"Exploring Motivations and Dropout Patterns in Internet-Based Interventions for Grief Following the COVID-19 Pandemic - A Qualitative Analysis"

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Abstract

Background. During the COVID-19 pandemic, online interventions like the Grief Covid intervention have been used to counteract the risk of prolonged grief disorder (PGD). While online interventions, including those addressing grief, offer many benefits, dropout is a common problem. With the help of self-determination theory (SDT), which explains motivation and behaviour change based on the three basic psychological needs: autonomy, competence and relatedness, it is possible to explain the reasons of adherence and dropout in online interventions. Additionally, people's attitudes towards technology could also have an influence on participation. Therefore, the aim of this study was to qualitatively assess how the SDT explains adherence to and dropout of the Grief COVID intervention, while also exploring how individuals' attitudes toward technology impact these factors.

Methods. Interview data were used from 14 participants who had taken part in the Grief COVID intervention and had either completed or dropped out. These were analysed using a mixed inductive-deductive thematic analysis based on the SDT and the three basic needs of autonomy, competence and relatedness, as well as a deductive approach to attitudes towards technology.

Results. Overall, four themes with a total of 13 sub-themes were identified. The results can be explained by the SDT, which identified clear factors for adherence and few for dropout. The desire for more human contact, flexibility, and a sense of benefit from the intervention were identified as significant factors. Familiarity with the technology and attitudes towards it also influenced participants' behaviour, and should be seen as an additional factor next to the SDT.

Conclusion. The results show possibilities for optimising adherence, which in turn could help to prevent dropouts in online interventions for people experiencing grief or PGD. Recommendations for an online intervention for grief management could be as follows, more human contact such as chat and videoconferencing with a psychologist and online support groups, as well as flexibility for participants to choose tasks, time and day.

Exploring Motivations and Dropout Patterns in Internet-Based Interventions

for Grief Following the COVID-19 Pandemic: A Qualitative Analysis

The COVID-19 Pandemic

The infectious disease "COVID-19" emerged for the first time in December 2019 and spread rapidly around the world (Idoiaga Mondragon et al., 2021). As a result, many people got infected with the virus or died from the complications associated with it. More precisely, according to the World Health Organization (WHO), over 7 million deaths were registered worldwide (WHO, n.d.). The mortality rate in Mexico was particularly high compared to other countries, with over 325.976 deaths ("COVID-19 Tablero México," n.d.). It is therefore not surprising that Mexico has the highest mortality rate to COVID in the USA, with over 10% (Pang et al., 2021). The high mortality rate has led to numerous psychological problems for the bereaved (Reitsma et al., 2021). The psychological problems of many people during the COVID-19 pandemic have been intensified by the significant changes in their social and professional lives. This led, among other factors, to severe stress and the development of depression, anxiety, sleep disorders and post-traumatic stress disorder (North et al., 2021; van Mulukom et al., 2022).

In addition to the effects of the pandemic, the management of the pandemic was also of crucial importance. Many governments have reacted quickly and decisively, and the measures have helped to positively influence the pandemic (Pawar, 2020). Nevertheless, especially in middle- and low-income countries, like Mexico, the provision of mental health treatment is limited by a lack of services (Gearing et al., 2023). Therefore, alternative treatments were particularly important during the COVID-19 pandemic, especially in the context of treatment against persistent grief disorder (PGD).

Persistent Grief Disorder During the Covid-19 Pandemic

According to the ICD-11 guidelines, PGD is present when, following the loss of a close person, there is a persistent grief reaction lasting at least 6 months, characterized by continuous preoccupation and longing for the deceased. This reaction exceeds the cultural,

contextual, and religious norms of the individual. Typical symptoms of PGD include anger, denial, sadness, guilt, difficulty accepting the loss and moving on without the person, and difficulty experiencing positive emotions. Additionally, this grief impairs the social and professional life of the bereaved ("ICD-11 for Mortality and Morbidity Statistics," n.d.). At the beginning of the pandemic, grief researchers were alarmed that the COVID-19 pandemic could lead to an increase in severe, prolonged and debilitating grief, known as PGD (Dominguez-Rodriguez et al., 2023; Eisma et al., 2020; L.I.M. Lenferink & P.A. Boelen, 2023).

An important factor leading to PGD is the lack of social support, which was prevalent during the pandemic (Wallace et al., 2020). People's grieving process was disrupted by COVID-19 as death was often sudden and special circumstances, such as the absence of funerals, prevailed, and deaths in disasters of this nature can cause greater psychological damage than occasional ones (Eisma & Tamminga, 2020). To counteract this, a limited number of pandemic-related online support interventions have been offered (Dominguez-Rodriguez et al., 2023; Reitsma et al., 2023).

Internet Interventions

Internet interventions are increasingly used in public health due to the growing importance of technology and restrictions imposed by the pandemic (Bennett & Glasgow, 2009). Next to that, research shows that online intervention have a very similar effect as face to face treatments for a variety of different mental health problems (Andrews et al., 2018; Dominguez-Rodriguez & De La Rosa-Gómez, 2022; Rigabert et al., 2020). In addition to their effectiveness, these interventions have other advantages, such as the accessibility in terms of time and location, cheaper than conventional methods, anonymity for people who fear stigmatization, and the self-determined pace that increases self-efficacy (Linardon et al., 2021; Schröder et al., 2016). Furthermore, these interventions are better suited than other treatment methods to reach people with low socioeconomic status (Arjadi et al., 2015). This is an effective way of reaching populations in countries who are

underprivileged, and have difficulty accessing mental health care (Zuelke et al., 2021).

Internet Interventions aimed at Grief

Online interventions for coping with grief have already been used in various contexts before the COVID-19 pandemic, such as for people who have lost a loved one to suicide or expectant mothers who have lost their child (Kersting et al., 2013; Litz et al., 2014). The effectiveness of these interventions has been confirmed, participants' grief symptoms were reduced, including a reduction in post-traumatic stress, persistent grief, depression and anxiety (Eisma & Tamminga, 2020; Kersting et al., 2013; Litz et al., 2014). During the COVID-19 pandemic, there was no noticeable increase in the availability of online grief intervention programs, and not many are aimed at the prevention of PGD. Nevertheless, some new grief counselling interventions have arisen that are specifically aimed at people who have lost someone during the COVID-19 pandemic (Dominguez-Rodriguez et al., 2023; Reitsma et al., 2023). The interventions described are an effective approach to coping with grief symptoms in adults (Zuelke et al., 2021).

Despite the many benefits offered by online interventions, including grief-aimed ones, insufficient adherence is a common problem with almost all such interventions, which has not been fully investigated (Beintner et al., 2019). In addition, the dropout rates are very high, and still higher than the offline measures (Lippke et al., 2021). There has been limited research into the reasons for this, which is why it is not possible to determine the reasons for the dropout as well as for the adherence sufficiently (Fernández-Álvarez et al., 2017; Nomeikaite et al., 2023). One possible explanation is that the definition of adherence may differ in health studies, which may affect the implementation and effectiveness of the intervention (Dominguez-Rodriguez & De La Rosa-Gómez, 2022). In the current study, *adherence* is defined as the motivation to implement the intervention as well as the use of the material on the website, and as the individual's compliance with the intervention. In addition, in this study, the term *dropout* is used for a person who does not finish the online intervention and therefore does not complete the program (Christensen et al., 2009). This

may reduce the implementation and effectiveness of the intervention (Dominguez-Rodriguez & De La Rosa-Gómez, 2022). In research, adherence and dropout are often investigated using qualitative analysis, as this method allows the data to be analysed effectively. One theory that is being used more frequently in qualitative research is the self-determination theory (SDT) (Bhatti et al., 2021; Moran et al., 2014; Visser et al., 2019).

Understanding Participation in Internet Interventions Using Qualitative Methods

      Self-Determination Theory. With the help of the self-determination theory, it is possible to explain the reasons why people drop out or complete their participation in internet interventions. In general, this theory describes people's motivation and behaviour change based on three basic psychological needs: *autonomy, competence* and *relatedness* (Alfonsson et al., 2016; Lie et al., 2017). The first psychological need, *autonomy*, describes the motivation of people when they have autonomy or control over their actions and goals. The second need, *competence* characterises people's motivation when they feel capable and effective to perform the intervention. While the third need, *relatedness*, is the need of the individual to be connected with others as well as caring for other people. The theory could be used to tailor internet interventions to the needs of the participants, and thus improve adherence to internet interventions and reduce the drop-out rate (Chiu, 2021; Rosli & Saleh, 2023). By focussing on the SDT and thus on the three basic needs, interventions can be made more accessible, motivational factors can be effectively integrated and the likelihood of dropping out can be reduced.

      Attitude to Technology. In addition to the SDT, people's attitudes towards technology could also have an influence on participation in online interventions. Accordingly, the study by Arjadi et al. (2018) shows that personal openness to use online interventions is a predictor of willingness to participate in online programmes. This is because the adherence and dropout is also determined by the characteristics of an individual, such as their attitude to the factor of being online (Stiller & Bachmaier, 2017).

In particular, people who are not technically skilled are prevented from continuing the intervention by external factors such as technical problems (Rodrigues et al., 2022; Tyler-Smith, 2006). Furthermore, online interventions can reduce the treatment gap of grieving people if the accessibility of these interventions is improved (Lenferink et al., 2021).

Current Study

There is limited research on the adherence and dropout rates in online interventions (Fernández-Álvarez et al., 2017; Nomeikaite et al., 2023). The aim of this study is therefore to qualitatively determine how the self-determination theory explains adherence to and dropout of the following online intervention Grief COVID, as well as to examine how individuals' attitudes towards technology influence these factors, which is shown in Figure 1.

Research Questions

The resulting research questions (RQs) are:

RQ1: *To what extent do the components of the self-determination theory explain people's adherence to the internet intervention regarding grief during Covid-19 pandemic?*

RQ2: *To what extent do the components of the self-determination theory explain people's dropout to the internet intervention regarding grief during Covid-19 pandemic?*

RQ3: *To what extent does people's attitude towards technology influences adherence and dropout to the internet intervention regarding grief during Covid-19 pandemic?*

Methods

To ensure that the essential information of the qualitative study is reported in full, the qualitative phase of the study follows the guidelines of the *Consolidated Criteria for Reporting Qualitative Research* (COREQ) (Tong et al., 2007). In total, the COREQ checklist consists of 32 elements, which can be found in the Appendix A. The present study received approval from the Research Ethics Committee of the Autonomous University of Ciudad Juárez (CEI-2021-1-266), Mexico, and is registered in clinical trials under the registration number (NCT04638842).

Design and Procedure of the Study

The current study is part of a larger study of the intervention Grief COVID (Duelo Covid in Spanish), employed by the ITLAS (Internet Treatments for Latin America and Spain) group. The study was used during the pandemic for people who had lost a loved one to counteract the risk of PGD as well as depression and anxiety. The study is a randomized controlled trial developed by psychologists. To register, participants had to create an account on the website and if they met the inclusion criteria, they were randomly assigned to a group. The inclusion criteria were internet access, possession of an email address, basic digital skills, proficiency in Spanish, loss of a loved one in the last 6 months followed by symptoms of depression, anxiety, or stress and psychological and pharmacological treatment (Dominguez-Rodriguez et al., 2023). The study included two groups, the intervention group individuals who could start the intervention directly and the control group individuals who were on the waiting list and could only participate in the intervention after 36 days. Moreover, the recruitment took place via social networks between November 2021 and December 2022.

The Grief COVID WEB Intervention (https://www.duelocovid.com/) consisted of a self-administered, free, web-based treatment. It comprised a total of 12 sessions over 36 days and was based on cognitive behavioural therapy, mindfulness and positive psychology. The researchers recommended that the participants complete a session every 3 days. The

various sessions were offered in the form of a *text* or *video*. In addition, each session followed a fixed structure, so each began with a mindfulness exercise to keep participants in the present moment, followed by psychoeducational videos to help participants understood the theme of the session, experiential activities such as relaxation techniques, visualisation and another mindfulness exercise at the end of the session (Dominguez-Rodriguez et al., 2021).

More specifically, session (1) consisted of psychoeducation in which participants learned about the stages of grief and how to cope with them. In session (2-4), the focus was on emotional relief through acceptance of loss and in session (5-6) on coping with loss during the pandemic, as well as normalising pain and promoting goodbye rituals. Moreover, in session (7-9) the participants dealt with reintegration into everyday life and social networks. This was followed by session (10-12), which focused on supporting the reintegration of the deceased and the resumption of the life project, as well as relapse prevention (Dominguez-Rodriguez et al., 2021).

Figure 1

Procedure of the study design.
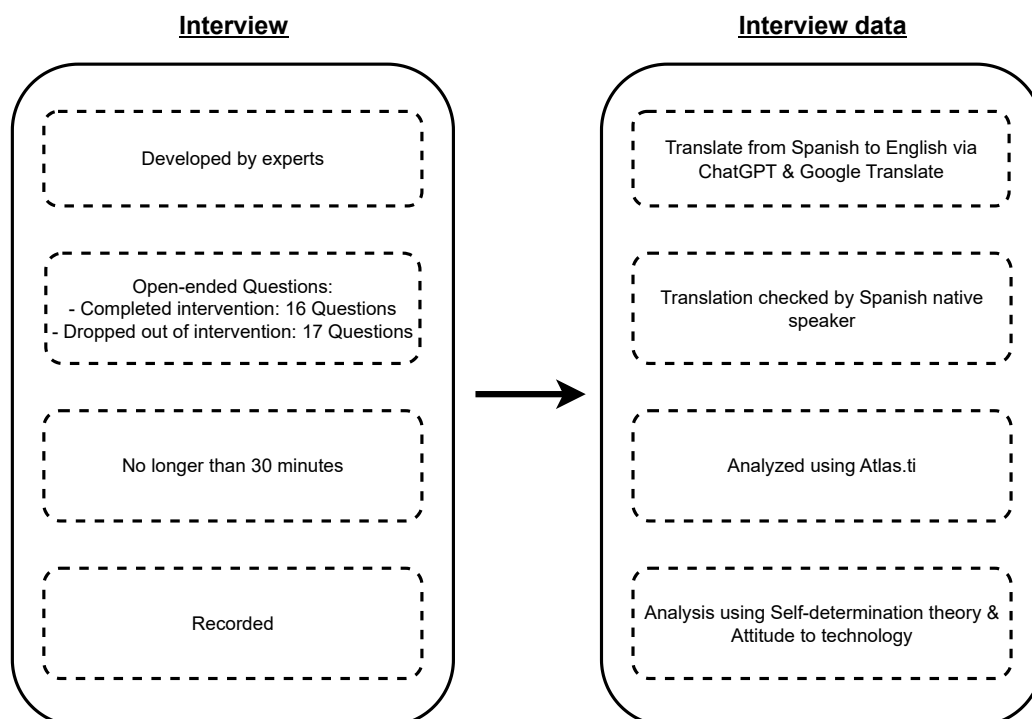
Participants

For the follow-up part of the study, the interviews, participants had to have previously taken part in the Grief COVID-19 intervention and therefore also meet the inclusion criteria described above. The collection of these participants was conducted by using data saturation (Martínez-Salgado, 2012).

Table 1

Participants and their Characteristics.

Participants	Gender	Age	Education	Waiting list	Implementation
P1	Female	46-60	Master´s Degree	No	12 /12modules
P2	Female	31-45	Bachelor´s Degree	No	12 /12modules
P3	Female	31-45	Bachelor´s Degree	No	12 /12modules
P4	Female	61-70	Bachelor´s Degree,	No	12 /12modules
P5	Female	31-45	Master´s Degree	36 days	12/12 modules
P6	Female	46-60	Bachelor´s Degree	No	12 /12modules
P7	Female	31-45	Bachelor´s Degree	No	12 /12modules
P8	Female	18-30	Bachelor´s Degree	1-2 months	12 /12modules
P9	Female	46-60	Master´s Degree	No	12 /12modules
P10	Female	46-60	Bachelor´s Degree	No	12 /12modules
P11	Female	31-45	Master´s Degree	30 days	0/12 modules
P12	Female	46-60	Bachelor´s Degree	No	6/12 modules
P13	Female	46-60	School Diploma	No	2/12 modules
P14	Female	46-60	No formal education	No	8/12 modules

A total of 14 participants was reached, of which 10 completed the interview, 3 dropped out and 1 never started the intervention. The participants were categorized into three different groups that already existed before the secondary study was conducted: *(1)* control group individuals who were on the waiting list and could only participate in the intervention after 36 days, *(2)* intervention group individuals who could start the

intervention directly and completed it, *(3)* individuals who could start the intervention directly but dropped out. Of the participants, 13 have the Mexican nationality and 1 has the Spanish nationality. In addition, 13 of them are female and 1 is non-binary. The age of the respondents is between 25 and 62 (Mdn=43.5; IQR=10).

Materials

The Interviews

The interviews were held between 18 February and 11 April 2021. The interviews were conducted via the online platform (https://zoom.us). Qualitative questions were used with the aim of investigating the experiences and opinions of users. The participants were asked the same questions in a consistent order. The questions are formulated open-ended and attempt to capture the individual experiences, motivations and challenges of participants. The questions are aimed at different aspects of the intervention, such as technical, health-related, materials, logistics, individual perception, for example, *What were the main problems that arose throughout the intervention?*. The questions differed depending on whether the participants had dropped out of the study (16 questions) or completed it (17 questions). Accordingly, question 16 was changed if the respondents had dropped out of the intervention, *What were the reasons why you could not complete the process?* and if they had completed the intervention, *What motivated you to conclude the intervention?*. Furthermore, users who had completed the intervention had one further question at the end of the interview *After finishing the intervention, what techniques or content that you learned in it have you continued to use?*. All the questions can be found in the Appendix B. The structure of the interview is based on two qualitative studies and was developed by two experts in the qualitative method (Freund et al., 2022; Lawler et al., 2021).

The criteria for the interviews were that an interview were held for no longer than 30 minutes, for the same amount of time, and that the camera and microphone were turned on. Furthermore, the interviews were conducted in Spanish and recorded.

Afterwards, these were then transcribed, and the transcripts were translated from Spanish to English using "Google Translate" and "ChatGPT" and checked by a native Spanish speaker. In the process, all identifiable information has been removed. The interview responses were analysed using the program "Atlas.ti".

Data Analysis

For the data analysis of the first and second research question, an inductive-deductive approach was chosen. The approach can be considered as *deductive* due to the fact that the elements of the self-determination theory were applied to the data, but also as *inductive* because original codes and themes were derived from the data. The analysis followed the six steps of the thematic analysis of Braun and Clarke (2012). However, they were adapted to account for the deductive nature of the study. An overview of the analysis steps is shown in the following Figure 2. This meant that, in contrast to the classical approach by Braun and Clarke (2012), the starting codes for the analysis were already predetermined by the constructs of the self-determination model and not generated solely out of the data.
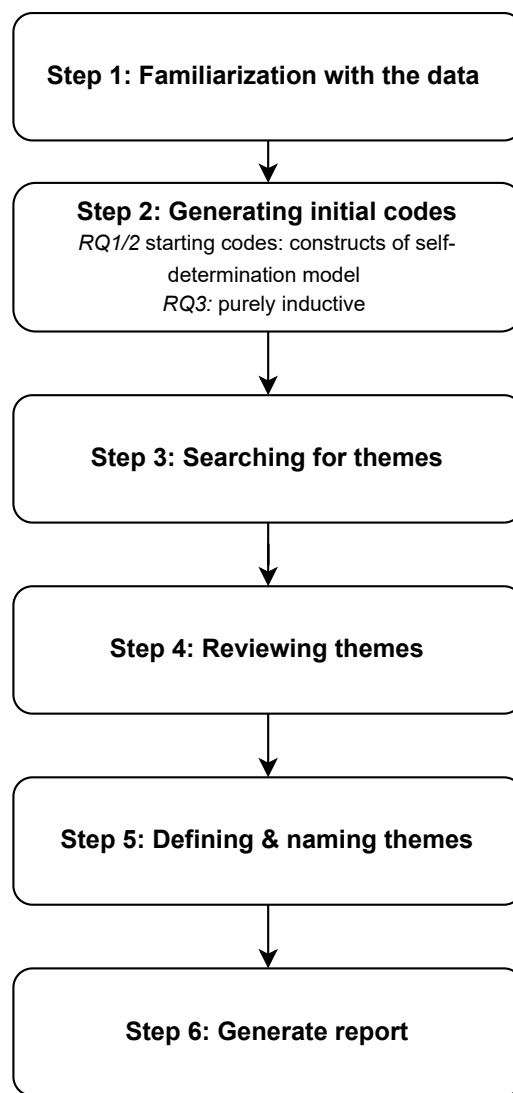
The analysis is carried out in collaboration with three students, so that inconsistencies and uncertainties regarding the coding could be discussed. The first step of the analysis was data familiarisation, which means that the data was read multiple times to get a general understanding of the important *themes* and *subjects* which were discussed by the participants. Next, the initial codes were generated. The starting codes were the three constructs of the self-determination model, *autonomy*, *competence*, *relatedness*, but they were also split into more specific codes. Then the theme ideas were developed, which is done by looking for recurring patterns or common observations in the data. These initial themes were then reviewed by the researchers and checked to see if they were coherent and clearly distinguishable from each other. Afterwards, the themes were named and sub-themes defined when it was necessary. Subsequently, the topics and sub-topics were repeatedly checked, by the three students, in four rounds during, the analysis and adjusted

if necessary. In this way, the reliability and validity of the analysis can be improved.

An *inductive* approach was chosen for the third research question. The first step was to read the data several times to gain a general understanding of the important issues related to the specific technology topic discussed by the participants in the interviews. The further steps of the analysis are the same as those already described for the first and second research questions.

Figure 2

Analysis steps of the current study adapted from Braun and Clarke (2012).

Step 1: Familiarization with the data

Step 2: Generating initial codes
RQ1/2 starting codes: constructs of self-determination model
RQ3: purely inductive

Step 3: Searching for themes

Step 4: Reviewing themes

Step 5: Defining & naming themes

Step 6: Generate report

Results

The analysis of the interview data resulted in 4 themes with 13 topics. In addition, the results are presented based on the structure resulting from the research questions, the first, and second research questions, followed by the third question. Table 2 provided an overview of the results, themes and sub themes, of the qualitative data.

RQ 1: Components of the Self-Determination Theory Explain People's Adherence

Theme 1: Autonomy

1.1 Self-management in Well-being

Self-management of well-being is about controlling and managing mental health. This includes the improvement of general mental well-being and the targeted reduction of symptoms. This theme was raised by 9 participants who described that gaining control over parts of their well-being was mainly their goal of participating, as illustrated by participant 8:

"I wanted to understand this process well. Reading the contents, watching the videos, I wanted to understand what has been researched, what explanations are given (…) my interest was to go through this process with this self-directed support and to learn more about the topic" (female, aged between 18-30, adhered to 12/12 modules).

There were even some participants who had specific mental health goals that they wanted to regain control over, such as respondent 4:

"because I needed to cover the emotional part in some way to take care of myself, it was the main reason that motivated me to take it this way" (female, aged between 61-70, adhered to 12/12 modules).

More than half of the users were motivated to take part in the intervention in order to gain control over their well-being.

1.2 Self-management in Actions

The described self-management in action explains the control over the participants' own actions during the intervention. A total of 8 participants stated that they were particularly motivated to carry out the intervention when they had the feeling that they were acting independently. In this context, self-determined time management was mentioned most frequently in connection with course participation. More precisely, user 7 described this as follows:

"advantage the course had was that, in this case, you could take it whenever you could. In my case, I was giving virtual classes, and sometimes, I had limited time. So, the advantage of this course was that you could schedule it yourself (…)" (female, aged between 31-45, adhered to 12/12 modules).

In addition, some participants mentioned flexibility as one of the motivation to adhere, like the quote of participant 9 visualised:

"The main thing is the content, very clear explanations, and there was also a written part if you preferred not to listen to the audio. I did it all the time with the videos" (female, aged between 46-60, adhered to 12/12 modules).

Respondent 8 added that the possibility of autonomy in the implementation of the intervention was a positive aspect:

" (…) I also liked the option of having the text for reading or video mode, so you could choose whether to read or follow the video" (female, aged between 18-30, adhered to 12/12 modules.

This shows that the majority of participants were motivated to complete the intervention when they felt in control of their own actions.

Theme 2: Competence

2.1 Psycho-Emotional Support: Enhancing Mental Well-being

Another theme relates to the theme above is the completion of the tasks, which can then increase the user's well-being. Overall, all respondents, with the exception of

participant 12, described that they were able to increase their level of well-being by successfully completing the tasks:

"but as it progressed to the middle of the module, well, I started to feeling much better, more this, calmer, more aware, more this now, accepting things as, how they happened and what happened, so yes, about halfway through, of the block was when I already felt a little better", for instance the quote of participant 1 (female, aged between 46-60, adhered to 12/12 modules).

This showed that almost all participants were more motivated to take part in the intervention if they felt they were able to cope with the tasks and get something effective out of it.

2.2 How the Intervention was Delivered

This theme describes the implementation of the intervention. In terms of the delivery and content of the intervention, 8 participants documented it as user-friendly and easy to use. The participants almost consistently explained that with the reason that the platform is user-friendly, like respondent 3:

"content is very easy to digest, the information is accessible (...) understood quite well" (female, aged between 31-45, adhered to 12/12 modules).

This indicated that more than half of the participants found the platform easy to use and this motivates them to continue the intervention, as they felt able to cope with the task.

Theme 3: Relatedness

3.1 Relatedness for Participation

The relatedness to participation characterises that the participants take part in the intervention for or through others close to them. A theme which was observed by all users, except participant 6, such as the quote of respondent 1 showed:

"my daughter was the one who told me that through the school they were giving these therapies and she told me "Mom, if you want, I'll sign you up." so that, so that you enter

this therapy because if you need it" then that is why I decided this (...)" (female, aged between 46-60, adhered to 12/12 modules).

Besides this, few users were motivated to take part for other people, which is for example exemplified in this quote of user 4:

"I wanted to continue being useful for my family, useful for the people I live with and I repeat to you again" (female, aged between 61-70, adhered to 12/12 modules).

The participants' responses emphasised their increased motivation to participate in the intervention when this involves working for the benefit of others or in collaboration with them.

3.2 Shared Experience

Another generated theme reported by the participants is the shared experiences of those involved with their grieving process and its consequences. The theme was outlined by half of the users, more specifically that other people with similar problems would also benefit from or implement the intervention:

"The pandemic has been international, it has affected everyone practically the same", as the quote of participant 5 (female, aged between 31-45, adhered to 12/12 modules) illustrated.

Furthermore, for instance, participant 9 added that the community gave him support:

"that you feel that obviously, you're not alone, that there is a process that most people go through. So, well, yes, it's part of that, it's... a way of actively doing something to recover and feel better" (female, aged between 46-60, adhered to 12/12 modules).

More than half of the participants were motivated to adhere to the intervention by their described common experience with other affected people.

RQ 2: Components of the Self-Determination Theory Explain People's Dropout

Theme 1: Autonomy

1.1 Difficulties of Controlling Actions

This theme explores the problem of being unable to control one's own actions within the intervention. Overall, 7 users stated to be more free regarding their interaction with the intervention. The reasons described were few options within the exercises and the specified time intervals.

"I think as a suggestion, perhaps some exercises could be more interactive. I mean, like on the page, you could have interactive exercises where you could identify the stages of grief and click on some buttons(..)", for example user 8 (female, aged between 18-30, adhered to 12/12 modules).

The participants described improvements in the form of more interactive exercises and a different solution with regard to the 3-day gap.

As a result, half of the participants mentioned difficulties in controlling their own learning process, which had a negative impact on their motivation to participate.

Theme 2: Competence

2.1 Overload Through Everyday Life

Overload due to everyday life describes the problems within the implementation of the intervention due to everyday stress. It is interesting to note that 5 of the users stated that they still had problems of completing the intervention. This represents contradictory information in the participants' responses with regard to the described competence. Several participants had these problems due to overload in their everyday life, for example participant 2 described overload due to work:

" (…)mostly because I wanted to continue with the platform exercises, but at the same time, I couldn't neglect my work, household activities, and besides, I have two dogs. So, finding time for them was the biggest challenge for me at that time, to continue with

the platform exercises" (female, aged between 31-45, adhered to 12/12 modules).

This highlighted the fact that the perceived stress of everyday life influenced the implementation of the intervention.

2.2 Overload Through Emotions

The theme defines the problem of the control of emotions during the intervention. In addition to the theme described above, 3 participants also declared an overload of emotions, more specifically that they did not feel able to complete the tasks of the interventions. As participant 12:

(...) "No, I didn't finish it. It was difficult for me to finish it because it causes me a lot of pain, right? (...) But without a doubt it was more for me, more for the fear of facing that pain and not knowing how to control it, how to handle it. So, I think that was like the main reason" (female, aged between 46-60, drop out after 6/12 modules) described.

Additionally, respondent 3 provided a possible explanation for this:

"(…)after doing all those activities you generate certain emotions that you finally have to stop in some way and you have to contain in order to continue moving forward, but how do you do it if, (…) I mean, like suddenly it's like an accumulation of many emotions and then when you finish, what happens?" (female, aged between 31-45, adhered to 12/12 modules).

The overload of emotions described above impaired the user's participation in the intervention.

Theme 3: Relatedness

3.1 Lack of Support

The theme "Lack of Support" characterise the perceived absence of other people during the intervention. In total, this was expressed by 12 participants. As a result, users outlined their lack of commitment to carrying out the intervention, as illustrated by the quoted comment from user 13:

"but somehow we don't feel like we have that obligation or that commitment to do

them, because there is precisely no one to follow up, someone to follow up on us because sometimes we don't carry them out, but I consider them to be good" (female, aged between 46-60 years, drop out after 2/12 modules).

Another consequence that few respondents described was that they could not carry out the intervention alone, as user 12's statement showed:

"(…) recognized that I couldn't do it alone, that I needed help and I sought therapy with a psychologist (…)." (female, aged between 46-60, drop out after 6/12 modules).

The statements of more than half of the participants illustrated the lack of support, what could influence the adherence, including the wish for follow-up sessions or other people during the intervention.

RQ 3: People's Attitude Towards Technology Influences Adherence and Dropout

Theme 4: Attitude to Technology

4.1 Lack of Human Touch

The lack of human touch represents the absence of human interaction within the intervention. In general, almost all participants, except for participant 10, 11, 14, (9 adhered, 2 dropped out) mentioned the lack of human contact during the intervention. Accordingly, several users stated that they would have preferred more human interaction, in general and through self-help groups, during the intervention. For example, user 4 stated:

"A minimum space if you want, but one that feels that there is someone behind, who knows what, who I know is with me and I know that in some way, not because it happens, that is, I think that in this therapy probably some videoconference or some communication between the groups and the person who designs the platform or whoever monitors it, more results can be obtained" (female, aged between 61-70, adhered to 12/12 modules).

In addition, a few participants mentioned more human contact in the form of a psychologist, like the quote of user 13 showed:

"So I, maybe I could suggest that, in these cases, ehh, I don't know, there could be

some contact so that this could be maybe a little more personalized, I don't know, maybe a therapy right now online or that some people They could go to a place at a low cost because psychological therapies (...)" (female, aged between 46-60, drop out after 2/12 modules).

Another participant 3 argued that they didn't even know who was helping them:

"one of those who designed that live, platform like being on the lookout or holding a meeting to see if the people who are taking it are really liking you, are understanding you, are doing your process (...)" (female, aged between 31-45, adhered to 12/12 modules).

Participant 5 added:

"(..) but it is true that sometimes I would have missed having some forum or some way of communicating with you to be able to see if I'm doing well if I'm not doing well, because that does cause you a little worry, that is, "am I doing the exercises well? (...)" (female, aged between 31-45, adhered to 12/12 modules).

This suggested that the majority of participants missed human contact, in the form of support groups or psychologist contact, in the intervention. Participants described that this lack of human touch had an impact on their participation in the intervention.

4.2 Familiarity with Technology

This theme represents users' familiarity with technology, including the use of online tools. Overall, more than half of the users (5 adhered, 3 dropped out) stated that they were interested in this type of intervention due to their familiarity with the technology:

"I was a distance education teacher at the Open and Distance University of Mexico, so I found it very interesting the way, how you, in some way, presented the therapy to me during the time I was in treatment carrying out the course (...) Regarding the use of the platform, it was easy for me because I know the media, how it works in relation to technology (...)", as the quote of user 4 (female, aged between 61-70, adhered to 12/12 modules) showed.

Interestingly, the participant 14 described how unfamiliar she was with the technology, but how easy it was to use:

"I think that for many people who needed to use it and didn't know much about technology, I think it was, it was simple, even though one is not that good, me, including myself, no, I'm not very familiar. with all the use of technology and that, but it was, it was simple" (female, aged between 46-60, drop out after 8/12 modules).

The statements indicated that the majority of users are familiar with technology. This could have led to the motivation of participation because of their interest in technology as well as the easy application.

4.3 Technology-Related Problems

This theme outlines technology-related problems that occur during the intervention. In total, this topic was addressed by 6 users (4 adhered, 2 dropped out), in which they described self-imposed technology problems, such as users 12 and 9 :

"In my case, no, sometimes I forgot the password and things like that"(female, aged between 46-60, drop out after 6/12 modules) and *"my mom couldn't... she wanted to continue the program, but for her, it's complicated to think about... it's like too difficult. Between the connection, the platform, etc. So, I suppose that for people who are not up to date with technology, it must be difficult"* (female, aged between 46-60, adhered to 12/12 modules).

Next to that, respondent 7 reported a technical problem that was caused by the intervention itself:

"I remember I stayed on session 3, for example, and once I tried to go to session 4, and it sent me back, it didn't let me enter. It happened like twice" and *" I just remember that on one occasion, the same session seemed to repeat (..)"* (female, aged between 31-45, adhered to 12/12 modules) .

Several participants described problems with the application of the intervention due to technical aspects, which made participation in the intervention more difficult.

Table 2

Coding framework of the motivation and dropout patterns of the internet interventions for grief.

Research Questions	Themes	Sub-Themes	Description of the Themes	Illustrative Quotes	Frequency (users)
RQ1	Autonomy	1.1 Self-management in well-being	Motivation through participants control of well-being	" because I needed to cover the emotional part in some way to take care of myself, it was the main reason that motivated me to take it this way"	n=9 (1,2,4,5,7,8,10,12,14)
		1.2 Self-management in actions	Motivation through users control of actions	"advantage the course had was that, in this case, you could take it whenever you could. In my case, I was giving virtual classes, and sometimes, I had limited time. So, the advantage of this course was that you could schedule it yourself (...)"	n=8 (3,4,5,7,8,9,10,12)
	Competence	2.1 Psycho-emotional support: Enhancing mental well-being	Motivation through self-efficacy during the intervention and the resulting influence on well-being	"but as it progressed to the middle of the module, well, I started to feeling much better, more this, calmer, more aware, more this now, accepting things as, how they happened and what happened, so yes, about halfway through, of the block was when I already felt a little better"	n=13 (1,2,3,4,5,6,7,8,9,10,11,13,14)
		2.2 How the intervention was delivered	Motivation through easy delivery of the intervention	"content is very easy to digest, the information is accessible (...) understood quite well"	n=8 (3,4,5,7,11,12,13,14)
	Relatedness	3.1 Relatedness for participation	Motivation to participate through or for other people	"I wanted to continue being useful for my family, useful for the people I live with and I repeat to you again"	n=13 (1,2,3,4,5,7,8,9,10,11,12,13,14)
		3.2 Shared experience	Motivation through common experience with other respondents	"that you feel that obviously, you're not alone, that there is a process that most people go through. So, well, yes, it's part of that, it's... a way of actively doing something to recover and feel better"	n=7 (1,5,6,7,9,10,11)
RQ2	Autonomy	1.1 Difficulties of controlling actions	Difficulties in participation due to less control over one's own actions, by specific exercises and time intervals, within the intervention	"I think as a suggestion, perhaps some exercises could be more interactive. I mean, like on the page, you could have interactive exercises where you could identify the stages of grief and click on some buttons(..)"	n=7 (2,3,8,9,10,12,14)
	Competence	2.1 Overload through everyday life	Difficulties in participation through overload of everyday stress	" (...)mostly because I wanted to continue with the platform exercises, but at the same time, I couldn't neglect my work, household activities, and besides, I have two dogs. So, finding time for them was the biggest challenge for me at that time, to continue with the platform exercises"	n=5 (2,7,10,11,12)
		2.2 Overload through emotions	Difficulties in participation through overload of emotions	"(…)after doing all those activities you generate certain emotions that you finally have to stop in some way and you have to contain in order to continue moving forward, but how do you do it if, (...) I mean, like suddenly it's like an accumulation of many emotions and then when you finish, what happens?"	n=3 (3,12,14)
	Relatedness	3.1 Lack of support	Lack of support during the intervention	"(...) recognized that I couldn't do it alone, that I needed help and I sought therapy with a psychologist (...)."	n=12 (2,3,4,5,6,7,8,10,11,12,13,14)
RQ3	Attitude to Technology	4.1 Lack of human touch	Absence of human interaction within the intervention	"So I, maybe I could suggest that, in these cases, ehh, I don't know, there could be some contact so that this could be maybe a little more personalized, I don't know, maybe a therapy right now online or that some people They could go to a place at a low cost because psychological therapies (...)"	n= 11 (1,2,3,4,5,6,7,8,9,12,13)
		4.2 Familiarity with technology	Users familiarity with technology	"I think that for many people who needed to use it and didn't know much about technology, I think it was, it was simple, even though one is not that good, me, including myself, no, I'm not very familiar. with all the use of technology and that, but it was, it was simple"	n=8 (2,4,5,8,10,11,12,14)
		4.3 Technology related problems	Technology related problems	"I remember I stayed on session 3, for example, and once I tried to go to session 4, and it sent me back, it didn't let me enter. It happened like twice" and " I just remember that on one occasion, the same session seemed to repeat (..)"	n=6 (2,7,9,10,12,14)

Discussion

The aim of this study was to qualitatively investigate the extent to which the self-determination theory explains adherence to, and dropout of, the internet intervention regarding grief during the COVID-19 pandemic. Next to that, it was aimed to examine how individuals' attitudes towards technology influence the adherence and dropout of this online intervention. The results can be explained with the help of SDT, which identifies clear factors that can lead to adherence and dropout. In addition, individual attitudes towards technology could also describe the results and identify factors that lead to adherence and drop-out.

Interpreting the Findings

Findings Regarding Adherence

One of the main findings of the current study was that the three basic needs of the self-determination theory were found in the data, more precisely *autonomy, competence* and *relatedness* could be recognised and could explain the *adherence* to the internet intervention. By satisfying these psychological needs, people are motivated to carry out the intervention, apply what they have learned and change as a result (Chiu, 2021).

One of the findings is that the need for *autonomy* is reflected in the participants' statements, such as in the description of the participants, who stated that the goal of their participation was to understand and control their well-being. More than half of the participants stated that this goal was achieved, which promotes adherence (Chiu, 2021). The fact that the participants' expectations were also met may have motivated them to continue with the intervention (Eisma & Tamminga, 2020; Taris et al., 2006). Another important finding that can promote adherence is the self-management described by more than half of the participants in the form of self-determination of the timing and application, which leads to participants being able to determine their own rhythm and thus increase their self-efficacy (Schröder et al., 2016). This may be related to the fact that people are more motivated to carry out an intervention when they experience autonomy

and thus control over their own actions (Chiu, 2021; Rosli & Saleh, 2023).

The second need *competence* illustrates the participants' need to feel capable of doing the intervention. Except for one participant, the users described their ability to increase their level of well-being the more modules they completed. This is underlined by the SDT, according to which users are motivated when they feel competent and effective in applying the intervention (Chiu, 2021; Rosli & Saleh, 2023). In addition, more than half of the participants stated that they felt able to perform the tasks and described them as user-friendly and easy to manage. Interestingly, research has shown that the tasks should not be perceived as too easy and should also be somewhat challenging in order to promote optimal motivation, which was not described by the participants (Chiu, 2021).

Furthermore, the need *relatedness* was also found in the data, nearly all respondents reported their participation for other people, which reinforces the intention to take care of others by participating in the intervention (Chiu, 2021). This can be supported by research in which interpersonal connections and belonging may be the most important predictor of motivation, which may affect users' adherence (Capon-Sieber et al., 2022; Kaufman & Dodge, 2009). Another main finding is that half of the participants mentioned being more motivated by the realization that other users were experiencing exactly the same problems, which can be explained had a feeling of connectedness can have a strong influence on the motivation to perform (Lie et al., 2017).

This could indicate that these needs have a significant influence on the implementation of the motivation in an intervention.

Findings Regarding Dropout

Furthermore, the second main findings of the current study was that the elements of the SDT were also found in the data and might help to explain the *dropout* to the internet intervention. However, only a few distinct factors can be identified that may have led to dropout. On the basis of the findings, half of the participants described a lack of *autonomy*. In particular, the users reported that they had difficulty controlling their

actions, which was related to the description of few exercises options and the given time interval within the intervention. This could promote the dropout of the intervention by not achieving the goals (Chiu, 2021; Rosli & Saleh, 2023). Some participants completed the intervention despite the feelings described, which indicates that the perceived lack of autonomy can contribute to dropout, but does not necessarily lead to it.

Moreover, concerning the feeling of the need for *competence*, a few participants described lacking this during their participation in the intervention. Specifically, the feeling of being capable and effective in performing tasks was diminished by overload in everyday life as well as due to emotions for the participants. This is underpinned by other studies in which overload and the time required to complete a task favoured drop-out (Krötz & Deutscher, 2022; Schulz et al., 2012).

Except for two participants, all others stated that they lacked for *relatedness* than felt it was present, which can promote the dropout. In general, users described that they lacked connection due to the lack of interaction with psychologists or other participants, therefore felt left alone in the intervention. Similar findings were generated by the study of Chiu (2021) illustrated that a connectedness in interventions can primarily take place through person-to-person interaction, for example through video conferencing. One study supported that the assignment of a mentor, a psychologist, strengthens the feeling of social connection, which was not the case in this intervention (Capon-Sieber et al., 2022). The exact factors which can lead to dropout are not completely known. However, the results may suggest that not fulfilling the three needs of the SDT may promote dropout behaviour, as possible lacks of competence, autonomy, and relatedness may demotivate participants to continue with the intervention.

The results on adherence and dropout partially support each other, as many similar factors were identified by the users. However, these were perceived differently by each participant, which can lead to contradictory results in some aspects.

Findings Regarding the Attitude Towards Technology

Another important finding from the results was that the *attitude of the users towards the technology* had an impact on *adherence* and *dropout.* Eleven participants criticise the absence of human interaction within the intervention, which is in line with the previous results with regard to relatedness, and can increase the dropout (Capon-Sieber et al., 2022). More precisely, users described that they find the technological intervention too impersonal and illustrate possible improvements in the form of online support groups and psychologists. This can be explained with the help of the study by Alfonsson et al. (2016) in which it is tested that therapeutic online support such as chat conversation with therapist or video chat promotes adherence in participants, which could be realised by integrating an online therapist.

More than half of the participants stated that they are familiar with technology and have consciously chosen an online intervention, which suggests that these users have a positive attitude towards technology. Studies confirm that people who have a positive attitude towards technology are more likely to accept the online information, which has a positive effect on their adherence (Stiller & Bachmaier, 2017). The participants in the grief intervention mainly emphasised the advantage of flexibility in terms of time and location, this is a benefit which is frequently mentioned in the scientific research in connection with internet interventions (Linardon et al., 2021). Six of the users indicated technology-related problems which make their participation more difficult and may lead to dropout. These technical problems were caused by the intervention itself or by a person's own behaviour, such as forgetting a password, or by older users who were not comfortable using this technology. Other studies have also reported the unfamiliarity and limited skills of older people in using technology, which in turn promotes dropout (Rodrigues et al., 2022). There is limited research on online grief intervention, which means that online tools can be further developed or improved (Wagner et al., 2020).

The results indicated that users' attitudes towards the technology, whether positive

or negative, might have influenced the adherence and drop-out behaviour. A positive attitude can enhance adherence, while a negative attitude tends to lead to dropping out.

Strength and Limitations and Future Research

One of the main strengths of this study is the holistic perspective as it analyses both dropout and adherence as well as the technology aspect. This allows a comprehensive understanding of the dynamics, motivations, and challenges that may have influenced the respondents. This made it possible to draw patterns and correlations between the different reasons, which would not have been possible by focusing on just one aspect. Especially that the study is quite unique in terms of its data, sample and research and the fact that there are not yet many comparable studies. Moreover, there are few studies that investigate the adherence and dropout behaviour in an online grief intervention (Dominguez-Rodriguez et al., 2023; Reitsma et al., 2023). This suggests that further research should be carried out in this field.

Another strength of the study is the use of self-determination theory, as it enabled a comprehensive analysis of the data and has often been used to analyse interviews. The three needs, autonomy, competence and relatedness, proved to be significant in terms of users' subjective descriptions of their adherence and dropout. It should be noted that this theory is used for the description of motivation and behaviour change, but was originally not used for the description of dropout (Alfonsson et al., 2016). Furthermore, it was possible to investigate the factors favouring adherence and dropout using the thematic analysis, and the deductive-inductive approach provided a flexible as well as structured framework.

One limitation is that the study data were translated, which were translated from Spanish to English using "Google Translate" and "ChatGPT". Nuances and meanings could have had an effect lost in translation, which in turn could affect the analysis. More specifically, the intentions of the participants could be misunderstood by the translated data and therefore misinterpreted. However, the translation of the data was checked and

discussed by a native Spanish speaker as well as complicated meanings were explained to the researchers. This ensured the quality of the analysis and minimised potential translation errors. As a result, the researchers exchanged more on the nuances and meanings of the language.

Another limitation is the homogeneous sample, in terms of the gender of the participants, consisting of women and one non-binary participant, the distribution of adherence and dropout, as well as the participation of people with higher socioeconomic status. However, there is no adequate sample size for qualitative data. Furthermore, the data collection of the interviews was conducted by the previous researchers using data saturation, which is reached when a certain diversity of ideas has been collected, meaning that no more elements relevant to the study would have been mentioned if even more participants had been included (Martínez-Salgado, 2012).

Implications

The results show possibilities for optimising adherence, which in turn could help to prevent dropouts in online interventions for people experiencing grief or the persistent grief disorder. Accordingly, recommendations for an online intervention for grief management could be as follows, more human contact such as chat and videoconferencing with a psychologist and online support groups, as well as flexibility for participants to choose tasks, time and day.

Further research should be conducted to investigate the factors that may lead to dropout and adherence. It is also important to examine whether COVID participants may experience different conditions for successful participation in COVID than in other bereavement cases (Dominguez-Rodriguez & De La Rosa-Gómez, 2022). Furthermore, specific characteristics and requirements of adherence should be defined more precisely and design tools should be adapted. It should also be investigated to what extent these results are culturally specific, as these studies are tailored to the needs of the Mexican population, or whether they can be generalised to a wider population.

Conclusion

This research study investigated to what extent dropout and adherence can be explained in the online grief intervention during COVID-19, using the self-determination theory and people's attitude towards technology. With the help of the SDT, it was possible to determine which factors can lead to adherence and in some cases to dropout. The results on which factors promote adherence and dropout are partly similar factors that are perceived in contradictory ways. This can be explained by the fact that the perception of a person is individual, more preciously each person has different needs in terms of autonomy, competence and relatedness. When participants have a wide choice in applying the intervention and flexibility, especially in terms of time and day, adherence is promoted. Furthermore, relatedness is one of the most important described aspects of motivation for the intervention, most participants lacked the exchange of information through online self-help groups and an online psychologist, which could partly favour dropout. In addition, some participants described a possible reason for dropout as excessive demands in everyday life or due to emotions, so that the participants were unable to cope with the intervention. Familiarity with the technology and attitudes towards it also influenced the behaviour, adherence and dropout, of the participants.

The integration of grief interventions in healthcare is becoming more important, especially with the increasing use of online interventions. The data from this study provides initial approaches to optimise adherence, which could help to reduce dropouts from online interventions for people with grief or persistent grief disorder.

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Appendix A

CORE Checklist
COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	11,12
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	11,12
Occupation	3	What was their occupation at the time of the study?	11,12
Gender	4	Was the researcher male or female?	11,12
Experience and training	5	What experience or training did the researcher have?	11,12
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	10,11
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	10,11
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	10,11
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	12,13
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	8,9,10,11
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	11,12
Sample size	12	How many participants were in the study?	10,11
Non-participation	13	How many people refused to participate or dropped out? Reasons?	10,11
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	8,9,10,11
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	11,12
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	10,11
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	11,12
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	11,12
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	11,12
Field notes	20	Were field notes made during and/or after the inter view or focus group?	
Duration	21	What was the duration of the inter views or focus group?	11,12
Data saturation	22	Was data saturation discussed?	10,11,12
Transcripts returned	23	Were transcripts returned to participants for comment and/or	11,12,13

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	12,13,14
Description of the coding tree	25	Did authors provide a description of the coding tree?	12,13
Derivation of themes	26	Were themes identified in advance or derived from the data?	12,13
Software	27	What software, if applicable, was used to manage the data?	11,12,13
Participant checking	28	Did participants provide feedback on the findings?	11,12,13
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	14-23
Data and findings consistent	30	Was there consistency between the data presented and the findings?	14-27
Clarity of major themes	31	Were major themes clearly presented in the findings?	14-23
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	24-28

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Appendix B

Interview Questionnaires

Interview for people that dropped out the intervention:

- Before entering this platform, have you received psychological therapy of any kind? If so, what was that experience like for you?
- Before entering this platform, have you participated in any other online intervention (self-applied) -If so, could you describe: What platform was it? What was that experience like for you?
- What were the reasons for using the COVID grief platform?
- How was your experience in relation to using the platform?
- How was your experience in relation to the operation of the platform?
- In relation to the materials used on the platform, what was your experience?
- What is your opinion about the tasks and activities designed on the platform?
- What were the main problems that arose throughout the intervention?
- How did you solve these problems? Or if they could not be solved, would you like to comment on it?
- What was the biggest challenge you faced when using the platform?
- What problems related to technology (internet access, computer equipment, knowledge of the platform, etc.) did you face throughout the intervention?
- What problems related to logistics issues (schedules, physical spaces) did you face throughout the intervention?
- What problems related to emotional issues (fear, sadness, anger, frustration, anxiety, etc.) did you face throughout the intervention?
- What problems related to your health status did you face throughout the intervention?
- Mention some proposals to improve the experience of the intervention.
- What were the reasons why you could not complete the process?

Interview for people that completed the Intervention:

- Before entering this platform, have you received psychological therapy of any kind? If so, what was that experience like for you?
- Before entering this platform, have you participated in any other online intervention (self-applied) -If so, could you describe: What platform was it? What was that experience like for you?
- What were the reasons for using the COVID grief platform?
- How was your experience in relation to using the platform?
- How was your experience in relation to the operation of the platform?
- In relation to the materials used on the platform, what was your experience?
- What is your opinion about the tasks and activities designed on the platform?
- What were the main problems that arose throughout the intervention?
- How did you solve these problems?
- What was the biggest challenge you faced when using the platform?
- What problems related to technology (internet access, computer equipment, knowledge of the platform, etc.) did you face throughout the intervention?
- What problems related to logistics issues (schedules, physical spaces) did you face throughout the intervention?
- What problems related to emotional issues (fear, sadness, anger, frustration, anxiety, etc.) did you face throughout the intervention?
- What problems related to your health status did you face throughout the intervention?
- Mention some proposals to improve the experience of the intervention.
- What motivated you to conclude the intervention?
- After finishing the intervention, what techniques or content that you learned in it have you continued to use?