Can you do psychodynamic therapy online (successfully)?

Manfred E. Beutel
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Psychodynamic psychotherapy online?

- Meta-analyses: internet-based guided/unguided self-help effective in anxiety, eating disorders, depression, obesity, PTSD, etc.; particularly with therapist support
  - Most participants recruited online
  - Acceptance/success varies in routine care
  - Lack of long-term outcomes and direct comparisons to psychotherapy

- Psychoanalysts'/psychotherapists’ concerns (Roesler 2017)
  - Negative effects of excessive internet use on mental health/relationships
  - Absence of nonverbal elements of communication leads to loss of therapeutic alliance and transference
  - “more suitable for cognitive-behavioral treatments”
Issues

• Is a psychodynamic online intervention feasible and effective?
  – Is there a therapeutic process?
  – What about therapeutic alliance?
• Is psychodynamic online self-help feasible and effective?
• (How) can online interventions be integrated into psychodynamic psychotherapeutic care?
  – Information and motivation
  – Blended care
• Conclusions
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We need to rethink our strategy of hoping the internet will just go away“
Psychodynamic Online aftercare

- following cardiological, orthopedic, psychosomatic inpatient rehabilitation
- Weekly structured writing task (12 sessions) based on supportive expressive therapy (SET; Luborsky, 1984)
- Identification of focus based on relationship episodes (CCRT)
- Supportive and expressive interventions
- beneficial effects of biographical writing (Pennebaker)
- Concept introduced during inpatient treatment
- Weekly commentary from online therapist (within 24h)
- Anonymity of participants (nickname) and therapists
time (t)

**Inpatient Medical Rehabilitation** (3-6 weeks)

- Blog
- Therap. feedback

**Screening**
- Screening negative
- Screening positive

**Randomisation**
- Intervention Group (IG)
- Control Group (CG)

**Baseline survey at the beginning of the rehab. (t₀)**

**Health training stress management at the workplace during inpatient rehabilitation**

**Survey at the end of the rehab. (t₁)**

**Survey after the intervention/control (t₂)**

**Follow-up (t₃)**

**Information about:**
- Sleep
- Nutrition
- Exercise
- Stress management
- Relaxation

**Inclusion:**
- Private internet-access
- Age: 18-59 years
- Employed/training
- Vocational distress
Blog: Writing instruction (example)

„Please describe a situation at your workplace, dealing with another person, which has concerned or preoccupied you most in the past week. Please indicate your wishes and your expectancies in this situation, and how you and the other person reacted. Also describe your thoughts and feelings in this situation....

To write about the situation please take your time (about 45 min.). After 45 minutes you will be informed, that you should come to an end.

Please do not bother with spelling, grammar or sentence structure, try to write in a continuous process without longer interruptions.“

Relationship patterns at the workplace – three core questions:

- What was your wish and expectation in the situation?
- How did the other person/s involved in the situation react?
- How did you react towards the other person/s?
Feasibility: Participation and number of blogs

N=1381 blogs; M = 5.95

Intervention group:
84% at least 1 Blog; 65% at least somewhat helpful

Control group:
2/3 use information; >50% at least somewhat helpful, more downloads compared to IG

Predictor of participation: Online login during inpatient rehabilitation
Primary outcome: subjective prognosis of work ability: Intention-to-treat analysis (LOCF)

Zwerenz, … Beutel (2017) Plos One https://doi.org/10.1371/journal.pone.0176513
Secondary outcomes: distress

Further improvements: stress, somatization, work-related attitudes

Zwerenz et al. (2017) Plos One https://doi.org/10.1371/journal.pone.0176513
“No tears, no sweat, no submission-I’m not afraid of going to work any more”

P: (unknown to therapist): return to work after lengthy psychiatric and inpatient psychosomatic treatments for anxiety disorder (arisen in work context about 2 years before)

Blog 3 (crisis):

P: “All colleagues are friendly. However, I feel scared that I commit many errors in my new work and nobody will tell me. .. A colleague told me that I may leave after having completed my four hours of reintegration, and he will finish it… I did not say a word, cleared my workspace and left. When I had left I realized I had left my purse behind. Now I feel bad. When you are used to function perfectly in any situation, my current state is inacceptable… I am suddenly afraid that my employer will regard my reintegration as a failure.”
Therapist response to blog 3

• T: validates fear of being a failure and suggests CCRT (out of several episodes):
  – Wish: “I wish that my coworkers value me as dedicated and competent”
  – RO: “while acting friendly, the others are observant and critical”
  – RS: “I am reticent, distanced and full of fear of failure”

• “Could it also be that you are afraid of not being accepted by your colleagues for not being perfect... that you distance yourself out of fear of being criticized?”

• “I noticed that you rated your health and work ability much worse- is there anything good you can do for yourself...?”
Blogs 4-5: working towards resolution

- P (Blog 4) “You are completely right, I am much more demanding about myself than about others.... I work longer to get it all done. Rewarded myself with yoga in the evening”

- P (Blog 5) “Hello... your suggestions for my relationship pattern fitted exactly till the beginning of last week. Since the middle of last week I feel different... I feel more trust in my colleagues and my supervisor who supports me... you helped me suggesting to treat myself to something good. ... Now I go to work without fear or distress. This was not the case at any day before my sick leave... All this made me receptive to new things and to mastering my work load, with positive stress. ... I have managed to refuse extra work – in a confident, friendly manner... This henpecking did not stress me at work and did not go home with me... Today’s relationship pattern is: I expect that others accept me as I am. The others respond in a friendly manner. I respond confidently and friendly, and I gain my appreciation by achievement”
“It surprises me that you see me this way...” - alliance rupture

1st blog: “When I returned to work my wish was fulfilled and I did not hear or see my supervisor.”

The online therapist inquires about the problem with her supervisor. The patient denounces “Mr. X” as “false, incompetent, perfidious,” but refuses to discuss specific episodes: “I do not want to deal with my boss in my time off, event though it might be better to do so”.

T incorporates the intense anger toward Mr. X in the CCRT (Blog 3 comment):

W: “I wish acknowledgement and appreciation for my commitment”

RO: “I am overlooked and mistreated, instead of acknowledging my achievement, I am criticized”

RS: “I could burst with anger, but shut off (and do not even let praise effort come through)”
Repairing the rupture

- Patient (Blog 4): “rage and frustration about Mr. X may be the case....I can and may not waste my energy with him. Aside from Bechterew disease I have macula degeneration in my right eye and an aneurysm in the other eye....I know that I get attention and that I am able to criticize. It surprises me that you see me this way. Or have I got mixed up and interpreted all wrong? Sometimes I am upset (bursting with anger sounds harsh) shall I swallow all of it? Regards ...

- Therapist: I have the impression that you felt misunderstood. ... My thoughts may have been misleading, and therefore it is important for us do discuss it.... From what you told me, it seems to me that you are quite capable of dealing with critique. Yet, with Mr. X this appears to be a different case....
Further course

• P (Blog 5): for the first time recounts specific episodes with Mr. X, how she felt reprimanded and embarrassed unjustly “next time I will interrupt him... This won’t be difficult for me”

• P (blog 6) describes a series of severe traumatic events “for the first time in my life” of being beaten, sexually molested and frightened “I have divulged too much about myself. My psyche feels good at this time.”

• Her last blog (week 12): “I have become aware of a lot of issues with my boss. I wish to end the helpful online therapy and thank you.”
Therapeutic alliance: Online (N=165) vs. STPP (N=61) vs. inpatient psychotherapy (N=1199)

Predictors of outcome: therapeutic alliance (patients) and number of blogs,
A special kind of relationship?

Therapeutic presence
- „After you have told me your feelings about our communication I can relate better to you. Up to now I have simply gone ahead writing about myself... for the first time I have realized in this blog that I am communicating with another human being, someone with feelings“

Therapeutic concern
- „My wife and I have found that you deal intensively with the patient, by assessing blogs over several sessions and by working your way into them ... “

Anonymity
- „That I did not have a direct counterpart did not bother me much, this might have caused too many irritations. That the contact remained completely anonymous I would have wished to be different in a longer study. ... personal introduction with name and foto of the therapist.“
- If I had know whether you are male or female, this would have influenced me generating corresponding answers“
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Psychodynamic online self-help
- with therapeutic support
Mc Cullough 2003; Johansson et al. 2014

Goals:
• Recognizing and relinquishing maladaptive defenses
• exposure to conflicted feelings
• Improvement in sense of self and relationships
• 8 modules over 10 weeks, exercises
• encouraging email feedback on completed modules and gradual access to subsequent modules
Psychodynamic online self-help
KEN-Online: Feasibility
(Becker et al. 2016)

N=69 patients (ITT)
multiple diagnoses: depression (84%), anxiety (68%), personality disorder (37%) depersonalization-derealization (22%)
Following inpatient treatment
High rate of additional f2f psycho-Therapy (82% IG, 68% CG)
Feasibility:
N=36 IG (N=13 completers)
N=33 WLC
57% most, 38% very satisfied

- Introduction
- Becoming aware of emotions
- Taming the fear
- Feeling it through
- Opening up
- Summary

Emotions
acceptance
experience
expression

tasks
Therapeutic feedback (IG)
Efficacy of KEN-Online as aftercare

**Emotional Competence**

**Intention-to-treat (ITT)**
\[ F(1,66) = 3.89, p = .053, d = 0.49 \]

**Completer**
\[ F(1,43) = 4.98, p = .031, d = 0.68 \]

**Depressive symptoms**

**Intention-to-treat (ITT)**
\[ F(1,66) = 6.01, p = .017, d = 0.60 \]

**Completer**
\[ F(1,43) = 19.01, p < .001, d = 1.33 \]
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Treatment information and motivation 'Reha:Info'

1. Determine patients' needs for information (focus groups patients/staff)
2. Tailor intervention to increase information and motivation (youtube format)

Four fictional patients’ stories

Experts’ statements
Results

• RCT with N=472 participants: High satisfaction & participation, no overall effect on motivation
• 88% of users (= participants IG and at least 1 video) very content; 86% would recommend Reha:Info and 69% were stimulated to think about rehabilitation
• Greater satisfaction and motivational gains in high vs. low users
Toward blended care: Online self-help (deprexis, IG) reduces depression as an adjunct to psychodynamic inpatient psychotherapy (v. TAU)

ANCOVA; Cohen d = .48; improvement of anxiety, QOL, self-esteem, not: DAS
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Conclusions

• Internet-based psychodynamic therapy is feasible and effective for a variety of chronic diseases added to routine care regarding return to work, reduction of anxiety, depression, somatization and better quality of life.

• In recent trials extended to oncology and as routine care (prescribed).

• Even without immediate personal contact/ nonverbal communication good alliance evolves between participant and therapist comparable to STPP.

• Engagement (blog writing) and alliance (patient) predictive of outcome.

• As in f2f, emotional reactions and felt concern of therapist important.

• Anonymity may promote disclosure vs. may be perceived as barrier.
Conclusions

• Flexibility and ease of access decrease barriers (24/7 availability, “convenient”), but promote a noncommittal stance (“drop-out”): necessity to provide support (setting, therapist)

• Psychodynamic online self-help feasible and effective

• Blended care:
  – Integrating online interventions into routine care
  – reaching across divides of sectors of treatment
  – Mobilizing self-help resources of patients
  – Tailoring interventions to pat. needs/internet use patterns/ context
  – Training therapists regarding therapeutic online use
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Institut für Wissensmedien

Universitätsmedizin Mainz
Drivers and Barriers to Acceptance of Web-Based Aftercare of Patients in Inpatient Routine Care: A Cross-Sectional Survey

Severin Hennemann¹,², Dipl-Psych; Manfred E Beutel¹, PhD; Rüdiger Zwerenz¹, PhD

Background: Web-based aftercare can help to stabilize treatment effects and support transition after inpatient treatment, yet uptake by patients seems limited in routine care and little is known about the mechanisms of adoption and implementation.

Objective: The aim of this study was to (1) determine acceptance of Web-based aftercare and (2) explore its drivers and barriers in different subgroups of a mixed inpatient sample.

Method: In a cross-sectional design, 38.3% (374/977) of the inpatients from a broad spectrum of diagnostic groups (psychosomatic, cardiology, orthopedic, pediatric, and substance-related disorders) filled out a self-administered questionnaire prior to discharge. Drivers and barriers to patients’ acceptance of Web-based aftercare were examined based on an extension to the “unified theory of acceptance and use of technology” (UTAUT). In total, 16.7% (59/353) of the participants indicated prior use of eHealth interventions.

Results: Acceptance (min 1, max 5) was low (mean 2.56, SD 1.22) and differed between diagnostic groups (Welch $F_{4,133.10} = 7.77, P < .001$), with highest acceptance in adolescent patients (mean 3.46, SD 1.42). Acceptance was significantly predicted by 3 UTAUT predictors: social influence (beta = .39, $P < .001$), performance expectancy (beta = .31, $P < .001$), and effort expectancy (beta = .22, $P < .001$). Furthermore, stress due to permanent availability (beta = -.09, $P = .01$) was negatively associated with acceptance.

Conclusion: This study demonstrated a limited acceptance of Web-based aftercare in inpatients. Expectations, social environment’s attitude, and negative experience with permanent availability influence eHealth acceptance. Improving implementation, therefore, means increasing eHealth experience and literacy and facilitating positive attitudes in patients and health professionals through education and reduction of misconceptions about effectiveness or usability.

Ready for eHealth? Health Professionals’ Acceptance and Adoption of eHealth Interventions in Inpatient Routine Care

SEVERIN HENNEMANN¹,², MANFRED E. BEUTEL¹, and RÜDIGER ZWERENZ¹

¹Department of Psychosomatic Medicine and Psychotherapy, University Medical Center, Mainz, Germany
²Department of Clinical Psychology, Psychotherapy, and Experimental Psychopathology, Institute of Psychology, University of Mainz, Mainz, Germany

eHealth interventions can be effective in treating health problems. However, adoption in inpatient routine care seems limited. The present study therefore aimed to investigate barriers and facilitators to acceptance of eHealth interventions and of online aftercare in particular in health professionals of inpatient treatment. A total of 152 out of 287 health professionals of various professional groups in four inpatient rehabilitation facilities filled out a self-administered web-based questionnaire (response rate: 53%); 128 individuals were eligible for further data analysis. Acceptance and possible predictors were investigated with a complex research model based on the Unified Theory of Acceptance and Use of Technology. Acceptance of eHealth interventions was rather low (M = 2.47, SD = 0.98); however, acceptance of online aftercare was moderate (M = 3.08, SD = 0.96, t(127) = 8.22, p < .001), and eHealth literacy was elevated. Social influence, performance expectancy, and treatment-related internet and mobile use significantly predicted overall acceptance. No differences were found between professional and age groups. Although acceptance of eHealth interventions was limited in health professionals of inpatient treatment, moderate acceptance of online aftercare for work-related stress implies a basis for future implementation. Tailored eHealth education addressing misconceptions about inferiority and incongruity with conventional treatment considering the systemic aspect of acceptance formation are needed.