Higher Theme 4: **Learning to live with video work.** Describes experiences of learning to deliver and accept FIp by VC		
Theme	Sub-themes	Codes
		Learning quickly as needs arose
		Learning through suck it and see
		Learning to use apps like spreadsheets as required
		Surviving the terror of the beginning
	Learning from colleagues	Clinicians having conversations to develop video practice
		Clinicians supporting each other to find way to do video work
		Colleagues learning experientially online together
		Finding out about blurring screen 6 months after starting video work
		Learning about fit-to-frame in MS Teams from co-therapist
		Learning from experience and good supervision
		Learning from other clinicans' online practice
		Learning how to use digital tools alongside co-therapist
		Learning MS Teams mainly from colleagues and passing onto families
		Learning to work by video with other clinicians
		Peer group as opportunity to discuss guidance for online work
Parallel contexts impacting video work	Anxiety and scepticism at starting video work	Anxiety about limitations as therapist online
		Fear that all clinical work would stop when lockdown hit
		Initial anxiety about doing video work right
		Initial anxiety about working online
		Initial anxious feelings about working with distress online
		Initial belief that video FI would not be workable
		Initial concerns about missing information, reticence and managing conflict online proved less bad than expected
		Initial concerns about video work lessened by families' appreciation of it
		Initial scepticism about video work
		Initial uncertainty about FI online
		Initially questioning ability to connect and empathise by video

Higher Theme 4: **Learning to live with video work.** Describes experiences of learning to deliver and accept FIp by VC		
Theme	Sub-themes	Codes
	Challenge of being thrown into it	Challenge of being open to helpful new digital tools
		Challenge of learning digital tools for mapping etc
		Clinicians now working through legal and ethical challenges where work might previously not gone ahead
		Experience and confidence maybe needed to try online working
		Feeling challenged by online context
		Knowledge and skills relate to F2F work, not video call
		Newness - having to attend to unfamiliar things
		Newness may explain different quality of attention
		Overcoming challenges of video work
		Thrown online by pandemic
		Video harder for clinician than families
		We never dreamed of doing it
	Pandemic shaping a new normal	Between-session tasks completed more due to lockdown
		Imperative to work by video to manage risk in lockdown
		In lockdown, video work was beneficial choice
		Lockdown as context for supportive and collective learning
		Missing touch may have related to video or lockdown
		Online was only choice in pandemic
		Pandemic as parallel context for video work
		Pandemic as stressful context for starting video work
		Pandemic context normalised video calls for families
		Pandemic stimulated guides to online work
		People more used to online work since pandemic
Resources to enable video call sessions	Resourcing video work for clinicians and families	Considering permissions to use school device for sessions
		Family members sharing resources where one lacks know-how or kit

Higher Theme 4: **Learning to live with video work.** Describes experiences of learning to deliver and accept FIp by VC		
Theme	Sub-themes	Codes
		Managers may assume clinic space no longer needed
		Need for confidential space for video sessions same as F2F
		Need for same clinical space at team base for onine FI
	Supporting families to use technology	Advice on stable phone position in information sheet
		Clinician like IT department
		Email use as sign that older adults may be able to engage online
		Getting support for someone struggling with technology
		Lot of work to enable older parents to use technology
		Need teaching facility to support older people to use technology
		Question of how to teach people to use IT with minimal input
		Sending information sheet to families help log on
		Sending YouTube video on how to use technology
		Supporting clients by phone to get started
		Supporting people to use phone for video
		Trainees could run IT sessions
Training, guidance and support for video work	Guidance rather than training received	Guidance for clinicians now available but not at start of pandemic
		Guidance for online work was mainly written
		Guidance for online working released at start of pandemic
		Guidance from AFT on safeguarding in video work
		Guidance on looking at camera to simulate eye contact
		Guides from Trust to using technology
		Limited guidance felt uncontaining
		Meriden produced helpful guide to setting up work and risk
		More written than hands-on training resulted in learning on the job
		No formal training received in working online
		No training before starting online FI

Higher Theme 4: **Learning to live with video work.** Describes experiences of learning to deliver and accept FIp by VC		
Theme	Sub-themes	Codes
		No training in online FI received
		Reading generic therapy guides to online working
	Organisations need to understand how to support video work	Guidelines for working by video call would be helpful
		More organisational understanding and support needed if video is offered
		Need for investment in IT equipment for NHS staff
		Organisations need to ensure service users are supported to understand implications of choosing video work
		Organisations should assess clinicians' skills and offer practical support
	Supervisors and supervisees in the same boat	Helpful conversations with supervisor new to video
		Hope that supervisor would monitor imoact of working online from home
		Intense relationships in online supervision group
		Learning from 'how to' conversations as supervisor
		Online supervision group as encouraging 'angels on my shoulders';
		Parallel process between online supervision and online therapy
		Peer supervision helpful as learning space
		Peer supervision helpful as learning space (2)
		Reflecting in supervision on observations on screen
		Regular supervision as important online as F2F
		Supervisor and supervisee learning together like everyone else
		Supervisor had not done online therapy before
		Using digital recordings to inform supervision
	Wanted - practical and accessible training in online FI	Need to learn IT skills and how to apply them in clinical practice
		Research into how technology can be applied in FI would be helpful
		Specific training in FI online could be helpful
		Training needs to acknowledge limitations and find work-arounds

Higher Theme 4: **Learning to live with video work.** Describes experiences of learning to deliver and accept FIp by VC		
Theme	Sub-themes	Codes
		Training on MS Teams far too technical for clinicians' starting abiities
		Training specific to family work by video would be good
		Training wanted with ideas to overcome challenges of video working

Higher Theme 5: **Technical problems.** Describes how limitations of technology, connection and IT skills impact FIp by VC		
Theme	Sub-themes	Codes
Connectivity and IT skills matter	Devices may be divisive	Audio problems due to inadequte NHS equipment necessitate using headphones
		Connectivity affected by device type and where people live
		Device type used not always obvious
		Impact of device on family positioning
		Preference for people using a laptop
		Webcam quality affects what clinician is able to see
		Working out audio problems at start of FI online
	Getting (dis)connected	Challenge of technical problems slowing down or distracting from sessions
		Clinician concern at being distracted from attending to process by poor call quality
		Clinician internet connection problems quite anxiety-provoking
		Connection drop-outs appear more likely from family end than Trust server
		Connection problems feel ok or very frustrating at different times
		Connectivity issues appear to be constant
		Connectivity problems really frustrating
		Families assuming responsibility for connection problems
		Families generally understanding of clinician dropping out
		Family members' engagement may be more affected by poor connection, being in phone and onscreen distractions
		Limited impact of connection problems
		Lost connection a challenge in online FI
		Marked variation in experience of call quality
		Minor call quality problems perhaps less disruptive to relationship than expected
		More connection problems at start of pandemic
		Occasions when Trust server appears to cause freezing for clinicians and colleagues
		Poor call quality undermines ability to respond to minutiae of family communications

Higher Theme 5: **Technical problems.** Describes how limitations of technology, connection and IT skills impact FIp by VC		
Theme	Sub-themes	Codes
		Poor connec tion making conflict management challenging
		Poor connection causing speech delays and drop-outs
		Sense that connectivity issues are improving but can still be very bad
		Session starts typically delayed due to joining issues
		Technical issues alongside successful work
		Technical issues experienced with most families
		Technology frustrations for clinicians
		Using phone for audio to save bandwidth gives a delay
		Varying call quality seems acceptable to people unless very bad
		Video session beginnings disrupted by getting everyone connected
		Wi-Fi shame experienced by clinician
	Impact of tech abilities	Avoiding digital tools that challenge IT skills
		Challenge of being open to helpful new digital tools
		Challenges with technology may be barrier for any family member
		Clinician identifying with people who might feel excluded by technology
		Clinician impressed by family members' technical ability
		Families unfamiliar with using technology may experience anxiety
		Person with technical challenges may be disadvantaged and feel disconnected
		Phone settings may result in poor framing on video call
	Stable platform for video FI	Availability of good technology and connection informing choice to do video sessions
		Need for adequate bandwidth
		Need for clinicians to have stable connection
		Need for stable connection and session environment for full range of FIp work
		Need for stable prop for phone used for video call
		Need to have all family members online with good connection
		Reliability of video platforms improved

Higher Theme 5: **Technical problems.** Describes how limitations of technology, connection and IT skills impact FIp by VC		
Theme	Sub-themes	Codes
		Unstable framing using phone for video session as mirror to chaotic lives
		Video as stable platform during pandemic
Limitations of camera and screen	Blinkered by the camera field of view	Field of view limits information about home environment
		limits of small video windows as challenging
		Limits to using body language to communicate by video
		Missing extra information from visiting family home in person
		More advanced cameras might allow better interaction
		Person's camera position dictates clinician's view
		video window size limits sensitivity to process
		View can be very limited by tech problems
	Inability to communicate with gaze	Can't engage quieter people with eye contact
		clinician unable to use gaze to invite others to speak
		Direction of gaze onlline makes two-chair work harder
		Inability to communicate individually using gaze by video
	Turning off the camera	Challenge of family members having camera turned off
		People joining from work may choose to turn camera off
Platform and medium differences	Attend Anywhere a 'bleep bleep bleep' nightmare	Attend Anywhere a 'bleep bleep bleep' nightmare
		Attend Anywhere as unstable platform
		Attend Anywhere may restrict use of creativity tools
		Attend Anywhere not geared up for FI
		Family able to connect to Teams but not Attend Anywhere
		Zoom a bit better than Attend Anywhere
		Zoom more stable than Attend Anywhere
	Platform as a Hobson's Choice	Clinician frustration with lack of platform choice
		Families have accepted using Trust approved platform
		Governance limiting family choice of platform
		Governance limiting platform choice

Higher Theme 5: **Technical problems.** Describes how limitations of technology, connection and IT skills impact FIp by VC		
Theme	Sub-themes	Codes
		Negotiating tech choices with family where governance allows
		Platform choice contentious during transition to video
		Platform choice more open at start of pandemic before Trust guidance established
		Using less secure WhatsApp when Trust platform fails
		Using Trust approved Teams felt fine
	Platform choice affecting families	Client familiarity with video call platforms helpful
		Family familiarity with platform helped engagement
		Platform choice debated by clinicians not clients
		Platforms needing more data affect less well-off families
		Platforms with simple connection procedure better for engagement
	Skype felt to be problematic	People disappear into little black boxes on Skype
		Platforms like Skype that prioritise loudest voice make it hard to invite other voices if conflict arises
		Skype makes it harder to move people around
		Teething problems with unpopular Skype at start of pandemic
	Video better than phone	Phone as less successful option
		Phone less successful device for video calls
		Video call more workable than phone
	Zoom generally preferred as platform	Clinician preferring Zoom for private work
		Clinicians finding Zoom easier to use than Teams at start of pandemic
		MS Teams preferred to Zoom for professional meetings
		My preference is Zoom
		Teams platform similar to Zoom Gallery mode but harder to log in
		Zoom a bit better than Attend Anywhere
		Zoom more stable than Attend Anywhere
		Zoom preferred platform for Gallery mode
		Zoom preferred to Teams

Higher Theme 6: **Video as option rather than default.** Describes the feeling that VC is best as an additional option and should not replace F2F		
Theme	Sub-themes	Codes
Keeping the options open	Hybrid working as an option	Hybrid working with some people F2F and some online
		Keeping choice between video and F2F a live issue
		Mix of F2F and video better than video alone
		Taking opportunities for F2F between video sessions
		Using F2F as an addition to video
		Working flexibly between video and F2F
	Mixed experiences of family preferences	Differing responses to F2F after video sessions
		Famiies now more likely than not to choose video
		Families chose F2F whenever feasible rather than video
		Families may choose video for sake of convenience
		Families more accepting of video than at start of pandemic
		Families requesting of out of hours appointments by video
		Families welcomed digital offer during pandemic but less so now
		Family choice may be informed by circumstances
		Family not worried about video but opted for F2F when available
		Many families prefer video due to geographic spread
		People less welcoming of video call since lockdown ended
		Some people like emotional, relational connection of F2F
	Need to keep video sessions available	Awareness of NHS move to offer digital choice
		Context informing suitability of offering video as choice
		Established video experience as additional tool
		Families have a right to be offered video as choice
		Offering phone, video or F2F as option for initial meeting
		Post-pandemic ability to offer video as choice in 'soft launch' approach

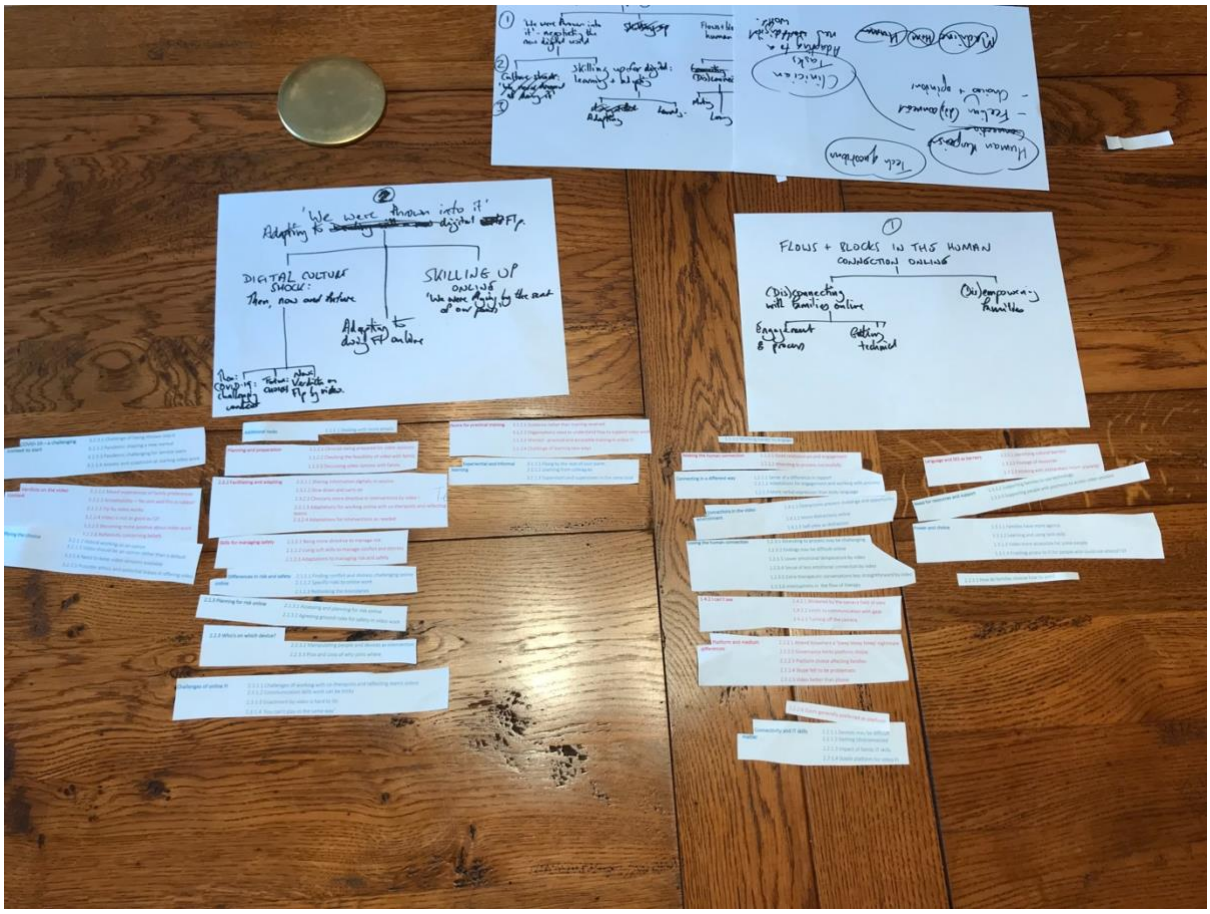
Higher Theme 6: **Video as option rather than default.** Describes the feeling that VC is best as an additional option and should not replace F2F		
Theme	Sub-themes	Codes
		Some people may prefer remote work to home visits F2F
		Video as additional string to bow
		Video as important option to bring dispersed people together
		Video call beneficial as a choice to offer
		Video call here to stay
		Video call part of choices offered in setting up work
		Video positive as long-term offer for families who would not be able to access FI otherwise
		Video work now very familiar
	Provider ethics and potential biases in offering video	Clinician preference for visiting home may not be shared by family
		Clinicians may prefer online for practical reasons
		Difficulty for families of choosing between F2F and video without understanding all implications
		Ethical and supervisor pressures for clinician offering choice between F2F and onine FI
		Ethical position of ensural personal bias does not interfere with offering video as choice
		Sharing ambivalence about video in conversation about family choices
	Video should be an option rather than a default	Clinician perception of digital evangelists
		Clinician thinking during FI screening about recommending online or F2F
		Evidence base lacking for exclusively digital FI service
		Need tlo put energy into retirning to F2F post-pandemic
		Offering convenience of home visits probably better than online
		Offering video as only option would exclude some people
		People appreciate video work but still prefer F2F
		Pleased to have F2F choice as well as video
		Prefer emphasis on home visits with video as option
		Process clearer and attended to differently F2F
		Risk of defaulting to video work when F2F possible
		Video as option rather than default

Higher Theme 6: **Video as option rather than default.** Describes the feeling that VC is best as an additional option and should not replace F2F		
Theme	Sub-themes	Codes
The big fight - video vs F2F	Acceptability – 'No one said this is rubbish'	Families have generally adapted to video sessions
		Family members able to attend by video have valued relapse prevention work
		Family responding well to online CBT-FI
		Mixed experiences of video work but well-received overall
		Most families have valued having support by video
		Positive feedback from family despite technical problems
	Commonalities between video and F2F	Feeling that difficult piece of work would not have been better F2F
		Nuts and bolts of therapy same by video as F2F
		Recognising F2F and video work each have value
		Relationship building key whether by video or F2F
		There are things you can and can't do
		Working with loss similar by video to F2F
	FIp by video works	Favourable overall impressions of video
		FIp by video works
		General impression that online FI seems to work
		General impression that online FI works
		Getting results in online work
		Online CBT-FI feels helpful after only 2 sessions
		Online FI works
		Overall sense of outcomes being similar to F2F
		People benefit from online FI
		Positive change experienced online
		Some cases video worked extremely well, some not
		Therapeutic outcomes good enough or good
		Video can be effective and safe
		Video sessions as important and valuable way of engaging and supporting families
		We are still doing therapy
		Worthwhile interventions by video when F2F impossible

Higher Theme 6: **Video as option rather than default.** Describes the feeling that VC is best as an additional option and should not replace F2F		
Theme	Sub-themes	Codes
	Specific outcomes	Family less engaged in between-session tasks electronically
		Narrative shift about psychosis in online FI
		No nightmares around risk but who knows
		People find online communication skills work helpful
		Positive behaviour outcomes by video
		Problem solving works quite well online
		Process shift in online work
		Success of between-session tasks for video clients
	Video is not as good as F2F	Clinician prefers F2F
		Convenience may compromise commitment to work
		No new opportunites for FI offered by digital functionality
		Perception that exclusively digital service would have questionable efficacy
		Some things more difficult on screen
		Value sometimes for client in leaving house and having informal interactions around sessions
		Video call does not mimic social interaction perfectly
		Video call is great but no substitute for F2F
		Video can be helpful but not as good as F2F
		Video problematic in different ways
		Wrong to assume that video sessions are equivalent to F2F

B5d: Clusters and sub-themes cut up and reorganised

by trial and error, referring back to raw data



Appendix B6. Extract of coded transcript

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Appendix B7. End of Study Form

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Appendix B7. Summary of Study Results for Participant Feedback

B7a: Practitioners

Experiences of Family Interventions for Psychosis by Video Call

Narrative summary of findings

For this study, 11 practitioners were interviewed about their experiences of family interventions by video call. A form of thematic analysis was used to analyse the transcribed interviews, recognising that the researcher has an influential, interpretative role in identifying themes in the data. Two family members were also interviewed; this data will be treated separately in the analysis, and is not included here.

Two main areas of experience were identified. The first was called '**The digital demand: Being 'thrown into' FIp by video.'** This describes the sense of video work as being a different culture, which participants largely felt 'thrown into' when COVID-19 struck, and to which many had strong responses. Many described feelings of anxiety and scepticism about the video medium to begin with, and for a few, those negative responses endured with experience. The jury appeared to be hung as to how well FIp by video call can work. Some participants noted that families generally accepted working by video, that outcomes were good, and that 'we are still doing therapy'. Others felt that the video context was problematic, and that it was 'no substitute' for in-person work. However, most participants thought that it was at least a helpful offer when face-to-face work was not possible, and that it should continue to be offered to families, perhaps as an option rather than as a default.

The video call culture carried demands of new and often unfamiliar tasks, and participants described having to learn very quickly in the challenging context of the

pandemic. Most participants described learning through experience and discussions with colleagues and supervisors/supervisees who were 'in the same boat'. Written guidance was consulted, but only one participant described practical training, which was in the use of the video platform and not pitched at the correct level for the trainees. Extra planning and preparation were a common way of compensating for this. Many participants spoke of adapting their work by sharing digital resources such as videos with families during sessions. However, some also felt relatively unskilled in IT and saw video work as a barrier to creative interventions such as using genograms. Organisations were seen as needing to support practitioners by providing practical training and good quality equipment and by protecting clinical spaces for online work.

Managing risk and safety, conflict and distress within the video call culture was a common concern. Participants spoke of anxieties around clients leaving the call during or after a difficult session, and of addressing these challenges when discussing ground rules. There was also concern about working with people in unsafe relationships via video call. That said, no serious risk incidents were reported. Participants described using more assertive techniques to manage risk, such as checking in verbally more often during sessions and making follow-up phone calls where necessary, and some also spoke about being able to use traditional therapeutic 'soft skills' by video, such as sitting with distress. Boundaries of privacy and confidentiality were another common safety issue, for example, family members joining from their garden or car.

The second main area of experience identified was called '**Flows and blocks in the human connection online.'** This theme reflects a preoccupation in participants' accounts with their ability to connect with families, to form therapeutic relationships and to work with

more subtle communications underlying the spoken word. Again, experiences differed, with some feeling that good relationships were formed by video and that it was possible to be sensitive to family process, while others sensed a distance in the emotional connection by video and felt it was harder to be attuned to process information. Adaptations reported included slowing the pace of sessions to attend to process and taking more time to establish relationships online.

The functioning of technology was experienced as a factor in the ability to connect. The camera field of view limited the information available to practitioners, both in terms of family body language and the family environment. Poor quality internet or equipment affected what could be seen or heard, and more serious connect drop-outs were experienced as a frustrating distraction. There was concern also that technology problems may affect less well-resourced families disproportionately. Having family members on separate devices meant that their facial expressions may be easier to read, especially if they use a laptop or PC rather than a phone, and some participants reported finding it easier to work with lively family dynamics in this way. However, this may be at the expense of family members' feeling of connection, not least because of the limits of using eye gaze, and their ablity to soothe each other when someone becomes distressed.

A frequently mentioned benefit of video call was that it enabled family members to join sessions who might otherwise have been excluded for reasons of geography, work or other commitments, health, and so on. Some felt that, in addition to offering a choice, the video context gave families more power and agency, for example in having control of their device and in using existing IT skills or learning new ones. However, the need to support

some people to use technology was often raised. In particular, it was noted that service users may need support to join video sessions, which may be a challenge in some settings.

Theme hierarchy with draft descriptors

1. **THE DIGITAL DEMAND: BEING 'THROWN INTO' FIP BY VIDEO**. *The over-arching theme 'The Digital Demand' describes the experience of participants finding themselves online because of the COVID-19 pandemic. There was a sense of culture shock as clinicians who had trained and practiced for many years face-to-face had to transfer their skills to the video context as best they could. Although there was written guidance for working online, clinicians had little practical training, and most described learning by experience and through conversations with colleagues.*

   1.1. The Digital culture shock. *Many clinicians described anxiety and scepticism at the change. However, verdicts with the benefit of experience were more mixed, with some seeing video as a helpful alternative to face-to-face and others viewing it as clearly inferior. These differences were also reflected in views about how video call should be offered as a choice.*

   1.1.1. **COVID-19 - a challenging context for starting video work.** *This sub theme describes participants' descriptions of their responses to the challenge of being 'thrown into' video work at the start of the pandemic. Many participants remembered feeling anxious and/or sceptical about the new medium. However, some felt that video helped them carry on when in-person contact was not possible and that video was even normalised, while others noted what a stressful time it was for everyone.*

   1.1.2. **Hung jury - verdicts on video.** *This sub-theme captures the difference of opinion between participants about working by video, with some saying 'it seems to work' and others that it is 'no substitute' for in-person FIp. Some participants noted that they became more positive about the format with experience, and others reflected on potential bias in their views. A few clinicians commented on broader impacts of video work, for example concerns about losing in-person skills.*

   1.1.3. **The digital offer.** *This sub-theme describes participants' comments about services offering video FIp. Many participants felt that video remains a beneficial choice to offer families, but some were concerned that it should not become the default option. A few noted the potential for bias to affect how the choice is offered, perhaps, for example, because video is more convenient for some providers.*

   1.2. 'A little bit more effort' - adapting to the digital workplace. *This theme describes clinicians' experiences of adapting their work for video sessions. Many participants spoke of doing extra work in the process, whether in preparing the sessions and communicating with families, or in seeking ways to adapt specific interventions to the video context.*

   1.2.1. **Planning and preparation.** *This sub-theme concerns participants' comments about getting ready for FIp by video. Some participants reported that the online context resulted in more email contact, and a few described doing extra thinking and preparation for the sessions. Many participants spoke about processes of*

planning for video work with families, for example checking what access family members have and conducting pre-session connection checks.

1.2.2. **Facilitating and adapting.** *This sub-theme gathers participants' comments on adapting sessions for the video context. Most participants described sharing information digitally, for example by sharing their screen to play videos. Some described slowing the pace of the work, while others felt they became more directive. Adaptations mentioned included inviting people to turn cameras on and off, for example during communication skills work or when working with a reflecting team.*

1.2.3. **Challenges of online FI.** *Many participants described experiencing barriers to their usual ways of working. For example, one commented 'you can't play in the same way,' reflecting many people's experiences of not being able to work so easily by drawing maps or moving people around. A few participants described difficulties specifically with communication skills work, for example because of a lack of felt connection. Other noted difficulties working alongside co-therapists and reflecting teams.*

1.2.4. **Who's on which device?** *This sub-theme captures participants' descriptions of the impacts of whether a family joined on one device, on separate devices or a mix. Most participants gave pros or cons of these arrangements, for example, one felt that it was easier to manage lively family dynamics when they joined on separate devices. Some participants commented on how families choose how to join, and a few described changing combinations as an intervention.*

1.3. 'Trial and error' - learning FIp by video. *This theme describes how participants thrown into the video world initially learned from experience, from each other and from any written guidance available at the time. Many found conversations with colleagues most supportive. The vast majority had no partial training, although many thought that would be helpful.*

1.3.1. **Experiential and informal learning.** *This sub-theme captures descriptions from many participants of having to learn rapidly when the pandemic began, which one called 'flying by the seat of your pants.' Most spoke about colleagues supporting each other by sharing their knowledge and experiences. Those who spoke about supervision said it was helpful, even though in all cases the supervisor was not experienced in working by video.*

1.3.2. **Desire for practical training**. *Most clinicians described reading guidance for doing online work was available but not receiving training. Some expressed a wish for practical training with a focus on specific techniques for doing FIp by video. A number of participants also commented on the need for organisations to support video work, for example by providing appropriate clinic spaces and equipment.*

1.4. Managing risk and safety online. *This theme captures clinicians' experiences of managing strong emotion and risk issues by video call. Most participants spoke of differences in managing risk and safety, and many also reflected on boundary changes, for example when families and clinicians are joining from home. Clinicians described using a variety of skills, including adapted planning, and being more directive about containing conflict or distress*

1.4.1. **Differences in risk and safety online.** *This sub-theme captures participant's experiences of risk and safety as being different online. Most clinicians revealed*

feeling challenged by this, for example if someone drops out or disconnects during a difficult session. Many also spoke about differences in boundaries for online work, with most concerned about protecting their clients' privacy and confidentiality.

1.4.2. **Skills for managing safety.** *This sub-theme describes participants' experiences using their skills to manage risk and safety. Most spoke about additional risk planning with families, for example addressing in the ground rules how people wish to be supported if they become distressed. Some clinicians noted intervening in a more direct way when emotions escalate, whereas others spoke of using softer skills, such as empathy and validation, to contain distress.*

2. FLOWS AND BLOCKS IN THE HUMAN CONNECTION ONLINE. *The over-arching theme 'Flows and blocks in the human connection online' describes participants' experiences of relating to others by video call, including forming therapeutic relationships and processing emotions. While many participants described forming good relationships online, others felt that there was less of a connection. Many described technical barriers to relating, including the limited view of the camera or video platform, the technical skill of participants and the quality of the internet connection.*

2.1. (Dis)connecting with families by video. *The theme '(Dis)connecting with families by video) describes the contrasting reports of clinicians, some of whom described having a good rapport online while others felt that the human connection was limited and that it was harder to pick up on subtle communications. Some participants commented on a different feeling to the online relationship and described adaptations they had made. Many reported using speech to compensate for body language hidden by the camera.*

2.1.1. **Connecting in a different way.** *This sub-theme collects descriptions from some participants of sensing a more abstract kind of difference in the rapport created with families online, for example the sense of not having met before when seeing a family face to face after video work. Many clinicians had made adaptations to facilitate engagement, such as slowing the pace of sessions, and several also reported using verbal responses to families where body language might be hidden from view.*

2.1.2. **Making the human connection.** *This sub-theme collects participants' accounts of building good relationships with families and of being sensitive to process by video call. Some clinicians felt that there was no difference in building rapport online, and one even found that it was easier to interrupt and comment on unhelpful family communications.*

2.1.3. **Losing the human connection.** *This sub-theme captures the experience of many participants that there was something missing in the human connection online. Most felt that it was harder to pick up subtle family communications online. Specifically, many also noticed that families brought less emotion to video sessions, and that there was a sense of emotional distance. Several also noted that endings could feel difficult. A few missed having spaces for informal chats and felt there was less flow in the work.*

2.1.4. **Distractions in the video environment.** *This sub-theme contains participants' experiences of distractions during video calls. A small number felt there were more distractions online, although descriptions of the impact were mixed. For*

example, one participant felt that distractions like the doorbell going humanised the sessions, whereas another felt like they were on hold when distractions occurred. A few participants spoke about the self-view on screen as a specific distraction for clinicians and family members.

2.2. <u>Video (dis)empowering families</u>. *This theme describes how families may by empowered or disempowered by video FIp. Many participants described how the video context enabled more people to take part for reasons including work and geography. Some noted that video may be more accessible, for example for neurodiverse people. Participants also described how video may offer families more agency, for example having control of their device, using their existing IT skills and learning new ones*

2.2.1. **Power and choice.** *The sub-theme 'Power and choice' describes participants' accounts of families being empowered by the video context. Some felt it offered agency, with one reporting an example of a family that became more proactive in seeking information online. A small number of participants felt that learning and using IT had a positive role in people's lives. Many also thought that video call was more convenient, and even more described a major advantage of video being that more family members were able to attend sessions*

2.2.2. **Language and SES as barriers.** *This sub-theme addresses cultural barriers to FIp by video, with most participants having concerns that people with low SES may lack access to good internet and equipment. A small number also felt that someone with 'paranoid' beliefs might be challenged by video calls. Two participants also spoke about working with an interpreter as challenging and better done face-to-face.*

2.2.3. **Offering resources and support.** *'Offering resources and support' collects participants experiences of supporting families and service users to access technology, for example producing an information sheet or links to a YouTube video. Some participants also provided more intensive support, for example conducting phone calls to help someone get started. Several participants noted that service users may need support to join sessions.*

2.3. <u>Can you see me? The technology interface.</u> *The theme 'Have you frozen?' describes ways that technology directly impacts on doing FIp by video call. Participants' accounts included the limited view afforded by the camera which can, for example, disrupt their ability to pick up on family communications or use their own body language to communicate. Most participants noted connectivity problems which, when bad, were frustrating. Device and platform differences were also raised.*

2.3.1. **The disrupting lens**. *The sub-theme 'The disrupting lens' collects descriptions from many participants of the limitations of the view afforded by the camera in video sessions. Clinicians reported that this reduced the information available to them. One also noted that the problem may be exacerbated by technical problems. A few participants commented that the inability to direct eye gaze towards individuals was a specific challenge, and two reported family members turning their cameras off.*

2.3.2. **Connectivity and IT skills matter.** *This sub-theme collects accounts of the impacts of internet connection quality, devices used and level of skills in using*

technology. Many participants reported that phones were less successful than other devices for video calls. All noted connection problems, with many experiencing it as a frustration. However, many participants also felt that these problems were not too disruptive, provided they were not too major. About half described IT skills as a barrier for families.

2.3.3. **Platform and medium differences.** *This sub-theme captures the impact of video platform on video FIp. Nearly all participants reported that NHS governance gave no choice over platform. None reported this as being problematic for families, although 2 noted that knowing the platform was helpful for families. Some clinicians expressed frustration with the approved platform, particularly Attend Anywhere. Many said they would prefer Zoom, although one preferred Teams.*

B7b: Family Members

Summary of Research Study Results: Experiences of Family Interventions for Psychosis by Video Call

Why do the study?
Family interventions for psychosis (FIp) is a therapy recommended for people with diagnoses of psychosis or schizophrenia. However, it is not as widely available as it should be. Doing the therapy by video call has been suggested as one way of making it more available, but we need to know more about it. We therefore wanted to ask service users, family members and practitioners about their experiences of family interventions for psychosis by video call.

How was the study done?
We invited service users, family members and practitioners from 3 different NHS Trusts to take part in an interview. The interviews were written out. We then followed a systematic process to find what themes there were that described how people's experiences. We then grouped together themes that similar meaning.

What were the results?
Unfortunately, it was very difficult to find people who wanted to take part in an interview. We interviewed 11 practitioners, but only 2 family members and no service users at all. Although the results therefore reflect more the experiences of practitioners, the family members' experiences gave different perspectives on these, which was very helpful.

We identified two overall themes. The first was called 'The digital demand: Being 'thrown into' FIp by video call'. It was about how people had suddenly had to work by video call because of the pandemic. The second was called ' Flows and blocks in the human connection online'. This was about how everyone wanted to connect with each other in the video sessions, and ways that this worked and ways in which it did not work.
Each of the two themes were divided into sub-themes, as described below. Some of these had more relevance to families than others.

1. The digital demand: Being 'thrown into' FIp by video call

1.1. *The digital culture shock*: Practitioners recognised the impact of the pandemic on families and on themselves. Having to suddenly start working by video call was an additional challenge. There were very mixed overall opinions about it from practitioners and family members, with some saying it worked well, some saying it had pros and cons, and others saying it was problematic or worse. However, practitioners thought people should have the choice of video call if they wanted it.

1.2. *'A little bit more effort'*: Practitioners reported doing more preparation and planning for video sessions. Some changed how they did things, for example being more directive about turn-taking in conversations. Some practitioners like to draw things out or do activities like role-plays, which they said was harder. Some practitioners also work with a co-therapist or a group of co-therapists, which family and practitioners found tricky.

1.3. *Learning FIp by video*: Practitioners had to learn very quickly, by a mix of practising with colleagues, reading guidance, some training and a lot of learning as they went along. Many practitioners commented on the limits of their technological skills.

1.4. *Managing risk and safety online*: Practitioners talked about their worries about keeping people safe remotely. Privacy and confidentiality were a common concern, although family members did not feel this was a problem for them. However, many participants said that it could be very difficult when there was conflict.

2. Flows and blocks in the human connection online

2.1. *(Dis)connecting with families by video*: Practitioners felt a difference in the relationship with families by video that was difficult to define. They adapted their practice, for example by slowing things down or by using less body language and more spoken word. Some felt that the human connection worked well. Other participants, including the family members, differed in their descriptions of how problematic it was, from noticing a loss of emotional response to feeling misunderstood. Practitioners also noted that there were more distractions.

2.2. *Video (dis)empowering families*: Practitioners and family members appreciated that video allows people to join sessions who would find it difficult to attend in person. Some practioners felt that service users might have more control by joining remotely, although only if they are able or supported to access it. Other practitioners said that people on low incomes or who did not speak English fluently might find FIp by video call more difficult.

2.3. *'You've frozen!' The technology interface*: Practitioners and family members commented on times when poor internet connection interfered with sessions. Practitioners in particular felt that this and the limited view offered by the camera interefered with the human connection too. They also noted that the number of people on each device made a difference, with most preferring one person to each device. However, some pointed out that this was often not a choice but a question of practicality, which one family member also raised.

What do the results mean?

Practitioners had almost all started working by video call as a result of the pandemic. Everyone found the transition a challenge, and although some took to it, others remained sceptical. Participants' feelings of connection in the therapy varied, and at its worst this could be experienced as very distressing for families. Some practitioners felt that working by video call limited how they could work, although many also commented on their limited technological skills. However, many practitioners did report successful therapeutic work by video, and appreciated that it made FIp more accessible to many people. The overall feeling was that working by video call was a new culture. We tend to think of therapy as being people in a room together, and this is largely how practitioners are trained. Perhaps, as we learn more about working by video call and training is adapted, we will find ways to overcome some of the challenges while retaining the advantages.

B7c: Feedback to Research Ethics Committee

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Appendix B8: Feedback to Research & Development departments

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