Integrating Internet-Based Self-Care Program with Face-to-Face Therapy for Depression: Observations and Emergent Insights

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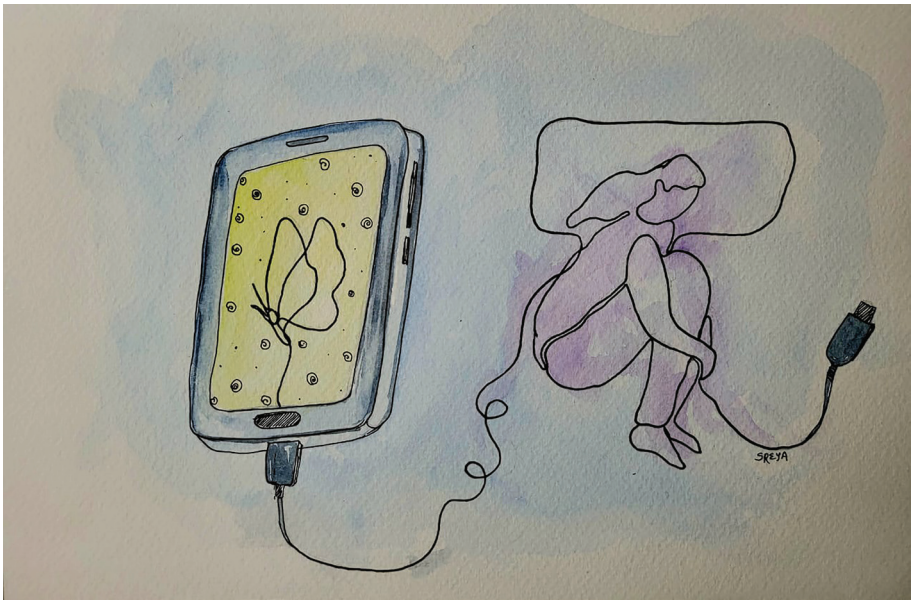
Depression is among the commonest mental health disorders, affecting over 322 million people worldwide, and is the single largest contributor to health loss.[1] In India, depression affects one in every 20 individuals, and most of the affected neither seek nor have access to treatment.[2] Technology-driven self-help and guided psychological interventions have shown promising results and could be a low-intensity and low-cost strategy to cater to a larger number of individuals seeking mental health care.[3] This assumes great importance in the context of scarcity of trained professionals to offer psychological interventions and observations that a significant proportion of individuals seeking treatment for common mental health concerns may receive only pharmacological interventions, despite voluminous literature suggesting the utility of psychological interventions.[4]



Internet-based interventions have been assessed in substantial research in the last 20 years, and several meta-analyses demonstrate their effectiveness in treating various psychiatric disorders, including depression and anxiety.[5,6] Different formats

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of internet-based interventions have been studied. Unguided internet-based interventions are stand-alone interventions where users navigate through structured self-help material independently, without human support. On the other hand, guided internet-based interventions involve minimal but regular contact with therapists, typically over email, to support, guide, provide feedback to, and reinforce users working on self-help material.[7,8] Guided interventions have been observed to result in higher retention rates and better outcomes as compared to unguided self-help interventions.[6,8]

Some challenges of internet-based interventions include a lack of therapeutic alliance, difficulty in adequately addressing crises or clarifying comprehension errors, and limited scope for individualization and translatability to real life. [9–11] A newer approach called blended interventions aims to address some of these challenges by integrating internet-based interventions with a few face-to-face sessions, thereby combining the advantages of both. They can be used in an integrated (where both are offered in varying ratios simultaneously) or sequential (where face-to-face sessions follow internet-based interventions or vice versa) format.[10] Blended interventions that are predominantly internet-based and supplemented with a few face-to-face sessions could help address some of the limitations of internet-based interventions while offering greater scope for therapeutic alliance and individualization. As blended interventions are still in a nascent stage of development, issues regarding the optimal ratio of Internet and face-to-face sessions, aspects to delegate to internet-based sessions, and characteristics of patients who might benefit are under consideration.[9,10,12] Preliminary evidence is promising, with a few studies finding blended therapy to be as effective as face-to-face therapy, without compromising on the patient-therapist working alliance or therapy outcome, saving clinician time and leading to lower drop-out rates.[10,13–15] A few studies from India indicate the potential receptivity and utility of internet-based self-help interventions for depression.[16,17] However, there is a lack of published literature on the experience of implementing blended interventions in clinical settings in India. Considering this, we present our observations from the field, and learnings from and challenges of using a blended intervention format, based on experiences with clients with mild-to-moderate severity of depression seeking treatment in a tertiary care setting.

Description of the Blended Intervention Format

Clients with a primary diagnosis of mild or moderate severity of depression or dysthymia and referred for psychotherapy by their treating psychiatrist were considered for the blended intervention as part of an ongoing doctoral study, following a screening protocol. The study was approved by the Institute Ethics Committee. Clients who had undergone structured psychotherapy within the last six months or those whose concerns indicated a need for a different form or more intensive/longer-term intervention, such as the presence of severe depression, suicidal ideation, comorbid diagnosis of Cluster B personality disorders, or depression secondary to marital discord, were not considered suitable for the blended intervention. While some clients were on medication when starting therapy, others were not on any medication for depression or opted specifically for psychotherapy. Clients were explained about the blended intervention and provided written informed consent before commencing therapy, and ethical approval from the Institute Ethics Committee was obtained.

Nature of Blended Intervention Used

The blended intervention was a brief, eight-week intervention combining an internet-based self-help program, Practice and Use Self-Help for Depression (PUSH-D),[16] and 4-6 face-to-face or video-based sessions with the first author. The internet-based structured self-help program PUSH-D was developed and pilot-tested by a team of mental health professionals, including the second and third authors, and found to be effective in reducing the severity of depressive symptoms when delivered along with minimal telephonic support.[16] It comprises ten essential modules relevant to depression (e.g., behavior activation, challenging cognitive distortions, managing excessive worries, self-compassion, and enhancing a sense of mastery). In addition, optional zones cover additional issues that clients with depression may face.[16] The blended intervention used in the present study followed the integrated format, with the internet-based program and face-to-face sessions running in parallel. The modules covered in PUSH-D served as a base for the structure and content of face-to-face/video-based sessions, and an eclectic approach with techniques analogous to the content in PUSH-D was used. The number of face-to-face sessions was kept flexible, drawing from research recommendations highlighting the need for flexibility in implementing blended interventions[9,18] and based on clinical judgment on a case-by-case basis. The frequency of face-to-face sessions varied from twice a week to once in two weeks, while clients continued to work on PUSH-D between sessions.

Functions Served by Face-to-Face/Video-Based Sessions

These served to help enhance clients' motivation to complete the internet-based self-help program and provided a therapeutic space for clients to share their current concerns and ongoing stressors and receive empathy and validation from the therapist. Sessions also focused on contextualizing relevant PUSH-D modules, providing guidance on real-life application of skills, and offering help with challenging exercises as required. Brief telephonic/e-mail support was provided on alternate weeks. This was meant to deepen therapeutic alliance, troubleshoot any difficulties in navigating PUSH-D, provide feedback based on progress, and offer therapeutic support and motivational push for sustained engagement with the program.

Observations and Client Experiences

Our observations presented below are based on the first 30 clients seen for the blended intervention. Client feedback regarding the blended intervention was sought through a form developed by the authors, and brief excerpts highlighting relevant client experiences are mentioned at appropriate junctures.

Most clients who were referred and approached expressed interest and were receptive to the concept of a blended

format. Clients were men and women aged 18-55 years, most in their 20s or 30s. Most of them were graduates and working professionals or pursuing graduation. Most were diagnosed with first episode of mild or moderate depression, while others had a diagnosis of recurrent depressive disorder or dysthymia. Around two-thirds of the clients had no comorbid conditions, though Cluster C personality traits were commonly observed. Generalized anxiety disorder, dysthymia, and obsessive-compulsive personality disorder were the most common comorbid diagnoses.

The clients who consented to blended interventions typically rated themselves as interested in learning self-help skills. Some reported logistic challenges that made it difficult to attend traditional psychotherapy sessions and hence preferred the blended intervention. Some also reported the flexibility the intervention offered and privacy as appealing. As clients were motivated for blended interventions and had fair levels of computer literacy, they could engage with the intervention without help from significant others.

> *"I liked the idea of having something structured to work on between sessions at home. It felt good to have material that I could keep returning to and revising strategies when I commute by metro..."*

> *"This was the kind of help I was looking for. I have a hectic and unpredictable schedule and wanted to learn to manage my depression better on my own. Although medicines helped, I wanted to learn to prevent this from happening again..."*

A few clients were uncomfortable with trying the blended format. The reasons they expressed were not being interested in internet-based programs, having tried them in the past, and/or looking specifically for longer-term interventions. Some clients also expressed feeling too unwell at the time of commencing therapy to focus on an internet-based program and expressed a preference for face-to-face psychotherapy. They were provided appropriate referrals for therapy.

> *"I have tried a few apps for mental health before. They helped a little, but I think I need more at this point. I would like to understand myself and the impact of some childhood experiences better. I think I need more than just a few sessions..."*

Most clients who completed the intervention reported finding the combination of the internet-based program, face-to-face sessions, and telephonic support as useful and were satisfied with the blended intervention.

> *"The combination of PUSH-D and sessions helped me. Though it was possible to read through the material and complete the program, I realized it is quite difficult to practice these skills correctly and consistently. The therapist helped set realistic expectations of myself and made me more aware of my thinking and mood by monitoring my workbook and providing regular feedback...."*

Some clients found the internet-based program to be the most helpful component, making the therapy process more structured and concrete from the beginning, thereby helping them inculcate self-care practices and improve self-confidence.

> *"I have attended a few sessions of therapy previously. It helped to talk about my difficulties, but it was expensive and I was looking for something more structured and concrete that I could work on and practice, like specific tips or strategies. PUSH-D helped me get started in the right direction.... I feel more confident about handling such situations in the future."*

Those with experience with traditional therapy formats tended to find face-to-face sessions the most helpful component and considered the internet-based program akin to homework exercises between sessions. Clients, in general, also expressed that regular feedback and having a professional to reach out to in case of difficulties were facilitative.

Most clients were able to work on several components independently. Clients who practiced some of the exercises between sessions reported that noticing their own efforts and consequent improvements gave them a sense of being self-reliant, less dependent on the therapist, and in control.

> *"Understanding cognitive errors and identifying them, as well as working of the emotional mind, rational mind, and wise mind, is helping a lot in controlling negative automatic thoughts..."*

In general, we observed that the combination of the internet-based program and face-to-face sessions was well-received. The preference for working independently on the internet-based program or relying on face-to-face sessions varied depending on clients' experiences and expectations of therapy (e.g., as being a long-term, therapeutic space to share and work through concerns with a therapist), motivation for therapy, and severity of symptoms. Although client experiences varied, most reported feeling more self-reliant, less dependent on the therapist at termination, and fairly equipped and confident to handle future difficulties.

Therapist Observations, Learning, and Challenges

This was the first experience with blended interventions for the first author, a trained clinical psychologist and therapist. The therapist had to first familiarize herself in detail with the content and functioning of the internet-based program in discussion with the other authors. These supervisory discussions and clinical experience helped in gauging client suitability, understanding their perceived needs and preferences, contextualizing PUSH-D, and deciding the focus of face-to-face sessions for each client. It has been observed that clinicians may experience a sense of not offering the 'best of themselves as therapists' to their clients when they deploy self-help/guided self-help or blended interventions.[19] Indeed, this was the therapist's apprehension in the present context too. Reflections on feedback from the clients and that clients who consented to a blended approach may have otherwise received only a few or no psychological intervention sessions due to logistic constraints and other barriers helped reduce this apprehension. In retrospect, it was also noted that the investment of the therapist's time in the blended intervention (6-10 hours per client on average) was much less compared to the time that might have been required for face-to-face sessions to provide more or less similar coverage of themes and skills (estimated average time of 10-20 hours per client). In resource-constrained settings, professional time thus saved could be used for offering psychological interventions to more clients or for clients needing more/prolonged intervention.

Considering the brevity of the intervention and reduced therapist contact compared to traditional psychotherapies, a challenge and learning was to assess and understand clients' concerns in a fairly quick manner while developing a good working alliance and being able to see the links between their concerns and various modules of the internet-based program. This was crucial to enhance their motivation further to complete the internet-based program and work on their concerns with the therapist's support.

It was a learning process to realize the kind of clients for whom a blended intervention format seemed suitable. The process also helped to understand the

importance of flexibility in the number and frequency of face-to-face sessions for each client. Most clients were observed to complete the internet-based program in about eight weeks, with an average of 4-6 face-to-face/video-based sessions around once in two weeks during this period, and brief and basic telephonic support and feedback messages about once in two weeks. Clients who were premorbidly relatively well-adjusted and motivated for therapy and had few and specific concerns of recent onset were generally able to complete the intervention with as few as three or four face-to-face sessions. They showed a higher sense of self-efficacy in taking the initiative to practice skills learned in the program, taking responsibility for consequent positive changes, and setting future goals for themselves. They were also more comfortable with a blended format than clients with longer-standing concerns or other comorbid or personality disorders. Clients who were comfortable or preferred introspecting about their thoughts and feelings were observed to require fewer face-to-face sessions, practiced skills, and completed PUSH-D with fewer reminders than clients who were primarily looking for a therapeutic space to discuss their concerns. These observations highlight the profile of clients who may be most suited for a blended format of intervention.

Those with prior experience with traditional therapy formats or having specific expectations of the therapy process involving long-term work were observed to take longer to adjust to a blended format and typically required more number and higher frequency of face-to-face sessions. Sessions often focused on identifying barriers preventing them from engaging with the program and working through these challenges. Barriers mainly included occasional technical issues in navigating through the program, low motivation, greater severity of depression, inability to make time for completing modules, or difficulty comprehending certain modules.

A related challenge faced by the therapist was understanding elementary technical aspects of PUSH-D to provide basic technical support in case of technical glitches. Studies on therapist perspectives of blended interventions have similarly observed that therapists' technical knowledge in helping clients with basic issues is important to sustain clients' motivation to complete the intervention.[12,20]

Motivating clients to start working on PUSH-D proved challenging in a couple of cases, particularly when clients presented with low motivation as a chief complaint. It was observed that such clients benefitted from more frequent face-to-face sessions supplemented with the internet-based program till motivation improved.

In contrast, some clients tended to work through the internet-based program very quickly, completing multiple modules superficially in a short time span. This is one of the challenges with clients working independently on self-help programs. Feedback messages though asynchronous, as well as brief telephonic support on alternate weeks were useful to provide feedback regarding their approach. Further, face-to-face sessions were used to contextualize relevant modules and motivate them to revisit the modules to learn and apply them in their daily life. For instance, some clients experienced difficulty in adequately grasping the key takeaways of some modules, such as understanding and identifying cognitive distortions or identifying relevant self-soothing skills. In such instances, the sessions focused on further simplifying and discussing these modules based on their concerns and identifying areas where these could be applied and practiced to consolidate their learning. These strategies were also revisited in subsequent sessions, to help the clients maintain continuity in using the skills and discuss their experiences of applying them between sessions.

Our observations on implementing the blended intervention are similar to studies that examined therapist perspectives of blended interventions in developed countries, which advocate more flexibility in deciding the ratio of online and face-to-face sessions (rather than a fixed protocol) and in choosing the content and sequence of internet-based modules for each client.[9,12] These studies also highlight the need to consider clients' interest and motivation for blended interventions, as those having reservations may not benefit sufficiently from the format, while it may be an attractive approach for difficult-to-reach patient groups or those preferring fewer face-to-face sessions for various reasons.[9,12]

The process of implementing the blended intervention also helped us understand and identify a few characteristics of clients who may benefit from this format. It would be important for clinicians to consider factors like the diagnosis and severity, other comorbid or personality disorders, and the presence of suicidal ideation or self-harm/high distress, which may require a different approach or intensive and long-term interventions. In addition, understanding clients' interest and comfort with the blended format, their basic knowledge of computer skills, and their ability to introspect and express their thoughts and feelings in writing could be additional factors to help decide on the potential use of blended intervention in a given case as well as the ratio of internet-based to face-to-face sessions. Checklists such as the "Fit for Blended Care Instrument"[21] could also serve as useful aids in helping clinicians assess a client's fitness for the blended intervention.

The observations made in this paper are derived from initial experiences of delivering blended intervention with a relatively small pool of clients who were treatment seekers registered either at a tertiary care center or an associated community mental health care setting and did not have a complex clinical picture or multiple comorbidities. They were typically graduates who were comfortable with using computers/smartphones. These factors limit the generalizability of the observations and highlight the need for further research using larger samples and in varied settings.

Need for further research notwithstanding, our clinical experience highlights the potential of utilizing blended interventions for depression in busy outpatient settings and offers insights into the approach to conducting such interventions.

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