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No Appointment Necessary: Treating Mental Illness Outside the Therapist’s Office

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Abstract
The majority of individuals struggling with a mental illness do not receive treatment, and given the extremely high prevalence of mental illness and the many barriers to seeking treatment (e.g., cost, local access, stigma), it is evident that face-to-face therapy cannot get close to meeting the enormous need. Thus, the field of psychotherapy has undergone some amazing transformations over the past 25 years, including the emergence of a class of efficacious interventions designed to reduce symptoms of mental illness that do not involve any face-to-face therapist contact. eHealth interventions that deliver psychological services or training programs via computer or other technologies may help reduce the burden of mental illness by using approaches that have the potential for cost-effective and widespread dissemination. In this article, both the many unresolved questions about how to develop and deliver eHealth interventions and their potential to help respond to the large unmet treatment need are highlighted.

Keywords
therapy, mental health, eHealth, technology

Twenty-five years ago, it was generally assumed that the therapist relationship and face-to-face talk therapy were necessary elements of a successful (nonmedicinal) treatment for mental illness. This idea had been made explicit back in the 1950s when Carl Rogers famously stated that two people being in psychological contact was one of the mandatory ingredients for psychotherapeutic change, and that change could only ensue if the client felt personally understood by the therapist (Rogers, 1957/1992). Even as late as 1997, Aaron T. Beck described “verbal mediation” in therapy as an essential ingredient for any effective anxiety therapy (Beck & Clark, 1997). Indeed, talk therapies have helped countless numbers of people who had been struggling, and there is now a long list of empirically supported, face-to-face therapist-based interventions (see APA Division 12’s Web site on Research-Supported Psychological Treatments: http://www.psychologicaltreatments.org/). (Note, the focus here is on changing views toward psychotherapeutic interventions. Although the question of changing attitudes about the necessity of medication is also fascinating, it is outside the scope of this thesis.)

In recent years, however, attitudes about the necessity of face-to-face talk therapy have been changing. Face-to-face talk therapy is not always required to effect sustained, meaningful psychological change. There are now a myriad of delivery methods for mental health services to reach people in need (see Kazdin & Rabbitt, 2013), from interactive computer programs to downloadable apps, including many that involve either minimal or zero therapist contact. Although there is a long history of (mostly untested) self-directed treatments, as the enormous market of self-help books makes clear, important advances have occurred in the last 15 years such that clinical science is now helping to determine when and how mental illness can be addressed outside the therapist’s office.

eHealth
The field of eHealth, for instance, has exploded in recent years, offering efficacious mental health services through the Internet that are computer-based or use mobile/
handheld devices, among other technologies (see Hilgart, Thorndike, Pardo, & Ritterband, 2012). Many of these programs try to model the kinds of tasks and interactions that might occur in the therapy room in well-tested cognitive behavioral interventions, such as reevaluating negative thinking patterns. Reviews of Internet-based psychotherapeutic interventions suggest impressive outcomes (e.g., 23 out of 26 Internet trials for depressive and anxiety disorders showed superior outcomes for Internet therapy over its control condition; Griffiths, Farrer, & Christensen, 2010), often with comparable effect sizes to the outcomes achieved in more traditional, face-to-face therapies (see Barak, Hen, Boniel-Nissim, & Shapira, 2008).

Within eHealth, the subfield of cognitive bias modification also shows promise (see Hakamata et al., 2010; MacLeod & Mathews, 2012; though many questions remain about its boundary conditions: see Hallion & Ruscio, 2011). These computer-based programs are designed to train disorder-relevant cognitive processing biases directly (e.g., shifting attention away from threatening cues for anxious individuals using a simple game where people have to identify a probe that repeatedly follows a neutral stimulus, like the word “couch,” rather than a threatening stimulus, like the word “death”). The impressive symptom-reducing effects of these programs are noteworthy, especially given that there is no therapist involvement and no explicit discussion of one’s problems.

Open Questions

There are still many open questions about these alternate delivery methods for mental health services, and the important ethical considerations that their use raises (Hilgart et al., 2012). In particular, concerns about how to reach a person in crisis (e.g., with suicidal intent), identity verification, maintaining privacy and confidentiality, and attrition (e.g., premature termination) are paramount, given the minimal or total lack of personal therapist contact with the client with these approaches (see Hilgart et al., 2012; and National Institute of Mental Health, 2007, for recommendations to minimize risk). Moreover, making sure that the people accessing services are in fact the people who could benefit from the services is a challenge, especially for those programs that rely on self-diagnosis (as opposed to prescreening to determine eligibility).

Other open questions center on how to maximize clinical outcomes with these more distant delivery approaches; in other words, what are the key mechanisms of change? Answering this is critical to enhance effects and to better distill the necessary ingredients rather than administering bulky treatment packages. For instance, who needs what type or level of intervention: entirely self-directed treatment, some therapist assistance to complement an Internet intervention, or all in-person treatment (see the interesting discussion by Mohr, Cuijpers, & Lehman, 2011, on supportive accountability and the possible role for nontherapist forms of human support)? Will the appropriate modality and delivery system depend on stage or severity of the problem area (e.g., prevention for someone at risk for alcohol abuse vs. treating a severely dependent, hazardous drinker), type of problem area (e.g., eating disorder vs. sleep disorder), personal factors tied to motivation and initiative, and so on?

Potential Impact Over the Next 25 Years

Perhaps the more significant question is “Why should anyone care?” One reason is that face-to-face talk therapies are still not used by the vast majority of people who need help (see Kazdin & Blase, 2011). More than two thirds of individuals struggling with a mental illness do not receive treatment (see Kessler et al., 2005), and rates of unmet need are even higher among minority populations (Wells, Klap, Koike, & Sherbourne, 2001). This means we need new approaches to meet the enormous burden of mental illness. To the extent we recognize that a therapist talking directly with a client is not always needed, we can greatly enhance access to treatments, opening up new lines of mental health communication, disseminating treatments far more widely, and potentially reducing costs while enhancing convenience (see Ritterband, Thorndike, Cox, Kovatchev, & Gonder-Frederick, 2009).

Of course, simply offering these interventions online does not mean that they will necessarily be widely used by the people with unmet treatment needs. However, it is clear that technology now plays a major role in health care. For instance, recent estimates suggest that 85% of American adults use the Internet (Pew Research Center's Internet & American Life Project Spring Tracking Survey, 2013), and Fox (2006) reported that 80% of online users use the Internet to seek health information. Thus, I am cautiously optimistic that by allowing people to access services in the privacy of their own home, we can one day transform provision of services in rural areas and may also reach the many people in need who will not actively seek treatment due to the inconvenience and stigma surrounding mental illness and its care. This hope follows in part from survey results indicating that convenience and anonymity are central reasons why eHealth users report pursuing these approaches (see Leibert, Archer, Munson, & York, 2006; Young, 2005). Thus, although much more research is needed to test the effectiveness of eHealth interventions and how best to disseminate them, the potential for impact is enormous.
I am in no way suggesting that face-to-face talk therapy is no longer needed. For many individuals, especially those who have not responded to other self-directed interventions and perhaps those with more severe problems (though this is not yet clear), therapy with a qualified clinician will be essential, but it is not required for everyone suffering with a mental illness. It is exciting to imagine what the next 25 years will bring.

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