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Experiences of internet-delivered cognitive behavior therapy for social anxiety disorder four years later: A qualitative study

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ABSTRACT

The current study is a qualitative follow-up of a study on guided internet-delivered cognitive behavior therapy (ICBT) for social anxiety disorder (SAD), conducted four years after treatment completion. The main aim was to capture participants' description of their experiences of the treatment, their view on treatment effects, memories of the treatment, and whether they continued using the gained knowledge after treatment. Sixty participants were selected from the original study's treatment group. A criterion based sampling approach was used based on the obtained treatment effect, and with a minimum of five completed treatment modules. E-mail invitations were sent, with information about the follow-up and the instruction to respond if interested in participating. Twelve semi-structured interviews were made and the material was analyzed using an approach based on grounded theory. The results showed that all participants found the treatment to have some effect, but they also found it to be demanding, difficult, and hard. Many appreciated to hear of the experiences of other participants in the online forum. Under the theme of memory, most could describe the setup of the treatment in general terms. The exposure module was mentioned by all, cognitive restructuring by most, and some also reported memories of the psychoeducation. A core process was identified which involved how the attained treatment effect was viewed over the time, and how this view changed from treatment completion to current time. The findings outlined in this study describe how treatment effects can be sustained via an active approach to the treatment and the symptoms of SAD.

1. Introduction

Cognitive Behaviour Therapy (CBT) has strong empirical support as treatment for Social Anxiety Disorder (SAD) (Acarturk et al., 2009; Ponniah and Hollon, 2008). With the expanded use of the internet, the accessibility of self-help treatments has increased (Andersson, 2014), and CBT administered over internet has been developed and tested for a range of conditions with promising results (Andersson, 2009; Carlbring and Andersson, 2006). Several randomized controlled trials and independent replications have shown that SAD can be treated with therapist-guided internet-delivered CBT (ICBT) (Andersson et al., 2014), including trials from Sweden (Andersson et al., 2006), Australia (Titov et al., 2008), Spain (Botella et al., 2010), and Switzerland (Berger et al., 2009). In addition, guided ICBT has been found to be as effective as face-to-face CBT in a few trials (Andrews et al., 2011; Botella et al., 2010; Hedman et al., 2011a). Moreover, effects tend to be sustained over time (Carlbring et al., 2009), even as long as five years after treatment completion (Hedman et al., 2011b). However, we still have limited knowledge of how patients experience guided ICBT.

The number of qualitative studies focused on the experience of CBT is remarkably low. Hodgetts and Wright (2007) reviewed qualitative studies focusing on the patients' experiences of different therapies, including three qualitative studies on CBT (Hodgetts and Wright, 2007). The results varied regarding how the patients valued the treatment and which part they had found to be helpful. The researchers concluded that the view of the patients should receive more research interest, and that clinicians may gain important knowledge by listening to their patients by asking open questions about their therapeutic experiences. In a qualitative study of cognitive therapy for SAD (McManus et al., 2010), reports from patients suggested that the treatment was experienced as an emotional roller coaster. Participants in the study also reported difficulties in changing maladaptive habits (e.g., avoidance of social situations). In a study on the experience of guided CBT self-help (Macdonald et al., 2007), participants reported a variety of experiences of the treatment (such as a gap between patients' expectancies of psychological therapy and their experience of the guided self-help), and the research group highlighted the importance of understanding

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patients' expectancies regarding treatment. A meta-synthesis of qualitative studies found reports of both advantages (e.g., acceptance of self-help dependent on prior experiences) and disadvantages (e.g., stigma associated with treatment) of guided CBT self-help interventions for depression in primary care (Khan et al., 2007). Participants' also described self-help treatment to be hard work. In a qualitative study of guided ICBT for depression (Bendelin et al., 2011) participants also voiced a variety of experiences and views regarding the treatment. For example, some appreciated the format, others missed seeing a therapist face-to-face and others felt pressured during treatment (e.g., because of deadlines for homework completion). Another finding in that study was that some participants did not actively engage in the treatment even if they read the treatment material (i.e., not implementing changes in their lives and not completing homework).

In CBT a great deal of time and effort is devoted to educating patients about their condition and how it can be treated. Even though psychoeducation always is included, few studies have focused on what participants actually learn during treatment (Harvey et al., 2014). Scogin et al. (1998) investigated acquired knowledge after bibliotherapy for depression. Although knowledge about depression increased, this knowledge gain did not correlate with a decrease in depressive symptoms (Scogin et al., 1998). A later study showed that knowledge about affective disorders and in particular it's treatment was of importance for later outcome in a two year follow-up (Kronmuller et al., 2007). In a large trial with 204 patients with SAD, knowledge about SAD and its treatment increased following guided ICBT, with a small, but significant, association between knowledge gain and outcome (Andersson et al., 2012). Overall, not much is known about what patients gain in terms of knowledge from guided ICBT and what they remember from their treatment.

The current study was a qualitative follow-up of a randomized controlled trial (Andersson et al., 2012). In the primary study, 204 participants were randomized to either guided ICBT including an online discussion forum or to a control condition, which in this case was an online discussion forum only. The main aim for the primary study was to compare guided ICBT for SAD with a moderated discussion forum, to investigate whether knowledge about SAD and treatment for the disorder was influenced by treatment, and to investigate the effect of therapists' experience on treatment outcome. Briefly, the trial showed an Hedges g effect size of $g = 0.75$ in favor of the treatment and knowledge, as assessed by the knowledge test, which increased following treatment with little gain in the control group.

The present study was initiated four years after treatment had been completed in that study. The main objective of the our qualitative study was to add to the body of knowledge regarding participants' experience of guided ICBT, their own views on the treatment, but also their reports regarding gained knowledge about SAD and its treatment and what they found to be of use to them in a long term perspective.

2. Method

2.1. Participants

Participants were recruited from the initial treatment group in the controlled trial of guided ICBT for SAD (Andersson et al., 2012). Inclusion criteria were a minimum of five completed treatment modules out of a possible 9 modules (in order to be able to participate in a meaningful interview related to treatment contents). Briefly, the treatment had started with an introductory module describing SAD and facts about CBT. Modules 2–4 described a cognitive model for SAD and introduced cognitive restructuring. Modules 5–7 introduced exposure and attention shifting exercises. Modules 8–9 mainly concerned social skills and relapse prevention. Participants were asked to complete one module every week, i.e. a 9-week treatment period was recommended. In the original trial the average number of completed modules was 6.8 (Andersson et al., 2012). In addition to the treatment participants were also involved in a moderated online discussion forum. The treatment was guided via e-mail (in a closed secure system) by a student or a more experienced therapist each week in association with the homework assignments. Additional reminders were sent in case of non-response during the treatment period. Typically, the guidance took about 10 min per patient and week, which is typical of guided ICBT (Andersson, 2014).

Criterion-based sampling was utilized in order to extract a sample which differed in terms of treatment effect, as measured by the Liebowitz Social Anxiety Scale self-rated version (LSAS-SR) (Fresco et al., 2001). The purpose of this selection was to enable a variation in attained effect and to tap different patients' experiences of the treatment. Participants were divided into three equally sized groups based on their scores on the LSAS-SR before and after treatment (e.g., change scores). We selected one group with large (31 points or more on the LSAS-SR), one with medium (between 15 and 30 points), and one group with little or no improvement on the LSAS (14 or less change), in line with the procedure in a previous study on the experiences of guided ICBT for depression (Bendelin et al., 2011).

Participants were contacted via e-mail, four years after the treatment period which had lasted for nine weeks. The e-mail contained information about the follow-up, the aim of the study, how it would be conducted and the instruction to notify their interest in participating by responding to the e-mail. A book was offered as a reward for participation in the interview. Thirty e-mails were initially sent based on the selection criteria above. Within two weeks 30 additional e-mails were sent. Ten e-mails were immediately notified as being undelivered. Thirteen individuals responded with interest of participation, one of which responded too late to be included in the study. Altogether, 12 interviews were made. Four participants belonged to the group displaying a large effect on LSAS, five from the medium group and three from the group with a small or no effect at all. Nine participants were women, three men, and their ages ranged between 28 and 67 years old. All participants gave their informed consent to participating and having the interviews audiotaped. The study was approved by the local ethics committee.

2.2. Material and procedure

All interviews were held over telephone and were audiotaped. The interview guide was formulated by the researchers to suit the aims of the study. In the Introduction, the interviewer presented herself and informed the participants about the study and the interview. The interviewer was a female psychologist with CBT orientation. The participants gave their consent to proceeding before the researcher moved on to the questions. The interview guide was semi-structured, containing seven open-ended questions divided into three general themes: how the participants experienced the treatment, how they were doing today regarding symptoms of SAD, and what they remembered of the treatment. The guide started with broad questions, to become more specific along the way, and ended with the opportunity to express whatever the participant wished to share with the researcher. The duration of the interviews varied but was usually about 15 to 20 min long.

2.3. Analysis

The interviews were recorded, transcribed and analyzed informed by the method of grounded theory (Pidgeon and Henwood, 1996). Grounded theory is suitable for exploring complex phenomena, processes, and finding a way to explain them in new ways (Strauss and Corbin, 1990). In the current study, the analysis began as soon as the first interview was transcribed, and transcriptions were continuously coded. Along the way, codes were categorized and categories modified in comparison with each other and the original text. Categories were organized along the line of the emerging theory. During the whole