

Clinical adaptation in videoconferencing psychotherapy for bipolar I disorder: a dyadic qualitative study in a public mental health service

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Abstract

Objective

Bipolar I disorder (BD-I) is associated with substantial interepisodic impairment and psychosocial burden, and psychosocial and psychotherapeutic interventions are central to its long-term management. However, less is known about how structured psychotherapy is adaptively delivered and sustained when transferred to videoconferencing formats, and about the disorder-specific demands this may place on therapists and patients. This study examined how euthymic patients with BD-I and their therapists experienced individualised metacognitive therapy (MCT+) delivered via videoconferencing in a Chilean public mental health service.

Method

This qualitative study was conducted within a broader programme of digital MCT+ delivered in a regional public psychiatric service in Chile. Fourteen therapist–patient dyads completed semi-structured interviews following treatment. Patients met DSM-5 criteria for BD-I and were in a euthymic phase (Young Mania Rating Scale, Spanish version, score ≤ 12). Data were analysed using constructivist grounded theory (GT), including line-by-line coding, constant comparison, theoretical sampling, and systematic dyadic comparison of therapist and patient accounts.

Results

Three interrelated categories were generated: *flexibility within fidelity*, describing the clinically reasoned adjustment of MCT+ structure in response to fluctuating clinical states; *therapeutic engagement and perceived availability*, referring to the deliberate interpersonal adjustments required to sustain engagement when non-verbal cues were reduced; and *barriers and facilitators of online delivery*, including reduced embodied interaction alongside improved accessibility, comfort, and reduced stigma. Across categories, fluctuations in affect, arousal, motivation, and interpersonal sensitivity required ongoing adjustment of therapeutic structure, pacing, and communication. We conceptualised this adaptive process as *relational calibration*.

Conclusions

For BD-I, videoconferencing psychotherapy appeared most clinically workable when treatment fidelity was enacted flexibly in response to fluctuating affective and interpersonal demands under altered communicative conditions. The findings illustrate how therapists and patients described adapting structured psychosocial interventions for remote delivery and point to therapist adaptive capacity as a potential target for training and supervision in digital bipolar care.

Introduction

Bipolar I disorder (BD-I) is a recurrent and disabling condition associated with high relapse rates, persistent functional impairment and elevated suicide risk (1, 2). Impairment and psychosocial burden frequently persist

between acute episodes, during euthymia, reflecting affective instability and interpersonal sensitivity that endure beyond symptomatic recovery (3–5). Structured psychosocial and psychotherapeutic interventions are therefore central to relapse prevention and functional recovery and are recommended as adjuncts to pharmacotherapy (6, 7). How these structured therapies are delivered and sustained when moved to videoconferencing, however, remains poorly understood (8, 9).

The rapid expansion of digital mental health interventions (DMHI) during the COVID-19 pandemic accelerated the use of psychotherapy delivered via videoconferencing, including for individuals with bipolar disorders (BD) (10–12). Research in this area has predominantly focused on clinical outcomes, feasibility, and acceptability (13). However, less attention has been paid to the therapeutic processes through which DMHI are established and sustained in online settings for people with Severe and Enduring Mental Illness (SEMI) presentations (14–16). Across existing systematic reviews, meta-syntheses, and qualitative reviews in bipolar disorder, qualitative evidence integrating data concurrently collected from both therapists and patients regarding the same intervention or care process remains notably absent (17–23). Previous authors have also highlighted missed opportunities to incorporate clinician or facilitator perspectives alongside patient accounts (24). Collectively, this suggests that qualitative evidence simultaneously capturing therapist and patient perspectives in BD remains particularly scarce.

Understanding these processes is particularly important in DMHI, where the absence of shared physical space may alter the conditions through which alliance, interpersonal engagement, and therapeutic responsiveness are established and sustained (25–27). Existing research suggests that videoconferencing may simultaneously facilitate access to care whilst also disrupting aspects of communication and relational attunement that are often central to psychotherapeutic work (28). Nevertheless, there remains limited understanding of how therapists and patients actively navigate these tensions in routine clinical practice, particularly in complex psychiatric populations (29, 30).

Individualised metacognitive therapy (MCT+) offers a structured yet adaptable therapeutic framework that foregrounds cognitive and emotional regulation, metacognitive reflection, and collaborative meaning making (31–34). Emerging metacognitive approaches in BD have demonstrated preliminary feasibility and potential clinical benefits in small trials and case series (35, 36). The relative structure of MCT+ therefore provides a clinically informative context in which to examine how therapists adapt manualised psychotherapy in situ, and how therapeutic engagement is collaboratively sustained within videoconferencing settings (37). However, qualitative research examining how MCT+ is delivered online, particularly from simultaneously integrated therapist and patient perspectives, remains limited, especially regarding the role of therapist adaptation and relational responsiveness in sustaining engagement.

The Chilean context provides a unique setting in which to explore these dynamics (38). The study was conducted in a regional public psychiatric service in Chile, where digital mental health provision remains unevenly implemented and resourced (39–43). These conditions make Latin American public mental health care a particularly underexamined context for understanding how structured digital psychotherapy is delivered under clinical and systemic constraints. To our knowledge, this is the first dyadic qualitative study exploring videoconferencing psychotherapy for BD-I within a Latin American public mental health setting (39).

Against this background, this study aimed to develop a dyadic understanding of how therapists and patients sustain videoconferencing MCT + for BD-I, and of the clinical adaptations this requires. Rather than proposing a general theory of digital psychotherapy, the study sought to generate a clinically grounded understanding of how structured treatment is adaptively delivered and made workable for individuals with BD-I under altered communicative conditions.

Method

Design and context

This qualitative study used constructivist grounded theory (GT) to examine how therapists and patients experienced MCT+ delivered by videoconferencing, an approach suited to process-oriented questions in evolving clinical contexts (44). It was conducted in a regional public psychiatric service in the Valparaíso region of Chile, a referral centre for complex mental health conditions. All therapy and interviews were conducted online between September 2021 and March 2023.

Participants and sample

The study drew on the same cohort of 14 therapist and patient dyads as the published quantitative evaluation of this programme (45). All dyads consented to the qualitative component and both members participated in semi-structured interviews. Patients were aged 18 to 65 years, Spanish speaking, and had a DSM-5 diagnosis of BD-I confirmed by a psychiatrist, in a euthymic phase (YMRS, Spanish version, score of 12 or below) (46). Exclusion criteria included severe learning disability, pervasive developmental disorder, significant language difficulties, and concurrent psychological treatment. Therapists were licensed clinical psychologists actively delivering synchronous online therapy and holding a postgraduate psychotherapy qualification. Baseline characteristics of the dyads are summarised in Table 1. Dyads were recruited in three phases between May 2021 and August 2022, supporting theoretical sampling.

Table 1
Patient Clinical and Sociodemographic Characteristics (N = 14)

Dyad	Age	Gender	Education	Marital status	Illness length (years)	Comorbidity	Substance use	Medication
1	27	Female	Technical	Single	5	None	None	Li, QTP
2	41	Female	Secondary	Married	14	None	Tobacco (past)	Li
3	26	Female	University	Single	6	Hypothyroidism	Drugs (past); alcohol (monthly)	Li, QTP
4	31	Female	University	Single	6	Hypothyroidism	Tobacco (current); alcohol	Li, LTG
5	35	Female	Technical	Single	15	None	Alcohol (yearly)	Li, QTP, LTG, CLZ
6	19	Female	Secondary	Single	6	None	Drugs (current); alcohol (monthly)	Li
7	23	Male	Secondary	Single	7	Hypothyroidism	Alcohol (monthly)	Li
8	42	Male	Technical	Married	13	None	Alcohol (weekly)	Li, VPA, ARI
9	36	Female	University	Single	20	Hypothyroidism	Tobacco (current); drugs (past); alcohol (yearly)	Li, QTP
10	28	Female	Technical	Single	11	Hypothyroidism	Tobacco (past); drugs (past); alcohol (monthly)	Li, LTG, BRX

Note. BD-I = bipolar I disorder. Dyad numbers link each patient to the therapist reported in Table 2. All patients met DSM-5 criteria for BD-I and were in a euthymic phase at baseline (Young Mania Rating Scale, Spanish version, score ≤ 12). Education was classified as university, technical/vocational, or secondary. Illness length refers to years since the first affective episode. Comorbidity refers to physical comorbidities; psychiatric and developmental conditions constituted exclusion criteria. Substance use includes current or past tobacco, alcohol, and recreational drug use, with alcohol frequency reported in parentheses where applicable. Previous psychotherapy indicates prior engagement in any formal psychological treatment before study participation. Medication abbreviations are as follows: Li = lithium; QTP = quetiapine; LTG = lamotrigine; CLZ = clonazepam; VPA = valproic acid; OLZ = olanzapine; ARI = aripiprazole; BRX = brexpiprazole; BUP = bupropion. Lithium-based regimens predominated (13/14), and psychotropic polypharmacy was common. Levothyroxine use reflected hypothyroidism and is represented under comorbidity. This cohort has been reported previously in aggregate form in a companion quantitative study (blinded for review).

Dyad	Age	Gender	Education	Marital status	Illness length (years)	Comorbidity	Substance use	Medication
11	42	Male	Technical	Married	10	Hypothyroidism	Alcohol (weekly)	VPA, OLZ
12	57	Female	University	Single	37	Hypothyroidism	Tobacco (current)	Li, CLZ
13	33	Male	Secondary	Single	7	None	Tobacco (current); alcohol (monthly)	Li, BRX
14	23	Prefer not to say	Secondary	Single	7	Hypothyroidism	None	Li, QTP, LTG, BUP

Note. BD-I = bipolar I disorder. Dyad numbers link each patient to the therapist reported in Table 2. All patients met DSM-5 criteria for BD-I and were in a euthymic phase at baseline (Young Mania Rating Scale, Spanish version, score ≤ 12). Education was classified as university, technical/vocational, or secondary. Illness length refers to years since the first affective episode. Comorbidity refers to physical comorbidities; psychiatric and developmental conditions constituted exclusion criteria. Substance use includes current or past tobacco, alcohol, and recreational drug use, with alcohol frequency reported in parentheses where applicable. Previous psychotherapy indicates prior engagement in any formal psychological treatment before study participation. Medication abbreviations are as follows: Li = lithium; QTP = quetiapine; LTG = lamotrigine; CLZ = clonazepam; VPA = valproic acid; OLZ = olanzapine; ARI = aripiprazole; BRX = brexpiprazole; BUP = bupropion. Lithium-based regimens predominated (13/14), and psychotropic polypharmacy was common. Levothyroxine use reflected hypothyroidism and is represented under comorbidity. This cohort has been reported previously in aggregate form in a companion quantitative study (blinded for review).

Table 2
Therapist Professional and Clinical Characteristics (N = 14)

Dyad	Gender	Theoretical orientation	Postgraduate qualification	Clinical experience (years)	Telepsychology experience (years)
1	Female	Cognitive	Master's degree	6	2
2	Female	Humanistic	Postgraduate certificate	9	1
3	Male	Cognitive	Postgraduate certificate	5	1
4	Male	Narrative	Postgraduate certificate	6	2
5	Female	Systemic	Postgraduate certificate	2	1
6	Female	Systemic	Postgraduate certificate	5	2
7	Female	Narrative	Postgraduate certificate	3	2
8	Female	Psychodynamic	Master's degree	1	1
9	Female	Narrative	Postgraduate certificate	2	1
10	Female	Narrative	Postgraduate certificate	1	2
11	Female	Narrative	Postgraduate certificate	4	2
12	Female	Cognitive	Master's degree	12	2
13	Female	Cognitive	Master's degree	1	1
14	Female	Cognitive	Postgraduate certificate	1	1

Note. Dyad numbers link each therapist to the patient reported in Table 1. All therapists were licensed clinical psychologists delivering synchronous videoconferencing psychotherapy within a Chilean public mental health service. One therapist completed professional training in Spain and the remainder in Chile. Clinical experience refers to years of post-qualification clinical practice. Telepsychology experience refers to years of experience delivering psychotherapy via online or videoconferencing formats. All therapists held postgraduate psychotherapy qualifications and delivered individualised metacognitive therapy (MCT+) as part of the broader study protocol.

Data collection

Following 12 weekly sessions of MCT+ delivered via Zoom, therapists and patients were interviewed separately using semi-structured, intensive interviews lasting 70 to 90 minutes, conducted from private settings, recorded and transcribed verbatim, then anonymised. Interviews explored experiences of digital

therapy, alliance and engagement using open ended questioning consistent with GT (46, 47). The therapist and patient interview schedules and the topic guide are provided in Additional file 1 (Tables S1, S2 and S3). Data collection and analysis proceeded concurrently; where indicated by emerging categories, up to three follow up interviews were conducted per individual, consistent with theoretical sampling, until theoretical saturation.

Data analysis

Data were managed in NVivo 14 and analysed using initial line-by-line coding, constant comparison within and across dyads, focused coding into higher-order categories, and interpretive integration of categories across therapist and patient accounts. Worked examples of this process are provided in Additional file 1: a fully coded sample transcript (Table S4), illustrative initial codes in gerund form (Table S5), and a line by line coding extract (Table S8). The refinement of focused codes into the three main categories is shown in Table S6, and the theoretical relationships between the categories and the central integrative process in Table S7. Transcripts and findings were not returned to participants for member checking, consistent with the interpretive epistemological position of GT.

Researcher characteristics and reflexivity

Consistent with GT, reflexivity was treated as integral to analysis. The first author, a Chilean clinical psychologist with over 15 years of experience in SEMI and a background in structured, in person therapies, maintained a reflexive journal and analytic memos, with attention to how prior expectations about face to face therapy might shape interpretation (47, 48). Excerpts from a case based memo and a conceptual memo are provided in Additional file 1 (Table S9). To support analytic credibility, coding and the development of focused categories were reviewed and discussed iteratively with the senior author, providing investigator triangulation within the research team.

Ethics

All procedures were conducted in line with international research ethics principles and relevant Chilean legislation. Identifiable information was restricted to the research team, and interview/session recordings were encrypted and stored in line with UK GDPR regulations. Ethical approval was obtained from the University of Edinburgh School of Health in Social Science Research Ethics Committee (REC) and the Chilean Ethical Committee (CEC) of the Valparaíso–San Antonio Health Service. This study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) (50).

Results

Analysis generated three interrelated categories describing how therapists and patients adapted structured MCT + to videoconferencing delivery in BD-I: (1) *flexibility within fidelity*, (2) *therapeutic engagement and perceived availability*, and (3) *barriers and facilitators in online therapy*. Across categories, therapists described ongoing adjustments to therapeutic structure, pacing and interpersonal engagement in response to patients' fluctuating clinical state, a process we conceptualised as *relational calibration* (Fig. 1).

Main category 1: Flexibility within Fidelity.

The first category concerned how therapists worked with, rather than simply followed, the structure of MCT+. Therapists valued the model as a roadmap but described moments in which strict adherence became difficult or clinically inappropriate, particularly when emotionally charged material emerged. In such instances, they reported moving away from the protocol to validate, pace, and respond to immediate needs.

"It often happens to me that I would like to break away from that structure and talk about a particular topic they are telling me about, and then I feel a bit trapped. With patients like [Name of Patient 1], I feel that this is valued, or perhaps it's more effective. I'm not sure if "more effective" is the right word, but I feel that we can reach more and explore more things with more subjective therapy, like a more narrative, freer approach..." (Therapist 1).

This tension was not simply experienced as a limitation of the model but as an ongoing clinical negotiation. Therapists described learning to use flexibility not as deviation, but as a means of deepening the therapeutic process within the structure.

"There are times when a patient shares something significant... and I feel like I have to pause the module... when I allow that space, the patient often feels more understood, and it deepens the therapeutic connection" (Therapist 7).

From the patient perspective, structure was generally experienced positively. It provided continuity, clarity, and direction, particularly when linked to everyday functioning and emotional patterns.

"What I like most about this therapy is that there's always a goal. Each session builds on the last, and it feels like I'm not just talking about my emotions but learning how to manage them. Before, therapy felt kind of open-ended, like we'd talk and then I'd leave, but now I feel like I'm working on specific things that actually help" (Patient 10).

Goal development emerged as a key organising element. Patients valued collaborative and evolving goals, while therapists highlighted the need to adjust direction in line with engagement and readiness.

"When I began therapy, my main focus was learning to manage my mood swings. However, as I made progress, my therapist and I introduced new goals, such as creating better routines and incorporating specific therapeutic modules, like improving self-esteem or working on attributional style... It felt like we were continuously moving forward together, rather than staying focused on the same issues" (Patient 8).

Therapists described this process of goal adjustment as requiring ongoing clinical judgement rather than protocol adherence alone. One therapist articulated this as actively reading the patient's readiness before introducing new modules, suggesting that the structure of MCT+ functioned less as a fixed sequence and more as a flexible resource to be deployed responsively.

"I tend to ask her questions, and in my head, I feel like I'm asking in a way that ensures understanding. I try to modify things to make them more meaningful or more aligned with what she needs, rather than just what she wants. For example, when we started talking about the 'attributional style' in the module, there were some things that weren't necessary to cover. However, because she mentioned experiencing voices and strange ideas, I focused on that, even though that module didn't specifically include that item. I'm always monitoring and adjusting accordingly" (Therapist 1).

Across accounts, the structure of MCT+ appeared most workable when enacted as an evolving, negotiated process rather than a fixed sequence, a pattern evident across dyads with differing therapeutic histories and clinical presentations.

Main category 2: Therapeutic engagement and perceived availability

The second category concerned how engagement was sustained in digital therapy. Patients consistently described the therapeutic relationship as central to whether treatment felt meaningful and safe. Engagement was experienced less as attendance and more like being met with presence, attention, and responsiveness. Warmth, empathy, and perceived psychological presence were particularly valued over and above limitations of the medium.

Therapists described engagement as an active process requiring deliberate relational work, including explicit checking, pacing, and efforts to compensate for reduced non-verbal cues. Accessibility facilitated engagement when it reduced barriers without diminishing relational quality. For some patients, the format was experienced as equally manageable as in-person care, suggesting that engagement depended less on the medium itself and more on how the relationship was enacted within it.

"I feel comfortable and good... I feel comfortable, whether it's having the therapist there in person or on the screen... I don't notice a difference" (Patient 2).

Patients also highlighted that engagement was strengthened when therapy addressed not only symptoms but also routines, relationships, and everyday life context. Thus, the therapeutic process extended beyond symptom-focused intervention into a more holistic relational space.

"One thing I liked was how they didn't just stick to one method. Some sessions were about my mood, others were about practical things like sleep, diet, or even just managing my schedule. It felt like everything was connected. It wasn't like 'Today, we're only going to talk about your symptoms'. It was more, 'Let's look at your whole life'" (Patient 5).

Therapists and patients converged in describing engagement actively constructed within each session rather than assumed by the format. This active quality distinguished the online setting from face-to-face therapy, where relational presence could be more readily taken for granted.

"In virtual settings, you lose those small but important moments, like a quick smile or nod, that help build connection. I've had to rely much more on verbal affirmations and being very intentional with my tone and words to ensure the patient feels understood. It's an adjustment, but it has made me more conscious of how I communicate" (Therapist 6).

Yet this deliberate relational work was not experienced solely as compensation for loss. For some patients, the online setting actively reconfigured the conditions of safety in ways that in-person therapy did not.

"For some patients, especially those with anxiety or discomfort in physical settings, the screen actually provides a sense of safety. They can control their environment, and that gives them a level of comfort they wouldn't have in an office" (Therapist 9).

This reframing was echoed in patient accounts, where the holistic quality of engagement, rather than the medium itself, emerged as the primary determinant of whether therapy felt meaningful.

"One of the things I really appreciated about the online sessions was how everything felt connected. Before, I'd have separate appointments, one with my psychiatrist for medication and another with a therapist to talk about my feelings or stress. But in these sessions, we could bring it all together. We'd discuss how I was doing on my meds, but also how I was coping with everyday challenges, and if there was something that wasn't working, we could figure out what to adjust. It felt like I was finally getting a treatment that looked at me as a whole person, not just as someone who has mood swings that need to be controlled. That made me feel more understood and supported, like all the pieces of my care were finally fitting together" (Patient 3).

Main category 3: Barriers and facilitators in online therapy

The third category captured how online therapy was experienced not simply as a setting with advantages and disadvantages, but as a relational environment that simultaneously constrained and reorganised therapeutic work. Therapists described difficulty accessing non-verbal cues, while some patients experienced the absence of physical presence as a reduction in emotional depth, containment, or immediacy.

"Being in the same room... that physical presence is grounding..." (Patient 4).

This suggests that videoconferencing altered not only the communication channel, but the texture of therapeutic presence itself. Therapists described a loss of embodied and sensory dimensions of interaction that typically inform clinical attunement.

"I think something very personal is lost in virtual sessions... you sense the presence of the other person... this is lost" (Therapist 7).

At the same time, therapists reported needing to compensate actively for these changes by working more explicitly at the level of communication and relational coordination.

"I often find myself over-explaining or double-checking... it's harder to 'read the room'" (Therapist 3).

These accounts suggest that the online format did not eliminate therapeutic processes, but instead redistributed cues, forcing therapists to work more explicitly and deliberately at the level of relational coordination. Technical issues were generally manageable and less impactful than relational and contextual challenges, particularly those related to maintaining presence and emotional rhythm. Major obstacles were less technological failures per se than disruptions to continuity, attunement, and the shared sense of therapeutic space.

The online format also introduced opportunities. For some, therapy from home increased comfort, openness, and willingness to disclose. Rather than simply weakening psychotherapy, the digital setting appeared to reconfigure how safety, distance, and exposure were negotiated, functioning as a variable context rather than a fixed limitation.

"I can join from home, and that makes it easier to stay consistent... before, I would miss sessions because I didn't feel like going out" (Patient 5).

The broader socio-political context also played a role. Therapists described the combined impact of the pandemic and social unrest in Chile as intensifying emotional demands for both patients and clinicians.

“Since the pandemic started... patients are coming with overwhelming fears... it’s not just about the virus anymore; it’s about a deeper anxiety over the future... like facing two crises at once” (Therapist 4).

These shared pressures situated therapy within a broader field of collective uncertainty, in which the task was not only to deliver treatment but to sustain therapeutic thinking under conditions of social strain. Taken together, the three categories do not offer a neutral account of digital psychotherapy; rather, they reflect a situated process, co-constructed by dyads navigating relational, structural, and historical complexity in tandem.

Discussion

This study examined how patients with BD-I and their therapists negotiated structure, responsiveness, and engagement in MCT+ delivered via videoconferencing in Chile. Three main categories were identified: *flexibility within fidelity, therapeutic engagement and perceived availability, and barriers and facilitators in online therapy*. Across categories, therapists described ongoing adjustments to therapeutic structure, pacing, and interpersonal engagement in response to patients’ fluctuating clinical states, a process we conceptualised as relational calibration. The present study provides a clinically grounded account of how structured psychotherapy for BD-I may be adaptively delivered through videoconferencing without reducing treatment to either rigid protocol adherence or unstructured supportive contact.

Flexibility within fidelity

The most prominent finding was a tension between protocol fidelity and therapist flexibility (49). Across both therapist and patient narratives, structure was valued, but only if sufficiently adaptable to the person and the moment. This is consistent with evidence suggesting that therapist flexibility, whilst maintaining core treatment principles, may contribute positively to psychotherapy outcomes (50). It also aligns with the broader principle of flexibility within fidelity, whereby adherence to core treatment components, rather than rigid procedural compliance, is clinically optimal in complex cases (51, 52).

In the present study, flexibility appeared less as deviation from the model and more as a clinically reasoned adaptation process that allowed MCT + to remain usable under fluctuating affective and interpersonal conditions. Therapists’ accounts of discomfort with high levels of structure are consistent with clinician responses to manualised interventions (53). However, these adaptations did not appear to reflect simple therapist drift (54). Rather, therapists described ongoing efforts to adjust pacing, sequencing, and emphasis so that treatment remained emotionally meaningful and clinically manageable for patients with BD-I. Departures from protocol sequence were therefore experienced not as failures of fidelity, but as attempts to preserve the therapeutic function of the intervention under changing relational and contextual conditions.

These findings have implications for therapist training. Training in digital psychotherapy may need to focus not only on protocol adherence, but also on clinically reasoned adaptation and decision-making regarding when and how to modify treatment pacing, emphasis, or sequencing without compromising intervention integrity.

This may be especially relevant in digital settings, where therapists must respond to reduced non-verbal information, increased contextual variability, and fluctuating engagement using more explicit communication and pacing strategies. Existing guidance regarding flexibility within manualised interventions remains relatively limited (55), and often insufficiently addresses contextual and cultural adaptation (56).

Patients also valued clear and collaboratively negotiated goals, which strengthened trust, motivation, and the sense that therapy was relevant to everyday life. Goal-setting processes were experienced not only as organisational tools, but also as mechanisms that helped anchor therapy within routines, relationships, and personally meaningful contexts. This is consistent with evidence that unclear goals are associated with poorer therapeutic relationship quality and worse clinical functioning (57), whereas goal agreement contributes positively to psychotherapy outcomes (58). These findings also align with competency-based approaches to therapist training (59) and broader common-factors literature emphasising alliance, collaboration, empathy, and goal consensus as predictors of therapeutic benefit (60). In this context, collaborative goal work functioned as a mechanism through which structured intervention became personalised and therefore clinically usable.

The findings are also consistent with broader discussions regarding responsive and personalised psychotherapy delivery, in which what sustains therapeutic work is not protocol adherence alone, but the fit between intervention structure and the patient's needs at a given moment (61, 62). From this perspective, flexibility within fidelity does not represent a tension to be resolved, but rather a clinically necessary adjustment process through which therapists modify the timing, intensity, and focus of intervention components (63, 64). This adaptive process may be particularly relevant in videoconferencing psychotherapy for BD-I, where therapists must compensate for reduced interpersonal cues and greater environmental variability through more deliberate communication and pacing strategies (65).

In this context, flexibility did not imply the absence of structure, but rather the responsive adaptation of structure according to fluctuations in affect, arousal, motivation, and interpersonal sensitivity. This may be especially important in BD-I, where changes in emotional activation and interpersonal meaning can alter patients' capacity to engage with structured intervention at different moments of therapy (49, 66).

Engagement as relational presence and perceived availability

Engagement was best understood not simply as attendance or compliance, but as a relational experience of availability, support, and interpersonal connection. Consistent with patient accounts, engagement extended beyond symptom management into the integration of therapy with routines, relationships, and everyday life experience. This echoes previous findings suggesting that therapists often worry more about alliance in telepsychology than patients do (26, 30, 67, 68), and that therapeutic alliance and empathic understanding can be maintained across psychotherapy formats (69, 70).

The present study adds nuance by suggesting that alliance in digital MCT + was not experienced as automatically weakened by physical distance (71). Rather, engagement appeared to depend on whether therapists could establish a sense of interpersonal immediacy through responsiveness, explicit communication, emotional checking, and adaptation to the patient's pace and preferences (29). Engagement therefore emerged not as a fixed property of the treatment format, but as an actively negotiated relational process under altered communicative conditions.

This also aligns with digital mental health research showing that flexibility of location and format can reduce barriers to treatment and support adherence. (13, 72–75). However, the present accounts suggest that access alone may not be sufficient on its own. Patients valued access within the context of a meaningful therapeutic relationship (76). This distinction may be particularly relevant in BD-I, where practical accessibility and relational depth may need to be sustained simultaneously rather than traded off against one another.

Patients also highlighted the importance of holistic and personalised care, particularly the integration of biological and psychological dimensions of BD. Feeling treated as a whole person, rather than solely as a diagnosis or medication regimen, was central to engagement. This is consistent with individualised approaches to BD management (77, 78), the limitations of overly categorical diagnostic frameworks (79), and the value of tailoring care to personal and clinical profile (80, 81). Engagement appeared to be strengthened not only by interpersonal skill, but also by the therapist's capacity to situate symptoms within a broader understanding of the patient's life context, routines, relationships, and treatment experience. This may be particularly important in BD, where patients frequently report experiences of being reduced to symptom monitoring or pharmacological management alone.

Barriers and facilitators in online therapy

Participants did report barriers associated with reduced non-verbal communication, technical instability, and the absence of shared physical space. These conditions required compensatory communicative strategies, consistent with evidence suggesting that videoconferencing can limit access to interpersonal cues relevant to empathy, treatment credibility, and relational attunement (26, 82, 83). For some participants, the absence of physical co-presence altered the interpersonal quality of therapeutic engagement and reduced feelings of immediacy or emotional safety (84–87).

However, rather than representing simple deficits, these barriers may be better understood as alterations in the conditions through which therapeutic engagement is established and maintained (84, 88). Technical disruptions were generally experienced as manageable rather than catastrophic, and some aspects of the online setting were experienced positively, including increased comfort, reduced stigma, and greater willingness to disclose sensitive material (84, 89, 90). Online psychotherapy may therefore reshape, rather than simply weaken, therapeutic interaction (89). Importantly, reduced embodied exposure appeared for some participants to increase psychological safety, suggesting that videoconferencing does not carry a single interpersonal meaning across patients (71).

The finding that the patient's environment became more directly implicated in therapy is also notable. Rather than the therapist alone providing the therapeutic setting, videoconferencing appeared to redistribute responsibility for privacy, continuity, and emotional safety across therapist, patient, and environment (91). This may introduce new vulnerabilities, but may also allow more contextually grounded therapeutic work shaped by the patient's everyday environment and routines (92, 93). Digital psychotherapy may therefore require clinicians to think differently about therapeutic setting, boundaries, pacing, and continuity of care.

These findings also help clarify why flexibility within fidelity remained central throughout the analysis. What therapists described in response to reduced interpersonal cues, altered privacy conditions, and contextual instability was not merely coping with online delivery, but actively adjusting how treatment structure and interpersonal engagement were implemented under changing conditions (49, 88, 94). In this sense, the barriers

and facilitators identified here can be understood as the clinical conditions that increase the importance of therapist responsiveness, pacing, and adaptive judgement in digital psychotherapy delivery.

Clinical implications

Clinically, therapists delivering digital MCT + may benefit from training that explicitly addresses adaptive fidelity, including how to maintain treatment structure whilst responding flexibly to emotional disclosures, resistance, fluctuating motivation, and changing goals. As suggested by the present findings, this may be particularly important in videoconferencing settings, where therapists must manage both manualised structure and medium-specific relational disruptions. For public mental health systems, implementation of digital psychotherapy for BD-I may therefore require not only technological infrastructure, but also training in pacing, collaborative goal revision, verbal attunement, and management of fluctuating affective and interpersonal states. The resulting adjustments are summarised in Fig. 1, which pairs observable clinical signals with corresponding therapeutic responses across the three domains.

Second, digital psychotherapy training may benefit from greater emphasis on relational micro-skills that help sustain engagement online, including explicit checking, pacing, collaborative clarification, and deliberate verbal attunement (95). These skills appear especially important when non-verbal cues are reduced, and therapists must rely more heavily on deliberate verbal communication to maintain attunement.

Third, work with BD may particularly benefit from approaches that integrate structured intervention with personalised, holistic care (96). Patients valued treatment that linked mood symptoms with routines, relationships, medication management, and broader life context, suggesting that psychosocial interventions for BD may be experienced as more meaningful when biological and psychological dimensions of care are integrated rather than separated.

Finally, the present findings suggest that online psychotherapy should not necessarily be conceptualised as a second-best alternative to face-to-face care. When delivered with sufficient responsiveness and adaptive flexibility, videoconferencing psychotherapy may offer distinctive clinical opportunities, as perceived by participants, particularly in settings where access barriers, stigma, geographical distance, or service fragmentation limit continuity of care. Rather than framing therapist adaptation as a deviation from evidence-based practice, training models may need to conceptualise adaptive responsiveness as a core clinical competency within digital psychotherapy delivery. These findings may be particularly relevant for middle-income public mental health systems where shortages in specialist bipolar care, geographical barriers, and service fragmentation increase reliance on remote delivery models.

Limitations and future directions

Several limitations should be considered. The study was conducted within a Chilean public mental health context during the later stages of the COVID-19 pandemic, at a time when videoconferencing psychotherapy had already become more established and socially familiar within routine clinical care. Findings may therefore not generalise to other healthcare systems, sociocultural settings, or phases of digital service implementation (15, 97). The sample was also limited to individuals with BD-I receiving a specific manualised intervention, which may reduce transferability to other diagnostic groups or treatment models (15, 98). In addition, the study relied on retrospective interview accounts rather than direct observation of psychotherapy sessions (99).

Relatedly, the findings reflect participants' self reported perceptions rather than observed in session behaviour or measured clinical outcomes, and post treatment interviews may be subject to social desirability and recall effects. Although coding and category development were audited through iterative discussion with the senior author, member checking was not undertaken, and the interpretations remain those of the research team and should be read as one credible reading of the data rather than a definitive account.

Future research could examine how adaptive processes unfold session by session within digital psychotherapy, and whether similar adjustment processes emerge across other psychotherapeutic approaches and psychiatric populations. Further work may also clarify how therapist characteristics contribute to alliance development and engagement under videoconferencing conditions. Future studies might additionally explore whether adaptive processes such as pacing adjustment, collaborative goal revision, or verbal attunement can be operationalised within routine outcome monitoring or feedback-informed treatment systems (15, 100–102).

Overall, these accounts suggest that, for participants, the perceived workability of videoconferencing psychotherapy for BD-I related less to the digital medium itself than to how therapists adapted structure, pacing, and interpersonal engagement to fluctuating clinical and contextual demands. Digital psychotherapy for BD-I may be most clinically useful when therapists respond flexibly to changes in affect, motivation, arousal, and interpersonal sensitivity whilst maintaining sufficient treatment structure and continuity. In public mental health settings, such adaptive delivery may help preserve continuity of care whilst addressing barriers related to access, stigma, and service fragmentation.

Conclusions

Videoconferencing MCT + for BD-I appeared clinically workable when treatment fidelity was enacted flexibly rather than rigidly, with therapists continuously adjusting structure, pacing, and interpersonal engagement in response to fluctuating affective and interpersonal demands, a process we conceptualised as relational calibration. The clinical usefulness of remote psychotherapy for BD-I, as described by participants, therefore appeared to relate less to the digital medium itself than to therapist adaptive capacity under altered communicative conditions. For public mental health services, particularly in middle income settings facing access barriers, stigma, and service fragmentation, these findings indicate that investment in therapist training in adaptive responsiveness, collaborative goal revision, and verbal attunement may be as important as digital infrastructure for sustaining continuity of care.

Abbreviations

ANID
National Agency for Research and Development
BD
bipolar disorder
BD-I
bipolar I disorder
CEC
Chilean Ethical Committee

COREQ
Consolidated Criteria for Reporting Qualitative Research
COVID-19
coronavirus disease 2019
DMHI
digital mental health interventions
DSM-5
Diagnostic and Statistical Manual of Mental Disorders,Fifth Edition
GT
grounded theory
MCT+
individualised metacognitive therapy
REC
Research Ethics Committee
SEMI
severe and enduring mental illness
UK GDPR
United Kingdom General Data Protection Regulation
YMRS
Young Mania Rating Scale.

Declarations

Ethics approval and consent to participate

All procedures were conducted in line with international research ethics principles and relevant Chilean legislation. Identifiable information was restricted to the research team, and interview and session recordings were encrypted and stored in line with UK GDPR regulations. Ethical approval was obtained from the University of Edinburgh School of Health in Social Science Research Ethics Committee (REC) and the Chilean Ethical Committee (CEC) of the Valparaíso–San Antonio Health Service. This study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ).

Informed consent was obtained from all individual participants included in the study, including consent for the anonymised use of their data in research publications.

Consent for publication

Not applicable.

Availability of data and materials

The interview data are not publicly available due to the sensitive clinical nature of the transcripts and the risk of participant identification, but anonymised excerpts supporting the analysis are included in the article and Additional file 1. Further reasonable requests may be considered by the corresponding author subject to ethical restrictions.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

Roberto Maluenda-Gatica contributed to conceptualisation, methodology, investigation, formal analysis, data curation, writing – original draft, visualisation, and project administration, and coordinated the overall research process and participant engagement.

Angus MacBeth contributed to supervision, methodology, and writing – review and editing.

Javier Morán-Kneer and **Ulises Ríos** contributed to resources and investigation by facilitating access to the clinical sample, and to writing – review and editing.

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Figures

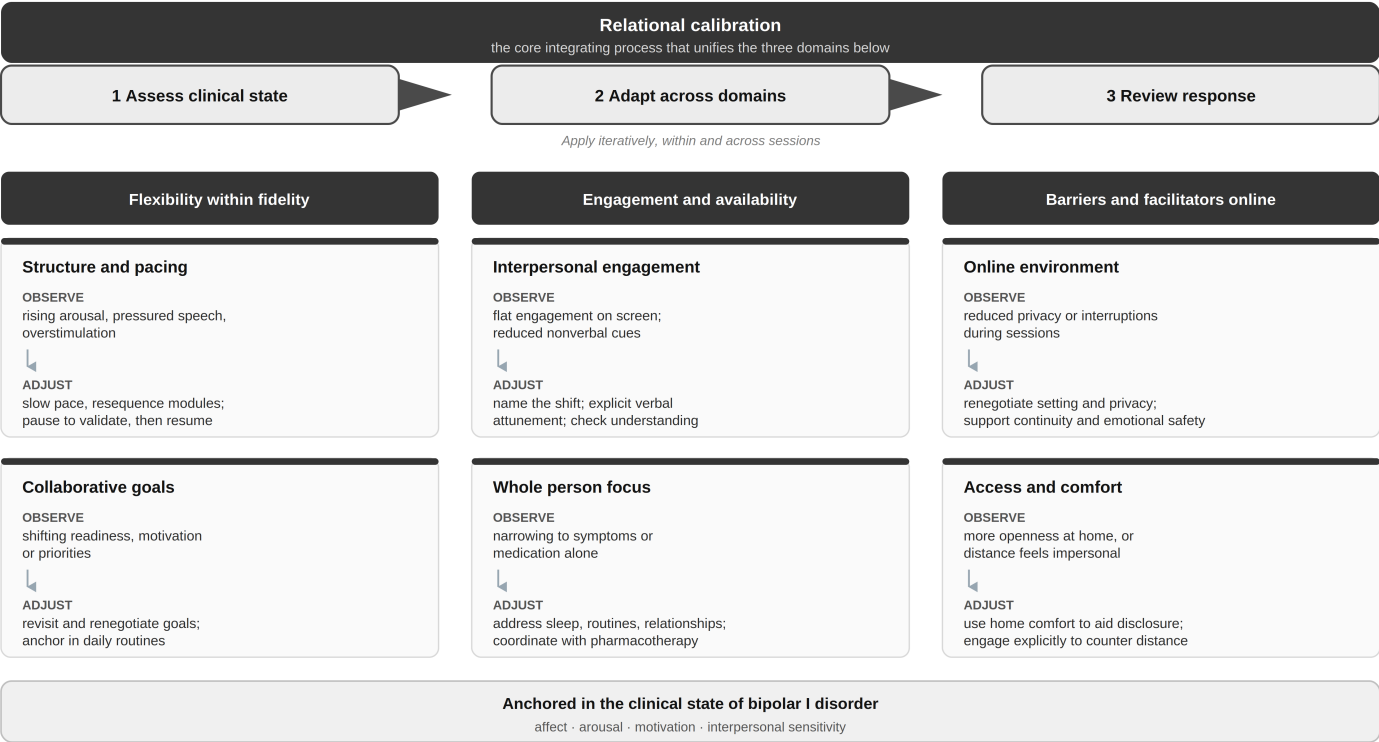


Figure 1

A clinical model for the adaptive delivery of videoconferencing psychotherapy in bipolar I disorder.

Note: The model summarises how therapists adapted structure, pacing, engagement, and online delivery conditions in response to fluctuations in affect, arousal, motivation, and interpersonal sensitivity. Each domain links observable clinical signals with corresponding therapeutic adjustments derived from the grounded theory analysis. BD-I = bipolar I disorder; MCT+ = individualised metacognitive therapy.

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