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<u>Walden University</u>

College of Psychology and Community Services

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Adeola C. James

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Walden University
2024

Abstract

Psychotherapists' Attitudes Toward and Experiences With E-therapy

in Trinidad and Tobago

by

Adeola C. James

MA, City University, London, 2012

BA, St. George's University, Grenada, 2001

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services

Walden University

February, 2024

Abstract

In some parts of the developing world, there are several factors impacting access to mental healthcare, such as limited financial resources, a dearth of mental healthcare professionals, the added burden of stigma attached to needing and seeking help and restrictive COVID-19 measures that were aimed at curbing the spread of the virus. The problem is that while online mental health interventions may be helpful in increasing access to mental healthcare, scholars have noted that there has not been the same rate of diffusion of these technologies among mental healthcare providers when compared with other health practitioners. The purpose of this generic qualitative study was to examine the attitudes and experiences of mental healthcare providers in Trinidad and Tobago about providing online services. The technology acceptance model provided the framework for the study, and data were collected via field notes and in-depth interviews with 10 mental healthcare professionals. The data were then analyzed using an eclectic approach to identify organic recurring themes and constructs. This research may add to the body of knowledge about online mental health interventions in the English-speaking Caribbean. Findings suggest that therapists found these technologies both easy to use and useful, with the subtheme of result demonstrability playing a key role in therapists' perception of usefulness. These findings may impact social change by informing policy guidelines, training, and risk management techniques that guide professional practice and increase access to mental healthcare.

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Dedication

In loving memory of my father, Ashton George James, who returned to Spirit in 2021, and my mother, Carol Ann Birchwood-James, who continues to be the wind beneath my wings in the land of the living. Thank you both for always believing in me.

Acknowledgments

My deepest gratitude to Source Energy/Creator for blessing me with good health, inspiration, and familial and other loving supports that allowed me to remain motivated to complete this program.

My sincerest thanks to my Walden committee. I could not have had a more supportive and knowledgeable committee. Special thanks to my chair, Dr. Benoliel, whose love and empathy saw me through many a rough patch along the road to completion. I thank you for your kindness and going above and beyond what was required of you to make me feel supported in my journey. Thank you.

The completion of this study could not have been possible without the stars of the show, the amazing participants who, in the middle of a pandemic, when therapist burnout was at an all-time high, said yes to a student-practitioner. Thank you so much for your time; your energy was appreciated, and insights that you offered surpassed anything that I could have anticipated gleaning in this study. Thank you for kind assistance.

Special thanks to the Government of the Republic of Trinidad and Tobago, particularly the Ministry of Health Ethics Committee, the Chief Medical Officer, and the administrative staff of the office of the Chief Medical Officer, who treated my application with dispatch. I appreciate all the courtesies extended towards me.

Finally, I thank my family, particularly my parents and my brothers and sisters for their constant encouragement and support to stay the course in the midst of deep personal tragedy and challenge. Special thanks to my brothers Adrian and Chad for their guidance

and direction. I thank you all for your love and for being my rock in the ocean of life.

Love you all!

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Chapter 1: Introduction to the Study

Introduction

This study explored the attitudes towards as well as the experiences of psychotherapists (hereafter called *mental healthcare professionals* or *mental healthcare providers*) in the Republic of Trinidad and Tobago regarding e-therapy (which will be referred to as *online mental health interventions*). Online mental health interventions are also known as *distance therapy*, *web therapy*, and *online therapy*, as well as *tele-mental healthcare*, *telepsychiatry*, and *telepsychology* (Caver et al., 2019; Victor, 2019). These interventions, as a modality for mental healthcare delivery, have remained significantly underexplored in the literature and thus underdeveloped with regard to their use in the developing world generally and the English-speaking Caribbean in particular (Phillip, 2017). Trinidad and Tobago is considered to be a high-income developing country by the International Trade Administration (ITA, 2022) and an emerging and developing economy by the International Monetary Fund (IMF, 2023).

According to reports published by the World Health Organization (WHO), there is a disproportionate number of persons in the developing world who are unable to access mental healthcare options when compared to individuals in the developed world—85% compared to 50% of persons in developed countries (WHO, 2014). This is further exacerbated by the barriers that must be surmounted to access mental health services in the developing world, including a dearth of financial and human resources (Maeder, 2014; Phillip, 2017) and sociocultural factors such as the stigma that may be attached to having a mental health issue and accessing mental health interventions (Phillip, 2017;

Rehm & Shield, 2019; Yorke et al., 2016). Whiteford et al. (2015) further identified a laissez faire approach to mental healthcare by most governments of developing countries as another barrier to access.

The aforementioned issues indicate that the need for interventions that allow for greater access and are culturally appropriate and cost effective (Wainberg et al., 2017). Online mental health interventions satisfy Wainberg et al.'s (2017) criteria and have proven to be quite versatile in terms of the range of disorders that can be treated and their accessibility (Zohuri & Zadeh, 2020). Online mental health interventions may be the services that are needed to address the issue of increasing access to mental healthcare in developing countries.

Mental health disorders have had a significant impact on how many people around the world experience their daily lives, and this seems to be a continuing trend. Rehm and Shield (2019) reported that mental health and addictive disorders impact more than a billion people around the globe and were responsible for 7% of global burden of disease regarding disability-adjusted life-years (DALYs) and 19% of years lived with disability. According to De Hert et al. (2021), persons living with severe mental health issues have a rate of mortality that is thrice that of the general population and a life expectancy reduction of 10–20 years that is consistently widening. Further, depression was cited as associated with most DALYs for both men and women but was more pronounced for women (De Hert et al., 2021). This also seems to be an ongoing trend, as Whiteford et al. (2015) asserted that health issues related to mental health rank a distant first in terms of the global burden of disease as mental health issues account for 32% of

years lived with disability (YLDs) and 13% of DALYs. The same study indicated that the impact of mental illness has gone underestimated by more than a third for many years and that estimates position mental illness "toe-to-toe" with circulation diseases and cardiovascular diseases as it relates to DALY (Whiteford et al., 2015). Indeed, in 2013, five diverse mental illnesses were featured in the 20 top causes of the global burden of disease (Vos et al., 2015). These included major depression in second place, anxiety disorders in seventh, schizophrenia in 11th, dysthymia in 16th, and bipolar disorder in 17th place (Vos et al., 2015). Additionally, the WHO (2010) estimated that three quarters of the global burden of neuropsychiatric diseases rests in the lap of low- to middle-income countries.

The most vulnerable group appears to be adolescents with mental illness. Mental illness affects 20% of adolescents all over the world, and mental illness is potentially the greatest factor driving disability in this demographic (Zohuri & Zadeh, 2020). Children who reside in the developing world are particularly at risk when numerous barriers to their access to mental healthcare solutions are factored into the equation (Hodgkinson et al., 2017). Considering that 90% of the world's children reside in the developing world (Clark et al., 2020), the threat to children in the developing world looms large.

The COVID-19 pandemic further negatively impacted this population as several studies have pointed to a steady increase in anxiety and depressive symptoms in children and adolescents (Racine et al., 2020). Studies focusing on the impact of the COVID-19 pandemic on persons living with severe mental illness show a heightened risk of mortality and morbidity primarily due to the predisposition of this population to develop

risk factors such as diabetes mellitus, respiratory tract diseases, and cardiovascular disease (De Hert et al., 2021). In a study conducted in the United States, it was found that even in the general population, the prevalence of depressive symptoms was more than three times higher during the pandemic than before in 2018 (Ettman et al., 2020). Disproportionately affected were low-income households and persons exposed to stressors such as job loss and bereavement (Ettman et al., 2020). This increase in depressive symptoms directly related to the COVID-19 pandemic was also recorded in China, with a study reporting a sharp rise in the prevalence of depression and anxiety when compared to data collected before the pandemic in 2019 (Li et al., 2020). The same holds true for Canada, with persons reporting high to extremely high anxiety quadrupling from 5% to 20% and persons reporting high levels of depression doubling from 4% to 10% since the COVID-19 pandemic started (Dozois, 2020). Additionally, 78% of Australians reported that their overall mental health had worsened since the onset of the pandemic (Newby et al., 2020). It is indeed a global trend, as a cross-cultural study of more than 59 countries found an increase in depression and anxiety symptoms since the pandemic started in March 2019 (Alzueta et al., 2021). Increased access to mental healthcare, particularly in countries with restrictive measures to combat the pandemic such as lockdowns and quarantines, is required if persons are to get the support necessary to cope.

In this chapter, I explore the early dynamics of online mental health interventions and the gap in the literature regarding the developing world. The purpose of the study and the research questions are highlighted. A snapshot of the theoretical framework of the

study, the various concepts that will be integral to the study, and the scope, limitations, and significance of the study will be examined.

Background

Several scholars have attempted to define online mental health interventions. Definitions include that of Richards and Viganó (2012), who referred to these modalities as the offering of mental health solutions through the use of broadband and technological solutions. They also indicated that these interventions could either be provided as an independent, self-driven service or under the supervision or assistance of a mental healthcare provider (Rochlin et al., 2004). Barak et al. (2008, 2009) and Barak and Grohol (2011) deconstructed cybertherapy as mental health interventions that are facilitated via the World Wide Web. The common thread in both definitions is the use of technology to increase access to mental healthcare.

A glaring gap in the development of the research around the use and effectiveness of online mental health interventions has been the seemingly limited attention paid to the developing world (Acharibasam &Wynn, 2018; Jack et al., 2014; Maeder et al., 2014). At the time of writing this, I was able to find 15 studies that had been conducted in the developing world, and none of them had been conducted in the English-speaking Caribbean. Indeed, of the 15 studies identified, six were conducted in Asia (Malhotra et al., 2013, 2014, 2015a, 2015b; Thara et al., 2008, 2012), one in Mexico (Mosso et al., 2012), three in Brazil (Hungerbuehler et al., 2016), one in Iran (de Oliveira Assis et al., 2010), two in South Africa (Chipps et al., 2012a, 2012b), one in Nigeria (Adebowale & Popoola, 2011), and one in Somalia (Abdi & Elmi, 2011). In their meta-analysis of online

mental health studies conducted in the developing world from 2000 to 2017, Acharibasam and Wynn (2018) identified 19 such studies, and none were conducted in the English-speaking Caribbean.

This lack of attention to the developing world has been the subject of some discussion by authors such as Acharibasam and Wynn (2018) and Maeder (2014), and at the time of writing this, I did not find research about online therapies and the English-speaking Caribbean. I aimed for this study to be part of the body of exploratory scholastic works by looking at the attitudes towards online therapies and their experiences with using these interventions by mental health professionals in Trinidad and Tobago. The potential for these technologies to revolutionize healthcare in a society where there is still great stigma attached to mental illness (Arthur et al., 2010; James et al., 2014; Yorke et al., 2016), where there is a dearth of mental health professionals (Maeder, 2014), and where privacy is paramount (Yorke et al., 2016) is great, but if mental healthcare professionals have defeatist attitudes towards these services or have had unfavorable experiences with these modalities, then these modalities may never get off the ground (Home, 2017). Gauging the attitudes and experiences of therapists then becomes a very important exercise.

Problem Statement

This study explored the attitudes towards as well as the experiences of mental healthcare providers in the Republic of Trinidad and Tobago regarding online mental health interventions. Despite the advances of telemedicine in the English-speaking Caribbean, scholars have pointed out that there seemingly has not been the same rate of

diffusion of these modalities into the realm of mental healthcare (Phillip, 2017). Indeed, the literature suggests that the slow rate of transference of online interventions in the arena of mental healthcare seemed to be a global phenomenon pre-COVID-19 pandemic (Earle & Freddolino, 2021). The literature further indicates that as providers usually act as gatekeepers, the attitudes and lived experiences of mental healthcare professionals are important as perceived usefulness (PU) and perceived ease of use (PEU) of innovations are the greatest predictors of adoption of technology (Cowan et al., 2019; Davis, 1989; Home, 2017; Venkatesh & Bala, 2008; Venkatesh & Davis, 2000). Further, it has been noted that therapists act as mediators of clients' attitudes towards interventions (Gun et al., 2011). As beneficial as online mental health interventions have the potential to be, how will patients be able to access and benefit if providers are hesitant, unaware, or just unwilling to engage? As such, examining the attitudes and experiences of mental healthcare providers in Trinidad and Tobago may be a good starting point for exploring the diffusion of online mental health interventions.

Purpose

The purpose of this qualitative study was to explore the attitudes towards as well as the experiences of mental healthcare providers in the Republic of Trinidad and Tobago regarding online mental health interventions as a modality for service delivery. I solicited the perspectives of mental health professionals in Trinidad and Tobago on the issue of using online mental health interventions in therapeutic practice as well as their personal experiences using these modalities. The attitudes and lived experiences of mental healthcare professionals are important as the literature suggests that PU and PEU of

innovations are the greatest predictors of adoption of technology (Davis, 1989; Home, 2017; Venkatesh & Bala, 2008; Venkatesh & Davis, 2000) and can even predict the continued usage of innovations (Home, 2017). Therapists then are the gatekeepers of these technologies and the use and diffusion of these modalities in therapeutic practice depends largely on their beliefs and experiences with reference to these interventions (Cowan et al., 2019).

Research Questions

This study explored the attitudes and experiences of mental health professionals in Trinidad and Tobago regarding the use of online interventions in their practice. Research questions that guided my study were as follows:

1. What are the attitudes of therapists in Trinidad and Tobago regarding the usefulness and ease of use of online mental health interventions?
2. What are the experiences of therapists in Trinidad and Tobago regarding the use of online mental health interventions in therapeutic practice in Trinidad and Tobago?

Theoretical Framework

This study employed the technology acceptance model (TAM). Proposed by Davis (1989), the TAM acknowledges that PU and PEU are fundamental determinants of the acceptance of innovations by new users. Potential gains that could be accrued are often impacted by users being reluctant to both use and accept innovations (Davis, 1989). According to Schultz and Slevin (1975), PU refers to the degree to which an individual perceives that a particular tool or process would enhance their performance. Davis (1989)

indicated that PEU captures the belief that a particular tool or process would require minimal effort. Davis (1989) was quick to caution, however, that the two concepts were subjective evaluations of effort and performance and may not be based in reality. The theory was further expanded a decade later with the integration of two processes: social influence processes, which speak to voluntariness, image, and subjective norm, and cognitive instrumental processes, which include output quality, job relevance, PU, and demonstrability (Venkatesh & Davis, 2000). In 2008, Venkatesh and Bala (2008) extended this with the birth of TAM 3, with which they looked further at psychological or emotional factors, specifically perceived enjoyment (PEN), computer self-efficacy (CSE), objective usability (OU), perception of external control (PEC), and computer anxiety (CANX) (Venkatesh & Bala, 2008). This theory provided a relevant backbone upon which the attitudes towards online mental health interventions were explored and will be further expanded upon in Chapter 2.

Nature of the Study

This study used a qualitative generic approach, and the data collection methods were in-depth interviews and field notes. The qualitative basic, pragmatic, or generic methodological approach refers to those approaches that do not fit neatly into any one qualitative approach as scientists struggle for methods that offer structure so as to maintain rigor but also flexibility to truly explore phenomena (Kahlke, 2014; Liu, 2016). This approach allows social scientists to explore the practical questions that may facilitate social change without being bound to a particular ideology or theory (Liu, 2016). It is used when the researcher wishes to inquire into a person's report of their subjective

opinions, beliefs, attitudes, or reflections on matters of the world (Percy et al., 2015). It also allows the participant to fully ventilate their experiences and perspectives without being confined by close-ended, rigid inquiry (McGrath et al., 2019).

The case study approach could have also been utilized as this research method, which is qualitative by design, uses natural life settings to build and extend theory (Barratt et al., 2011; Yin, 2018). Theory is allowed to emerge through inductive reasoning (Barratt et al., 2011; Yin, 2018). This method would have generated enough data on the attitudes towards and experiences with online mental health interventions by therapists in the Republic of Trinidad and Tobago, as it usually involves soliciting different perspectives (Barratt et al., 2011; Yin, 2018). However, as this study was concerned with examining the participants' attitudes towards and their experiences with online technologies to deliver mental health interventions (the landscape of which was virtually unknown) and case studies are usually concerned with in-depth studies of one "case" with clear, recognizable boundaries (Percy et al., 2015), the qualitative basic approach seemed apt.

The sample for this study was meant to be drawn from the Trinidad and Tobago Association of Psychologists (TTAP) and the Inter-Religious Organization of Trinidad and Tobago (IRO). The TTAP is the recognized body for mental health professionals in Trinidad and Tobago. Further, as a result of the religiosity of the society, faith-based counselors are often among the first port of call for individuals seeking counseling for their mental health issues (Maharajh et al., 1997; Ramkissoon et al., 2017). I thought it prudent then that the views of faith-based counselors be solicited. However, after contact

with both entities did not bear participant fruit, I initiated my backup plan to solicit participants on social media, particularly Facebook and LinkedIn.

I also sent a flier with a cover letter to the Trinidad Muslim League, the Sanatan Dharma Maha Sabha of Trinidad and Tobago Inc, the Trinidad and Tobago Association of Social Workers, and the Baptist Union of Trinidad and Tobago asking for assistance in disseminating the flier. Ultimately, I was able to recruit and conduct in-depth interviews with 10 participants. Parse (1990) indicated that two to 10 participants is a sufficient and adequate sample size for qualitative research. I used my field notes as another source of data. After the data were collected, the transcripts of the interviews were examined using an eclectic approach, specifically the holistic and in vivo approaches to generate initial organic codes. This method allowed for the natural emergence of patterns and themes from an initial examination of the raw data (Gibbs & Taylor, 2010; Saldaňa, 2012, 2015). The data then underwent thematic analysis with the themes disaggregated according to TAM 3. I then built narratives that synthesized what the raw data revealed, the main tenets of TAM 3 and the literature surrounding online mental health interventions.

Definitions

This study uses the following terms and concepts to frame the inquiry:

Anglophone or English-speaking Caribbean: Formerly called the *British West Indies*, the Anglophone Caribbean refers to the 17 English-speaking territories in the Caribbean (Robinson, 2015). The list includes Anguilla, Antigua and Barbuda, The Bahamas, Barbados, Belize, British Virgin Islands, Cayman Islands, Dominica, Grenada,

Guyana, Jamaica, Montserrat, St. Kitts, St. Lucia, St. Vincent, Trinidad and Tobago, and Turks and Caicos.

Attitudes: The definition of attitudes used for this study followed that suggested by McDougall (1933), which is every single sort of belief or opinion as well as intangible qualities of personality, including sentiments. It is the essence of what is captured by PU and PEU in TAM (Davis, 1989), TAM 2 (Venkatesh & Davis, 2000), and TAM 3 (Venkatesh & Bala, 2008).

Caribbean: In this study, the word *Caribbean* aligns with the traditional definition of the Caribbean in the Anglophone world, which defines the Caribbean as all the Caribbean islands (including Bahamas ,which is not bounded by the Caribbean Sea), Belize, Guyana, Suriname, and French Guiana (Lewis & Allahar, 2014).

Developed country: According to the United Nations Department of Economic and Social Affairs (2021), a developed country is one that comprises a sustainable, high-income economic environment that is driven by harnessing existing technology, has modern infrastructure, and is further characterized by a high standard of living.

Developing country: The IMF (2015) characterizes developing countries as those countries that are less less industrialized and have a low Human Development Index when compared to other countries.

E-therapy: The provision of mental healthcare through the use of telecommunication technologies (Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013). This term is used interchangeably with online mental health interventions, distance therapy, web therapy, and online

therapy, as well as tele-mental healthcare, telepsychiatry, and telepsychology (Caver et al., 2019; Victor, 2019).

Mental healthcare/mental health services: Refers to any intervention, whether diagnosis, assessment, counseling, or treatment, offered for the maintenance or enhancement of mental health or the treatment of mental health issues (American Psychological Association, n.d.). This treatment may be offered as an inpatient or outpatient service and in a group setting or as an individualized treatment plan (American Psychological Association, n.d.).

Mental healthcare professionals: For this study, the term *mental healthcare professionals* is defined as individuals practicing within the scope of mental healthcare as defined by the Mental Health Professional Practice Act (MHPPA, 1992). According to the MHPPA (1992), mental healthcare providers include physicians and surgeons practicing mental health therapy, registered nurses specializing in mental health nursing, qualified psychologists, psychologist residents qualifying to engage in mental healthcare, clinical social workers, certified social workers, marriage and family therapists, associate marriage and family therapists, clinical mental health counselors, and associate mental health counselors. As the literature indicates that the first port of call for mental health issues in Trinidad and Tobago is faith-based counselors and healers (Maharajh et al., 1997; Ramkissoon et al., 2017), for this study, they are included in this definition.

Mental healthcare providers/practitioners: Please see *mental healthcare professionals*.

Online mental health intervention: Use of the internet to connect the mental healthcare provider with their client (Rochlin et al., 2004).

Psychotherapists: Please see *mental healthcare professionals*.

Psychotherapy: Please see *mental healthcare/mental health services*.

Assumptions

For this study, I assumed that respondents answered in an honest manner to the interview questions posed (Yin, 2009). However, the literature indicates that sometimes, particularly when interview questions are probing or embarrassing, respondents may not be truthful with their answers (Doody & Noonan, 2013). I hope that assurances of confidentiality and measures to protect anonymity encouraged interviewees to speak candidly about the subject matter and perhaps even branch off into other related avenues of inquiry that would enrich the data, but this was not guaranteed (Doody & Noonan, 2013). Considering the exploratory nature of the study, I believe that in-depth interviews and field notes best captured the rich data necessary to paint a holistic picture of therapists' attitudes toward online mental health interventions in Trinidad and Tobago**.**

Scope and Delimitations

This qualitative study explored the attitudes and experiences of mental health professionals in Trinidad and Tobago towards online interventions because attitudes and experiences have been shown to be strong predictors of adoption and continued usage of innovations, especially in healthcare (Davies, 1989; Home, 2017; Venkatesh & Bala, 2008; Venkatesh & Davis, 2000). My delimitation was the sample of 10 mental health professionals. This narrow focus was chosen because the landscape regarding the use of

these technologies in therapeutic practice in Trinidad and Tobago was virtually unknown. Data gleaned in this study may be applicable to other countries of the English-speaking Caribbean and other Developing Island States and close-knit communities.

Limitations

Research Paradigm

This study used a qualitative generic approach, which inherently has some limitations, one of which is researcher bias, as the researcher is recognized as the main instrument for collecting, analyzing, and interpreting the data (Kahlke, 2014; Liu, 2016; Percy et al., 2015). To mitigate against the impact of researcher bias, I used several strategies, such as member checking, as suggested by Sandelowski (1993); the generation and meticulous recording of rich, detailed description, as prescribed by Janesick (2011); and drawing upon data derived from multiple sources to enable triangulation (Denzin, 2007; Fusch et al., 2018).

I adopted a heightened state of self-awareness so as to maintain some semblance of objectivity during the exercise (Probst, 2015). This awareness was complemented by a documented protocol and procedure outlining the data collection process and the steps followed to record, analyze, and safeguard the data collected during the course of the study (Saldaňa, 2015; Yin, 2014).

The results from my study are not generalizable, but transferability can be achieved if there is enough rigor incorporated into a research design (Moser & Korstjens, 2018). I achieved transferability through meticulous recordkeeping and providing thick description of my methodological process.

Participants

Participant reporting was taken at face value. I could not verify each participant's credentials or years of practice as a mental health professional because there is no licensure requirement to practice as a psychotherapist in Trinidad and Tobago. Whilst TTAP is the government-recognized body for mental health professionals and membership is highly recommended, there is no mandate to join the association as a prerequisite for practice. Indeed, some practicing faith-based counselors may fall outside the association's membership requirements.

Significance of Study

Ultimately, I sought through this study to add to the body of knowledge on the use of online mental health interventions in the developing world (Acharibasam & Wynn, 2018; Jack et al., 2014; Mader et al., 2014), particularly the gap regarding the English-speaking Caribbean (Arthur et al., 2010). This qualitative study may be significant to potential consumers of research such as practicing psychotherapists, application creators, policymakers, and scholar-practitioners for a variety of reasons. These reasons include the extension of research, the potential to build capacity through the use of technology, and the potential of these technologies to increase access to mental healthcare, particularly for vulnerable populations.

Reduction of Research Gaps

Data gleaned from this study may be useful to therapists in the developing world, particularly in the English-speaking Caribbean, where there is great need to implement interventions that will increase access to mental healthcare for clients whilst offering

solutions that protect privacy. Whilst client confidentiality and privacy are paramount the world over, in developing and close-knit countries such as the English-speaking Caribbean, accessing mental healthcare and mental illness still carries stigma (Arthur et al., 2010; Youssef, 2016). The dissemination of the data collected from this study may make practitioners and potential clients more aware of alternative mediums of treatment that are usually relatively cheaper than traditional face-to-face interactions (Berry et al., 2019).

Practice Implications

The findings of this study may generate dialogue within mental healthcare professional associations should the data indicate that one of the barriers to the incorporation of these evidence-based modalities into practice is the attitudes and experiences of mental health professionals to the intervention. Overcoming predispositions and negative perceptions is important in making it possible to see the introduction or growth of these interventions in the mental health profession in Trinidad and Tobago, whether as hybrids or stand-alone interventions as attitudes towards these interventions and lived experiences determine their initial use and continued propagation (Home, 2017). In addition to this, the data collected and feedback elicited from this study may be instructive in the creation of policy guidelines and risk management techniques that may guide the introduction to and usage of online mental health interventions in the Republic of Trinidad and Tobago and the English-speaking Caribbean by extension.

Build Capacity

The potential of these technologies to address the scarcity of mental health professionals in the developing world may be of particular interest to scholar-practitioners and policymakers. Kohrt et al. (2018) indicated that one of the major challenges that developing countries, and indeed the international world, face in addressing the provision of mental healthcare is the dearth of mental healthcare professionals. The Republic of Trinidad and Tobago is no exception, as reflected in the country's Developmental Needs List published by the Ministry of Education, which identified psychiatry as one of the sectors where critical human capacity building is needed (MOE, 2019). The potential for savings in terms of time, convenience, and cost is tremendous, and these resources may be best directed towards expanding client bases, especially in remote geographical areas.

Mitigation of Barriers to Mental Healthcare

Besides the scarcity of mental health professionals as identified by Kohrt et al. (2018), developing countries face additional barriers to mental healthcare, including cost (Kilbourne et al., 2018) and the lack of interventions to suit the diversity of clientele (Ramos et al., 2021). Tele-mental health interventions have been found to be cost-effective when compared to the traditional face-to-face modality (Berry et al., 2019) yet flexible enough to reach many demographic groups (Kilbourne et al., 2018). Such interventions may also be used as a supplement to face-to-face interventions (Wentzel et al., 2016), thereby reducing costs to the patient and decreasing operational overhead for clinicians.

Increased Access to Mental Healthcare, Especially for Vulnerable Groups

Persons residing in remote geographical locations are just one sector of the population that can benefit from these interventions should the research findings show some utilization of online mental health interventions by therapists in Trinidad and Tobago. This research may have value for therapists who are interested in mental interventions for adolescents and preadolescents who have been found to be at the greatest risk for mental illness (Zohuri & Zadeh, 2020). Adolescents and children have been found to be particularly receptive to online mental health interventions (McWilliams & Myers, 2018). Given the alarming trend of depression and suicide among this population in Trinidad and Tobago through the years (Ali & Maharajh, 2005; Kolves & De Leo, 2014; Maharaj et al., 2008; Modeste-James et al., 2023; Toussaint et al., 2015), the implementation of interventions through a medium to which they are naturally predisposed is critically needed.

Heckman et al. (2017) demonstrated a decrease in depressive symptoms in persons living with HIV/AIDS when online mental health interventions were employed. Given the fact that the Caribbean records one of the highest HIV infection rates in the world (Challacombe, 2020), therapists with clients living with HIV/AIDS or other diseases that may still carry stigma may find value in interventions that offer anonymity.

This emphasis on anonymity may also be the case for survivors of sexual assault and domestic violence. In fact, Recommendation 19 (1992) of the Convention on the Elimination of All Forms of Violence and Discrimination Against Women (CEDAW) published by United Nations Entity for Gender Equality and the Empowerment of

Women, indicates that it is the responsibility of state stakeholders to provide support to survivors of rape, sexual assault, and other gender-based violence, as well as family-based violence, in the form of counseling, specialized healthcare workers, and rehabilitation (UN/EGEEW, 1992). Steinmetz and Gray (2017) demonstrated that survivors of rape and other sexual offenses indicate that anonymity of the intervention allowed for more enriching and positive counseling outcomes. This was also the case for survivors of domestic violence (Jones et al., 2014), especially in close-knit communities. A good example of these technologies being employed by a country was the initiative implemented by the Office for Victims of Crime to address the needs of victims of rape in rural communities in the United States. It allowed victims to access critical services and information whilst protecting the identity of the victim (Office for Victims of Crime, 2014).

The need for anonymity becomes even more impactful in communities with close neighborly ties usually found in rural communities where there is a lack of client confidentiality (Myers, 2019; Steinmetz & Gray, 2017). Indeed, Wasco and Campbell (2002) found that politically conservative views, philosophies aligning with patriarchy, and a culture of denying the existence of sexual violence in communities posed additional burdens on advocates (Wasco & Campbell, 2002). The study indicated that these factors hindered many victims from accessing services after their ordeal as well as prevented them from making police reports. All the characteristics of a small town—that is, conservative viewpoints and a culture of denial of issues—can be used to aptly describe most English-speaking Caribbean countries, with the added complication of close family

ties through intermarriages in villages and communities. Anonymous interventions such as the one implemented by the Office for Victims of Crime may prove valuable in giving assistance and support to survivors. Indeed, research has shown that positive outcomes can be derived from the use of tele-mental health interventions in remote areas (Myers, 2019; Steinmetz & Gray, 2017). These interventions may also be useful if survivors are placed in shelters or halfway houses; continuous care with the same provider could be achieved. Shut-ins and their caregivers could also benefit from these modalities offering them flexibility and social support as well as access to relevant supplementary information (Pruitt et al., 2014). It is clear, then, that these modalities could be quite useful and impactful in the Caribbean context.

Summary

This chapter explored the global issue of mental healthcare, which provided the backdrop for this study. This study enquired after the attitudes of mental healthcare professionals towards as well as their experiences with online mental health interventions, which may have significant positive impact in countries where there is a scarcity of resources, a dearth of mental healthcare professionals, and stigma attached to being mentally ill and accessing care. The problem statement, purpose, and research questions of the study were outlined, as well as the nature of the study, along with a cursory look at the research paradigm that was used in the execution of the study. The operationalization of key terms and concepts used in the study was articulated, as well as necessary assumptions and parameters for the study. The potential impact of the study in developing countries was addressed. The chapter that follows contains a review of the

current research regarding key concepts, frameworks, and variables explored by the study.

Chapter 2: Literature Review

Introduction

This study explored mental healthcare providers' attitudes and experiences with online mental health interventions in the Republic of Trinidad and Tobago. A review of the literature suggests that this topic has remained virtually unexplored and thus underdeveloped with regard to its use in the developing world in general (Acharibasam & Wynn, 2018) and the English-speaking Caribbean in particular (Phillip, 2017). In this chapter, I will operationalize a definition of online mental health interventions as well as the various modalities explored. I will then examine the existing evidence of the effectiveness of online mental health interventions through several variables such as gender, age, nationality, modality, and psychiatric disorders.

The TAM (Davis, 1989, 1993; Venkatesh & Bala, 2008; Venkatesh & Davis, 2000) will then be explored and the nexus made with this study regarding the role that attitudes and experiences play in the adoption and use of novel technologies. I will then delve into the status of mental healthcare in developing countries, mental healthcare in the English-speaking Caribbean, stigma and discrimination, mental healthcare in Trinidad and Tobago, and the role of practitioners. To conclude, perceived existing gaps in the research and the future direction of research in the area of online mental health interventions will be explored.

Literature Search Strategy

In order to access a wide cross-section of articles for the study, I included articles that were published in English that had a focus on online mental health interventions and

studies on online mental health interventions that were conducted in developing countries. Developing countries included low- and middle-income economies, as they are considered less industrialized and have a low Human Development Index when compared to other countries (IMF, 2015). The search included articles published as primary studies as well as meta-analytical articles between the years 2000 and 2020 because prior exploratory searches suggested a dearth of material on the subject matter.

Using the diverse terms for online mental health interventions outlined in Caver et al. (2019) and Victor (2019) as well as the classification of online mental health interventions articulated in Barak and Grohol (2011), I conducted searches with various permutations of the following key terms: *e-therapy, distance therapy, web therapy, online therapy*, *tele-mental healthcare, telepsychiatry, e-counseling, e-mental health, telepsychology, virtual therapy, remote therapy, online counseling, psychotherapy, self-help counseling, online cognitive behavioral therapy, online mental health support, mental health blogs, mental health apps, gaming therapy*, and *social media support*. I also searched for any articles on mental health in the English-speaking Caribbean, mental health in Trinidad and Tobago, telemental health and the English-speaking Caribbean, and online mental health interventions and the English-speaking Caribbean. These searches were conducted on various databases including PsycINFO, Google Scholar, PubMed, MEDLINE, EBSCOhost Research Databases, and ProQuest for studies published from 2000 to 2021.

Theoretical Foundation

Technology Acceptance Model

This study employed the TAM, TAM 2, and TAM 3 as the theoretical framework. It has been established that user acceptance is the greatest factor in the adoption or rejection of technology (Davis, 1993), and as this study involved soliciting the perspectives of mental healthcare professionals regarding online mental healthcare interventions, it was the perfect launchpad to find out how the technology has been accepted or rejected and the reasons behind these decisions. Its suitability was further bolstered by findings that TAM theory was able to predict a significant portion of the use or acceptance of health informatics (Holden & Karsh, 2010). Proposed by Davis (1989), the TAM established that behavioral intentions, specifically PU and PEU, were fundamental determinants of the acceptance of innovations by new users. The theory further espoused that PU has an effect on behavioral intention and further that PEU has an impact on PU (Davis et al., 1989). Potential gains that could be accrued were often impacted by users being reluctant to both use and accept innovations (Davis, 1989; Davis et al., 1989).

TAM is based on concepts first articulated by Schultz and Slevin (1975) and Ajzen and Fishbein's theory of reasoned action (Ajzen & Fishbein, 1977). According to Schultz and Slevin (1975), PU refers to the degree to which an individual perceives that a particular tool or process would enhance their performance, and Ajzen and Fishbein (1977) examined the "correspondence" between "attitudinal predictors and behavioral criteria" (p. 888). Davis (1989), therefore, seemed to be an amalgamation of the two

concepts as he indicated that PEU captures the belief that a particular tool or process would require minimal effort. Davis (1989) was quick to caution, however, that the two concepts were subjective evaluations of effort and performance and might not be based in reality. The theory was further expanded a decade later with the integration of two processes: social influence processes, which speak to voluntariness, image, and subjective norm, and cognitive instrumental processes, which include output quality, job relevance, PU, and demonstrability (Venkatesh & Davis, 2000). An additional extension of the theory, TAM 3, looked further at the psychological or emotional factors, specifically, PEN, CSE, OU, PEC, and CANX (Venkatesh & Bala, 2008).

The TAM 3, proposed by Venkatesh and Bala in 2008, is an expansion of the original TAM conceived by Davis in 1989 (Rauniar et al., 2014). The TAM was devised to forecast the adoption and utilization of innovative technology by individuals (Adams et al., 1992; Karahanna & Straub, 1999). It postulates that individuals' behavioral intention to use technology is guided by two views: PU, the level to which an individual feels that using technology would result in better performance, and PEU, the degree to which an individual feels that using technology will be seamless (Adams et al., 1992; Karahanna & Straub, 1999). The theory also proposes that perceived utility and perceived simplicity of use will mediate the impact of external variables (such as design characteristics) on behavioral intention (Adams et al., 1992; Karahanna & Straub, 1999).

There has been substantial evidence of support for the TAM over the past two decades. Prior research on the TAM can be categorized into three areas: replication studies focusing on the psychometric features of TAM constructs, theoretical studies

establishing the relative significance of PU and PEU, and extension studies incorporating additional determinants (Al-Gahtani, 2016; Holden & Karsh, 2010). However, the original TAM had limitations in its narrow focus on PU and PEU as the sole determinants of technology acceptance, neglecting the influence of social and cognitive factors (Al-Gahtani, 2016).

Therefore, to address these limitations, Venkatesh and Davis (2000) introduced TAM 2, an extension of the TAM, which includes determinants of PU and PEU in broader aspects. The determinants of PU are subjective norm, image, job relevance, output quality, result demonstrability, and PEU (Venkatesh & Davis, 2000). These determinants are categorized into social influence (subjective norm and image) and system characteristics (job relevance, output quality, result demonstrability, and PEU) (Venkatesh & Davis, 2000).

Perceived Usefulness

The concept of PU is of utmost importance in the organizational setting. It refers to an individual's perception and belief that the utilization of a particular technology will significantly improve their job performance and overall effectiveness (Ariff et al., 2012; Rauniar et al., 2014). This term aligns with the notion of "utility," which refers to the capacity of a system to offer advantages. In organizational contexts, exceptional performance is often recognized and rewarded through various means such as incentives, salary increases, and promotions (Ariff et al., 2012). Users have an expectation of a positive relationship between the utilization of the system and improved job performance, and consequently, a system that is believed to be highly effective is characterized in this

manner (Durodolu, 2016). This highlights the importance of PU in shaping individuals' perceptions of the benefits that technology can offer in their professional capacities, thereby solidifying its position as a crucial factor in the adoption of technology (Kamali, 2018; Rauniar et al., 2014). User experiences, subjective norms, image perceptions, job relevance evaluations, output quality assessments, and result demonstrability considerations are all determinants of PU (Venkatesh & Bala, 2008).

Experience

Experience plays a pivotal role in shaping users' perceptions of the PU of a technology. As individuals accumulate hands-on familiarity and knowledge through their interactions with similar technologies, they develop a more nuanced understanding of the potential benefits that a technology can offer (Horst et al., 2007). This increased familiarity empowers users to recognize and appreciate the practical advantages that the technology brings to their professional or personal tasks.

Greater experience with technology positively influences the perception of usefulness for several reasons. First, users with extensive exposure are likely to have encountered diverse features and functionalities of the technology, allowing them to assess its versatility and applicability across various scenarios (Rauniar et al., 2014). Second, past interactions contribute to a user's knowledge base, enabling them to anticipate how the technology can enhance their job performance or overall effectiveness (Rouidi et al., 2022). In other words, the learning curve associated with technology becomes smoother for experienced users, fostering a more positive attitude toward its usefulness. Moreover, experienced users often develop a sense of confidence and

competence in utilizing the technology, reducing any apprehension or uncertainty (Venkatesh & Bala, 2008). This heightened confidence further contributes to a positive perception of the technology's usefulness, as users feel more adept at incorporating it into their routines.

Subjective Norm

The subjective norm dimension, which comprises "internalization" and "identity," is a critical factor in determining how individuals perceive the utility of technology (Yuan et al., 2021). Internalization refers to the process by which an individual incorporates external influences, including societal expectations and the viewpoints of significant others, into their personal value system (Putra & Samopa, 2018). In the context of technology adoption, this implies individuals internalizing the beliefs and opinions of important figures, making them integral components of their attitudes toward technology (Putra & Samopa, 2018). Within this dimension, identity refers to the extent to which individuals align themselves with the opinions and expectations of significant others, such as colleagues, friends, or mentors (Yuan et al., 2021). The influence of these key figures, serving as role models or holding influence in an individual's social or professional circles, significantly shapes the individual's perception of the utility of technology (Yuan et al., 2021).

The subjective norm dimension posits that individuals' adoption of technology is contingent upon their internalization of external expectations and the degree to which their identity is congruent with the viewpoints of influential individuals (Kokku, 2021). At its core, the perception of technology's utility among individuals is significantly

influenced by the attitudes and beliefs of influential figures (Venkatesh & Bala, 2008). This highlights the social and psychological factors that contribute to technology's acceptance and adoption. Subjective norms play a crucial role in reflecting how an individual perceives the societal expectations and pressures associated with the implementation of a particular technology (Venkatesh & Bala, 2008). The norms are influenced by the normative beliefs of individuals, which are manifestations of their comprehension of the societal expectations pertaining to technology adoption (Venkatesh & Bala, 2008).

Image

The image dimension involves the way in which users perceive the social relevance-related consequences of adopting a new technology (Venkatesh & Bala, 2008). It entails the intricate ways in which users perceive the potential for technological engagement to enhance their social standing (Venkatesh & Bala, 2008). Technological adoption is regarded by users not solely as an instrument, but also as a way to augment their standing within their professional or social networks, in addition to the symbolic and material advantages that are linked to it (Putra & Samopa, 2018). This dimension acknowledges the social and psychological aspects associated with technology use, in which the opinion of users regarding the adoption of the information technology system is significantly impacted by the perceived image (Putra & Samopa, 2018).

Job Relevance

The job relevance dimension is centered on users' perceptions of the effectiveness of technology in relation to their professional roles (Hornbæk & Hertzum, 2017). It

delves into the users' beliefs regarding the practical applicability and significance of the technology within the context of their specific job responsibilities (Hornbæk & Hertzum, 2017). Users evaluate whether the technology aligns with the demands and intricacies of their professional tasks, assessing its relevance to the core functions of their roles (Lai, 2017). This dimension goes beyond mere utility and involves the extent to which users perceive the technology as a valuable and integral tool that can substantially contribute to the efficiency and success of their job performance (Venkatesh & Bala, 2008). It reflects a user-centric perspective on the alignment between technology and professional roles, which is crucial for fostering positive attitudes toward technology adoption (Venkatesh & Bala, 2008.

Output Quality

Output quality refers to the degree to which the results generated by the technology are regarded as accurate and dependable (Venkatesh & Bala, 2008). In regard to the accomplishment of their task prerequisites, users conscientiously evaluate the favorable effects produced by a technology (Shanmugavel & Micheal, 2022). This dimension involves the ways in which users perceive the value, advantages, and overall positive impacts that result from employing the technology to complete their particular duties (Venkatesh & Bala, 2008). The capacity of the technology to improve task satisfaction is assessed by users who emphasize the importance of positive results and additional value as critical elements that shape their perceptions and attitudes (Kamali, 2018). The output quality dimension signifies the extent to which users expect to derive practical benefits and positive outcomes from the efficient utilization of technology,

thereby ultimately influencing the technology's perceived utility (Venkatesh & Bala, 2008).

Result Demonstrability

The aspect of result demonstrability pertains to the simplicity with which the advantages of the technology can be demonstrated (Venkatesh & Bala, 2008). The perceived efficacy of technology adoption is enhanced when the positive outcomes are tangible and demonstrable; this is because users are able to directly observe and value the benefits of adopting the technology (Venkatesh & Bala, 2008). This dimension encompasses the way in which users perceive concrete and verifiable outcomes that they expect to experience as a direct result of using the technology (Yuan et al., 2021). Individuals desire elucidation regarding the tangible effects of the technology, placing significant value on discernible results that can shape their perspectives and convictions (Venkatesh & Bala, 2008). The ability to demonstrate results has a substantial impact on users' comprehension of the practical ramifications and tangible impacts of the technology. This, in turn, is a critical factor in influencing their overall evaluation and acceptance of the technology (Huang et al., 2012).

Perceived Ease of Use

PEU refers to the extent to which an individual perceives that a particular tool or process would enhance their performance (Davis, 1989) and that using the technology will be a seamless process (Adams et al., 1992; Davis, 1989; Karahanna & Straub, 1999). Ease of use is determined by CANX, computer self-efficacy, OU, computer playfulness (CPLY), and perceptions of external control (Venkatesh & Bala, 2008).

Computer Anxiety

CANX is a feeling of distress or fear that individuals experience when using or thinking about using computers or similar technologies (Simsek, 2020; Venkatesh & Bala, 2008). This anxiety can prevent people from fully engaging with technology, limiting their participation in various tech-centric environments, such as workplaces, schools, and social activities (Simsek, 2020; Venkatesh & Bala, 2008). Anxiety triggers vary, with some people fearing irreversible mistakes, system malfunctioning, rapid technological changes, or privacy breaches (Simsek, 2020). To mitigate CANX, it is crucial to provide supportive measures such as practical training, demonstrations, user-friendly guides, and continuous technical help (Hornbæk & Hertzum, 2017). Creating an approachable and supportive learning environment can help alleviate this anxiety, promoting wider acceptance and optimal use of technology (Hornbæk & Hertzum, 2017; Simsek, 2020).

Computer Self-Efficacy

CSE pertains to a person's conviction to effectively utilize a computer system for various tasks or job requirements (Ariff et al., 2012; Venkatesh & Bala, 2008). CSE affects users' comfort and proficiency in managing different digital platforms and software, extending beyond basic computer literacy to include more advanced functions like database management or software troubleshooting (Ariff et al., 2012; Venkatesh & Bala, 2008). Individuals with high CSE are typically more adaptable to new technologies and are better problem-solvers in digital contexts (Simsek, 2020; Venkatesh & Bala, 2008). Conversely, those with low self-efficacy may resist new technologies and

encounter greater difficulty with computer-related tasks (Simsek, 2020; Venkatesh & Bala, 2008).

Objective Usability

OU refers to the assessment of a system based on the actual effort needed to perform certain tasks, not merely the presumed or expected effort (Durodolu, 2016; Venkatesh & Bala, 2008). OU evaluates various measurable aspects such as task completion time, process steps, and interaction complexity (Durodolu, 2016; Venkatesh & Bala, 2008). For instance, software might seem intricate because of its many features. Yet, if it facilitates the efficient completion of tasks, it is considered to have strong OU. The actual usability of a system may not always match user perceptions and this fact underscores the importance of designing intuitive systems and educating users about them (Durodolu, 2016; Hornbæk & Hertzum, 2017). By bringing user perception in line with true usability, the use of the system can be made more effective (Venkatesh & Bala, 2008).

Computer Playfulness

CPLY pertains to the degree of spontaneous mental engagement or enjoyment an individual experiences when interacting with computer systems (Huang et al., 2012; Venkatesh & Bala, 2008). It characterizes a person's inclination to view these interactions as entertaining, inventive, and flexible rather than as strictly utilitarian tasks and this playful attitude encourages a more exploratory learning environment, potentially enhancing user satisfaction and positively impacting attitudes toward technology use (Huang et al., 2012; Venkatesh & Bala, 2008). However, the level of CPLY can be

influenced by personal comfort with technology, the task at hand, and the design of the system (Chen, 2018). User-friendly and intuitive interfaces can stimulate more playful interactions than more complex systems (Chen, 2018).

Perception of External Control

PEC refers to an individual's understanding of the availability and adequacy of technical and organizational resources designed to aid in the use of a particular system (Al-Gahtani, 2016; Venkatesh & Bala, 2008). PEC can greatly influence the willingness of a person to use the system, and adequate resources and support, such as technical help desks, training programs, and supportive organizational policies, can enhance user confidence and promote system usage (Venkatesh & Bala, 2008). However, a lack of such support can lead to resistance or under-utilization (Al-Gahtani, 2016; Venkatesh & Bala, 2008).

Perceived Enjoyment

PEN refers to the degree of pleasure or delight a user experiences while using a particular system, disregarding any direct impact on their productivity or performance outcomes (Hornbæk & Hertzum, 2017; Venkatesh & Bala, 2008). PEN involves the inherent joy that arises from the usage of a system itself, irrespective of any potential efficiency benefits and intrinsic enjoyment of a system, like a mobile app, website, or software, can significantly influence its usage (Hornbæk & Hertzum, 2017; Venkatesh & Bala, 2008). Factors such as gamification elements, visual design, and user-friendly interfaces contribute to this enjoyment (Hornbæk & Hertzum, 2017). Even if the system does not directly improve productivity or performance, users are more likely to

frequently engage with it and explore its features if they find the experience enjoyable and engaging (Hornbæk & Hertzum, 2017; Venkatesh & Bala, 2008).

TAM 2 explains the effects of these determinants on PU and behavioral intention through social influence and cognitive instrumental processes. In TAM 2, subjective norm and image represent the social influence processes, and they positively influence PU through internalization and identification mechanisms (Billanes & Enevoldsen, 2021). The impact of subjective norm on PU and behavioral intention attenuates over time as users gain more experience with the system (Billanes & Enevoldsen, 2021). The cognitive instrumental processes are captured by job relevance, output quality, result demonstrability, and PEU. Individuals form perceptions of usefulness by mentally comparing the system's capabilities with their job requirements (Rouidi et al., 2022). TAM 2 posits that PEU and result demonstrability directly and positively influence PU (Amofah & Chai, 2022). Moreover, job relevance and output quality moderate the relationship, with higher output quality strengthening the effect of job relevance on PU (Amofah & Chai, 2022).

TAM 2 model suggests that individuals initially form perceptions of ease of use based on anchors such as CSE, CANX, CPLY, and perceptions of external control (Venkatesh & Bala, 2008). However, individuals adjust their judgments after gaining hands-on experience with the system and the adjustments are influenced by system characteristics, specifically PEN and OU (Venkatesh & Bala, 2008). CSE and perceptions of external control continue to play a strong role even with increased experience, while the effects of CPLY and anxiety diminish over time (Venkatesh & Bala, 2008). The

adjustments on PEU are stronger with more hands-on experience with the system, although the specific moderating role of experience was not evaluated in the original study (Venkatesh & Bala, 2008). Empirical studies conducted by Venkatesh and Davis provided strong support for TAM 2, demonstrating its effectiveness in understanding technology acceptance (Lai, 2017). Similarly, Venkatesh's model of PEU provides insights into the initial formation of ease-of-use judgments and the subsequent adjustments based on hands-on experience.

TAM 3, an integrated model of technology acceptance, was developed by combining TAM 2 and the model of the determinants of PEU (Feng et al., 2021). It is a comprehensive framework designed to predict and explain user acceptance of technology. By considering both cognitive and affective factors, TAM 3 presents a more comprehensive framework that encompasses all the factors influencing individuals' adoption and use of technology (Lai, 2017; Shachak et al., 2019). Three theoretical extensions were proposed in TAM 3 that extend beyond the previous models. These extensions were included to provide a rationale for integrating TAM 2 and the model of PEU (Venkatesh & Bala, 2008). Regarding crossover effects, it was suggested that the determinants of PU would not influence PEU, and vice versa. TAM 3 does not posit any crossover effects between these two constructs. TAM 3 maintains the theoretical processes of social influence and cognitive instrumental processes, as seen in previous models (Lisha et al., 2017). The effects of factors such as subjective norm, image, job relevance, output quality, and result demonstrability on PU are explained by these

processes. However, it was argued that these processes do not play a significant role in forming judgments about PEU (Fröhlich et al., 2022).

PEU is closely associated with self-efficacy beliefs and procedural knowledge, which are developed through hands-on experience with a specific system (Fröhlich et al., 2022). Social influence processes, such as compliance, identification, and internalization, may not strongly influence perceptions of ease of use beyond an individual's own general computer beliefs and firsthand experience with the system (Holden & Karsh, 2010). Additionally, the determinants of PEU, which include traits and emotions like CSE, CPLY, and CANX, are considered stable and not easily influenced by social or cognitive processes (Xie et al., 2022).

It was further suggested that the determinants of PEU would not directly influence PU (Xie et al., 2022). The determinants of PEU consist of individual differences, computer use and general beliefs about computers (Al-Gahtani, 2016). These variables are categorized as control beliefs, intrinsic motivation, and emotions (Al-Gahtani, 2016). However, PU is a cognitive belief related to the instrumental benefits of using a system, similar to extrinsic motivation (Al-Gahtani, 2016). Factors such as control over the system, enjoyment or playfulness, and anxiety about using the system do not inherently contribute to the formation of beliefs about the instrumental benefits of system use (Al-Gahtani, 2016). The presence of control or enjoyment does not guarantee improved job performance, and higher levels of playfulness or enjoyment do not necessarily translate into greater effectiveness (Al-Gahtani, 2016). Therefore, it was expected that the determinants of PEU would not influence PU (Al-Gahtani, 2016).

TAM 3 introduces three relationships that were not empirically assessed in previous studies (Venkatesh & Bala, 2008). These relationships involve the moderating role of experience in three specific contexts: (i) the relationship between PEU and PU, (ii) the relationship between CANX and PEU, and (iii) the relationship between PEU and behavioral intention (Venkatesh & Bala, 2008). In the first relationship, it is suggested that as users gain more hands-on experience with a system, they will have a better understanding of its ease of use (Venkatesh & Bala, 2008).

While PEU may become less influential in forming behavioral intention over time, it will still play a significant role in shaping perceptions of usefulness (Venkatesh & Bala, 2008). This argument is grounded in action identification theory, which distinguishes between high-level and low-level action identities (Vallacher & Wegner, 2012). PU is considered a high-level identity related to users' goals, while PEU is a low-level identity representing the means to achieve those goals (Venkatesh & Bala, 2008). With increased experience, users can assess the likelihood of achieving their high-level goals based on their experiences with low-level actions (Venkatesh & Bala, 2008).

The second relationship focuses on the moderating effect of experience on the link between CANX and PEU. It is proposed that with more experience, the impact of CANX on PEU will diminish (Venkatesh & Bala, 2008). As users become more familiar with a specific system, system-specific beliefs will have a stronger influence on PEU compared to general computer beliefs (Abdullah & Ward, 2016). System-specific factors such as OU and PEN will become more salient over time, while the effects of general computer beliefs, including CANX, will decrease (Abdullah & Ward, 2016). This is

consistent with research on anchoring and adjustment, which suggests that the role of initial anchors declines as individuals acquire more adjustment information (Epley & Gilovich, 2006).

The third relationship examines the moderating role of experience on the association between PEU and behavioral intention and it is anticipated that the effect of PEU on behavioral intention will weaken with increasing experience (Venkatesh & Bala, 2008). PEU is initially crucial as users encounter a new system, but as they become more proficient and gain hands-on experience, its impact on behavioral intention diminishes (Venkatesh & Bala, 2008). Users develop procedural knowledge about the system, reducing the significance of PEU in their intention formation (Venkatesh & Bala, 2008).

TAM 3 was developed to provide an integrated model that captures the various determinants of technology acceptance while accounting for the lack of crossover effects between PU and PEU, the distinct processes involved in their formation, and the limited influence of PEU determinants on PU (Venkatesh & Bala, 2008). TAM 3 proposes that experience moderates the relationships between PEU and PU, CANX and PEU, as well as PEU and behavioral intention (Venkatesh & Bala, 2008). As users gain more experience with a system, the influence of PEU on PU and behavioral intention is expected to change, while the impact of CANX on PEU is anticipated to decrease.

Al-Gahtani (2016), conducting extensive research into key factors impacting technology adoption, framed within the context of the TAM 3, observed the influence of PEN, specifically in the realm of e-learning. He claimed that the sense of enjoyment derived from using a technology significantly increases user engagement and also

underscored the importance of CSE and the PEC, both of which have a positive correlation with a higher rate of technology acceptance (Al-Gahtani, 2016). However, he also noted that the impact of self-efficacy might be less pronounced among users with significant prior computer experience (Al-Gahtani, 2016). Furthermore, Al-Gahtani (2016) brought attention to the variable influences of OU and CANX on technology acceptance, stating that they could have either positive or negative effects, contingent upon the context.

Chen (2018) provided further dissection of these factors within the lens of TAM 3 and reiterated the positive influence that PEN, CSE, and OU have on technology acceptance. Chen (2018) argued that these elements can cultivate more positive attitudes toward technology use among users and that a strong PEC can boost user confidence, reducing hesitancy towards adopting new technology. Like Al-Gahtani (2016), Chen (2018) also emphasized that high levels of CANX can obstruct technology acceptance.

Ariff et al. (2012) explored the vital components that significantly influence users' intent to employ internet banking systems. His research underscores the importance of CSE, PU, PEU, and Perceived Control in motivating users' technology adoption behaviors. Simply put, Ariff's research indicates a direct positive correlation between these factors and the users' inclination to use the system (Ariff et al., 2012). The stronger the users' perceptions of their own computer skills, the usefulness of the system, the ease of using it, and the control they have over it, the stronger their intention to adopt the technology (Ariff et al., 2012). Notably, in this study, Perceived Control was found to have a stronger influence on users' intent to use internet banking systems than both PU

and PEU (Ariff et al., 2012). This finding demonstrates its central role in predicting users' intentions to adopt new technology. Furthermore, Ariff's findings validate the vital role of external factors, such as CSE, in the formation of the TAM and Behavioral Intention, and as essential determinants of technology use intentions (Ariff et al., 2012). In this study, CSE plays a critical role in encouraging users' acceptance of the systems (Ariff et al., 2012).

In a research conducted by Elshafey et al. (2020), similar impacts of PEN, CSE, OU, PEC, and CANX on technology adoption were identified. This was particularly the case in the context of Building Information Modeling (BIM) and Augmented Reality (AR) integration in the construction industry. The researchers argued that the level of satisfaction or pleasure derived from using BIM-AR technology could significantly influence its acceptance (Elshafey et al., 2020). The more enjoyable users found the technology, the higher its perceived utility and ease of use (Elshafey et al., 2020). The researchers also identified the positive role of CSE in fostering confidence among users, enhancing PEU, and thus boosting the likelihood of adoption (Elshafey et al., 2020). Putra and Samopa (2018) added weight to these findings in their study on E-lampid technology. They also highlighted the importance of PEN but suggested that its impact might be lower compared to other factors, such as CSE, which they found to be more influential (Putra & Samopa, 2018). Putra and Samopa (2018) also emphasized the crucial roles of OU and the PEC in technology acceptance. The latter was associated with the availability of external support and resources (Putra & Samopa, 2018). Both studies underscored the negative impact of CANX on technology adoption, pointing to the

necessity of strategies to mitigate this anxiety and encourage acceptance (Elshafey et al., 2020; Putra & Samopa, 2018).

A meta-analytical study by Tao et al. (2020) into TAM and user acceptance of consumer-oriented health interventions found that TAM was a robust foundation theory for examining the factors that determine adoption of these modalities. The researchers indicated that TAM theory was the most utilized ground theory in the examination of online health interventions (Tao et al., 2020); a factoid that was also cited by (Ammenwerth, 2019). PEU was identified as being one of the most important constructs and the researchers recommended that health interventions should be designed to enhance the healthcare experience and have user friendly interfaces (Lazard et al., 2016; Toa et al., 2020). Further, the study found that necessary measures should be taken to assure that consumers possess self-efficacy, that they have control over the intervention, that influencers cosign on the usage and that there are enough support systems in place should consumers require assistance (Tao et al., 2020). These finding resonate very strongly with the core constructs of TAM.

As aforementioned, attitudes and experiences are not just predictors of adoption but also for continued use (Home, 2017). As Davis (1989) acknowledged in his groundbreaking work, measures that were more accurate for explaining and predicting system use do not just have theoretical value. They are also valuable for vendors assessing user demand, administrators evaluating vendor offerings but also perhaps policy and decision makers seeking to find cost effective, accessible and practical solutions to real social issues such as access to mental healthcare (Ammenwerth, 2019;

Davis, 1989; Tao et al., 2020). Therefore, current attitudes towards online mental health interventions by mental health professionals in Trinidad and Tobago can safely predict initial usage and adoption. The adoption and usage of innovations are critical if the benefits to be derived from technology can be maximized (Tao et al., 2020). In particular, the factors that drive persons to initially adopt an innovation are particularly important as others may be encouraged to adopt by the same pull factors. This theory would provide a relevant backbone upon which therapists' attitudes and experiences can be explored as TAM theory deconstructs both variables into categories or themes that can assist in the disassembling and interpretation of the data collected as well as provide a cohesive framework for the reporting of the findings.

Literature Review

The Current Global Mental Health Reality

Globally, depression and other mental health issues have been linked to the more than 800,000 persons that die due to death by suicide; 90% of this figure has been attributed to depression alone (WHO, 2016). The stark reality of these statistics emerges when we contemplate that if left untreated, these mental health issues can adversely impact someone's whole lifespan; affecting their productivity in school as a child (Auerbach et al., 2018), their personal and professional productivity as an adult and even impacting the Gross Domestic Product (GDP) of a country (Knapp & Wong, 2020; Trautman et al., 2016). Indeed, the World Economic Forum has predicted that by 2030, mental health issues will account for more than half of the burden of noncommunicable diseases (Bloom et al., 2011). Quantified, this amounts to US$16.1 spent over the period

(Bloom et al., 2011). The most comprehensive research on the global burden of mental healthcare indicates that mental illness affects every aspect of an individual's and a country's life (WHO, 2014). Its socioeconomic impact can be seen in vulnerability to homelessness, high unemployment rates and the resulting poverty and poor health and educational outcomes (Topor et al., 2014; WHO, 2014).

Persons with mental illnesses can suffer discrimination and stigma due to cultural attitudes and beliefs about mental illness (Yorke et al., 2016). They are often faced with restrictions related to the use of their civil rights and participation in civil society (Mascayano et al., 2016) and they often encounter high levels of sexual and physical abuse even at the hands of institutions that are intended to assist them (Jennings, 2016; WHO, 2014). The most severe cases of persons living with mental illness are less likely to receive medical treatment for their physical injuries and find it difficult to access emergency services (WHO, 2014). Children with mental illnesses are often excluded from school which results in further marginalization and indeed the highest unemployment rates than any other demographic (Staiger et al., 2018). Considering the aforementioned, it should come as no surprise to many that those with mental and psychosocial issues are likely to experience disability and premature death; just about one million persons die from suicide each year and exponential others are left bereaved by suicide (Schotanus-Dijkstra et al., 2014).

Interventions that eliminate some of the barriers to access, which include a dearth of financial and human resources (Clough et al., 2019; Evans-Lacko & Thornicroft, 2019) and sociocultural factors such as the stigma that may be attached to accessing

mental health interventions (Clough et al., 2019; Evans-Lacko & Thornicroft, 2019; Rehm & Shield, 2019), are critical in what is becoming literally a life and death situation. Death by suicide continues to be a major cause of death among the 10- to 24-year age group and has been the second leading cause of death since 2007 (Zohuri & Zadeh, 2020). This represented a more than 56% increase from previous years (Zohuri & Zadeh, 2020). The WHO estimates that of the 800,000 persons are lost to death by suicide each year, more than 90% of those deaths are due to depression (WHO, 2014). This mental health crisis has increased exponentially with the advent of COVID-19 where the risk of suicide has increased whilst concurrently access to mental healthcare interventions has decreased (Gruber et al., 2020). What COVID-19 has taught us is that there must be established protocols and mediums by which therapy can continue seamlessly in the event of national and global emergencies.

In an effort to maximize capacity, online mental health interventions were offered as early as 1982 (Kanani & Regeher, 2003) and 1990s saw the genesis of E-Clinics in the United States offering mental healthcare through encrypted sites was (Skinner & Zack, 2004). While the use of the internet to offer psychological interventions especially with the advent of COVID-19 (Di Carlo et al., 2021) and the benefits of these therapeutics have been established (Di Carlo et al., 2021; Lopez at al., 2019), the effectiveness of online therapeutic interventions is an ongoing academic exploration by scholar-practitioners. Thus far the use and effectiveness of E-therapy has been established across several variables including sex as demonstrated by Silence (2013) which used an all-female sample and Kramer et. al (2013) utilized male participants only. The effectiveness

of these interventions with regard to age has already been established with Mosso et al. (2012) having reported their findings on the impact of virtual therapy in infants 0-28 months old and Klinger et al. (2011) used a cohort of 65 years old and older. Online mental health interventions have proven effective in a diverse range of disorders from anxiety (Varquez et al., 2013) to pathological gambling (Giroux et al., 2013). Diverse modalities have also been tested from asynchronous conversation (Dirkse et al., 2015) to virtual reality (Kramer et al., 2013). Even diverse nationalities have benefitted from these interventions from Mexicans (Mosso et al., 2012) to the French (Klinger et al., 2011).

Even though the provision and use of online mental health interventions in therapeutic practice has been rapidly expanding since the 1990s (Di Carlo et al., 2021; Lopez et al., 2019), some scholars lament that the literature has not been able to keep up with the technology and that online mental health interventions are untested interventions (Peterson et al., 2020). However, some studies have shown that online mental health interventions can be even more effective than face to face interactions (Di Carlo et al., 2021; Lopez et al., 2019)).

Online Mental Health Interventions

The History of Online Mental Health Interventions

There have been several attempts by scholars to define and capture what exactly is online mental health interventions. Definitions that align with this current include the one articulated by Richards and Viganó (2012). Richards and Viganó (2012) conducted a qualitative meta-analysis of 123 studies and concluded that online mental health interventions was the provision of mental healthcare via broadband and emerging ICT.

Earle and Freddolino (2021) indicated that it is the use of Information and Communication Technologies (ICT) to enable direct professional interactions in a virtual environment (Earle & Freddolino, 2021). In short, it is the provision of mental healthcare through the use of telecommunication technologies (Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013).

E-therapy is not a new phenomenon scholars like Grady (2012) claim that the use of telemental healthcare happened even earlier with the Dartmouth experiments which entailed using a two-way television to deliver services to severely mentally unwell patients rather than transporting them to another hospital for talk therapy. E-Clinics began popping up in the 1990s (Skinner & Zack, 2004) and within recent times, the number of E-clinics has exploded (Lopez et al., 2019) primarily due to the COVID-19 pandemic (Di Carlo et al., 2020; Peterson et al., 2020). Consequently, the issue of online mental health interventions and their suitability for and effectiveness in treating mental health concerns have been placed on the front burner of research forays (Di Carlo, 2021; Lopez et al., 2019). What follows is an examination of the literature and the effectiveness of these modalities regardless of sex, age, the mental health issue being treated, nationality and the modality being employed. The aforementioned may make these interventions suitable to spaces where low cost, confidential and easily accessible solutions that adhere to any existing COVID-19 restrictions are needed.

Barak et al. (2008) represents the initial efforts made by scholar-practitioners to catalogue and classify the diverse modalities that fall under the umbrella of online mental health interventions. From the data collected, the researchers were able to offer a

tentative operational definition for online mental health interventions (Barak et al., 2008). The researchers in that study concluded that online mental health interventions could either be offered via a website or through other ICT, that these therapeutics could be in group format or an individual intervention, that they could be static or incredible interactive and immersive and that they could be offered in real time or asynchronous (Barak et al., 2008). Barak et al. (2009) built upon the foundation set by the initial findings of Barak et al. (2008) and defined these modalities as the provision of mental health interventions online and asserted that all these modalities could be classified into four categories. The category was online counseling and psychotherapy which encompassed all interventions between client/s and a therapist using the internet as the instrument of communication (Barak et al., 2009). The next category was psycho-educational websites that provided general information on psychology related topics (Barak et al., 2009).

The third category was self-guided, self-help applications and the last category was peer-led interventions or internet support forums and blogs (Barak et al., 2009). Barak and Grohol (2011) saw the addition of a catch-all category for any other modalities that do fall with the previously established categories. These modalities include smartphones apps, gaming therapy and virtual reality (Barak and Grohol, 2011). The aforementioned classification, therefore, provides the perfect framework for cataloguing the various modalities for data collection and analysis and continues to be the classification used by researchers for online mental health interventions (Lattie et al., 2019; Lauckner & Whitten, 2016).

The Effectiveness of Online Mental Health Interventions

Diverse Modalities and Effectiveness. An examination of the literature has indicated that online mental health interventions have been effective regardless of the modality utilized. Effectiveness has been established in studies using asynchronous chat (Langarizadeh et al., 2017) and synchronous modalities chat (Pompeo-Fargnoli et al., 2020). Participants in these studies reported an enhanced therapeutic alliance attributed to the depth of exchange of personal information by clients (Langarizadeh et al., 2017; Pompeo-Fargnoli et al., 2020). Lekka et al. (2015) dubbed this phenomenon as the online disinhibition effect. Current studies indicate that online mental health interventions had a greater e positive impact on the therapeutic alliance than traditional face to face sessions (Di Carlo et al., 2021; Lopez et al., 2019).

Studies such as Wang et al. (2020) have concluded that psychoeducational websites can be quite effective and the same can be said of self-guided internet-based interventions (Giroux et al., 2013; Mitchell et al., 2003). These cognitive-behavior therapy (CBT) based interventions have been effective in the treatment of disorders such as bulimia (Mitchell et al., 2003) and compulsive gambling (Giroux et al., 2013).

Blogs and online support groups have been proven effective in a number of studies including a study on the bereaved by suicide (Schotanus-Dijkstra et al., 2014), adolescents living with depression and anxiety (Bickerstaff et al., 2021) and persons living with chronic pain (Mariano et al., 2019). With regard to blogging, researchers concluded that it proved to be a deeply cathartic experience that unearthed subconscious and unconscious motivations and issues (Bickerstaff et al., 2021). In the ‘other types of

online interventions' category, virtual therapy has been found to be effective in the treatment of anxiety (Varquez et al., 2013), Post-Traumatic Stress Disorder (Kramer et al., 2013) and panic attacks (Wagelin et al., 2016).

Diverse Disorders and Online Mental Health Interventions. Despite being tested on an ever increasing number of disorders, especially since the COVID 19 pandemic (Di Carlo et al., 2021; Fernandez et al., 2021), the diversity of mental health disorders treated by online mental health interventions has had no impact on the effectiveness of these modalities (Di Carlo et al., 2021; Fernandez et al., 2021). Mental health issue that have been addressed using online therapy include the bereaved by suicide (Schotanus-Dijkstra et al., 2014), gambling obsessively (Giroux et al., 2013), depressive disorders (Richards & Richardson, 2012) generalized anxiety (Ruwaard et al., 2012), agoraphobia (Gega et al., 2013) and, Post Traumatic Stress Disorder (PTSD) (Klein et al., 2009). It has been further established that the severity of the disorder had no effect on the efficacy of online mental health interventions (Klein et al., 2009).

Online Mental Health Interventions and Sex of Clients. Pre-pandemic, the vast number of clients that utilized online therapy were female (Toscos et al., 2018). However, scientific studies indicated that online therapy was efficacious despite the sex of patients. In Weiss et al. (2018) only female participants were recruited and Kramer et al. (2013) used only male clients. Sergeant and Mongrain (2014) recruited and utilized just about an equal number of male and female participants to determine the efficacy of internet based Positive Psychology Interventions (PPIs).

Age and the Effectiveness of Online Mental Health Interventions. The age of clients has not had an impact on the efficacy of online therapies. Traditionally (and by traditionally, I mean pre-pandemic) the average age of clients utilizing these modalities did tend to be younger; 39.4 for online interventions compared to 44.5 in traditional face-to-face interventions (Peterson et al., 2020; Toscos et al., 2019). However, with the advent of COVID-19 and the forced migration of psychotherapists to the online space, a wide range of clients have had to navigate these modalities. Online therapy has been successfully used with children as clients (Peterson et al., 2020; Toscos et al., 2019) as well as adults (Hall, 2020). Virtual Reality (VR) therapeutics has experienced success with seniors (65 yrs and old) for dementia (Moyle et al., 2018) as well as infants 0-28 days old to mitigate against attachment and developmental disorders whilst in critical care (Mosso et al., 2012). Adolescents in particular found online therapy very cathartic and effective (Peterson et al., 2020; Toscos et al., 2019).

Online Mental Health Interventions and Nationality. Numerous studies have proven that nationality is not a barrier to the use and efficacy of online therapy. E-therapy has been used to treat pathological bereavement in Spanish nationals (Baños et al., 2005), arachnophobia in in nationals of Italy (Juan et al., 2005) and social anxiety disorders in Australian nationals (Malbos et al., 2011). Efficacy is not limited to G8 countries and studies have established the effectiveness of these modalities in Ghana (Amos et al., 2020), Iran (de Oliveira Assis et al., 2010) and Mexico (Mosso et al., 2012) just to name a few.

Therapists' Views About Online Mental Health Interventions

Despite evidence demonstrating the effectiveness of online mental health interventions, psychotherapists continue to lag behind other health professionals in the use and adoption of online interventions (Parisi, 2020). Indeed, in 2009, Ishizuki and Cotter indicated that human and social workers lagged their counterparts in other sectors in the use of online technologies in practice (Ishizuki & Cotter, 2009). Cited as some of the reasons behind this lag were disadvantages of the technologies, namely, the loss of assessment capacity, safety of personal and confidential information and lack of sufficient training in the modalities (Ischizuki & Cotter, 2009). Twelve years onward therapists have the same issues with online therapy with clinicians citing concerns about the eroding of the therapeutic alliance, technological glitches and the protection of data (Jones et al., 2017; Peterson et al., 2020). In fact, the researchers noted that the clinicians interviewed had more concerns than clients about using telemental health interventions whilst simultaneously acknowledging the advantages of convenience and the disinhibition effect (Peterson et al., 2020). This dissonance was also observed in a study by Connolly et al. (2020). Despite citing more advantages than disadvantages of telemental health interventions, therapists were still quite reluctant to use the modalities (Connolly et al., 2020). The researchers in that study concluded that their attitudes were related to the insufficient prior exposure to telemental health modalities and suggested that acceptance may increase with time (Connolly et al., 2020).

However, if unfamiliarity with the technology is the issue, then why are therapists in the same holding pattern that they were in 12 years ago? Further, in contrast to mental

health therapists, other health professionals have had little hesitation in employing the technologies for physical illnesses (Parisi, 2020). Why the hesitation from mental health professionals? Parisi (2020) may have uncovered an explanation for this phenomenon. Parisi (2020) found that the more experienced the therapist was, the less open they would be to trying new technologies and the less swayed they would be by evidence-based information on the use of online mental health interventions. Additionally, therapists were most likely to employ online mental health interventions where it was deemed "appropriate" by the therapist such as longer commute times (Parisi, 2020). In addition to this, the researcher noted therapists' recommendations for more knowledge and training on practical matters such as camera and mike set up, the use of hand gestures, body positioning and the like (Parisi, 2020). Understanding therapists' views on online mental health interventions in Trinidad and Tobago may provide an explanation for the rate of diffusion of these innovations as therapists are the end users and providers of these technologies; gatekeepers if you will.

Mental Healthcare and Developing Countries

According to the United Nations Conference on Trade and Development (2022) just about 83% of the world population lives in developing countries and an estimated 80% of those living with mental illness are unable to access mental health interventions (Clough et al., 2019). Despite the fact that mental illness now accounts for 7.4% of the world's burden of disease (Vos et al., 2015), policies, practice and political will have yet to catch up with the realities of this pandemic (Rosen et al., 2020). In fact, the resources

allocated to mental healthcare in developing countries is usually a paltry sum and highly disproportionate when compared to physiological ailments (Rathod et al., 2017).

In the Caribbean, less than 5% of the annual budget is allocated to mental healthcare (Youssef et al., 2014) even though mental health disorders are the leading cause of disability in the Caribbean (WHO, 2019). Inaccessibility of mental health services is incredibly pronounced in countries and communities with limited resources (Rathod et al., 2017) and expose potential clients to poverty, disenfranchisement, lack of educational and employment opportunities and discrimination and stigma (Rathod et al., 2017). Preliminary research indicates that there is need for capacity building in terms of mental healthcare professionals, data collection and research to drive policy, political will and the resultant interventions (Phillip, 2017; Rathod et al., 2017; Whiteford et al., 2015). All these deliverables, however, must be hinged on research conducted in nonhomogenous, less developed, low income, culturally diverse locales that respect and perhaps incorporate the traditional knowledge and cultural expressions of natives (Ahuja et al., 2018; Rathod et al., 2017). The lack of research in mental healthcare is perhaps one of the greatest barriers to accessing interventions but even this runs a distant second to stigma and discrimination (Thornicroft et al., 2019).

Stigma and Discrimination

Stigma and discrimination have been described as the most profound barrier to mental healthcare (Thornicroft et al., 2019) with some theorists opining that perhaps it is more destructive than the primary clinical condition itself (Semrau et al., 2015; Thornicroft et al., 2019). Stigma is described as using one's social political or economic

power for ostracizing, labelling, stereotyping, discriminating or being prejudiced against a group of people to their detriment (Thornicroft et al., 2019). In practice, stigma is exercised or experienced in various forms such as experienced stigma where the individual or the group has personal life experience being treated inequitably, internalized stigma where, having being discriminated against, the individual now holds stigmatizing views about themselves (Thornicroft et al., 2019), anticipated stigma where the social group or individual expects to be treated unfairly and perceived stigma which speaks to the views of the affected on the extent to which other persons stigmatize (Thornicroft et al., 2019). There is also stigma endorsement which covers the discriminating views of persons affected about other individuals in the same situation and treatment stigma which covers the stigma attached to help seeking (Thornicroft et al., 2019). Therein lies the greatest danger that stigma poses to persons with mental illness; that it prevents the individual from seeking interventions (Mascayano et al., 2016; Thornicroft et al., 2019). The longer the illness remains untreated, the grimmer the outcomes; this is especially true for major depression, bi-polar disorder, anxiety disorders and psychosis (Thornicroft et al., 2019). Interventions then that offer complete privacy and anonymity especially in close knit communities and small island developing nations such as the Caribbean, may encourage those affected to seek care earlier and maintain treatment protocols.

Attitudes Towards Mental Health in the Caribbean

Traditional understandings of mental health in the Caribbean revolve around the supernatural with spirits and curses being cast as the source of mental illnesses (Cohen et al., 2016; Ramkissoon et al., 2017). Conversely, the first recorded mental health

treatment was recorded by a Spanish monk in Jamaica in 1542 who reported that the native Tainos (an ethnic group of Caribbean First Peoples) would hang unguents, herbs and food blended for the affected persons on fruit trees (Beaubrun et al., 1976). People in the Caribbean believe that persons suffering from mental illness are violent, uncontrollable and unpredictable and generally to be avoided (Arthur & Whitley, 2015; Youssef et al., 2014). Scholars have suggested that perhaps these attitudes can be traced back to the British Slave Trade in the Caribbean where it has been strongly suggested that the mentally ill were either killed by their masters or, by the 18th century, jailed in plantation dungeons (Beaubrun et al., 1976). By 1776, the first Lunatic Asylum was established in the Caribbean with involuntary commitment being one of its hallmarks (Beaubrun et al., 1976). However, even then, access to mental health was restricted to Caucasians until Emancipation (Hickling & Gibson, 2012).

These attitudes and beliefs persist today and even in the younger generation (Youssef et al., 2014) and among medical and emergency professionals (Kohn et al., 2000, Youssef, 2016). In a study conducted by Youssef et al. (2014), 673 college students across three English speaking Caribbean islands were questioned on their knowledge about and attitudes towards mental illness. Overall knowledge about mental illness was poor and the attitude score were indicative of stigmatization (Youssef et al., 2014). Additionally, respondents believed that there was no cure for mental illness (Youssef et al., 2014). These results were further confirmed by an additional study by Youssef (2016). These beliefs then, endure and reflect the current reality. Beliefs and attitudes such as these not only perpetuate stigmatizing behaviors but can impact on help seeking.

If persons believe that there is no remedy for their ailment, then they will not seek medical attention and if they believe that their illness comes from a supernatural source then they will seek out supernatural interventions.

Mental Healthcare in Trinidad and Tobago

The Republic of Trinidad and Tobago is a multiethnic, multiracial, and multireligious society that has sought to forge a national identity out of legacies of imperialism, colonialism, the enslavement of Africans, East Indian indentureship and forced migrations to the two islands (Cudjoe, 2011). According to the Central Statistical Office, the total population of Trinidad and Tobago in the latest census stands at approximately 1.3 million with the two major ethnic groups being descendants of Africans and descents of East Indians (CSO, 2011). The two islands that form one country under one central government achieved independence from their British colonizer in 1962 and in 1976 became a Republic with a president as titular Head of State (Cudjoe, 2011).

Healthcare is administered primarily through a national insurance system with therapies and medicaments being provided free of charge to citizens, residents and visitors alike (HSA, 1987). There is a government program called Chronic Disease Assistance Program (CDAP) that provides free medication to citizens for chronic illnesses through over 250 private pharmacies (MOH, n.d.b). Over 47 different medicines are available with six of these being antidepressants (MOH, n,d.c). Healthcare including mental healthcare is administered and managed by the Ministry of Health and the Minister of Health has oversight and is in charge of policy (MOH, n.d.a.). There are 45

specialized institutions that offer outpatient mental health services (MOH, n.d.d) but only one mental health institution for inpatient services (MOH, n.d.d). There are also private institutions that offer health services and private doctors account for more than 54% of primary health providers (UNV, 2018). Trinidad and Tobago has one of the highest literacy rates in the Caribbean (Esnard, 2021), was determined to be one of the best places to be born a girl in the Commonwealth in 2011 earning 3rd place (Bachan et al., 2011), was found to be the fifth happiest country on earth in 2012 (Gallup News, 2012) and the happiest Caribbean island in 2015 (Helliwell et al., 2015).

Yet this overflow of happiness directly juxtaposes one of the grimmer statistics on Trinidad and Tobago- historically Trinidad and Tobago has one of the highest rates of suicide in the English-speaking Caribbean (Hutchinson et al., 1999b; Parasram, 1999). This trend still persists (Modeste-James et al., 2023) and even surpasses that of developed countries such as the United Kingdom (Kolves & De Leo, 2014). Quite a number of factors have been identified as being the drivers of this phenomenon which include the marginalization of certain ethnic and socioeconomic groups (Parasram & Maharajh, 1993), mental illness and family disputes (Hutchinson et al., 1991), so called “copycat suicides” and substance abuse (Maharajh, 1992), stress (Hutchinson & Simeon, 1997; Youssef, 2016) anxiety, being bullied, loneliness and marijuana usage (Modeste-James et al., 2023) and conflicts that arise out of generational gaps (Maharajh, 1998). It has been estimated that in a country with a population of 1.3m people, more than twelve hundred are admitted to hospitals annually for suicide attempts (Trinidad Guardian, 2017) and

more than one quarter of the population is affected by mental illness (News.gov.tt, 2012; PARL, 2018).

In a Joint Select Committee of Parliament enquiry into the state of mental health and mental health services in Trinidad and Tobago, stakeholders indicated that the detection of mental illnesses and the accessibility of services are the major barriers to addressing the issue of mental illness in Trinidad and Tobago (PARL, 2018). Factors cited as barriers include stigma surrounding treatment seeking and the use of available services as well as the lack of data and the limited array of drugs available under the CDAP (PARL, 2018). Mental health professional interviewed by the JSC proffered that the negative stereotyping associated with mental illness contributed to the under-reporting and delayed or low diagnosing of mental illness within communities (PARL, 2018). The absence of therapeutic interventions offered at public institutions and the reliance on prescribed drugs were also noted (PARL, 2018). Depressive disorders, anxiety disorders and trauma-related stress disorders made up the bulk of diagnoses (PARL, 2018).

Recently there has been an increase in the incidences of depression nationally and the Secretary of the Association of Psychiatrists of Trinidad and Tobago, Dr. Varma Deyalsingh, indicated that this upsurge was directly correlated to current economic conditions in the country specifically economic recession (Trinidad Guardian, 2017). The COVID-19 pandemic further exacerbated the situation with males being the most vulnerable group identified at that time according to Director of the St. Ann Psychiatric Hospital in Trinidad, Dr. Samuel Shafe (Looptt, 2020). Dr. Shafe indicated that men

ignore their mental health issues and only seek intervention when matters become critical (Looptt, 2020).

Whilst the past and current literature has captured the high rates of suicide among the East Indian population (Hutchinson et al., 1999b; Mahy, 1993; Roopnarine et al., 2022; Toussaint et al., 2015) with the most vulnerable being Hindu youth (Toussaint et al., 2015) and whilst it is recognized that depression among the national population remains largely undiagnosed but standing at more than a quarter of the population (PARL, 2018), of growing concern is the high rates of suicide among adolescent youth of all ethnicities in Trinidad and Tobago (Kolves & De Leo, 2014; Ramkissoon et al., 2017; Toussaint et al., 2015). In a study conducted in 2023 by Modeste-James et al. (2022) it was found that 22.2% (28% females and 16% males) reported suicidal ideation within the last year (Modeste-James et al., 2023). The dearth of mental healthcare professionals assigned to the school system has been described as woefully inadequate with only five clinical psychologists assigned to service all schools in Trinidad and Tobago and a backlog of 225 assessment reports as of 2018 (PARL, 2018). With these findings in mind, it is imperative that interventions targeting adolescents need to implemented urgently and given the success rate of online mental health interventions among the youthful population (Orsolini et al., 2021), perhaps these modalities could be explored. There is, therefore, urgent need for the development of literature that explore these modalities in more local and culturally specific settings.

Psychotherapists in Trinidad and Tobago

The recognized professional body for mental healthcare professionals in Trinidad and Tobago is the Trinidad and Tobago Association of Psychologists (TTAP) and all persons wishing to practice in Trinidad and Tobago are encouraged to join the Association (TTAP, n.d.;TTAP, 2017). TTAP was established in 1962 and is recognized as the governing body for practicing psychotherapists through an Act of Parliament (No. 84) in 2000 (TTAP, n.d.). An examination of the Trinidad and Tobago Association of Professional Psychologists (Incorporation) Act reveals that its main purpose was to establish the Association as a legal entity with powers to transact business whether in real property or otherwise, outline the Association's aims and objectives and to grant the Association the power to make rules to govern its members [Trinidad and Tobago Association of Psychologists (Incorporation) Act, 2000]. There is no mention of who is considered a psychologists or which professionals would be encapsulated under this umbrella term, no mention of licensure or qualifications required and they are no regulations or any other subsidiary legislation attached. The Act does empower the Association to "maintain and improve the standards of conduct and proficiency of the profession of psychology" [Trinidad and Tobago Association of Psychologists (Incorporation) Act, 2000. §.3].

The Association's website, however, seems to suggest that professionals encapsulated under the TTAP would include any individual offering psychotherapy or counseling (TTAP, 2017). Additionally, the Association further informs that in Trinidad and Tobago, a psychologist who is considered qualified to practice in the area of

psychotherapy or counseling would have a Masters level qualification in psychology or counseling with supervised training from a university recognized by the Accreditation Council of Trinidad and (TTAP, 2017). The author of the aforementioned post, Dr. Katija Khan, who was a past president of the Association, indicated that whilst the Association was actively working on formulating and articulating a licensure process, there was currently no licensure requirement to practice in Trinidad and Tobago (TTAP, 2017). The Association, however, does keep a registry of practicing therapists and the general public can access this information for free (TTAP, n.d.). The Association does have an Ethics and Licensure subcommittee that is responsible for reviewing and keeping current the code of conduct and ethics and upholding the standards therein as well as to formulate and disseminate criteria directly related to certification and licensure (TTAP, n.d.).

The TTAP's website did allude to a code of conduct and I was able to find a document online entitled Guidelines to Ethical Principles Trinidad and Tobago Association of Psychologists Ethical Principles of Psychologists and Code of Conduct and a copy is attached at Appendix A. An examination of the document reveals no licensure or registration criteria nor any specific guidelines for online mental health interventions (TTAP, n.d.). The absence of any guidelines with regard to online mental health interventions is interesting given the fact that at the start of a national COVID-19 lockdown in 2020, the Association made a direct appeal to therapists to consider online therapeutic interventions such as "telephone therapy, mobile video calls, online audio calls, online video calls, text therapy, and email therapy" (TTAP, 2020). The Association further launched a free crisis intervention hotline which offered free counseling to the

public via phone and social media modalities (TTAP, 2020) and well as virtual mental health series (TTAP, 2020). Therefore, as much as there have been documented forays into the realm of online mental health interventions, professionals have seemingly been operating in a vacuum.

Apart from seeking intervention from a psychologist, or indeed in lieu of same, the literature indicates that persons with mental health issues in Trinidad and Tobago often turn to faith-based personnel for counseling and other interventions (Frederick et al., 2018; Hatala & Roger, 2022; Ramkissoon et al., 2017). These faith-based counsellors may or may not be members of the TTAP as there is no mandate nor statute that compels them to do so and they may possess training and qualifications in the field of mental healthcare as well as they may not. Regardless of their training and or qualifications, they play an active role in the provision of counseling especially in the area of couples and family therapy (Frederick et al., 2018) and soliciting their views should give a holistic picture of the lay of the land in Trinidad and Tobago regarding online mental health interventions.

Attitudes Towards Mental Healthcare in Trinidad and Tobago

Attitudes and beliefs around mental illness in Trinidad and Tobago reflect the beliefs of the wider Caribbean society with mental illness being associated with evil spirits and the casting of malevolent spells (Arthur & Whitley, 2015; Cohen et al., 2016; Ramkissoon et al., 2017; Yousef et al., 2014). As aforementioned, the Republic of Trinidad and Tobago is a multiethnic, multiracial, and multireligious society that has sought to forge a national cultural and social identity out of legacies of imperialism,

colonialism, the human trafficking and enslavement of Africans, the indentureship of East Indians and forced migrations to the two islands (Cudjoe, 2011). Perhaps it is this national identity that may explain homogenous beliefs around mental illness and by extension, intervention seeking, despite the diversity of the people. According to the last national census by Central Statistical Office of Trinidad and Tobago, the ethnic and religious composition of Trinidad and Tobago is distributed as follows: African (34.2%), East Indian (35.4%), mixed ethnicities (22.8%), Caucasian (0.59%), Chinese (0.30%), Indigenous (0.11%), Syrian/Lebanese (0.08%) and Other (0.17%), Protestant which includes the religion indigenous to the islands, the Spiritual/ Shouter Baptist (32.1%), Roman Catholicism (21.6%), Hinduism (18.2%) and Islam (5%; CSO, 2011).

Religion in particular has a huge impact on beliefs towards mental illness and intervention seeking and it has been noted that there has been no clear-cut divide between psychiatry and religion (Maharajh & Parasram, 1999). As such, the belief in demonic possession and spell casting is very high (Arthur & Whitley, 2015; Bignall et al., 2015; Cohen et al., 2016; Ramkissoon et al., 2017; Youssef et al., 2014). This phenomenon holds true even among healthcare professionals (Ramkissoon et al., 2017) with the first port of call for intervention being the priest or traditional healer (Maharajh et al., 1997). Indeed, quite a number of people believe that there was little benefit to be derived from psychiatric intervention (Ramkissoon et al., 2017). These traditional views that often clash with medical science have created a unique blend of beliefs which include the neurobiological, religious, superstitious and those based in folk medicine (Ramkissoon et al., 2017).

Apart from religion as the main driver of beliefs surrounding mental health, persons of Afro-Trinidadian descent were found to be more likely to associate the causation of mental illness to malevolent spirits (Ramkissoon et al., 2017). This phenomenon has also been observed in Afro- Americans in the United States and is clearly a legacy of their African cultural beliefs (Bignall et al., 2015). Age has also been cited as a factor in beliefs towards mental illness and intervention seeking with persons in the 18-29 age group being more than 15 times more likely that the 40 plus age range to believe that mental illness was caused by evil spirits and spell casting and were seven times more to seek out spiritual or traditional therapies (Ramkissoon et al., 2017).

Treatment seeking includes a multipronged approach with the use of biomedicine, herbs, spiritual advisors and prayer (Cohen et al., 2016). Stigma and discrimination regarding being affected by mental illness and seeking care is quite high (Arthur et al., 2010; Brown & Bodden, 2017; Cohen et al., 2016; Ramkissoon et al., 2017). There is hope in the younger generation where 77% of younger persons believe that mental illness has a biomedical causation (Ramkissoon et al., 2017).

Given the fact that it is clear that mental health interventions that eliminate the current barriers to healthcare are urgently needed and that mental health professional are the critical link in the search for these interventions, this study should shed some light as to the current landscape with regard to the usage of these interventions if at all, the currents perspectives of these service providers and their experiences with the technology. From the aforementioned literature review it has been established that TAM

theory covers these core concepts and should provide a sturdy foundation upon which this issue can be explored.

Summary and Conclusions

From the literature review above we can see that the effectiveness of online mental health interventions has been established in the literature especially for the most vulnerable age group 10- 24; an age range that seems to have an affinity for technology. What is not known about this modality are the attitudes and experiences of mental health professionals in Trinidad and Tobago and indeed the wider English-speaking Caribbean. This information is key as PU and PEU (attitudes) as well as social influence and cognitive instrumental processes (experiences) towards innovations are the greatest predictor of adoption of technology and can predict the continued usage of innovations (Home, 2017). This study may capture the factors that push or pull users to the technology which can further inform modifications of the technology to address the needs of clients.

In Chapter 3, I will explore the rationale for the research design, state and operationalize key concepts of the study, articulate the role of the researcher and fully ventilate the methodology used in the exploration of the phenomenon. This will involve articulating the logic behind participant selection, the instrumentation used to collect the data and procedures for recruitment, participation and data collection. The data analysis plan will be presented as well as how trustworthiness was established. Ethical procedures that guided the methodology will also be discussed.

Chapter 3: Research Method

Introduction

The purpose of this qualitative study was to explore the attitudes towards as well as the experiences of mental healthcare providers in the Republic of Trinidad and Tobago regarding online mental health interventions. I sought to collect data on the perspectives of mental healthcare professionals in Trinidad and Tobago on the issue of the use of these interventions in therapeutic practice. The attitudes and lived experiences of mental healthcare professionals are important because the literature suggests that PU and PEU towards innovations are the greatest predictors of adoption of technology or actual system usage (Davis, 1989; Home, 2017; Venkatesh & Bala, 2008; Venkatesh & Davis, 2000) and can even predict the continued usage of innovations (Home, 2017; Hong et al., 2006).

I analyzed data collected through in-depth interviews and field notes. The study involved conducting of interviews with 10 mental health professionals who represented a wide ambit of practitioners from psychiatrists to traditional healers. Ultimately, I sought in this study to add to the underdeveloped body of knowledge of the use of online mental health interventions in the developing world (Acharibasam & Wynn, 2018; Jack et al., 2014; Mader et al., 2014; Phillip, 2017), particularly addressing the gap regarding the English-speaking Caribbean (Arthur et al., 2010).

In this chapter, I will explore the rationale for the research design, state and operationalize key concepts of the study, articulate the role of the researcher, and fully ventilate the methodology used in the exploration of the phenomenon. This will involve articulating the logic behind participant selection, the instrumentation used to collect the

data, and procedures for recruitment, participation, and data collection. The data analysis plan will be presented as well as how trustworthiness was established. Ethical procedures that guided the methodology will also be presented in the chapter.

Research Design and Rationale

Through this qualitative study, I sought to examine the attitudes towards as well as the experiences of mental healthcare providers in the Republic of Trinidad and Tobago in relation to online mental health interventions. Research questions that guided my study were as follows:

1. What are the attitudes of psychotherapists in Trinidad and Tobago regarding online mental health interventions and their use in the Trinidad and Tobago context?
2. What has been the experiences of psychotherapists in Trinidad and Tobago regarding the use of online mental health interventions in therapeutic practice in Trinidad and Tobago?

This study used a qualitative generic approach, and the data collection methods were in-depth interviews and field notes. The qualitative generic methodological approach refers to those approaches that do not fit neatly into any one qualitative approach as scientists struggle for methods that offer structure to maintain rigor but also flexibility to truly explore a phenomenon (Kahlke, 2014). This approach allows social scientists to explore the practical questions that may facilitate social change without being bound to a particular ideology or theory (Liu, 2016). It is used when the researcher wishes to enquire into a person's report of their subjective opinions, beliefs, attitudes, or

reflections on matters of the world (Percy et al., 2015). It also allows participants to fully ventilate their experiences and perspectives without being confined by close-ended, rigid inquiry (McGrath et al., 2019).

The case study approach could have also been utilized, in that this research method, which is qualitative in nature, uses real-life settings to build and extend theory (Barratt et al., 2011). Theory is allowed to emerge through inductive reasoning (Barratt et al., 2011). This method would have generated sufficient data relative to the attitudes towards as well as the experiences of mental healthcare providers in the Republic of Trinidad and Tobago in relation to online mental health interventions as it usually solicits different perspectives (Percy et al., 2015). However, this study was concerned with examining the attitudes and lived experiences of mental health professionals in relation to online technologies to deliver mental health interventions and case studies are comprehensive examinations of a "single case," using several methods and multiple data sources. As none of the groups of people above constitute a "case" in that sense, the qualitative generic approach seemed apt.

Role of the Researcher

It is trite knowledge that no researcher enters the exercise of enquiry free from their own personal politics, inherent biases, experience, preconceived notions, and hunches that may impact the choice of research topic, participants, and the design of the data collection tool (Flick, 2018; Henderson, 2018; Twining et al., 2017). These concerns become more pronounced in qualitative research because the researcher is the collector and interpreter of the data (Flick, 2018; Henderson, 2018; Sandelowski, 1993, 2010;

Twining et al., 2017). In qualitative research, the responsibility of defining the data collection methods, collecting and analyzing data, and presenting results and recommendations rests with the researcher (Flick, 2018; Henderson, 2018; Merriam & Tisdell, 2016; Twining et al., 2017).

It is quite reasonable, then, to understand the danger of researcher bias given the integral role played by the researcher. Researcher bias is very real, and if not managed, may impact the dependability and credibility of a study (Morse, 2015). Researcher bias has been defined as prejudice or selectivity in research that introduces a deviation in outcome beyond natural fortune (Mullane & Williams, 2013). Morse (2015) indicated that there are three sources of researcher bias: (a) the pink elephant bias, where the researcher sees what they want to see or what they have anticipated; (b) the qualitative design itself and the selection thereof, which are essential in order to explore the phenomena; and (c) the unconscious decisions made by the researcher in the research design. In these instances, it is the duty of the researcher to be vigilant in establishing and maintaining an inductive approach, verifying all data during the data collection exercise and being circumspect about comparisons and conclusions.

To ensure that researcher bias was kept to a minimum, I utilized member checking as suggested by Sandelowski (1993, 2010); rich, detailed description as suggested by Janesick (2011); and multiple sources to enable triangulation (Marshall & Rossman, 2011; Stake, 2010).

Methodology

Participant Selection Logic

A group of persons, objects, and even periods of time that form the focus of a qualitative study is called the population (Moser & Korstjens, 2018; Shaheen & Pradhan, 2019). A population is a well-defined group with similar traits that bind the group together and make the population distinctive (Moser & Korstjens, 2018; Shaheen & Pradhan, 2019). The population targeted in this study was psychotherapists practicing in Trinidad and Tobago. Given the fact that the term *psychotherapist* in this study has been operationalized to include psychologists, psychiatrists, counselors, pastoral counselors, traditional healers, psychiatric nurses, life coaches, and social workers, and further that there is no licensure body for mental health providers in Trinidad and Tobago (Moodley et al., 2013; TTAP, 2017), the total population was unknown.

My research examined the attitudes towards as well as the experiences of mental healthcare providers in the Republic of Trinidad and Tobago in relation to online mental health interventions. According to Moser and Korstjens (2018), the analysis of sample size is a crucial component of research design, as an accurate estimate of sample size can increase the internal validity of a study and assist the researcher in making valid conclusions about the findings (Burkholder, n.d.). A sample is any subset of a population that does not amount to the entire defined population (Moser & Korstjens, 2018). Moser and Korstjens (2018) further indicated that the main criterion for making decisions about the sample is to identify what one wishes to say at the end of the study, and this is why purposeful sampling is utilized in qualitative studies.

There is ongoing debate around the issue of how many participants are sufficient for a qualitative study sample. Scholars such as Voss et al. (2002) and Fusch and Ness (2015) suggested keeping cases to a minimum so as to allow for more in-depth observation, the generation of richer data, and a more comprehensive exploration of the phenomenon. Other researchers have posited that a microsample could never be used to adequately explore an identified issue and that such a study would be neither internally nor externally valid (Eisenhardt, 1989). Eisenhardt (1989) indicated that larger samples are more representative of populations and aid in limiting the effects of extreme observations. Other schools of thought hold that large sizes can quickly become very difficult to manage, especially for novice researchers (Ritchie et al., 2013). It is worth noting that the development of psychological theories, some of which still hold relevance today, relied on microsample studies and even studies with one case. Exhibit A would be the grandfather of psychoanalysis, Sigmund Freud, whose extensive forays in a multitude of areas were accomplished with one subject (Freud & Freud, 2001). Authorities such as Ridder (2016) contended that sample size would depend on the questions to be asked of participants.

Amid this plethora of opinions on sample size, how does one determine the appropriate sample size for a qualitative study? Boddy (2016), Bernard and Bernard (2012), Rossi et al. (2013) and Sandelowski et al. (1997) suggested that before settling on a sample size, the qualitative researcher should take several factors into consideration. First, the researcher should take into account the subject matter of the research or the phenomenon that is to be explored, the theoretical or conceptual framework to be

utilized, the qualitative approach that will be employed, what would be considered credible in academic circles, and the time and resources allocated for the data collection exercise (Bernard & Bernard, 2012; Boddy, 2016; Rossi et al., 2013; Sandelowski et al., 1997). Further, the researcher should consider the potential utility of the findings as well as the purposive sampling method to be used in the study (Sandelowski et al., 1997).

The researcher may then turn their mind to the question of how large the sample size should be in order to attain saturation while taking into account all the factors mentioned in the previous paragraph. My study explored the attitudes towards as well as the experiences of mental healthcare providers in the Republic of Trinidad and Tobago in relation to online mental health interventions. A judgment or purposive sample technique was employed. With this technique, the researcher purposefully selects the most productive or relevant sample to answer the research question at hand (Burkholder et al., 2016; Ridder, 2016; van Rijnsoever, 2017). Consequently, I conducted in-depth interviews with psychotherapists in Trinidad and Tobago.

Fusch and Ness (2015), Van Rijnsoever (2017), and Yin (2014) indicated that saturation is reached when no new information emerges in the data, and Parse (1990) articulated that a sample size between two and 10 is sufficient for a qualitative study. Given my time constraints, limited resources, and experience in conducting qualitative research, a sample size of 10 seemed most practical. I recruited through the circulation of a flier on social media. Using this flier, I briefly explained the purpose of the study and asked interested persons to contact me via email. When prospective participants

contacted me, I then forwarded the participant package outlined in the Data Collection Procedures section.

Instrumentation

As I sought in this study to examine the attitudes towards as well as the experiences of mental healthcare providers in the Republic of Trinidad and Tobago in relation to online mental health interventions, the perspectives of therapists were key to this study. As a result of the scarcity of information and literature on this topic and indeed on the use of these interventions in the developing world (Acharibasam & Wynn, 2018; Jack et al., 2014; Mader et al., 2014), rich data were needed in order to extend existing theory (Fusch et al., 2018; Moser & Korstjens, 2018). Moser and Korstjens (2018) asserted that the foci of research, not the personal preferences of the researcher, determine the data collection method to be employed. The main sources of data for this study were in-depth individual semistructured interviews and my field notes.

As this research was exploratory in nature, there was no established instrument that could be utilized. Therefore, a novel instrument was constructed to explore the subject matter. Scholars such as Rubin and Rubin (2012) and Moser and Korstjens (2018) indicated that qualitative instruments should focus on observation, questions, and description. Scholars have further advocated for semistructured interviews, as this modality allows the researcher to remain focused whilst allowing for a full ventilation of the issues surrounding the subject matter as each participant may have a unique perspective and viewpoint (Burkholder et al., 2016; McGrath et al., 2019; Moser & Korstjen, 2018; Ritchie et al., 2013; Rubin & Rubin, 2012).

As I produced the instrument, I established the content validity as well as the sufficiency of the data collection instruments to answer the research questions. The construction of the interview questions was guided by empirical research, particularly TAM 3 (Venkatesh & Bala, 2008) and the categories for online mental health interventions as espoused by Barak and Grohol (2011). The interview questions enquired about participants' contingency plans for facilitating sessions relative to the COVID-19 pandemic, participants' understanding of what online mental health interventions are, modalities that participants would characterize as online mental health interventions, whether participants had any experience with these modalities, and what was that experience like for them. Further enquiry was made into participants' thoughts and feelings regarding these modalities, as well as their thoughts and feelings as to what were, to their mind, the challenges and benefits of such interventions. An interview protocol was produced to ensure that the interview process and procedures were streamlined for all participants (Flick, 2018). I established content validity by using expert reviewers to elicit feedback on the questions for the interview as suggested by Zamanzadeh et al. (2015). My dissertation committee served as reviewers of my interview protocol.

Procedures for Recruitment, Participation, and Data Collection

The data collection process began as soon as I obtained approval from the Institutional Review Board (IRB# 10-29-21-0495444; October 29, 2021) and additional approval from the Ministry of Health (November 8, 2021), as all health-related research conducted in Trinidad and Tobago must have the written approval of the Chief Medical Officer of the Ministry of Health. Data were collected using individual semistructured

interviews. The hallmark of interviews is the depth of focus on the participant and the chance at a comprehensive examination of the phenomenon (McGrath et al., 2019; Moser & Korstjens, 2018; Ritchie et al., 2013; Rubin & Rubin, 2012). Scholars have indicated that interviews are the gold standard as it relates to collecting rich data and when the focus is on capturing diverse perspectives, especially minority perspectives, on the phenomenon (McGrath et al., 2019; Moser & Korstjens, 2018; Ritchie et al., 2013). It has been asserted that multidimensional topics, complex themes, and delicate subject matter that need to be explored are best examined via interviewees as the opportunity for clarification and a thorough understanding of motivations, decisions, or impacts is present (McGrath et al., 2019; Moser & Korstjens, 2018; Ritchie et al., 2013).

Robust interview techniques include the outlining of clear expectations and interview protocols, supplying the participant with sufficient information on the purpose of the interview and using probes or open-ended questions (Burkholder et al., 2016; Janesick, 2011; McGrath et al., 2019). Establishing rapport with the participant whilst maintain a position of neutrality and using appropriate body language can help participants relax into the process without the researcher compromising their role as researcher (Burkholder et al., 2016; Janesick, 2011; McGrath et al., 2019). It has also been suggested that the interviewer end the session by inviting the interviewee to add any further information should they wish to do so (Janesick, 2011).

Interviews can be conducted via several mediums. These include audio-conference, face to face, video conference, email or asynchronous chat, and synchronous chat or instant messaging (McGrath et al., 2019). Authorities on the subject indicate that

not all interview modalities are created equal, and particularly with non-face-to-face measures, interviewers are restrained from observing and analyzing nonverbal cues that may tell a story that contradicts what is conveyed verbally (Burholder et al., 2016; Janesick, 2011; McGrath et al., 2019). Additionally, Burkholder et al. (2016) and McGrath et al. (2019) suggested that nonverbal probes from the interviewer, including indications of interest and active listening via body language, are very important when interviewing.

Face-to-face interviews would have been my preferred method of interviewing, as such interviews allow the interviewer to have control over the interview environment and afford the opportunity to observe and decode nonverbal responses to questions (Janesick, 2011; McGrath et al., 2019). Additionally, the researcher is able to give nonverbal feedback to the participant (McGrath et al, 2019). The synchronicity of time and place that face-to-face interviews allow cannot be replicated by other modes of interviewing (Opdenakker, 2006).

There are disadvantages to this interviewing modality and these include the time required for set up, the synchronizing of schedules and the fact that the physical setting may offer distractions that may prove disruptive to the interview (Janesick, 2011; McGrath et al., 2019). There is also the chance that participants may become intimidated by the process and may shut down or become unresponsive (McGrath et al., 2019). Emergent events may also hamper face to face interviews. At the time of writing this, most jurisdictions, including Trinidad and Tobago imposed restrictions geared towards combatting the COVID-19 pandemic. In Trinidad and Tobago, only essential services

were allowed to remain open and strict social distancing guidelines were implemented (Public Health Regulations, 2019).

Social distancing guidelines meant that internet-based audio-visual conferencing apps such as Zoom and Skype would need to be employed. Bampton and Cowton (2002) and O'Connor and Madge (2017) call all other modalities that are not face to face interviews, e-interviews and these include videoconferencing, telephone interviews, email interviews and synchronous and asynchronous chat.

Videoconferencing Interviews

These feature synchronous communication in times of time but asynchronous in terms of place or space (O'Connor & Madge, 2017; Opdenakker, 2006). It allows researcher and interviewee to connect in real time through audio and video over broadband networks (O'Connor & Madge, 2017; Opdenakker, 2006). Videoconferencing interviews can cut down on travel time and the hassle of finding a time slot and a place that is convenient to all parties especially in geographically remote areas (O'Connor & Madge, 2017; Brampton & Cowton, 2002). However, there are associated hardware costs and technical difficulties associated with the technology as well as the most crucial concern of security and privacy issues for content exchanged online (O'Connor & Madge, 2017; Opdenakker, 2006).

Telephone Interviews

These offer the same features and benefits but do not have the benefit of video (Brampton & Cowton, 2002; O'Connor & Madge, 2017; Opdenakker, 2006). One added benefit is its relatively low cost when compared to videoconferencing (Brampton &

Cowton, 2002; O’Connor & Madge, 2017) and its wide reach (Opdenakker, 2006). As a result of its accessibility by diverse populations, harder to reach target groups can easily be accessed such as mothers at home, carers, undocumented workers, the visually impaired and shut ins (O’Connor & Madge, 2017; Opdenakker, 2006).

Email and Asynchronous Text Interviews

These interviews involve questionnaires being emailed to participants for a response and for interviewees that are hearing impaired, this modality and synchronous chat would be the most practical solution (Brampton & Cowton, 2002). Like the other e-interview modalities, one saves time and it offers a convenient methods by which researcher and interviewee can connect (Brampton & Cowton, 2002; Opdenakker, 2006) but the question of security and privacy of information transmitted is a cause for concern (Ishizuki & Cotter, 2009). Some scholars also contend that the response rate to email questionnaires may be a challenge (Brampton & Cowton, 2002; Opdenakker, 2006).

Synchronous Chat

This modality offers individuals the ability to communicate synchronously but from asynchronous places. It offers all the benefits and disadvantages of telephone interviews but with the added benefit of reaching interviewees who are deaf (Opdenakker, 2006)

The modality that was chosen to conduct interviews was the one that offered convenience, security, time and cost savings and the one that makes practical sense when the socioeconomic context of interviewees were considered. Telephone interviews would not be ideal as field notes were one of my primary sources of information and much is

lost when body language cannot be observed (Brampton & Cowton, 2002; O'Connor & Madge, 2017; Opdenakker, 2006). I concluded then that video conferencing would be the most practical option.

Field notes also played a very important role as a data collection technique in this qualitative study. Field notes refers to the copious notes recorded by researchers during or after the observation of the phenomenon being studied (Phillippi & Lauderdale, 2018). Besides aiding in the establishment of credibility, it also added further dimension to what was being studied by capturing seemingly behaviors such as body language, changes in the tone of the interviewee and other incidental information that can aid in the researchers understanding of the issue (Phillippi & Lauderdale, 2018).

Data Collection Procedures

I used in-depth, semistructured interviews and field notes as the primary methods of data collection for this study that examined the attitudes towards as well as the experiences of mental healthcare providers in the Republic of Trinidad and Tobago regarding to online mental health interventions. I anticipated that the data collection span a period of four weeks but in reality, data collection took 8 months.

Initially, the Trinidad and Tobago Association of Psychologists and the Inter-Religious Organization were sent an email asking for their cooperation in circulating a recruiting flier and asking that persons interested in participating contact me via email for further information. When weeks passed without progress being made on the end of TTAP and the IRO, I initiated my contingency plan and began circulating the flier on social media particularly Facebook, and LinkedIn, hoping to reach a broader audience for

recruitment. From this effort, I received six responses. However, only two met the initial inclusion criteria- neither of the psychologists that responded was a member of TTAP, and two of the respondents did not have the requisite years of experience in the field. In addition, the traditional healers willing to participate in the study requested face to face meetings which was not part of the initial data collection plan because of COVID-19 health concerns and Trinidad and Tobago's COVID-19 guidelines.

After another month, with no other responses, I reapproached the IRB with a request to change the data collection procedures. The changes requested were to adjust the recruitment criteria to include psychologists or psychiatrists who were not members of the recognized association for psychologists, the Trinidad and Tobago Association of Psychologists (TTAP) and to adjust the recruitment criteria to include psychologists or psychiatrists with less than five years of clinical practice. I thought that perhaps they may be able to add different perspectives to the study. I also requested an adjustment of the mode of conducting interviews to include face-to-face interviews to facilitate contact with the traditional healers. These changes were approved and I amended the consent form and participant flier as instructed by the IRB. I recirculated the flier to those interested in participating but could not meet the inclusion criteria previously and the flier was circulated widely on LinkedIn and Facebook. I also sent the flier with a cover letter to the Trinidad Muslim League, the Sanatan Dharma Maha Sabha of Trinidad and Tobago Inc, the Trinidad and Tobago Association of Social Workers, and the Baptist Union of Trinidad and Tobago asking for assistance in disseminating the flier.

Interested persons contacted me via email and a participant package was emailed to prospective participants. This contained information on the study, the consent form and invited interviewees to contact the researcher should they have any further questions and concerns about how data gleaned will be utilized, stored, discarded as well as issues surrounding confidentiality or any other concerns. Participants were required to sign and return consent forms by email at any time before the interview began and were informed that they could withdraw from the study at any time.

On the day of the interview, the interview protocol was followed and the actual interview involved me taking copious notes and making an audio recording. The audio was then be uploaded to NVivo for transcription and storage. After the transcription of the interview, the participant was emailed a summary of the interview to confirm the accuracy of the content of the transcript and to confirm that I understood what they conveyed during the interview.

Data Analysis Plan

This study explored the attitudes towards as well as the experiences of mental healthcare providers in the Republic of Trinidad and Tobago in relation to online mental health interventions. My sources of data were open ended, semi structured interviews and field notes be the sources of data in this study. My interview guide inclusive of interview questions is attached at Appendix B.

The data collected were analyzed or examined via the application of the data analysis technique of grounded coding. This method allowed for the natural emergence of patterns and themes from an initial examination of the raw data (Gibbs & Taylor, 2010;

Saldaňa, 2012, 2015). Thematic analysis was used after this initial coding process to synthesize the diverse themes and ideas into propositional statements that support the researcher in explaining the nexus between themes and concepts (Averill, 2014).

The analysis of data in qualitative research involves preparing and organizing the data for analysis and then disaggregating the data into themes, patterns or, motifs (Averill, 2014; Saldaňa, 2012, 2015). This reduction is called coding (Averill, 2014; Saldaňa, 2012, 2015) and Miles, Huberman and Saldaňa (2014) that a robust approach to coding is precoding whereby the researcher creates a preliminary list of codes that is derived from the research questions or the theoretical or conceptual framework or the research questions. This allows for the prevention of errors in coding, maintaining standardized coding when there is more than one researcher and, for the easy organization of data (Gibbs & Taylor, 2010; Saldaňa, 2012, 2015). The drawback to this approach is that the narrow focus of the codes may prove restrictive and may not allow for fresh codes and patterns to come to the fore from the data (Gibbs & Taylor, 2010; Saldaňa, 2012, 2015).

I did not use a precoding structure when I analyzed the data I collected. Instead, I employed the Eclectic approach to the data analysis by combining the Holistic and the In Vivo methods of data coding. Eclectic approaches speak to combining two or more first cycle coding methods in a purposeful manner (Saldaňa, 2012, 2015). The holistic approach looks at the body of data as a whole and captures the main themes or idee fixe in the data whilst the In Vivo methods uses the words verbatim from participants to examine possible categories of data (Saldaňa, 2012, 2015). These two methods, though

similar, support and enhance each other and, are both grounded in the data. With this eclectic approach, the researcher can scan for repeating words and phrases as well as create contrast and, compare statements, (Gibbs & Taylor, 2010; Saldaňa, 2012, 2015). I selected this technique as an additional safe-guard against researcher bias as I wish to prevent the projection of my personal thoughts and feelings unto the data.

After this first round of coding the data was then analyzed and categorized by themes according to TAM 3 through pattern coding which is a thematic analysis technique. Thematic analysis is a second round qualitative coding technique that is employed after the initial round of coding (Averill, 2014, Saldaňa, 2012, 2015). It involves arranging synonymous codes or metacodes to form propositional statements (Averill, 2014; Saldaňa, 2012, 2015). It requires the constant comparison of words and sentences to those that have been previously coded (Gibbs & Taylor, 2010; Saldaňa, 2012, 2015). Thematic analysis allows for the integration and synthesis of persistent patterns and seeks to evaluate and describe the connection between different arising from the data (Averill, 2014; Saldaňa 2012, 2015). The researcher is able to incorporate theories, analogies and organize the data (Averill, 2014; Saldaňa, 2012, 2015). I then built a narrative that synthesized the research questions, the reassembled data, TAM theory, concepts arounds online mental health interventions and other relevant literature. After interpretation, I articulated inferences based on my interpretation and understanding of the data. Finally, I examined discrepant cases for divergent perspectives. Discrepant cases refer to outliers or cases that may contradict the general research findings (Yin,

2018). Discrepant cases can be quite valuable as alternative perspectives on the phenomenon being explored can be captured and analyzed (Yin, 2018).

Issues of Trustworthiness

Qualitative research designs have inherent weaknesses primarily as the research is the main instrument of data collection and thus there exists the possibility of the researcher bringing their own experiences, perceptions, personal politics and, biases into the research process (Morse, 2014; Moser & Korstjens, 2018). To establish the trustworthiness of a study, concepts such as credibility (internal validation), dependability (reliability), authenticity (external evaluation), transferability and, conformability (objectivity) should be addressed (Morse, 2014, Moser & Korstjens, 2018). These concepts can be established through the use of several tools as outlined below.

Credibility

Credibility refers to the faith, trust or confidence in the research findings through the establishment of a direct link between the raw data and the analysis of said data by the researcher (Flick, 2018; Munn et al., 2014). There are several tools can be employed to ensure credibility. These include long field engagements, persistent observation, peer debriefing, the triangulation of data, the analysis of negative cases, referential adequacy, and, member checks (both process and terminal) (Flick, 2018; Munn et al., 2014).

My study did not attempt prolonged engagement in the field, nor persistent observation as this project was time sensitive and I had limited resources. Instead, I collected data from ten (10) interviewees and not just a lone participant and this may serve to strengthen the credibility of the study through triangulation. Data triangulation

through the collection of and the comparison of multiple sources of data examining the same phenomenon serves as an objective control for researcher bias (Flick, 2018; Marshall & Rossman, 2011; Stake, 2010). As such, the data collected from the interviewees as well as the use of my field notes served as part of the data triangulation process. Additionally, my compliance with the established protocols for the study added to the establishment of credibility at every stage of the data collection process including after completion. As the research instrumentation was novel, future researchers interested in replicating instrument quality would be able to establish reliability by following the meticulous process recorded by the researcher (Turner, 2010).

To ensure quality, trustworthiness and credibility a research plan could include the cataloguing of the coding process and the use of independent coders with intercoder agreements to ensure quality interpretation (Marshall & Rossman, 2011; Stake, 2010). There are some scholars, however, who oppose rigid structures to ensure quality, trustworthiness and credibility. Sandelowski (1993, 2010) presented a seemingly contrasting view to the exercise of strict protocols and procedures in the qualitative research process. Sandelowski (1993) lamented the imposition of rigidity that can sometimes characterize these standards and said that these safeguards to ensure validity and trustworthiness may actually be a threat to the validity of the study. He said the imposition of all these measures "makes a fetish of it [trustworthiness] at the expense of perfecting a craft and of making rigor an unyielding end in itself" (Sandelowski, 1993 p. 1).

What Sandelowski (1993, 2010) recommended was member checking which can include such exercises as seeking clarification from interviewees to checking out evolving interpretations of the data. Basically, it is the incorporation of set procedures that allow members to check and review the accuracy and adequacy of researcher's synthesis of data (Marshall & Rossman, 2011; McGrath et al., 2019; Sandelowski, 1993, 2010; Stake, 2010). I will use member checking in my study. Also called respondent or participant validation, member checking may include returning a transcript to a participant for confirmation or debriefing the results with Participant for their agreement and feedback (McGrath et al., 2019). McGrath et al. (2019) suggested that this process can add a lot of value to the novice researcher as it provides an opportunity for the researcher to check the quality of the data (McGrath et al., 2019). While it can have its disadvantages which include divergent views on interpretation (McGrath et al., 2019; Varpio et al., 2017), member checking exponentially increases the reliability and the strength of the data collected as it diminishes researcher bias and allows for the transferability (Flick, 2018; McGrath et al., 2019). It is for this reason that as soon as possible after the interview I sent each participant an executive summary of what I believed they said and asked for their feedback. Once feedback was received, I made amendments as necessary and proceeded with the data analysis.

Transferability

Transferability refers to the extent to which the results arising out of a study can be applied to other contexts and can be accomplished through thick description (Anney, 2014; Coghlan & Brydon-Miller, 2014; Moser & Korstjens, 2018). Thick description is

essential for anyone who is interested in the transfer of the original findings to another person or context (Anney, 2014; Coghlan & Brydon-Miller, 2014; Moser & Korstjens, 2018). Transferability can be achieved through the use of rich, deep description of processes, procedures and methods used in the data collection and data analysis process (Anney, 2014; Coghlan & Brydon-Miller, 2014; Moser & Korstjens, 2018). Therefore, documentation such as copious field notes, the interview protocol, marginal notes during interviews and even having the audio recordings and transcripts available for review are important. Even emails sent back and forth between participants and the interviewer on changes to be made to the interview transcripts was preserved for my records.

Dependability

Dependability refers to consistent results that can be repeated over time (Anney, 2014; Flick, 2018). There are several recommended tools to establish dependability and these include the use of numerous sources of data or data triangulation, replicating analysis and splitting data and the use of an audit trail or an inquiry audit (Anney, 2014; Flick, 2018). I used an audit trail whereby I meticulously documented the various procedures and steps followed in conducting the research (Anney, 2014). I closely adhered to the steps prescribed in the interview protocol for preparing for, during and the conclusion of the data collection and analysis process so that anyone reviewing my process at a later date would have a clear picture of what was done and why.

Confirmability

Confirmability is the extent to which the findings of the study can be confirmed by other scholars (Flick, 2018). It ensures that the results of the study are free from bias

and driven by the data and authorities in this field recommend the use of at least two strategies during qualitative enquiry (Flick, 2018; Moser & Korstjens, 2018). I used the strategies of the audit trail and the reflexive journal. An audit trail is an in-depth description of how the researcher collected and analyzed the data and the audit trail may include samples of how codes were identified and clustered and how collected was collected and analyzed (Flick, 2018; Moser & Korstjens, 2018; Yin, 2011). The reflexive journal allows the researcher to capture and reflect upon assumptions or biases that may corrupt the results of the study (Allen, 2017; Rogers, 2018). The researcher's writing provides an opportunity for the researcher to examine perhaps their own unconscious perspectives regarding the phenomenon being investigated (Allen, 2017; Rogers, 2018).

Ethical Procedures

According to the World Medical Association, there is always a risk of harm when human beings are included in a research study and this risk increased when vulnerable populations are included in research projects (Amdur & Bankert, 2010). While none of the proposed participants to be included in the study will be considered vulnerable, as per Walden guidelines, IRB approval was sought before any recruitment or data collection began as well as the approval of the local research ethics committee for Trinidad and Tobago, the Chief Medical Officer of the Ministry of Health.

In addition to adhering to any IRB guidelines and stipulations as well as any parameters established by the local ethics committee for Trinidad and Tobago and the Chief Medical Officer of the Ministry of Health, I followed the guidelines articulated within the Declaration of Helsinki (2013). As such, participants were provided with

detailed information on the study and written consent was obtained. On this consent form, participants were provided with a background to the study, the commitment in terms of time for interviews, information on their rights as participants including the fact that they could withdraw from the study at any time, how their data would be protected and information on the study and my contact information should they have any queries or concerns.

Individual rights to confidentiality and privacy should be vigilantly and actively protected (World Medical Association, 2013). My materials included a confidentiality clause informing as to how this data would be treated and protected during and after the data collection process. For each participant, I assigned an alphanumeric pseudonym. All records, notes and transcripts were password protected when uploaded to hard drives. Participants were informed that as per research guidelines, their data will be kept for 5 years after which all records will be destroyed. Participant were further notified as to who would be able to view their data which may include dissertation committee members and other members of Walden faculty involved in the review and approval processes.

Summary

The purpose of this qualitative study was to explore the attitudes towards as well as the experiences of mental healthcare providers in the Republic of Trinidad and Tobago in relation to online mental health interventions. I interviewed mental healthcare professionals in Trinidad and Tobago on the issue of the use of these interventions in therapeutic practice. The attitudes and lived experiences of mental healthcare professionals are important as the literature suggests that PU (attitudes) and PEU

(experiences) towards innovations are the greatest predictor of adoption of technology. This chapter outlined the proposed research design including issues related to sampling and sample size, the role of the researcher, participant selection, data collection tools and procedures as well as issues surrounding trustworthiness and ethical procedures.

The chapter that follows will explore the data collection and analysis process including the setting for the study, participant demographics and how data were collected. Chapter 4 will further outline and discuss the data analysis process and present evidence of trustworthiness. The findings of this study and the answers to the questions and sub questions will be presented.

Chapter 4: Results

Introduction

This study focused on exploring the attitudes and experiences of mental healthcare providers in the Republic of Trinidad and Tobago regarding online mental health interventions. Although the Republic of Trinidad and Tobago offers its citizens free healthcare and has 45 specialized institutions offering outpatient mental health services, Trinidad and Tobago has one of the highest rates of suicide in the English-speaking Caribbean (Hutchinson et al., 1999b; Modeste-James et al., 2023; Parasram, 1999; Roopnarine et al., 2022), surpassing developed countries such as the United Kingdom (Kolves & De Leo, 2014). These statistics may suggest that the mental health needs of Trinidad and Tobago populations are underserved and that these populations may require more access to mental health services.

Online mental health interventions are versatile regarding the range of disorders that can be treated and make mental health treatment more accessible (Zohuri & Zadeh, 2020). Online mental health interventions may be the services that are needed to address the issue of increasing access to mental healthcare in developing countries such as the Republic of Trinidad and Tobago. However, a limited scientific inquiry has been conducted into using these modalities in the English-speaking Caribbean (Phillip, 2017). Mental healthcare practitioners are suggested to influence the rate of telemedicine adoption significantly as they moderate the relationship between these modalities and clients and are often instrumental in the formation of clients' attitudes towards these modalities (Békés et al., 2021). They therefore act as gatekeepers to the general public's

access to online mental health services (Home, 2017; Hong et al., 2017). This reinforces the importance of exploring mental health practitioners' adoption behaviors and provided the rationale for this study. A qualitative generic approach research methodology and design were employed to address the research problem and answer the following research questions.

The central research question was as follows: What are the attitudes and experiences of mental health professionals in Trinidad and Tobago regarding using online interventions in their practice?

Sub question 1: What are therapists' attitudes in Trinidad and Tobago towards the use of online mental health interventions?

sub question 2: What are therapists' experiences in Trinidad and Tobago regarding using online mental health interventions in therapeutic practice in Trinidad and Tobago?

In the following chapter, I review the recruitment practices and study setting, describe participants' demographics, explain the data collection and analysis procedure, discuss the practices employed to ensure the trustworthiness of the data findings, and present the research results. The chapter concludes with a summary of the overall study.

Participant Recruitment and Study Setting

The data collection exercise was conducted between November 2021 and June 2022. As per the initial approved data collection plan, the Trinidad and Tobago Association of Psychologists and the Inter-Religious Organization of Trinidad and Tobago were contacted to request their help in disseminating a recruitment flier to

potential participants. Unfortunately, neither organization could assist, so I began circulating the flier on social media, particularly Facebook and LinkedIn, hoping to reach a broader audience for recruitment. From this effort, I received six responses. However, only two met the initial inclusion criteria—neither of the psychologists who responded was a member of TTAP, and two of the respondents did not have the requisite years of experience in the field. In addition, the traditional healers willing to participate in the study requested face-to-face meetings, which were not part of the initial data collection plan because of COVID-19 health concerns and Trinidad and Tobago's COVID-19 guidelines.

After another month, with no other responses, I reapproached the IRB with a request to change the data collection procedures. The changes requested were to adjust the recruitment criteria to include psychologists or psychiatrists who were not members of the recognized association for psychologists, the TTAP, and to adjust the recruitment criteria to include psychologists or psychiatrists with less than 5 years of clinical practice. I thought that perhaps they might be able to add different perspectives to the study. I also requested an adjustment of the mode of conducting interviews to include face-to-face interviews to facilitate contact with the traditional healers. These changes were approved, and I amended the consent form and participant flier as instructed by the IRB. I recirculated the flier to those interested in participating but could not meet the inclusion criteria previously, and the flier was circulated widely on LinkedIn and Facebook. I also sent the flier with a cover letter to the Trinidad Muslim League, the Sanatan Dharma Maha Sabha of Trinidad and Tobago Inc, the Trinidad and Tobago Association of Social

Workers, and the Baptist Union of Trinidad and Tobago asking for assistance in disseminating the flier.

Potential participants contacted me via email to either request additional information or to begin the study enrollment process. A total of 13 potential participants contacted me for enrollment in the study, and I was able to successfully recruit 10 participants. Interested respondents were emailed an information package containing a brief background on the study, an outline of the interview process, and a consent form 1 week before the date of their actual interview. The package also included my contact information and a request for interviewees to contact me should they have further questions or concerns about how data would be utilized, stored, or discarded. Potential participants were further instructed to contact the research liaison at Walden University if they had confidentiality concerns. Participants were invited to electronically sign and return consent forms by email before their scheduled interviews and were informed that they could withdraw from the study at any time. I used the interview protocol in conducting the interviews, took field notes, and employed reflective journaling throughout the research process. All interviews were recorded, and this contributed to the validity of the research findings. The recruitment and study setting did not differ from the methodology's original recruitment plan presented in Chapter 3.

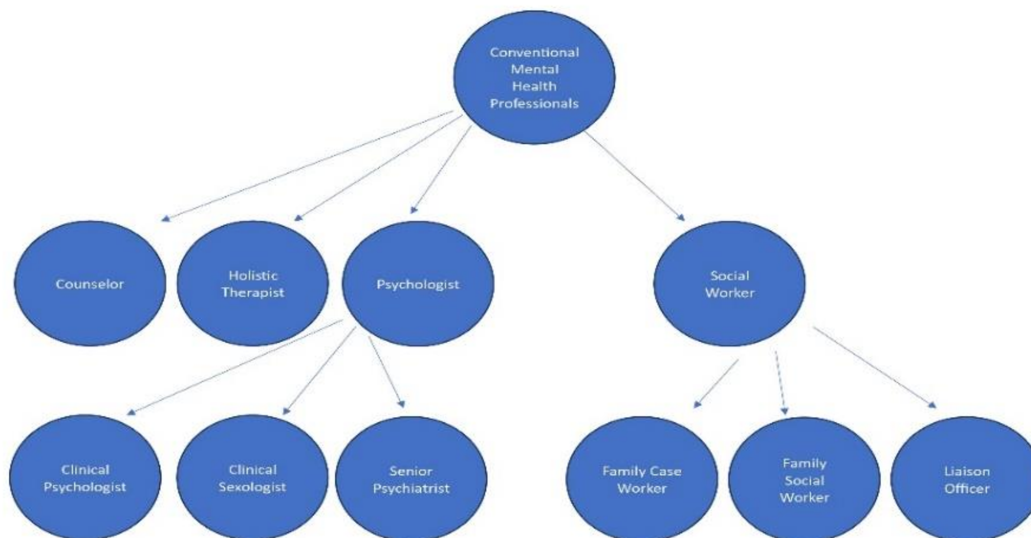
Participant Demographics

As illustrated in Appendix D, participants' ages ranged between 26 and 76 years old with an equal number of males (n=5) and females (n=5) participating. Most study participants possessed a Bachelor's degree or higher (8 of 10) and quite a number had

more than one vocational title. Participants' job titles were placed under one of the two categories I created after perusing the data. These categories consisted of conventional mental health practitioners or professionals (*n* = 8) and unconventional mental health practitioners or professionals. Unconventional mental health professionals consisted of spiritual/religious advisors and healers (*n* = 4), educators (*n* = 2), and others (*n* = 3; talk show host, director, and editor), and as illustrated in Figure 1, conventional mental health practitioners consisted of counselors, holistic therapists, psychologists, and social workers. The study participants held professional memberships in various associations (see notes in Appendix D), and most (*n* = 7) had been practicing in their field for 23 years or longer. All participants of the study specialized in some form of counseling, which included specialization in adolescent and adult therapy, counseling and mediation, counseling for mood and behavioral disorders, counseling for survivors of abuse, counseling for developmental disorders, counseling for human sexuality, and counseling for spiritual healing.

Figure 1

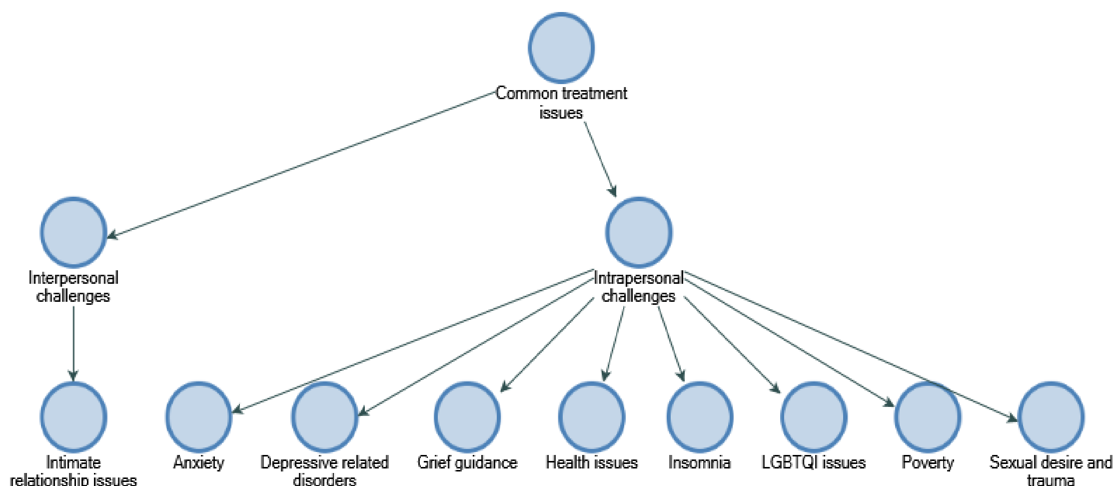
Subcategories of Conventional Mental Health Professionals



Regarding common treatment issues, most participants (n = 8) of the study reported helping clients with interpersonal challenges, with four participants stating that their common treatment issues were centered around anxiety and depressive-related disorders, as illustrated by Figure 2.

Figure 1

Common Treatment Issues



Finally, participants were asked to describe their current clientele. Participants' responses suggested a wide variation in the age groups, ethnicities, and cities of residence for those seeking medical attention. However, it was found that all participants of the study reported treating women more frequently than their male counterparts. More specifically, participants of the study suggested that their current clientele was anywhere between 60% to 83% female. Most (n = 7) did report an increase in the number of males seeking treatment in recent times, with one therapist attributing this shift to a larger national shift away from stigma regarding health seeking and the national mental health conversations during the COVID-19 pandemic. Participant 5 stated,

> But we notice a change there too; that more males are recognizing that they're human too and they are feelings that hurt and help is available. I wish more would come in, but you know, we are grateful … Yes. So the stigma isn't is an issue that I definitely think is changing. The pandemic helped the conversation. Local

> celebrities helped the conversation. The fact that every day during the pandemic, we had government speak about the pandemic and the effects. Not only the health effects, the physical health but also the mental health. I think Dr. Othello came on and she was speaking about nationwide thrust to provide mental health services for the whole nation. Wow, that's a biggie. So indeed we have some good progress I believe. And the future looks good for providing health services generally and mental health services in particular to the population.

Data Collection

I followed the interview protocol during each interview, which was audio recorded. I also took copious field notes, made marginal notes, employed reflective journaling, and documented the procedures and steps I took throughout the recruitment, data collection, and analysis process to inform an audit trail. During the interviews, I employed reflective journaling wherein I wrote down any preexisting biases about the research phenomena, which I reviewed before and after each interview with participants and while conducting data analysis to remind myself of my biases so that I could ensure that I avoided them while collecting and analyzing the data.

Using the predetermined interview questions, I asked each participant about their attitudes and experiences regarding online mental health interventions. I created the most relaxing environment possible by ensuring a conversational style to build rapport with each participant to make them comfortable enough to provide a detailed description of their attitudes and experiences. Employing a conversational style interview was in line with recommendations from Yin (2018) regarding employing a guided versus structured

conversation to garner a thick and rich description of the phenomena of interest. Interview sessions lasted between 32 and 45 minutes. There were no unique or unusual experiences while conducting the interviews.

Data Analysis

I explored the attitudes and experiences of mental healthcare providers in the Republic of Trinidad and Tobago regarding online mental health interventions. I employed grounded coding (Gibbs & Taylor, 2010; Saldaňa, 2012, 2015) and thematic analysis using the eclectic, holistic, and in vivo coding methods (Saldaňa, 2012, 2015). Therefore, the first step in data analysis consisted of transcribing participants' audio-recorded responses. I first transcribed the recordings by uploading the recordings to NVivo 12 and using the transcription feature. I then manually went through the automated transcript by listening to participants' recordings and made the necessary corrections in the transcripts. This process allowed me to familiarize myself with the data.

Once all transcripts were manually checked, I created placeholders called nodes for demographics and associated elements, the research questions, and the theoretical framework. Once the nodes were created, I assigned all of the participant's responses to the research sub question nodes for analysis. Assigning all of the participant's responses to the sub research questions allowed me to compare participant responses to identify the initial codes. Initial codes identified were given a node under the corresponding research sub question node, and excerpts of participants' responses representing that initial theme were assigned to each corresponding node. Initial codes included “advantages,”

"disadvantages," "challenges," "pre-COVID usage," "post-COVID usage," "reasons for transitioning to online interventions," "preference to face to face," "benefits for clients," and "benefits for therapists," just to name a few. All participant responses were reviewed in conjunction with the two research sub questions while considering the elements associated with the theoretical framework. Once initial code generation was complete, the initial codes were compared to one another to identify categories or potential groupings of initial themes.

In addition, redundant or ambiguous themes were identified for elimination or better categorization. Initial codes were grouped under an identified category or theme suggested to represent the initial codes and relate to each research sub question. These categories were identified as the initial themes of participants' responses. These initial themes were then compared across the entire data set, research question, and sub questions. Once the initial themes were identified and compared across the data set, they were each defined clearly and given a definition representing the major themes identified in this research study. These major themes were then assorted as per TAM 3. Discrepant cases were then examined for unique perspectives. For example, eight of participants mentioned loss of assessment capacity as a disadvantage of using online mental health interventions. The exceptions were two of the traditional healers, and one offered the explanation that they did not need a face-to-face interaction for assessment because they were reading energy (Participant 7). The final step in the analysis consisted of presenting the research findings in this chapter's study results section. The following section

provides a review of the practices employed to bolster the trustworthiness of the findings of this study.

Evidence of Trustworthiness

Trustworthiness in the study was bolstered by employing member checking, using triangulation, ensuring a rich and thick description of the phenomena of interest, maintaining copious field notes, creating and abiding by an interview protocol, creating marginal notes during interviews, audio recording all interviews, maintaining an audit trail, and reflexive journaling. By employing all of these practices during the study process, I bolstered the trustworthiness of the research findings, as described in more detail in the following section. More specifically, credibility, transferability, dependability, and confirmability were all bolstered in this study by employing the above practices. The following describes how these practices were used in conjunction with the four criteria associated with trustworthiness.

Credibility

To bolster the credibility of the study findings, I employed member checking and data triangulation in the current study. To wit, after each interview, I sent each participant an executive summary of my interpretation of the overall meaning for each interview question and asked for their feedback. All participants of the study were provided with an executive summary. Respondents had minimal feedback, which was incorporated, and I proceeded with data analysis. I also took copious field notes during the interview process, which were used in the data analysis portion of this study to provide context to participant responses. Therefore, data collected from interviewees and field notes were

part of the data triangulation process. Finally, I ensured compliance with the established interview protocols and all semistructured interviews were audio recorded, further bolstering the credibility of the research findings.

Transferability

Transferability "refers to the degree to which the results of qualitative research can be generalized or transferred to other contexts or settings" (Trochim, 2006, p. 1). Transferability is achieved through the use of in-depth description of procedures and methods—that is, meticulous documentation of the steps, protocols, or procedures used in the data collection, and analysis process (Anney, 2014; Coghlan & Brydon-Miller, 2014; Moser & Korstjens, 2018). Therefore, creating thorough documentation of any practices employed within the study and providing a detailed account of how the study was conducted bolster the transferability of the research findings. Therefore, documentation such as copious field notes, the interview protocol, marginal notes during interviews, and the audio recordings collected in this study bolstered the likelihood that other researchers can apply the research findings to a different context (Anney, 2014; Coghlan & Brydon-Miller, 2014; Moser & Korstjens, 2018). Overall, a rich and thick description of the research phenomena was generated from the audio recordings and various methods employed in this study to accurately capture participants' attitudes and experiences of using online mental health platforms in the Trinidad and Tobago context, bolstering the transferability of these research findings.

Dependability

Research describes dependability as the stability of the practices used within a study to collect and analyze data and research often achieves dependability by employing an audit trail (Anney, 2014; Flick, 2018). Therefore, I maintained an audit trail throughout the research process. More specifically, I maintained meticulous documentation on the various procedures and steps conducted in this study. I also adhered to the interview protocols described in the study, further bolstering the dependability of the research findings.

Confirmability

In order to bolster the confirmability of the research findings, I employed an audit trail, reflective journaling and provided participants quotes verbatim in the presentation of the research findings to illustrate that my conscious and unconscious biases had minimal influence on the findings. Using participants' quotes verbatim from their interviews reduced the likelihood that my unconscious or conscious biases influenced the overall research findings by altering participants’ viewpoints. In addition, the audit trail and reflective journaling provide a detailed and vivid account of the practices and procedures I employed while conducting this research study. The following section reviews the study results relating to the research questions and sub questions.

Study Results

The central research question was what are the attitudes and experiences of mental health professionals in Trinidad and Tobago regarding the use of online interventions in their practice? The first sub question was what are therapists’ attitudes in

Trinidad and Tobago regarding the use of online mental health interventions? The second sub question was what are the experiences of therapists in Trinidad and Tobago regarding the use of online mental health interventions in therapeutic practice in Trinidad and Tobago? An analysis of the data uncovered themes that support the conclusions that therapists in Trinidad and Tobago found online mental health interventions to be useful and easy to use. Usefulness and ease of use, according to TAM, are the greatest determinants of adoption (Davis, 1989). Therefore, the presence of themes supporting these concepts could suggest adoption of these technologies by therapists in Trinidad and Tobago.

PU is the extent to which someone perceives that a process or an invention would improve their work performance (Davis, 1989; Home, 2017). PU is deconstructed into several factors namely, experience, subjective norm, image, job relevance, output quality, result demonstrability, and PEU (Venkatesh & Bala, 2008). Conversely, PEU is conceptualized as the extent to which an individual believes an innovation or process would enhance performance and that the transition to using the innovation would be effortless (Davis, 1989; Karahanna & Straub, 1999). Ease of use is determined by CANX, computer self-efficacy, OU, CPLY and perceptions of external control (Venkatesh & Bala, 2008).

Sub question 1

Perceived Usefulness

With Sub question 1 sought to determine the attitudes of therapists in Trinidad and Tobago regarding the use of online mental health interventions. As illustrated in

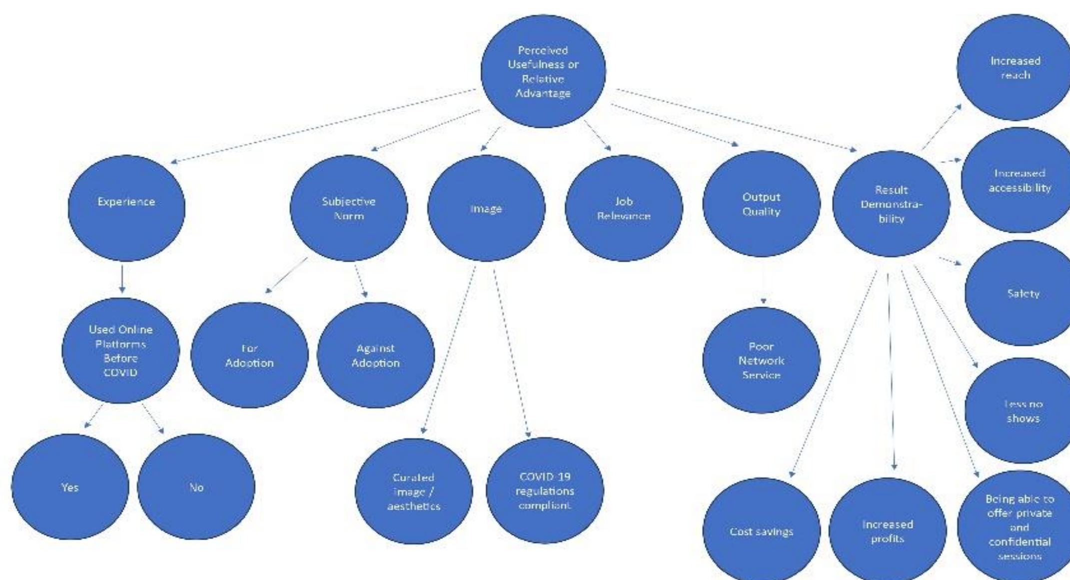
Figure , participants' experiences, subjective norms, image, job relevance, output quality, and result demonstrability were all explored when considering participants PU of employing online mental health services. In addition, the relative advantage of using an online mental health platform was also considered since the relative advantage is considered synonymous with PU (Venkatesh & Bala, 2008).

Experience. Most study participants (n = 6) suggested they had never used an online platform for the treatment of patients prior to the COVID-19 outbreak. While respondents reported a wide range of experiences with different platforms, it was only during the pandemic that there was a concerted and consistent effort by all participants (*n*=10) to use these for therapeutic sessions. For example, Participant 2 was asked if they had ever used any online support group, such as a private group on social media, to reach clients or facilitate sessions, and they responded, “no”. Similarly, Participant 10 was asked if they had ever used an online platform such as Zoom or Facebook video to conduct a session and responded, “no, just phone calls”. Participant 8 stated, “I still did face-to-face sessions. Yes, I did not have an online service until then, so that was implemented at that point”.

It would seem then that the COVID-19 pandemic was the catalyst for the widespread use of online mental health interventions and the expansion of the types of platforms being used to extend mental health services to clients.

Figure 3

Factors Influencing Perceived Usefulness



Subjective Norms. Subjective norms refer to the belief that influential persons or an influential group will approve and endorse an identified behavior (Marikyan & Papagiannidis, 2023). In the context of this study, influential people could include the Government of Trinidad and Tobago, the therapist's peers, citizens of Trinidad and Tobago and clients. Most participants (n = 8) suggested that the subjective norm pre-pandemic was not to adopt technology in the form of online mental health platforms. More specifically, participant responses suggested their clientele did not want virtual sessions and preferred face-to-face. Indeed, one therapist reported being sought out *during* the pandemic by clients because they had heard that he was still offering face to face sessions during the pandemic. Participant 9 reported,

> Because some people came to see me because of that. In other words they were seeing other people, but because these other people were not doing face to face

> sessions, they had to see somebody. Once they heard that I was seeing people face to face, they came to see me. (Participant 9)

The fact that clients even wanted face to face sessions when virtual sessions were cheaper than in person (Participant 8) further underscores this point. Therefore, even with added expense and in the midst of a raging pandemic with restrictive government lockdowns, some clients still preferred face to face sessions. Therapists also reported preferring face to face sessions with only two participants indicating that they were neutral regarding preference. Those that preferred face to face cited loss of assessment capacity (*n*=8), interruptions due to technical issues (*n*=8) and needing to try harder to establish a bond with the client (*n*=3). One therapist cited the culture of Trinidad and Tobago as one where Trinbagonians are hardwired for connection:

> Now, part of that, I submit has to do with our cultural heritage of being highly relationship oriented. We are so social it's ridiculous. It's exemplified in the fact that almost every month we have a public holiday, a little lime. (Participant 5)

It is worth noting, however, that the COVID-19 pandemic saw a shift in the Subject Norm- a new normal if you will where those persons still offering face to face sessions were the outliers. Excerpts of Participant responses regarding adopting online mental health interventions are described in Table 1.

Table 1

Participant Responses Supporting Subjective Norms Theme

Subtheme	Participant excerpts
For adoption	I met them just purely online. All of them got my number through like either a client that I had, or maybe like a friend of a friend or, you know, my friends kind of market for me sometimes. And firstly, I am cheaper obviously than a therapist in those different countries and I mean, they did want to talk to a Trini. So yeah, they were fine with the online, and I was fine with the online, too. (Participant 7)
	But for the persons who could, you could tell like they were pleased when the option came up. It was like yes we could do that. Like I already do these things for meetings. I know what I am doing. Oh, wow, we could actually do counseling like that. That kind of way. (Participant 6)
	I mean for, in the past pre pandemic for the international clients, I mean, there was no choice. (Participant 9)
Against adoption	Depending on the client that you had to provide care to, there was some hesitancy in some cases, which were based on evidence, not, you know, how I feel about it, but based on providing the best possible care for that client, you may choose not to use certain platforms. (Participant 5)
	Researcher: But now that you have altered it there is now a preference for online is that what you are saying?
	Participant 8: It is about 50/50.
	Researcher: So even though the online is cheaper, they still prefer coming out face to face.
	Participant 8: Yes, a lot of them.
	So I prefer in person just because I'm better able to sense things that are happening in clients' bodies that they may not be saying. I don't think I can yet do that well via the virtual space. (Participant 1).
	I mean it's two years now we've been doing this and some clinicians still say they prefer the face to face. Clients are still, I want to say harassing us because it's becoming you know, "When allyuh opening up?" "I wearing my mask, can I come?" People are getting antsy. They want face to face. They want that connectivity with us. (Participant 5)

Image. According to TAM theory, Image is the extent to which the user determines that the innovation enhances one's social status (Venkatesh & Bala, 2008). In the study, 8 participants commented on the impact of image on their adoption behaviors. participants (*n*=8) reported wanting to set an example and comply with the Government's COVID-19 guidelines. More specifically, Participant 10, a former social worker, religious leader and traditional healer, stated the following when asked why they did not do any in-person sessions:

> Because it was my preference, one because it was the right thing to do, two because you are looking out for you and the other person, and you wanted to help at the time when the COVID strike, you know, they were talking about help to flatten the curve, so then you didn't want to put yourself or your family or anybody else and their families at risk.

Others (*n*=4) mentioned the ability to curate and have more control over their professional image more effectively online especially with the use of backgrounds and filters. Participant 1 stated the following regarding using an online platform for sessions, "you can dress however you want, so you are in your avatars, getting to choose an avatar and appearing how you would like to be". This sentiment was also echoed by Participant 7:

> I get dressed a little bit more comfortably. So I don't have to worry too much about how I look per se. Also my Zoom feature on my computer has like an automatic blurring system, so I don't have to put on makeup. So my face looks way better. So I mean, I've learned that it's a lot easier for me. I don't have to

worry too much about myself… And it's a lot easier to portray myself as professional in like a Zoom contact because I don't worry that much about how I look to them.

Job Relevance. Job relevance speaks to the person's perception that the innovation is pertinent to their job (Marikyan & Papagiannidis, 2023). Most participants of the study suggested they felt the use of online mental health interventions was relevant to their job (n = 9) and recognized online mental health interventions as valuable to their job performance particularly in the midst of a pandemic and a national lockdown. Indeed, under this circumstances, very few (*n*=1) hesitated in using the technology in spite of their (the therapists') own reservations about privacy and confidentiality, loss of assessment capacity and potential disruptions from technical issues. For example, Participant 8 stated,

> It is not as terrible as I expected it to be. You know I really anticipated that it would be horrible in terms of.
>
> Interviewer: What did you think your experience would be like?
>
> Participant 8: I thought that given that it is going to be home environment, people would get distracted a lot more. You know there's baby crying, there is mother in the background, mother-in-law in the background that sort of thing. So I anticipated that that it would be a very distractible environment. A lot of interruptions that sort of thing. But it did not pan out, even when those things were present, it was fairly transient, we got over it very quickly.

Others saw the technology as relevant from the start and advocated for its use in their workplace. Participant 6 stated,

> As soon as it was relevant, I most certainly was not adverse to it. I was like certainly, I will do that. Because I mean I was telling you I mean I couldn't believe I was the only one at work who just kept saying, we have to set up this virtual counseling.

Another participant noted the convenience of using the technology. Participant 10 stated, "sometimes people might call you girl, I want to talk to you, and it might be a little after hours. So you have the technology, so you use it". Participant 7 actually preferred the use of online mental health interventions for certain mental health challenges:

> For the agoraphobes, it definitely works against them for sure, but getting out of their house is a whole problem on its own. So honestly, sometimes building up to that is actually helpful. So you start with online therapy, and then you slowly start venturing out, so for certain cases of any kind of agoraphobia, I would say for sure online therapies are a really good starting point.

Another therapist found online mental health interventions to be the only option when connecting with clients with different needs. Participant 3 was only able to connect with a visually impaired and a hearing impaired client in different countries through using the technology:

> I'll give you one who is hearing impaired and so we needed to now, we can't use voice. So WhatsApp, Zoom, all of that is not going to work. So the WhatsApp

> texting actually is what came in here and not the Zoom. The Zoom was not going to work, but WhatsApp did.
>
> The second client is visually impaired, so he cannot see. He also does not live in this country. So we made arrangements for somebody there to get him a cell phone that talks him through everything that comes on his phone. So even if I send him my flyer, he's able to get the information off the flyer.

Even therapists whose practice required a more "hands on" approach found workarounds to bypass perceived limitations of the technology. Participant 1 said,

> There have been some things that I have been able to offer clients online as body based work, of course they are doing the touch themselves. If they have a partner who is willing and able, I may be instructing the partner in terms of how to administer certain kinds of touch, and I would use like models to demonstrate how to do different kinds of touch and strokes. So, for example, this is one of my puppets. And so I would demonstrate you know how to do certain kinds of touches or teach. I would share videos, and I would even do things like mirror with where the client and myself are mirroring each other.

Output Quality. Output quality is the perception of quality ascribed to the technology's ability to perform the task (Marikyan & Papagiannidis, 2023). Six study participants suggested that they did not experience good output quality due to technical issues which included internet connectivity and issues with software and devices. In fact, some of these issues were so disruptive that they literally ended sessions prematurely leaving the client virtually (no pun intended) abandoned. Participant 5 reported,

> Well, the soft technologies require electricity that is reliable and connectivity that is reliable, and sometimes in the middle of our meeting with the client "zoops" it not there or we are frozen, or it interrupts the pace of the counseling that you're providing, and you never want that when you dealing with people's pain and suffering, and we have no control over it.

Excerpts of other participants' responses supporting this finding are described in Table 2.

Table 2

Participant Responses Regarding the Output Quality Theme

Subtheme	Participants excerpt
Technical issues	The internet connection was so terrible sometimes that I can't even hear anything that they're saying. I can't see them at all at some points, you know. Yeah, so I honestly I didn't like that at all because I felt it really just interrupted the whole therapy experience. (Participant 7)
	So not everybody is able to do the Zoom, you know, [they don't have the] internet connectivity and the device to do it on. (Participant 6).
	And then the third thing is I wouldn't call it technophobia, but I think a mix of all the issues that could be wrong in technology. Internet dropping, mic not working, camera not working properly, distractions, you are not sure what the person is really doing. All those kinds of things that could perhaps compromise the effectiveness of a therapy session. (Participant 9)
	But anyhow, so we got to do virtual counselling. And that was a little bit better. The internet, I don't know why if it's the system or what, but the internet in here is a bit choppy… the internet would drop, and we might lose the call. So there was some of that happening. (Participant 9)
	I think that the other aspects of it, like for example writing prescriptions, having them collect prescriptions. Again, I think a company came up with an app that would allow you to send the prescription to the pharmacy, but that too would be an issue because you'd have to write a prescription, leave it somewhere for them to collect. (Participant 9)

Result Demonstrability. Result demonstrability is evidence of tangible results arising from using the technology (Marikyan & Papagiannidis, 2023). This means that the

benefits arising from the use of the technology should be such that users are able to communicate these results to others and the results should be explicit or obvious and measurable (Marikyan & Papagiannidis, 2023). All ten participants suggested tangible results associated with employing online interventions.

For example, Participant 6 mentioned that clients are more likely to attend online sessions, “once we can set up the time that's convenient to them, they're more likely to come on the session”. Participant 8 offered that online interventions saved on transportation costs and they no longer need to move around to various physical locations:

> So myself and my other psychologist they have to transfer from site to site. It is not a matter that we are staying at one point for the entire day. It is a matter that we go there when we have a client. We you get stood up, it is a large problem. So the online aspect cuts that down significantly.

The advantages of the technology positively impacting on the provider’s bottom line was also echoed by Participant 3 who indicated that it offered them the opportunity to earn FOREX at a time when FOREX was difficult to source. Participant 2 spoke about expanding her ability to connect with diverse peoples including those who were introverted, had tight schedules and those that spoke limited or no English:

> I think that it has definitely allowed me to reach more people of different people who are introverted, who don't really like to come out of their house or go in person and meet people. People who are really busy and don't have the time to like leave where they are to come down to my office so it has helped me to really

> reach a wider range of individuals. It has also helped me to interact with people who don't even talk much English. So using Google Translate and all of these things, I must say it has been quite an interesting experience to be able to reach people because there's a lot of foreigners and stuff, ambassadors who do come to me for advice about different things.

Participant 3 was able to expand their reach beyond their usual geographical catchment areas and able to connect with clients who were differently abled, stating:

> The advantage that we have now is that now we have quite a number of persons who do not live within the geographical area that I live…I've done it in Hawaii. I've done in Bermuda. I've done in Guyana, St. Lucia. A number of places I've done, the United Kingdom… There is a client who is not from this country but he has, well, there are two clients. I'll give you one who is hearing impaired and so we needed to now, we can't use voice. So WhatsApp, Zoom, all of that is not going to work. So the WhatsApp texting actually is what came in here and not the Zoom.

Whereas Participant 7 pointed to the fact that the technology offered a means to connect with clients who were neurodivergent and to younger age groups:

> So for example, memes are like a really big thing in my office right. So sometimes they can't tell me how they feel. So they'll just like pull up their Instagram or something on their laptop. And they'll like scroll through some different memes to me and they'll be like, well, this is how I feel. This is how I'm going… And like it just registers for some reason. So memes, I have to say is like

> a huge form of communication, especially from like my, I guess, 25 to 30 year olds because I mean that's where the meme thing was really big. My younger clients are more like the Tik Toks. So I get shown a lot of those when they share their screen with me.

Participant 1 indicated that the technology became part of their personal safety protocol and used it to screen clients before sessions:

> I've also found that in terms of screening clients, especially for me I have had some uncomfortable situations with male clients and so it offers some level of screening when I am working with or considering working with a male client.

Participant 6 contributed to the safety theme by asserting that online mental health interventions offered a safe space for stigmatized or marginalized groups and persons to garner support, help and community:

> So that was a WhatsApp group. We've kind of facilitated psychoeducational group sessions. So not necessarily a support group, but more in, we do the group. We kind of present on some things. People then talk about how they feel, and then we kind of bring in some educational element to it… And I was trying to connect him to that group because he didn't know any gay people. And I was like, don't go and meet random gay people. This is a very controlled group.

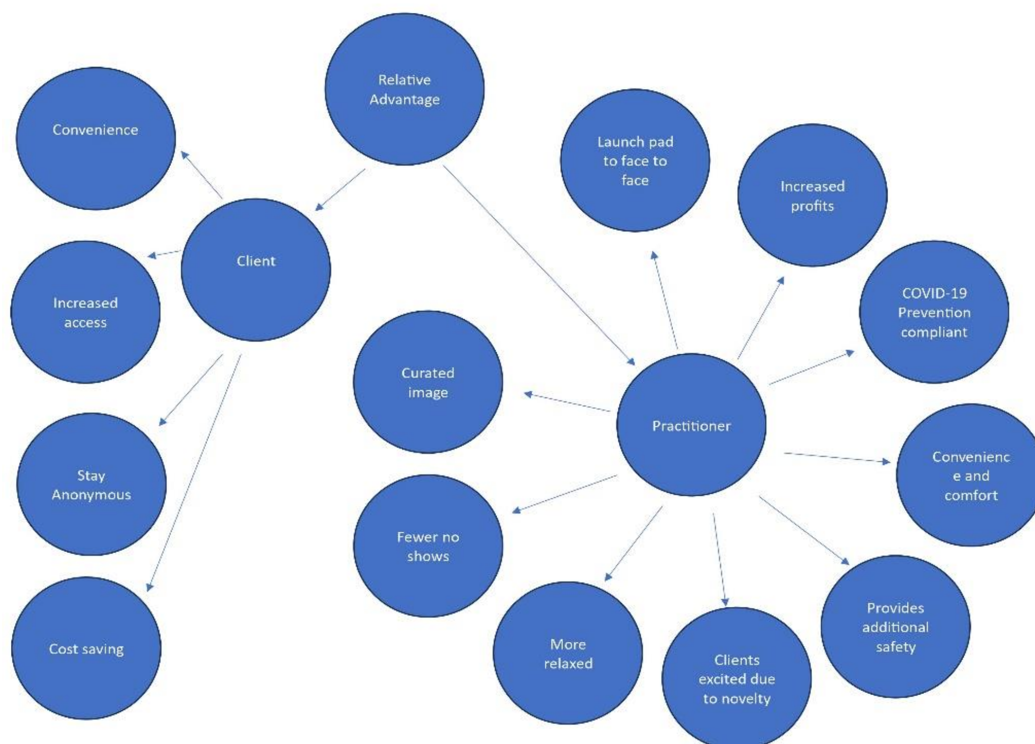
Relative Advantage or Perceived Usefulness

Regarding relative advantage or PU, participant responses suggested several advantages for clients and practitioners alone and mutual benefits. There were also disadvantages associated with online mental health interventions practitioners alone. For

example, advantages for clients consisted of allowing clients to stay anonymous. With respect to the advantages for practitioners alone, all participants suggested positive advantages associated with implementing online mental health interventions. These included fewer no shows (n = 6), allowed for better record keeping (n=1) increased profits due to increased clientele (n=5), cost saving because of less overheads (n=3), able to respond immediately to emergency requests (n=3), feeling more relaxed (n = 2), greater control over schedule (n=3), more control over their appearance (n=2), excited clients due to novelty (n = 1), using online interventions provides additional safety for the practitioner (n = 2).

Figure 4

Practitioners' Perceived Relative Advantage for the Client and Self



Excerpts of participants' responses are described in Table 3.

Table 3

Responses Supporting the Theme and Subthemes of the Relative Advantage for Clients and Practitioners

Regarding	Subthemes	Participant excerpts
Client	Stay anonymous	So it is less of a risk I guess, like cutting down on their travel time and their interaction with people on their way to a session. (Participant 1) So again, this facilitated it well because nobody wants to see a High Court judge pull up into a yard to get counseling, you see. So he did not need to leave home. He had the privacy of his own space and so on…They can be anonymous, so there's that confidentiality and the privacy as well. (Participant 3)
Practitioner	Fewer no shows	Well one of the benefits I kind of mentioned is that for the clients who can do the virtual; once we can set up the time that's convenient to them, they're more likely to come on the session. (Participant 6) Well, one you get stood up a lot less. (Participant 9)
	More relaxed	I get dress a little bit more comfortably. So I don't have to worry too much about how I look per se. (Participant 7) I know also I wear some of that anxiety though. Because I think I was saying before, I become very aware of how much time I'm taking away from people's… I become very aware of that. In the virtual sessions I kind of relax more. (Participant 6)
	The client is excited due to the novelty	Well, I guess it is because of COVID. But the novelty of the newness of this way of doing therapy, I think people had a certain kind of excitement about that, and that most certainly was encouraging. (Participant 6)
	Provides additional safety	I've also found that in terms of screening clients, especially for me, I have had some uncomfortable situations with male clients, and so it offers some level of screening when I am working with or considering working with a male client. (Participant 1)
	Better record keeping	And the reason that I like email in that context is that it's written. A phone call, you might forget what was said or you might misrepresent what was said. But with email, you have texts that you could refer to. And you could kind of track things based on a conversation over a couple of weeks, you could see the emails they send and the timing and... so from that point of view, and I think that too became, so like somebody would come and see me once and perhaps wouldn't want to come back for whatever reason related to the pandemic, but we could keep in touch by email. (Participant 9)

Regarding	Subthemes	Participant excerpts
	Cost savings due to less overheads	There is once again, cutting down cost of traveling to and from the office space and so time wise, cost wise in terms of travel expenses and of course the convenience of comfort of being in my home space there are those benefits. (Participant 1)
	Greater control over schedule	So one of the other things about online appointments are that they tend to be more, what's the word," precise in the sense that in person somebody might get stuck in traffic or they can find a place to park. Whereas with online, because you're not limited by those physical conditionality's, if you say it's four o'clock, it's four o'clock. (Participant 9)
	Better positioned to respond to emergencies	We set the appointment. It was at 12:00 o'clock. I remember that clearly and she said before she hung up, "Could you say something to encourage me, to lift be because I feel so down?" I said a few words to encourage her and I said, but we'll talk more when I get there. And the Friday before I got there, the station called and said the person that called in on your radio program just committed suicide. Now had I had technology, I would have never waited so long. I would have dealt with it immediately. But because we are into the face-to-face, right? (Participant 3) Well, that would depend because sometimes people might call you girl, I want to talk to you. And it might be a little after hours. So you have the technology. So you use it. (Participant 10)
	More control over professional image	I know that they are, and I know that they don't worry that much about me per se as a person, but my own like thoughts are still there. If my dress looks okay, if my pants have like dog on it. Those are like concerns that I have because I don't want them to see me as like unprofessional. And it's a lot easier to portray myself as professional in like a Zoom contact because I don't worry that much about how I look to them. (Participant 7)

The relative advantage of employing an online intervention in mental health treatment was also described by participants as related to the perceived positive and negative aspects for both client and practitioner jointly. As illustrated in Figure 5, positive factors influencing participants' perceived relative advantage of using an online mental health intervention included that these were more convenient. More specifically, sub themes identified for convenience included (a) reduced travel time and costs, (b) more comfortable, (c) reduced treatment time, (d) more accessible, and (e) improves

logistics. The prevention of the transmission of COVID-19 was also mentioned and it was perceived that both shareholders benefited from the additional accessibility that the technology offered.

Excerpts of participants' statements supporting each identified positive subtheme are described in Table 4.

Figure 2

Positive Relative Advantage for Both Client and Practitioner

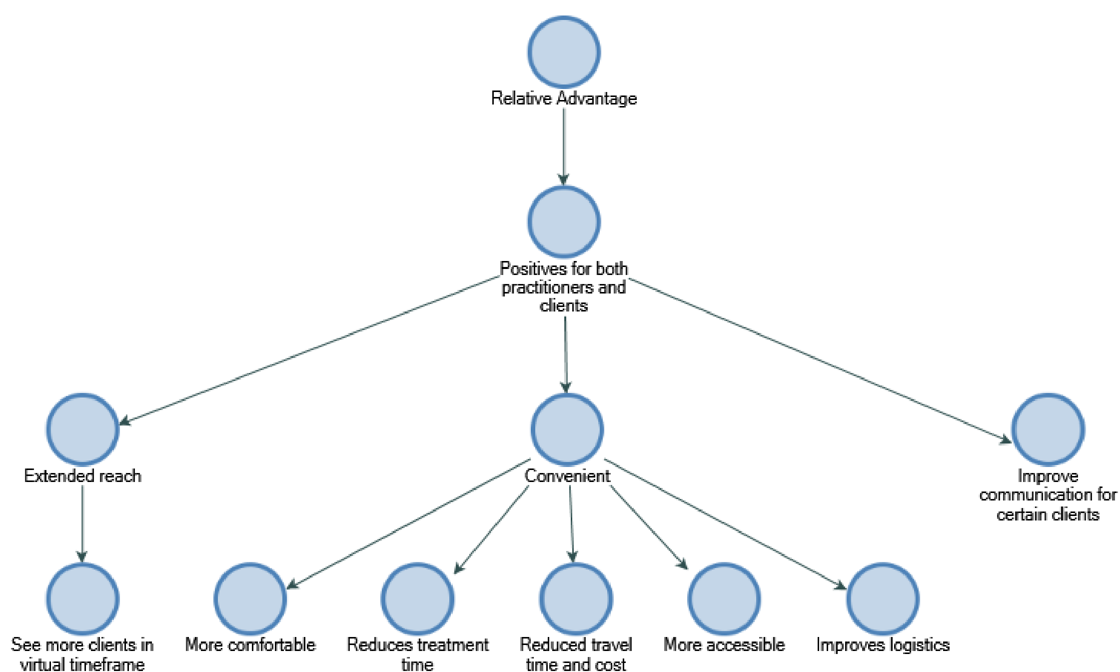


Table 4

Responses Supporting the Theme and Subthemes of the Joint Relative Advantage for Clients and Practitioners

Regarding	Subthemes		Participant excerpts
Positive	Extended reach		The advantage that we have now is that now we have quite a number of persons who do not live within the geographical area that I live. (Participant 3)
			I could definitely see the advantages for them in terms of like the more practical real-life reasons like you can't get transportation. (Participant 7)
			You can actually have more sessions on virtual than in-person sessions, I have found. (Participant 6)
	Convenient	Reduced travel time and cost	It is less in terms of transportation or transit time. (Participant 9)
			Like cutting down on their travel time and their interaction with people on their way to a session. And of course, I guess there's also been money saving aspect of that right. (Participant 1)
		More comfortable	I get dress a little bit more comfortably. So I don't have to worry too much about how I look per se. (Participant 7)
			There are settled in their homes. They get to choose the environment they want. They get to create this kind of space that makes them comfortable. (Participant 1)
		Reduces treatment time	Had I had technology, I would have never waited so long. I would have dealt with it immediately, but because we are into the face-to-face, right? So I sat in the office the Saturday. This spot was still available. I never even filled it with another client and I sat in the office and I reminisced on this thing, and I said, if something else had been done, she would have been alive today sitting in front of me. (Participant 3)
		More accessible	So it provides that access to areas where I would not usually have access to specifically. (Participant 9)

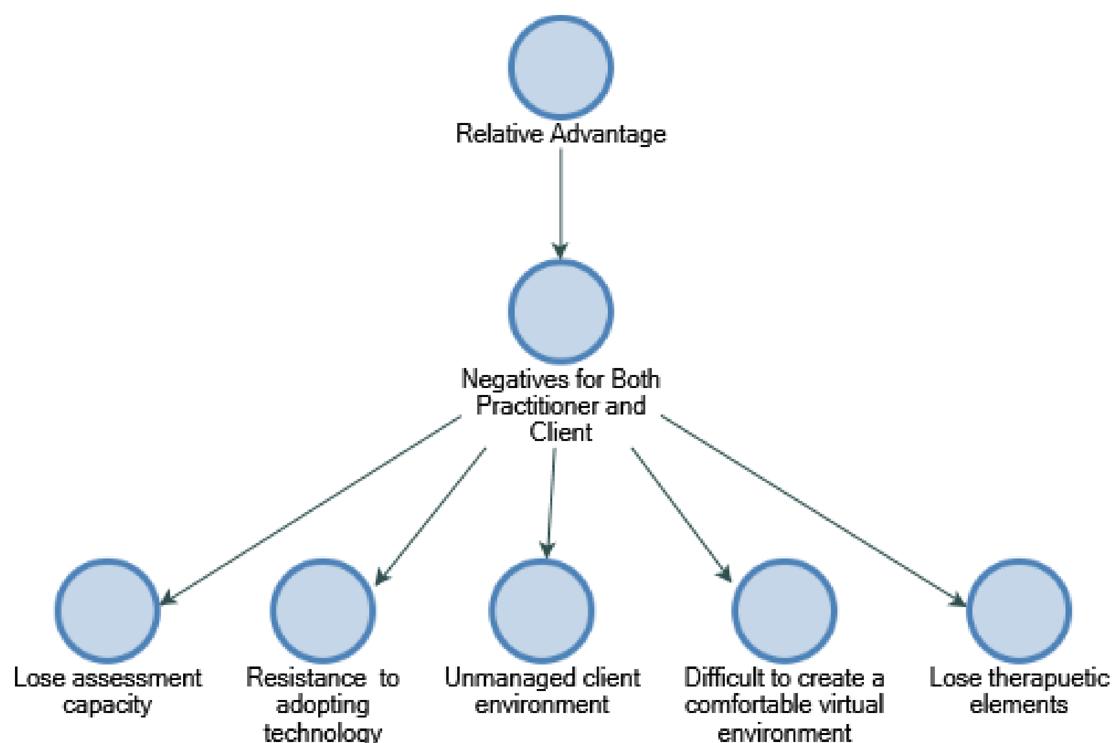
Regarding	Subthemes	Participant excerpts
		If they live alone or they have like agoraphobia and they just prefer the comfort of their room and that kind of thing then fine. That I think works for them. (Participant 7)
	Improves logistics	But you might find that one session runs longer than anticipated and the other client would arrive. So it is in our interest for them not to cross paths. So the office staff would advise me that the other client has arrived and we will slip the other person through the back door so that they never meet. (Participant 3)
Negative	Lose assessment capacity	I like to have them in my office because I could see their facial expressions better. I could see their body language better. (Participant 7)
		One could argue that you kind of need to see the person. Because you need to read body language and kind of facial expression, but you might not be able to do just of a telephone conversation. (Participant 9)
		One of the realities of being a human being is, to my understanding, that more than 90% of our communication as human beings are nonverbal. And, you know, yes the technology gives us some access to the nonverbals depending on which one we using. The entirety of the human communication system as a human being is lost. (Participant 5)
	Resistance to adopting technology	Tele-counselling would not have been considered professional by the state, by the division where I'm at. (Participant 6)
		I mean it's two years now we've been doing this and some clinicians still say they prefer the face to face. Clients are still, I want to say harassing us because it's becoming you know, "When allyuh opening up?" "I wearing my mask, can I come?" People are getting antsy. They want face to face. They want that connectivity with us…Now, part of that, I submit has to do with our cultural heritage of being highly relationship oriented. We are so social it's ridiculous. (Participant 5)
		People still wanted the face-to-face. (Participant 9)
		Some of the population that we serve are not very savvy technically, or they don't have access to the internet or both, or they're not

Regarding	Subthemes	Participant excerpts
		comfortable with using the technology. (Participant 5)
	Unmanaged client virtual environment	Yes, those sort of interruptions [people in the background]. Oh my word, yes. So it's the management of the environment that the client is in. (Participant 3)
		You are not sure what the person really doing. All those kinds of things that could perhaps compromise the effectiveness of a therapy session. (Participant 9)
		And I had to call them in. Because it was couples' counselling, I felt it was difficult for me to manage when they had conflict when they were in the stage by themselves and I am across here. (Participant 6)
		This is a very controlled group. So he got my number that way and he Oh God is a pest. And so it is a lot of what you doing? Well I'm on work. He says so you ate. I'm like what? Why do you always ask me if I ate? He says I just ask. And then he would say, well, I wake up this morning and I was feeling real anxious and "duh duh duh duh". And, and so I have to manage that because at any hour he day or night, if he feels anxious, if he gets a headache, he's texting me. (Participant 6)
	Difficulties in creating comfort	but you can at least see and be able to tell some kind of micro expressions in the face sometimes. And so that was a bit better. But there still is some restriction there in terms of closeness and how do you create a connection between clients and counsellor that seems trustworthy (Participant 6)
		I have to try extra hard in terms of letting them know that okay I understand exactly what you're saying. Everything has to be slightly more exaggerated because when you're online, it's a little bit muted, you know. (Participant 7)
	Lose therapeutic elements	So for those cases, especially one the environment and two, if their mental health is not the greatest, I would prefer if they leave their house because leaving their house, like just leaving your home sometimes, really does help your mental. (Participant 7)

As illustrated in Figure 6, participant responses regarding negative factors influencing participants' perceived relative advantage for both client and practitioner jointly included (a) losing assessment capacity (n = 6), (b) resistance to adopting technology (n = 5), (c) unmanaged client environments (n = 3), (d) difficulty in creating a comfortable environment (n = 2), and (e) losing therapeutic elements (n = 1). Table 4 provides the excerpts of participants' statements supporting each negative subtheme identified.

Figure 3

Negative Relative Advantage for Both Client and Practitioner



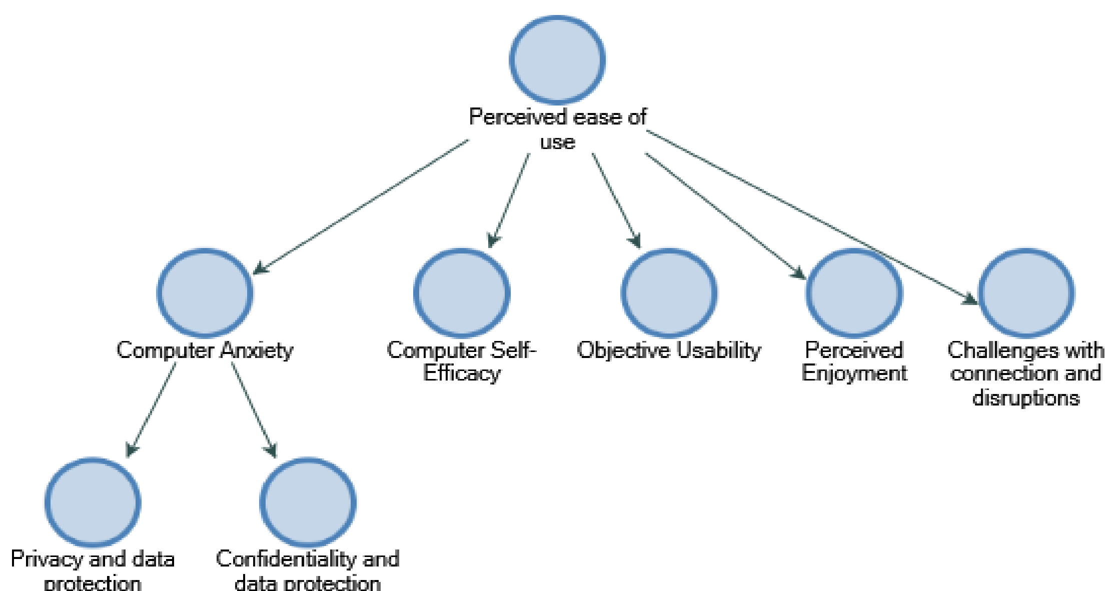
Perceived Ease of Use

PEU is suggested by the theoretical framework to be influenced by an individual’s CSE, perceptions of external control, CANX, playfulness, PEN and OU. In addition to

these elements of the theoretical framework, participants also suggested their perceptions of how easy it is to use online mental health interventions were based on their perceived challenges with connecting online and potential disruptions. Therefore, one subtheme identified under PEU was challenges with connection and disruptions (n = 5). The following section will review these elements of the theoretical framework supported by Participant responses in this study that are suggested to influence PEU, as illustrated in Figure 7.

Figure 7

Perceived Ease of Use



Computer Anxiety. CANX is the level of a person's apprehension when faced with the opportunity to use a computer (Marikyan & Papagiannidis, 2023). Half of the participants of the study (n = 5) suggested they experienced CANX as it related to their concerns associated with privacy (n = 2), confidentiality (n = 3), data protection (n = 5),

anticipated disruptions in the flow of the therapeutic process (*n*=2) and just the prospect of using the technology (*n*=2). Participant 9 reported,

> I guess part of it is the generation I'm from, the technology is new. I'm not as accepting of it as perhaps some of my younger colleagues. So there's always, for me personally, some degree of, I wouldn't say discomfort, discomfort might be a strong word, but some degree of tension about using it.

It is worth noting that computer anxiety decreased with usage. One participant reported expecting the worst in terms of disruptions and broadband issues but indicated that even when these incidents happened they were quickly resolved (Participant 8).

Computer Self-Efficacy. CSE is defined as the belief by an individual that they can perform an articulated task or job using the technology or computer (Marikyan & Papagiannidis, 2023). All participants in the study made statements supporting the element of CSE specifically using the technology to conduct therapeutic sessions as they had used the technologies to perform other tasks prior such as virtual meetings and scheduling appointments. Therefore, it can be inferred, any hesitancy on their part to use the technology for therapeutic sessions had nothing to do with their ability to proficiently use a computer to perform that task.

Objective Usability. OU is described as an assessment of systems based on the actual effort needed to finish a specified task (Marikyan & Papagiannidis, 2023). Nine participants in the study made statements supporting the OU element of the theoretical framework. Indeed, participants reported being pleasantly surprised (Participant 8),

changing their mind completely to a more positive outlook (Participants 2 and 7) and, preferring it in certain situations like a pandemic (*n*=9).

Perceived Enjoyment. PEN is the personal perception that using a specific system is enjoyable separate and apart from performance benefits (Marikyan & Papagiannidis, 2023). Three study participants made statements supporting the element of PEN from the theoretical framework with Participant 1 describing the experience as fun “you know it's not quite the same, but you know close enough I think to make you feel Oh, that was fun”, breaking the monotony of lockdown (Participant 6) and exchanging media (Participant 7).

Computer Playfulness. CPLY refers to the user’s ability to interact with computers in a spontaneous, imaginative, and inventive way (Marikyan & Papagiannidis, 2023). Three participants made statements that alluded to CPLY specifically the sharing of clips, memes, and TikTok videos to convey present emotional states (Participant 7), the use of avatars (Participant 1) and an excitement to try out novel technology (Participant 6). Participant 6 pointed out that online mental health interventions proved to be a welcome change from the disconnect of lockdowns that came with COVID-19 and clients welcomed interacting with and trying something new.

Perceptions of External Control. PEC refer to the individual perception of the availability of institutional support mechanisms and resources to facilitate the use of a system (Venkatesh & Bala, 2008). The majority of participants (*n*=8) made statements indicating that they felt they had the institutional support and resources they needed to effectively implement and use the technologies in therapeutic practice. Responses,

however, seem to be divided done private sector versus public sector lines with the two participants attached to the public sector both having a negative view of resources allocated to online mental health interventions, the bureaucracy involved in establishing and maintaining these interventions, and the perceived lack of policy directive from “the top”. Participant 9 recounted relying on donations from foreign diplomatic agencies for basic hardware and pointed out that the system needed more technological “add ons” in order to be completely seamless. The lack of resources allocated was also echoed by Participant 6 who indicated that the lack of adequate space potentially comprised the privacy and confidentiality of clients:

> Well some of it is logistics in terms of the actual infrastructure. And so we have two counselling rooms, but all of the phones are on a desk and they only desks are in one large room. So all of the officers… all of them is one large room. And so if you're on the phone, first of all, it's just distracting everybody, but also if somebody just wants to lean in and pay attention, they can hear what you're saying.

The bureaucracy of the public sector was also singled out by participants as one the factors that undermined the use of these technologies:

> The resistance was just the logistics around it. It meant that you had to book IT. IT had to go and find a separate desktop…Drill some holes here. Then IT had to get the cord and run the wire, set up the computer and connect it to the network. All could have been done in a day. But when it is the government system, right. So the people who drilling the holes in the wall is not the people who running the

> cord. And the people who doing those other two thing is not the IT guy who setting up the link. (Participant 6)

A lack of clear policy directives was also cited as being a barrier to PEU with one Participant reporting that they (the employees) were the drivers of the technology in the absence of no directive from administration (Participant 6). In other institutions there was a virtual (no pun intended) shut down of services with patients only being issued refills without being seen initially and that video counseling of patients were established one year after the initial lockdowns in 2020:

> I mean not in any organized way. I think what had happened in the public sector is that clinics as well had shut down because of the lockdown and because of the fear of COVID and that' on both sides of the equation, both the patients and the treatment teams. So they were just refilling prescriptions for the most part. And of course, people would complain about that because in some instances it might have been six months or nine months when you hadn't seen anybody. You would just go to the health centre, get your prescription and fill it… And then as people began to become more accustomed to the pandemic, and the availability of these virtual platforms for interaction, the propensity for some people to access those increased… I would say that would've begun probably early 21. (Participant 9)

The reported reality from those in the private sector was marked different with most (*n*=7) reporting being able to pivot in a relatively short space of time with clear direction from administration as to the direction the institution was heading in and guidelines to be implemented for professional practice. Participant 5 reported,

> What the company did, we took an organization decision and the board of directors gave us agreement on our policy decision and we devised policies to manage provision of care. So we have different, a whole set of protocols that clients must adhere to in order to access our services virtually, yeah. There are certain restrictions that we put in the policy. For example, they have to dress appropriately because if it's virtual, you don't want to be providing services to someone in their birthday suits, you know. They have to be in a confidential, secure location, for example without any possibility of disturbance. So those are two examples of what was inside the policy that governed the provision of services remotely.

Similarly, Participant 7 reported the ability to rapidly transition to online mental health interventions and the changes in policy that this transition necessitated:

> So between March and April, I did close for a short period of time, right. So I did close for maybe 3 weeks I would say. Yeah, I closed for about three weeks just so I could get the office ready, get like all the sanitization gear, any PPE I thought I needed to get, because the intention was to start back like as soon as possible face to face.

Table 5 provides excerpts from participants' responses supporting the theme and subthemes identified in this study.

Table 5

Responses Supporting the Theme and Subthemes of Perceived Ease of Use

Theme	Subthemes		Participant excerpts
Perceived ease of use	Computer anxiety	Privacy and data protection	I mean that on the one hand. I think on the other hand. I think we still have, which is also kind of paradoxical, a fear of your information not being private. (Participant 9)
		Confidentiality and data protection	I did invest in Zoom and some of my clients who actually did not use Zoom or didn't want to use Zoom we ended up using WhatsApp video. It is not HIPPA compliant, but it is encrypted. So there is some level of protection there and they were aware that it was not HIPPA compliant and they were fine with it. (Participant 7)
			Others were concerned about confidentiality, especially with clients who may be in a domestic violence environment. (Participant 5)
	Computer self-efficacy		I like it now with certain things. So for certain clients on certain issues, I think online therapy is enough. I've learned different techniques. I've learned different ways to bring things across. So it's a lot easier now for me. (Participant 7)
	Objective usability		I initially preferred face to face as well. I see that online has its advantages. It is not as terrible as I expected it to be. You know I really anticipated that it would be horrible. (Participant 9)
			So I anticipated that that it would be a very distractible environment. A lot of interruptions that sort of thing. But it did not pan out, even when those things were present, it was fairly transient, we got over it very quickly. (Participant 8)
			Oh I have changed my mind completely. I love online! (Participant 7)
	Perceived enjoyment		You know it's not quite the same, but you know close enough I think to make you feel Oh, that was fun. (Participant 1)

Computer playfulness	I get to show them like little videos and clips on stuff by sharing my screen as well. So I mean, that's kind of fun. And they get to do the same thing. So for example, memes are like a really big thing in my office right. So sometimes they can't tell me how they feel. So they'll just like pull up their Instagram or something on their laptop. And they'll like scroll through some different memes to me and they'll be like, well, this is how I feel. This is how I'm going. And I was like, oh, okay. And like it just registers for some reason. So memes, I have to say is like a huge form of communication, especially from like my, I guess, 25 to 30 year olds because I mean that's where the meme thing was really big. My younger clients are more like the Tik Toks. So I get shown a lot of those when they share their screen with me. (Participant 7). There was also a certain novelty in virtual sessions that made people more excited to be honest… There was an almost, the COVID took so much from you. There was a kind of excitement about being able to not be in the same place and still connect in a way where you could see somebody But the novelty of the newness of this way of doing therapy, I think people had a certain kind of excitement about that. And that most certainly was encouraging. (Participant 6)
Perceptions of external control	And they didn't have the resources to provide the number of tablets needed…In the public sector, the issue was tools because people didn't want use their private phones or tablets or laptops for it. So the provision of tablets and there was a little delay with that. So initially the "online" was really telemedicine. People being called on the telephone. But the British High Commission, they did a donation of tablets as an initiative they had in sort of like the middle of 21. And they distributed tablets to all the health authorities to facilitate virtual sessions. (Participant 9) And then, and there was a struggle to get virtual counselling on because I remember

I just kept asking my boss over and over and over, and partly it was because you were just hearing this all over the place. People had started already doing Zooms. You were hearing who were in their private practice, doing virtual counselling. That just took forever…I think my boss also was just you know. It was COVID all these cases, all these different things happening, trying to do the rotation, people's family dying, people getting COVID. It was not high up on her list of priorities. It's like if you all can get me job done with what you are doing, don't bother me. (Participant 6)

Answer to Research sub question 1

From the analysis of the data, it would seem that most of the study participants (*n*=6) had never used online mental health interventions before the COVID-19 pandemic. In addition, six of the participants in the study suggested that the traditional subjective norms in Trinidad and Tobago were against adopting online mental health interventions. However, the use of online mental health interventions soon became the default or subjective norm with the advent of the COVID- 19 pandemic. All of the participants (*n*=10) in the study suggested they could identify the use of an online mental health intervention within their practice. Most participants (*n*=8) responses supported the theme that the use of online mental health interventions enhanced their image and nine of the participants made statements supporting the theme of job relevance. All participants reported result demonstrability. Most participants (*n*=6) suggested the output quality, as it related to poor network service, was a significant challenge in the Trinidad and Tobago context. Therefore, any PU of using an online mental health intervention as it relates to participants' perceptions of its relevance to their practices is mediated by the negative

output quality created by the poor network services and connectivity in the Trinidad and Tobago context. With regard to perceived ease of use half of the participants suggested they had CANX as it pertained to privacy, disruptions, confidentiality, and data protection. One participant described this phenomenon as “technophobia” (Participant 9). All participants, however, report computer self-efficacy. Objective usability was also quite high with nine of the participants reporting being pleasantly surprised and preferring it in a pandemic setting. However, only three participants reported perceived enjoyment and two participants reported computer playfulness. Perceptions of external control were high with most participants making statements supporting this theme (n=8). Therefore whilst participants perceived that the technology was easy to use, there was very little enjoyment or playfulness to be derived from the technologies.

Finally, participants' responses suggested that participants could equally see the positives and negatives associated with implementing online mental health interventions. Positive factors suggested by participants to bolster the relative advantage of implementing or adopting online mental health interventions included convenience and practitioners' ability to extend their reach by seeing more patients in a day virtually than they could in a face-to-face session and also reaching participants that otherwise may not have access without the online option. Negative factors suggested to exist relating to the adoption of an online mental health intervention consisted of practitioners fearing they would lose their ability to assess the nonverbal cues of their clients, thereby hindering their treatment capacity. They also noted resistance to adopting technology within the Trinidad and Tobago context. Therefore, based on participants' responses, it is evident

that although participants had a positive attitude toward the usefulness and ease of use of online mental health interventions, negative output quality and lack of enjoyment and playfulness negatively impacted upon their overall perception of these interventions.

sub question 2

sub question 2 sought to determine therapists' experiences in Trinidad and Tobago regarding the use of online mental health interventions in therapeutic practice. As suggested by the theoretical framework, the user experience of participants significantly influences participants' CANX, playfulness, PEN, and OU. Participants of the study used a wide range of mediums to provide mental health interventions.

Participants showed preference for video-conferencing with the Zoom platform being the platform of choice (n = 10). Only two participants used encrypted medical platforms [TheraNest (*n*=1) and Doxy.Me (*n*=1)]. Skype (n=6), WhatsApp video (*n*= 5), Microsoft Teams (*n*= 3), Facebook Messenger video (*n*= 3), FaceTime (*n* = 3), Google Meet (*n*= 3), and Teleport (*n*=1) were mentioned by clients. Synchronous/ instant messengers also proved to be well utilized by providers with WhatsApp text messenger being the messenger of choice (*n*= 9) followed by Facebook (*n*= 6), Telegram (*n*= 1), and Signal (*n*=1). Psycho-educational website (*n*= 10), self-directed internet interventions such as questionnaires (*n*= 8), and Vlogging (n=8) were popular mediums among the therapists interviewed.

Therapists also used asynchronous messaging specifically Email (*n*=7) and Text Messages (*n*=4) as well as Online support groups (*n*=6). Synchronous audio conferencing or telephone calls was another medium by which sessions were conducted by therapists

(*n*=6) with one therapist reporting that they had been using these modalities for at least 40 years to conduct sessions (Participant 5). Virtual reality, Gaming, and Virtual Worlds were utilized by practitioners (*n*=5) as well as various apps such Moonology and Google Translate (*n*=5). Blogs were the least favored form of outreach (*n*= 3).

From the responses, one can clearly see a mix of encrypted and unencrypted platforms were utilized by therapists in their practice in an effort to reach clients. The use of unencrypted platforms lends credence to therapists' and clients' concerns about confidentiality and privacy.

Most of the participants interviewed (*n*=7) had used at least six different categories of online mental health interventions from the possible 12 categories established by Barak and Grohol (2011). Therefore, even though the COVID-19 pandemic may have been the catalyst for widespread adoption, therapists ensured that clients had numerous avenues available to access mental healthcare despite whatever personal reservations they, the therapists, may have had about online mental health interventions. Participant responses supporting these platforms are described in Table 6.

Table 6

Participant Responses Supporting Online Mental Health Interventions

Subtheme	Participant excerpts
Online support groups	We have done a support group on WhatsApp, but that's the thing I mean, I know it is a support group. (Participant 6)
Vlogs	[on Facebook Live] we would've done definitely mental health and so general things. So grief and loss, anxiety and depression, and that was kind of covered within the mental health sessions, and there was something that we did that we talked about. (Participant 6).
Synchronous/ Instant messengers	Well I've done WhatsApp video, but we also do WhatsApp text. So I do text therapy as well for just, it's not like a really big thing, just a couple of clients who just not ready, you know, to show their face and stuff, which is fine, and WhatsApp is still considered the safest way to go for that. (Participant 7)
Smartphone apps	It has also helped me to interact with people who don't even talk much English. So using Google Translate and all of these things, I must say it has been quite an interesting experience to be able to reach people because there's a lot of foreigners and stuff, ambassadors who do come to me for advice about different things. And it's a wonderful way of being able to reach everyone. (Participant 2)
	The second client is visually impaired, so he cannot see. He also does not live in this country. So we made arrangements for somebody there to get him a cellphone that talks him through everything that comes on his phone. So even if I send him my flyer, he's able to get the information of the flyer. So sometimes we are able to send him things and he's able to understand everything that I send him because it makes it audio. (Participant 3)
Asynchronous messaging	And the reason that I like email in that context is that it's written. A phone call, you might forget what was said or you might misrepresent what was said. But with email, you have texts that you could refer to. And you could kind of track things based on a conversation over a couple of weeks, you could see the emails they send and the timing. (Participant 9)
Virtual reality	One of my clients, he has it now because he is afraid of flying. So we simulating like airplanes and going on a runway and that kind of thing. So yes, I would say it is fairly new to me though as well. It's not something that I use frequently only because of the knowledge base on it is not the best. (Participant 7)
Gaming and virtual worlds	And so you know you can dress however you want, so you are in your avatars, getting to choose an avatar and appearing how you would like to be. And my students always came as well not always. It was interesting teaching beings that didn't look like humans in an online space. (Participant 1)

Subtheme	Participant excerpts
Psycho-educational websites	So I have my website and it does have some psychoeducational material. It's not a lot. It's mostly geared towards COVID. I have like how to deal with COVID for children. I have one for, I think practitioners and that kind of thing. But there is a site. Oh gosh, I have to get it for you that I do send certain people to specifically. It is called AU Academy … So, this is geared towards autism. (Participant 7)
Telephone calls or synchronous audio conferencing	We've always had telephone counseling session, that's from almost day one or day two of our existence (1985). We've had that, but we expanded to Zoom and meetings, WhatsApp, emails. (Participant 5)
Synchronous video-conferencing	But for the three weeks that I was closed, I did use online, so I did invest in Zoom like everybody else, right, so I did invest in Zoom and some of my clients who actually did not use Zoom or didn't want to use Zoom we ended up using WhatsApp video. (Participant 7) So it's wholly outside of the sessions we would go on Skype and FaceTime or whatever. (Participant 9) Yes we used, and we have used Skype. (Participant 5) (Facetime) Besides our Facebook page, that is the only real or significant online presence that we have, so that is what we would usually refer to particularly for the same reason. (Participant 9) (Google Meet) So I have used that if it's like informal meetings and chats and that kind of thing. (Participant 1)
Interactive, self-directed internet interventions or exercises such as online questionnaires	Sometimes, you know, it's maybe a personality test that you want the client to take or another kind of test that you want them to take as part of like homework to see where your personality lies, see how we can use that to incorporate strengths to deal with this issue. So I've done that for certain. (Participant 6)

Answer to Research sub question 2

Participants' responses regarding their experiences in Trinidad and Tobago regarding the use of online mental health interventions in therapeutic practice suggest limited use until COVID-19. Though those that did use these technologies previously did have a long history of usage with one Participant reporting using teleconferencing for more than 40 years in their practice. It was clear, however, that the restrictions arising out of the pandemic was the catalyst for widespread implementation. Whether we can say there was adoption of these technologies would require a longitudinal study. Participants'

responses did suggest the use of a wide range of platforms and mediums used to connect to and communicate with clients.

Summary

Online platforms for mental health interventions was not considered the most desired medium for therapeutic sessions normally due to several factors namely, Trinidad and Tobago's culture, initial cost associated with implementation, privacy and confidentiality concerns, not being having control over the therapeutic environment, loss of therapeutic assessment, not being considered suitable for the treatment of all mental health issues, and "technophobia"; used here as an umbrella term by Participant 9 for issues with broadband connectivity and hardware malfunction and the lack of self-efficacy of some clients. However, therapists' responses suggest that these technologies were the most desirable interventions given the unique context of a pandemic.

In Chapter 5, I will present an interpretation of the study findings, the implication for positive social change and as well as recommendations for future research . The limitations of the study will be discussed and suggestions for practice, training, and policies will be presented in Chapter 5.

Chapter 5: Discussion, Conclusion, and Recommendations

Introduction

This qualitative study was designed to explore the attitudes and experiences of mental healthcare providers in the Republic of Trinidad and Tobago concerning online mental health interventions. Ten counselors from the Republic of Trinidad and Tobago were recruited into the study to garner their perceptions and experiences regarding the use of online mental health interventions. Research findings suggest that study participants had positive attitudes toward online mental health interventions. However, several challenges and barriers exist that could significantly impede therapists in the Republic of Trinidad and Tobago from readily adopting online mental health interventions. This chapter provides a detailed review of the data collection and analysis process, including a discussion of the evidence of trustworthiness and a review of the research findings. I will summarize the research findings, followed by a discussion of the implications. Chapter 5, as the discussion chapter, will also contain a discussion of the limitations of the current study and recommendations for future research.

This qualitative study explored the attitudes and experiences of mental healthcare providers in Trinidad and Tobago regarding online mental health interventions. A total of 10 counsellors with varying years of experience in the field participated in the study. Their perspectives provide valuable insights into the realities of implementing online mental health interventions in a developing country context and in the English-speaking Caribbean generally and in the Republic of Trinidad and Tobago specifically. In this chapter, I will present an interpretation of the findings that includes a look at the adoption

of technology in therapeutic practice, both pre-pandemic and during the COVID-19 pandemic; challenges to adoption; reported benefits of adoption; and what factors facilitated and hindered adoption. The chapter will also cover the limitations of the study, recommendations for further research, implications of the study for social change and the social determinants for health, as well as implications for therapeutic practice in Trinidad and Tobago.

Interpretation of Findings

Adoption of Online Mental Health Interventions and the COVID-19 Pandemic

From the data gleaned in this study, it was evident that COVID-19 pandemic acted as a catalyst and was the primary driver for the expanded usage and adoption of online mental health interventions in Trinidad and Tobago, as all the therapists interviewed in this study cited face-to-face sessions as their primary delivery modality until the COVID-19 pandemic. This preference for face-to-face sessions among psychotherapists has been well established in the literature (Connolly et al., 2020; Ischizuki & Cotter, 2009; Peterson, 2020) and has been identified as one of the reasons why therapists lag behind their counterparts in the medical field in the adoption of new technologies for service delivery (Parisi, 2020). This phenomenon of COVID-19 being the main driver of adoption in Trinidad and Tobago mirrors the global mass adoption of online mental health interventions due to restrictive measures to curb the spread of COVID-19 (Ganjali et al., 2022; Witteveen et al., 2022). The data from this study suggest that this forced migration to these digital platforms due to the pandemic brought about a dramatic change in the local therapeutic landscape as therapists had to set aside their

articulated preference for face-to-face interactions to comply with public health safety measures.

While participants generally held positive attitudes towards online mental health interventions, several barriers and challenges existed that could significantly impede their widespread adoption. These challenges included the initial cost of implementation, efficacy of clients, onboarding clients despite client preferences for face to face, therapists' own preferences for face to face, technological issues such inconsistent broadband, "technophobia," and concerns about privacy.

Challenges in the Adoption of Online Mental Health Interventions

From the findings of this study, several challenges to the adoption of online mental health interventions in Trinidad and Tobago were identified and are explored below.

Cost

Therapists may face substantial initial cost when investing in the necessary technology for online therapy, and this can be a barrier to adoption. This cost may include the expenses related to purchasing necessary hardware and software, including access to encrypted counseling-specific platforms, setting up an online payment system, securing a high-speed internet connection, creating a suitable space for conducting therapy sessions, as well as lost time:

> It took a couple months just because to do the virtual service network it needed to be there was online payments had to be structured etc. I had a separate account

> everything and organizing with the online payment company. The bank, the online payment everything. (Participant 8)

The price tag attached to the start-up of online therapy services can be daunting and is not isolated to Trinidad and Tobago. Finmodelslab (2023) estimated that the startup cost for an online counseling service in the United States can be anywhere from US$2,000–$25,000, depending on the size and scope of the practice. The cost for website development ranges from US$500–US$5,000, access to an online encrypted platform is US$300–US$5,000, data storage and security costs about US$2000, and US$500–US$3,000 is needed for equipment (Finmodelslab, 2023). There are, of course, other costs involved, but these would have been pertinent to a face-to-face practice as well.

Confidentiality and Privacy

This issue of confidentiality and privacy emerged as a major concern in online therapy, with 9 out of the 10 participants citing this issue as their number one concern with online mental health interventions. Participant 9 indicated that despite the dawn of the information age, with so much information at people's fingertips, "I think on the other hand. I think we still have, which is also kind of paradoxical, a fear of your information not being private." Participant 5 offered other reasons for these concerns from both sides of the fence:

> Some of the population that we serve are not very savvy technically, or they don't have access to the internet or both, or they're not comfortable with using the technology. They feel somebody's listening in on them because, as you know, in

> our environment, confidentiality is king or queen … And I always tell people one of the most frequent hobbies we have in the Caribbean is being a "Maco."

For clarity, the word "Maco" is a local term for a gossip. This perspective is also bolstered by the lengths that clients were willing to go through pre-pandemic so that they would not be seen at the therapist's office, including parking across the street from the therapist's office, asking for sessions to be done in the therapist's car in a secluded location, and exiting the therapist's office through a secret door:

> I have recognized that some people hide their vehicles and walk to the office, you see. So what we did we provided a space that people can actually now park without being seen by people who are walking on the streets or driving by so that people have the freedom because some people are uniformed officers.
>
> Interviewer: So you guys have to operate like Double Palm now. You have to hide.
>
> Participant 3: Actually I have two doors. One door that I would let a customer in and we never call names if we coming out we never call names of the person. But you might find that one session runs longer than anticipated and the other client would arrive. So it is in our interest for them not to cross paths. (Participant 3)

The stigma attached to having a mental health concern and the stigma attached to health seeking may be a motivating factor for these behaviors, and the impact of stigma and discrimination in the Caribbean relative to mental health issues has been well established in the literature (Phillip, 2017; Yorke et al., 2016). Privacy and confidentiality are paramount in therapy; the digital realm heightens these concerns. The inability to

guarantee absolute digital security could possibly hinder online therapy's adoption. Therefore, a comprehensive approach that includes public education campaigns, technological improvements, and guidelines for therapists to maintain privacy and confidentiality in online sessions is necessary to address these concerns.

Loss of Assessment Capacity

Another theme arising from the findings seemed to be diminished assessment capacity due to the loss or limited access to nonverbal cues in online therapy. Therapists often rely on body language, facial expressions, and gestures during face-to-face sessions, which may not be easily observed online (Ishizuki & Cotter, 2009). This loss can limit the therapist's understanding of the client's emotional state and potentially impact the therapy's effectiveness (Békés et al., 2021). Participant 3 shared,

> I want to be able to use a lot of stuff your gesticulations etc. How you're sitting and whether you are fidgeting. As I am now, you cannot tell if I am fidgeting with my hands. But there are some automatic responses that people gave when they are uncomfortable with a question or statement that you needed. And some people are able to manage it with their face, but they might not manage it with the shaking of the legs.

Participant 7 expressed the same concerns: “I like to have them in my office because I could see their facial expressions better. I could see their body language better.” Indeed, 8 out of the 10 participants in the study mentioned loss of assessment capacity as their biggest challenge to using online mental health interventions. This is not novel information to the academic world. Loss of assessment capacity has been cited as a major

challenge since the formative stages of these interventions (Ishizuki & Cotter, 2009; Rochlen et al., 2004), pre-COVID-19 pandemic (Connolly et al., 2020), and continues to be identified as a challenge in the current literature (Barker & Barker, 2022). Indeed, the only participants who did not mention loss of assessment capacity as a challenge were two of the nonconventional therapists. Participant 2, a metaphysician, proffered a possible reason for this anomaly: “Before COVID, I did mostly in person sessions and then I realized that energy doesn't need a physical thing. As soon as I saw you I could have read the energy.”

Difficulty in Establishing Therapeutic Alliance

Some participants reported difficultly with establishing rapport with their clients and needing to try harder to cultivate therapeutic alliance. Participant 7 reported, “You really have to try a lot harder … to get like my emotions and stuff across … Everything has to be slightly more exaggerated because when you're online, it's a little bit muted, you know.” Similarly other participants reported that it took longer to gain participants’ trust and cultivate and reassure clients that they were in a safe space. The experiences of the participants in the study align with the findings of other studies on therapists’ experiences with online mental health interventions. In Békés et al. (2021), a study also conducted during the COVID-19 pandemic, the researchers reported that one of the main challenges that therapists experienced when using online mental health interventions was not being able to feel emotionally connected with the client and an inability to establish an empathic connection. However, the findings in another study, Khan et al. (2022), indicated that online mental health interventions facilitated the therapeutic alliance

through a disinhibition effect. Perhaps exploring this phenomenon could be a possible area for future research.

"Technophobia" or Computer Anxiety

"Technophobia," it seems, could possibly deter some individuals from embracing online therapy. Technophobia, according to Participant 9, should include not just the resistance and aversion to new technologies, but also the anticipation of everything that can go wrong with technology:

> Yeah. Internet dropping, mic not working, camera not working properly, distractions. You are not sure what the person really doing. All those kinds of things that could perhaps compromise the effectiveness of a therapy session. So I think for all those reasons, I think people by and large preferred to come in.

These concerns can certainly be amplified when technical issues arise in therapy sessions. Malfunctioning hardware or software and poor broadband connectivity can impact the effectiveness of online therapy (Békés et al., 2020). In a study of 190 therapists, most of whom were from the United States, therapists reported that by far, their greatest challenge in offering online therapy was the technical aspect (Békés et al., 2020). Interestingly enough, though, when this survey was repeated less than a year later, technological issues did not present as a concern (Békés et al., 2021). It would seem, then, that this might be part of the learning curve, and with practice and time, these issues seem to iron themselves out.

Suitability

Therapists in this study indicated that needs specific to the client may render the client unsuitable for online mental health interventions. Therapists asserted that online mental health interventions may not be suitable for certain disorders such as severe depression and exposure therapies. Indeed, the findings of other studies have expressed similar views, especially with respect to severe depression and psychosis (Cowan et al., 2019; Davies et al., 2020; Kotera et al., 2021). This runs contrary to other studies that have established the effectiveness of these modalities for all mental health issues, including severe depression (Richards & Richardson, 2012) and psychosis (Donahue et al., 2021). Clearly, there is need for further scholastic exploration in this area to gain consensus.

The findings indicate that clients' specific mental health needs and self-efficacy can affect the adoption of online interventions or the therapist's choice of modality. For example, participants reported that clients with agoraphobia found online therapies beneficial as they could access care without leaving their comfort zones while the therapist used the online technology as a starting point to build up to them leaving their homes. However, conditions such as OCD that often require exposure therapies were seen as less suitable for online intervention. Some clients had anxiety around contracting the COVID-19 virus and preferred to be online: "But the thing is, she is also paranoid, so she has anxiety and she is super paranoid about contracting COVID. So I think that's why she loved the Zoom sessions" (Participant 6).

Therapists also questioned the self-efficacy of some clients, which they saw as a potential barrier to the success of online therapy. Therapists noted that some clients might not be comfortable or adept with technology, which could limit their ability to engage effectively in online therapy. Furthermore, clients' access to necessary resources, like a stable internet connection and appropriate hardware, also impacted the use of online interventions. Participant 6 pointed to those limitations when they said, "So not everybody is able to do the Zoom. You know, internet connectivity and the device to do it on." These findings corroborate the findings of other studies that asserted that clients may not have the necessary internal and external resources, and skills to navigate the world of online therapy (Amos et al., 2020; Kaihlanen et al., 2022; Khan et al., 2022).

Loss of Control of Setting and Session

Participants indicated that the therapeutic setting also plays a crucial role in treatment outcomes, as holding therapy sessions in environments where the client experiences stress or trauma can be detrimental to progress. Likewise, some therapists in the study reported having less control over session dynamics and the client's behavior and setting in an online setting. Disruptions, distractions, and a fear of being discovered accessing services or even chatting with a stranger by family members were perceived as hampering sessions. Therapists divulged that this anxiety related to being discovered was increased considerably in situations where there was a history of domestic violence. Interruptions, arguments, and fights during couples and family counseling as well as technological issues had left therapists in these situations feeling powerless to regain control over the session. These blurred lines also manifested themselves as clients who

used these modalities to contact therapists outside of the professional setting and to push the boundaries of formality:

> This is a very controlled group. So he got my number that way and he Oh God is a pest. And so it is a lot of what you doing? Well I'm on work. He says so you ate. I'm like what? Why do you always ask me if I ate? He says I just ask. And then he would say, well, I wake up this morning and I was feeling real anxious and "duh duh duh duh." And, and so I have to manage that because at any hour he day or night, if he feels anxious, if he gets a headache, he's texting me. (Participant 6)

This phenomenon was noted in James et al. (2022) where therapists noted that the maintenance of professional boundaries in online therapy was much harder than face to face sessions from both sides of the therapeutic fence. Therapist noted an urge to divulge more of their private life whilst some clients did not seem to respect the therapeutic space; indeed, one client wanted to have her session done in bed with a glass of wine (James et al., 2022). The limited control over the client and the therapeutic setting was also observed in Békés et al. (2020) and Békés et al. (2021) but only in the case of younger, less experienced therapists. Researchers concluded that older, more experienced therapists were able to harness their experience and vast skill set to overcome these challenges (Békés et al., 2020, 2021).

Culture

From the findings, cultural preferences for in-person interactions could possibly impede the adoption of online therapy. These cultural norms place significant value on face-to-face connections, challenging the shift to virtual therapy. Therapists in the study

reported that clients were willing to meet face to face even in the midst of a pandemic and the resultant severe health guidelines and restrictions and in some cases opted in to pay 20% more to see a therapist face to face. Indeed, Participant 9 was able to attract new clients during the pandemic because they were one of the few mental healthcare providers that continued to have face to face sessions.

This cultural affinity for face to face reflects the findings of migrant studies in other parts of the world. Kaihlanen et al. (2022), a study on immigrants accessing online mention health solutions in Finland, found that migrant groups had a strong preference for face to face sessions as this cohort of clients valued human contact, hand gestures and physical touch. Some participants in Kaihlanen et al. (2022) even viewed digital mental health services as less professional than face to face.

Adoption of Online Mental Health Interventions Pre-COVID-19

Even though the therapists interviewed demonstrated an overwhelming preference for conducting sessions in person, the majority (*n*=6) of them had previously used online technology in their practice to conduct sessions before the COVID-19 pandemic, albeit not to a great extent. The willingness to adapt to societal changes despite decided personal preferences signifies a level of resilience within this community. Their use of online mediums signifies a recognition of the digital era and its growing impact on various aspects of life, including mental healthcare. These changes are not isolated to Trinidad and Tobago. Pierce et al. (2021, p.3) calls this phenomenon “a revolution in mental health delivery”. Perhaps this revolution is the actualization of what was

envisioned by the Internet of Things paradigm- the interconnection of all aspects of our daily lives through the internet (Kumar et al., 2019).

Interestingly, despite using these modalities in their practice, some therapists were unaware that they were characterized as online mental health interventions. When asked about online mental health interventions, therapists readily identified video-conferencing and to a lesser extent, audio-conferencing and emails. However, as the individual participants and I perused the various categories of online mental health interventions as articulated by Barak and Grohol (2011) via the interview prompt (Appendix C), without exception, it became evident that their (the therapist's) use of online mental health interventions was far more expansive than they originally thought. This insight reveals a gap in their awareness of the full spectrum of what is classified as online mental interventions, suggesting that therapists might not view these as distinct therapeutic methods but simply as additional communication channels. Even nonconventional therapists, who preferred in-person interactions (in fact a couple demanded that I interview them in person) had been leveraging digital tools in their pre-pandemic practice to expand their reach to an international audience. When Participant 4, a Hindu pandit and self-professed 'Obeah Man', was asked if he used online mental health interventions pre-pandemic, he reported:

> Yes, WhatsApp and Zoom, Skype … WhatsApp video, and text too … I do Instagram too … And Facebook.
>
> Interviewer: Is that Instagram video?
>
> Participant 4: I use video call.

Participants acknowledged using online platforms to reach clients who could not travel or were geographically distant. It would seem then that despite not necessarily identifying their activities as 'online interventions,' they, the therapists, contributed to the evolution of digital mental healthcare. This phenomenon was observed in both digital natives and digital immigrants in the study. This lack of recognition could result in overlooking best practices for online therapy, potentially impacting client privacy, data security, the therapeutic alliance, and the effectiveness of interventions. Notably, the use of online platforms by traditional healers suggests an evolving mental health landscape where traditional and modern therapeutic methods coexist and evolve together.

This lack of awareness on the part of the therapists suggests a need for greater education among mental health practitioners about what constitutes an online mental health intervention. This could contribute to wider acceptance and implementation of these tools in practice and a clearer understanding of their benefits and limitations. This limited awareness about the wide range of options is not isolated to Trinidad and Tobago. After consultations with clinicians, practitioners and educators in the field of psychology, Gratzer and Goldbloom (2020) asserted a need for updating the educational material and training given to clinicians and identified five areas for further education for clinicians if they are to be adequately prepared for offering E-therapies to clients. Two of these areas were “Knowledge of Options” and “App Selection” as the authors found that many mental health providers had limited knowledge of online mental health interventions and limited working knowledge of the apps available (Gratzer & Goldbloom, 2020 p. 232).

Trinidad and Tobago as Early Adopter

This data collected in this study suggest that Trinidad and Tobago could be classified as an early adopter in the use of online mental health modalities in therapeutic practice with participants reporting the utilization of these technologies, specifically audio-conferencing, as far back as 1985:

> We've always had telephone counselling session, that's from almost day one or day two of our existence (1985). We've had that, but we expanded to Zoom and meetings, WhatsApp, emails. (Participant 5)

If we take into consideration the assertions of Kanani and Regehr (2003)that the first psychotherapeutic interventions offered online was in 1982 and that 1990s saw the emergence of E-clinics in the United States which offered mental health services through encrypted sites (Skinner & Zack, 2004) then Trinidad and Tobago is positioned as an early adopter. Therefore, whilst scholars such as Hughes et al. (1999), Ishizuki and Cotter (2009) and Grady (2012) were admonishing psychotherapists for their resistance to online mental health interventions, therapists in Trinidad and Tobago were already incorporating these technologies into everyday practice as evidenced by the testimony of Participant 5. Indeed, Trinidad and Tobago demonstratively has a noteworthy history of utilizing online mental health technologies as evidenced by the existence of NGOs such as Lifeline, a respected crisis support, and suicide prevention service (Lifelinett, n.d.). This NGO has been a forerunner in using online platforms to reach individuals in for more than four decades; they began operations in 1978 to be exact (Lifelinett, n.d.).

Adoption in the Private Sector Versus Public Sector

The findings indicate differences in the adoption of online mental health services between the public and private sectors in Trinidad and Tobago. In the public sector, this adoption seemed to be a grassroots process initiated by individual therapists and health workers in response to the pandemic. Participants' concerns about a lack of guidelines were exacerbated by the complex bureaucratic structure of the public sector and these administrative hurdles significantly hampered the swift adaptation to online therapy. Moreover, participants noted that resource constraints further impeded the efficient implementation of these digital services and could further complicate the move to online therapy:

> So the provision of tablets and there was a little delay with that. So initially the "online" was really telemedicine. People being called on the telephone. But the British High Commission, they did a donation of tablets as an initiative they had in sort of like the middle of 21. And they distributed tablets to all the health authorities to facilitate virtual sessions. (Participant 9)

This aligns with the assertions of Maeder (2014) and Phillip (2017) that increased access to mental health services in the developing world is often compromised by a dearth of financial resources and a laissez faire approach to mental healthcare by most governments of developing countries (Whiteford et al., 2015).

On the other hand, the evidence seems to indicate the transition to online therapy in the private sector was a top-down approach, with decisions made at higher management levels. This strategy facilitated a more coordinated and seamless transition.

Chronological Age, Number of Practice Years, and Adoption

In this study, it was observed that participants, regardless of age or years in practice, made use of online mental health interventions. Some of the therapists even had a long history of using technologies like teleconferencing in their practices. Participant 5, the most senior Participant in terms of chronological age and years in clinical practice, stated they have used teleconferencing in therapeutic practice for over 40 years and was in the midst of designing an app that would further increase access to mental healthcare for existing and potential patients. Participant 5 said,

> We've always had telephone counselling session, that's from almost day one or day two of our existence [1985]. We've had that, but we expanded to Zoom and meetings, WhatsApp, emails.

This participant's long history with telephone counseling and their ability to adapt to new platforms such as Zoom and WhatsApp illustrate that neither age nor years in practice served as a barrier to technological adoption. This runs contra to the suggestion by Parisi (2020) that and many years of practice act as barriers to adoption of new technologies and the assertions of Venkatesh et al. (2012) that chronological may prove to be a barrier to adoption due to comfort with traditional methods or perceived complexity of technology.

Wan-Chen et al. (2023) similarly observed that older, more experienced therapists, or those working in community mental health facilities, demonstrate better preparedness and efficiency in implementing online counseling. Hennemann et al. (2017) found no association between age and attitudes towards online therapy whilst Békés et al.

(2021) found significant evidence that older, more experienced therapists had fewer issues of any sort in their online sessions Given how divided the scholastic world seems to be regarding this issue, perhaps the variables of chronological age and years in practice and the impact of them on the usage and adaptation of online mental health interventions, could be an area for future research.

Advantages of the Use of Online Mental Health Interventions in Trinidad and Tobago

The adoption of online mental health interventions in therapeutic practice in Trinidad and Tobago has proven advantageous to therapists in several ways.

Launch Pad to Face-to-Face Sessions

The study findings indicate that online mental health interventions may actually provide a beneficial steppingstone for individuals dealing with mental health challenges related to anxiety disorders such as agoraphobia even though this may seem, at first blush, counterproductive. One participant noted,

> Well I've done WhatsApp video, but we also do WhatsApp text. So, I do text therapy as well for just a few clients who are not ready, you know, to show their face and stuff, which is fine, and WhatsApp is still considered the safest way to go for that. For the agoraphobes, it definitely works against them for sure, but getting out of their house is a whole problem on its own. So honestly, sometimes building up to that is actually helpful. So you start with online therapy, and then you slowly start venturing out., so for certain cases of any kind of agoraphobia, I would say for sure online therapies are a really good starting point. (Participant 7)

This method of using synchronous or asynchronous text therapy as a launching pad for other mental health interventions as the therapeutic sessions progress or the use of multimodal online mental health interventions, aligns with the assertions of Schwartzman and Boswell (2020). According to Schwartzman and Boswell (2020), specific types of psychopathy or social challenges may act as barriers to accessing traditional face to face interventions and that online mental health interventions can be used to enhance current treatment options. These specific pathologies include patients who have toxic shame associated with care seeking, are shy or have social anxiety (Lee et al., 2017) and patients whose pathology manifests as the lack of motivation to do even the most basic of tasks (Imel et al., 2017).

Bouchard et al. (2000), explored the effectiveness of online mental health interventions on person living with agoraphobia. Participants in that study reported that online sessions acted as a desensitization tool that allowed their clients gradually become comfortable with engaging in face-to-face meetings and venturing outside their homes (Bouchard et al., 2000). The findings of my study may indicate that the effectiveness of online mental health interventions can be replicated in the developing world despite cultural and technological challenges.

Ease of Business

Participants reported that online platforms allowed therapists to connect with their clients easily, even when they are not physically in the same location. This made conducting sessions from the comfort of their homes or offices possible; simplifying logistics and making it easier to manage their practice. Additionally, participants

mentioned that clients were more likely to attend online sessions, attend sessions on time and reported less cancellations. Therapists in this study reported that even when clients did cancel appointments, there was less inconvenience and disruption to their schedule. This paves the way for greater control over the schedule at both ends. This supports the findings of Lynch et al. (2021) where less cancellations or missed sessions by clients were reported whilst offering administrative agility to therapists and administrative staff.

Impacts Positively on the Bottom Line

Whilst the initial startup of an online counseling business may incur some additional costs, therapists reported that online mental health interventions also had financial benefits. For example, the cost of traveling to and from office spaces or the cost of maintaining a physical space for practice can be substantial and therapists reported reducing these overhead costs by conducting sessions online, thereby contributing positively to their bottom line. Khan et al. (2022) also arrived at the same conclusions with therapists opting for online interventions as a result of the rising cost associated with procuring an office space. Therapists in that study described online interventions as a relatively cheaper and less complex business model (Khan et al., 2022).

Increased Geographical Reach and Accessibility

Perhaps one of the more significant benefits of online mental health interventions reported by therapists was the opportunity for therapists to expand their reach to a wider range of clients. They reported no longer being limited to those living in their immediate geographical area and being able to provide services to clients across the country, regionally and internationally. Expats residing in other countries were able to benefit

from a familiar voice and accent as members of the Trinidad and Tobago Diaspora living abroad searched for and were able to connect with a therapist from home. Therapists reported being sought out by members of the Diaspora for the opportunity to speak Trinbagonian English and not having to think about speaking Standard English. Therapists remarked that accessing therapy in Trinidad and Tobago was significantly cheaper than the jurisdictions their clients were currently residing. Online platforms made mental health services more accessible to clients with difficulties attending in-person sessions due to geographical, mobility, or time constraints. The potential for online interventions to transcend time and space was cited from its inception (Reamer, 2013) and continues to be one of the more important advantages of using these technologies (Sander et al., 2022).

Increased Inclusivity for Vulnerable Groups

The findings suggest that online mental health interventions offer increased inclusivity for vulnerable groups specifically those persons who are differently abled, neurodivergent, younger people and those persons who speak a different language from that of the therapist.

Differently Abled. Therapists were able to connect with clients who had auditory impairments as well as clients who were visually impaired. This runs contra to the current research that deems online mental health interventions unsuitable for individuals with auditory and visual impairments (Cowan et al., 2019). Further research in the suitability of these modality for the visual and auditive impaired may be needed for more definitive

answers given the fact that hitherto this study, only pre-pandemic studies are available for examination.

Increased Access and Expression for Neuro-Divergent Persons. Previous studies also indicated that online mental health interventions were unsuitable for persons who were neurodivergent or who had "cognitive impairments" (Cowan et al., 2019; p. 2512). Findings from this study suggests that the various modalities under the umbrella of online mental health interventions offered these clients the flexibility and media [through the use of emojis, memes, videos, Tik Toks and Instagram reels] to express their current affect and concerns. Exploring online mental health interventions and its effectiveness and suitability for persons living with neurodivergence may be another valid area for future study. They would have also had to migrate to digital platforms for therapy during the COVID-19 pandemic. It would be interesting to capture their experiences and thoughts about using these interventions.

Younger Persons. The findings of this study indicate that younger persons seem to adapt well to online technologies and even prefer these modalities to the traditional face to face sessions. This can be quite valuable information for any holistic plan to address the current mental health crisis among children and adolescents all over the world (Zohuri & Zadeh, 2020) and Trinidad and Tobago specifically (Kolves & De Leo, 2014; Ramkissoon et al., 2017; Toussaint et al., 2015). These findings echo the conclusions of other studies that online mental health interventions are quite effective among youthful populations (McWilliams & Myers, 2018) and young people actually prefer online session to face to face interactions with their therapist (Nicholas et al., 2021). Indeed the

National Institute for Health and Care Guidance in England has recommended that digital interventions be the first port of call for youth seeking mental healthcare (Wise, 2019).

Eliminating Language Barriers. Applications such as Google Translate have allowed therapists in Trinidad and Tobago to expand their reach and services to persons speaking a language other than that of the therapist. Whilst the example given by Participant 2 in the study is of a client in India speaking Hindi and connecting to the therapist via Google Translate, perhaps these technologies can be more locally applied specifically with regard to expanding health services extended to the burgeoning Venezuelan population resident in Trinidad and Tobago. Trinidad and Tobago has a growing number of Venezuelan nationals fleeing economic hardship in Venezuela (Amnesty International, 2023).

Quick Response to Emergency Requests

Current research indicates that online mental health interventions may not be suitable for persons in the throes of a mental health crisis (Cowan et al., 2019; Khan et al., 2022; Kotera et al., 2021). However, therapists in this study indicated that the use of online platforms for mental health interventions allowed them to respond quickly to emergency requests from clients. This can be particularly valuable in situations where immediate assistance is required but the client is unable to travel to a physical location. The example given by Participant 3 is particularly poignant as they emotionally recounted losing a client to suicide whilst waiting for their physical meet up on the other island:

> I said a few words to encourage her and I said, but we'll talk more when I get there. And the Friday before I got there, the station called and said the person that called in on your radio programme just committed suicide. Now had I had technology, I would have never waited so long. I would have dealt with it immediately. But because we are into the face-to-face, right? (Participant 3)

Further enquiry into this issue may result in more definitive answers.

Convenience and Comfort

The convenience of being able to engage in therapy from the comfort of one's own home for both therapist and client was another advantage highlighted by the therapists. Therapists indicated that this was especially relevant to clients that were well known or in the public eye. “Nobody wants to see a High Court judge pull up into a yard to get counselling, you see” (Participant 3). Other participants mentioned foreign diplomats stationed in Trinidad and Tobago, police officers and other public personalities especially preferred the convenience of their home. In terms of how they benefited, therapists mentioned being able to dress a little bit more comfortably, being in the comfort of their own surrounds, not having to travel as well as not having worry about how they looked because of the employment of filters or an avatar if immersed in a virtual world. Participants also reported feeling less anxious about therapy sessions so it would seem that there are benefits for the mental health of therapists. Participant 6 reported that

> I know also I wear some of that anxiety though. Because I think I was saying before, I become very aware of how much time I'm taking away from people's lives…I become very aware of that. In the virtual sessions I kind of relax more.

The theme of convenience and comfort has always been cited and continues to be cited as one of the benefits of online mental health intervention (Ishizuki & Cotter, 2009; Khan et al., 2022). In other studies therapist have reported feeling more relaxed during virtual sessions so this study corroborates these findings (James et al., 2022). What seems to be novel information though seems to be the use of filters and avatars to take the focus and pressure off of the therapist so that the client receives the undivided attention that they deserve. Further exploration of this phenomenon may be necessary to draw conclusions as to whether this truly enhances or detracts from the therapeutic experience.

Safety

The findings suggest that therapists, especially those that identify as female, may feel safer in online environments and may use online environments as part of their screening process before arranging face to face sessions. Further examination of this phenomenon may be needed as I could find no articles in the established research exploring this issue. Relevant still to the issue of safety, the findings indicate that online mental health interventions, one on one sessions as well as closed/ private support groups, may provide a safe space for marginalized and/ or stigmatized communities particularly members of the LBGTQAI2S+ community. This aligns with the current literature that telepsychiatry can provide safe, anonymous access to mental care as well as support and community to marginalized groups (Whaibeh et al., 2020). Further studies

specific to Trinidad and Tobago and the Caribbean context may be helpful in generating data that may inform increased access and inclusivity to societies that have been traditionally deemed homophobic (Crawford, 2019; Phillip and Williams, 2013).

Public Health and Personal Health and Safety During COVID-19

The main advantage cited by therapist in favour of online mental health interventions was prevention of the transmission of the virus at the community level in the midst of the COVID-19 pandemic, the resultant health and safety guidelines and concerns about their own health and that of their clientele. Whilst most (*n*=6) had reported using online therapies in their practice prior to the advent of the COVID-19 pandemic, concern for life and limb prompted the mass migration. This is in keeping with the findings of current studies that have suggested that the COVID-19 pandemic was the main driver of the worldwide exodus to online mental health interventions (Markowitz et al., 2021; Taneja et al., 2023).

Anonymity

The data captured in this study indicate that clients benefit from the anonymity that online therapy can offer, which may be particularly advantageous for those dealing with stigmatized issues or those who are simply uncomfortable with face-to-face sessions. As noted by Participant 3:

> So again, this facilitated it well because nobody wants to see a High Court judge pull up into a yard to get counseling, you see. So, he did not need to leave home. He had the privacy of his own space and so on…They can be anonymous, so there's that confidentiality and the privacy as well. (Participant 3)

Whilst other studies point to anonymity as beneficial and one of the pull factors towards online mental health interventions (Myers, 2019; Steinmetz & Gray, 2017; Wasco & Campbell, 2002), others suggest that anonymity raises legal and ethical questions surrounding the confirmation of identity (Khan et al., 2022) and counseling someone (if we can affirm that they are a someone and not a bot) who might be "catfishing" the therapist (Amos et al., 2020).

In summary, there were clinical benefits such as accessibility, flexibility, safety, the ability to be anonymous and the ability to provide continuous care during the pandemic. At the other end, participants noted some unexpected or nontraditional benefits, such as reduced self-consciousness about their physical appearance during sessions. This is in line with the TAM's postulates that PU and ease of use influence technology adoption.

Factors Influencing Adoption

The findings suggest that contrary to Venkatesh et al. (2012) and Parisi (2020) speculations, perhaps considerations other than chronological age and years in practice may be at play in the decision to adopt online mental health interventions. According to TAM, PU and PEU are the fundamental determinants of the acceptance of innovations by new users (Davis, 1989). From the findings, participants deemed online mental health interventions and both useful and easy to use.

Perceived Usefulness

PU refers to the degree to which an individual perceives that a particular tool or process would enhance their performance (Davis, 1989; Home, 2017) and it is broken

down into the following determinants: subjective norm, image, job relevance, output quality, result demonstrability, and PEU. Whilst pre-pandemic, therapists had limited experience with using online mental health interventions in their daily practice and the subjective norm was for face-to-face sessions as reported by participants, the subjective norm soon became online sessions due to the mass migration of psychotherapists to the online space. This reflected a global trend that has already been established in the literature (Békés et al., 2021; Smith et al., 2022).

Image also played an important role in the adoption of online mental health interventions in therapeutic practice as therapists wanted to lead by example and comply with the Government of Trinidad and Tobago's COVID-19 guidelines and restrictions. This supports the current literature as compliance with national and international guidelines regarding health and safety has been cited as the main push factor in the mass transfer of therapists all around the world to the online space (Javed et al., 2020; Kaihlanen et al., 2022). Therapists in Trinidad and Tobago also enjoyed the ability to better curate their professional image through the use of backgrounds and filters.

Therapists in the study also thought that online mental health interventions were relevant to their job especially with regard to their appropriateness within the context of a pandemic. Further, even before the pandemic, therapists incorporated online interventions into treatment plans as online interventions served to increase the reach of therapists to clients in remote areas, clients located regionally and internationally as well clients with special needs. These findings support the current literature in this respect as scholastic works such as Cowan et al. (2019) and Di Carlo et al. (2021) reported similar findings.

Therapists also considered these interventions to be suitable for the treatment of most mental health challenges and ideal for certain disorders such as agoraphobia where therapists reported using these technologies as a stepping stone towards getting clients out of the house and into a face-to-face session. These findings dovetail with the established literature that articulates that therapists believe these interventions are relevant to their job and may be the only intervention appropriate to meet the need of specific clients (Schwartzman and Boswell, 2020).

Whilst therapists reported not experiencing good output quality due to technical difficulties which seems to be an international phenomenon (Amos et al., 2020; Békés et al., 2021; Javed et al., 2020) the interventions produced tangible results. As such, the theme of result demonstrability proved to be a big pull factor in the adoption and acceptance of online mental health interventions. All participants indicated that they derived tangible results from using telemental health interventions. These benefits included cost savings, increased accessibility for clients, increased reach to clients, clients more likely to attend sessions, increased profits, being able to vet clients before face-to-face sessions and being able to offer confidential and private sessions to clients. The current literature around the adoption of online mental health interventions points to the same results with therapists reporting a wide range of tangible benefits for both themselves and clients from using these modalities (Amos et al., 2020; Békés et al., 2021; Javed et al., 2020; Khan et al., 2022).

Perceived Ease of Use

PEU refers to the extent to which an individual perceives that a particular tool or process would enhance their performance (Davis, 1989) and that using the technology will be a seamless process (Adams et al., 1992; Davis, 1989; Karahanna & Straub, 1999). Ease of use is determined by CANX, computer self-efficacy, OU, CPLY and perceptions of external control (Venkatesh & Bala, 2008). Half of the participants reported CANX related to their concerns with maintaining the confidentiality and privacy of clients and their information as well as anticipated disruptions to therapeutic sessions. However, all participants made statements supporting CSE which has been established as a moderating factor for CANX (Venkatesh & Bala, 2008).

Indeed, self-efficacy emerged as a crucial element in the adoption of online mental health interventions in this study. As therapists perceived themselves as capable and competent in using online technologies, they reported a smoother transition and adoption process. Additionally, those who had prior contact with these technologies, either in their personal life or professional practice, also reported a less challenging adjustment period. For instance, Participant 7 shared, “Like I already do these things for meetings. I know what I am doing” and Participant 3 indicated that they had already used the technology online to participate in a distance learning course so it was an easy transition:

> I’ll tell you why it wasn't so hard for me because I was doing a training program in Trinidad. It was costing over $700.00 and change per week to go down to do it,

> airfare, transportation, etc...and then COVID hit and the same course I did online". (Participant 3)

These findings reflect the conclusions of similar studies regarding the moderating effect of CSE in the adoption and use of online therapeutics by psychotherapists (Békés et al., 2020; Sander et al., 2022).

With the exception of one participant, all participants made positive statements about the usability of the modalities and three of those participants reported being pleasantly surprised by the experience as they had been anticipating a less than ideal experience. Participant 7 said, "Oh I have changed my mind completely. I love online!" while Participant 9 shared, "It is not as terrible as I expected it to be. You know I really anticipated that it would be horrible" and Participant 8 shared:

> So I anticipated that that it would be a very distractible environment. A lot of interruptions that sort of thing. But it did not pan out, even when those things were present, it was fairly transient, we got over it very quickly. (Participant 8)

Indeed, some therapists reported enjoying using the technology and even being playful with it especially as it related to the use of virtual worlds and the exchange of emojis, memes and videos between therapist and client. Relative to being pleasantly surprised by the user experience, studies exploring the adoption of online mental health interventions have recorded analogous sentiments by therapists; that hands on experiences with telemental mental health interventions reduces therapists' concerns about the effectiveness and usability of the modality (Békés et al., 2020; Cowan et al., 2019; Sander et al., 2022). This seems to bolster the claims of the TAM that individuals adjust

their judgments after gaining hands-on experience with the system and the adjustments are influenced by system characteristics, specifically PEN and OU (Venkatesh & Bala, 2008).

Perceptions of external control differed depending on whether the therapist was engaged in private practice or employed in the public service. Two of the participants were employed in the public service of Trinidad and Tobago and one of the participants was employed in both the public and private practice and this presented a unique opportunity in terms of insight. Whilst participants in the public sector reported a rocky transition to online mental health interventions citing a lack of human and financial resources, a laissez faire approach by seniors and bureaucracy, those in the private sector were able to pivot almost immediately and enjoyed a seamless transition. The experience of those in the public sector in this study, echo the experiences of public servants in other jurisdictions (Vera San Juan et al., 2021; Rains et al., 2021) and underscores the value of governments prioritizing resources and streamlining systems in order to facilitate adoption.

These findings corroborate one of the assertions of TAM that PEU and result demonstrability positively and directly influences PU (Amofah & Chai, 2022; Venkatesh & Bala, 2008) as despite the myriad of technical difficulties that therapists experienced, the accrued benefits of the technology allowed for adoption. Therapists also adjusted their perceptions on ease of use as they gained more hands-on experience with the modalities which also aligns with the assertions of the TAM (Venkatesh & Bala, 2008). In short, the more confidence that participants had in their own computer skills, the usefulness of the

system, the ease of using it, and the control they have over it, the stronger their intention to adopt the technology which supports and corroborates the findings of Ariff et al. (2012) and Elshafey et al. (2020).

Further, these results demonstrate a broad range of factors that can influence a therapist's perception of the usefulness of online mental health interventions. While some may see only the clinical advantages, others may value the personal comfort and freedom they provide. The point to note here is that the construct of usefulness is multidimensional and encompasses both tangible and intangible benefits. The diversity of perceived benefits uncovered in the findings implies that mental health professionals might be more open to online interventions if they are made aware of the myriad ways they can be useful beyond just the immediate clinical advantages.

Limitations of the Study

While potentially providing valuable insights, this study has several limitations. This study employed the basic generic approach and one of the inherent limitations of this design is the possibility of researcher bias as the researcher is collects, analyses and interprets the data which is all filtered through their own personal politics and inherent biases (Liu, 2016; McGrath et al., 2019). The sample size was relatively small and may not be fully representative of all therapists in Trinidad and Tobago thus limiting the generalizability of the findings. The study relied on self-reported data which could potentially introducing bias, such as overestimating technological proficiency, underreporting challenges or blurring the lines of honesty in order to portray themselves in a better light to the researcher. The study focused primarily on therapists' perspectives,

excluding the experiences of clients receiving online interventions. The cross-sectional design captured a single point in time, and it did not track changes over time or delve deeply into technological considerations such as Trinidad and Tobago's digital infrastructure or technology accessibility. The scope was also limited, focusing on technology use in psychotherapy without exploring important legal, ethical, or professional issues in depth. The study was conducted during the COVID-19 pandemic, which may have influenced the results, casting uncertainty on how findings might change in a post-pandemic context.

Recommendations for Future Research

Previous studies have highlighted the advantages of online mental health interventions, such as increased access to care, convenience, and potential cost-effectiveness (Messina & Loffler-Stastka, 2021; Norwood et al., 2018; Rutkowska et al., 2023; Zuiderwijk et al., 2015). However, the challenges uncovered in this study, such as privacy concerns, initial implementation cost, bureaucracy, technological difficulties, and cultural barriers, align with previous research indicating that while these online modalities offer promise, significant challenges remain. The data collected in this study revealed that these barriers are not unique to high-income countries but are also prevalent in developing countries like Trinidad and Tobago. The current study supports previous research on the advantages and challenges associated with online mental health interventions. It has also highlighted the specific challenges that mental healthcare providers in Trinidad and Tobago face in integrating these technologies into their

practice. Further research is needed to develop strategies to overcome these barriers and make online mental health interventions more accessible and effective in this context.

Future research in this area could focus on exploring whether the adoption and usage of online mental health interventions persist once the current lockdown measures are relaxed and fears around COVID-19 ease. This is particularly important considering that the pandemic significantly catalyzed the shift towards online therapeutic practices in Trinidad and Tobago. One aspect to consider is how the adoption of these online platforms changes over time. It would be valuable to investigate if the initial surge in usage was merely a reaction to the immediate crisis or if it signifies a more long-lasting change in therapeutic practice. This would involve longitudinal studies that track the use of online mental health interventions over time. It would allow researchers to observe the trends in usage as the pandemic resolves and in-person options become safer, giving us a clearer picture of the lasting impact of COVID-19 on the delivery of mental health services.

Further, it would be interesting to investigate the factors influencing continued use of these platforms. For example, what role the quality of the online therapeutic relationship would play, how practical aspects such as ease of use, cost, and access to technology would affect continued use, how the cultural context of Trinidad and Tobago would influence the adoption and continued use of these technologies. There could also be exploration into the potential for blending online and in-person therapeutic practices post-pandemic; whether a hybrid model could offer the advantages of both online and face-to-face sessions, providing a more flexible, client-centered approach to therapy.

Implications

The findings of this study could have implications for the social change and the social determinants of health and for human services and practice.

Social Change

The World Health Organization (n.d.) defines the social determinants of health as those nonmedical variables that can impact one's health. The findings of this study may assist government agencies in the formulation of economic policies that prioritize the availability of financial resources and personnel assigned to public health systems and well as the streamlining of the bureaucratic process to increase access to mental healthcare particularly in crisis situations. Participants in this study who work in the public healthcare system identified insufficient funding, lack of formal guidelines, a complicated bureaucratic process and a dearth of human resources as the main challenges to delivering quality mental healthcare. This is not an unusual story for the developing and indeed even developed countries struggle with the same issues especially during the COVID-19 pandemic (Gruber et al., 2020). The literature indicates though that improving the daily lives of persons living with mental illness not only has positive effects on an individual also positively impacts productivity and upon a country's GDP (Knapp & Wong, 2020; Trautman et al., 2016)

This study may contribute to the current conversations that participants indicated are being had around mental and mental health seeking and may inform public education campaigns designed to assist in destigmatizing mental health issues and mental health seeking. Ultimately, the findings may assist policymakers in designing strategies that

eliminate barriers to mental healthcare and increase access to affordable mental health services for all regardless of location, age gender, sexual orientation, language, neuro-competence, residency status and other socioeconomic factors.

The data may encourage therapists in the developing world specifically the English-speaking Caribbean to tweak current treatment plans to incorporate online mental health interventions. These interventions could look like blended models of treatment, gradual progressions from online to face to face or strictly online treatment plans that offer anonymity to circumvent the anxiety and stigma that may surround mental health seeking. These strictly online treatment plans may be beneficial in very small, interconnected communities such as Tobago and rural areas of Trinidad and Tobago. Indeed, any small island developing state may find online mental health interventions useful for the anonymity provided by these modalities.

Recommendations for Practice

Guidelines Regarding Platform/Application Choices

The findings from the study highlight that participants utilized a variety of platforms to connect with their clients from video conferencing platforms such as Zoom and Skype to instant messaging apps such as Whats App and Facebook Messenger. The most popular platform among therapists was Zoom. However, therapists indicated that they used both encrypted and unencrypted platforms to conduct sessions which points to significant concerns regarding privacy and confidentiality. A noteworthy finding was that only two participants, Participant 7 and Participant 8, used platforms specifically

designed and encrypted for psychotherapy sessions, namely TheraNest (www.theranest.com) and Doxy.Me (www.doxy.me.com/en/).

The vast majority of participants in this study opted for Zoom as their platform of choice for delivery of service which is a safe choice given that Zoom is HIPAA, PIPEDA, GDPR and NHS Guidelines compliant (Zoom, n.d.). However, therapists also reported using a wide range of modalities and platforms; some of which are not compliant or are partially complaint with international privacy standards for healthcare providers. For example, Skype is not HIPAA compliant but Skype for Business is compliant (Hipaajournal, 2022) and whilst quite a number of participants used WhatsApp Text and WhatsApp Video for sessions, WhatsApp is neither HIPAA compliant (Hippajournal, 2023) nor GDPR compliant (Masoni & Guelfi, 2020). Whilst these standards are only persuasive in the Trinidad and Tobago context, it would seem that the Trinidad and Tobago Association of Psychologists may have opted to adopt HIPAA compliance standards as participants reported that the Association held a training exercise that focused on HIPAA compliance for its members just after the migration to online modalities:

> I can't remember precisely, but I'm fairly certain that they probably had one or two kind of webinars in terms of the practitioners and perhaps just kind of, I guess, reinforcing like ethical guidelines on that kind of thing via like zoom, HIPAA compliance and stuff like that. (Participant 7)

Even the TTAP has been using WhatsApp video and audio as part of their outreach to migrant communities in Trinidad and Tobago (MHIN, 2020). It would seem

then that clearly articulated and nonambiguous guidelines need to be constructed and disseminated either by TTAP or the Government of Trinidad and Tobago to protect the privacy of clients and assist in establishing professional standards by which all mental health providers must abide.

Integrative Mental Health Models

The study also re-inforced the significant role nonconventional therapists, including religious leaders and spiritual healers play in Trinidad and Tobago's mental health landscape. These therapists reported they enjoy deep-rooted trust within the community perhaps due to shared cultural context and understanding. This is not novel information and has been the focus of quite a number of studies on mental health in the Caribbean with scholars noting that psychiatry and religion and spirituality were intrinsically linked in the Caribbean landscape (Maharajh and Parasram, 1999). Scholars further note that nonconventional therapists were often the first responders of choice in a mental health crisis (Maharajh and Parasram, 1999) particularly in rural communities (Wagenaar et al., 2013) and that even healthcare professionals believed in demonic possession and spellcasting (Ramkissoon et al., 2017). Perhaps then, a hybrid model such as what exists in some parts of Brazil (Moreira-Almeida & Koss-Chioino, 2009), areas of Pakistan (Javed et al., 2020) and some Indigenous communities in Canada (Allen et al., 2020) which formally integrates these nonconventional therapists into the current mental health system could improve service delivery and outcomes. If we accept that “mental health is a state of emotional, physical, social and spiritual wellbeing” (MOH, n.d) then it follows that integrative models that addresses and nurtures the spiritual beliefs of clients

may produce and indeed, has been proven to produce better health outcomes (Allen et al., 2020). This approach could involve collaboration with conventional mental health professionals, cross-referrals, joint training programs, and the development of integrative treatment models.

Addressing Stigma

The research suggests that while there has been an increasing national conversation and awareness about mental health in Trinidad and Tobago, the stigma associated with mental health issues persists. This stigma often stems from misconceptions, fear, and negative attitudes towards mental illness and those who seek help for these conditions (Arthur et al., 2010; James et al., 2014; Yorke et al., 2016). The lengths that clients were willing to go to avoid being seen, the adaptations that therapists made to their offices spaces and even being willing to have sessions in their car highlight underscore this fact. Participants of the study consistently brought up the issue of confidentiality as a key factor in both face-to-face and online therapy sessions. Further public education is sorely needed. Campaigns should be culturally and age appropriate, use diverse mediums to connect with different audiences and focus on integration within the public school system.

Confidentiality and Privacy

The need to ensure privacy and confidentiality in therapy sessions is a fundamental ethical and legal requirement in mental health practice (Lustgarten et al., 2020). The participants in this study highlighted the extreme measures they instituted in the pre-online era to ensure that this was achieved and this underscores the importance

placed on maintaining the client's confidentiality. While online platforms can offer similar privacy advantages (Myers, 2019; Steinmetz & Gray, 2017; Wasco & Campbell, 2002), the study revealed concerns about potential breaches in the digital space. For example, unencrypted platforms pose a risk of third-party intrusion, leading to a potential breach of confidentiality. With the advent of online platforms, while the physical efforts to maintain privacy might have reduced, digital efforts and the awareness about ensuring the same level of confidentiality have become more critical (Lustgarten et al., 2020). These findings suggest that while the medium has changed, the principles and efforts to maintain privacy remain the same, and therapists continue to go to great lengths to ensure their client's confidentiality. Therefore, a comprehensive approach that includes public education campaigns, technological improvements specific to the online therapy space and guidelines for therapists to maintain privacy and confidentiality in online sessions and after the sessions, especially with regard to the storage of data, is necessary to address these concerns.

Professionalism

In this study, seven of the therapists that participated were not registered with the local psychotherapist association, TTAP. This statistic presents raises questions concerning the standardization of practice, professional development, and adherence to established guidelines within the field of mental health in Trinidad and Tobago. The absence of registration may indicate that these therapists may be practicing in a manner that is not necessarily aligned with the professional standards established by the Association. When conventional therapists were asked about their nonregistration with

TTAP, all indicated that they had been registered with the organization initially but either because of their personal feelings about the direction the Association was heading in, their individual perceptions of the utility of the organization as well as the fact that registration was not mandatory, caused their registration to lapse. Up to the time period that interviews were conducted, participants mentioned that as far as they were aware, the TTAP had no articulated code of conduct nor general guidelines for practice nor any articulated guidelines specific to Telemental health. If their assertions are to be believed, the lack of direction and guidelines coupled with the absence of a licensure requirement in Trinidad and Tobago may allow for a lot of variation in the quality of mental healthcare delivery in Trinidad and Tobago. This is an area that needs critical attention by policymakers.

Expansion of the Concept of Mental Healthcare and Mental Health Providers

This also problematizes the issue of what is required for registration as a mental healthcare provider and what is recognized as psychotherapy or mental healthcare and what is a psychotherapist or mental healthcare provider in Trinidad and Tobago landscape. If the Government of Trinidad and Tobago clearly articulates that mental health has emotional, physical, spiritual and social components (MOH, n.d.f.), then it follows that mental healthcare interventions and mental healthcare providers would span a wide range of disciplines and modalities, traditional and alternative, none being more important than the other but working in tandem for optimum outcomes. Whilst traditional healers and some pastors and priests may not have the requisite qualifications to register as a Member (some may have graduate qualifications in other areas or no formal

qualifications at all), they are often the first contact for mental health seekers (Maharajh and Parasram, 1999; Ramkissoon et al., 2017; Wagenaar et al., 2013) and may have a great many years of counseling experience. They often build strong bonds of trust within communities, which can be instrumental in fostering mental wellbeing (Allen et al., 2020; Wagenaar et al., 2013) and offer culturally appropriate interventions (Allen et al., 2020).

This also underscores the importance of cultural competency in mental healthcare. Recognizing and validating these practices can also promote inclusivity in mental healthcare provision and reduce stigma; encouraging more individuals to seek help (Allen et al., 2020). Their nonregistration and inherently working “off grid” could potentially impact the quality and safety of the therapeutic services provided to clients, particularly in the context of online mental health interventions where issues such as confidentiality, data security, and ethical guidelines for online practice become vital. Unregistered therapists may miss out on educational and training opportunities, potentially affecting their practice quality.

The advent of online mental health interventions has raised various ethical considerations, such as the use of encrypted platforms for communication, client data storage and protection, and ensuring client confidentiality (Ishizuki & Cotter, 2009; Reamer, 2013; Stoll et al., 2020). All mental healthcare providers need to be included into the fold for quality assurance purposes. These findings suggest a pressing need for a national licensure and/ or a registration program and a legal requirement for all mental health providers to register with a professional body. This framework should also recognize and register both conventional and nonconventional therapists

Recommendations for Training

The study revealed a critical gap in the area of training for therapists in the use of online platforms and that is the lack of formal training in the use of these modalities. As the field of online mental health interventions continues to evolve, it will be necessary to continually create, re-evaluate and update guidelines and best practices specific to online mental health providers, to ensure the efficacy and ethical use of these tools. Therapists identified facing unique challenges in the online space that could potentially hamper the efficacy of sessions. These include technical difficulties, lack of familiarity with the platforms' features, issues related to self-presentation, such as maintaining appropriate camera angles, maintaining a professional image during video sessions and establishing and maintaining professional boundaries. These findings align with the current research which underscore that online mental health interventions are a specialized area of practice and require distinct training and skills that are not always transferable from face-to-face practice (Connolly et al., 2020; Gratzer & Goldbloom, 2020; Khan et al., 2022; Kotera et al., 2021; Smith et al., 2022). The literature further indicates that each type of online intervention may require a different skill set (Khan et al., 2022) and that there are few training programs for online therapy (Stoll et al., 2020). Theorists further assert that there are unique ethical and legal considerations relevant to the provision of mental healthcare online that need guidance and regulation such as the provision of service across international jurisdictions and confirming the identity of clients (Khan et al., 2022).

In recognition of online mental health interventions being a specialized area of practice, jurisdictions such as the United Kingdom and Canada have already formulated

and issued guidelines aimed at standardizing practice methods and ensuring quality mental healthcare. In the case of Canada, the updated Canadian Counselling and Psychotherapy Association's Standards of Practice contains guidelines and instruction relevant to online therapy (CCPA, 2021) and in the United Kingdom the British Association for Counselling and Psychotherapy (BACP) has not only issued practice directions for delivering online mental health therapeutics but also offering continuous training to members (BACP, 2018). There is urgent need for similar but culturally relevant codes of practice and training in Trinidad and Tobago if there is to be quality assurance in mental healthcare services provided online.

Extending Reach to Clients

The adoption and increased familiarity with online mental health interventions have the potential to significantly broaden the reach of therapists based in Trinidad and Tobago. This offers the opportunity for these professionals to extend their services to regional and international clients, including Trinidad and Tobago nationals living abroad. These modalities offer the opportunity to transcend geographical limitations is a significant advantage of online therapy, making mental health services more accessible to people who might not have been able to access them otherwise due to distance, mobility issues, or a lack of local resources (Amos et al., 2020; Kotera et al., 2021; Sander et al., 2022). However, this expansion of reach also requires careful consideration of certain factors such as licensure regulations across different regions, time zones, and cultural and linguistic considerations (Cowan et al., 2019). For instance, therapists serving international clients need to be aware of the mental health laws and licensing

requirements in the client's location. Most States in the United States require licensure in the State where the therapist is located and where the client is located in order to offer services (Cowan et al., 2019). In terms of future steps, professional associations and regulatory bodies in Trinidad and Tobago could work towards developing guidelines for therapists who provide services to clients outside the country. This might involve collaborations with international mental health organizations and associations to understand and navigate the legal and ethical considerations involved.

Setting Advanced Technology-Based Service

The COVID- 19 pandemic has underscored the need for contactless services across many sectors, including mental health. The traditional, face-to-face model of mental health support has needed to adapt rapidly to a more remote and digital approach. Although online therapy has been successful in providing continued mental health support during this time (Khan et al., 2022; Kotera et al., 2021), it is clear from the findings of this study that more technological enhancements are needed to truly offer a comprehensive, contactless service. There is a dire need for more secure, user-friendly digital tools for administrative tasks associated with therapy, such as electronic signing and secure document exchange. Digital tools for self-help resources, mental health education, appointment scheduling and reminders, and automated check-ins between sessions could also enhance the overall contactless service. However, integrating more technology into mental health services must be done with caution. Privacy and confidentiality are critical considerations in mental healthcare, so any technologies utilized must have robust data protection measures in place.

Expanding Reach to Differently Abled Individuals

Online mental health interventions present a significant opportunity to expand access to mental health services for individuals who are differently abled or neurodivergent. These groups often face additional challenges in accessing traditional, in-person mental healthcare, such as physical accessibility issues, sensory sensitivities, and social anxiety (Lai, 2023). Online platforms can also be tailored to better suit the unique needs of these individuals. Therapists can adjust the pacing of sessions, use visual aids, or employ other alternative communication methods that can be more challenging to incorporate into traditional therapy sessions like the use of emojis and videos that participants incorporated into their practice in this study. In addition, certain technologies can aid communication and comprehension for special needs clients. For instance, real-time transcription services can assist those with auditory processing difficulties, while various assistive technologies can make therapy more accessible for those with physical disabilities.

Conclusion

While the potential to positively impact and improve quality of life for many living with mental health issues is significant, the study's findings also highlight that OMHIs should be just one part of a broader effort to make mental healthcare more inclusive and accessible. The therapists interviewed noted the importance of ongoing training to better understand and meet the needs of differently abled, neurodivergent clients, younger clients and stigmatized groups along with a need for research into best practices for online therapy within these groups. These findings suggest that increased

training, awareness, and resource provision may be necessary to help practitioners understand and harness the potential of online interventions. Further, it is crucial to address the various concerns surrounding privacy, stigma, cultural beliefs around mental health and mental health seeking, and cultural competence to enhance the acceptance and use of online mental health interventions in Trinidad and Tobago.

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Appendix A: Code of Conduct

Guidelines to Ethical Principles Trinidad and Tobago Association of Psychologists

Ethical Principles of Psychologists and Code of Conduct

GENERAL PRINCIPLES

PRINCIPLE A: COMPETENCE Psychologists endeavour to maintain high standards of competence and responsibility in their work. They may use scientific, professional, technical and administrative resources in the interest of continuing professional education. By this means they are also more appreciative of their limitations in expertise and of the need to protect those whom they serve. PRINCIPLE B: INTEGRITY Psychologists, while promoting integrity in the professional practice of psychology, in the teaching of and research in psychology, as well as other areas where psychologists find themselves occupational and socially, seek to deal fairly and honestly without misrepresentation of any kind.

PRINCIPLE C: PROFESSIONAL AND SCIENTIFIC RESPONSIBILITY Psychologists do everything in their power to serve the best interests of their patients, clients or other recipients of their services. In this regard, psychologists consult with and refer to other professionals and institutions to the extent that their clients' needs are best served. Psychologists concern themselves with the ethical compliance of their colleagues' scientific and professional conduct. They are obliged to consult with colleagues in order to prevent or avoid unethical conduct. Research - ethical standards in human and animal subjects. Psychologists undertake projects to advance knowledge.

PRINCIPLE D: SOCIAL WELFARE AND RESPONSIBILITY Psychologists accord appropriate respect to the fundamental rights, dignity and worth of all people. They seek to contribute to the welfare of those with whom they interact professionally. Sensitivity to real and ascribed differences in power between themselves and others characterize the relationship between psychologists and recipients of service. Such others are not exploited or misled during or after professional relationships. The knowledge of psychology is used to contribute to human welfare and to alleviate the cause of human suffering. In so doing psychologists are encouraged to contribute a portion of their professional time for little or non-personal advantage.

GENERAL STANDARDS APPLICABILITY OF THE ETHICS CODE This Ethics Code applies to psychologists only in their work-related activities as psychologists. It does not apply to their private or personal lives that have no bearing on their professional roles. However, psychologists should be aware of prevailing community standards of good behaviour and of the impact on clients, patients, other recipients of psychological services, and the profession in general if such standards are conformed to or deviated from.

BOUNDARIES OF COMPETENCE Psychologists provide services, teach and conduct research only within the boundaries of their competence based on their education, training, supervised experience, or appropriate professional experience. In new areas, psychologists provide services, teach and conduct research only after they have received appropriate education and training, supervision and/or consultation from persons who are competent in the new area of psychology. In emerging areas of psychology for which

there do not yet exist recognised standards, psychologists take steps to ensure the competence of their work and that their clients, patients and other recipients of service are protected from harm.

MAINTAINING EXPERTISE Psychologists maintain a reasonable level of awareness of current scientific and professional information that impacts on their field of activity, and they take steps to maintain competence in the skills that they use.

BASIS FOR SCIENTIFIC AND PROFESSIONAL JUDGEMENTS Psychologists rely on scientific and professionally derived knowledge when making scientific or professional judgements or when participating in academic or professional endeavours.

DESCRIBING THE NATURE AND RESULTS OF PSYCHOLOGICAL SERVICES When psychologists provide services as clinicians, counselors, therapists, consultants, teachers, etc., they provide information beforehand about the nature of the services and appropriate information afterwards about results and conclusions, using language that is understandable to the recipients of those services. If such information cannot be provided, psychologists inform the recipients of their services of the fact at the outset of the service.

HUMAN DIFFERENCES Where differences of age, gender, race, ethnicity, national origin, religion, sexual orientation, disability or socioeconomic status significantly affect a psychologist's work with individuals or groups, the psychologist gets training, experience, supervision or consultation to ensure the competence of her/his services, or makes appropriate referrals. RESPECTING OTHERS In their work-related activities, psychologists respect the rights of others to hold different beliefs, values, attitudes and opinions from their own.

NON-DISCRIMINATION In their work-related activities, psychologists do not engage in unfair discrimination against others on the basis of age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, socioeconomic status or any other basis prescribed by law.

SEXUAL HARASSMENT Psychologists do not engage in sexual harassment. Sexual harassment refers to sexual solicitation, physical advances and verbal or non-verbal behaviour which is sexual in nature, which occurs in a psychologist's work environment and that either: is unwelcome or offensive or creates a hostile working environment and the psychologist knows or is told this; or is severe or intense enough to be considered abusive by a reasonable person in that same context. Sexual harassment can consist of a single act or repeated acts. Psychologists treat sexual harassment complaints with dignity and respect.

OTHER HARASSMENT In their work-related activities, psychologists do not engage in harassing or demeaning behaviour towards others based on factors such as age, gender, race, ethnicity, national origin, religion, sexual orientation, disability or socioeconomic status.

PERSONAL PROBLEMS AND CONFLICTS Psychologists are aware that their personal problems and conflicts can have an impact on the effectiveness of their performance in work-related activities. They avoid entering into activities when they know or should know that their personal problems and conflicts can cause harm to the recipients of their psychological services. Psychologists have an obligation to be alert to and to get assistance for personal problems at an early stage, in order to avoid impaired

performance. When psychologists become aware that their personal problems may interfere with their work-related activities, they take appropriate steps such as getting professional assistance or consultation and determine whether to shorten, suspend or terminate their work-related activities.

AVOIDING HARM Psychologists take reasonable steps to avoid harming those that they work with or to minimize the harm if it is foreseeable and unavoidable. This especially refers to research involving experimentation on human or animal subjects.

MISUSE OF PSYCHOLOGISTS' INFLUENCE Psychologists are alert to and guard against personal, financial, social, organisational or political factors that might lead to misuse of their influence. MISUSE OF PSYCHOLOGISTS' WORK Psychologists do not engage in activities in which it seems as though their skills or data will be misused by others, unless corrective steps can be taken to prevent such misuse. If psychologists learn that their work has been misused or misrepresented, they take steps to minimise or correct the misuse or misrepresentation.

MULTIPLE RELATIONSHIPS In many communities and situations, it might not be possible for psychologists to avoid social or non- professional contacts with clients, patients, students, research participants and other recipients of their services. Psychologist must be sensitive to the potential harmful effects of these other contacts on their work and on the persons involved. They should avoid entering into these social or non- professional relationships if it will impair their objectivity in their work or if there is the danger of harm or exploitation of the persons involved. Similarly, psychologists do not engage in a professional relationship with someone when a pre-existing relationship

with that person could be harmful to the parties involved. If, due to unforeseen circumstances, a potentially harmful multiple relationship has arisen, the psychologist attempts to resolve it with maximum concern for the other person(s) and compliance with the Ethics Code. BARTER WITH PATIENTS OR CLIENTS Psychologists usually avoid receiving goods, services, or other non-monetary compensation from patients or clients in exchange for psychological services offered. A psychologist may not engage in bartering, save where it is recognised as an appropriate cultural expression and will not affect the clinical relationship. Psychologists may not initiate such practices. EXPLOITATIVE RELATIONSHIPS Psychologists do not exploit persons with whom they are involved in work-related activities. Psychologists do not engage in sexual relationships with students or supervisees in training.

CONSULTATIONS AND REFERRALS When making consultations and referrals, psychologists do so with the best interests of their clients or patients in mind, and with appropriate consent. When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients or patients effectively and appropriately.

THIRD PARTY REQUESTS FOR SERVICES When a psychologist agrees to provide psychological services for someone at the request of a third party, the psychologist attempts to clarify at the outset the role of the psychologist, the uses of the services provided or the information obtained, and the limits of confidentiality If there is a foreseeable risk of the psychologist being asked to perform conflicting roles as a result of a third party request for services, the psychologist makes clear the nature and direction of

his or her responsibilities, keeps all parties informed as matters develop, and resolves the situation in accordance with the Ethics Code.

DELEGATION TO AND SUPERVISION OF SUBORDINATES Psychologists delegate to their employees, supervisees, and research assistants only those responsibilities that are appropriate for those persons based on their level of education, training and experience. Psychologists provide proper training and supervision for their employees, supervisees and research assistants to ensure that such persons perform their work effectively, responsibly and ethically.

DOCUMENTATION OF PROFESSIONAL AND SCIENTIFIC WORK Psychologists document their professional and scientific work appropriately in order to facilitate provision of services later by them or other professionals, to ensure accountability, and meet other requirements of institutions. When psychologists believe that their records will be used in legal proceedings involving recipients of their services, they document their work in sufficient detail and quality so as to withstand reasonable scrutiny.

RECORDS AND DATA Psychologists create, maintain, disseminate, store and dispose of records and data related to their professional and scientific work, in a manner that allows adherence to the Ethics Code.

FEES AND FINANCIAL ARRANGEMENTS As soon as is possible in a professional or scientific relationship, psychologists clarify compensation and billing arrangements with the recipients of their services. Psychologists do not exploit recipients or payers of their services with regards to their fees. Psychologists do not misrepresent their fees. If

limitations to services can be foreseen from limitations in financing, psychologists discuss this as early as possible with the recipients of their services.

REFERRALS AND FEES When a psychologist pays, receives payment from, or divides fees with another professional other than in an employer-employee relationship, the payment to each is based on the services provided (e.g. clinical, consultative, administrative, etc.) and is not based on the referral.

RESPONSIBILITIES PROFESSIONAL STANDARDS Psychologists are responsible for maintaining professional standards of conduct in the many roles that they perform such as researcher, educator, therapist, diagnostician, supervisor, consultant, administrator, social interventionist, and expert witness.

CONSEQUENCES OF WORK Psychologists accept responsibility for the consequences of their work and make every effort to ensure that their services are used appropriately. Psychologists' take credit only for work they have actually done. Psychologists retain full professional liability to persons who, in the course of a professional relationship, suffer personal injury by reason of the psychologists actions or omissions.

LIMITS OF OBJECTIVITY Psychologists have a responsibility to avoid relationships that may limit their objectivity or create a conflict of interest.

CONSULTATION WITH OTHER PROFESSIONALS Psychologists have a responsibility to consult with or cooperate with other professionals and institutions to the extent that allows them to serve the best interest of their clients, patients, or other recipients of their services.

SOCIAL RESPONSIBILITY Psychologists are aware that they bear a heavy social responsibility because their recommendations and professional actions may alter the lives of others. They are alert to personal, social, organizational, financial or political situations and pressures that might lead to misuse of their influence.

STRUCTURING THE RELATIONSHIP Psychologists discuss with clients or patients as early as is feasible in the therapeutic relationship, appropriate issues such as the nature and anticipated course of therapy, fees and confidentiality. When a psychologist's work with clients or patients will be supervised, the above discussion includes that fact, and the name of the supervisor when the supervisor has legal responsibility for the case. When the therapist is a student intern, the client, or patient is informed of that fact.

Psychologists make reasonable efforts to answer patients' questions and to avoid apparent misunderstandings about therapy. Whenever possible, psychologists provide oral and/or written information, using language that is reasonably understandable to the patient or client.

EVALUATION AND ASSESSMENT SUPPORT FOR EVAUATION AND ASSESSMENTS Psychologists base their diagnostic statements, recommendations, assessments and reports on information and techniques that are sufficient to support their findings.

APPROPRIATE USE OF ASSESSMENTS AND INTERVENTIONS Psychologists use tests, interviews and other assessment techniques in a manner that is appropriate and that takes in account the limitations and the extent of usefulness of such tests, interviews and techniques. Psychologists do not misuse assessment tools and they take steps to prevent

unqualified persons from using assessments tools. Psychologists do not release raw test data to unqualified persons. Psychologists take reasonable steps to preserve the integrity and security of tests and other assessment tools. They must be willing to release all test data to another trained professional if requested by clients. OBSOLETE TESTS Psychologists do not base their assessment decisions and recommendations on tests that are obsolete, outdated and not useful to the current purpose for which they are being used.

EXPLAINING ASSESSMENT RESULTS Psychologists take reasonable steps to ensure that assessment and test results are explained in a manner that is understandable to the person being assessed. THERAPY STRUCTURING THE RELATIONSHIP Psychologists discuss with their clients or patients the nature and anticipated course of therapy, fees and confidentiality as soon as possible in the therapeutic relationship. Psychologists make efforts to answer clients' or patients' questions and to avoid misunderstandings. Where possible, psychologists provide oral and/or written information that is understandable to the client or patient.

COUPLE AND FAMILY RELATIONSHIPS When a psychologist agrees to provide services for several people who have relationships with each other (e.g. husband, wife, parents and children), the psychologist attempts to clarify from the stare: 1. who is the patient or client; and 2. the relationship that the psychologist will have with each person. 3. Psychologists are culture-sensitive to tests which have been normalised for foreign populations. They inform clients or patients of the limitations of such test.

PROVIDING MENTAL HEALTH SERVICES TO THOSE SERVED BY OTHERS In deciding whether to provide services to a client or patient who is already receiving such services elsewhere, the psychologist carefully considers the treatment issues and the client's or patient's welfare. The psychologist discusses these issues with the client or patient in order to avoid any confusion or conflict, consults with other service providers where appropriate, and proceeds with caution. SEXUAL INTIMACIES WITH CURRENT PATIENTS OR CLIENTS Psychologists do not engage in sexual intimacies with current patients or clients.

THERAPY WITH FORMER SEXUAL PARTNERS Psychologists do not do therapy with former sexual partners. INTERRUPTION OF SERVICES Psychologists take reasonable steps to facilitate care for their clients in the event of the psychologist's illness, unavailability, relocation, or the client's relocation or financial limitations.

SEXUAL INTIMACIES WITH FORMER THERAPY PATIENTS

a. Psychologists do not engage in intimacies with a former therapy patient or client for at least two (2) years after cessation or termination of professional services.

b. Because sexual intimacies with a former patient or client are so frequently harmful to the patient or client, and because such intimacies undermine public confidence in the psychology profession and thereby deter the public's use of needed services, psychologists do not engage in sexual intimacies with former therapy patients and clients even after a two year interval except in the most unusual circumstances. The psychologist who engages in such activity after the years following cessation or termination of treatment, bears the burden of demonstrating that there has been no exploitation, in light

of all relevant factors including, 1. the amount of time that has passed since therapy terminated, 2. the nature and duration of the therapy, 3. the circumstances of termination, 4. the patient's or client's personal history, 5. the patient's or client's current mental status' 6. the likelihood of adverse impact on the patient or client and others, and 7. any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a post termination sexual or romantic relationship with the patient or client.

TERMINATING THE PROFESSIONAL RELATIONSHIP Psychologist do not abandon clients or patients. Psychologists terminate a professional relationship when it becomes clear that the client or patient no longer needs services, is not benefiting from, or is being harmed by continued service. Prior to termination for whatever reason, and provided that the client or patient allows it, the psychologist discusses the patient's or client's needs, provides appropriate pre-termination counselling, makes referrals if possible, and facilitates transfer or responsibility to another service provider if the client or patients requests so immediately.

RESOLVING ETHICAL ISSUES FAMILIARITY WITH THE ETHICS CODE Psychologists have a responsibility to be familiar with the Ethics Code and how it applies to their work. Ignorance of or misinterpretation of the Ethics Code cannot be used as a defense against a charge of unethical conduct.

CONFRONTING ETHICAL ISSUES When a psychologist is confronted with a situation or has to take a course of action and is uncertain as to whether the Ethics Code would be violated, the psychologist consults with other psychologists, as soon as practicable, who

are knowledgeable about ethical issues, in order to arrive at an appropriate course of action. In extenuating circumstances, where they have to act at once, consultation with another psychologist as soon as possible after the fact should be done.

CONFLICTS BETWEEN ETHICS AND ORGANIZATIONAL DEMANDS When the demands of an organization with which a psychologist is affiliated conflict with the Ethics Code, the psychologist does his/her best to adhere as fully as possible to the Ethics Code.

DEALING WITH ETHICAL VIOLATIONS When a psychologist has reliable evidence that another psychologist may be violating the Ethics Code, the psychologist attempts to resolve the situation informally, if appropriate, by speaking to the other psychologist about the situation in a manner that does not violate confidentiality issues. If an informal resolution is not appropriate, the matter should be brought to the attention of the Executive of the Trinidad and Tobago Association of Psychologists as soon as possible for appropriate action.

COOPERATING WITH ETHICS COMMITTEE Psychologists cooperate with investigations, procedures and resulting requirements of the Trinidad and Tobago Association of Psychologists while doing their best to resolve any confidentiality issues. Failure to cooperate is in itself an ethics violation. IMPROPER COMPLAINTS Psychologists do not file or encourage the filing of ethics complaints that are frivolous or petty and which are intended to harm the respondent rather than protect the general public. Clients who bring complaints forfeit the rights to confidentiality if the complaint goes through.

FORENSIC ACTIVITIES PROFESSIONALISM Psychologists base their forensic activities on knowledge born out of training and experience in the discharge of their professional duties. In the forensic field, psychologists are engaged in assessments, consultations, reports and expert testimony. As practitioners, psychologists are obliged to be informed with legal and quasi-legal regulations as best serving the public interest. They are also required to be cognizant of opportunities to contribute to legislation as it affects the rights of the public and profession. In forensic testimony and reports, psychologists testify truthfully, honestly and frankly and consistent with applicable legal procedures and describe fully the bases for their testimony and conclusions. FORENSIC ASSESSMENT Psychologists provide oral or written testimony of the psychological characteristics of an individual or group, only after they have conducted an examination of individuals or groups using standard psychological assessment techniques. When such an examination is not possible, psychologists are obliged to state the impact of their limited information and are further sensitive to the extent of their conclusions and recommendations. TEACHING, TRAINING, RESEARCH AND PUBLICATION In the preparation of programmes for education and training in Psychology, psychologists ensure that there is an accurate description of content, goals and requirements of the programme. Advertising of whatever kind, must not be misleading, but must describe the audience for which the programme is intended, the educational objectives, the presenters and the fees involved, whenever applicable. In teaching or training, psychologists recognize the power they exercise over students or supervisees and therefore make reasonable efforts to avoid engaging in conduct that is

personally demeaning to students or supervisees. The teaching of the use of specialized techniques or procedures that require specialized training, such as the interpretation of test results or diagnostic formulation to individuals who lack the prerequisite training is strongly discouraged. It is the psychologists' responsibility to provide appropriate feedback to students and supervisees, based on their actual performance on relevant and established programme requirements. Psychologists design and conduct research and report research findings according to recognized standards of scientific competence and ethical research. Researchers and assistants are permitted to perform only those tasks for which they are appropriately trained and prepared. Psychologists obtain from most institutions, relevant authorities and from research subjects written approval prior to conducting their research. Participants are to be informed as to the nature of the research they are participating in, in language that is understandable and non-technical. Psychologists do not present elements of another's work or data as their own, even if the other work or data is cited occasionally. The taking of responsibility and credit only for work they have actually performed is the right of every psychologist. Psychologists who have to review material submitted for publication, grants or other research proposals, respect the confidentiality of and the proprietary rights in such information, of those who submitted it. PUBLIC STATEMENTS 1. Psychologists comply with this Ethics Code in public statements relating to their professional services, products and publications or to the field of psychology. 2. Public statements, announcements of service and promotional activities of psychologists serve the purpose of providing sufficient information to aid the consumer public in making judgements and choices. 3. Psychologists make reasonable

efforts to prevent others (such as employers, publishers, sponsors, organizational clients, and representatives of the print or broadcast media) from making deceptive statements concerning psychologists' practice or professional or scientific activities. 4. Psychologists do not make public statements that are false, deceptive, misleading, fraudulent or unfair. These include but are not limited to the following: a. False or deceptive statements concerning: 1. Their training, experience or competence; 2. Their academic degrees; 3. Their credentials; 4. Their institutional or association affiliations; 5. Their services 6. Scientific or clinical basis for results or degree of success of their services; 7. Their fees; or 8. Their publications or research findings. b. A statement falsely implying unusual, unique or only one of a kind of abilities. c. A statement intended or likely to appeal to a client's fears, anxieties or emotions concerning the possible results of failure to obtain the offered services. d. A statement comparing the advertiser's services with another psychologist's services, unless the comparison can be factually substantiated. 5. Psychologists do not participate for personal gain in commercial announcements or advertisements recommending to the public the purchase or use of property or single source products or services when that participation is based solely upon their identification as psychologists.

COMPETENCE 1. Psychologists provide services, teach and conduct research only within the boundaries of their competence, based on their education, training, supervised experience, or appropriate professional experience. 2. The psychologist discourages the practice of psychology by unqualified persons and assists the public in identifying psychologists competent to give dependable professional service. 3. When a psychologist

or person identifying himself/herself as a psychologist violates the Psychologists' Code of Ethics, the psychologists who know firsthand of these activities should bring this to the attention of the Executive of the Association as soon as possible for appropriate action. 4. Psychologists participate in continuing education programmes and keep informed of new professional procedures and knowledge. 5. Psychologists obtain whatever training, experience or counsel is necessary to enable them to recognise differences among people, such as those that may be associated with age, sex or socioeconomic and ethnic backgrounds or other relevant variables. 6. Psychologists recognise that personal problems and conflicts may interfere with professional effectiveness. Accordingly, they refrain from undertaking activities in which their personal problems are likely to lead to inadequate performance or harm to a client, colleague, student or research participant. If engaged in the activity when they become aware of their personal problems, they seek competent professional assistance to determine whether they should suspend, terminate or limit the scope of their professional or scientific activities.

Appendix B: Interview Questions

Interview Protocol

Time of Interview:

Date:

Place:

Interviewer:

Interviewee:

Position/ Designation of Interviewee:

(Briefly describe project, inform interviewee what the material will be used for and who will see their responses, inform interviewee of their right to withdraw at any time and how their identity will be protected and that the interview is to be recorded. Affirm their consent again)

Questions:

1. Collection of bio such as age, qualifications, professional title, professional memberships
2. How long have you been a practicing mental healthcare professional?
3. What is your area of specialization?
4. What would you say is the most common mental health issue that you treat in your practice?
5. How would you describe your clientele in terms of general demographics?

6. Ok, so we're going to jump straight into this…during the COVID-19 pandemic and the related restrictions in Trinidad and Tobago, how did you facilitate sessions with your clients?
7. When you think of online mental health interventions, what comes to mind?
8. What modalities do you associate with online mental health interventions?
9. What is your experience with any of those modalities in your therapeutic practice?
10. What are your thoughts about these modalities?
11. This is a list of online mental health interventions as classified by Barak and Grohol (2011). Do you employ either of these in your current practice? And if yes, how would you describe that experience? (List found at Appendix C)
12. Do you think that there are any benefits?
13. What about downsides?
14. Is there anything else that you would like to add?

(Conclude by thanking interviewee, letting them know that they are going to receive a transcript of the interview and will be allowed to edit the material on the transcript and re-iterate how their identity will be protected).

Appendix C: Interview Prompt—List of Online Mental Health Interventions

1. Online support groups such as private groups on social media (Facebook, Whats App etc.)
2. Encouraging blogging or micro- blogging on a social media platform as a form of journaling
3. Encouraging vlogs such as Facebook Live, YouTube, Tik Tok
4. Synchronous / Instant messengers such as,
    - Whats App
    - Telegram
    - Facebook
5. Smartphone apps such as MY3 or Not OK
6. Asynchronous messages
    - Email
    - Text messaging
7. Virtual Reality
8. Gaming and Virtual Worlds
9. Psycho-educational websites
10. Synchronous Audio Conferencing
11. Synchronous Video Conferencing
    - Encrypted medical sites such as Cliniko, TheraNest and Quenza
    - Zoom
    - Facebook or Whats App messenger video call feature

- Skype

12. Interactive, self-directed internet interventions or exercises such as online questionnaires or other tasks.

Appendix D: Participant Demographic Information

Participant	Age	Gender	Education	Professional Title	Professional membership	Practicing (years)	Specialty	Common treatment issues	Description of clientele
PARTICIPANT 1	49	Female	1. B.A. Theatre Arts with Psychology 2. M.Ed. Human Sexuality 3. Certified Sex Coach 4. Certified Sex & Faith 5. Trainer/Facilitator	1. Clinical Sexologist 2. Sex Educator	World Association for Sex Coaches	8 years	Human Sexuality (Psycho-Educational Counselling and Education)	Lack of sexual desire in relationships and sexual trauma	i. Ethnicity- Mostly of African descent. ii. Nationality- Citizens of Trinidad & Tobago iii. Average age group- 25-34 (40% of clients) (33% are 35-44). Also 65% are female. iv. City of residence (East Trinidad, East Tobago, West Trinidad, West Tobago, South Trinidad, North Trinidad)- East Trinidad and South Trinidad; West Tobago
PARTICIPANT 2	42	Female	1. Ph.D. Metaphysics and metaphysical sciences 2. Master in DNA Theta Healing, manifestation and abundance 3. certified Hypnotherapist 4. Certified past life regressionist 5. Master of Reiki (Usui, Lighterian and Karuna Reiki)	1. Holistic therapist 2. Metaphysician, 3. Spiritual life coach	Metaphysics and Metaphysical Association	25 years	Counselor for survivors of abuse	Obeah and anxiety	A good mixture of people (African, Indians)
PARTICIPANT 3	59	Male	1. Licensed Marriage Officer 2. Certified relationship counselor and mediator	1. Pastor 2. Motivational Speaker 3. Talk Show Host	No Answer	25 years	Counselling and Mediation	Issues affecting Intimate Relationships	i. Ethnicity- Black and East Indian ii. Nationality- Local, Regional and International iii. Average age group- 25-34 (15% of clients), 35-44 (20%

									of clients) over 45 (65%) Male- 30% Female 70% iv. City of residence (North Trinidad, East etc)- Tobago, Trinidad East and West, Caribbean Islands, Hawaii
PARTICIPANT 4	26	Male	1. Certified astrology	Spiritual healer Obeah man	No answer	10 years	1. Spiritual healer 2. Mind reader 3. Palm reader 4. Face reader	Relationship and health problems	i 60% Indian ii 20% Black iii Trinidad and Tobago iv 15 years and older (75%)
PARTICIPANT 5	76	Female	Ph.D. Counselling Psychology	Psychologist		42 years		Marital-Relationship Issues	i Mixed in Trinidad ii Trinidad iii 50%: 25-34, 50% 35-44, 33% male, 66% female iv North Trinidad, East, and West.
PARTICIPANT 6	41	Male	M.S. Social Work	Family Social Worker		23 years	Social work/Counseling	Poverty, LGBTQAI issues, depression, anxiety	i. Ethnicity- Afro-decent. ii. Nationality- Trinidadian. iii. Average age group- 25-34 (50 % of clients), 35-44 (50% of clients) Male- 30% Female 70% iv. City of residence (North Trinidad, East etc)- Santa Cruz (North).
PARTICIPANT 7	30	Female	1. Bsc. Psychology 2. Bsc. Sociology 3. Msc Group Processes And Intergroup Relations (Psychology) 4. Certification Cognitive Behavioural Therapy	Psychologist	1. BPS 2. TTAP 3. IPHM	7 years	Emotional/Mood and Behavioral Disorders	Depressive-related and anxiety-related disorders	Ethnicity- 85% Indo-Trinidadian; 10% Afro-Trinidadian; 5% Mixed ii. Nationality- 80% Trinidadian; 15% International (Canada, USA, China, UK) and 5% Tobago iii. Average age group

			5. Certification Mindfulness-Based Cognitive Therapy 6. Certification Dialectical Behavioural Therapy - Level 1 And 7. Certification Rational Emotive Behavioural Therapy						25-34: 74% 35-44: 11% Teens: 15%
PARTICIPANT 8	34	Male	1. B.Sc. Psychology (Hons). 2. M.Sc. Clinical Psychology	Clinical Psychologist	1. TTAP full member 2. Member of Arima Business Association, 3. Member of Heliconia Association for Young Professionals	4 years	1. Firearm/Security Personnel Assessment 2. Psychoeducational Assessment 3. General Individual Adolescent/Adult Therapy (CBT/PCT)	Anxiety	i. Ethnicity- 33% Indo, 40% Afro, 27% mixed or other ii. Nationality- Trinidadian iii. Average age group- 25-34 32% of clients), 35-44 27% of clients) Remainder is split equally between below 25 and above 45 iv. Male- 16.8% Female 83.2% v. City of residence North, Northeast and Central
PARTICIPANT 9	60	Male	1. B.A Surgery 2. MD Psychiatry 3. Diploma Substance Abuse 4. Certification in Neuropsychology	Senior Psychiatrist	TTAP	30 years	1. Developmental disorders 2. Psychosis 3. Suicide/self-harm	1. Insomnia 2. Depression 3. Anxiety	i. Ethnicity- Mixed ii. Nationality- TT, few Caribbean and international clients iii. Average age group- 25-34 (20…% of clients), 35-44 (25…% of clients) Male- 35% Female 65% iv. City of residence (North Trinidad, East etc)- North Trinidad
PARTICIPANT 10	55	Female	1. BA in Social Work 2. Multiple online courses through Harvard regarding: a. Christianity	1. Family Case Worker 2. Liaison Officer 3. Spiritual Mother and Elder	1. Ministry of Family Services and Social Development	30 years	1. Counseling 2. Case Worker 3. Spiritual Guide 4. liaise between government	1. Poverty 2. Counsel 3. Grief guidance	i. Ethnicity- all races. ii. Nationality- all nationalities.

	b. Blood pressure control	4. Counselor	2. West Indian Spiritual Baptist Sacred Order		assistance and members	4. Depressio n	iv. City of residence (North Trinidad, East etc)-
	c. Studying online	5. Educator				5. anxiety	
	d. Coping during COVID-19	6. Mentor					
	e. Bible and theology	7. Minister of Religion					
	f. Ordained minister						

Note. Some information has been redacted to protect the privacy of participants