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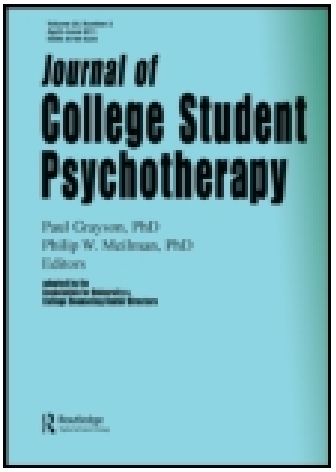

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The Acceptability of Therapist-Assisted, Internet-Delivered Treatment for College Students

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The Acceptability of Therapist-Assisted, Internet-Delivered Treatment for College Students

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University and college counseling centers struggle with rising service demands without a corresponding increase in resources. Consequently, counseling centers must seek creative ways to not only maintain the status quo, but expand capacity while preserving effectiveness. In other countries, therapist-assisted, Internet-delivered treatment has been effective in treating several common disorders while conserving one third to one half the per client therapist time, suggesting that Therapist-Assisted Internet Based Cognitive Behavioral Treatment (TAI-CBT) could be an alternative treatment option offered through counseling centers in the United States and one possible solution to increase the number of students effectively treated per therapist hour for certain students seeking services. In this study, 334 students were surveyed to assess the acceptability of this mode of treatment; 217 of these students were currently in counseling or had received counseling in the past. TAI-CBT was endorsed by 34% of the students with past counseling and 16% of the students with no history of receiving counseling. These proportions were comparable to the rates for those who expressed interest in group therapy, which is commonly offered in counseling centers.

KEYWORDS alternative treatments, counseling, Internet, online, therapist-assisted

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Over the past few years, college and university counseling centers have experienced a mismatch in available effective services as compared to the number of students seeking wellness and success (Barr, Krylowicz, Reetz, Mistler, & Rando, 2009; Bushong, 2009). Ninety-one percent of counseling centers report a trend of increasing complexity and severity of student problems and illnesses encountered (Gallagher, 2011). The demand for counseling services has increased without a corresponding increase in available resources (Barr et al., 2009; Bushong, 2009). Forty-six percent of counseling center directors report using waiting lists when counselors' schedules fill (Gallagher, 2011). Moreover, directors express concern that students will not get the services they need (Gallagher, 2011).

Counseling centers have attempted to deal with service shortfalls in a variety of ways. Many centers resort to the following, less than desirable strategies:

1. *Overloading staff*: Some centers increase counselor caseloads or counselor clinic hours. However, psychotherapy outcomes decline when counselors or psychologists spend more than 24 hr per week providing psychotherapy (Vocisano et al., 2004).
2. *Limiting scope of service and referring to outside providers*: 94% of centers reported using these strategies (Gallagher, 2011). On the surface, these strategies can be effective, provided students have the resources to pay for outside services. However, too often students do not have the necessary insurance or the financial means to cover copays. Transportation can be another obstacle to outside referrals.
3. *Reducing frequency of counseling sessions*: Some counseling centers rely on widening the time between sessions. However, studies have found that patient outcomes are lower when the frequency of sessions is reduced below an acceptable threshold (Freedman, Hoffenberg, Vorus, & Frosch, 1999; Reece, Toland, & Hopkins, 2011).
4. *Developing strict session limits*: Most counseling centers define themselves as "short-term" service providers. Many have needed to cap the number of therapy sessions each student is eligible to receive. Brief treatment can sometimes be effective, but not always. If individuals do not receive an adequate number of sessions to treat their problems, they are more likely to experience repeated episodes. With each repeated relapse and recurrence of depression or mania, for example, episodes (period of time with symptoms) tend to become longer and more severe, and are triggered by less intense stressors (Greden, 2003; Lewinsohn, Allen, Seeley, & Gotlib, 1999).

These strategies to cope with excessive demand can result in suboptimal outcomes for students. In order to enhance the treatment experience, it is

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crucial to consider alternative modes of treatment that have strong evidence of efficacy. Optimal treatment needs to be delivered with a frequency associated with positive outcomes balanced by efficient use of the students' and counselors' time.

One promising direction that broadens options for innovative and effective treatments is to rely on technological advancements. Currently, 49% of counseling center directors report using some form of online services—almost exclusively self-help resources (Barr, Krylowicz, Reetz, Mistler, & Rando, 2011). Although many online self-help resources can be effective for highly motivated clients, completion rates for online self-help materials without counselor support are typically very low (Newman, Szkodny, Liera, & Przeworski, 2011). Outside of the United States, however, several countries, agencies, and organizations are using a model of treatment that is Internet based with the addition of a therapist-assisted component. This hybrid approach has had completion rates comparable to face-to-face psychotherapy.

Most U.S. residents have access to a computer, tablet, or smart phone. As compared to prior generations, college and university students have become technologically savvy. Given this emerging generation of computer-literate students, a therapist-assisted Internet-based program may be a natural fit with college and university counseling centers. Such a program could eliminate or reduce waiting lists, reach students who cannot or do not currently access treatment, provide services to distance learners, and offer real-time savings benefits. This type of treatment could also eliminate the squeezing in of sessions in an already busy schedule for both therapists and students. Therapist-Assisted Internet Based Cognitive Behavioral Treatment (TAI-CBT) could potentially increase the number of students counseling centers treat *without* significantly increasing therapists' expenditure of time. With online treatment, therapist contact could be in sufficient frequency to maximize effectiveness.

What sort of problems and treatments might be especially suitable for an Internet-based, therapist-assisted treatment? Anxiety is the most frequently reported problem that leads students to seek counseling. Cognitive Behavioral treatment (CBT), a highly effective treatment for anxiety, is readily adaptable to online presentation. CBT is skill-based, problem focused, and works best when practiced in vivo through homework assignments. Studies in Australia, Sweden, the United Kingdom, and Switzerland have found that CBT presented over the Internet using therapist assistance (TAI-CBT) can be highly effective in treating anxiety, with positive outcomes persisting at follow-up (Anderson & Cuijpers, 2009; Foroushani, Schneider, & Assareh, 2011). International providers of TAI-CBT have found this alternative treatment to be time saving for counselors, requiring one half to one third of the counselor time when compared to traditional face-to-face individual therapy. Counselor contact tended to be 10 to 15 minutes weekly via phone

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or video conferencing. Interactive online educational modules provided students training in the model and how to apply it in their lives. TAI-CBT is easily navigated by students, and can be especially appealing when enhanced with animation, avatars, and advanced technology. Treatment can be delivered via hand-held devices, smart phones, computers, iPads, and other mobile devices—devices students already own. Students could conceivably receive effective treatment without leaving the comfort of their own home and without investing in additional expensive equipment.

In therapist-assisted CBT, like traditional psychotherapy, the therapeutic alliance can be established, which increases compliance and completion rates for self-help via the Internet (Berger et al., 2011; Spurgeon & Wright, 2010). With TAI-CBT students have access to their therapist in measured weekly contacts and via phone conversations, e-mails, video-conferencing, and therapist-assisted anonymous group chats (Andrews, Cuijpers, Craske, McEvoy, & Titov, 2010; Klein, Richards, & Austin, 2006). Although the duration of each therapist contact is reduced relative to in-office face-to-face treatment, the abbreviated contact has been demonstrated to lead to positive outcomes.

There are many randomized controlled trials, meta-analyses, and published studies internationally that support the efficacy of TAI-CBT in patients with anxiety disorders and depression (Andrews et al., 2010; Cape, Wittington, Buszewicz, Wallace, & Underwood, 2010; Carlbring et al., 2007; Cavanaugh & Shapiro, 2004; Durham et al., 2005; Griffiths, Farrer, & Christensen, 2010; Klein et al., 2006; Perini, Titov, & Andrews, 2009; Richardson, Stallard, & Velleman, 2010; Robinson et al., 2010; Titov, Andrews, Choi, Schwencke, & Mahoney, 2008). In a meta-analysis of 22 randomized controlled trials of TAI-CBT for depression, panic, social phobia, and generalized anxiety disorders, benefits were evident across all disorders. Completion rates were high, sometimes higher than for face-to-face treatment, and relapse rates were low. In addition, positive gains were evident even at one year follow-ups. High adherence rates were attributed to high privacy, low cost, and convenience factors. The authors concluded that TAI-CBT can be as effective as face-to-face treatment (Andrews et al., 2010).

These treatments have been demonstrated to work well in patients with mild to moderate anxiety, depression, social anxiety, agoraphobia, eating disorders, and substance abuse. (Patients with more severe pathology or with an elevated suicide risk require traditional face-to-face counseling). Internet treatment typically consists of well developed, online educational modules that are interactive and engaging. Therapist assistance comes in various forms: chat room responses, weekly telephone contact, or video conferencing. Phone or videoconferencing sessions are 10 to 15 minutes per week. The online interactive modules are available to students 24 hours per day, while the therapist contacts are scheduled in advance.

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Although TAI-CBT has been heavily researched internationally, it is still in its infancy in the United States. The National Institute of Mental Health funded several grants in 2010 examining a similar model, the results of which are yet to be published. A study conducted by the U.S. Veterans Affairs examined the use of TAI-CBT for veterans with posttraumatic stress disorder and found the treatment to be effective (Litz, Engel, Bryant, Papa, 2007).

Before we consider employing TAI-CBT in the United States, one important question is the willingness of U.S. students to participate in this innovative treatment. Would Internet-delivered treatment be an acceptable form of treatment for college students? To test this hypothesis, this study determined the acceptability of TAI-CBT treatment for anxiety among enrolled college students. A similar acceptability study conducted in Australia (but not limited to college students) found high acceptance rates, but noted that those less familiar with it were somewhat skeptical (Gun, Titov, & Andrews, 2011). This study replicates treatment acceptability studies conducted in New South Wales, Australia (Wootton, Titov, Dear, Spence, & Kemp, 2011), using a population of college students attending a large southeastern U.S. university.

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METHOD

Participants

Survey participants were 334 currently enrolled students at a large southeastern university. This sample of convenience was recruited via several routes: from the counseling center Web page, from the counseling center Facebook site, from computers in the counseling center waiting area, and from student volunteers recruiting participants over the lunch hour using survey iPods in high traffic areas on campus. Four modes of recruiting participants were used in order to insure that both students currently involved in treatment programs with the counseling center (survey completed through the Web site, Facebook page, and in the clinic) and students not currently receiving treatment (iPod recruits) would complete surveys.

Survey

The team of researchers developed the Acceptability of Therapist-Assisted, Internet Based Treatment of Anxiety Survey (ATAIBTA). Students were asked 9 questions: (a) consent to participate; (b) gender; (c) status as undergraduate or graduate; (d) level of anxiety; (e) past treatment for anxiety; (f) treatment modalities they would consider (i.e., individual face-to-face therapy, group therapy [Taming the Anxious Mind]), or counselor-assisted online anxiety treatment); (g) preferred mode of communicating with a counselor if TAI-CBT was the treatment modality (i.e., telephone conversation, video

conferencing, online chat, e-mail); (h) perceived advantages of TAI-CBT; and (i) perceived disadvantages of TAI-CBT.
The choices for perceived advantages were:

- Reduced time involved as compared to an office visit;
- No need to travel to appointment;
- Reduced costs as compared to an office visit;
- Privacy and anonymity working over the Internet;
- Embarrassment and shame in needing a face-to-face office visit;
- Face–to-face office visit is too uncomfortable;
- Face-to-face office visit unsuccessful in past;
- My symptoms are not severe enough to have an office visit; and
- Face-to-face office-based treatment not available or have long wait lists.

The choices for perceived disadvantages were:

- Preference for individual face-to-face office visits;
- My condition is too complicated to be handled online;
- I need to see the person I am speaking with;
- I am not good about communicating my ideas in writing or online;
- Online therapy seems like make-believe or a pretend treatment;
- I don't know enough about online therapy;
- I am skeptical it would help;
- I am too independent and prefer to deal with my symptoms on my own;
- I am too embarrassed to discuss problems over the phone or by e-mail;
- I have no time for online therapy;
- Sounds risky;
- I prefer to be treated with medications only;
- My issues are not that severe to warrant treatment;
- Online therapy is too confronting; and
- I do not have access to a computer/Internet or I am not good with computers.

This survey relies on face validity and parallels items from a similar survey conducted in Australia (Andrews et al., 2010).

Procedure

Before administrating the survey, researchers obtained approval from the university's research with human subjects review board. The survey was created through the Campus Labs survey system. It was made available online through the counseling center's Web site and Facebook page. All participants were presented brief descriptions of three modes of treatment—face-to-face

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individual therapy, group psychotherapy, and TAI-CBT—and then asked to complete the survey. No incentives were offered.

RESULTS

Descriptive Data

Two hundred seventeen students completed the survey via the counseling center Web site, Facebook page, or clinic computers ("clinic" participants, i.e., primarily students currently seeking services). One hundred seventeen students completed the survey through the iPods ("nonclinic" participants, i.e., students not currently in treatment). Among the "clinic" participants, 36% were male and 64% were female, and 69% were undergraduates and 31% were graduate and professional school students. Forty-five percent of these participants reported feeling more anxious than their friends *most* of the time, and 41% more anxious than their friends *some* of the time. Forty-two percent reported receiving past treatment for anxiety. The "nonclinic" participants were 57% male and 43% female. Eighteen percent reported feeling more anxious than their friends most of the time, and 50% more anxious than their friends some of the time. Nineteen percent of the "nonclinic" sample reported receiving treatment for anxiety in the past.

Survey Results

Overall, participants expressed a preference for individual face-to-face treatment. Seventy percent of the "nonclinic" sample and 62% of the "clinic" participants preferred this treatment modality. Group therapy was an acceptable treatment modality for 19% of the "nonclinic" respondents and 31% of the "clinic" participants. Of particular relevance to this study, TAI-CBT was acceptable to 16% of the "nonclinic" participants and 34% of the "clinic" participants. Overall, students currently connected to the counseling center found all three modes more acceptable than did the nonclinic participants. Thirty-one percent of the nonclinical sample indicated that they would not find any of the three treatment alternatives acceptable. Overall, 71 students reported interest in group therapy and 74 reported interest in TAI-CBT. Forty one of these students reported interest in both group and TAI-CBT, while 31 reported preferring TAI-CBT over group therapy. Five students, all graduate and professional school students, preferred TAI-CBT to either individual or group therapy.

Both groups expressed a preference for video conferencing over telephone, online chat, or e-mail as a means of communicating with a therapist if TAI-CBT were the treatment mode provided. Fifty-six percent would like video conferencing, 45% would accept telephone contact, 42% would accept online chat, and 35% e-mail communication.

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The identified advantages of TAI-CBT were: (a) no need to travel to appointments (82% of respondents), (b) reduced time involved compared with an office visit (56%), (c) reduced cost relative to an office visit (40%), and (d) avoiding long waits for face-to-face treatment (27%). The identified disadvantages of TAI-CBT were: (a) prefer face-to-face individual therapy (73%), (b) need to see the person I am speaking with (49%), (c) skeptical about whether TAI-CBT would help (41%), (d) don't know enough about TAI-CBT (31%), (e) believe my condition is too complicated to be handled online (31%), (f) I'm not good at communicating my ideas online or in writing (26%), and (g) online treatment seems like pretend treatment, 24%.

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DISCUSSION

The primary aim of this study was to examine the acceptability of using Internet-based therapy with college students. To our knowledge, this is the first survey of American college students regarding their interest in this treatment modality. As expected, most students prefer individual, face-to-face treatment. According to this study, a minority—16% of the nonclinical and 34% of the clinic-based sample—would consider TAI-CBT treatment. This level of interest in TAI-CBT is comparable to interest in group therapy, which is offered in 85% of counseling centers (Barr et al., 2011). Although these results suggest there are students who already would be receptive, we would surmise that more students would be open to this treatment if they were more aware of it. Once it is actually implemented, in other words, acceptance would presumably grow. Many students imagining TAI-CBT presumably picture hour-long video conferences, a misconception which would be soon corrected. Many young Americans would seem good candidates to venture into the world of online therapy. It is likely that many students who are not comfortable coming into the counseling center may find TAI-CBT an appealing alternative.

There are strong reasons to believe TAI-CBT might prove of appeal. Actively enrolled college students are required to have easy access to a computer and the Internet as well as be familiar with computer navigation, making therapist-assisted online treatment viable for most students. Further, many students have access to multiple personal electronic devices and can be considered advanced in their communication technologies: Skype, Facetime, video-conferencing, and chat rooms are a common part of a student's normal daily routine. Computer access, education, and training will all play a role in the growth of this innovative treatment modality. If computer access can be provided with minimal support, this type of treatment may be viable to reach distant patients. Of course, cost may be a limiting factor; initial investments would be needed to conduct such a treatment.

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According to our survey's results, college students already affiliated with the counseling center were more likely to accept online treatment as a viable option as compared to college students in the general population. Nonusers of the counseling center appear to be more apprehensive about beginning such a treatment, however. Some students may be reluctant to try a counseling modality that is completely new to them. Other students may need the more intensive counselor contact in traditional face-to-face counseling. Because feeling comfortable in a counseling modality and having high expectancy that a treatment will be effective is important in achieving positive outcomes, patient preferences may need to be considered and weighed by university centers so that students with less favorable opinions of TAI-CBT are given alternative options and are not lost to follow-up.

Limitations and Significance

This study had several limitations. It used a relatively small sample of convenience from a single university in the southeast United States. Generalizability to other college, universities and clinical settings is unknown. Also, this study asked students' about their perceptions of TAI-CBT as well as other treatments. How students would actually react to this treatment would be an obvious area for future inquiry.

Nevertheless, the results of this survey show preliminary evidence that TAI-CBT is acceptable to a substantial portion of college students. Such acceptance is important, because we believe TAI-CBT may provide a useful treatment alternative that could expand the counseling center's capacity to respond to several common types of cases: (a) the subpopulation with mild to moderate disorders and without suicidal ideation; (b) distance learners (assuming legal issues are worked out); and (c) students who want evidence based online educational materials and exercises accessible 7 days per week, 24 hours per day. College students are comfortable on the computer, and roughly as many consider online treatment a viable option as those accepting group therapy. Like group therapy, which has long been a strategy for providing effective treatment while reducing campus clinic waiting lists, TAI-CBT may offer college counseling centers an opportunity to reach more students, perhaps double the number of students per counselor, with a new, acceptable, and affordable treatment. We should add that although CBT is readily presented in an online educational modality, expanding offerings to include other theoretical orientations would be important to explore.

College students frequently operate on tight schedules with very little free time. Advantages of this type of treatment for college students are that it saves time, is convenient, is affordable, and may be as efficacious as other face-to-face modalities. It certainly is preferable to placing students on a long waiting list. The main advantage for therapists, of course, is saving several hours of valuable clinical time each week.

Considerations in Implementing TAI-CBT

Creating and implementing a therapist-assisted online treatment involves several steps and considerations. The laws governing online or telehealth interventions are rapidly evolving and vary from state to state. Knowledge of the legalities and legislation in any jurisdiction is essential prior to designing a program. All online materials should be compliant with laws governing technology in mental health, including HIPAA, HITECH, and state laws governing mental health practice. Laws currently confine mental health providers to practice within the states where they are licensed. Therefore, this treatment modality would not be a viable option for distance learners who live out of state or in other countries. Legislation is evolving and these laws may be subject to amendments in the future.

Further, providing telephone or videoconferencing consultation with patients requires particular skills which may differ from face-to-face treatment, and therefore additional training for all telemental health providers is necessary. This additional training would need to insure that these providers are practicing within their area of expertise. The American Psychological Association Continuing Education office approves several reputable providers of telemental health training. The Telemental Health Institute is one such established and reputable provider. The Zur Institute also provides training for psychologists, counselors, social workers, and other mental health providers.

In addition, advance planning for identifying and responding to students who experience a mental health crisis is obviously necessary. Knowing the crisis resources in relevant communities and having crisis contacts for any student being treated is essential.

Although these considerations may be time consuming and costly early in the development of TAI-CBT treatment, we believe the long-term benefits in terms of greater availability of treatment and reduced demands on therapists' time would likely offset the initial costs in time and money. In the long term, offering TAI-CBT may increase capacity and expand the availability of effective treatments to distance learners and students who currently have limited access to counseling. In summary, TAI-CBT may be a strategy for counseling centers to "work smarter, not harder" in the face of increasing demands without corresponding increases in funding.

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