

Interpersonal Psychotherapy and Interpersonal Counseling

Digital Training Tools in Finland

**KASPERI MIKKONEN, VIIVI MONDOLIN, SUSAN LAITALA,
SAMULI I. SAARNI, AND SUOMA E. SAARNI ■**

It is a challenge to realize the outcomes of clinical trials in naturalistic environments. The demand for evidence-based practices like interpersonal psychotherapy (IPT) and interpersonal counseling (IPC) often exceeds health systems' possibilities for training, implementing, supervising, and sustaining services. These challenges are not limited to evidence-based practices for mental health and have been approached successfully with digital tools in many fields of service. We briefly describe the Finnish approach for using digital tools in trying to close the service gap for IPT and IPC.

FIRST-LINE THERAPIES INITIATIVE IN FINLAND

The *first-line therapies* initiative is a comprehensive program for providing early, evidence-based practices for mental health to all according to need in Finland. National implementation of IPT and IPC is included, as they are recommended treatments for adult and adolescent depression and have been found feasible in small regional pilots.^{1,2}

The initiative takes a holistic view of digitally supported implementation of evidence-based practices for mental health. It includes, for example, a 24/7 service platform for psychoeducation, with over 30 self-help programs, a digitally supported system for assessing therapy needs (the *Finnish Therapy Navigator*³) and implementing stepped care, a large variety of online therapy services, a

support portal for professionals, a tool for individual- and system-level outcome measurement (the *Finnish Psychotherapy Quality Registry*⁴), and a digitally aided training model for large-scale training and supervising of evidence-based therapeutic modalities, as described here.

Our approach is based on the proposition that a successful implementation of IPT and IPC requires permanently fixing the processes *around* treatment provision. Training many therapists alone is unlikely to translate into permanent clinical gains or treatment provision. The work processes need to be changed to enable early identification of the right patients, timely provision of IPC and IPC, and ongoing support for fidelity. Digital solutions excel in standardizing and scaling processes and in shortening routine tasks. This makes large-scale implementation of new therapies faster and can make new ways of working “stick” much better than nondigital approaches.

DIGITAL FRONTIER OF THERAPIST TRAINING

A necessary step in ensuring continuity of IPT and IPC services is the continuous training of therapists in volumes that match population needs and personnel turnover (currently about 10% in Finland). Scalable training that considers individual learning styles can be achieved using digital solutions and modern e-learning principles. E-learning can be defined as a theoretical framework that combines educational theories and technology.⁵ It is used synonymously with digital learning but is differentiated from distance learning, such as Zoom lectures.⁶

Digital learning has been evaluated in the context of therapist training with encouraging results. In a wait-list-controlled randomized controlled trial, a digital training alone significantly improved the participants' subjective and objective knowledge of an evidence-based trauma therapy, self-rated competencies, and willingness to conduct the therapy.⁷ In another trial, in-person training and digital training were compared in the training of skills in dialectical behavior therapy. In-person training outperformed digital training in trainee satisfaction, self-efficacy, and motivation, but digital training was superior in increasing knowledge. There were no differences between training methods in observer-rated clinical proficiency or self-reported clinical use.⁸ Digital training has also been used previously in the context of IPT with a reported support for its feasibility and efficacy.⁹ Over a decade ago, Bennett-Levy and Perry from Australia reviewed the overall potential of digital training, stating that most of the didactic, modeling, and self-experiential elements of therapist training can be undertaken via digital training, allowing the in-person training to focus on skills practice and role play. They estimated that digital training can reduce trainer time required by at least 50%.¹⁰ Since then, digital trainings have been a staple in national-level therapist training in Australia.¹¹ A systematic review including 20 studies reported that digital trainings were associated with improvements in both knowledge and skill levels, which are generally comparable with in-person training, and concluded that digital training is a way to increase the reach and cost-effectiveness of therapist training programs.¹²

THE MODEL OF DIGITALLY AIDED IPT AND IPC TRAINING IN FINLAND

In the first-line therapies initiative, focus on digitally supported training has been the spearhead in the strategy of national dissemination of evidence-based practices, including IPT and IPC. Based on the literature presented above, digital training is seen as a solution for increasing flexibility and training volumes without compromising the learning outcomes. Because of this, we chose to build a centrally operated digital learning platform and a digitally aided model of therapist training and make this open for all publicly funded healthcare providers.

Our system aims to secure high-quality, standardized IPT and IPC training permanently available in Finland in needed volumes. A centrally operated digital platform, a shared knowledge base, and a combination of digital and in-person training modalities form our training model of IPT and IPC. The digital platform is an open-source, Drupal-based learning management system operated by Helsinki University Hospital. The system allows the creation of versatile digital trainings, user progress monitoring, and automatic evaluation through exams. The content hosted in the system has a modular structure, which means that it can easily be used in multiple trainings. For example, a module consisting of interpersonal development during adolescence included in IPT for Adolescents (IPT-A) training can be used in other training programs with similar needs. The knowledge base defines the learning objectives, learning methods, and evaluative processes used in the training (e.g., what is included in the training, who can act as a supervisor, what the supervision involves).

The IPT and IPC trainings consist of learning activities in the described learning platform and supervised interventions. All theoretical content included in the trainings is delivered via the platform and consists of various modalities (e.g., text, videos, tables, graphs) and interactive assignments (e.g., multiple-choice questions, essays with automated feedback) and are based on standard manuals of IPT and IPC, which have been translated and adapted for Finland.¹³⁻¹⁶ This adaptation included, for example, filming of 15 video demonstrations of techniques with professional actors and formulating case vignettes that reflect the Finnish healthcare system. Training is approved by the Finnish society for dynamic and interpersonal psychotherapy. Passing the IPC training requires completing the digital training with a multiple-choice exam (approximately 15 hours), attending supervision (15 hours), and conducting 3 IPC interventions from 2 problem areas and monitoring the interventions with selected patient-reported outcome and experience measures. The IPT training is similar but includes a more profound digital training (approximately 25 hours) and more supervision (21 hours). As with IPC, the IPT trainee must conduct 3 interventions from 2 different problem areas with outcome monitoring. The adolescent versions of the digital trainings have the same structure as the adult counterparts but include content about adolescent depression and development as well as videos and vignettes with adolescents. The structure and content of the supervision is standardized so that every session

includes skills training, role play, and facilitation of feedback-informed treatment using the measures gathered during the interventions.

RESULTS AND EXPERIENCES SO FAR

The first version of the digital platform was built in 2021. Digital trainings for IPC-A and IPT-A were created first with adult versions a year later. During the first year, 300 IPC-trainees and 70 IPT-trainees completed the digital training with an estimated 1000-2000 new trainees nationally for 2023-2024. After a year of experience, it is evident that digitally aided IPT and IPC trainings are feasible and well-accepted solutions for trainees, supervisors, and organizations.

For trainees, digital training offers flexibility in learning. Trainees can progress in the course at their own pace, and learning can occur in small units. This is suggested to reduce the cognitive load of the training.¹⁷ The content can be used as an interactive manual after the training, and the system itself includes all the necessary materials for conducting the interventions (e.g., symptom measures, various documents used during the interventions).

For supervisors, the platform helps to ensure that a specific level of theoretical understanding has been achieved before moving forward in the training. Thus, all the time used for in-person training can be used to practice skills and conduct role play. The role of the supervisor is to confirm that every trainee takes an active part during the supervisions and that everyone reaches a desired skill level. Digital trainings are also created to train and support beginner-level supervisors.

For organizations, digitally aided training is a tool to strengthen the level of employee competence in IPT and IPC and to maintain a specific service level. Digital solutions reduce costs associated with training employees and allow the training to be optimized to the organization's needs and timetables. For example, new employees can begin the training as a part of their onboarding period, and those who have completed the training can be assigned periodic booster training and skills tests automatically. Standardizing the training and the supervision also helps the organization train and move employees toward supervisor roles more promptly. With standardized models, organizations can more aptly predict the resources needed to train the employees in a given time.

SUMMARY

The first-line therapies digital learning environment will allow us to train a substantial number of IPT and IPC clinicians. Our model of continuous training aims to permanently increase the availability of the interventions and help maintain competence and fidelity in the long term. Other digital tools provided will help place IPT and IPC in their ideal positions within a stepped care framework. The only plausible way to answer the high demand for evidence-based practices in mental health is to apply digital tools in all parts of the process: training

therapists, implementing treatment methods, following outcomes, and sustaining best practices.

REFERENCES

1. Ranta K, Parhiala P, Law R, Marttunen M. Treating adolescent depression in multi-professional school services with IPC-A. Implementation results from the national pilot trial. *Psychiatria Fennica*. 2022;53:36–55.
2. Kontunen J, Timonen M, Muotka J, Liukkonen T. Is interpersonal counselling (IPC) sufficient treatment for depression in primary care patients? A pilot study comparing IPC and interpersonal psychotherapy (IPT). *J Affect Disord*. 2016;189:89–93.
3. Saarni S, Nurminen S, Mikkonen K, et al. The Finnish therapy navigator—digital support system for introducing stepped care in Finland. *Psychiatria Fennica*. 2022;53:120–137.
4. Saarni SE, Rosenström T, Stenberg JH, et al. Finnish Psychotherapy Quality Register: rationale, development, and baseline results. *Nord J Psychiatry*. 2023 Jul;77(5):455–466. doi:10.1080/08039488.2022.2150788. Epub 2022 Dec 21. PMID: 36541920.
5. Choudhury S, Pattnaik S. Emerging themes in e-learning: a review from the stakeholders' perspective. *Comput Educ*. 2020;144:103657.
6. Guri-Rosenblit S. “Distance education” and “e-learning”: not the same thing. *High Educ*. 2005;49:467–493. <https://doi.org/10.1007/s10734-004-0040-0>
7. Sansen LM, Saupé LB, Steidl A, Fegert JM, Hoffmann U, Neuner F. Development and randomized-controlled evaluation of a web-based training in evidence-based trauma therapy. *Prof Psychol: Res Pract*. 2020;51(2):115.
8. Dimeff LA, Harned MS, Woodcock EA, Skutch JM, Koerner K, Linehan MM. Investigating bang for your training buck: a randomized controlled trial comparing three methods of training clinicians in two core strategies of dialectical behavior therapy. *Behav Ther*. 2015;46(3):283–295.
9. Kobak KA, Lipsitz JD, Markowitz JC, Bleiberg KL. Web-based therapist training in interpersonal psychotherapy for depression: pilot study. *J Med Internet Res*. 2017;19(7):e257.
10. Bennett-Levy J, Perry H. The promise of online cognitive behavioural therapy training for rural and remote mental health professionals. *Australas Psychiatry*. 2009;17(Suppl):S121–S124.
11. Bennett-Levy J, Hawkins R, Perry H, Cromarty P, Mills J. Online cognitive behavioural therapy training for therapists: outcomes, acceptability, and impact of support. *Aust Psychol*. 2012;47(3):174–182.
12. Frank HE, Becker-Haimes EM, Kendall PC. Therapist training in evidence-based interventions for mental health: a systematic review of training approaches and outcomes. *Clin Psychol Sci Pract*. 2020;27(3):20.
13. Weissman MM, Markowitz JC, Klerman GL. *The Guide to Interpersonal Psychotherapy: Updated and Expanded Edition*. Oxford University Press; 2017.
14. Weissman MM, Verdelli H. *Interpersonal Counseling for Primary Care*. Columbia University College of Physicians and Surgeons; 2018.

15. Wilkinson P, Cestaro V, Weismann MM. *IPC for Adolescents Manual*; 2019.
16. Mufson L, Dorta KP, Moreau D, Weissman MM. *Interpersonal Psychotherapy for Depressed Adolescents*. 2nd ed. Guilford Press; 2011.
17. Young JQ, Van Merriënboer J, Durning S, Ten Cate O. Cognitive load theory: implications for medical education: AMEE Guide No. 86. *Med Teach*. 2014;36(5):371–384.