A qualitative exploration of Internet-based treatment for comorbid depression and alcohol misuse

Millie J. Darvell, David J. Kavanagh *, Jennifer M. Connolly

Institute for Health & Biomedical Innovation and School of Psychology & Counselling, Queensland University of Technology, Australia

ARTICLE INFO

Article history:
Received 19 December 2014
Received in revised form 20 March 2015
Accepted 20 March 2015
Available online 30 March 2015

Keywords:
Web-based intervention
Internet-based treatment
Comorbid depression and alcohol misuse
User’s perspective

ABSTRACT

Background: Many Internet-based treatments for depression and for alcohol misuse have a positive impact, yet little is known about how these treatments work. Most research on web-based interventions involves efficacy trials which, while important, offer little explanation about how people perceive and use online programs.

Objective: This study aimed to undertake a qualitative exploration of participants’ experience, perceived impact and use of an integrated web-based program for comorbid depression and alcohol misuse. Specifically, it explored users’ perspectives on the intensity of their treatment and the level of support they received.

Methods: Interviewees were drawn from participants in a randomised controlled trial of the OnTrack web-based treatment for depression and alcohol misuse, which compared Brief Self-Guided, Comprehensive Self-Guided and Comprehensive Therapist-Assisted versions of the program. Twenty-nine people (9–11 from each condition) completed semi-structured telephone interviews asking about their impressions and experiences with the program. Interview transcriptions were subject to a 6-step thematic analysis, employing a conceptual matrix to identify thematic differences across groups.

Results: Positive experiences and outcomes were more pronounced among participants receiving the comprehensive treatments than the brief one, but other responses were relatively consistent across conditions. A major theme was a wish for more individualisation and human contact, even in participants receiving emailed assistance. Some confused follow-up research assessments with therapist support. There was little correspondence between the perceived impact of the program and the amount reportedly completed, and some participants said they used strategies offline or completed exercises mentally.

Conclusions: This study highlighted discrepancies between how web-based treatments are intended to be used and how people actually engage with them. A challenge for the next wave of these interventions is the provision of individualised responses and coaching that retains an emphasis on self-management and constrains cost.

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1. Introduction

The past decade has witnessed an enormous growth in the implementation of Internet-based treatment for mental health issues (Griffiths et al., 2010). In Australia, web-based interventions have helped to overcome multiple barriers associated with traditional face-to-face therapy, including geographic isolation (Jorm, 2012), affordability (Foroushani et al., 2011; Postel et al., 2005), paucity of mental health providers (Lehtinen et al., 2000; Montero-Marin et al., 2013) and the stigma associated with accessing services from mental health facilities (Holmwood, 2001). Web-based interventions therefore have potential to reach many individuals who would otherwise be unable or unwilling to access appropriate treatment (Foroushani et al., 2011; Postel et al., 2005).

Numerous trials have supported the utility of the Internet as a treatment modality for depression and problem drinking, albeit as independent problems. Web-based interventions for depression have varied markedly in their focus and intensity of support, ranging from self-guided programs (Clarke et al., 2009; Hoek et al., 2011), through minimally supportive interventions (Christensen et al., 2006; Clarke et al., 2009; Vernmark et al., 2010), to programs that incorporate email and other forms of therapist contact (Perini et al., 2009; Ruwaard et al., 2009; van Straten et al., 2008). Web-based cognitive-behavioural therapy programs have been found efficacious in treating sub-threshold (Perini et al., 2009; Spek et al., 2007, 2008) and moderate (Andersson et al., 2005; Warmerdam et al., 2008) levels of depression, across adolescent (Hoek et al., 2011; O’Kearney et al., 2006) and adult (Spek et al., 2007) samples.

Alcohol misuse also responds well to Internet-based treatments, which typically apply a harm-reduction paradigm, incorporating strategies to reduce problem drinking (Finfgeld-Connett and Madsen, 2008). These interventions are associated with reductions in alcohol
consumption (Cunningham et al., 2009; Matano et al., 2007; Riper et al., 2007; Westrup et al., 2003), in weekend drinking (Doumas and H. E., 2008), academic problems (Kypri et al., 2008) and intrapersonal and other alcohol-related problems (Cunningham et al., 2005; Hester et al., 2005; Linke et al., 2007). Comprehensive Internet-based interventions for drinking problems appear equivalent, but not superior, to face-to-face treatment (Rooke et al., 2010).

Although no study has previously investigated the effects of web-based treatment for co-existing depression and alcohol problems, two have examined these comorbidities in a computerised format. Kay-Lambkin et al. (2008) compared computerised CBT for depression and alcohol or cannabis misuse with a "live" therapist-delivered intervention with identical content, and with a brief intervention (BI). Alcohol misuse responded well to the BI alone, but improvements in depression were more pronounced with intensive treatment. A more immediate improvement in depression was also noted in those receiving "live" treatment, but after 3 months this superiority was lost, and in fact condition had the highest relapse rates. It was argued that the self-help nature of computerised treatment may have rendered participants more able to sustain improvements over time (Kay-Lambkin et al., 2008). In a similar study, Kay-Lambkin et al. (2011) compared supportive counselling to an integrated treatment delivered either by a computer or therapist. Improvements among those receiving computerised treatment were at least equivalent to those receiving face-to-face treatment and surprisingly, computerised treatment was associated with superior alcohol-reduction outcomes. These findings are promising for the implementation of computerised treatments for depression and alcohol misuse, although cannot necessarily be generalised to Internet-based interventions.

1.1. Internet-based interventions from the user’s perspective

Qualitative methods can enhance the interpretation of randomised controlled trial (RCT) results (Council, M.R., 2000) and facilitate our understanding of the mechanisms of change in web-based treatments (Bendelin et al., 2011), particularly in more complex interventions comprising many active ingredients (Murtagh et al., 2007). At present, however, knowledge of user acceptability, engagement and satisfaction towards web-based interventions is sparse (Kaltenthaler et al., 2008), with only a handful of studies qualitatively investigating user’s experience of more complex computerised or Internet-based interventions. In their study of ‘live’ online CBT delivered via instant messaging, Beatte et al. (2009) found that being able to express themselves in text and developing a virtual therapeutic relationship were key themes among patients with depression. The importance of human connectedness has also been emphasised in more recent investigations concerning guided Internet-based CBT for depression (Bendelin et al., 2011; Doherty et al., 2012). While both studies found support to be facilitating and comforting, Bendelin et al. (2011) found that some participants were disappointed they did not receive more assistance, regardless of how much they were offered. This study demonstrated that users’ motivation, attitudes, and perceived impact of treatment varied considerably, depending on whether they adopted a hands-on or sporadic approach to treatment (Bendelin et al., 2011).

Research into self-guided computerised and web programs has articulated both deficits and advantages of this mode of delivery. Since these treatments are particularly susceptible to high rates of attrition, most work has been interested in identifying reasons for non-completion and poor motivation (Donkin and Glozier, 2012; Postel et al., 2011). Donkin and Glozier (2012) found that a significant barrier to persisting with an online depression program was that participants felt they were unsupported and unaccountable. Similarly, Gerhards et al. (2011) reported that many users desired some kind of support to provide personal assistance and set sufficient standards for adherence. Although both studies found that these issues decreased motivation, they also revealed multiple positive aspects associated with the absence of support, including enhanced control, freedom and a duty to oneself (Donkin and Glozier, 2012; Gerhards et al., 2011). Interestingly, Gerhards et al. (2011) found that many participants without support blurred the distinction between research aspects and the intervention, so that screening and questionnaire activities were perceived to be part of treatment. This confusion appeared to hinder adherence to the online program and in some cases precluded participants from starting it (Gerhards et al., 2011). These findings may explain why quantitative research has been inconsistent in terms of indicating that support can both facilitate (Andersson and Cuijpers, 2009; Vernmark et al., 2010) and inhibit (Kay-Lambkin et al., 2008) treatment gains.

Qualitative research has also shed light on the ingredients perceived to be most and least effective in web programs. Gerhards et al. (2011) found some participants regarded mood diaries as the most valuable treatment component, while others experienced them as a burden. Some users find web-based interventions too simplistic (Donkin and Glozier, 2012) or lacking in skill-building (Kay-Lambkin et al., 2012), particularly if they have long-standing problems (Poole et al., 2012). Research focused on the user’s perspective has also helped to elicit various suggestions for improving participants’ engagement and progress when using online programs. These include the need to regularly update the intervention (Brouwer et al., 2009; Cruzen et al., 2008), provide email reminders (Postel et al., 2011), allow for more flexibility in treatment protocols (Postel et al., 2011) and offer follow-up questionnaires to further progress (Brouwer et al., 2009). The need for more personal support is consistent across these studies (Donkin and Glozier, 2012; Gerhards et al., 2011; Kay-Lambkin et al., 2012; Postel et al., 2011), irrespective of the intensity of support provided.

1.2. OnTrack Alcohol and Depression

OnTrack Alcohol and Depression is a web program that blends motivational, cognitive-behavioural and mindfulness-based strategies, to address co-occurring alcohol misuse and depression. Based on feedback from potential users about preferred structure (Klein et al., 2010), it allows users to access modules, tools and resources in any order and pace, while offering a recommended order and asking them to trial a strategy for several days before accessing another. An initial module encourages a consideration of incentives for change, builds self-efficacy, assists users to identify sources of social support, and cues development of a detailed plan for behaviour change. Additional content includes a consideration of strengths and resources, pleasant activity scheduling, planning forisky situations, managing cravings, problem solving, drink refusal, cognitive restructuring, assertiveness and negotiation training, anger management, dealing with guilt and shame, identifying links between depression and alcohol use and early warning signs, reviewing improvements across the program, and relapse prevention.

All program components are highly interactive and encourage personalization through selection of icons and text entries, and each tool creates a printable summary page, a history of which is available from every screen. Brief videos illustrate key concepts throughout. A diary displays planned actions and allows monitoring of drinking and mood, which populates progress graphs. Resources include fact sheets about alcohol and depression, and downloadable audios about mindfulness and dealing with cravings. A help button on every screen provides advice on suicidality, and phone numbers for emergencies and for services on alcohol and drugs, mental health problems, grief, and relationships, among others.

The current study is informed by an RCT on this program (Kavanagh et al., in preparation), which randomised 327 participants to one of three conditions: (a) Brief Self-Guided intervention (B-SG), which only offered the initial module on motivation, self-efficacy, social support and planning; (b) Comprehensive Self-Guided treatment (C-SG), giving users full access to the program, or (c) Comprehensive Therapist-Assisted treatment (C-TA), which added emailed therapist support.
over the first 12 weeks. Emails in the C-TA rewarded individual participants’ progress, assisted with lapses, encouraged continued use of the program and suggested modules that were not yet accessed. Sentences in these emails contributed to or were adapted from a library of templates, to maximise consistency and treatment fidelity. All participants also received regular standard emails to remind them to use the program. The trial assessed depression and alcohol-related outcomes at 3, 6, 9, and 12 months, using online surveys and single-blind phone interviews. Results are reported separately (Kavanagh et al., in preparation).

1.3. Aims

This study investigated participants’ experience, use and overall perceptions of the web-based programs. In particular, we aimed to identify whether differences existed across the three treatment conditions, given their variability in comprehensiveness and whether therapist support was included.

2. Method

2.1. Participants

Ethical approval for this study was granted by the Queensland University of Technology’s Ethics Committee (Approval # 9000000222). A total of 29 participants from the OnTrack Alcohol and Depression trial took part. Participants in the RCT were recruited via multiple media outlets including the radio, television, newspapers and social media, as well as through local community and health organisations. Participants in the trial were aged 18 years or over, consumed more than 14 standard drinks per week for women or 28 for men, and scored at least 14 on the Depression, Anxiety and Stress Scale (DASS) (Lovibond and Lovibond, 1995). They could not be intravenous drug users, daily illicit substance users, pregnant, acutely suicidal, opposed to completing supervised detoxification prior to the study (i.e. highly dependent on alcohol), or have a diagnosis of bipolar disorder or history of psychosis. Details of the trial’s methodology are in a separate paper (Kavanagh et al., in preparation).

Initially, 36 trial participants expressed interest in the current study, although some were lost due to time constraints (n = 1), change of mind (n = 1), being unable to contact (n = 4) and having only vague recollections of the trial (n = 1). In total, 9 participants from the B-SG (8% of the total B-SG sample), 11 from the C-SG (10% of the total C-SG sample), and 9 from the C-TA (8% of the total C-TA sample) were interviewed. Sixteen participants were female (55%; 56% in B-SG, 45% in C-SG, 67% in C-TA). Ages were not provided by two participants. The remainder ranged from 24 to 63 years (M, SD for B-SG: 46.3, 5.1; C-SG: 49.6, 9.9; C-TA: 45.9, 13.6).

2.2. Procedure

Participants were initially approached by a personalised email reminding them of the original trial, and inviting them to participate in a related but separate study. Interested participants were asked to respond with a selection of suitable days and times to be interviewed. Participants were recruited in two waves. Initially, opportunistic sampling was employed, whereby participants most recently contacted by the research team were selected first (Onwuegbuzie and Collins, 2007). This method was chosen, given the anticipated difficulty of contacting and recruiting participants who had not recently engaged in any research-related activity. Emails were sent to 40 participants at a time across treatment conditions, beginning with participants who had completed all follow-up interviews. Emails were sent approximately a week apart, and this process was repeated until all participants who had not withdrawn from treatment had been contacted.

Given the difficulty of obtaining participants from the B-SG (the condition with the highest rate of attrition) a criterion sampling method, via a second email, was subsequently employed. This email differed slightly from the original in that it highlighted the team’s interest in hearing from B-SG participants, regardless of whether they found the program helpful or not. Three additional participants were recruited via this method.

All interviews were conducted via telephone and were audio recorded. A semi-structured format was used to guide the interviews (Appendix A). The interviewing process was flexible in that newly emerging themes were permitted to be incorporated into the interview schedule over the course of the project. Questions differed slightly depending on the treatment condition to which participants were allocated and the degree to which they elaborated on topics. Questions covered participants’ perceived impact of the program, their engagement with and use of the program, and their overall perception of treatment. Interview durations ranged from 14 to 62 min, with an average of 29 min. Audio recordings were transcribed verbatim by the primary researcher to maximise data familiarisation (Bird, 2005), and transcripts were subsequently checked against audio files.

2.3. Transcript analysis

The transcript analysis drew on King and Horrock's (King and Horrocks, 2010) system of thematic analysis and was guided by a 6-step theoretical thematic analysis outlined by Braun and Clarke (Braun and C. V., 2006). The process of interpretation followed a ‘theory-driven’ essentialist paradigm, wherein participants’ responses were approached with specific inquiries in mind, and were based on the researcher’s interest in experiences that resided within the individual (Braun and C. V., 2006). This process involved: 1) repeated reading of the data and noting initial ideas; 2) generating codes for as many themes as possible; 3) searching for, and sorting codes into, potential themes; 4) reviewing themes at both the extract level (reading all exerts for each theme) and entire data set level (re-reading all data); 5) refining and defining themes and sub-themes, and; 6) producing a write-up of the data. To facilitate the process of generating and sorting themes, a thematic conceptual matrix, organised by themes and treatment conditions, was utilised (Miles and Huberman, 1994). The entire set of responses was subject to these processes rather than analyses being conducted separately for each group.

The primary researcher was responsible for coding and identifying themes in the data set. To enhance observer agreement, data was reviewed by the supervisor at the second and third phase of the analysis, to enable any discrepancies to be discussed and resolved prior to conducting further analyses.

3. Results

Results were grouped into four major categories relating to users’ experience of the OnTrack program: overall outcomes, perceived mechanisms of change, limitations and weaknesses of the program, and program–user incongruities, with each category comprising several themes and sub-themes (see Table 1). The following section illustrates these results using participant quotations, accompanied by a participant identification number.

3.1. Overall outcomes

3.1.1. Program as a precursor, adjunct or follow-up

More than two-thirds of participants indicated that OnTrack served as either a preliminary, adjunct or follow-up treatment to external mental health support. Most commonly, and in all three conditions, participants reported that the program served as a precursor to offline treatment. This progression was often attributed to an increase in motivation, an enhanced confidence to address problems, an awareness of treatment options and a more conscious recognition of the extent of one’s problems. Interestingly, this theme was more common among participants in comprehensive treatments than those in the B-SG, and
was endorsed by participants who had both positive and negative experiences with the program.

It gave me the motivation to then be able to go and get some help face-to-face (23 – C-TA)

3.1.2. Primary outcomes

Participants reported significant, positive changes which they attributed to the program. Improvements in drinking and, to a lesser extent, mood, were frequently described by participants in all interventions, particularly those in the comprehensive conditions. Participants reported that they had either ceased or substantially reduced their drinking, that they felt happier, more in control and stable, and that they no longer drank alcohol to escape, but for enjoyment.

I feel a lot better about myself... I've cut down my drinking a lot... I feel like I'm on track... I've got strategies now (2 – C-TA)

Other changes included improvements in physical health, weight, sleep, energy, and social and intimate relationships. Several participants reported major life transitions or milestones that they ascribed to program completion, such as getting married, obtaining work or undertaking a university degree. For example, a participant said:

I got my licence on my 55th birthday... [beforehand] I didn’t think I’d be sober enough to drive... the freedom it’s given me it’s just immense (23 – B-SG)

Participants also reported improved coping strategies, particularly if they received comprehensive treatment. They said they felt more equipped to deal with various alcohol-related challenges, including triggers, urges and lapses, along with daily stressors.

3.1.3. Secondary outcomes

Almost all participants with positive treatment experiences maintained that the program produced dramatic changes in their awareness. They said they were more conscious of problems, costs or dangers associated with their drinking, the pace of their drinking, and drinking triggers including links between their mood and intake. This awareness was more profound among participants receiving comprehensive treatments.

It was revolutionary for me to count drinks (…) and then match that to mood (20 – B-SG)

I'm more aware of what triggers me to feel like, oh gee I'd just like to go and have a drink now (13 – C-TA)

Many participants reported a change in attitudes towards life, particularly in the C-TA condition. They described being less tentative about change and more optimistic, confident and mindful.

The major thing that I got out of it really was learning to live in the moment... (10 – C-SG)

Several participants also described developing an increased capacity to self-reflect since completing the program. This was more pronounced after comprehensive treatments.

3.1.4. No significant improvements in mood or alcohol problems

Some participants were unable to report any positive outcomes from the program, while at least one in each condition reported that improvements were only evident while using the program. Exclusive to the B-SG, some participants believed that the program worsened their condition or exacerbated other issues they were encountering at the time.

It was actually another failure, another lack of follow-through, another lack of support (25 – B-SG)

3.2. Perceived mechanisms of change

3.2.1. Qualities unique to web-based treatment

Many participants described being attracted to and motivated by a variety of virtues exclusive to web-based treatment. Of these,
accessibility, anonymity and privacy were the most highly regarded, and endorsed by participants across conditions, regardless of whether they found the program successful.

To get that kind of program in the past I would've had to have gone to a bookshop and chosen out of all of the self-help books the one that I thought from the cover looked about right, paid money for it, taken it home, you know, found that it doesn't really suit or it's a bit weird... (5 – C-SG)

3.2.2. The program’s underlying paradigm

Participants in all three conditions complimented the program for being non-partisan, focused on the here and now, realistic, and not requiring an elaborate account of their childhood. Some were also impressed that the program did not employ ‘religious’ aspects (20 – B-SG).

The program said to you ‘how much did you drink today, how do you feel today’... it just asked questions about you and how you're feeling, without saying to you ‘don't drink it's bad for you’ (27 – B-SG)

3.2.3. Tools and strategies

Despite the passing of time between when participants last accessed the program and when they were interviewed, most could recall tools they found particularly useful. Irrespective of treatment condition, the diary was the most highly regarded and in every participant’s list. A disparity between participants’ individual circumstances and the program’s conceptualisation of comorbid depression and alcohol misuse was sometimes reported. Some said that the interaction between drinking and mood was too heavily emphasised, while others commented that the program did not cover alternative drinking motives such as anxiety, habit and boredom. In some cases these factors caused them to feel disconnected from the program.

It was targeted in a sense at people who were having difficulty with functioning in life with their drinking, um, whereas I, as both a blessing and a curse in certain senses was having any difficulty functioning (26 – C-TA).

In response, several suggested assistance at the outset of treatment to facilitate a more individualised, meaningful journey. Some proposed an initial phone consultation, wherein they could express primary concerns and obtain clearer directions for treatment. Others recommended an online tool to help them select and engage only with components that were applicable to them. These suggestions were almost exclusive to participants in comprehensive treatments.

There probably wasn't enough um help in targeting which aspects of the program to put most emphasis in... whether (...) the survey could've made it much more clear to me that yes that is the original issue so therefore having identified this, don't worry about these aspects of the program (25 – B-SG)

3.2.4. Other adverse circumstances that instigated change

Several participants across conditions ascribed the desire to change their behaviour to adverse circumstances. Usually this involved medical incidents, such as being diagnosed with life-threatening diseases or being hospitalised due to alcohol poisoning.

I got an unfavourable medical report, I thought right, ok, you know how to do this, so I cut right down, (…), and I used the tools that I had found on (...) OnTrack (23 – B-SG)

Some considered that their positive changes in drinking, such as focusing on quality rather than quantity (14 – C-TA), were not a result of the program.

3.2.5. Program deficiencies enhanced autonomy

Two participants in B-SG reported that the program’s perceived insufficiencies prompted alternative help-seeking, which generated positive changes. One recalled searching elsewhere for information, making her more self-sufficient (23 – B-SG). Another said that the program’s failure to sufficiently engage her prompted her to seek external assistance.

It wasn’t intensive enough, it just wasn’t involved enough for me, that it wasn’t personalised enough for me… I tried it for about three months and that wasn’t helpful, so I decided that I would go [elsewhere] (25 – B-SG)

3.3. Limitations of the Program

3.3.1. Lack of individualisation

The most commonly reported limitation of the program was that it insufficiently addressed individual needs. Participants in B-SG tended to experience the program as lacking in proactive strategies.

It didn't tell me anything that I didn’t already know (16 – B-SG)

A disparity between participants’ individual circumstances and the program’s conceptualisation of comorbid depression and alcohol misuse was sometimes reported. Some said that the interaction between drinking and mood was too heavily emphasised, while others commented that the program did not cover alternative drinking motives such as anxiety, habit and boredom. In some cases these factors caused them to feel disconnected from the program.

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3.3.2. More human, less computer

Participants commonly perceived the program as impersonal, which at times made them feel isolated and unaccountable for their engagement with it. Several, especially in B-SG, were dissatisfied with the absence of human responses, and described the standard emails that reminded them to log onto the program as factory line in tone (23 – B-SG).

It’s like someone gave me pamphlets and (said) here you go... it obviously still worked ’cause I was ready to do it, but... you don’t really want to feel by yourself (4 – B-SG)

Participants receiving comprehensive treatment were more concerned about limited opportunities and resources for relationship building, which affected their engagement with certain aspects of the program. Some suggested that an initial face-to-face meeting might
resolve this issue, while others suggested Skype, photos or introductory videos presenting members of the team.

Getting to know the counsellor or whatever you call them upfront... That raises I think the level of commitment... once you establish the relationship... it’s much more effective and easier to do it over the phone (14 – C-TA)

Interestingly, the distinction between the therapist providing email support and the researchers conducting follow-up assessments was blurred for some C-TA participants.

3.3.3. Information about the program and treatment options

Several participants wanted more upfront information from the program about their treatment options, such as the potential for local, in-person psychological services that are government-subsidised.

Maybe a better approach is just to say... not only do you need to think about having a doctor... but maybe you need also to think about, um, some kind of support... like maybe a counsellor or psychologist (20 – B-SG)

Participants also reported a need for the program to make its parameters more explicit in order to avoid unrealistic expectations. This theme was exclusive to participants across conditions who had primarily unfavourable experiences.

On the front page of your um, of your site (...) I would talk about that very idea that this program might not work for you... we’re not promising it will work but it’s a great first step and (...) the more attempts that you make... the more likely you are to succeed (5 – C-SG)

3.3.4. Help! The need for a crisis intervention

Irrespective of participants’ satisfaction with the support they received, across conditions, several advocated for human contact during critical moments. Such moments were variable, ranging from difficult social situations and family tension to afternoon cravings. Most participants envisaged a hotline as being highly beneficial, while others suggested an online, ‘live chat’ option or a chat room dedicated to OnTrack users. While email support would have satisfied some participants, most wanted instantaneous contact and felt this would be particularly valuable in early stages of treatment.

It’s all very well to do diaries and read stuff but a lot of people, I think, also need some sort of human interaction and prompts during crisis moments... If you had this sort of button there (...) and when it’s green you know there’s someone at the other end that you can sort of have a dialogue with... someone to say hang on, hang in there, don’t give up today (11 – C-SG)

3.3.5. Booster, upkeep and follow-up strategies

Increased human contact via email or telephone was suggested almost universally, even among the majority who were satisfied with current support. Some expressed a desire for weekly or fortnightly calls to enhance accountability and support. Others highlighted a need for periodical ‘check ups’ to ensure that web-based activity was mirroring their progress offline. Additional recommendations included emails or web links to keep participants stimulated and hopeful about overcoming their problems.

Maybe some positive stories about overcoming adversity and things like that... sort of like a diversionary tactic... a diversion from going and grabbing that next drink (24 – C-SG)

At least one person from each condition recommended a follow-up program to consolidate learning and promote longer-term accountability and progress. Suggestions included short programs, phone calls or surveys.

It would have been a good idea to have a small follow-up program... to reconfirm everything... I think that if I would’ve had that small follow-up program I probably wouldn’t be in the position I’m in now (3 – C-SG)

3.4. Program–user incongruities

3.4.1. Adaptive approaches taken to the program

Several participants across conditions described approaching the program and engaging with it in ways that personally suited them. Some selected only components relevant to their circumstances. More commonly, they adapted some online tools to suit offline use, such as converting the web-based diary into a pocket calendar or excel spreadsheet.

I didn’t really like the online thing... I started to keep a diary myself instead (B-SG – 12)

Several participants said they mentally utilised concepts or tools without entering information into the program.

Well the online concept of it I really didn’t utilise anywhere near its, its full capacity... I looked at it often but didn’t do too much on it... except in my mind, and I was comfortable doing it that way (7 – C-TA)

3.4.2. Emails (therapist support)

Participants in the C-TA were also asked to comment on the emails they received during the first 12 weeks of the program. Surprisingly, two participants had no recollection of the therapist coaching; two recalled the emails but did not think they were influential, and three said that follow-up assessments were more instrumental than the therapist’s emails. Despite this, several participants reported a worsening in their condition after emails ceased, maintaining that emails reinforced the content of phone calls, enhanced reflection and accountability, and served as reminders to revisit the program.

It was easier to just go ‘oh well it doesn’t matter anymore’... I did start drinking quite a bit again (13 – C-TA).

Most participants reported little impact of the presence or absence of therapist support. Some speculated that this was due to a preference for oral communication, or to not formerly establishing a strong enough connection with the therapist.

Had there been... an hour long introductory meeting or something along those lines, then I may have been able to step away and actually actively engage with an email (26 – C-TA)

3.4.3. (Non) completion of the web-based program

Across conditions, less than a third of participants said they completed the program. Interestingly, there seemed to be little association between how much was completed and the favourability of impressions or perceptions of effectiveness. Many participants who ultimately had positive outcomes did not complete the program.

I know I did all the [...] questionnaires and [...] interviews, but as for the online modules I can’t remember... the whole online thing completely escaped me (24 – C-SG)
All participants who stopped using the program when they felt able to continue alone had positive outcomes.  
I had actually made a decision that I’ve got enough tools now for me to start actually working on that… I felt that I’d gone as far as I could go, or needed to go, or wanted to go (23 — B-SG).

4. Discussion

4.1. Synthesis of results

The aim of this study was to better understand how participants’ perceived a web-based treatment for comorbid depression and alcohol misuse. Approximately two thirds of participants perceived the program as beneficial. In addition to positive changes in mood and drinking, many described complementary effects such as improvements in physical well-being, interpersonal relationships, self-awareness and general coping. Reported improvements were more pronounced among participants receiving comprehensive treatments. In contrast, several interviewees who completed the brief intervention believed the program aggravated their difficulties, due to its failure to deliver sufficient content and support. Regardless of how successful participants found the program, most viewed it as an encouraging step to further addressing their problems, with more than two thirds indicating that they sought professional help after completing the program. This finding has important clinical implications, as it highlights the utility of web-based treatment in overcoming ambivalence and increasing awareness as an initial step to addressing comorbid depression and alcohol misuse.

Accessibility, privacy and the program’s underpinning philosophy were highly regarded by participants in all conditions, and seen as critical to their satisfaction and engagement with treatment. Similar to previous research (Gerhards et al., 2011), the diary was perceived as the main ingredient responsible for generating awareness, irrespective of treatment condition. Many users also regarded the team’s follow-up phone assessments as a highly influential component. This finding is consistent with Gerhards et al. (2011) who found that participants misconstrued some research activities as being part of treatment. In the current study, follow-up assessments had the unintended consequence of being experienced as treatment and, in some cases, counselling. Other circumstances such as medical problems and a perceived sense of program incompleteness were also seen as instigating change, with some participants indicating they would not have made progress otherwise.

Many of the program’s perceived limitations echoed those in previous studies. Consistent with research on both online and computerised interventions (Donkin and Glozier, 2012; Kay-Lambkin et al., 2012; Poole et al., 2012), participants were primarily concerned with the program’s lack of tailoring to individual needs, knowledge and circumstances. Not surprisingly, brief intervention participants were dissatisfied they did not learn anything new, whereas those in comprehensive treatments felt they were exposed to material without personal relevance. Assistance at the outset of treatment to enable a more individualised journey was recommended. Especially popular was the notion of an initial phone consultation or online tool that would facilitate a more personalised treatment path. This finding is curious, given the extremely high level of flexibility enabled by the program, whereby users could select the modules they wanted, at any pace and order, and the ability to expand the menu so that specific program segments could readily be reviewed for selection. The perceived need for guidance may reflect limited initiative and self-sufficiency in some users; characteristics that are known to influence ways in which users approach web-based treatment (Bendelin et al., 2011).

For some participants, the perceived omission of important information about the program resulted in disillusionment. Given the difficulties many participants faced when completing treatment, there was an expressed need for information about additional support and forewarnings that the program may not work for certain people. The conduct of the randomised controlled trial precluded the encouragement of significant outside assistance and the program already had extensive information about services. However, it seems that additional information about these services or a greater featuring of them may be needed in routine use of the program outside a research trial. Informing participants of anticipated challenges and limitations of web-based treatment may reduce the disappointment that participants with high expectations may experience (Bendelin et al., 2011), although warnings like these may also undermine confidence.

The program’s perceived lack of individualised responsiveness was highly consistent with the respondents’ popular demand for additional support and human connectedness. While participants in the B-SG desired increased contact, those in comprehensive treatments sought more meaningful therapeutic relationships through Skype, photographs or initial face-to-face meetings. Similar findings were reported in Beattie et al. (2008) who found that, in the absence of visual cues, participants perceived therapeutic relationships as mechanical rather than trusting and accountable. Regardless of treatment condition, participants also voiced the need for professional human contact during trying moments, suggesting that a hotline or live-chat option may be a useful addition, especially in early phases. Other recommendations for boosting engagement and progress included increased telephone and email contact, website and mental health updates, and a follow-up program. Overall, findings concur with previous studies, indicating that irrespective of the amount of support provided, further assistance is consistently welcomed by users of computerised and web-based treatments (Donkin and Glozier, 2012; Gerhards et al., 2011; Kay-Lambkin et al., 2012; Postel et al., 2011).

One of the most interesting findings was that participants’ perceived improvements were not a function of how much of the program they reportedly completed. Researchers are frequently troubled by the high attrition rates that characterise web-based interventions, including those for depression and alcohol misuse (Andersson et al., 2009; Postel et al., 2011). This study suggested that poor adherence does not necessarily result in poor perceived outcomes, provided users engage with treatment principles. Participants did not perceive a need to complete the program to derive benefits: instead, they reported mentally engaging with treatment concepts, converting online tools to offline formats, and only using the program while it was seen as necessary. These reports might explain why previous studies have found participants can improve significantly after using web-based programs for only a few weeks (Farvolden et al., 2005; Postel et al., 2011) and why others have not seen found differences in outcomes between compliant and non-compliant users (Christensen et al., 2004). Contrary to previous studies (Donkin and Glozier, 2012), more adherent participants in this study were no more likely to perceive the program as valuable than less persistent users. Some of the most positive reviews were obtained from participants who only completed part of the program or reportedly did not access it at all. Positive experiences were more related to persisting with the program until it was no longer needed, or engaging with its concepts in personally meaningful ways, than to completing the program per se. However, these findings were based on perceptions rather than objective indicators of improvement.

Unexpectedly, most participants receiving therapist coaching said it had little impact, even though some recalled a diminished sense of accountability and progress when it ceased. Such reactions may well be dependent on individual differences and the relationship participants had with their therapist. In a study on guided web-based treatment, Bendelin et al. (2011) found that some users relied on being ‘pushed’, while others appreciated working alone, while knowing they had back-up support. Other research has indicated that highly intense therapeutic relationships can lead to interruptions in clients’ progress, whereas relationships perceived as important, but not central, are more associated with consistent change (Cummings et al., 1994). Consistent with...
previous research [Bendelin et al., 2011], some participants may have attributed initial improvements to the research team rather than to themselves, leading to decreased self-efficacy and to setbacks experienced when emails ceased at 3 months.

4.2. Limitations

A limitation concerns the gap between participants’ first access to the program and when they were interviewed. Participants in the original trial were recruited between early 2010 and mid-2011, but interviews took place in early 2013. Thus, some interviewees were not contacted until 36 months after commencing treatment. Recollections of the program may therefore have been subject to significant recall difficulties, some of which were noted during interviewing. Participant’s perceptions of the program may have also been influenced by their current situation along with external factors, such as receiving additional support since completing the program. Any memory difficulties may have been exacerbated by alcohol misuse, and some participants admitted that their drinking during treatment interfered with their ability to recall certain aspects of it. Although the primary researcher was not involved in the RCT, the interviewing process and analysis may have been influenced by knowledge of the trial’s preliminary results, as well as the primary researcher’s personal experience and perceptions. In addition, while themes were reviewed by the second author at several stages, no other inter-rater reliability checks were conducted. The recruitment method utilised in the current study yielded a sample that was relatively gender-balanced, and had both participants with positive and with negative experiences. However, the views of volunteering participants may have differed among those who chose not to undertake the interview.

5. Conclusions

This study represents the first qualitative exploration of participants’ experience of a web-based treatment for comorbid depression and alcohol problems. Findings offer understanding of how this sample of participants use, engage with and respond to Internet-based treatment with and without therapist guidance. Overall, treatment experiences appeared more positive in the comprehensive treatment conditions, where participants received enhanced support for their efforts and were more able to engage with treatment concepts in adaptive, personally meaningful ways. The findings highlighted the challenge of differentiating the impact of treatment components from research activities, given participants’ tendency to blur this distinction, and indicated a discrepancy between ways in which web-based treatments are designed to be used and how participants actually engage with them. The current findings offer important insights into ways to improve the study, design and implementation of web-based programs. A challenge for the next wave of these interventions is the provision of individualised responses and therapist support, while retaining an emphasis on supported self-management and constraining cost.

Trial registration

ACTRN12610000061033.

Conflicts of interest

There are no competing interests to declare.

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CBT</td>
<td>Cognitive Behaviour Therapy</td>
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<tr>
<td>RCT</td>
<td>Randomised controlled trial</td>
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<td>B-SG</td>
<td>Brief self-guided intervention</td>
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<tr>
<td>C-SG</td>
<td>Comprehensive self-guided treatment</td>
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<tr>
<td>C-TA</td>
<td>Comprehensive therapist-assisted treatment</td>
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Acknowledgements

The authors would like to acknowledge the funding of the OnTrack Depression and Alcohol trial by the National Health and Medical Research Council (APP 553095).

Appendix A. Qualitative questions in the semi-structured interview

<table>
<thead>
<tr>
<th>Condition</th>
<th>Question</th>
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<tbody>
<tr>
<td>All</td>
<td>1. What changes have you noticed in your life since doing the program? (Anything else?)</td>
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<td>2. Was anything surprising or unexpected about your experience with the program? (Can you tell me more about that?)</td>
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<tr>
<td></td>
<td>I. After being in the program, were there (any other) things that didn’t work out the way you’d hoped? (Can you tell me more about that?)</td>
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<tr>
<td></td>
<td>II. Did anything (else) work out better than you’d expected? (Can you tell me more about that?)</td>
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<td>3. What made you stop using the program?</td>
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<td>4. What was motivating about your experiences with the program?</td>
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<td>5. What part of the program was most useful? Why?</td>
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<td></td>
<td>6. Thinking back to your experience with the program, are there any ways in which it could have been more effective?</td>
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<td></td>
<td>7. There were 3 conditions in the On Track program, a self-guided brief intervention, a self-guided full intervention, and a therapist-guided full intervention. As you know, you were allocated to the x condition. How do you think being allocated to this condition affected how you went overall?</td>
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<td></td>
<td>8. Were there particular challenges you faced where you really would have liked the support of a therapist? (How might a therapist have helped with that?)</td>
</tr>
<tr>
<td>C-TA only</td>
<td>1. Were there any ways the therapist support could have been more effective?</td>
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<td></td>
<td>2. What differences did you notice after the therapist support ended at 3 months?</td>
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References


