

How can clinicians work effectively with e-mental health resources?

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1. What are e-mental health resources?

e-mental health refers to provision of mental health services electronically rather than through the usual face-to-face methods that have prevailed ever since Breuer announced the 'talking cure'. Sometimes e-mental health includes services provided by telephone or video conference but, in my view, these approaches are broadly analogous to face to face service delivery. I will not therefore discuss these kinds of services in this article. Rather, I will be considering a broad range of services including online self-help, synchronous online text exchange (chat) and delayed online text exchange (e-mail and SMS).

During the past decade, there has been very substantial development of these kinds of services in Australia. In part they have been stimulated by Commonwealth policy, which has funded the development of services such as e-couch (including MoodGym), myCompass, MentalHealthOnline (formerly Anxietyonline), virtualclinic and eheadspace. However, there is also growing international interest among both researchers and practitioners in the potential of e-mental health (Moock, 2014). As a result we now have at least a preliminary understanding of both the potential and the limitations of these approaches. We are also in a position to begin to think about the interface between e-mental health and traditional services provided by mental health practitioners, counsellors and therapists.

2. Understanding the potential and limitations of e-mental health as stand-alone services.

e-mental health has several advantages when compared with standard face to face services. In particular there are benefits associated with access to services, convenience of services and quality of services. There are also a number of disadvantages or limitations. In particular, there are problems with client engagement (or non-engagement), service responsiveness to client needs and communication inefficiency. I will consider each in turn.

Service access

Access to services is a complex phenomenon, which is affected by geographical considerations, cost considerations and a variety of client related factors. At the present time, a range of free e-mental health services are available to anyone with internet

access. Given the ubiquitous nature of the internet including availability through public libraries and via smart-phones this means very few people are completely without access and a majority of Australians have access within their own home.

By contrast, there are many regions that are not locally serviced by free face to face mental health services and access often means travelling to a regional centre. Even then, there may be a limited range of professionals and lack of specialist expertise in treatment of specific problems or disorders. Furthermore, some people are housebound because of physical and/or mental health impairment and unable to access even local services.

Equally importantly, many people are reluctant to seek help from conventional face-to-face services for a variety of reasons including embarrassment, concerns about privacy and fear of being required or expected to submit to some form of unwanted treatment. There is evidence that one of the factors that draws people to online mental health services is that they feel more in control and less vulnerable than they would dealing with a face to face professional (King et al, 2006; Rodda et al, 2013). For such people, e-mental health may provide the only point of access to mental health services because they would simply not seek help from conventional services.

Service convenience

Many e-mental health services allow the user 24-hour access and completion of modules at a user-determined rate. Increasingly, services are available through phone apps, which provide portability and enable use while travelling on public transport to and from work or during breaks. Synchronous online chat such as provided by Kids Helpline or eheadspace offer limited service times but they extend well beyond standard face to face services and there is no need to travel to or from appointments, no problems with parking and no sitting in waiting rooms.

Service quality

Online self-help services such as those provided through e-couch, on-track or mental health online are typically carefully designed and have a good track record for effectiveness (Christenson et al 2014; Eell et al., 2014). Typically they are based on CBT but there is growing interest in development of other therapies for the online environment. People tend to over-rate the importance of fidelity as a component of service quality but insofar as it is important, online therapies have it all over individual therapist.

Many e-mental health programs include interactive exercises and quizzes, which the user can retain and refer to. Often users of face-to-face therapy have difficulties with concentration and/or memory and feel they do not always take in the things that are discussed during sessions. This is not a problem in the online environment. The modules don't disappear and the user can refer back to them whenever it seems helpful to do so. Online chat and e-mail communications also leave a record that the client can save and refer back to.

Some e-mental health services and programs include routine outcome measures that enable the user to track progress and in some cases they come with recommendations when progress is not as expected.

There is now sufficient research evidence to suggest that use of e-mental health for common problems like anxiety and depression has broadly similar impact on symptoms as engagement with a face to face therapist. However, one of the limitations of our knowledge is that the data is limited to people who complete programs and people drop out of online therapy more than is the case with face to face therapy (see below). It would be useful to know more about the people who drop out. We tend to assume poorer outcomes but this may not be the case.

Client engagement

An important limitation identified in studies of online therapies is that they are often not successful in engaging clients and in sustaining interest (Twomey et al., 2014). Users often seem to register and start a program but lose interest and disengage quickly. This is especially true of self-help modules (Donker et al., 2014). They also tend to adopt a piecemeal approach to the therapy modules rather than working through them systematically, as intended. As indicated above, we need to know more about therapy impact for those who do not last the distance. Unfortunately, dropping out of the therapy usually also means dropping out of the research so we are left speculating about whether dabbling was better than nothing – or even perhaps as useful as completing a whole program.

Responsivity to client needs

Probably the greatest limitation of online self-help compared with face to face therapy is the lack of attunement to specific client needs. Most are designed for treatment of diagnoses such as anxiety (in its various forms) and depression. However, while there are certain symptoms that are highly characteristic of such diagnoses, the specific concerns of individuals with the same diagnosis can be highly variable. The self-help programs try to address this issue through breadth of material but this also comes at a cost because much of the material may seem to the user to be of only marginal relevance. By contrast, face to face therapists are able to custom design treatment so as to maximize relevance.

e-mental health interventions based on e-mail exchange or synchronous chat are less affected by this limitation. However, the process of identifying the specific client needs and issues can be cumbersome (see below).

Communication efficiency

Communication efficiency is not a major issue in online self-help, where there is often no interpersonal communication process. There is increasing interest in various forms of therapist support for self-help, whether by e-mail, SMS message or phone calls, however

this is typically to motivate and encourage of to assist with specific difficulties so the communication needs and challenges are less substantial than is the case when the whole therapy is provided through interpersonal communication.

Communication efficiency is however a major issue when the e-mental health is entirely or mostly delivered through some form of internet mediated text exchange. Face to face and telephone communication is relatively efficient compared with real-time (synchronous) chat or e-mail exchange. The main reason for this is that the composition and keyboard work required for text communication is more time consuming than speech. Studies that have compared an hour of text communication with an hour of face to face or telephone communication have found that the amount of information exchanged by text is one third or less of that exchanged by speech (Chardon et al., 2011). It is possible that the process of text composition results in more considered communication but it is unlikely that this advantage compensates for inherent inefficiencies of text communication.

Because of this inefficiency, an online chat session may be dominated by basic information gathering, with insufficient time for effective problem-solving. There are potential solutions to such problems – especially by gathering relevant information by means of a pre-session module the client completes. However, attempting to simply replicate a standard face to face or telephone session in the online environment will be at best partially successful.

Aside from inefficiencies associated with reduced communication content, there is also loss of information because of lack of non-verbal cues such as vocal inflection, rate of speech, eye contact, posture etc. These cues often provide important information about the emotional state of the person and this information is not always clearly transmitted in text.

3. Integrating e-mental health with standard face-to-face therapy.

The aim of integration is to add value. The central question is how the two modalities can complement each other in such a way as create a therapy experience that is more successful than the provision of one or other approach on its own. In this section I will outline ways by which e-mental health can add value to face-to-face therapy and how face-to-face therapy can add value to e-mental health. I will also suggest some practical strategies by which this added value might best be achieved.

While we know quite a lot about the effectiveness of online self-help therapies and there is developing research concerning various forms of therapist support, less is known about the integration of e-mental health with face-to-face therapy. What follows is based on my clinical experience and discussion with other therapists rather than on formal research trials. The aim is to provide some preliminary guidance rather than definitive recommendations.

Supplementary support

Some clients need some kind of contact, reassurance or advice outside of the regular therapy hour. The therapist is often not well placed to provide this and may be reluctant to work with clients who need this kind of support. The availability of services such as Lifeline, Kids Helpline, eheadspace, Mensline and Turning Point makes supplementary support readily available. When a therapist becomes aware that a client is likely to have needs for support outside of therapy, working with the client to identify and explore e-mental health services is a sensible approach.

The challenge for the face-to-face therapist is to integrate this supplementary support into the therapy. I don't think it is satisfactory simply to outsource it, especially if it is needed regularly. One of the aims of therapy will be to assist the client to manage episodic crises without recourse to external supports. This means both the client and the therapist better understanding how the needs arise and exploring coping strategies. It is therefore important to discuss in therapy the circumstances that led the client to make use of this kind of e-mental health and to explore the support experience, including benefits and limitations. This is not to discourage use but rather to ensure that use of e-mental health supports is part of a dynamic process of therapeutic change rather than a static solution.

Therapists can only make effective use of this kind of supplementary supported by developing familiarity with the range of services and, in particular the target client group and type of support offered by each service. Mindhealthconnect (mindhealthconnect.org.au) is a useful starting point as it operates as a kind of clearinghouse for a wide range of e-mental health services. However it is currently more oriented to helping clients find services than therapists so you might have to pretend to be your client to navigate it effectively.

Supplementary therapy

As outlined above, the e-mental health environment includes a substantial and growing number of self-help treatment modules. These are especially helpful for therapists who lack expertise in CBT as the modules are mostly built on CBT principles and practices. The availability of these modules opens up a variety of options in the face to face therapy environment, meaning there are strategic choices for the therapist and client.

One approach is to make the face-to-face therapy supplementary to the self-help. The self-help is in effect the principal therapist and the face to face therapy operates as a support for the online self-help. There is already evidence that quite low-level support can enhance the effectiveness of these self-help programs. With this approach, the therapist may help guide the client to the most relevant modules, discuss and explain anything that is unclear, check homework and help the client extrapolate from general principles to the specific contexts for her or his difficulties. The therapist stays within the CBT framework and the primary role is to assist the client to make optimal use of the therapy. The therapist can also address flagging motivation and ambivalence, both of which appear to be an issue for online self-help without a therapist.

To be effective in this supportive role, the therapist needs a good understanding of CBT principles as well as familiarity with the modules. One way of achieving both is for the therapist to work through the modules personally, preferably before the client commences.

A different approach altogether is to make the online therapy supplementary to the face-to-face therapy, which operates as a primary therapy. This is broadly analogous to what the psychoanalyst, Ralph Greenson, referred to as therapy “parameters” when he discussed the use of relaxation and other behaviour strategies in the course of a psychoanalytic therapy (1967). In this approach the e-mental health self-help modules are used to fill gaps in the face-to-face therapy or provide interventions the therapist might think useful but does not have the training or expertise to provide in the therapy or would prefer to keep separate from the therapy.

With the right client, this approach has the potential to deliver major efficiencies, especially in the context of the quite restricted quota of Medicare funded sessions. In principle a client could concurrently engage in a brief interpersonal or psychodynamic therapy while undertaking a course of CBT online. There are however real risks with this approach, which should not be minimized. The main risk is that the client becomes overwhelmed and confused by different and possibly competing models and frameworks. I am not personally convinced that the models and frameworks are so different. However, CBT uses a strong psychoeducational model and it would require an adept therapist to do the necessary translational work to ensure compatibility with an interpersonal or psychodynamic approach. It is possible that the therapists most tempted to in effect out-source the CBT to the online therapy would be those with the least understanding of CBT and therefore least well-equipped to do the translational work.

I suspect that, in practice, most therapists (and indeed their clients) will prefer a hybrid approach whereby the e-mental health is used a bit like a textbook in a tutorial. By this I mean that it provides a steady reference point and a systematic guide to learning, while the face-to-face therapy explores in a more informal way current issues and concerns. Linkages to the online modules will be explicit at times but more often implicit. Some clients will seek more frequent explicit linkages and a sensitive and responsive therapist will accommodate this (while gently exploring the issues behind this need). Other clients will tend to ignore the online homework and the diligent therapist will do a little prodding to encourage use.

Challenges associated with integration of face to face therapy and e-mental health

I have already flagged some specific risks associated with different approaches to integration of face-to-face therapy and e-mental health. However, I think there are some broader issues and challenges that need to be kept in mind. These can be summarized as diffusion of responsibility, therapy splitting and over-servicing.

Diffusion of responsibility is a problem when it becomes unclear or uncertain as to who has the primary responsibility for the treatment. This is particularly problematic when the client needs monitoring for risk and more so when risk management interventions are required. Diffusion of responsibility is unlikely when the e-mental health intervention is a self-help program or module. However, when it is a more active treatment such as e-headspace, there is potential for both the face to face therapist and the e-mental health therapist to manage risk independently and possibly at cross-purposes, especially if one or both service providers is unaware the other is involved in treatment. This kind of problem is not completely avoidable as a client may choose not to disclose engagement with both types of service. However, my advice to the face to face service provider is, where possible, to open lines of communication with the e-mental health service provider so that roles are clear and decision making can be shared where appropriate.

Therapy splitting occurs when, instead of using one form of therapy to support or complement the other, the client uses one to reduce the impact of the other. This might be understood as a form of resistance to change and might be unintentional. It could take the form of idealizing one therapy and devaluing the other. It could take the form of excessive focus on inconsistencies to devalue both. Alternatively, it could take the form of addressing one part of the problem using one therapy and a different part through the other therapy but never really integrating the two, with the result that the experience of therapy is fragmenting.

Some clients are especially prone to splitting processes and I recommend caution in use of e-mental health with such clients. When it is used, considerable attention to splitting will be necessary and this will mean genuine engagement by the face-to-face therapist with the e-mental health therapy. It will also mean that the therapist will need to take an active role in integrating the two therapies. An outsourcing approach is unlikely to be successful.

Some clients are passive consumers of therapy and do not understand that therapeutic change is an active process that depends more on the client than on the therapist or the therapy. Such clients are at risk of being over-served as they are likely to accept any offering or opportunity for support but without making effective use of it. There are users of synchronous chat services in particular who are also in face-to-face therapy with one or more providers but may not be making effective use of any of the therapy.

I think face-to-face therapists should be thoughtful when recommending e-mental health to clients who are simply looking for additional support. This is not to suggest that it is always inappropriate. As indicated above, there are circumstances when the availability of such support could be very important and valuable. However, it is incumbent on the therapist to monitor the use of e-mental health and ensure that it is not simply being used as part of a pattern of avoidance and/or passive dependence.

Training clinicians to use e-mental health

The Commonwealth has invested heavily in the development of e-mental health and has recently funded a project designed to provide training that will assist mental health practitioners to make effective use of e-mental health. I should declare an interest here as I am part of the QUT led team that has contracted with the Commonwealth to develop and provide this training.

I expect that training will be available in a variety of forms including workshops, webinars and online resources. Some training resources are already available (Black Dog Institute, 2014). Training will provide an introduction to some of the e-mental health resources that are currently available, with particular emphasis on those funded by the Commonwealth and in particular those with an established evidence-base for effectiveness. It will also include tips and recommendations about integration of face-to-face and e-mental health.

We have some preliminary evidence to suggest that practitioners such as GPs are well disposed towards e-mental health as they see it as a useful additional resource they can make available to patients. On the other hand, people such as psychologists may be more wary because e-mental health may be viewed as competing with face-to-face therapy. Some may even fear that there is an agenda of replacing Medicare funded face-to-face therapy with e-mental health as a cost saving measure. Training will necessarily be concerned with addressing such concerns.

Conclusion

e-mental health is an emerging approach to provision of mental health services. Australia is a leader in development of such services, in part because the Commonwealth has had a policy of supporting the development of a range of e-mental health services. Such services have some clear advantages, when compared with traditional modes of service delivery, but are also subject to some important limitations. Understanding the advantages and limitations of e-mental health is essential if practitioners are to make effective use of the available resources. It is likely that practitioners will find many opportunities to effectively integrate e-mental health with face-to-face therapy. However, it is important to appreciate that there is not a strong empirical base to guide integration and integration should be approached with some caution. There will shortly be opportunities for practitioners to learn more about e-mental health, including optimal ways of integrating it with face-to-face therapy.

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