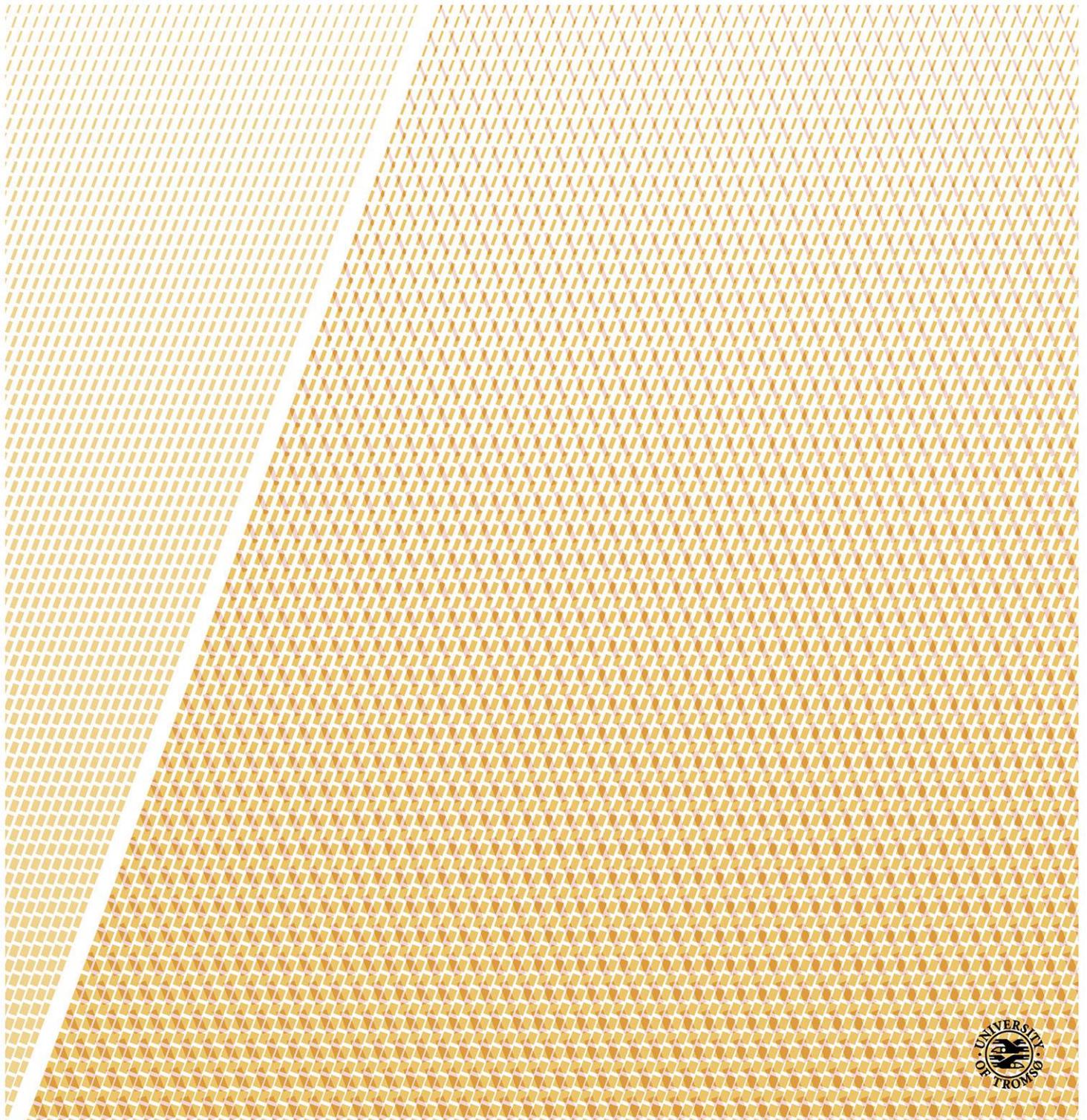


“Light my fire” - Perspectives on Motivation, Helpfulness and Implementation of Guided Internet-based Cognitive Behavioral therapy.

Maja Wilhelmsen

A dissertation for the degree of Philosophiae Doctor – October 2014



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DEDICATION

This work is dedicated to my husband, Thomas and my boys; Snorre and Birk. Without their support, understanding, encouragement, and love it would not have been possible to finish this work.

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Foreword and acknowledgement

From winter 2010 until autumn 2014, I have had the joys and challenges of planning, conducting and interpreting interesting interviews, and writing this thesis. Most of my work has been part-time combined with working as a general practitioner. From autumn 2013, I have had the opportunity to focus fully on research to understand better the treatment of depression. I have learned an enormous amount and could never have completed this project without some fantastic helpers.

My first acknowledgement, of course, goes to my supervisors Nils Kolstrup and Mette Bech Risør, who have contributed equally with their profound knowledge, endurance and interest. Nils, you have contributed to my progress through your unique understanding of the challenges and advantages of combining research and clinical practice. Mette, I have strongly valued your deep understanding of methods, methodology and epistemology. The members of the interdisciplinary research group comprising my two supervisors, Knut Waterloo, Martin Eisenmann, Kjersti Lillevoll and Ragnhild Høifødt, have added their knowledge about eHealth and were important for ensuring the continuity of my research. Ragnhild and Kjersti, you both provided a warm and inspiring way to include me in the community of Ph.D. students and thus gave me a valuable feeling of belonging.

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Summary of thesis

Depression is common and imposes tremendous burdens for patients, their family and society. Implementation of internet-based cognitive behavioural therapy (ICBT) within general practice is recommended. Better results have been shown for treatment with ICBT when support is given. Therefore there is interest in exploring guided ICBT as an affordable alternative for treatment in the early stage after the onset of depression. General practitioners (GPs) have shown positive attitudes towards ICBT; although it is currently rarely used in regular care in general practice.

This thesis is based on two studies: a patient study and a GP study. This has resulted in three papers that explore guided ICBT using an online intervention called MoodGYM combined with short module follow-up consultations. This treatment approach was designed to be compatible with general practice in Norway.

The patient study was embedded in a randomized controlled trial that investigated the effects of the programme on the symptoms of depression. Semi-structured interviews and a phenomenological–hermeneutical approach enabled us to explore in depth how the 14 patients gave meaning to their lived experience from both working with an online intervention and being supported with short consultations inbetween the online modules. Paper one explores the patients' motivation and identifies a sense of relatedness as the most important aspect. The need for relatedness was satisfied if the patient could identify with the online material, achieve feelings of being valued by an important other and feel connected to the therapist. Paper two explored those aspects perceived by patients to be helpful. The findings indicated the importance of MoodGYM as a structured approach to working with the patient's depression and the patient as an active agent. The patients valued a trusted professional to whom they could self-disclose feelings and from whom they could receive feedback.

In the GP study, GPs were provided with a training package in guided ICBT and they were asked to implement guided ICBT into regular care. Eleven GPs were interviewed. We used a thematic approach to investigate their experiences. Paper three presents the patterns identified in the interviews. GPs valued ICBT as a structured approach for supplementing their treatment of depression. They also valued ICBT as a tool for enabling patients to become an

active agent in their own health care. It was coherent with their role to recommend ICBT, but module follow-ups were difficult. The most important aspects in treatment for depression were to open up for patients and allow them to ventilate their feelings and sustain a trusting relationship. GPs did not find strategies to combine these human aspects with module follow-ups, they instead returned to standard treatment.

Overall, the two studies that explored the treatment of depression from the perspective of patients and GPs show that a theory-based online supplement is perceived as positive because it adds structure to the consultation and engages patients. However, it is also important that the therapeutic setting provides patients with the opportunity to self-disclose and ventilate their feelings about their problems and develop a relationship with the GP built on engagement with the patient as a unique person. I suggest that treatment of depression in general practice would benefit from a flexible approach in which GPs recommend self-help while continuing to use the patients' stories as a starting point for dialogue. This would benefit both patients and GPs.

Norsk sammendrag

Depresjon er svært utbredt og fører til enorme byrder for pasienter, deres familier og samfunnet. Det er anbefalt å implementere internettbasert kognitiv atferdsterapi (ICBT) i allmennpraksis. Det er vist bedre resultater om behandlingen er støttet og derfor utforsker vi guided ICBT. Dette vil man kunne tilby på et tidlig stadium i forløpet av depresjon og det vil være et rimelig alternativ. Allmennleger har vist positive holdninger til ICBT. Imidlertid er ICBT sjelden brukt i vanlig behandling i allmennpraksis.

Denne avhandlingen er basert på to studier; pasientstudien og allmennlegestudien. Ut fra disse studiene har vi skrevet tre artikler som utforsker guidet ICBT som denne avhandlingen er basert på. Artiklene utforsker bruken av den internettbaserte intervensjonen MoodGYM kombinert med korte oppfølgingskonsultasjoner. Denne behandlingsformen er designet for å være kompatibel til allmennpraksis i Norge.

Pasientstudien var i forlengelsen av en randomisert kontrollert studie som undersøkte effekten av MoodGYM på depresjonssymptomer. Semi-strukturerte intervjuer og en fenomenologisk hermeneutisk tilnærming ble valgt for å utforske i dybden hvordan de 14 pasientene ga mening til deres levet erfaring. Vi ønsket å få innsikt i både hvordan det var å arbeide med det internettbaserte programmet og det å bli støttet med korte konsultasjoner mellom nettmodulene.

I første artikkel ble motivasjon utforsket. En følelse av tilknytning ble identifisert som det viktigste aspektet for å fremme motivasjon. Behovet for tilknytning ble tilfredsstillt dersom pasienten kunne identifisere seg med det nettbaserte innholdet i programmet. Dersom de følte at de ble verdsatt av sine kjære og følte at de etablerte god kontakt med terapeuten, styrket også dette følelsen av tilknytning. I andre artikkel utforsket vi aspekter pasientene oppfattet som hjelpsomme i behandlingen. Våre funn indikerte at MoodGYM var til hjelp i form av å være en strukturert tilnærming når pasientene tok tak i sin depresjon og pasienten dermed var en aktiv aktør i behandlingen. De så verdi av å ha en profesjonell de kunne åpne opp for og snakke om følelser med, samt at de kunne motta tilbakemeldinger.

I allmennlegestudien ble allmennlegene gitt en opplæringspakke i guidet ICBT. Intensjonen var at dette så skulle implementeres i vanlig klinisk praksis. 11 allmennleger ble intervjuet og vi brukte tematisk tilnærming i analysen av deres erfaringer. I den tredje artikkelen

presenteres mønstret som vi identifiserte i intervjuene. Legene verdsatte ICBT som en strukturert tilnærming for å supplere sin depresjon behandling. De satt også pris på ICBT som et verktøy som gjorde det mulig for pasientene til å bli en aktiv aktør i sin egen helse. Det samstemte med deres rolle som allmennpraktikere å anbefale ICBT, men modul oppfølginger var vanskelig. Viktigst i depresjon-behandlingen var å åpne opp for pasienter slik at de kunne ventilere følelser og dermed opprettholde de et tillitsfullt forhold. Allmennlegene fant ikke strategier for å kombinere disse menneskelige aspektene med modul oppfølging. Legene valgte i stedet å vende tilbake til standard behandling etter anbefaling.

Samlet viser disse to studiene, som utforsker depresjon-behandling fra perspektivet til pasienter og fastleger, at et nettbasert program som er basert på anerkjent teori oppleves som positivt fordi det gir struktur til konsultasjon og engasjerer pasientene. Det er likevel viktig at den terapeutiske tilnærmingen åpner opp for at pasientene selv kan fortelle fra sitt liv og lufte sine problemer. Lege-pasientforholdet bør bygge på et engasjement i pasienten som en unik person. Jeg foreslår at behandling av depresjon i allmennpraksis bør inkludere anbefaling av nettbasert selvhjelp, men tilnærmingen må være fleksibel og legene må fortsette å ha pasientenes historier som utgangspunkt for dialogene. Dette vil gagne både pasientene og legene.

List of papers

Patient Study

Paper 1 “Motivation to persist with Internet-based cognitive behavioural treatment using blended care: a qualitative study”

Wilhelmsen, M., K. Lillevoll, M. B. Risor, R. Hoifodt, M. L. Johansen, K. Waterloo, M. Eisemann and N. Kolstrup (2013). BMC Psychiatry **13**(1): 296.

Paper 2 “Patients’ Experiences of Helpfulness in Guided Internet-Based Treatment for Depression: Qualitative Study of Integrated Therapeutic Dimensions”

Lillevoll, K. R., M. Wilhelmsen, N. Kolstrup, R. S. Hoifodt, K. Waterloo, M. Eisemann and M. B. Risor (2013). J Med Internet Res **15**(6): e126.

GP Study

Paper 3 “Norwegian General Practitioners’ Perspectives on the Implementation of a Guided Internet-based Cognitive Behavioural Therapy of Depression: A Qualitative Study”

Wilhelmsen, M., R. S. Hoifodt, N. Kolstrup, K. Waterloo, M. Eisemann, R. Chenhall and M. B. Risor (2014). J Med Internet Res **16**(9): e208.

Abbreviations

CBT: cognitive behavioral therapy

CCBT: Computer-based cognitive behavioral therapy

DSM: Diagnostic and Statistical Manual of Mental Disorders

GP: general practitioner

ICBT: Internet-based cognitive behavioral therapy

ICD: International Classification of Diseases, Injuries and Causes of Death

NICE: National (England and Welsh) Institute of clinical excellence

NPT: normalization process theory

RCT: randomised controlled trial

SDT: Self-determination Theory

WHO: World Health Organisation

WONKA: World Organisation of Family Doctors

1 Introduction

1.1 Background

Symptoms of mental health disorders are very common. Every year, one-third of the European population is estimated to experience a mental disorder, of which depression and anxiety are the most frequent (Wittchen, Jacobi et al.2011). In Norway, the same tendencies as in the rest of Europe are found. The annual prevalence is about one in three for symptoms of mental disorders and about half of the Norwegian population will have a mental disorder during their life (Kringlen, Torgersen et al.2001, Mykletun, Knudsen et al.2009). Mental disorders, of which depression is one of the most frequent, are one of our biggest health challenges because of deficiencies in available treatments and poor service provision (Nutting, Rost et al.2002, Wittchen, Jacobi et al.2011). Rethinking of treatment modes is needed, and internet-based intervention is a promising way to increase the accessibility of evidence-based treatment (Johansson and Andersson2012, Richards and Richardson2012).

1.2 Depression

Depression has troubled humans in all times and its documentation goes back to ancient Greek descriptions (Gruenberg, Goldstein et al.2005). Depression includes emotional symptoms such as a depressed mood or perhaps aggression. Motivational symptoms are also common if the patient has loss of interest or initiative. Cognitive symptoms, such as negative thoughts or feelings of hopelessness and somatic problems, such as loss of energy and sleep disturbances, are often part of the disorder. Many will experience some of these symptoms as part of normal life, but when the symptoms are many, long-lasting and intense they can interfere with normal functioning (Kringlen, Øgar et al.2008).

Gruenberg et al. presented the evolution of formal classification systems of depression in the 20th century. The stated goals of classifications are to ensure good communication between health workers, to enhance understanding of the disorder and to enable effective treatment. At first, the classifications of depression were tied to aetiology, but these have since evolved to specific descriptive criteria. Two classifications are often deployed currently. The Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) includes a list of nine symptoms, of which at least one must be either depressed mood or loss of interest or pleasure to justify a diagnosis of depression. The nine symptoms are: 1) depressed mood; 2) loss of interest; 3) significant weight loss or gain, or increase or decrease in appetite; 4) insomnia or hypersomnia; 5) psychomotor agitation or retardation; 6) fatigue or loss of energy; 7) feelings

of worthlessness or excessive or inappropriate guilt; 8) diminished ability to think or concentrate or indecisiveness; and 9) recurrent thoughts of death, recurrent suicidal ideation without a specific plan or suicide attempt, or with a specific plan. The International Classification of Diseases, Injuries and Causes of Death 10 (ICD-10) is the other classification. The ICD-10 symptom criteria are very similar to those of the DSM-IV and the minor differences will not be presented here. Depression is divided into three grades of severity in the classification systems; mild, moderate and major (Gruenberg, Goldstein et al.2005).

1.2.1 Prevalence and cost of depression

About one in five people will go through a period of depression during their lifetime and one in 10 will experience depression during a year (Mykletun, Knudsen et al.2009). Women are more likely to go through depression than men (Kringlen, Torgersen et al.2001). Depression imposes a tremendous emotional, financial and social burden on the patient, their family and society (Gustavsson, Svensson et al.2011). A survey by the World Health Organization (WHO) in 60 countries showed that depression impairs the person's own perceived health state to a greater degree than other chronic diseases (Moussavi, Chatterji et al.2007). The WHO has predicted that depression alone will be the second most prevalent cause of disease burden in the world in 2030 (WHO, Colleges et al.2008). Epidemiological studies highlight the early onset of depression. In Norway, one in 10 people of working age is incapacitated, and incapacity because of poor mental health occurs on average 9 years earlier than the average incapacity caused by somatic disease, which results in the loss of many working years. The proportion of people incapacitated by a mental health condition is also increasing (Mykletun, Knudsen et al.2009).

1.2.2 Living with depression

Symptoms of depression include low self-esteem and lack of initiative. Patients experiencing depression have described this as a feeling of being inadequate and a weak person (Gask, Rogers et al.2003). One study (Kayali and Iqbal2013) has shown that women with depression consider depression as part of who they are. Some report a feeling of not being "at home" in their lives as part of depression and that this feeling is necessary to alter their lifestyle. Only by going through the depression could they regain a feeling of being "at home" in their lives. This implies that there is no sharp line distinguishing between what is experienced as part of the person and what is experienced as part of depression as a disorder.

Gask and Rogers et al. (2003) found that patients with lived experience from the treatment of depression have expressed that it was difficult to feel that they deserved the best treatment and to seek follow-up. The results of this study implied that the depression itself, which is accompanied by low self-esteem and lack of initiative, makes them less likely to receive care for their particular needs in treatment. They suggested that a systematic approach is needed to improve the treatment of depression. This study showed the complexity of enabling good treatment for depression and that the patient's perspectives must also be considered.

A review reported (Ebmeier, Donaghey et al.2006) that depression can be accompanied by cognitive abnormalities that impair the person's role both in private and at work. Depression can also interfere with attempts to recruit cognitive processes to therapeutic processes. This makes treatment a challenge. Ultimately, the risk of premature death, especially suicide as a cause of death, is elevated for people experiencing depression. In 2011, 598 people committed suicide in Norway. This is a too many. In comparison 168 people died in traffic accidents in the same year (Sentralbyrå 2014).

Treatment can reduce symptoms and shorten the course of the disease and may reduce the chance of recurrence (Wampold2001, Mykletun, Knudsen et al.2009), thereby leading to positive changes in the patient's life. Experiencing depression in life and working with the treatment for depression are often described as filled with "darkness". This thesis focuses on ways to add "light" by exploring motivation and helpfulness from the perspective of the patient, and engagement to implement tools to improve treatment from the perspective of the general practitioner (GP).

1.3 Treatment of depression

The aetiology of depression is complex and depends on several factors. Genetic factors have a role in the aetiology (Ebmeier, Donaghey et al.2006). Stressful life events are considered to be one of the most important triggers of depression (Kringlen, Øgar et al.2008). Research has recommended that mental illness should be detected and treated at an early stage, before more severe expressions can occur (Kessler, Merikangas et al.2003, Wittchen, Jacobi et al.2011).

According to the most recent recommendation from the National Institute for Health and Clinical Excellence (NICE) in England and Welsh (Pilling, Anderson et al.2009) depression should be managed in a stepped-care way, situated initially in primary care. Low-intensity psychosocial interventions recommended for sub-threshold or mild to moderate depression include individual guided self-help based on the principles of cognitive behavioural therapy (CBT), internet-based CBT (ICBT) or a structured group-based physical activity programme.

It is explicitly recommended not to prescribe anti-depressants for these patients unless defined complicating factors are present. It is recommended that moderate to severe depression should be treated with antidepressant medication combined with high-intensity psychological treatment such as CBT or interpersonal therapy. Furthermore, treatment should be reviewed and sequenced by, for example, increasing frequency of appointments and adjusting medication if there is an inadequate response. People with chronic physical health problems and moderate to severe depression who do not respond to treatment should be considered for collaborative care between primary and secondary health service. The national guidelines in Norway align with such stepped-care recommendations and the GP is expected to initiate treatment (Helsedirektoratet2009).

As mentioned above, guidelines for the treatment of depression comprise many specific procedures, a rationale for the prescription of medication and recommendations on when referral is appropriate. On the other hand, treatment of depression requires more than procedures. One large study of 576 patients explored their perspectives on treatment of depression in general practice. The participants were interviewed by asking many open questions, and the average interview lasted one hour, indicating an in-depth approach. The participants valued the specific procedures included in the treatment. Nevertheless, they emphasized that access to a health worker who was able to listen, understand and be empathetic was essential to their treatment of depression. Almost half of the patients suggested that these important relational tasks were performed well by their GP (Palmer, Gunn et al.2010). Another study that explored patients undergoing treatment for depression in general practice also reported the importance of good interpersonal skills, such as the patient being understood and listened to, as essential in the treatment of depression. However, some of these patients noted that it was, at times, difficult to discuss their problems in a good and therapeutic way with their GP (Gask, Rogers et al.2003).

1.3.1 Access to treatment

There are various challenges to providing good treatment for depression. Three challenges have been identified in the treatment of depression in Norway (Helsedirektoratet 2009). For patients with depression, the first challenge is to accept that they have a problem and thus to seek help. Stigmatizing attitudes to mental disorders are responsible for distress and reluctance to seek appropriate help. However, studies have found that both people in general and patients who have experienced mental disorders express less embarrassment and expect less stigma when seeking help from GPs compared with other health workers (Barney,

Griffiths et al.2006, Barney, Griffiths et al. 2009). The first contact with the health care system is often through GPs. There is often little delay in seeing a GP because waiting lists are short (Pilling, Anderson et al. 2009). The second challenge is the diagnosis of a mental disorder. There is an ongoing debate regarding when the label of depression should be applied in general practice (Dowrick 2009). Some argue that diagnosing mild severity opens the opportunity to provide treatment at an early stage (Kessler, Merikangas et al. 2003). Others argue that the criteria for the diagnosis should be limited to avoid medicalization and to decrease the overall demand for clinical treatment because depression is often self-limiting (Gruenberg, Goldstein et al. 2005). The third challenge is the time interval (or treatment delay) from when the patient has been diagnosed until the onset of treatment. In some countries, the GP refers a patient to health workers in primary care who are specially trained in treating mental health disorders, such as mental health nurses. In other places there is a low threshold for referral of mental issues to specialized care. However, most mental health problems are now treated in primary care (Wittchen, Jacobi et al. 2011, Hermens, Muntingh et al. 2014), and treatment for mild to moderate depression situated in primary care is consistent with international (Pilling, Anderson et al. 2009) and national recommendations (Helsedirektoratet 2009).

In Norway, almost all inhabitants are enrolled in a system called *fastlegeordningen*, which gives all inhabitants one specific GP whom they can access for all health problems. Even though Northern Norway is rural, most people live only a short distance from their GP and GPs are available for follow-up. In Norway, the GP is the health care worker most likely to provide treatment for depression (Helsedirektoratet2009). This means that the GP is often able to start and provide treatment, and thus, there is little treatment delay. A joint report by the WHO and World Organization of Family Doctors (WONCA) suggested that integration of mental health care into primary care improves the treatment of mental health conditions (WHO, Colleges et al. 2008). This is considered to be the best way to ensure access for treatment in a way that minimizes discrimination and stigma. It is important for individuals and their community's perceptions of their disorder if they stand in the same queues, receive appointments in the same way and see the same doctors as people with other conditions. The report also presents a pyramid of mental health services. In contrast to the NICE recommendations for stepped care (Pilling, Anderson et al.2009), the base of this pyramid focuses more on self-care. Overall, the report also emphasizes the importance of the health worker–patient partnership for promoting an active role of individuals with mental disorders

in their own care in all steps. Primary care is the first level of formal services in the pyramid. Primary care is used most frequently and at a lower cost compared with the higher levels, which comprise specialist psychiatric services, psychiatric services in general hospitals and community mental health services. The positive aspects of primary care are that it facilitates important values of person-centred and holistic service, and represents continuity in the relationship between the patient and the health worker (WHO, Colleges et al. 2008). A good relationship with a health worker provides continuity and by itself has been found to be a positive influence on outcomes (Di Blasi, Harkness et al. 2001).

In Norway, most patients are given treatment in general practice, but it is unclear whether they are given good treatment. Mykletun et al. (2009) suggest that the GP's willingness to give sick leave for depression instead of helping the patients to cope with their life most likely aggravates the condition for the individual. The number of patients treated for mental illness and the prescription of anti-depressants are increasing in Norway. Most depressed patients are treated by GPs and most anti-depressants are prescribed by doctors in primary health care. Mykletun et al. also suggest that one of the major challenges in providing good treatment for patients with a mental disorder in Norway is the need to improve access to treatment options that do not include psychotropic drugs by improving competence of GPs and by strengthening their toolkit. CBT is mentioned as a useful treatment strategy. Patients also tend to prefer consultation with a therapist rather than being prescribed medication (Proudfoot, Goldberg et al. 2003, Ebmeier, Donaghey et al. 2006, Gun, Titov et al. 2011).

Research has suggested that GPs do not have the confidence, knowledge and necessary tools to treat patients with mental illness in a non-pharmacological and evidence-based way (Richards, Ryan et al. 2004, Mykletun, Knudsen et al. 2010). A Cochrane review (Huibers, Beurskens et al. 2003) explored whether it is effective for GPs to deliver psychosocial interventions, but found the research to be very limited for drawing conclusions about outcomes. A study of Norwegian GPs found that they see treatment of depression as part of their work, although they feel that they lack the skills and competence to provide good treatment (Mykletun, Knudsen et al. 2010).

1.4 Cognitive behavioural treatment

As mentioned above, substantial research supports CBT as a preferred psychotherapy in treatment of depression (Hans and Hiller 2013). CBT can be presented in a model of three parts: situation, thoughts and feelings. In this model, there is a connection between the parts.

Negative and dysfunctional thoughts relate to feelings or emotions and can lead to depression. In CBT, the patients learn to challenge their own patterns of thinking (Beck 1995).

CBT is an often-used approach in specialized mental health services. One challenge with standard CBT in routine specialized mental health services is the time demanded for such an approach (Hans and Hiller 2013), which makes this therapy inaccessible to many. Patients with depression referred by their GP to a specialized health care usually encounter long waiting lists, which lead to treatment delay, normally 3–6 months in Norway. Moreover, there is less available specialized mental health care in rural and remote areas of Norway. In the Northern Norway Health Region, where about 32% of the citizens live in rural areas, there are 0.59 psychologists per 1000 inhabitants compared with 1.11 per 1000 in metropolitan areas such as Oslo and Akershus (Sentralbyrå 2009).

Reviews have been conducted and found that outpatient CBT is effective in reducing the severity of depression (Hoifodt, Strom et al. 2011, Hans and Hiller 2013). However, Reese et al. (Reese, Rosenfield et al. 2013) claim that there is a substantial and worrying gap between the theories of CBT, interventions supported by research and the interventions offered to patients in the community. To narrow this gap, more knowledge is needed about what promotes and inhibits the intended interventions. Efforts have been made to teach GPs CBT. Several studies have shown that GPs trained in CBT experience barriers in treating depression such as a lack of confidence and time constraints (King, Davidson et al. 2002, Wiebe and Greiver 2005, Davidsen 2008, Aschim, Lundevall et al. 2011). ICBT puts less strain on the GP's time because much of the treatment is done as homework by the patient. An internet-based programme also presents the theory and is thought to demand less detailed theoretical knowledge by the GP and thus makes it easier for the GP to gain confidence.

1.5 Internet-based cognitive behavioural treatment

A core element recommended in the treatment of depression is the encouragement of patients to engage in their own health and recovery (Helsedirektoratet 2009). Interventions on the Internet offer a low threshold treatment, are accessible and fit with the “digital lifestyle”. ICBT is structured and follows a manual, which makes this therapy suitable for self-help procedures (Churchill, Hunot et al. 2001, Andersson, Bergstrom et al. 2005). The intention of self-help is that the patients engage in their own treatment. Mykletun et al. (2009) claim that low adherence or “drop-out” is a serious barrier to good treatment for mental disorders in Norway. A meta-analysis concluded that there was no significant difference in adherence between face-to-face CBT and ICBT in terms of completed sessions (van Ballegooijen,

Cuijpers et al. 2014). However, better adherence and better outcome in reducing symptoms of depression have been suggested by several reviews when ICBT is supported by a therapist compared with allowing the patient to work completely independently (Johansson and Andersson 2012, Richards and Richardson 2012).

A meta-analysis by Ferrand and Woodford (Ferrand and Woodford 2013) suggested three main ways to approach self-help CBT: including ICBT, computerized CBT (CCBT) including CD-R and books. Self-help CBT can be self-administered, meaning that the programme is recommended to patients who complete the programme on their own. Self-help CBT can also be supported in two different ways; minimal contact follow-up or guided. The first way is to provide a rationale for treatment and then to provide minimal-contact follow-ups where there is no focus on process issues. The second way is to give support through guided follow-ups (also called therapist administered). With this approach, the patient attends regular and scheduled meetings that can be face-to-face or by telephone or mail. The role of the therapist is to focus on process issues. Process issues are all the issues arising from working with the self-help material. This meta-analysis also found better effectiveness in the treatment of depression when support was given compared with CBT as self-administered self-help. However, it was concluded that it is unclear what the support should best comprise.

1.5.1 ICBT and the patient

Clinical effectiveness and cost-effectiveness are important when evaluating whether a new technology should be implemented into clinical practice. Maxwell (1992) suggests that these are only two of the total of six indicators needed to evaluate the quality of a health service. Other indicators are safety, equity, accessibility and acceptability. The last indicator of acceptability monitors whether the people involved in a new approach find it comfortable and valuable. A review (Kaltenthaler, Sutcliffe et al. 2008) of patient satisfaction reported in clinical trials with CCBT as the treatment for depression found positive attitudes already in 2008 that indicated the acceptability of treatment. The limitations of this study were that all participants were completers and the drop-out rate was high. This study concluded that more qualitative research is needed to gain a better understanding of the patients' perspectives. Later studies have also confirmed positive attitudes. In an Australian survey, both health workers and patients reported being comfortable with treating mild to moderate depression with evidenced-based online interventions (Gun, Titov et al. 2011). Pre- and post-measures in a clinical trial also explored the acceptability of CCBT with brief face-to-face consultations

and found a positive patient experience. Interestingly, the women found the programme to be more helpful than the men (Cavanagh, Shapiro et al. 2009).

Acceptability can be interpreted as more than just positive attitudes or measurement of satisfaction. Acceptability can also be understood as what is helpful to or what motivates patients. Some recent qualitative studies have explored patients' experience with internet-based treatment without face-to-face follow-ups. Motivation is important to ensure patients persist in treatment. Many patients do not persist with treatment using ICBT. Identified barriers to persistence were lack of computer skills (Gerhards, Abma et al. 2011), time constraints (Bendelin, Hesser et al.2011, Donkin and Glozier 2012) and low mood (Donkin and Glozier 2012). The latter of which implies that depression itself is a barrier to persistence with ICBT. Limited worth and lack of identification with the programmes were also noted as challenges (Gerhards, Abma et al.2011, Donkin and Glozier 2012). In one study, many patients sent the research team emails to contextualize the questionnaire answers that they gave in the programme, which they felt otherwise would be misunderstood. This indicated that they struggled to "fit" their answers into the existing alternatives. They also reported that a lack of therapeutic relationship meant that they had problems engaging with the computer intervention (Donkin and Glozier 2012). Overall, in these studies, the patients indicated that they wanted more human support as a motivator to adhere and/or as personal support to gain a deeper understanding to make the programme helpful (Bendelin, Hesser et al.2011, Gerhards, Abma et al. 2011). Positive aspects of ICBT were identified in various ways: to be reminded by email or phone enhanced persistence (Donkin and Glozier 2012), and to be able to work on their own gave a feeling of autonomy or control (Bendelin, Hesser et al. 2011, Gerhards, Abma et al. 2011, Donkin and Glozier 2012). The ability of the patient to translate the content from the online programme into actions or to implement new ways of thinking into daily life was also found to be helpful (Bendelin, Hesser et al. 2011, Donkin and Glozier 2012). The perception that the programme is helpful and noticing improvement were identified as important reasons for persisting with treatment (Gerhards, Abma et al. 2011, Donkin and Glozier 2012), and increased insight into depression and/or the patient is useful (Bendelin, Hesser et al. 2011, Gerhards, Abma et al. 2011). Overall, several dimensions relating to the use of ICBT by depressed patients have been studied, but little is known in depth about the patients' experiences with ICBT supported with face-to-face consultations.

1.5.2 ICBT in general practice

GPs with training and education in mental health are more positive towards depression and more often use non-pharmacological treatment (Richards, Ryan et al. 2004). By contrast, as mentioned above, research shows that, despite training, it has been difficult to implement short versions of specialized psychological treatment into general practice (King, Davidson et al. 2002, Wiebe and Greiver 2005, Davidsen 2008, Aschim, Lundevall et al. 2011). Guided ICBT puts less strain on the caregiver and has been suggested as an alternative in general practice (Hoifodt, Strom et al. 2011, Kivi, Eriksson et al. 2014). In the national guidelines for the treatment of depression in Norway, online interventions are recommended as a low-intensity option (Helsedirektoratet 2009). Studies of GPs found have positive attitudes to eHealth and online interventions (Gun, Titov et al. 2011, Sinclair, Holloway et al. 2013). In one interview study, GPs reported that they incorporated recommendations to online health information only if they had knowledge of trusted sites (Ahluwalia, Murray et al. 2010). Other studies have reported that GPs do not use eHealth and online interventions in their daily practice because of a lack of knowledge of reliable web sites and because they feel unfamiliar with such approaches (Sinclair, Holloway et al. 2013, Hermens, Muntingh et al. 2014). Some GPs have also reported insecurity about ensuring a good patient–health worker relationship when they used internet interventions (Hermens, Muntingh et al. 2014). GPs questioned by both Sinclair and Hermens did not have training in the treatment of depression in which online interventions are integrated. Adequate training of primary care health workers is claimed to be required for improving mental health care. Primary health care workers must learn how to provide treatment in a patient-centred manner and to understand how to motivate and prepare patients to engage in their treatment at home (WHO, Colleges et al. 2008). Little is known about the experiences of integrating online interventions or guided ICBT in primary care. To our knowledge, no papers have explored the experiences of GPs who are trained in such approaches.

Meta-analysis of supported ICBT has indicated a solid evidence base for its effect on reducing symptoms of depression (Johansson and Andersson 2012, Richards and Richardson 2012). However, many aspects are highlighted as unknown or as a challenge such as low adherence and a lack of knowledge about what is helpful to the patient and what follow-up support should consist of. Evidence indicates better outcomes and adherence if human support is given compared with ICBT as self-administered self-help (Johansson and Andersson 2012, Richards and Richardson 2012). This implies that aspects of the patient–health worker

relationship influence treatment in a positive way. Better understanding of the complex aspects involved and the work required is needed for guided ICBT to be helpful to the patient and to be implemented into routine practice. Given the recent development of ICBT and the limited implementation in general practice settings, research is still in its early stages. Qualitative research may improve our understanding of how patients and GPs experience ICBT and the translation of knowledge into practice. This knowledge may contribute to improving the treatment of depression in general practice.

1.5.3 MoodGYM as an optional guided ICBT in general practice

MoodGYM is an ICBT programme developed at the Centre for Mental Health Research at the Australian National University. MoodGYM is a self-help programme that can be considered as a first step in the treatment of depression in the national guidelines for the treatment of depression in Norway (Helsedirektoratet 2009). MoodGYM has been proven to be effective in alleviating symptoms of depression (Christensen, Griffiths et al. 2002, Hoifodt, Lillevoll et al. 2013). MoodGYM is a free internet-based self-help programme that comprises five interactive modules that introduce CBT principles. The principles are presented to the patient through online exercises in a way that allows MoodGYM to demonstrate the relationship between what one thinks and what one feels. One module presents relaxation techniques and another includes sections on managing relationships and increasing engagement in positive activities. It has been suggested that MoodGYM can be effective in primary care even if the provider (i.e., the GP) lacks extensive specialized training (Proudfoot, Goldberg et al. 2003). Our research group conducted a trial exploring MoodGYM combined with short consultations in treatment of depression, which is compatible with general practice. This trial of patients recruited from general practice concluded that this mode of treatment was effective in reducing symptoms of depression (Hoifodt, Lillevoll et al. 2013).

2 Considerations of research design and method

Explicit and deliberate choices in research are important to ensuring good quality. These choices and components of research are not conducted in a linear fashion, but are in constant interplay throughout the research pathway. Maxwell's model (2013) comprised five components: 1) goals, 2) research questions, 3) conceptual framework, 4) methods and 5) validity. Choices are made about the interplay of these components. In all components, ethical considerations must also be included. With this as a framework, the following text shows how and why my research group and I made what we considered to be the most suitable choices when designing and conducting the two qualitative studies that this thesis is based on. Within this section, I also make transparent the most important discussions that these choices are based upon and reflections made in their extension.

2.1 Goals

Who we are and what we bring with us when we approach the task of medical research influences what we look for and the results that we find (Malterud2003). Maxwell encouraged researchers to be open and to reflect constantly about who we are and to aim to convey how this might influence the research process. One aspect of making this transparent is clarifying our goals as practical, personal and intellectual (Maxwell2013). In the following, I discuss the different goals of this research.

Practical: As I understand, this is the overall research goal. For me, the overall goal was to contribute to the discussion about improving the treatment of depression in the context of general practice.

Personal: In winter 2010, I was ready to go back to work after maternity leave after the birth of my youngest son. My friend strongly recommended that I should apply for her two jobs because she had to resign. I contacted the project leader and supervisor, Nils Kolstrup. I was happy to win both jobs: working as a GP at Kaigata legekantor while writing my Ph.D. For 3.5 years, 50% of the work was research combined with clinical practice, a combination that I appreciated. By autumn 2013, I was ready to give my thesis my full concentration.

At first, I was interested in research because I saw it as an opportunity to dig deep into a field, as a contrast to a hectic clinical day. Having more flexible days while my children were young was also part of my motivation because I had heard that research was often more flexible than clinical practice. I admit that at times, it has felt flexible, although it was rather overwhelming in other hectic periods. My dream was to find the opportunity to have a year abroad, and I

worked systematically to make it possible. To improve my English and to be inspired by a vibrant environment for medical anthropology, I worked as a guest Ph.D. student at Melbourne University from August 2013 to July 2014. I learned a great deal both as a researcher and personally during this period.

The project involving the use of ICBT in general practice was interesting for several reasons. A project based on the principles of CBT was interesting because CBT was something that I had heard about and wanted to learn more about. As a GP, I was used to and enjoyed, talking to people. I found it and still find it, interesting to hear their stories. Learning about research interviews was therefore appealing. My background from 1 year of studying Criminology at the University of Oslo was also motivating because that discipline has a strong tradition of qualitative research.

After working within the field of eHealth, both as a researcher and as a GP trying to apply it, I was keen to understand how such an approach could be integrated into treatment in a good way. I hope that my own experiences have helped me to capture the participants' stories. However, I have also tried to ensure that I did not act as a defender of ICBT or assume that my experience was the same as that of others.

Intellectual: In an inductive way, I wanted to explore the meaning of experiences with ICBT from the perspective of the participants. The participants are both the patients and the GPs whom we interviewed. In the patient study, our aim was to understand more about the patients' meaning of the lived experience before, during and after treatment with guided ICBT. In the GP study, our interest was the GPs' perspectives and how they made sense of their choices when intending to implement this novel approach into their everyday clinical practice.

2.2 Research question

The goals of a study are an overarching aspect that directs the research. The more focused research questions (also called aims) evolve into the process of having a goal, choosing a method, gathering data and analysing the data. Who we are as researchers and our conceptual framework are also parts of the process. All of these aspects will, in an interactive way, influence each other (Maxwell2013). Quantitative researchers often aim to say something about significant causality or correlation expressed in numbers. In qualitative research, one can explore the participants' reflections on causality when exploring a phenomenon, and one may infer causal processes. However, Kvale (2009) argues that the overall research question

of “why” is hard to answer initially. “What” or “how” questions are much more suitable for qualitative approaches. I tried to keep this in mind when formulating my research questions. The research group that I was in knew the field quite well, but the process remained to focus the research questions for each paper, and they were revised several times. As Maxwell (2013) argues, the research question evolves as a result of an interactive design process as opposed to being established as a starting point. Especially in the patient study, we had to ask ourselves many times after the interviews were conducted: “What did the participants tell us that was relevant to the practical and intellectual research goals seen in light of identified gaps in the previous literature that warranted research?” From this knowledge, the research questions, or aims, evolved and helped to focus the analysis, conceptual framework and hopefully, in a clear way communication of the results in the final papers. The final research questions are as follows;

Patient study

How do patients experience ICBT with a focus on motivational aspects leading them to persist with ICBT, using the self-determination theory (SDT) as a theoretical perspective?

How do patients experience ICBT focusing specifically on those aspects of the therapy that they consider to be most helpful?

GP study

What aspects were perceived by GPs to affect their implementation of guided ICBT in daily practice?

2.3 Conceptual framework

When conducting research, one must work with concepts that are coherent with the rest of the scientist’s own conceptual apparatus and that are, to some extent, socially coherent with the rest of the scientific community (Johansson and Lynöe2008). What “glasses” we have on influence the truth that we seek and the approaches that we choose. An important part of doing research is to be aware of the choices that we make on our way and how we argue logically for the path that we take. Reflecting about what “glasses” we have on makes us conscious of this process.

Choosing a research pathway requires awareness and decision-making on many levels. When conducting both qualitative and quantitative research, epistemology, methodology and method are all important aspects that are intricately connected. Epistemology refers to the theory of

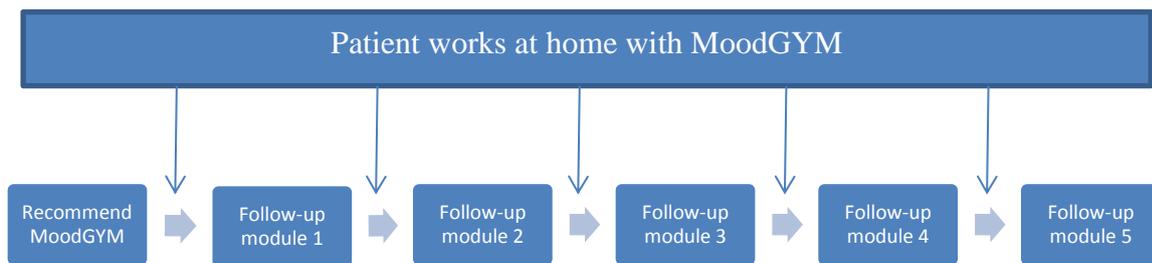
knowledge. This is more at a philosophical level; e.g., defining what the nature of scientific knowledge is. Methodology involves justifying the method through theory that explicitly tries to formulate the logic that a researcher uses to produce knowledge; e.g., as a specific paradigm within qualitative research. Method refers to research action. Research methods are the practical activities that a researcher performs to gather, manage, analyse and report data (Carter and Little 2007). Carter and Little (2007) argue that objectives, research questions and design shape the methodology and that methodology shapes the objectives, research question and design. This is a cyclic view of how components in qualitative research interact. As mentioned above, it can also be seen as a complex interplay. As presented by Maxwell (2013), the components of qualitative research are in constant interplay between the conceptual framework, goals, validity, research question and methods. In other words, the research pathway is not entirely given when the research question is formulated because the relationship between the pathway and research question is a continuous ongoing process. To explore the phenomenon that we wanted to investigate, we reflected often on the conceptual framework. Conceptual framework is introduced by Maxwell (2013) as one of the five components of designing qualitative research. In the following, I make transparent the different aspects of my conceptual framework, such as the context of the study, concepts, underlying assumptions, expectations and the theoretical philosophical approach that have informed my study. I begin by presenting the broader eHealth research that I have been involved in to explain the study context of the two qualitative studies that this thesis is based on. I also reflect on what I think are important aspects of my pre-understanding. In the subsequent sections, I describe in detail what knowledge we wanted to explore and what we saw as data and finally, how we planned to obtain these data, thus explaining the epistemology and methodology of this thesis. I finish by presenting the theoretical framework used to understand and interpret our findings for each paper.

2.3.1 eHealth research in Tromsø, study context and me

To understand who the participants were and to grasp who we are as researchers, it is obvious that a description of the study context needs to be provided. From autumn 2010 until autumn 2012, a randomized controlled trial (RCT) was conducted at UiT The Arctic University of Norway (trial registration: Australian New Zealand Clinical Registry ACTRN 12610000257066). This RCT offered guided ICBT to a group of patients experiencing depression. The patients had sought help from their GP and were referred to the clinical trial. I visited all GP offices in Tromsø to encourage the GPs to refer patients. The patients had

symptoms of mild to moderate depression. Patients who were suicidal, psychotic or drug abusers were excluded. We used the Norwegian translation of MoodGYM as an internet-based programme in the intervention. In-between the online modules face-to-face consultations (module follow-ups) were offered. In total, the intention was to have five module follow-ups, although this was flexible to some extent (see Figure 1: Intended module follow-ups). The therapists were two psychologists without specialized training in CBT (Ragnhild Sørensen Høifødt and Kjersti Lillevoll). The consultations were of a motivating nature inspired by a short manual. However, if time allowed, the consultations also allowed reflections in general. To simulate the conditions in general practice in Norway, the time spent in face-to-face consultations was only 20–30 minutes, compared with 40–60 minutes in conventional CBT.

Figure 1: Intended module follow-ups.



In addition to exploring clinical effectiveness, we also wanted to investigate the patients' thoughts and reflections. Patients from the RCT were recruited to in-depth face-to-face interviews to explore their experiences with treatment (the patient study). The measurements of clinical effectiveness concluded that this mode of treatment was effective in reducing symptoms of depression (Hoifodt, Lillevoll et al.2013). From this conclusion, the next step was to implement this complex intervention into general practice.

A training package based on the Norwegian translation of MoodGYM was developed. The presenters at the course were a GP (Nils Kolstrup) and two psychologists (Ragnhild Sørensen

Høifødt and Kjersti Lillevoll). It was a 3-day course for GPs held in the spring of 2011. GPs from all of Norway were invited to participate; however, most participants came from the north of Norway. The training comprised: (1) an introduction to CBT principles, (2) presentation of and a group session on, MoodGYM's content, (3) a patient's description of his experiences with guided ICBT and (4) a presentation of the manual for follow-ups and links to an online version of the manual. The manual comprised a short summary of each module and suggestions for follow-up questions. Originally, the intention was to conduct a trial to explore the clinical effectiveness of guided ICBT in regular care in general practice. All of the GPs participating in the course agreed to participate in this trial. Unfortunately, the recruitment of patients proved to be difficult and we decided to stop the trial. The participants in the GP study were recruited mainly from those GPs who completed this course. In-depth face-to-face interviews were conducted to explore their experiences with implementation of ICBT into their daily clinical practice.

Communication in an interview setting is influenced by several factors. An interview is more than just exchanging words. One dimension is the structure of the interview—how the interview guide is followed. A second dimension is the characteristics of the parts of the interview and a third dimension is the interaction between the parts and the influence of this interaction (Ryen 2002). In both studies, the interviewers were young female health workers. One of which was also a therapist in the RCT (Kjersti Lillevoll) and another was a presenter at the course for GPs (Ragnhild Sørensen Høifødt). We had all read a substantial amount of research supporting the use of self-help, eHealth and ICBT. In parallel to my Ph.D. studies, I worked as a GP. The advantage of a GP background was an interest in the dialogue with people and exploring their stories. I was familiar with the psycho-education literature about depression and the treatment of depression. A pre-understanding of the field of eHealth and depression allowed me to easily understand the language in the field. On the other hand, this pre-understanding might make me search within the interviews to confirm my assumptions about the world. A strong pre-understanding may lead to the falsification of findings by trying to validate the researchers' own understanding during the interview (Kvale 2009, Maxwell 2013). To reduce the chance of confirming our positive assumptions about ICBT, we constantly reflected on our pre-understanding and how it could influence us in conversations between us as interviewers and with an experienced researcher in medical anthropology (Mette Bech Risør). Our intention was to be curious and open to the participants' stories and not to assume that they shared our thoughts and reflections on MoodGYM.

In the patient study, one interviewer was a psychologist (Kjersti Lillevoll) and the other (me) was a GP. We discussed several times between ourselves and with co-researchers and concluded that the overall content and length of our interviews were similar. The psychologist had more first-hand experience with the programme as a therapist in the RCT. I had thought that this would influence the interviews to be more nuanced than mine. However, in the end such a difference was not identified. I was satisfied that both of us had been able to establish an atmosphere that was open to hearing personal stories and emotional reflections. As a GP, I found it strange in the patient study to listen to the patients tell about their problems without giving advice or acting as a helper, as I normally would. This relationship was new to me and I spent many hours reflecting on it with my co-researchers. I found comfort in and acceptance of, this relationship in the overall research goal to improve treatment for depression in the context of primary care.

In the GP study, I, as a GP, interviewed other GPs, which meant that I was investigating my own field. I was very concerned to have “big blind spots” because I knew the field and thereby could forget to ask the basic questions. This shared understanding is problematic in qualitative research because of the intention to investigate aspects of everyday life that are taken for granted (Kvale 2009). However, findings from research interviewing GPs have found that if the interviewers are GPs themselves, a wider focus and more emotionally charged dialogues are possible (Chew-Graham, May et al. 2002). The interviews that a psychologist (Ragnhild Sørensen Høifødt) conducted in the GP study lasted longer than my interviews. One possible explanation is that she was new to conducting qualitative interviews and therefore rephrased questions several times due to a fear of missing information and making the interviews longer. Another possible explanation is that the psychologist addressed aspects that are normally taken for granted to a greater extent. However, we found that the content of our interviews was quite similar. A third possible explanation is that as a psychologist, she was used to having longer sessions in clinical practice and therefore found it natural to talk for longer in the interviews. However, in the patient study, there was no clear difference in the length of the interviews when I was a GP and the other interviewer was a psychologist (Kjersti Lillevoll). The clinical background is therefore not likely to explain the difference entirely. Another reason could be that all the GPs knew of me as a GP and therefore, a trusting atmosphere was quickly established, which made the interview shorter.

2.3.2 Exploring the person's own view

A qualitative, oriented study does not focus on numbers or measurements, but rather focuses on grasping content and meaning. There are often few subjects and many variables (Aase and Fossåskaret 2007). Human beings are perceived as social individuals who are able to change attitudes and learn new things and are active agents in a social world. Ryen (2002) argued that an exploration of these changes and new things can best be explored in a qualitative manner and that an analysis of information from few subjects may be transferable to others in a similar situation. However, exploring change demands trust and openness in the interview setting.

Exploring phenomena such as helpfulness and motivation associated with the experience of ICBT does not provide numeric data and the variables are mostly unknown. Exploring the nuances and searching for a deeper understanding of experiences with this treatment involved trying to understand the perspective of the participants; each person's own view. The aim was to obtain knowledge about what engaged the participants with an internet-based treatment programme and how it engaged them. Overall, our interest was how the participants made sense of their experiences and behaviour rather than determining what actually happened. Their beliefs and thoughts were real to us, which gave our approach what is known as a "realistic view" (Maxwell 2013).

2.3.3 Lived experience

Edmund Husserl founded phenomenology with the starting point that science is merely preoccupied with explaining natural objects or events, whereas the understandable meanings of these events or objects are taken for granted. If, for instance, a biologist were to study a fish, the fish is an object to be scientifically explained. The meaning, which we obtain from lived experience about what makes a fish a fish to us, does not receive any attention. In our "natural attitude", the meaning of many phenomena is not reflected on, but as phenomenologists, we investigate the meanings taken for granted in everyday life. Phenomenologists use lived experience as a starting point in their work. Without such reflection, it is difficult to become aware of the practices that we are part of. Such an awareness may help us to improve our practice (Lindseth and Norberg 2004). Therefore, if the task at hand is to understand experience as it is understood by those having it, the empirical knowledge of this can be approached using phenomenology.

In this research, we asked questions to reveal meaning. We wanted to investigate the experiences of patients and GPs about treatment using MoodGYM and how to create meaning and make sense of such treatment in everyday life. For instance, we asked about the patients' experiences of being sick and living in a computerized society with the expectancy of fulfilling the treatment and how they motivated themselves. We also asked about what they found to be helpful when using MoodGYM. To approach phenomena with phenomenology means to shift from a mechanistic view of known influencing factors or variables to an interest in the relationships, interactions, meaning and human interpretations (Maxwell 2013). Taking a phenomenological attitude, both the listener and the narrator take part in the narrated meaning when telling. The participant is not a ship filled with black and white facts, but together nuanced narration from lived experience is made. The researcher does not collect data passively, but rather takes an active part in the dialogue with the participants. The researcher contributes to the dialogue by asking the right questions, showing empathy and interest and displaying body language that indicates curiosity. By narrating, the teller refrains from judging and the listener may not judge (Lindseth and Norberg 2004). As researchers we need to analyse the data gathered. If what the patients say is just repeated a researcher is not needed (Ryen 2002). It is not expected that a single fundamental truth will be found, because the whole truth can never be understood fully. Instead, the search focuses on the possible meanings in a continuous process (Lindseth and Norberg 2004). Our intention was to have a phenomenological attitude in the meetings with the participants.

Epistemology within science has moved from believing that there is one fundamental truth to the opposite stand, that there is no truth (Johansson and Lynöe 2008). My approach is from a position somewhere in the middle—that truth is complex and can be seen and interpreted in different ways. A different story might be found if somebody with a completely different pre-understanding and background had conducted the interviews with the same participants; or if the same interviews were conducted 10 years ago when the Internet was not part of our daily lives, a totally different truth would be revealed. Our common world was completely different then and therefore, the experience with MoodGYM would also be different. The particular stories that I found today may be different to those found to be true from depressed patients and GPs 10 years from now. However, the perspective of the individual and the general arguments elucidated may be fruitful for later studies of the treatment of depression in the context of general practice. The intention was not to believe that I knew the truth about the

variables that influence the choices that the participants make, but instead I asked them to tell their own stories and to explore how they themselves found the “shoe fitting”.

2.3.4 Exploring aspects of interest in the patient study

Exploration of the patients’ experience with ICBT expressed in the interviews involved a recursive process backward and forward to find the meanings of their lived experience.

Motivation and helpfulness were identified as important aspects. In this section, I try to make transparent how we approached such diffuse concepts. In the subsequent sections, I present the theoretical framework used to define the concepts and to better understand our findings.

The patients’ thoughts and explanations in relation to their treatment of depression were what we intended to grasp, to open up and to display in their lived experience.

For analysis, the interviews had to be transcribed into text (Lindseth and Norberg 2004).

Ricoeur (1991) argues that a text has an autonomous status compared with speech. There are two ways of reading. One can just read a text as an authorless and wordless object and thereby explain it in terms of internal relationships. Linguists approach a text this way using a structural analysis. Alternatively, one can try to communicate with the text and thereby interpret it. Interpretation moves from the text and tries to find meaning through a hermeneutic approach. The overall conception of reading is then the recovery of meaning. To explain is to bring out the structure. To interpret is to follow the path of thought opened up by the text. This hermeneutic theory claims that it is possible to interpret and explain written text and has inspired Lindseth and Norberg (2004), among others, to interpret other written types of data. Inspired by Ricoeur, Nordberg and Lindseth combine phenomenology and hermeneutics when investigating lived experience. They argue that both written text and transcribed interviews can be assessed using the same method as Ricoeur uses to explain and interpret text.

Lindseth and Nordberg (2004) suggest using the combination of naïve reading and structural analysis to formulate a final comprehensive understanding. The essence of the meaning itself can thereby be elucidated from lived human experience. Essential meaning is something that is familiar through our way of living, actions, narratives and reflections. According to Norberg, (2011) the advantage of an interview is that one can ask for explanations. In this way, the explanations perceived by a person can be uncovered. To investigate lived experience, interviews needs to be fixed in text, which again always needs interpretation. The task at hand is not to describe or explain something as a general social phenomenon but to understand the experience expressed in the interview texts (Lindseth and Norberg2004). With

this theory at hand, we tried to map out the structure of the interviews and to interpret the text to elucidate meaning expressed by the patients who were interviewed. One explanation did not exclude another possible explanation, but they followed one another and thereby gave a deeper insight of the experiences under investigation. In our research, the content of what the patient, as an individual, was telling us was our data.

Assessing the phenomena of motivation and helpfulness may be easier said than done because thought and knowledge around such phenomena may be very diffuse, even to the person describing them. However, there is no doubt that choices and thoughts are made in the process. Lindseth and Norberg (2004) argued that narration may reveal choices made from lived experience. Information and knowledge would thereby be uncovered even without patients necessarily being conscious of talking about the phenomenon; e.g., by inviting patients to tell their story of depression and the treatments that they have been through. To explore motivation and helpfulness, the stories should be analysed in terms of what they say, what they talk about and what they refer to when interpreted. Thus, a hermeneutical approach was deemed to be suitable from these aspects. The intention was also to focus on the understandable meaning of these experiences and their meaningfulness, which makes a phenomenological approach useful as methodology. Analysing the text using phenomenological hermeneutics can be done to explore the essence in lived experience. In the patient study, we were interested in the lived experiences and how the patients gave meaning in terms of motivation and helpfulness and therefore, we found phenomenological hermeneutics to be a suitable approach for understanding our data.

Part of our conceptual framework was our knowledge of the existing literature in the field of eHealth because it informs our assumptions and beliefs. Motivation is an important element in persistence with any treatment programme. A meta-analysis has found adherence to be a challenge both in face-to-face CBT and with ICBT (van Ballegooijen, Cuijpers et al. 2014). Several reviewers have found that ICBT yields greater retention when combined with human support compared with self-administered self-help (Johansson and Andersson 2012, Richards and Richardson 2012). This indicates that there is something in the human interaction or the patient–therapist relationship that increases motivation to continue treatment. On the other hand, if the patient is motivated to complete the intervention, little is gained if the patient is not able to make the intervention meaningful and helpful. Knowledge about what patients find helpful in ICBT is limited. We wanted to explore what is experienced as helpful within both the specific content of MoodGYM and the support given in the consultations. The reduced

time during the consultations compared with CBT given in specialized care may interfere with the doctor–patient relationship, which may again inhibit motivation to progress and the perceived helpfulness of the treatment. Therefore, we were interested in elaborating on the connection between the patient and the helper.

We wanted to include in the analysis all relevant events, thoughts and reflections expressed by the patients. The use of internet programmes by patients experiencing depression makes the phenomenon completely different from the ordinary treatment of depression, which may include medication for depression and from the usual face-to-face cognitive therapy. The fact that the patients are depressed increases the difficulty in motivating and helping them because a cardinal sign of depression is the lack of initiative and a feeling of hopelessness. Inspired by previous literature and findings in the interviews, we decided to interpret in greater depth the motivational aspects and what was perceived as helpful. Understanding more about these aspects might lead to improved treatment in the future.

2.3.4.1 Theoretical framework for exploring motivation (Paper one)

In Paper one, we argue that it is useful to explore motivation to understand more of the aspects that may improve adherence. Many theories try to explain how motivation is influenced. Møller (2010) claimed that health professionals often see motivation as a parameter only within the patient and one that can easily be measured. This knowledge about measurements does not give useful information about how motivation can be improved. Such information will only help to map out the current situation. It is more interesting to explore what people involved in a change find motivating rather than to measure how motivated people are. Møller (2010) argues that motivation means to want and make efforts to change. However, motivation is not something that is only within the person. Motivation must be seen as a complex phenomenon that depends on the social contexts and interpersonal relationships that it is embedded in. We were inspired by this definition of motivation and wanted to explore motivation as something more than a number on a scale. We were also interested in the connection with the therapist. Prochaska's theory of motivation argues that the relationships that a person has can influence motivation. He claims that a person goes through different stages of motivation when a change is made and tailoring the relationship between the patient and the mental health worker can enhance motivation and therefore the outcome (Prochaska and Norcross 2001). We know that ICBT with human support improves outcomes, but we do not know what this support should comprise. We wanted to explore what the

patients who had lived experiences with treatment perceived as motivating in terms of their thoughts, reflections and events.

SDT offers a broad perspective on human functioning and motivation (Ryan and Deci 2000, Verstuyf, Patrick et al. 2012, Moran, Russinova et al. 2013) and says that humans naturally have intrinsic motivation, but require supportive conditions to maintain and enhance it. Our aim was to explore motivation and especially the aspect of how to understand support, SDT gave us a useful framework for exploring and understanding supportive conditions and motivation. Intrinsic motivation is driven by an interest or enjoyment in the task itself. These aspects exist within the person, the way that they think and what goals within themselves they seek; for example, to feel happy or to feel proud. A patient might complete their modules in MoodGYM because they find it interesting to know more about depression or because they like the idea of working on their own by the computer and the exercise gives them self-satisfaction. These are examples of intrinsic motivation.

According to SDT (Deci and Ryan 2000, Ryan and Deci 2000), three basic psychological needs should be satisfied to enhance intrinsic motivation: relatedness, competence and autonomy. Relatedness includes a sense of recognition, belonging with peers, family or community and a need to feel connected to and valued by, important others. Competence involves socio-contextual success with optimal challenges, feedback and freedom from demeaning evaluation. Competence will only enhance motivation if it is accompanied by a sense of autonomy. This implies that motivation is strongly connected to people as social beings and that social connections can influence motivation. This theory is suitable for understanding the stories presented to us in the patient study because the social dimension was a recurring finding. Extrinsic motivation is factors outside the person and are explained by STD. Examples of extrinsic factors are being rewarded and appreciated by a spouse or a work supervisor, having a nice office and so on. Another example of extrinsic motivation would be if the patient completes modules just because the therapist expects this or to achieve recognition from the therapist. Extrinsic factors were not identified as important in the patients' stories and were therefore not a focus in our analysis. This is described further in Paper one.

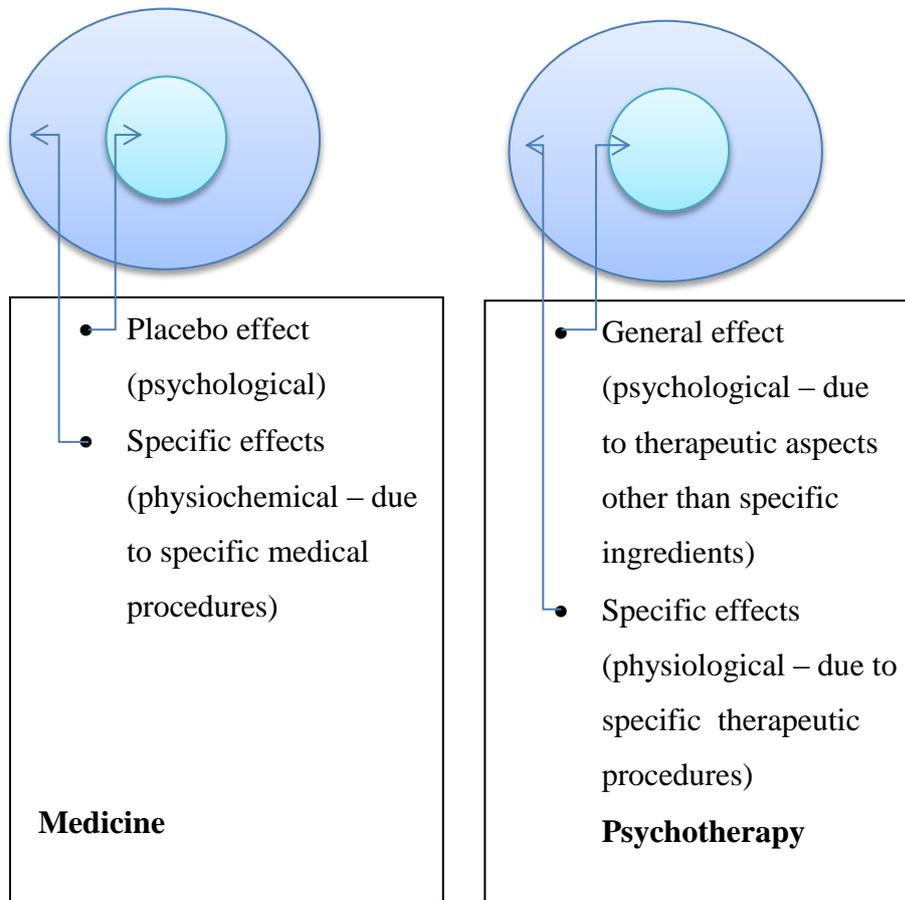
2.3.4.2 Theoretical framework for exploring helpfulness (Paper two)

In Paper two, we argue that it is useful to explore what is experienced as helpful in guided ICBT and how it is experienced. The intention of psychological treatment is that it should help patients live their life with fewer symptoms of their mental disorder. Evidence indicates

the ICBT leads to promising reductions in the symptoms of depression and that this outcome is better when treatment is supported by a health worker (Johansson and Andersson 2012, Richards and Richardson 2012). These findings are based on measurements on the effects of support, which show that support is helpful, but they do not provide detail about how it is helpful. Little is known about what patients themselves perceive as helpful and whether and how they find support improves treatment. We wanted to explore what the patients who had lived experience from treatment perceived as helpful in terms of thoughts, reflections and events.

As mentioned above, ICBT is based on cognitive behavioural theory. We could have investigated our data only on helpfulness in relation to what is known as therapeutic elements specific within CBT. With CBT as our only framework we could have held our focus on the connections between situations, thoughts and feelings and how homework increased awareness of thought patterns (Beck 1995) and how these were integrated into everyday life. On the other hand, the interviews identified nuanced and complex aspects with elements of social meanings. The theory of CBT alone could not help us to understand all our findings. There is an ongoing debate about what is helpful in psychotherapy. Wampold (2001) discusses the tension between the medical model versus the contextual model. The aim of the medical model is to determine the specific effects of a therapy; for example, the effects specific to CBT compared with those of psychodynamic therapy. The general effects are the results of the common shared factors of all psychotherapy. These general effects can be compared with placebo effects. Clinical studies using the medical model to explore psychotherapy try to exclude general effects. Figure 2 shows a re-creation of this model to illustrate the comparison.

Figure 2: Medical models in medicine and psychotherapy. (Wampold2001)



In contrast to this medical model of psychotherapy, Wampold argues that evidence from substantial research favours the contextual model because the effect is the same overall for all psychotherapy for depression, independent of specific factors. The contextual model includes the same components as the medical model of psychotherapy. However, Wampold argues that the shared components of all approaches to psychotherapy are most influential in treating patients' (or clients') problems, complaints or mental disorders; shared components are most helpful. These shared components give the general effects. The point is not to exclude general effects, but rather to be aware of their therapeutic effects and importance in treatment. To optimize psychotherapy, both specific factors and common shared factors should be considered. Wampold quotes Grencavage and Norcross when discussing the five most common shared factors identified: 1) client characteristics—positive expectations, hope or faith and a client who actively seeks help; 2) therapist qualities—cultivation of hope and warmth-positive regard; 3) change processes—providing the opportunity for ventilation of problems, practice of new behaviour and provision of rationale; 4) treatment structures—use

of techniques, exploration of emotional issues and adherence to theory; and 5) relationship elements—development of alliance and engagement. This theory therefore presents a wide spectrum of what can be understood as helpful within psychotherapy. In the interviews, a wide spectrum of different aspects were experienced as helpful in reducing the symptoms of depression. Inspired by Wampold's theory, we aimed to understand in greater depth the specific elements experienced as helpful with ICBT and to explore all helpful aspects, including what are known as common factors of psychotherapy.

2.3.5 Exploring aspects of interest relevant to implementation in general practice

In the GP study, we wanted to explore the experiences of implementing guided ICBT into regular clinical practice from the GP's point of view. There are few studies on ICBT given in regular care and therefore, the aspects important to the process of implementation are not mapped out in detail. In the patient study, we explored motivation and helpfulness, which are both complex and somewhat diffuse phenomena and thus a phenomenological–hermeneutical approach was suitable. However, the intention of the GP study was to explore, in a more straightforward way, patterns in the stories describing the professional work at hand and the GPs' thoughts regarding this issue. This required us to adjust our methodological basis.

We chose thematic analysis, a method that is used widely in the medical field (Braun and Clarke 2006). The acknowledgement of this approach in our research community was an important reason for choosing it. Thematic analysis is a flexible tool because it has theoretical freedom and can be used in relation to different epistemological positions. This flexibility demands that the researcher make explicit the choices that are made (Braun and Clarke 2006). We chose to continue to have a phenomenological attitude in the encounter with the participants because we aimed to be open, without judgement and to display curiosity in trying to understand how the participants made meaning of their lived experience (Lindseth and Norberg 2004). We had a realistic view and took a data-driven inductive approach because the coding was strongly linked to the data, rather than trying to fit the coding to an already existing theory (Braun and Clarke 2006). However, we continually discussed within the research group our interpretation in light of the existing literature and could never free ourselves from theory and our pre-understanding.

2.3.5.1 Theoretical background implementation (Paper three)

Implementation in general practice also requires motivation of the GP, although implementation in general practice is strongly influenced by the clinical complex context. The GP's positive attitudes and motivation are clearly not the only factors. Their behaviour can be affected by many external aspects, such as clinical guidelines, organizational aspects of time, financial resources and tools available. Medicine is not just something that the doctor delivers, but is created through the doctor's interaction with the patient. These were the reasons for not continuing with SDT in the GP study. The choice to recommend ICBT to patients with depression and to follow up with these patients is part of a professional decision. The dual process theory is a model often used to explain such decision-making (Croskerry 2009, Ingemansson, Bastholm-Rahmner et al. 2014). This theory suggests that health workers use two pathways to make a clinical decision: a fast and intuitive system, and a slow and analytical system. This theory focuses on the cognition of the health worker making the decision. In contrast, ICBT is a novel approach and is therefore not an established alternative in everyday clinical practice. The choice to use ICBT requires both a clinical decision through the health worker's cognition during the consultation and the effort to implement this approach as a possible alternative in a complex clinical context.

Many theories have been developed to explain aspects that affect the implementation of innovations in health care (e.g., (Grol and Wensing 2004)). We chose normalization process theory (NPT), which was developed by May and Finch (May and Finch 2009, Murray, Treweek et al. 2010), as a framework to explore the implementation of ICBT because it is derived from multiple qualitative studies that explored the implementation of complex intervention and eHealth contextualized in regular health practice. Others have considered this theory to be valuable when evaluating implementation of new treatment of depression in primary care (Gunn, Palmer et al. 2010, Coupe, Anderson et al. 2014). There is a gap between the development of new treatments and knowledge and the implementation of these interventions into practice to benefit the patient or population groups that they are intended for. According to NPT, successful implementation occurs when a practice is normalized to the point where the health workers find it natural to choose that practice or it "disappears from view".

Implementation depends on a complex interplay of four main components of the work of health workers (May and Finch 2009, Murray, Treweek et al. 2010). Work is defined as

purposive social action that involves investments personally and as a group to achieve goals. Promoting and inhibiting aspects outside the health worker influence the process. Firstly, “coherence”- is the work to make sense of an intervention. Health workers need to grasp and agree on what is involved and they must find it relevant. Practice is made possible by a set of ideas about meaning, use, utility and competence. Gunn and Palmer et al. (2010) claimed that one important aspect of coherence in the treatment of depression was agreement on the technique to deploy. Secondly, “cognitive participation”- means that health workers must engage in the complex intervention. This may involve enrolling in training or positioning themselves to use an intervention. Legitimation of a practice is essential for promoting cognitive participation and is closely bound to norms and conventions. As Gunn and Palmer et al. (2010) emphasized, health workers need to join in with depression work. Thirdly, “collective action”- is the effort required to enable the intervention to happen or the work to make the intervention function. The work is done to make the treatment compatible with the other activities in a hectic clinical setting. Efforts to make the intervention work through interactions with other stakeholders are one aspect of collective action; e.g., the doctor–patient encounter and developing a trusting relationship with the patient. Organizational effort is also needed to apply the skills within the clinical practice setting.

In the treatment of depression, health workers perform various forms of work to provide treatment, such as applying certain techniques, organizing time in a hectic day and sustaining the patient–health worker relationship (Gunn, Palmer et al. 2010). The last component, “reflexive monitoring”- comprises gathering information about the formal and informal appraisals of the benefits and costs of the intervention. Implementation of a complex intervention in the clinical setting does not occur in a linear fashion but rather occurs through the dynamic interplay and within the wider context of the interventions comprising organizational structures, social norms, group processes and conventions. There is constant interplay between these components, which are interwoven. In the writing of Paper three, it was a challenge to separate these components when analysing our data and identifying patterns. The advantage of NPT is that by exploring these components, we can show the various aspects of work done or not done when implementing ICBT into regular practice.

2.4 Method and method discussion

2.4.1 Interview

Qualitative research methods include a diversity of approaches such as interviews, observations, text analysis and use of visual media (Ryen 2002). The aim and focus that the researcher wishes to explore will determine the best approach. This is achieved by the researcher asking the question: “How may I gain access to knowledge about the focus?” If the main intention is to explore how things are acted out in practice, asking the person may not give an answer. It is not given that a person is always conscious about what he does in action. For example, it is likely that a woman working in the fish industry may find it difficult to explain how she removes scales from shrimps, but she could easily demonstrate this. If she has thoughts on the subject, it is not certain that they coincide with observed findings. First-hand information about what is actually acted out requires observation. On the other hand, if the intention is to explore what the person thinks she does or what she thinks about what she does, observation may not give trustworthy data. Only the person herself can elaborate on her own thoughts either in writing or orally. The advantage of communicating orally is the opportunity to make clarifications on the spot and thereby to avoid misunderstanding (Ricoeur 1976).

Deciding which method is most suitable depends on the issue(s) explored in the study and the context of the research (Ryen 2002, Kvale 2009, Maxwell 2013). If our aim were to explore what exactly was done when under treatment with MoodGYM, observation would be more suitable. For example, we could have followed GPs during their work to see how they used ICBT in their daily practice. Focus group interviews are a good way to obtain different opinions and to create a climate for a discussion (Kvale 2009). Focus group interviews could have been another alternative way to explore other aspects of implementation. The GPs from the course could have met regularly to evaluate and discuss their experience with MoodGYM. Focus group interviews would give less time with each participant, and thus the more in-depth narratives and reflections might have been lost in a group. NPT can be used to evaluate complex interventions in a clinical setting or as a tool to facilitate the implementation process. Hypothetically focus group interviews could with advantage have been combined with NPT in a prospective way to facilitate the work of implementation. For the patient study, we explored the experiences of treatment for depression from the patients’ point of view, which is

a very sensitive topic. To obtain honest descriptions of both the GPs' and patients' experiences, we considered that one-to-one and face-to-face interactions were most suitable.

With epistemology anchored within positivism one tries to find an objective truth through liberation from theology, feelings and opinions, often in a quantitative way (Johansson and Lynöe 2008). Hypothetically, we could have approached ICBT in a more quantitative manner using a survey. From the point of view of the motivation theory of Ryan and Deci (Deci and Ryan 2000, Ryan and Deci 2000), we could have used a deductive approach as a basis for a survey where possible intrinsic and extrinsic factors can be rated on a 1–10 scale. The patients could then rate these factors according to their perceived importance and whether they were considered to be part of their treatment. We could have measured those motivational factors that were considered to be most important and how often they appeared in this group. These results could be combined with the measures of the effects of the treatment to give a deeper understanding and to indicate coherence. By performing a survey like this, with the intention of measuring and counting motivational factors, we could have identified whether there were any relationships between various factors and the treatment results. The limitation of using such a survey is that the variables that the researcher wants to explore and takes for granted as true may be uninteresting for the participants. The use of online material in the treatment of depression is a new and undiscovered field in general practice and the variables that influence the adoption and success of this specific treatment are largely unknown. We chose not to use a highly structured interview such as a survey comprising pre-formulated variables in a questionnaire because it could prevent or inhibit the elaboration of new knowledge about this approach and the everyday life of the participants as experienced from their point of view

An in-depth interview is meant to open up the opportunity for elaboration and nuance. Interviews often comprise narratives, which convey how participants make sense of events and their participation in social life. By understanding we enable us to cope in the world and therefore interviews can give an important contribution to research (Kvale 2009). The aim of an interview is to understand more of the participants' attitudes and reflections. Interview knowledge is acquired first by structuring what the interview will explore; i.e., by creating an interview guide. Knowledge is then acquired through the social interaction between the interviewer and participants by determining what questions are to be asked, and how, and through the answers given. Finally, knowledge gained through the interview is restructured through transcription, analysis and reporting.

Maxwell (2013) argues that when performing qualitative research, the researcher is the research instrument and thus influences the entire process. We constantly tried to reflect on how we were instruments in the process and how we, as researchers, played an active role. For me, this meant being prepared to focus during the interviews and to learn from my experiences after the interviews were finished. I will now present some examples of my preparations. I chose to wear neutral clothes and minimal make-up during the interviews. I learned the interview guide by heart so the questions could come more naturally as part of the dialogue. I focused during the interviews by formulating open questions without appearing to judge and listened carefully to the participants. This was a challenge to me. I wanted the participants to feel that they were the experts on their own experience and I was the curious researcher who wanted to learn from them. I was conscious that my body language was important, and I tried to show that I was interested by keeping eye contact, leaning forward and so on. I used my own experiences to communicate and to try to understand the participants. I tried not to assume that participants shared my way of making meaning of the world. I think that it was an advantage that there were two interviewers because we could reflect together about ourselves as instruments and learn from each other in the process after each interview.

In both studies, we chose to use an interview guide to ensure that the main topics that we wanted to explore were brought up in the interview (see Appendix 1 and 2). Using a semi-structured interview, we ensured that the main topics were explored but still provided the opportunity for the patient to talk freely from the topic chosen. The main topics in the patient study were: a) the participants' experience with the ICBT programme, b) changes in the participants' everyday life during blended care (guided ICBT), and c) elements of motivation to persist with ICBT. The main topics in the GP study were: a) the GP's general views on their work with depressed patients, b) motivational aspects for learning to use ICBT, c) experiences implementing guided ICBT, and d) implications of the use of ICBT for consultation quality and patient–doctor interaction. These guides were revised several times in the beginning of the interview period as our insight increased to ensure that relevant topics were covered in the future interviews. However, in the interviews, we aimed for an open dialogue similar to a conversation. The guide was used more as a reminder than a script. In the patient study, we conducted a pilot interview before the first interview to try out the questions. As Maxwell recommends (2013), I articulated my immediate reflections after each interview, and these reflections often touched upon the relationships that I experienced with

the participants. These immediate reflections helped me to inform the analysing phase to grasp important aspects of the interview. It was also a way for me to reflect constantly on myself as a research instrument and on the awareness of my pre-understanding. The participants were not invited to give feedback at a later stage of the research process.

2.4.2 Location

Part of the preparation for an interview is finding a location. Choosing a location may also influence the communication in the interview. Ryen (2002) argues that it is positive to conduct the interview where the knowledge is made and to avoid “office chair” interviews. Conducting interviews in the participant’s home may be perceived as safe and relaxed, and may allow the participant to feel in control. When interviewing, the interviewer tries to grasp the participant’s experience. The goal is not to impose the researcher’s interpretation upon the participant. Being a curious and interested listener will help the important aspect of the participant’s own understanding to come to the surface. Trying to build trust and not to provoke are essential. Choosing the home as the location may strengthen the participant’s feeling of being the expert and thereby may allow us to obtain more complete information about the participant’s personal experiences. In the patient study the patients attended therapy in an office at the University of Tromsø, and conducting the interviews here was an alternative. If the interviews were conducted where the patients received their therapy, patients might feel that they were meeting us as advocates of the treatment mode. We felt that this could disturb the neutrality we were trying to establish and could inhibit the participants from opening up to elaborate on their more critical or negative perceptions. On the other hand, this location might enhance the feeling of confidentiality.

We chose to be flexible about both the time and location of the interviews. In the patient study, all participants preferred to meet at a co-researcher’s office at the University of Tromsø. This office had a comfortable chairs and a home-like atmosphere. It was on a completely different part of the campus from where the treatment had been given. To make it easier for the patients to find the office, I met the patients at the main entrance to our local hospital and walked with them to the office. The 5-minute walk to the office was a nice opportunity to tell them something about myself. I offered coffee or tea to make them feel welcome. This location worked well, and we found that a trustful dialogue was possible. In the GP study, the GPs chose their home, office or the University of Tromsø as the location. There was no big difference in the interviews in relation to where the interviews were

conducted. In all settings, the GPs served me coffee, and I felt that an informal atmosphere was established.

2.4.3 Sampling and participants

Who is asked will influence what the stories reveal. Finding a person with knowledge about the topic chosen is essential to achieve an informative interview. Silverman (2005) argues for purposive sampling in the selection because it illustrates the aim, features or processes that we are interested in. The characteristic of the participants interviewed for each study are described below. In both studies, the numbers of interviews were appropriate for the purpose. Still, our findings from both our studies should be interpreted as only a partial description of the full range of experiences with ICBT.

2.4.3.1 Patients interviewed

All patients in the RCT had been referred from primary care for symptoms of depression. Patients had to be aged 18–65 years and to have access to the Internet; those who were suicidal, psychotic or drug abusers were excluded (Hoifodt, Lillevoll et al. 2013). All patients in the intervention group of the RCT were given a debriefing session by their therapist after finishing treatment. After this session, they were given written information about our qualitative research and a written consent form. All arrangements for the interviews were made over the telephone. Among the patients who gave their consent initially, continuous recruitment was conducted. We changed to strategic recruitment after about 10 interviews to include men and women, both younger and older, and both completers and non-completers. Several non-completers refused to be interviewed. In total 14 patients were interviewed in the patient study.

Comparative information may lead to a deeper understanding of a phenomenon that a researcher aims to explore, such as, for example, going abroad also reveals information about our home country (Ryen 2002). Interviewing both those patients who dropped out of treatment and those who completed ICBT provided the basis for a deeper understanding of the patients' experiences. These two groups of patients can be considered as comparative, and interviewing patients from both groups would thereby strengthen our understanding of depressed patients receiving this treatment. It is a limitation that the recruitment of non-completers turned out to be difficult. The stories might have been more nuanced if both groups could have contributed more voices.

A purposive sample of participants is when the recruited participants have knowledge relevant to what the researcher wants to explore (Silverman 2005). One strength of the patient study was that patients were referred by their GP or by another health worker in primary care as a result of clinical evaluation. Thus, the patients were not self-selected for treatment. We wanted to explore their lived experience from guided treatment. It was important that they could be candidates for such treatment in an everyday clinical practice. They had the unique knowledge that we wanted to explore and were therefore a suitable purposive sample. On the other hand, these patients had agreed to join the RCT and to be interviewed. It is possible that these patients were more motivated and in some way, different from patients in an everyday clinical setting. ICBT can also be used as self-administered self-help or guided in ways other than face-to-face. It would be interesting to explore other types of support, but this was outside the scope of this thesis.

The patients were interviewed shortly after the treatment ended. The advantage was that they could easily remember their thoughts, reflections and events from their time during treatment. Nevertheless, the stories about helpful elements can explore only what was immediately helpful and not what was helpful over time.

2.4.3.2 GPs interviewed

Self-selected GPs, mostly from the northern parts of Norway, participated in the 3-day course mentioned above. A training package in guided ICBT using MoodGYM was presented during the course. All GPs returning to clinical practice gave their consent to participate in follow-up research on the treatment approach. To strengthen our analysis and to allow for comparisons, we included two additional GPs who had not completed the course. These two had only attended a 3-hour presentation of this treatment model given by one of the GPs who had attended the course. In total, a purposive sample (Silverman 2005) of 11 GPs was recruited. All arrangements for the interviews were made over the telephone. Participants were both men and women, of various ages and with various lengths of experience as a GP. There was an over-representation of women at the course and therefore the GPs interviewed are also over-represented by women. More male participants might have resulted in other stories. The GPs were self-selected, which may be a source of selection bias. The GP stories may have been different if the selection had been random. There is a chance that the GPs in our study were more interested in both mental care and online interventions than other GPs in general. Still, our aim was to explore aspects of the GPs' experiences as they intended to implement

ICBT into everyday clinical practice, and accordingly, motivated GPs had the knowledge that we were interested in. In addition to interviewing the GPs, the intention in the GP study was to interview patients who had gone through guided ICBT with their GP. One patient was interviewed. Recruitment of patients was difficult and therefore, this part of the GP study was stopped. With more resources and time it would be interesting to explore stories of patients from regular clinical setting in general practice in a future study.

2.4.4 Analysis

Analysis of the data starts during the interview, as mentioned above. The interviewer interprets the statements in the interview from what is said, the tone of voice, body language and pre-understanding (Malterud 2003, Maxwell 2013). Subsequent to each of my interviews, I recorded my immediate reflections about the interactions and interpretations. This was helpful for remembering the first impression of the interview as a whole. All the interviews were transcribed. The transcription in itself is an interpretation of the data. Therefore, researchers were encouraged to transcribe their own interviews (Kvale 2009). In the patient study, I transcribed all interviews that I conducted, but because of time constraints, Kjersti's interviews were transcribed by an extern assistant. In the GP study, the second author (RH) and I transcribed all the interviews ourselves. When transcribing, many choices are made such as interpreting unclear wording, punctuating and how to include para-linguistic expressions. After the oral interviews were transcribed to text, the transcriptions were checked several times by reading and listening concurrently. The written text was subsequently imported into NVivo software for further analysis.

The process of not only reporting what the participants said but also trying to understand what the stories and reflections mean has been challenging. Concurrent reading and re-reading of the interviews, analysis of the data and reading the existing literature were performed. A few central theories with their concepts were chosen to understand the findings better. These theories are presented in the Conceptual Framework section and were useful for trying to explain and understand motivation, helpfulness and implementation associated with the ICBT. We found that this improved the explanatory power. The following section explains the analysis of each study in detail.

2.4.4.1 Analysis of the patient study

The methodology used to analyse the data from the patient study was based on the phenomenological–hermeneutical method presented by Lindseth and Norberg (2004). The epistemology that this methodology is based on is presented in the Conceptual Framework section. Following this approach, the interviews are transcribed into text and analysed in a hermeneutical stepwise manner. Three steps guide the researcher to interpret the essence of the lived experience underpinning the stories and reflections that the participants tell. We wanted to investigate the essence of the phenomena of motivation and helpfulness experienced by patients during treatment with guided ICBT. The first phase of this approach is “naïve reading”. The text is read several times to grasp the meaning of the text as a whole then a formulation of this understanding is made. We read all of the interviews several times and created a text for each interview that contained what we interpreted as the most important aspects of the interview.

The second phase is a structural analysis, which is described as a structural thematic analysis through which one seeks to identify and formulate themes. A theme captures a thread of meaning of lived experience. Initially, the entire text is divided into meaning units. In our analysis, a meaning unit was a text section that captured an event, thought or reflection that we saw as relevant to the participant’s experience with depression and/or ICBT. These units were later condensed and each formulated condensed section was then coded. In this phase, we made a table in “Word” with two columns. In the column to the left, the meaning units from the interviews were placed in their original order. In the column to the right, we wrote the condensed meaning. The final table for each interview was then imported into NVivo and the condensed sections were then coded.

The third phase was creating a comprehensive understanding. In this phase, the themes and sub-themes are summarized and reflected on in relation to the research question and the context of the study. With this methodology it is also recommended to deepen the understanding of the interviews by exploring them in light of existing literature. The results should be written in everyday language. In a recursive manner, moving backward and forward, we discussed the overarching themes and sub-themes in relation to the naïve understanding, the research question and the text as a whole. The basis of our analysis was inductive; i.e., the themes were closely related to the data. However, we also critically interpreted our findings in light of SDT in the final phase to give depth to our understanding

and to help us to explain many of our interpretations. Finally, these results were discussed in light of the existing literature on the field of eHealth. The end-points of this analysis are presented as Papers one and two.

2.4.4.2 Analysis of the GP study

The basis for the analysis of the data from the GP study was a method called thematic analysis. This is a theory that celebrates the active role that the researcher takes when identifying patterns, selecting what is of interest and reporting it to the reader. As mentioned in the Conceptual Framework section, it is important to state explicitly the choices made in the process of this flexible approach. However, the method also provides a step-by-step guide for conducting this thematic analysis. Many of the steps align with Lindseth and Norberg's (2004) steps of analysis used in the patient study, although others were slightly different.

The steps comprise six phases of analysis with the end-point of identifying and interpreting the meaning of patterns within and across the dataset (Braun and Clarke2006). In the GP study these phases were followed as recommended and were not conducted in a linear fashion, but rather through a recursive process of moving backward and forward.

1) "Familiarizing yourself with your data". This first phase started with transcribing all of the interviews and thus to form an overview of the interviews. This was followed by reading all of the transcripts while listening to the original audio recordings and noting down thoughts. Next, the transcripts were re-read in an active way, and more ideas were noted.

2) "Generating initial codes". In this phase, we imported transcripts to NVivo 10. The entire dataset (all text from the interviews) was coded and some parts were coded several times. The coded text was identified in relation to semantic content in an inductive way. Thoughts, reflections and events expressed by the GPs were coded.

3) "Searching for themes". The relevant codes are gathered to create potential themes. A theme is defined as something important that captures a patterned response or meaning within the data set in relation to the research question. There should be a distinction between the themes and a meaningful coherence within a theme (Braun and Clarke2006). Potential themes that we saw in relation to the GPs' experience of implementing ICBT were discussed among the research group and potential themes were created.

4) “Reviewing themes”. In this phase, we re-read and checked whether the themes worked in relation to the coded extracts and the interviews as a whole.

5) “Defining and naming themes”. This phase is meant to identify the “essence” of what each theme is about. In this phase, we organized the overarching themes and linked the analysis to the theories in the field that we found relevant. The use of mind maps was helpful in this process. Thirty or more mind maps were made to test and visualize how I understood “what was going on” by making a simplified picture of a part of the complex data.

6) “Producing the report”. We created a rich thematic presentation meaning that we analysed and presented major parts of the dataset to give the reader a sense of what we identified and interpreted as the predominant and important themes relating to the aspects of implementation. Quotations to illustrate the findings were included in the paper. The analysis is an interpretation of a thematic story-line. The framework of NPT improved our understanding of our findings in the final phase and helped us to find coherence within the story-line and to anchor the analytical claims. This gave our interpretations explanatory strength. Finally, these results were discussed in light of other existing literature. The end-point of this analysis was presented in Paper three.

2.5 Validity

Validity refers to the relationship between research and reality or, as Maxwell (2013) encourages researchers to ask themselves, “How might you be wrong?” Kvale (2009) discusses three types of validity: validity of craftsmanship, communicative validity and pragmatic validity.

Validity of craftsmanship is about being a trustworthy and good researcher; conducting methods in a structural way and having the necessary qualifications and knowledge in the field. This type of validity is about making good decisions throughout the entire research process (Kvale 2009). In our two studies, we investigated thoughts, reflections and events related to the patients’ treatment using ICBT or implementing ICBT. Thus, we argue that in-depth interviews were the right approach for accessing valid information about this matter. We chose to interview participants about their lived experience with the matter of interest (ICBT) to access their nuanced stories.

Kvale (2009) notes that interview studies are sometimes criticized because it can be questioned whether one can know whether a participant is telling the “truth”. One must

assume that narratives recreate the experience. However, an obvious difficulty concerning the validity of narratives is whether they are communicating things that actually happened. After all, a story is a rhetorical structure that is made to persuade or provide a perspective about what happened. The stories told are fashioned with a peculiar audience in mind as well as with an attempt to structure an experience. A position in anthropology takes this into account and presumes that the narrative derives its power by transforming and disorienting the lived life. To enhance the meaning of an experience for a person, this transformation and disorientation needs to be included (Mattingly 1998). As I understand this theory, the limitation of a narrative is that it may not reveal what really happened in the participants' life, but instead we grasp information about the person's own version of the situation and what the person considers to be true. In our studies, it was the participants' interpretation and what they perceived as important that were communicated, and this was what we wanted to investigate.

In both studies, a thematic approach guided our analysis to ensure a structural approach and to ensure that the themes identified were consistent with the stories from the interviews. We made a substantial effort to read the existing literature within the field to improve our theoretical understanding and thus to improve our ability to interpret our findings. To ensure quality in gathering, analysing and interpreting the data, it was important to work and constantly discuss our decisions within a multidisciplinary research group. Our different backgrounds ensured a diversity of qualifications and knowledge in the field. Working in a group helps one avoid becoming "blind" to alternative explanations (Malterud 2003). Here, I have presented some aspects showing the validity of my craftsmanship as a researcher and how this has produced valid research. This is also reflected in the arguments in all parts of this thesis; i.e., the background, methods, results and discussion reflect my deliberate and knowledge-based choices and conclusions.

The second criterion of validity is communicative validity. Valid communication is needed both in the interview setting and when communicating the final report. Our intention in the interviews was to explore information about the experience with ICBT from the participants' perspective. As mentioned above, the interviewers in both studies were young female health workers who were also involved in other roles conducting research on MoodGYM. This background influenced us as researchers, but it may also have influenced the data obtained and thereby the result of the studies (Ryen 2002, Malterud 2003). The advantage of having health workers as interviewers is the openness that patients often give immediately. I always

find it astonishing how patients whom I never have met before will, after only a few seconds, reveal their innermost secrets. In many non-professional relationships, it can take years of friendship before a person talks about such private matters. One disadvantage of us being health workers was that we may have been seen as part of the health system and therefore as defenders of MoodGYM. Another aspect of being a health worker that conducts an interview, is that there is an imbalance of power in relation to the patient being interviewed (Stige, Malterud et al. 2009). As a result, the threshold for a patient to be critical or negative towards ICBT could be high, which could interfere with patients sharing trustworthy information about their experience. There is also a chance that the patients could tell stories that are too sensitive if they see us as health workers and forget that we are researchers. To reduce the possibility of gaining too sensitive or overly positive stories, we made it clear before each interview that we were not there to defend the treatment. We made it clear that we were talking with them as researchers and that our aim was to understand their experiences better.

It is a challenge to understand the interpretation of the experiences that the participants talked about. One method of validation is to negotiate within the interview setting the meaning of what the participant aims to convey. The interpretation is also validated using common sense and through critical discussion in light of the existing literature and theory (Kvale 2009). To validate our interpretation in the interview setting, we asked clarifying questions and tried to sum up what the participants had said and thus allow them to make corrections. As mentioned in the sections above, a critical analysis and a theoretical framework were essential for validating our final interpretation. By exploring our findings in light of the existing literature, we could investigate connections that could support or challenge our arguments. If our findings were in total contrast to previous findings, we would have to ask ourselves, “Might we be wrong?” Finally, we have written our papers in a way that communicates the important aspects of our knowledge such that they are understandable to our readers.

The third validity criterion is pragmatic validity. Research has pragmatic validity when the interpretation and understanding can be used in some way (Kvale 2009). Hopefully, the suggestions that we present in these papers will be of use to both researchers developing and exploring internet-based interventions and health workers in clinical practice who are curious about supplementing treatment with online material in Norway. These papers also aim to add to the discussion globally.

An extension of pragmatic validity is generalizability. Kvale (2009) argues that the results do not need to be generalizable but may be transferable to other relevant situations. Ryen (2002) argued that an exploration of change can, in a good way, be explored qualitatively and that an analysis of information from a few subjects may be transferable to others in a similar situation. Although the sample size was appropriate for the needs of the two studies and we have obtained a deeper understanding of these participants' perspectives, our findings should be interpreted as only a partial description of the full range of patients' and GPs' experiences with ICBT. Each reader must evaluate whether the situation is relevant and whether the results can be transferred. Nevertheless, it is likely that the overall results from the three articles can be transferred to other primary care settings in Norway and perhaps across borders. As an extension of the results, we have also made some practical suggestions, which we argue could improve the motivation of patients and elements of training that may enhance the GP's recommendation of ICBT.

2.6 Ethical considerations

There are ethical issues involved in any study of individuals. We have followed the ethical guidelines for medical research in the Helsinki Declaration. Ethical approval was given by the Regional Ethical Committee, Tromsø (2011/2163).

Written informed consent was obtained from all participants before the interview. In the patient study, the patients had participated in the RCT and had therefore received free treatment. This could make them feel obligated to agree to be interviewed. In qualitative health research that explores experience of treatment, the interview itself can have a preventive or therapeutic effect on the patient's condition. In the patient study, I felt that I was to some extent exploiting the participants because I normally work as a GP. I was used to helping patients in our encounters. As a researcher, I received my data, but I asked, "What did the patients receive?" The participants in this study were patients who were struggling, or had struggled, with depression. When struggling with depression, a person can be vulnerable. Reduced concentration and impaired initiative are cardinal symptoms of depression (Kringlen, Øgar et al.2008).

In the interview setting of the patient study, the patients openly talked about very intimate and delicate episodes from their lives. They discussed how they had struggled with work, had personal relationship problems, had trouble sleeping and experienced sorrow. They provided insights into their darkest periods, details that they might not even tell their friends. They gave

so much of themselves. It is possible that the patients wanted to participate to ventilate their thoughts about their experiences. Alternatively, they may have wished to improve treatment and thus the driving force could have been to help others in a similar situation. It is also possible that during their “dark” periods, using their energy on an interview to contribute to research became a burden for them. However, our impression was that the burden was minimal. There is a risk that the integrity of participants can be violated when private information is exposed. To minimize the chance of such violation, the encounter must be respectful. A respectful approach includes normal politeness, awareness of body language and being receptive to possible reservations of the participants (Kvale 2009). It was important for us not to pressure the patients to expose more than they wanted to share. Of course, the integrity of the participants was also sustained in the communication of our findings.

Norway is a small country, and many of the GPs in the GP study knew of me or the project leader (Nils Kolstrup) because we are both GPs. Knowing either of us could have seemed like a source of pressure to agree to an interview. In the GP study, the topic for the interviews was less sensitive compared with the patient study, but a respectful approach was also maintained. We chose to give a gift voucher to the participants (1000 kr) in exchange for approximately one hour of their time to reduce the burden of using their professional time. This is often done to recruit GPs who have a very hectic workday and are often asked to participate in research. Not wasting or exploiting time or effort is an ethical consideration. Therefore, the relevance of a study must always be considered carefully in terms of the scientific outcomes and the opportunity to improve the human situation (Kvale 2009). We hope that both studies will contribute to scientific knowledge in the field of eHealth. Our contribution has increased our understanding of the participants and, hopefully, will contribute to the discussion about ways to improve treatment of depression in general practice.

Confidentiality must always be considered when conducting interview research (Malterud 2003, Kvale 2009). This was an ethical consideration in both studies. In the GP study not only the GPs who told the stories, but also the patients they spoke about needed to preserve their anonymity. In both studies recordings of the interviews were stored safely. When the interviews were transcribed names were removed from the documents and a number was given to enable us to link them to the recordings. Sometimes, details of people in the stories or the context were changed slightly to ensure confidentiality.

3 General discussion

3.1 Principal findings

In this thesis, I have addressed the gaps in the evidence from multiple trials that have found that guided ICBT can reduce the symptoms of depression (e.g., (Spek, Cuijpers et al. 2008, Andersson and Cuijpers 2009, Johansson and Andersson 2012, Hoifodt, Lillevoll et al. 2013)) and the lack of knowledge about how the patients being treated and the GPs treating patients experience different aspects of guided ICBT. To explore guided ICBT used in the context of general practice, we aimed to explore the patients' perceptions about their motivation to use ICBT and how it was found helpful to them with brief follow-up consultations. We also wanted to understand more about the GPs' perspective of the processes and work required to implement ICBT in the everyday clinical setting. Hopefully, this knowledge will contribute to improving the treatment of depression in general practice.

3.1.1 Patient study

The phenomenological–hermeneutical approach identified two overarching themes in the interviews of the 14 patients that explored their experience with ICBT. One theme related to the aspects perceived as influencing their motivation to persist in treatment, and the other theme related to the meaning of what the patients found to be helpful in this mode of treatment.

In paper one aspects of motivation are explored. The patients had an intrinsic motivation to seek treatment for their depression that was related to the hope of recovery and wanting to gain control of their lives. To be able to choose how, when and where to complete the ICBT modules satisfied their need for autonomy and was identified as a condition supporting their motivation. Not to be alone, but to have a sense of belonging towards partners, friends or family was essential to strengthening their motivation towards wanting to recover. An ability to identify themselves with and to relate the theory and examples given in the online modules in MoodGYM to their personal context and problems in everyday life was essential to wanting to continue working with the material. The connection with the qualified therapist in the face-to-face consultation was established when they received acknowledgement of their problems from the therapist and perceived a flexible approach. This connectedness was also identified as a condition supporting their motivation. Overall, the findings in a framework of SDT (Deci and Ryan 2000, Ryan and Deci 2000) indicated that a sense of relatedness,

understood as identification, belonging and connectedness, could strengthen their motivation to persist with this mode of treatment.

We identified five themes related to helpfulness presented in paper two. In light of Wampold's (2001) conceptual model both general aspects and specific aspects were identified and discussed. General aspects of treatment were perceived as helpful. The patients found it helpful to take action to address their problems. It was of value to the patients to be able to ventilate about their problems to a competent professional who was engaged in their treatment. Two aspects were identified as helpful when the patients reflected on aspects related to the specific elements of the guided self-help using MoodGYM. Acquiring new and relevant knowledge was perceived as positive and being able to restructure this knowledge was often necessary. The treatment was also considered to be helpful when the patients were able to make actual changes in their perceptions and interactions in relation to either the self-help material or the face-to-face consultations. Paper two discusses this in more detail.

3.1.2 GP study

In 11 interviews, we explored GPs' perspectives on implementing ICBT into general practice (Paper three). Using a thematic analysis, we identified that the GPs acknowledged ICBT as a credible tool that was based on a theory that they trusted. They expressed engagement in learning about the programme and implementing it into general practice. Their belief in ICBT was strengthened by the training in ICBT. GPs hoped that ICBT could benefit patients by improving their treatment of depression and by empowering the patients with regard to their own health. They also hoped that ICBT could benefit the GPs themselves by increasing their work satisfaction. The motivating aspects were that the ICBT added structure and an agenda to treatment. GPs discussed their hectic and varied practices, which constrained their ability to implement ICBT. They identified as challenges a lack of confidence, reluctance to change their habits and concerns about negative impact on interaction with their patients. Mere recommendation of the online intervention was integrated into their practice and they did not provide module follow-ups as part of their treatment. When interpreting these findings in the framework of NPT (May and Finch 2009, Murray, Treweek et al. 2010) the components of "work" to implement recommendation of MoodGYM was undertaken, but to varying degrees. This was not the case for module follow-ups. Instead, they returned to standard treatment after recommending MoodGYM. GPs described the standard treatment of depression as unstructured and, at times, frustrating, while also comprising the most important elements for

the treatment of depression. They aimed to include active listening and acknowledging patients' problems in their standard treatment. Paper three discusses this in more detail.

3.2 Discussion in light of the existing literature

3.2.1 To add theory

Substantial evidence supports the value of psychotherapy as a treatment for depression, but there is a debate about which aspects of treatment lead to improvement (Wampold 2001, Ebmeier, Donaghey et al. 2006). The focus of this thesis is not to identify the elements in the explored treatment that resulted in improvement, but rather it explores how patients and GPs, with a common goal of improving the patient's life, give meaning to their experience with ICBT in terms of motivation, helpfulness and implementation. A pattern seen in both of the studies, of experience with ICBT combined with brief consultations, is the value of adding structure to the treatment of depression. This structure comprised specific elements such as the principles of CBT and online interactive material. A previous qualitative study that included interviews of Norwegian GPs highlighted the lack of tools to use in mental health treatment (Mykletun, Knudsen et al. 2010). The GPs in our GP study made sense of, and engaged in, MoodGYM. This suggests that MoodGYM may provide a specific tool for the treatment of depression. Making sense and engagement are important parts of the work needed to implement complex interventions into everyday practice (May and Finch 2009, Murray, Treweek et al. 2010). Our findings in the GP study indicate that information about the programme conveyed in the 3-day course gave them confidence, strengthened their engagement and encouraged them to recommend the online programme in their clinical practice. These findings are consistent with those of a previous study that found that having more information about the effectiveness of online programmes and training would increase the use of internet-based treatment of depression (Gun, Titov et al. 2011).

Mohr suggests that the rationale of "what, why, when and how" must be defined in depth to enable the development of implementable technical interventions to change behaviour (Mohr, Schueller et al. 2014). We argue that obtaining information about such rationale and evidence helps the clinician to incorporate a technically based treatment approach into the clinical setting. From our findings in the GP study we argue that if a clinician obtains information about such rationale and evidence, this can help to facilitate implementation of a technical-based treatment approach into a clinical setting. The GPs noted that knowing about theory-based material and having access to a structured concrete programme was beneficial to their

ability to recommend such as programme. The use of evidence-based psychological interventions is enhanced when health workers learn both the techniques and the underlying theories (Reese, Rosenfield et al. 2013). However, an evidence-based programme based on theory was not the only important aspect of their experience with ICBT. Both the GPs and patients emphasized that for guided ICBT to be valuable, the patients needed to relate the treatment to their personal context. An important aspect that facilitated this was through the development of a trusting patient–health worker relationship that allowed the patients to open up about their problems in life, created a dialogue that communicated hope or faith in improving the situation and gave patients ownership of their treatment.

3.2.2 To make treatment personal for each patient

The studies identified as especially important the ability to relate the treatment to each patient’s personal context and to support each patient’s motivation to persist with treatment (see Paper one). This implies the psychological need for relatedness in support of the intrinsic motivation (Deci and Ryan 2000, Ryan and Deci 2000). Not objectifying the patient, but tailoring and adjusting treatment to the patient as a unique person in the personal context, can be understood as a confirmation of the importance of a patient-centred approach. To view the patient as a person with personal health needs rather than as a condition is considered to be essential in general practice (Reeve, Dowrick et al. 2013). A large study (Palmer, Gunn et al. 2010) explored what is important and preferred as part of the treatment of depression in general practice according to community stakeholders (government, health sector and academia) and patients. The authors found a pattern in the responses that highlighted the need to incorporate the complexity of patients’ experiences and the multifactorial nature of care in the treatment of depression instead of aiming for a “one-size-fits-all” approach. Three main domains were identified as essential to providing the best treatment of depression, and important tasks were mapped out within each domain. These tasks were seen as interwoven and not as separate tasks. The relational domain, which included the tasks of “listening, understanding and empathy”, is strongly connected to a “competence domain”. The competence domain provides the GP with appropriate training and education. The third domain was the “system domain”, in which the lack of time is the main barrier. The important task of “holistic assessment and tailored treatment for individuals” requires a system with enough time. In another study (Gask, Rogers et al. 2003), a group of patients undergoing treatment for depression in general practice said that it is important to be listened to and to have more time in consultations. Palmer et al. (Palmer, Gunn et al. 2010) note that their

findings strongly emphasize the relational domain such as listening. This finding contrasts with the current focus within health care systems and evidence-based medicine on implementation of technical and mechanical aspects of competent care for depression. These domains should not be seen as a dichotomy because both domains are equally important. However, relational tasks are more difficult to measure and therefore may need extra attention and demand an organizational context that provides enough time to focus on such tasks.

3.2.3 The doctor–patient relationship

Both studies identified an engagement with the patient as a unique person as positive. The findings indicated that engagement was facilitated by a good doctor/therapist–patient relationship. Qualitative studies of the patients’ experience with ICBT without face-to-face consultations have found a need for more support (Gerhards, Abma et al. 2011, Donkin and Glozier 2012), indicating that the patients felt that they lacked human contact. WHO and WONCA have also suggested that a trusting relationship is fundamental in the treatment of depression in primary care (WHO, Colleges et al. 2008). A systematic review (Di Blasi, Harkness et al. 2001) of the doctor–patient relationship shows that a good relationship significantly influences health outcomes. The relationship is considered to be good when the combination of cognitive care and emotional care is given. Cognitive care is described as giving clear diagnoses and positive expectations. Emotional care is given by being warm and friendly or firm and reassuring. “Practitioners who attempted to form a warm and friendly relationship with their patients and reassured them that they would soon be better, were found to be more effective than practitioners who kept their consultations impersonal, formal or uncertain”. This indicates that the relationship itself has a therapeutic effect.

Reeve and Dowrick et al. (2013) claim that to ensure the quality of primary care in a context dominated by evidence-based medicine, the core role of the GP is to give care based on an understanding of the personal experiences of health that need to be enhanced. In our GP study, the GPs endorsed the need to add structure and a theory base to treatment. They experienced work satisfaction when they had something concrete to offer, which suggests that they liked having control during the consultation. Barry et al. (Barry, Stevenson et al. 2001) suggest that physical problems can be solved in an acceptable way using a formal manner with the GP in control, but psychological problems are firmly rooted in the everyday context and thus need a different approach. The study shows that both patients and doctors are more satisfied when the patient story, called the “voice of the lifeworld”, is the starting point for approaching psychological issues. The GPs in our GP study returned to their standard

treatment after recommending MoodGYM. They aimed to include active listening to allow the patients to talk about their problems in everyday life. This may imply using an approach of the “voice of the lifeworld” in standard treatment. Perhaps this choice is influenced by expectations of the patients. Previous research that has explored the treatment of depression in general practice emphasizes that both the GP and patient are equally important in facilitating their engagement in the treatment (Gask, Rogers et al. 2003).

3.2.4 Common factors of psychotherapy

The GP study identified a paradox. The GPs expressed a need to improve their competence and therefore wanted to supplement treatment with a theory-based online intervention. On the other hand, they also noted that elements of standard treatment are most important in the treatment of depression, despite the fact that they devalued this treatment approach and described it sometimes as frustrating. As noted in the study by Gunn and Palmer (2010), the GPs and patients tell stories that imply the importance of the health worker’s competence. I have argued earlier in this thesis that standard treatment opens up for the “the voice of the lifeworld” to ensure the application of what is known as “patient-centred medicine”. Patient centred medicine is often highlighted as a core task in enabling good care in general practice (WHO, Colleges et al.2008). This raises the question: “How does a GP give good patient-centred medicine as part of the treatment of depression?” The GP study showed that use of standard treatment clearly does not lead to work satisfaction, a finding that was consistent with that of another study of GPs’ perspectives on mental care in Norway (Mykletun, Knudsen et al.2010). Davidsen (2008) report that Danish GPs give “talking therapy” when treating patients with mental issues. This treatment comprises therapeutic elements, but lacks theory and is therefore difficult to learn.

One way to explore how to provide improved treatment of depression is to discuss the aspects in a contextual model. Wampold reviews (2001) a substantial amount of evidence on psychotherapy (e.g., trials and meta-analyses) and argues that the medical model, in which the only emphasis is on documenting the effect of the specific factors in the treatment, is wrong (see Figure 2: Medical models in medicine and in psychotherapy (Wampold2001)). He presents the contextual model in which he claims that the specific factors work as a necessary framework, which can be exchanged with other specific factors. The common shared factors that are shared within all psychotherapies have documented effects and cannot be exchanged. One of the common factors is the “client characteristic”; i.e., a person actively seeking help and having faith or hope in the treatment. The patient study identified the patient as an active

agent as important to both motivation and helpfulness. The GP study identified that patient motivation and initiative were essential for success when implementing guided ICBT into regular care. Our findings are consistent with this theory that patients' hope or motivation can be strengthened by both a trusting relationship based on alliance and engagement that reflect the common factor of "relationship elements" and that the "therapist qualities" comprising warmth and acknowledgement enhance a sense of helpfulness.

Both the patient and GP studies showed that providing an opening for self-disclosure or ventilation of thoughts and feelings and a rationale for treatment, which can be categorized under the shared factor "change processes", were important in the treatment of depression. The fifth shared common factor is "treatment structures", which is defined as adherence to theory and use of techniques or the need to include specific factors. In the GP study, the GPs were clear that having a theory base to treatment was important for work satisfaction and for improving the treatment given. ICBT made sense to the GPs and was compatible with what they acknowledged as credible. The positive aspects were structure and agenda when communicating with the patients, which align with this common factor (Wampold 2001).

It is well known that the step from evidence-based medicine to changing treatment in day-to-day practice is complex and takes time (Norman 1999). Embedding follow-ups of internet-based interventions or mobile apps is novel and challenging in general practice. As for all interventions given by GPs, it is important to find strategies to integrate them into patient-centred medicine. Our findings indicate that the integration of guided ICBT into treatment of depression requires that the GPs combine ICBT with engagement in the patient and allowing the patient to open up about his/her lifeworld. I suggest that GP training in internet-based interventions could be divided into two parts. In the first part, the theory-base of the specific aspects should be communicated clearly. This would allow the GPs to feel comfortable and confident to talk about the theory in a general way and to link theory back to the patients' stories as a starting point. The rationale for a framework of specific factors such as CBT in treatment should be made clear and should therefore support the common factor of "treatment structures". The second part should emphasize the value of the common factors in psychotherapy and highlight that these align with many elements of the treatment they currently give. The GPs might feel more confident and skilled if they knew that this part of treatment also is evidenced based but is not so easy to measure.

One recent paper from Sweden compared treatment-as-usual in primary care given by GPs and nurses with ICBT with minimal contact follow-ups given by licensed psychologists. This

study found no differences in outcomes of the symptoms of depression after 3 months and concluded that ICBT may be delivered successfully in primary care (Kivi, Eriksson et al. 2014). This study can clearly also be viewed as evidence supporting the treatment GPs currently give. Research has concluded that there is a need to improve the theory base of the treatment given in general practice (Davidsen 2008, Mykletun, Knudsen et al. 2010); this idea was also expressed by the GPs and patients in our two studies. Nevertheless, our findings indicate strongly that a formal and manual driven use of guided ICBT is not preferred by patients or GPs. I think it is important that internet interventions are not seen as a substitute for the treatment currently given, instead as an extension of the GP as a therapist. A flexible use of the programmes that incorporates an understanding of the complexities of the treatment of depression may be a better solution. eHealth and ICBT are novel treatment modes for both patients and GPs. More research is needed to explore whether this approach is acceptable and effective in the treatment of depression in primary care. However, competences in theories are not enough to implement new treatment into regular care.

3.2.5 More than just to add knowledge of the treatment approach

One of the major challenges to providing good quality treatment for mental disorders in Norway is to improve competence among GPs in treatment options besides psychotropic drugs (Mykletun, Knudsen et al. 2009). However, competence was just one of many aspects highlighted in the GP study. A meta-analysis of studies that explored the implementation of care for depression found that merely giving GPs training did not improve treatment (Sikorski, Luppá et al. 2012). Other studies have also found it difficult to implement specific methods successfully to improve the treatment of depression in primary care (e.g., (Huibers, Beurskens et al. 2003, Davidsen 2008, Aschim, Lundevall et al. 2011, Hermens, Muntingh et al. 2014)). The qualitative studies imply that it is not only lack of knowledge but also a complex process in which the relational aspects and organizational aspects are important (Aschim, Lundevall et al. 2011, Hermens, Muntingh et al. 2014). This indicates that it is not only “what” we implement but also “how” we implement interventions that matters. NPT claims that complex processes are needed to implement complex interventions. NPT suggests four main components of “work” required to implement interventions: coherence (make sense), cognitive participation (engagement), collective action (efforts) and reflexive monitoring (feedback) (May and Finch 2009, Murray, Treweek et al. 2010). Based on the NPT framework in the GP study, our findings indicate that the “work” of module follow-ups was

problematic in the entire process of implementation. Ultimately, GPs did not make the effort to talk about the process issues associated with MoodGYM in the follow-ups.

Treatment of depression is not something that the GP delivers to the patient; rather, it is done through interactions with the patient. The GP study found that the relational aspect is important when choosing not to include module follow-ups. However, perhaps in a few years, the patients may be more used to talking to a health professional about information gained from the Internet and may then not see this as a barrier to making it personal. Perhaps it needs to mature as an option for people in general. The organizational aspects can promote or inhibit the GP's making an effort to implement treatment (May and Finch 2009, Murray, Treweek et al. 2010). The GP study found that lack of time for preparation and during consultations was problematic. Organizing time and financial training were indicated as important for enabling a change in the treatment of depression. Having enough time within the organization and incitements for this treatment may enhance use. Lack of competence was found to be frustrating, although improving competence may not remove all of the frustration. A qualitative study exploring work with patients' feelings of despair and hopelessness, which are often part of depression, found that even therapists qualified in psychotherapy experience feelings of vulnerability and frustration in their encounters with these patients (Gee and Loewenthal 2013). It is possible that improving the GPs' competence could make them more comfortable when dealing with hopelessness and depression.

The incomplete implementation noted in the GP study could be interpreted as suggesting that GPs should not deliver treatment for depression. A review of the literature on the treatment of depression treatment in general practice reports that the research focus has shifted to preferring mental health specialists within the primary care setting (Sikorski, Luppá et al. 2012). More collaboration with other mental health specialist in primary care could be an alternative for primary care in the Norwegian context and might provide a solution to implementation barriers of internet interventions in primary care. The current situation in Norway is that GPs treat most mental health issues; thus, such a transition would demand great systemic changes. We argue that GPs are in a unique position to provide the first step in the treatment of depression. They can offer holistic treatment and give patients the opportunity to open up and talk about how depression is triggered by stressful events (Kringlen, Øgar et al. 2008), including the onset of physical and chronic disease often presented in general practice. GPs can help to explore how it feels when depression is part of the patient as a person (Gask, Rogers et al. 2003, Kayali and Iqbal 2013) as they get to know

the person over time. However, there is without doubt room for improvement. Better mental health care in general practice would benefit the GPs' work satisfaction and would provide affordable, available and good treatment to the patients compared to referral to specialized care.

4 Conclusion and future perspectives

Strengthening the treatment of depression in primary care is emphasized globally. The role of GPs is considered to be central in the treatment of depression because of the great burden of depression and the unmet demand for treatment (WHO, Colleges et al.2008, Mykletun, Knudsen et al. 2009). To implement evidence-based psychological interventions by teaching both the techniques and underlying theories will help to improve treatment (Reese, Rosenfield et al. 2013). Our findings imply that training in specific factors relevant to an approach based on a psychological theory is warranted and will have a positive effect on implementation. Both the GPs and patients endorsed ICBT because the online material comprises self-help procedures that can supplement the treatment of depression and give patients ownership of their treatment. However, a number of concerns and paradoxes were identified when exploring experience with ICBT.

In paper two, from the patient study, we conclude that both specific and general aspects of guided ICBT were considered helpful. In extension of the results, in paper one and three, we have made some practical suggestions that may improve the use of ICBT. I argue that these suggestions can contribute to the discussion about how to improve treatment of depression in general when initiated by a GP. In Paper one we suggest four steps to consider during encounters with patients with depression to increase their motivation: 1) communicating hope by educating patients about the effectiveness of ICBT and the good prognosis for depression, 2) encouraging patients to enlist the support of important others in their progress towards recovery, 3) communicating that the therapist has adequate competence and can give qualified feedback and 4) focusing on acknowledgement, flexibility and understanding in the meetings with the patient. This may increase a feeling of connectedness and autonomy. In Paper three from the GP study, we suggest that three aspects should be emphasized when offering training to encourage GPs to recommend ICBT: 1) ICBT is theory based and credible, 2) ICBT increases the GP's work satisfaction by providing a tool to offer the depressed patient and 3) ICBT facilitates empowerment of patients for their own health.

Among the common shared factors of psychotherapy (Wampold 2001) the relational element; alliance and engagement with the therapist and change process; for the patient to be able to ventilate problems, were indicated as helpful in the patient study. Relational aspects of treatment were also reflected in the unstructured aspects of standard treatment described, which were seen as both frustrating and helpful by the GPs in the GP study. Perhaps learning about the underlying theories of the common shared factors from psychotherapy could inform

this part of treatment. Increased understanding of how specific aspects and common factors of psychological treatment supplement each other could improve the treatment of depression in primary care in Norway. Overall, I argue that a flexible approach, in which GPs recommend self-help while continuing with a main focus on common shared factors of psychotherapy in the follow-ups, could be positive. GPs could blend standard treatment with a recommendation for internet interventions; a blended format. Under this approach, the GPs could use the patient's lifeworld as a starting point in the dialogue. The patient will therefore set the agenda. The GP will link back to the specific factors of the theory-based approach only when it is suitable. This would add valuable structure to the treatment of depression and could be used to make minor adjustments to standard treatment follow-ups. This would benefit both the patients and the GPs. More research is needed to explore whether ICBT positively supplements treatment of depression in general practice and to monitor the different dimensions of the quality of such treatment.

5 References

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