



Experiences of undergoing Internet-based cognitive behavior therapy for procrastination: A qualitative study



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ABSTRACT

Internet interventions constitute a promising and cost-effective treatment alternative for a wide range of psychiatric disorders and somatic conditions. Several clinical trials have provided evidence for its efficacy and effectiveness, and recent research also indicate that it can be helpful in the treatment of conditions that are debilitating, but do not necessarily warrant more immediate care, for instance, procrastination, a self-regulatory failure that is associated with decreased well-being and mental health. However, providing treatment interventions for procrastination via the Internet is a novel approach, making it unclear how the participants themselves perceive their experiences. The current study thus investigated participants' own apprehension of undergoing Internet-based cognitive behavior therapy for procrastination by distributing open-ended questions at the post-treatment assessment, for instance, "What did you think about the readability of the texts", "How valuable do you believe that this treatment has been for you?", and "The thing that I am most displeased with (and how it could be improved) is ...". In total, 75 participants (50%) responded, and the material was examined using thematic analysis. The results indicate that there exist both positive and negative aspects of the treatment program. Many participants increased their self-efficacy and were able to gain momentum on many tasks and assignments that had been deferred in their everyday life. Meanwhile, several participants lacked motivation to complete the exercises, had too many conflicting commitments, and were unable to keep up with the tight treatment schedule. Hence, the results suggest that Internet interventions for procrastination could profit from individual tailoring, shorter and more manageable modules, and that the content need to be adapted to the reading comprehension and motivational level of the participant.

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1. Introduction

During the last two decades extensive research has been performed with regard to treatment interventions delivered via an online interface (Andersson, 2014). According to a recent meta-analysis (Olthuis et al., 2015), Internet interventions are deemed promising and cost-effective in the treatment of a wide range of psychiatric disorders and somatic conditions, for instance, social anxiety disorder (Boettcher et al., 2013), depression (Kivi et al., 2014), panic disorder (Carlbring et al., 2006), tinnitus (Hesser et al., 2012), and irritable bowel syndrome (Ljótsson et al., 2011). Furthermore, it has been suggested that guided Internet-based cognitive behavior therapy (ICBT) and face-to-face treatment produce equivalent overall effects (Andersson et al., 2014). Current research has also investigated the distribution of treatment interventions via a smartphone with encouraging results (H. Ly et al.,

2014; Dagöo et al., 2014), extending the usefulness of Internet interventions by providing non-intrusive and evidence-based methods in the everyday life of the general population. Also, several recent clinical trials have explored the potential of using treatment interventions delivered via the Internet for personal concerns and behavioral problems that can be debilitating, but do not necessarily warrant more immediate care, such as, stress management for middle managers (K.H. Ly et al., 2014), social skills training for young adults (Lehenbauer et al., 2013), and behavioral training in migraine self-management (Kleiboer et al., 2014).

However, apart from the large number of clinical trials examining the efficacy and effectiveness of Internet interventions, qualitative research concerning the experiences of undergoing treatment interventions delivered via the Internet is still scarce (Ly et al., 2015). Bendelin et al. (2011) conducted interviews with twelve participants with regard to their overall impression of ICBT for depression, revealing differences in terms of their motivational level to complete the reading and exercises included in the treatment program. Particularly, those participants who took responsibility for their involvement and attributed progress to their own efforts benefitted more from the treatment interventions (Bendelin et al., 2011). In a similar manner, Olsson Halmetoja et al.

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(2014) investigated the experiences of going through ICBT for social anxiety disorder at a four-year follow-up, indicating that most participants had a positive attitude towards the treatment program, but that some also perceived the content as hard to comprehend and the exercises as emotionally challenging, while others expressed a need for additional support and feedback from their therapist. Moreover, Rozental et al. (2015) explored the incidence and characteristics of negative effects occurring during the treatment period of four different clinical trials of ICBT, providing evidence for the existence of events that were perceived as negative or unwanted. For instance, participants reported experiencing deterioration as well as symptoms unrelated to the condition targeted by the treatment program, some of which were connected to gaining more insight about their problem, but also feeling pressured by the tight treatment schedule and having difficulties performing many of the exercises.

Using qualitative research as a way of investigating how participants themselves apprehend and use Internet interventions is an important issue, as it could help identify the advantages and disadvantages of the treatment format (Bendelin et al., 2011), and distinguish factors that might increase adherence and decrease the number of drop-outs (Rozental et al., 2014a). Prior investigations have, for instance, found that Internet interventions could benefit from tailoring the frequency and type of feedback to the needs and characteristics of the specific participant (Svartvatten et al., 2015), the use of reminders and motivational prompts to help increase compliance (Donkin and Glozier, 2012), the provision of an intuitive and more interactive interface (Beattie et al., 2009), and the adaption of texts and procedures to account for individual differences in reading comprehension and computer skill (Gerhards et al., 2011). In addition, qualitative research is also of special interest in the case of testing treatment interventions that have not previously been evaluated or involving a novel condition that has not yet been thoroughly examined, particularly as it can further the understanding of mediators of change and help develop more effective treatment interventions (Andersson et al., 2009). Hence, in the current study, qualitative research was used to explore the responses to open-ended questions distributed at the post-treatment assessment of the first clinical trial of ICBT for procrastination (Rozental et al., in press). Procrastination is defined as “to voluntarily delay an intended course of action despite expecting to be worse off for the delay” (Steel, 2007, p. 66), and is considered to be a common self-regulatory failure that can affect personal functioning and well-being (Stead et al., 2010). Finding treatment interventions that can help people deal with their difficulties with procrastination is therefore warranted, and could, in turn, prevent the manifestation of more severe mental health issues (Sirois and Pychyl, 2013). However, as noted in a recent review (Rozental and Carlbring, 2014), research on procrastination has primarily involved the investigation of different personality constructs believed to be associated with the degree of severity, e.g., a high degree of impulsiveness and a lack of self-control, while paying less attention to the efficacy of treatment interventions for procrastination. Principles derived from cognitive behavior therapy (CBT) are often referred to as helpful, but have only been explored in a few single case-studies and group therapies without the use of randomization or standardized outcome measures (Rozental et al., in press), limiting the understanding of what relieves difficulties of procrastination. Similarly, the impression of different treatment interventions for procrastination is largely unknown (Klingsieck, 2013), making it imperative to investigate in order to distinguish what factors are seen as helpful and unfavorable by the participants themselves. Furthermore, as prior research of ICBT has indicated, guided self-help seems to be beneficial for treatment outcome (Arnberg et al., 2014), revealing a strong correlation between the therapist's input and progress during treatment (Palmqvist et al., 2007). The importance and type of guidance have also been explored using qualitative research in relation to, for instance, depression (Svartvatten et al., 2015), and generalized anxiety disorder (Paxling et al., 2013), but has not yet been examined with regard to

procrastination. On the one hand, guided self-help could be regarded as an external source of control and should therefore increase adherence and the efficacy of ICBT for procrastination. On the other hand, the results of Rozental et al. (in press) did not find any differences between guided and unguided self-help, making the role of therapist support in the treatment of procrastination less clear, warranting further research. Thus, the purpose of the current study was twofold: 1) among self-referred participants receiving ICBT for procrastination during a treatment period of ten weeks, and receiving guided self-help or unguided self-help, what are the experiences of undergoing treatment interventions delivered via the Internet? 2) What factors of the treatment program were perceived as beneficial and disadvantageous in terms of managing procrastination?

2. Material and methods

2.1. Participants

The current study was part of a clinical trial examining the efficacy of ICBT for procrastination (Rozental et al., in press). Participants were recruited through advertisements and reports in the Swedish media, as well as information on social networks. Eligibility was assessed via an online screening process consisting of self-report measures investigating the severity of procrastination, depression, anxiety, and degree of quality of life, as well as self-disclosed information regarding the participants' sociodemographics and problems with procrastination (Rozental et al., 2014b). The inclusion criteria included difficulties primarily associated with procrastination, i.e., a minimum of 32 points on the Irrational Procrastination Scale (Steel, 2012), and not having any other ongoing psychiatric condition warranting more immediate care, e.g., severe depression, suicidal ideation, bipolar disorder, misuse of drugs or alcohol dependency, psychosis or schizophrenia, and attention-deficit/hyperactivity disorder. In addition, a Swedish citizenship and fluency in Swedish were required, as well as having a computer with access to the Internet. No concurrent psychological treatment was permitted, and in the case of taking any psychotropic medication the dosage had to be stabilized twelve weeks prior to entering the treatment. Detailed information regarding the inclusion and exclusion criteria as well as the self-report measures can be found in Rozental and Carlbring (2013).

In total, 150 participants were deemed eligible for inclusion in the clinical trial and randomized into three conditions: 1) guided self-help, receiving support from a master's degree-level therapist, 2) unguided self-help, receiving no support, and 3) wait-list control, receiving unguided self-help after the first treatment period had ended. For the purpose of the current study, the participants were distributed open-ended questions related to their experiences of undergoing ICBT for procrastination at the post-treatment assessment. However, because the open-ended questions were optional to complete, only 75 participants (50%) are included in the analysis of the current study. A full description of the participants' sociodemographics, divided by responders and non-responders to the open-ended questions, can be obtained in Table 1.

Potential differences between responders and non-responders to the open-ended questions were examined using two-sided independent *t*-tests and Pearson χ^2 -tests. Results indicated that no difference was obtained with regard to the gender distribution of the two groups, $\chi^2(1) = 0.97, p = .33$, and that no difference was observed in terms of age, $t(148) = 1.24, p = .22$. Furthermore, no difference was found in terms of the allocation of the two groups between guided self-help and unguided self-help, $\chi^2(1) = 0.48, p = .49$. Also, possible differences related to the severity of procrastination, depression, anxiety, and degree of quality of life at post-treatment assessment were assessed, indicating that there were no differences on any of the self-report measures, $t(104) = -0.60$ to $0.17, p = .55$ to $.98$, except for quality of life, $t(104) = 2.09, p = .04$. However, due to multiple comparisons,

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