Author's response to reviews

Title: Motivation to persist with Internet-based cognitive behavioural treatment using blended care: a qualitative study

Authors:

Maja Wilhelmsen (maja.wilhelmsen@uit.no)
Kjersti Lillevoll (kjersti.lillevoll@uit.no)
Mette B Risør (mette.bech@uit.no)
Ragnhild S Høifødt (ragnhild.s.hoifodt@uit.no)
May-lill Johansen (may-lill.johansen@uit.no)
Knut Waterloo (knut.waterloo@uit.no)
Martin Eisemann (martin.eisemann@uit.no)
Nils Kolstrup (nils.kolstrup@uit.no)

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Cover letter

Thank you so much for considering my paper for BMC Psychiatry! And thank you so much for reviewing my paper and giving very good feedback.

We have revised the paper as explained in the following text.

Revisions recommended by Donkin

1. It paper would benefit from clarifying if the aim is to understand experiences or motivation. It becomes a little unclear at times.

We are inspired by Møller’s definition of motivation as a complex phenomenon that must be seen as bound to a context and not as a psychological factor within the individual that easily can be measured. We see motivation in a framework of Self Determination Theory where psychological needs in the situation influence the intrinsic motivation to want to do something. It is motivation as it is experienced during treatment in an everyday context we try to grasp. It is not motivation or experience, it is what is experienced by the participants as motivating.

The phrasing throughout the paper is changed to clarify this.

2. Cite source of current recommendations as mentioned in abstract

In the background second section, the recommendations for future research to improve treatment are cited. The word “recommended” is added to tie this to how
it is expressed in the abstract.

“Therefore it is recommended to find steps to improve patient persistence with Internet interventions [17] and to identify the impact of different elements of therapist support in such interventions [12, 15].”

3. Many readers of this journal may not understand what a phenomenological heuristic approach entails. It would be useful to expand on this to help the readers understand your methods.

Under the section “Interview schedule and data collection” the theory of phenomenological hermeneutics is now expanded to help the reader to understand how and why this approach was chosen.

4. Were there any other inclusion criteria other than seeking help from the GP for depression? Eg., speaking Norwegian? Being over 16 or 19 years of age? Etc.?

Under the heading “study context”, the inclusion criteria “age and access to the internet” are included and our article explaining more about the RCT and findings concerning effect is cited.

5. It would be useful to clarify what was meant by “supportive nature only” for the face to face interventions. Was it supportive psychotherapy (ie dealing with day-to-day problems)? Technical support for the program? Psychoeducation and reinforcement of the principles in the program? Was it scripted and were there any limitations on what was talked about? Also, was it the same therapist? What was their training?

Under subtitle “Study context” section two we have tried to clarify this:

“Patients were asked to complete the five ICBT modules at home and were given short, face-to-face consultations between modules with their therapist at a small clinic at the University of Tromsø. The consultations were of a supportive nature only with a guided script consisting of three compulsory subjects: (a) symptom monitoring, (b) discussion of the topic of the last module in MoodGYM, and (c) introducing the next module and discussing patient motivation. Other issues of importance to the patient could also be discussed if there was more time. The two therapists in the study were both psychologists with limited training in CBT.”

6. At what stage of recruitment did continuous recruitment change to strategic recruitment? And how was n=14 decided on?

A) Rephrased to “The change from continuous to strategic recruitment was made after approximately 10 interviews to include men and women, both younger and older, and both completers and non-completers.”
B) It is phrased as a pragmatic choice. In the applied approach pragmatic choices concerning time and capacity are accepted depending on how many participants could be interviewed—see cited source on pragmatic sample number (Malterud 2012). Besides, it is recommended not to interview too many as this may influence the depth of the analysis.

7. Could you clarify, did all non-completers attend the debriefing interview?
Under the subtitle “participants” it is now clarified that not all non-completers attended the debriefing.

8. Please clarify whom the pilot interview was conducted on.
It is clarified that this was a test person who had gone through the entire data program and who is a friend of MW.

9. Whilst the support of family is important and an appropriate part of treatment, it seems that the second and third lot of quotes in the belonging section are not directly related to treatment? This would benefit from some clarifying and linking back to the goals of the paper or using quotes that make this link. Without this, some of the points in the discussion seem to be an over-extension of findings.

It is now explained to a greater extent how the quotes under subheading “belonging” refer to the treatment. An extra quote is added to strengthen this connection.

10. Can you provide a reference that MoodGYM is more user friendly than other programs? Or can this be reworded to be less definitive?
To make it less definitive, the phrasing is now changed to: “A reason could be that possibly MoodGYM is a more user-friendly program yielding these findings.”

11. In the discussion, the statement that “According to Prochaska, tailoring the therapeutic relationship and treatment intervention to the patient’s stage of change can enhance the outcome, specifically the percentage of patients completing therapy, and the ultimate success of treatment” needs to be explicitly linked back to the study.

We have now attempted to more clearly link back Prochaska’s theory to our findings in the discussion:

“According to Prochaska, tailoring the therapeutic relationship and treatment intervention to the patient’s stage of change can enhance the outcome, specifically the percentage of patients completing therapy, and the ultimate success of treatment. While in the stage of action, patients need the advice of an
expert (Prochaska and Norcross 2001). In our findings patients often told stories that indicated that they were in a stage of action when motivated to persist in treatment, and the fact that the therapist was a psychologist, an expert, was experienced to strengthen this motivation.”

12. A unique aspect of your paper is interviewing those that did not complete the intervention. It would be useful to discuss any differences between these and those that completed. I understand that the sample size is small but it would be beneficial nonetheless.

Under “results” findings identified in the interviews by the non-completers are to a greater extent presented. This is also mentioned in the discussion, but not emphasized too much as the sample size is so small.

Minor Essential Revisions
1. In introduction, paragraph 1, I believe the sentence “However, general practitioners (GPs) currently treat most patients with depression, and as treatment they are widely and increasingly prescribing antidepressants” would read better as “and as a treatment they”.
We agree and the sentence is changed accordingly.
2. Paragraph 2 of the introduction seems to jump around a bit. It may benefit from restructuring so that sentences flow on from the previous one.
Efforts are made to make this section flow better.
3. Paragraph 2, sentence 1. I wonder if there are better papers about the effectiveness of iCBT for treating depression? Perhaps the systematic reviews and meta-analyses that focus solely on depression? Such as Andersson & Cuijpers (2009) (http://www.tandfonline.com/doi/abs/10.1080/16506070903318960) or similar?
This good source is now added to the paper. Our own RCT is also cited.
4. In paragraph 2 of the introduction. The phrase “address the requests of patients”, do you mean the treatment desires? Answer questions that they may have? It may be beneficial to clarify this.
It is clarified that we refer to the request for follow-up given in consultations.
5. The statement about short interventions not being effective seems slightly
irrelevant to the paper as not addressed at all. I believe that it could be removed without impacting the paper.

We agree and it is now removed.

6. Page 5, the sentence beginning, “According to Møller…”. Could you please expand on what you mean by an independent parameter and decontextualised factor”.

To explain more what Møller means it is now phrased as follows:

…..health professionals often see motivation as a parameter only within the patient that can easily be measured, and this view must be challenged. She argues further that it is more interesting to explore what is motivating, rather than measuring how motivated people are. We are inspired by her conclusion that motivation to change must be seen as a complex phenomenon depending on social contexts and interpersonal relationships.

7. Page 5, the sentence beginning “Prochaska claims…” may be clearer to include motivation in this. Eg., “that a person goes through different stages of motivation when a change is made”

This sentence is now re-phrased as recommended.

8. The rate of completion may be better suited in results section.

The rate of completion is not really a result in this study, but of the RCT. This is why we choose to keep it in the introduction.

9. The last portion of the last sentence in the Intrinsic Motivation results, beginning “while others…” may be more appropriate in the Hope for Recovery Section.

The way it is written now we find it is bridging the sections, leading it to the section about hope. We choose to keep it this way to make the paper flow better. Hope this is okay.

10. The sentence in the results section, page 10, under competence and autonomy reading “Neither represented the technical challenges of logging on and manoeuvring within the ICBT programme a problem” does not seem to make sense?

Is now rephrased to:
“Learning while working on a laptop demanded very few practical adjustments from our participants, and computer skills were not an issue. The participants did not express any technical challenges of logging on or problems with manoeuvring within the ICBT programme.”

11. As the really unique part of this study is the therapist component, the paper maybe strengthened by focusing on this part more. What more was there about the therapist interactions that aided motivation? It feels a little lost in the paper. The part in the discussion interaction with the therapist is expanded but not to a great extent. To emphasize this focus more is a big job, and we are not sure it will improve the paper. Our other paper on “helpfulness” (cited in the paper already) also explores the connection with the therapist and supplements this paper.

12. Why do other patients in the waiting room make relatedness worse?

To clarify the sentence is changed to

"The presence of other patients in the waiting room just made matters worse as it was experienced as more stressful that other patients waited for the GP and made it more difficult to open up and connect (Pollock and Grime 2002, Pollock and Grime 2003)."

13. The discussion would benefit from some elaboration on the difference between blended care and guided CBT, and the implications of this for the findings and generalisation.

This discussion is a bit beyond the scope of our aims with the paper. We find it will make the paper too long and prefer not to include it.

14. Would also benefit from elaborating how relatedness may change with GP delivering treatment (which has been discussed in discussion), but given that step three of recommendations is a therapist with appropriate competencies, further elaboration is warranted.

It is brought in to the discussion if maybe a course in ICBT may be adequate competence. The third recommendation is changed to: “Third, communicating that the ICBT deliverer has competence and can give qualified feedback.”

Discretionary Revisions

15. Page 11, paragraph 2, “regardless” means that despite the challenges presented previously, but it appears that this sentence supports the previous
statements. So regardless may not be appropriately used here.
Regardless is removed.

16. Page 15, paragraph 1, sentence 2 needs to aligned (spatially) with previous sentence. It looks like formatting has changed.
This could not be found in our document- maybe formatting again…

17. It is useful to tie the findings back to a theory as you have with SDT. I wonder about structuring the results under the three components of SDT: relatedness, belonging and connectedness to really reinforce this and make it easier for the reader to tie back to the theory.

Our findings are already sorted under headings that link to SDT. To sort all findings under only the three parts of relatedness: belonging, connectedness and recognition would be too narrow when linking back to our data. We therefore chose to keep the headings as they are.

Revisions recommended by Patricia Kinser

Minor Essential

* one aspect of the phenomenological hermeneutic qualitative analysis process is to acknowledge biases prior to engaging in the analysis of data. Was this done a priori? The authors acknowledge their "dual roles" later in the manuscript; however, it would be appropriate to describe this briefly in the analytical strategy and procedure section of the paper.

This aspect was with us as researchers during the entire process and is now also expressed under the subheading “Interview schedule and data collection”:

By obtaining a narration of the patient’s own perspective and stories, motivation as lived experience could be explored and analysed, but only by trying to ‘bracket’ what is taken for granted and focus on actual experience. Also, with a phenomenological approach it was of great importance to try to set aside what we as researchers took for granted as facts and strive to listen and analyze without judgment, but concentrate on experience. As health workers, we also prepared ourselves to be open-minded, curious and set aside our medical interests.

English: The language is improved throughout the paper. A professor (Richard Chenhall at University of Melbourne) with English as a native language has helped us.

This version only with the two tables at the end,

Best Regards,
Maja Wilhelmsen