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## RESEARCH ARTICLE

### **Feasibility Study of a Psychodynamic Online Group Intervention for Depression and Anxiety**

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## **Abstract**

Dynamic Interpersonal Therapy (DIT) was originally developed as a brief psychodynamic intervention for the treatment of depression and anxiety. More recently it has become the psychodynamic protocol for depression within Improving Access to Psychological Therapies services across the UK. The aim of the present study was to pilot and evaluate the feasibility of a group online version of DIT – Online Group Dynamic Interpersonal Therapy – and the perceived helpfulness of psychodynamically informed self-help materials. Twenty-four participants were randomly assigned to three groups. Participants in Condition A ( $N = 8$ ) took part in an online DIT group, with self-help materials, facilitated by a therapist. Participants in Condition B ( $N = 8$ ) were given access to a closed virtual group space where they could interact with each other and were supplied with the same self-help materials used by participants in Condition A, but without online therapist facilitation. Participants in Condition C ( $N = 8$ ) received no instructions or facilitation, but had access to an online mental well-being site where they could meet virtually in a large, open, moderated virtual group space to discuss their psychological difficulties. This feasibility study was underpowered to detect significant differences in rates of change between facilitated and unfacilitated provision of material, but decline in symptoms was significantly superior to control only for the facilitated group when the groups were considered separately. The encouraging superiority of the combined treated groups against control also suggests that the DIT self-help materials are helpful and appear to support the process of change.

*Keywords:* anxiety, depression, dynamic interpersonal therapy (DIT), online therapy, psychodynamic therapy.

## **Introduction**

In 2009, the updated NICE Guideline (CG90) on the management and treatment of adults with a primary diagnosis of depression in primary and secondary care stated that for

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patients with mild to moderate depression who decline other treatment modalities, the clinician may consider brief psychodynamic psychotherapy. In light of this revision, brief psychodynamic therapy has now been recommended as one of the therapeutic approaches provided through the Improving Access to Psychological Therapies (IAPT) initiative in England. Dynamic Interpersonal Therapy (DIT) has been selected as the protocol for its delivery (Lemma, Target & Fonagy, 2011a, 2001b).

DIT is a time-limited (16 sessions) intervention that is specifically designed to address depression and other mood disorders (Lemma et al., 2011a, 2001b). In order to explore DIT's potential as a "low-intensity" type of intervention, and to address the need to consider both more accessible and more cost-effective early interventions given current economic pressures on mental health services (Kazdin & Blase, 2011), here we discuss the application of DIT in a modified format for delivery online in a group setting. We do not consider that this is a viable alternative to face-to-face therapy for many patients.

However, for those individuals who find it hard to contemplate face-to-face interaction with a therapist. either for reasons of accessibility or by virtue of their own psychological difficulties, online therapeutic interventions have a potentially significant role to play in increasing access to psychological therapy.

Traditionally, the psychoanalytic community has been highly skeptical of online interventions, concerned that any alteration to the standard analytic frame compromises the analytic relationship. Yet, several psychoanalysts over the years have been using various forms of communication for treatment, including correspondence (e.g., Hofling, 1979), telephone, (e.g., Leffert, 2003; Lindon, 1988; Rosenbaum, 1977), and more recently e-mails, videos and Skype. A survey of psychoanalysts' practice in the UK ( $N = 62$ ), carried out by the British Psychoanalytical Society, revealed that 31% of respondents had conducted analysis via telephone/Skype (Fornari-Spoto, 2011). Those analysts who do use new technologies to communicate with patients, for example via texts, or those

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bold enough to have braved Skype analysis, are nevertheless careful not to advertise the fact too widely, with a few notable exceptions (Carlino, 2011; Dini, 2009; Ermann, 2004; Fiorentini, 2011; Lingardi, 2008). Consequently, the psychodynamic psychotherapy literature in this area is very scarce. Practitioners of other therapeutic modalities have been far more enterprising in this domain, not least cognitive behavioral therapists, who have developed a range of guided self-help resources and made creative use of new technologies to deliver online interventions (e.g., Hedman et al., 2011).

From a psychoanalytic point of view, the emphasis with regard to new technologies has been placed on the requirement to understand more about how these technologies interact with the prerogatives of an individual's internal world, how they may alter psychic structure itself in fundamental ways, and the implications of this for the individual's functioning (Lemma and Caparrotta, in press). Equally important, however, is the exploration of how new technologies could help individuals with mental health problems to access help informed by psychoanalytic views and the extent to which online adaptations of psychodynamic treatment models may be feasible and effective.

There are some encouraging signs that, as technological advances fundamentally alter the way we relate to each other in our daily lives, a more active and open engagement with new technologies, and how they may be integrated within psychodynamic ways of working, is emerging. It is in this spirit of openness that we set about to study whether facilitated internet applications of DIT are possible.

### **Online Group Dynamic Interpersonal Therapy**

The assumptions informing the online group DIT (OLDIT) protocol are similar to those of the standard face-to-face protocol, and are the same as those that underpin other brief dynamically oriented approaches: (i) that behavior is unconsciously determined, (ii) that internal and external influences shape thoughts and feelings and therefore inform our

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perception of ourselves in relationships with others, (iii) that adult interpersonal strategies and ways of relating are generated by childhood experience, particularly within the family, (iv) that unconscious processes including defenses and identifications (projective and introjective processes) underpin the subjective experience of relationships, (v) that thinking about behavior and emotional experience in terms of mental states has significant therapeutic effects, and (vi) that therapy should focus on the patient's current relationships, including the relationship with the therapist (Fonagy & Target, 2008; Lemma et al., 2011a).

DIT's starting point is interpersonal. It is based on the common clinical observation that patients who present as depressed and/or anxious invariably also present with difficulties in, and distress about, their relationships. The approach focuses on presenting distress/symptoms, which are jointly formulated as possible responses to interpersonal difficulties/perceived threats to attachments (loss/separation) and hence also as threats to the self. In the course of these discussions it is recognized that perceived threats can both result from, and cause, difficulties in thinking clearly and realistically, not only about the external world, but also about the internal world, one's own thoughts, feelings, and experiences with others. It is assumed that improving the patient's ability to reflect on his own and others' thoughts and feelings will improve his ability to understand and cope with current attachment-related interpersonal threats and challenges (Allen, Fonagy, & Bateman, 2008; Bateman & Fonagy, 2012). Mentalization is one of a family of concepts, drawing on social cognition research, that is increasingly finding its way into the psychotherapeutic lexicon (Dimaggio, et al., 2011; Lecours & Bouchard, 2011; Liotti & Gilbert, 2011; Lysaker, et al., 2011; MacBeth, Gumley, Schwannauer, & Fisher, 2011; Vanheule, Verhaeghe, & Desmet, 2011).

We can envision that this type of discourse may be implemented in the context of group as well as individual treatments, face-to-face or across digital media. Lemma

(unpublished) created an online group adaptation of DIT. In this implementation participants are given self-help materials over an 8-week series of virtual group meetings that aim to support a reframing of the individual's symptoms of depression/anxiety as manifestations of a relational disturbance. The online implementation is based around self-help materials that aim (a) to assist the individual to understand the connection between his presenting symptoms and what is happening in his relationships by identifying a core, unconscious, repetitive pattern of relating, which becomes the focus of the therapy; and (b) to encourage the individual's capacity to reflect on his own states of mind and so enhance his ability to manage interpersonal difficulties. The intervention attempts to create an online group process consisting of exchanges between group members and with the therapist, with the potential to provide fertile ground for the exploration of interpersonal patterns as they evolve within the group. The therapeutic objective remains the same: enhancing the patient's capacity to understand the interpersonal problems they appear to be struggling with, which they currently either cannot fully understand or understand in a maladaptive way, attributing – often unconsciously – unlikely or unhelpful motivations to others as well as to themselves.

The structure of the OLDIT program mimics to some extent the structure of face-to-face group psychological treatment. On the same day each week, the participants are sent self-help materials for that week via e-mail. These provide some background information and invite them to reflect on questions that are pertinent to the week's focus, which are all in the interpersonal/relational realm. Participants are actively encouraged to discuss their thoughts about this with other group members. The first 3 weeks focus on working towards the "formulation" of a relational pattern that is felt to be currently problematic for the individual and setting some realistic, interpersonal goals. Weeks 4–7 focus on encouraging the translation of insight into interpersonal change, with emphasis placed on supporting the individual participants', and the group's, mentalizing capacity (Bateman &

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Fonagy, 2012), their capacity to think in terms of the subjective states that underpin their current relationships, and their attempts at addressing these difficulties in the course of the OLDIT therapy. As in the face-to-face implementation of DIT, the final week is identified as focusing on the affective experience of ending the group and planning for the future.

An important feature of the online intervention, which sets it aside from its face-to-face counterpart, is the very active encouragement incorporated in the self-help material to make use of the group, in addition to guiding the participants' own "private" self-reflection, and encouragement to achieve their goals. Members of the group can exchange messages with each other, nonsynchronously, in a closed group, which is monitored by personnel ("guides") of the provider of the online service, Big White Wall (BWW).<sup>1</sup> Activities on the online site are monitored 24 hours a day so members of the OLDIT group can be assured that should any exchanges between them prove to be unhelpful/abusive this will be addressed. This is very important to ensure the participants feel safe at all times.

The purpose of the present pilot investigation was to establish whether a facilitator ("therapist") was necessary for the establishment of a therapeutic group process. The design of therapist-facilitated OLDIT calls for the therapist to be available to respond once per week, for 1 hour, at a predetermined time and day, to the interactions between group members, and to issues addressed to the therapist. The exchanges with the therapist are nonsynchronous, like those between members of the group, but if the group members are online at the same time as the therapist they can exchange messages fairly rapidly during that time period. The therapist's identity is known by the group members but, in keeping

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<sup>1</sup> BWW is an anonymous, online mental well-being site that facilitated this study. In 2008, BWW in partnership with the Tavistock and Portman NHS Trust began to offer an early intervention online for those experiencing psychological distress.

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with the general policy on BWW, the participants use “avatars” to preserve anonymity. For many of the individuals who use BWW the promise of anonymity is one of its attractions.<sup>2</sup>

The present study was designed to establish the acceptability and feasibility of OLDIT. This included assessing the accrual rates, the feasibility of randomization, the drop-out rates, the possibility of intensive outcomes monitoring, and the experience of self-help materials. A key question that needed to be answered before further development of the model could be undertaken was whether a trained facilitator was needed to oversee the group. Clearly, if the intervention is feasible without a facilitator, and can rely simply on (a) the self-help material, which could be automatically distributed, and (b) the BWW “guide”, who intervenes only in the case of obvious abusive behavior, then the facility will be considerably more economic than if the administration of OLDIT requires a therapist. Self-help materials on their own have been made available as part of the IAPT program (Clark, et al., 2009) but randomized controlled trials suggest that without the involvement of a support worker the impact of self-help computer programs such as “Beating the Blues” may be limited (Kaltenthaler, Parry, Beverley, & Ferriter, 2008).

## **Method**

### **Design**

The overall study comprised two phases. The initial phase comprised a very small-scale ( $N = 5$ ) qualitative feasibility study looking at the possibility of an online application of DIT and piloting the guided materials to evaluate their acceptability and relevance to individuals presenting with depression and/or anxiety. The participants who took part responded to an online advertisement on BWW and received the 8-week OLDIT facilitated by a therapist (one of the authors). They completed an evaluation questionnaire at the end

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<sup>2</sup> Interestingly, as the group progresses, participants have been observed to “lapse”, as it were, into revealing their “real” identities.



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of the 8 weeks. The user feedback, and the therapist's experience of facilitating the group, led to some modifications both to the guided materials and to the delivery of the intervention in the second phase of the study.

The second phase involved randomly allocating 24 users of BWW who responded to an online advertisement about OLDIT to 3 conditions:

- *Condition A*: 8 people who received 8 weeks of therapist-facilitated OLDIT in a closed group. The participants also had access to the main BWW site.
- *Condition B*: 8 people who were offered a closed virtual space within BWW where they could come together as a group, along with the same guided materials as Group A. This group, however, was without therapist facilitation. The participants also had access to the BWW main site.
- *Condition C*: 8 people who acted as controls and had access only to the general support provided by BWW's main site.

The participants in Conditions B and C were offered the opportunity of receiving therapist-facilitated OLDIT at the end of the study period.

## **Participants**

Twenty-four individuals who were currently using the BWW main site were recruited through an online advertisement posted on the site explaining the purpose of the study.

In order to be eligible to take part in the study, participants had to meet the following inclusion criteria:

- Over 18 years of age
- Not in any other formal therapy at the time of applying
- Scored no less than 5 (mild) on PHQ-9 and GAD-7.

The exclusion criteria were:

- Scoring above 19 on PHQ-9
- Scoring above 14 on GAD-7.

Demographic data are challenging to collect in the context of internet anonymity.

Twenty-four percent of the participants declared they were male and 76% female; 46% of participants gave their age as 20–40 years, 50% as 41–50, and 4% as 61+. In terms of ethnicity, 38% identified themselves as White British, 10% Asian, 10% White other, and 42% “Not stated”.

We also collected demographic data about employment and living arrangements: 38% of the participants were employed (including part-time employment), 24% unemployed, 5% students, 5% off work for medical reasons, and 28% not stated. In terms of living arrangements, 24% lived alone, 41% were living with children and/or a partner, 2% were living with parents, and 33% not stated.

## Measures

The outcome measures used were the PHQ-9 (Kroenke, Spitzer, & Williams, 2001) and the GAD-7 (Spitzer, Kroenke, Williams, & Lowe, 2006). These are brief, symptom-oriented reports covering symptoms of depression and anxiety, respectively, based on DSM criteria for Major Depression and Generalized Anxiety Disorder. Mild cases of anxiety or depression are indicated by scores of 5 or above on both instruments. They were administered weekly, online, on the same day for each of the groups; all participants agreed to this. In recognition of the time spent on the weekly completion of these measures, participants were offered a £50 iTunes voucher at the end of the process. Adherence to this assessment schedule was good in Conditions A and C, but was quite

poor for those in Condition B despite the incentive paid upon completion of the course of treatment.

### **Weekly Reporting**

For the purpose of this evaluation we considered the completion of questionnaires as an indication of the consideration of mental health issues by participants. Table 1 displays the mean number of weekly reports completed by participants. The analysis of variance yielded a significant  $F$  ratio, indicating that the number of reports completed differed significantly across the 3 groups,  $F(2,21) = 4.08, p < .04$ . Pairwise comparisons between the groups suggest that the group receiving no facilitation but receiving the materials manifested greatest difficulty in completing the forms relative to the group receiving facilitation ( $t = 2.81, df = 14, p < .006$ ). Combining the two groups without facilitation (Conditions B and C) still showed a significant reduction in adherence to the measurement protocol relative to Condition A ( $t = 1.96, df = 22, p < .03$ ).

TABLE 1 ABOUT HERE

Treatment acceptability for participants in Condition A only was assessed by using a 9-item, 5-point Likert scale questionnaire designed for the study, which asked a mixture of open-ended questions as well as seeking ratings about the perceived helpfulness of (a) the group, (b) the self-help materials, and (c) the therapist's facilitation. This was e-mailed by the therapist after the last session; all 8 participants responded.

### **Treatment of Missing Values and Data Analysis**

Missing observations were estimated by linear extrapolation in cases of single values missing between two observations and using the last value carried forward method in cases of premature termination of data collection. Since participants provided weekly

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data, mixed effects regression models (Statacorp, 2011) could be applied to these reports to examine whether the rate of decline of reported symptoms could be predicted on the basis of the treatments administered. Group and time (weeks) were treated as fixed effects with participants as random effects including intercept and slope. The initial observation of the symptom was included as a covariate in the model. In tests of significance both facilitated and unfacilitated OLDIT groups were referenced to the control condition. Wald chi-square was used to test the significance of the models, and the facilitated group was contrasted with both of the control groups separately and together. In order to increase power in some contrasts, participants in Conditions B and C were combined to examine the effect of expert facilitation.

## Results

### Baseline data

Initial values of the PHQ and the GAD are shown in Table 2. There were no significant differences between mean levels of either depression or anxiety self-ratings at the start of the trial. The analysis of variance on PHQ yielded a nonsignificant group effect,  $F(2,21) = 0.37, ns$ . The GAD scores were also very similar,  $F(2,21) = 0.02, ns$ . Clinical caseness as used in IAPT services on the PHQ is indicated by a score of 10 or above, whilst on the GAD it is indicated by scores of 8 or above, reflecting the optimal combination of specificity and sensitivity for moderate cases of anxiety and depression, respectively (Glover, Webb, & Evison, 2010). All the participants in Conditions A and C and 88% of the participants in Condition B were above the clinical cut-off point on one or other of these measures in their first reports. Interestingly, in the second or third weeks a number of the participants who had reported being below the clinical cut-off point started to report clinical levels of anxiety or depression, such that all the participants were above the caseness threshold on one of the measures during the first 3 weeks of the study.

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However, overall the participants in this study were significantly less symptomatic on these measures than those attending IAPT programs (Glover, et al., 2010).

TABLE 2 ABOUT HERE

### End of Treatment Data

Table 3 displays the final observed values of the PHQ and GAD scores from participants. Pre–post comparisons reported here are based on the last reported value and reflect different lengths of observation. Across the sample, there was a significant reduction of reported levels of both depression ( $t = 2.54$ ,  $df = 23$ ,  $p = .009$ ) and anxiety ( $t = 2.62$ ,  $df = 23$ ,  $p = .007$ ) between the first and last recorded observation. The reduction in reported depression was significant for the group provided with facilitated or unfacilitated group experience and self-help materials, that is, Conditions A and B ( $t = 2.04$ ,  $df = 15$ ,  $p = .03$ ) but not for the control group ( $t = 1.43$ ,  $df = 7$ ,  $p = .10$ ). The reduction in anxiety levels was larger and statistically significant for the group receiving OLDIT ( $t = 3.34$ ,  $df = 15$ ,  $p = .002$ ) but not for the control group ( $t = 0.58$ ,  $df = 7$ ,  $p = .30$ ). Overall, however, there were no differences in the mean levels of either depression or anxiety reported by participants in the three groups,  $F(2,20) = 0.015$ ,  $ns$ , for PHQ;  $F(2,20) = 0.044$ ,  $ns$ , for GAD) in the last completed observation (the last “session” they attended). The percentage of participants scoring below the clinical cut-off (i.e., recovered) was slightly higher on the PHQ in the facilitated group and apparently substantially higher on the GAD. Because of the small sample size these contrasts were not statistically significant (recovery on the GAD  $p < .10$ ; recovery on both measures  $p < .10$ ). Comparing Condition A with the two unfacilitated groups, there was a significantly greater likelihood of recovery in the facilitated group ( $\chi^2 = 3.63$ ,  $df = 1$ ,  $p < .05$ ).

TABLE 3 ABOUT HERE

### **Trend Analysis**

The models' trend suggested a significant reduction in reported symptoms in the participants receiving online self-help materials (Conditions A and B) compared with the control group (Condition C). We also created separate contrast models for the facilitated and the unfacilitated groups (Conditions A and B). Comparison of the trend of decline of the PHQ scores for the three groups yielded no significant differences. The Condition A versus Condition C contrast showed some indication of a more marked decline in PHQ scores for the facilitated group ( $\beta = -0.53$ , 95% CI [-1.22, 0.158],  $z = 1.51$ ,  $p = .13$ ) but the Condition B versus Condition C contrast of trends yielded even smaller effects ( $\beta = -0.40$ , 95% CI [-1.08, 0.28],  $z = 1.16$ ,  $p = .25$ ). Combining Conditions A and B yielded a marginally significant coefficient for the difference between the rate of decline of depression scores for the treated versus control group ( $\beta = -0.47$ , 95% CI [-1.03, 0.09],  $z = 1.73$ ,  $p = .09$ ).

A similar analysis for anxiety scores showed slightly stronger effects. Comparison of the trend of decline for the Condition A versus Condition C contrast yielded a significant effect indicating a steeper decline in GAD scores for the facilitated group than the controls ( $\beta = -0.57$ , 95% CI [-1.12, -0.22],  $z = 2.04$ ,  $p = .04$ ) but the Condition B versus Condition C contrast of trends yielded a nonsignificant effect ( $\beta = -0.40$ , 95% CI [-0.93, 0.13],  $z = 1.49$ ,  $p = .14$ ). Combining the two treatment groups indicated that the decline of anxiety was increased by the provision of self-help material ( $\beta = -0.49$ , 95% CI [-0.94, -0.05],  $z = 2.16$ ,  $p = .03$ ).

### **Qualitative Data**

All the participants in Condition A completed a Likert-type rating (5-point scale) on a questionnaire administered after the end of the therapy as well as answering some open-ended questions about their experiences. They all found the self-help materials to be helpful, with 50% saying they had been “very helpful”. Participants observed that the self-help materials provided a “calming” and “structured” way to reflect on their difficulties. This contrasted with greater variation when asked how helpful the group had been, with only 33% saying it had been “very helpful” and 50% scoring in the mid-point range of the scale, suggesting greater uncertainty about the function of the group itself. All the participants felt that the therapist’s input had been helpful, with 66% rating it as “very helpful”. However, when asked if they thought the self-help materials would be useful without any therapist input, 66% answered positively.

## **Discussion**

This preliminary study has shown that facilitated web-based applications of DIT are possible and may lead to higher rates of recovery from symptoms of anxiety and depression in individuals with mild to moderate clinical presentations than are likely without self-help materials. This feasibility study was underpowered to detect significant differences in rates of change between facilitated and unfacilitated provision of material, but decline in symptoms was significantly superior to control only for the facilitated group when the groups were considered separately. The encouraging superiority of the outcome in the combined treated groups versus control also suggests that the DIT self-help materials are helpful and appear to support the process of change. This suggests that the self-help materials warrant further study so that they can be evaluated on a larger scale as a possible alternative to computerized cognitive behavioral therapy.

There was significant difficulty in collecting data from those who received DIT self-help materials but no facilitation from an online therapist. The rate of attrition from the trial

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was clearly highest for this group, and considerably higher than the group receiving no attention at all. This is surprising, especially in the light of the relatively high level of reward offered for completed response sheets. The no-treatment control group intriguingly provided data at a level comparable to the facilitated group. This suggests that there may be some reactance associated with receiving self-help materials without facilitation. However, given that these participants were also invited to work together in an unfacilitated group, we cannot exclude the possibility that the reactance is to the unfacilitated group experience rather than the self-help materials per se. There may have been anxiety about being invited to take part in a closed group without the safety of a therapist's background presence to moderate the group process even though BWW was still providing general moderation. The results suggest that the group process may be an important confounding variable: once a closed group is set up, this may initiate certain conscious and unconscious expectations that need to be addressed and managed by a facilitator.

Because of the design of the study, with the absence of a condition where self-help material was provided without requirement for group attendance, it is not possible to reach any conclusions as to whether the DIT self-help materials require facilitation (and, if so, of what kind) in order to be of help, or whether it was the group dynamics that negatively impacted on the participants' experience. A study evaluating the self-help materials without any group component would provide an answer to this question.

Our understanding of the role of the therapist in the online intervention has evolved over the two groups we have run. In the first group, the therapist was very active and took up the group's transference systematically, as would be the case in face-to-face analytic group therapy. Although this appeared to be helpful, our experience was that it encouraged greater dependency on the therapist's interventions, such that the group came together largely only the day before the therapist was known to be available and on



the day itself. In their feedback, the participants in the initial qualitative pilot study fed back their disappointment that they did not “get more” from the therapist.

In an attempt to explore whether the therapist’s input could be minimized without affecting the participants’ experience of the intervention and its helpfulness, in the randomized study the therapist was less active and largely restricted their role to (a) containing the group process by setting and managing the boundaries for the group and keeping track of each group member (e.g., inviting them into the group if they appeared to be withdrawing), (b) summarizing the relational themes that were emerging (e.g., anxieties about the possibility of trusting others or the wish to withdraw in the face of more personal inquiry), and (c) responding to difficult group dynamics when these emerged and created impediments to the group’s capacity to remain supportive of each other (e.g., aggressive or excessively critical comments about a specific group member). The transference to the therapist was addressed only if it appeared to interfere significantly with the group process. This more “light-touch” approach did not appear to elicit any negative comments in the qualitative data: no reference was made by any of the participants to feeling deprived or disappointed by the relative lack of therapist intervention. We say “relative” because the therapist nevertheless plays an important role as “keeper” of the therapeutic process.

Interestingly, the nonsynchronous nature of the exchanges, both between group members and with the therapist, did not elicit the frustration one might have anticipated. Rather, several of the participants observed spontaneously that they valued the possibility to opt in and out of contact and the opportunity for self-reflection that this slower pace offered. A distinctive feature of some individuals who avail themselves of online help may be that they value not only the remoteness of the contact, but also the opportunity to pace their interactions with others: knowing that the contact is nonsynchronous may promote a greater feeling of control and safety, allowing them to titrate intimacy. Synchronous exchanges, whilst gratifying on some level, may nevertheless be experienced by some

individuals as too threatening, even if they take place remotely.

An important feature of this study is that all the participants had access to the BWW main site as and when required, as they were all members of the BWW online community. The study design did not control for this; we do not have a condition that indicates recovery rates without any kind of supportive experience. These preliminary observations suggest that the control participants who had access only to the main BWW site also improved over the study period. This could mean that access to this mental well-being site can be of help as an intervention in its own right, but this cannot be assumed in the absence of a control group given access only to web experience that includes the mental health resources available to everyone without the rich set of resources offered to BWW users. Clearly, this and other limitations suggest that a further study on a larger scale is warranted with controls for specific web experience, self-help with and without group process, and group process with or without facilitation. Further, in a comprehensive investigation, follow-up data would also be crucial to determine whether benefits from this more general peer support are sustained over time or merely reactive to the current levels of support participants receive whilst members of the BWW online community.

The conclusions that may be reached from this study are limited by the nonrepresentative nature of the sample. Indeed, the inadequate information available to the investigators about the participants in this study precludes generalizations beyond the present sample. The small number of individuals participating further limits the reliability of inferences that can be made. Further, although the intervention was based on a preexisting treatment manual, applying the manual in the online group context was taking the process described in the original manual beyond its intended scope. Further work is required in providing an online adaptation of DIT that is sufficiently robust for therapists other than the developers to be able to replicate the procedures recommended with confidence. Caution is further suggested by the relatively high rate of attrition in Condition

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B, where facilitation was not available. Nevertheless, the study represents one of the first attempts on the part of the psychoanalytic community to respond to Alan Kazdin's challenge to develop methods of intervention that are "fit for purpose" in a digital age and contain within them the potential to deliver mental health services to populations who are in need of services but whose access is limited by their particular set of personal difficulties, their physical situation, or simply by the limited number of services that can ever be made available to a population whose mental health needs are increasing at an alarming rate while resources to address such needs are rapidly shrinking (Kazdin & Blase, 2011).

## **Conclusion**

The delivery of psychological interventions through the online medium cannot meet the needs of all patients. Moreover, there is a need to study further how to establish an effective therapeutic setting in an online environment. However, online interventions can increase accessibility and make a creative and cost-effective contribution as part of an overall strategy to support early intervention within mental health.

Further studies may show OLDIT as being able to make a contribution to this demographic clinical challenge. Despite the understandable reticence amongst psychodynamic practitioners to engage with the delivery of online interventions, this study suggests not only that it is possible to deliver a psychodynamic intervention online, but also that psychodynamically informed self-help materials are potentially helpful.

Being able to offer choice is an appropriate target as part of the effort to increase access to psychological therapies. The currently available evidence-based models for online assistance are limited to a single modality and could be enhanced by approaches based on a psychoanalytic model being available in computerized form. This preliminary study also suggests that the generic support provided by an online mental well-being site

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such as BWW may have significant therapeutic effects, and this possibility also requires urgent investigation. These questions warrant further research on a larger scale.

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*Table 1: Number of Reports Completed by Participants*

	<b>Condition A</b>	<b>Condition B</b>	<b>Condition C</b>	<b>Conditions B + C</b>
Completed reports				
(mean)	8.00	4.25	6.88	5.56
<i>SD</i>	1.41	3.49	2.75	3.33

*Table 2: Initial Values of the PHQ and GAD Scores*

	<b>Condition A</b>	<b>Condition B</b>	<b>Conditions A + B</b>	<b>Condition C</b>
<b>Depression</b>				
PHQ (mean)	12.50	9.63	11.06	10.63
PHQ (SD)	3.78	4.24	4.15	3.46
% Clinical at outset	62.5	62.5	62.5	75.0
% Clinical in first three sessions	87.5	75	87.5	81.25
<b>Anxiety</b>				
GAD (mean)	10.37	9.38	9.87	9.50
GAD (SD)	4.03	2.88	3.42	4.31
% Clinical at outset	75.0	75.0	75.0	62.5
% Clinical in first three sessions	100	87.5	87.5	87.5

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<b>% Clinical on either measure</b>	100	87.5	100	93.75
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**at outset**

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Table 3: Final Values of the PHQ and GAD Scores

	Condition A	Condition B	Conditions A + B	Condition C
<b>Depression</b>				
PHQ (mean)	8.63	9.13	8.88	8.00
PHQ (SD)	6.23	4.09	5.09	3.85
% Nonclinical in last session	62.5	50.0	56.3	50.0
<b>Anxiety</b>				
GAD (mean)	6.50	8.38	7.43	8.50
GAD (SD)	5.32	2.83	4.23	4.31
% Nonclinical in last session	75.0*	50.0	62.5	25.0
<b>% Nonclinical on both</b>	62.5	37.5	50.0	25.0
<b>measures</b>				

\*  $p < .05$  in contrast with Condition C



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