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Does E-Therapy for Problem Drinking Reach Hidden Populations?

TO THE EDITOR: Currently, nearly one in every 13 adults abuses alcohol or is alcohol dependent. In addition, several million adults also engage in risky drinking behavior that could lead to alcohol-related problems. However, only a small proportion of the people with alcohol problems ever seek and engage in treatment (1). A national survey in the United States (2) found that only 16% of those with alcohol use disorder had received treatment in 2001. In the Netherlands (3), only 10% of the problem drinkers ever got professional help. Women, higher-educated people, employees, and elderly people are harder to reach for face-to-face care. Several things have improved the accessibility of alcohol interventions (4, 5).

To fill the gap in accessibility, an e-therapy program was developed in the Netherlands. The content and elements of the e-therapy program are comparable to the ones of face-to-face treatment as usual. This e-therapy program distinguishes from other Internet interventions by forming an ongoing personal relationship between the therapist and client that takes place solely via Internet communications. It involves more than self-help or answering a question online. It is a structured and complete treatment program in which clients remain anonymous. The aim of this study was to determine if e-therapy indeed reaches another population with alcohol problems.

We compared the baseline characteristics of 172 e-therapy clients with a consecutive series of 172 face-to-face clients admitted for treatment as usual. All e-therapy clients gave their informed consent to participate in the research project. For the face-to-face clients, we used anonymous data files. The results showed that the baseline characteristics of the two groups differed by gender, age, education, and work situation. Chi-square tests were used to compare proportions and t tests to compare means. The e-therapy group involved significantly more women than the face-to-face group (χ^2=9.25, df=1, p=0.002). People in the e-therapy group more highly educated (χ^2=46.56, df=2, p<0.001) and more often employed (χ^2=69.13, df=1, p<0.001) than the people in the face-to-face group. E-therapy clients were also significantly older than face-to-face clients (t=3.24, df=342, p=0.001).

Our conclusion is that e-therapy serves a new group of people with alcohol problems. We reach more women, higher-educated people, employed people, and elderly people—the groups that are difficult to reach in regular face-to-face therapy. The Internet offers an opportunity for improving access to therapy for problem drinkers. Our next step is to compare the efficacy and effectiveness of e-therapy and face-to-face therapy.

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Remission: What's in a Name?

TO THE EDITOR: Nancy C. Andreasen, M.D., Ph.D., et al. (1) made a case for establishing "remission" criteria for schizophrenia, noting that this would provide a more homogeneous means of comparing outcome data. "Remission" was defined by the authors as a low level of symptoms that "do not influence an individual's behavior" (p. 441).

The criteria represent increased precision over such nonspecific descriptors as symptom improvement or stabilization, which could prove valuable as we seek to better understand schizophrenia, its course, and the use of various interventions. We laud this initiative and thank Dr. Andreasen et al. for their effort, although we disagree on what these criteria should be called. We are wary of reifying a decrease in a subset of symptoms without any reference or measure of real improvement in functional outcome or quality of life with the rather bold imprimatur of "remission."

The authors duly noted this limitation in their text because the criteria are confined to three dimensions of psychopathology (positive symptoms, negative symptoms, and disorganization) and did not address other domains (e.g., cognition, psychosocial symptoms) that are critical to functional recovery. They further added that "symptom quiescence" does not necessarily equate with functional improvement. The problem is that the majority of the specialists and lay users of this term from here on will not have the nuanced sophistication of its authors. This is more than semantic quibbling because nomenclature is not just a matter for psychiatric researchers anymore. It has implications for patients, families, direct-to-consumer advertising, insurance companies, governments, and societies at large.

For the average person, remission implies that all explicit signs of the disease are gone and that the individual is now freed from illness to resume his or her natural trajectory in life. However, the patient with schizophrenia who, according to these criteria, would be in "remission" is likely to remain