Therapists' experiences of conducting cognitive behavioural therapy online vis-à-vis face-to-face

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THERAPISTS' EXPERIENCES OF CONDUCTING COGNITIVE BEHAVIOURAL THERAPY ONLINE VIS-Á-VIS FACE-TO-FACE

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Denna uppsats utforskar olika terapeuters erfarenheter av att bedriva kognitiv beteendeterapi på nätet respektive ansikte-mot-ansikte. Elva terapeuter deltog i semistrukturerade intervjuer, som analyseras tematiskt med en abduktiv ansats. Resultaten visade att terapeuterna såg ansikte-mot-ansikte-terapi som en starkare upplevelse än internetterapi, och den senare som mer manualbaserad men också innehållande mer arbetstidskontroll. Många deltagare tyckte också att allians kunde skapas lättare och snabbare i ansikte-mot-ansikte och att internetterapi är starkt beroende av klienternas inre motivation. De sista temana berörde fördelarna med hybridterapi och att båda terapiformerna attraherade olika klienter och terapeuter. Kliniska implikationer som bör undersökas är om arbete med internetterapi kan buffra terapeuters utmattning, samt huruvida terapiformen kan förbättras genom att bli mindre manualberoende för att bli lättare att individualisera.

This thesis explores therapists' experiences of conducting cognitive behavioural therapy (CBT) online and face-to-face. Eleven therapists partook in semi-structured interviews, which were thematically analysed using an abductive approach. The results indicate that the therapists viewed face-to-face-therapy as a stronger experience than internet-based CBT, and the latter as more manualised but providing more work-time control. Many participants also thought that working alliance may be achieved faster and more easily in face-to-face-therapy, and that internet-based CBT is heavily reliant on the intrinsic motivation of the clients. The final themes concerned the advantages of blended therapy and that both therapy forms appealed to different clients and therapists. Clinical implications in need of investigation are whether working with internet-based CBT might buffer therapist exhaustion, and whether this therapy form can be improved by becoming less manual dependant in order to be easier to individualise.

Cognitive behavioural therapy (CBT) conducted over the internet is becoming a frequently researched form of treatment. Yet, considering the promise it shows it is still implemented into public health care on a surprisingly small scale. In a report from the Swedish Association of Local Authorities and Regions (SKL), internet-based CBT (ICBT) is defined as "a treatment program built on a standardised self-help manual for a specific diagnosis with methods from cognitive behavioural therapy (CBT) conducted via the internet along with active support from a therapist with basic psychotherapeutic competence in CBT" (2013, p. 8). There are many types of ICBT, ranging from those exclusively based on self-help material without therapist interaction to blended therapy where face-to-face-sessions are interwoven with support over the internet (Andersson, Bergström, Buhrman, Carlbring, Holländare, Kaldo & Waara, 2008). In this thesis the focus was specifically on ICBT with therapist support. This therapy form has proven to be effective against many different psychiatric disorders, such as depression, stress and sleeping difficulties, as well as anxiety disorders such as social phobia and panic syndrome – just to mention a few. (Andersson, Carlbring, Ljótsson & Hedman, 2013). ICBT has several advantages when compared with traditional face-to-face-therapy. It has been shown to be cost- and time-efficient (SBU, 2013) and provides an easy way to reach clients who either avoid or have difficulty receiving treatment from a clinic, for example due to large distances (Ash, 2010),

their specific problems (such as social phobia) or the severity of their symptoms (SBU, 2013). ICBT also increases the choices of treatment available to clients (SBU, 2013). However, ICBT also have some disadvantages compared to face-to-face. It alters the relationship between therapist and client since the non-verbal aspects of the contact disappear and text-based communication replaces speech, which makes assessing suicide risks more difficult. Lastly, this therapy form does not allow health care on the same terms since it excludes clients who lack the technical equipment required, for example access to the internet and a computer or smartphone (SBU, 2013).

Bearing these disadvantages in mind, the disproportionately large amount of quantitative research done on ICBT assesses its treatment outcomes and efficacy positively. This research, however, lacks some of the important nuances that can be provided by a qualitative perspective, since only a relatively small amount of studies have focused on the actual experience of ICBT. Some of these nuances indicate that clients can experience a certain aspect of the therapy in completely different ways. For example, Bendelin et al. (2011) show that some clients experience ICBT as impersonal, non-genuine and inhibitory for creating an working alliance, while others find it easy to create and maintain relationships over the internet. This suggests that ICBT has complex and multifaceted aspects that require in-depth qualitative investigation rather than quantitative. Such research could provide more knowledge on how ICBT could fit into regular health care, by inquiring its advantages and disadvantages.

Research with a qualitative perspective is a much needed contribution for Swedish health care in particular, since they are at the forefront of implementing ICBT. The Swedish National Board of Health and Welfare (Socialstyrelsen, 2010; 2014) has recommended ICBT as the second priority for adults with a moderate depressive episode and as a possible treatment method for other mood and anxiety disorders. At the present it is offered in a few counties as an alternative or complement to face-to-face-therapy (SBU, 2013). These treatments are usually based on modules that the client works with independently while keeping in contact with a therapist over text messages (SKL, 2014). ICBT has also been a popular research subject in Sweden the last 15 years (SKL, 2013) and a number of clinical projects are still active in Stockholm, Uppsala and Örebro among others (SKL, 2014).

Despite the large volume of internet-based treatments already in operation and under research, the Swedish Council on Health Technology Assessment (SBU) still holds a sceptic stance towards ICBT. In a report from 2013 they write that despite the fact that research is abundant, there are still gaps of knowledge and ambiguities that prohibits ICBT being launched on a wider scale. For instance, there is still limited knowledge on how effective ICBT is compared to therapy conducted face-to-face (SBU, 2013). This deficiency in contemporary research has also been noted in a meta-analysis written by Andersson, Cuijpers, Carlbring, Riper and Hedman (2014). This study argues that too few studies have been done to directly compare internet treatment with face-to-face therapy. Instead, most current studies have compared ICBT to a waiting list or control group (SBU, 2013).

Andersson et al. (2014) have analysed the articles that actually make a comparison between treatment modalities, but most of these cannot show any significant differences in efficacy. They note, however, that both modalities do yield positive results as opposed to non-treatment.

This study aims to fill some of the above mentioned knowledge gaps. This will be done first of all by comparing ICBT to face-to-face-therapy. It will also adopt an explorative and qualitative stance to catch complexities and nuances in the data. Most of the qualitative research on the subject has focused on the client's perspective. Since there are only a handful of studies examining the topic from the therapist's point of view, this has led to a certain degree of skewness in the research. Because therapy is a collaborative effort, this study endeavours to obtain information on the therapists' experiences to contrast the hitherto prevailing client perspective. This thesis will thereto focus more prominently on two specific areas that have proven particularly important for successful therapy – the working alliance and motivation.

Working alliance has recently been put forward as a key factor for treatment outcome in CBT (Kåver, 2011). Because of this, much of today's research on ICBT revolves around finding out more about the possibility of creating such a relationship over the internet. There is some support that the alliance indeed has a relation with treatment outcome in ICBT (Bergman Nordgren, Carlbring, Linna & Andersson, 2013). This thesis uses Kåver's (2011) definition of working alliance, which is an "interpersonal collaboration" defined by "an emotional therapy relation, safety and trust as well as a clearly elaborated agreement on goals and methods/techniques to reach those goals." According to Rogers (1957) a working alliance demands that the therapist has an unconditionally positive regard for the client, as well as showing themselves empathic, warm and congruent (genuine).

Klasen, Knaevelsrud and Böttche (2012) and Sucala et al. (2012) have compiled two of the more ample reviews on the subject of working alliance in ICBT to date. They arrive at very similar conclusions. Firstly, creating a working alliance online is a distinct possibility, and moreover it is at least equal to the working alliance in face-to-face-therapy. The examined articles that compared working alliance face-to-face with ICBT found no significant difference between the modalities. This is also confirmed by the most influential article on the subject, written by Cook and Doyle in 2002. Secondly, they both found some support for working alliance affecting the treatment outcome, but point out that this area of research needs more exploring. Thirdly, Sucala et al. (2012) and Cook and Doyle (2002) found evidence that the more modalities of communication used (for example, mail, chat or video chat), the stronger the working alliance is perceived to be by the client.

Research done from the therapist's viewpoint gives a different perspective. Sucala, Schnur, Constatino, Miller, Brackman and Montgomery (2013) examined clinicians' thoughts about creating a working alliance online. Even though they thought it possible, these therapists highlighted that they thought that the working alliance was more important in face-to-face-therapy. The participants conveyed that they

had difficulty reading the clients' emotions and communicate warmth and empathy over the internet. They also thought that they were less skilled at constructing a working alliance over the internet than face-to-face. Calero-Elvira, Santacreu, de la Torre, Purriños and Shih (2014) report that working alliance might be equivalent in both forms of therapy from a client's perspective, but that therapists experienced the working alliance established in face-to-face as better than online.

It is evident that ICBT often suffers from a high amount of dropouts among participants, and not enough qualitative research has been done on the subject of what makes a client persist in ICBT (Donkin & Glozier, 2012). Practically nothing has been done from a therapist point of view. The research that does exist highlights the client's intrinsic motivators – such as noticing their improvement, feeling in control or feeling a sense of duty to themselves – as key for client adherence. External motivation from the therapist seemed to also have an effect. This motivation could take the form of reminders of the reason for seeking treatment, showing the client their improvement or by any other means stressing the benefits of the therapy (Donkin & Glozier, 2012). The importance of intrinsic motivation is supported by Gerhards et al. (2011) and Bendelin et al. (2011) who arrive at the conclusion that many of the clients who did not complete the treatment had expected more social (external) support. Bendelin et al. (2011) adds that clients who attribute their success to their own efforts benefit most from treatment over the internet. Finally, Reynolds, Stiles, Bailer and Hughes (2013) speculate that the client's motivation in ICBT is also dependant on their level of symptoms. In the study, therapists assessed the communication with their clients. The more symptoms the client presented, the worse the therapists assessed the communication to be.

To recapitulate, the purpose of this thesis is thus to explore therapists' experiences of conducting face-to-face and internet based CBT, with a special focus on how they have experienced their contact with the clients. By comparing and contrasting these experiences with each other, the study aims to identify potential strengths and weaknesses in each modality of therapy, particularly in the areas of working alliance and motivation.

Method

The qualitative stance chosen for conducting this study was thematic analysis, as described by Braun and Clarke (2006). This method attempts to derive overarching themes in the data, which can reflect it in an equitable way. More specifically an abductive approach was used, which is a combination of inductive bottom-up analysis and deductive theory-driven analysis (Langemar, 2008). This allowed deriving new themes emerging from the data, as well as interpreting the more specific themes – working alliance and motivation – according to recent research.

According to Braun and Clarke (2006) thematic analysis is flexible enough to incorporate different scientific epistemologies. In spite of this, it is not entirely easy to specify the position of this particular thesis. It is based on a belief that reality is something subjective, since I am interested in the individual views of the participants (Langemar, 2008), and as such has difficulties fitting with a more positivistic stance, such as essentialism or realism (Braun & Clarke, 2006). However, since the purpose is not to explore how the participants create their reality among others, but merely to describe it, it is also problematic labelling it a purely social constructivist study (Braun & Clarke, 2006). Fairly accurate would be to emphasise its phenomenological standpoint (Langemar, 2008). This thesis makes no assumptions of generalising the results to any other individuals than those participating in the study.

Participants

Eleven psychotherapists were recruited for semi-structured interviews. This group consisted of five men and six women. Their age varied between 31 and 48, with a mean of 37 years of age. All therapists had worked for at least one year with online therapy, with the exception of one therapist who had recently started at the time of the interview and had only finished two treatments. All participants had at least three years of experience with face-to-face-therapy. Ten of the 11 therapists were licensed psychologists, and the 11th was a sociologist and licensed psychotherapist. All therapists reported that they used computers and internet every day, in their free time as well as in their line of work, and described their proficiency as “good” or “very good”. For a more detailed overview, see Table 1.

Table 1. *Overview of the participants.*

#	Experience of face-to-face CBT	Disorders treated in ICBT	Disorders treated in face-to-face CBT	Years as internet therapist	Years as face-to-face therapist
1	OCD clinic	Depression, hypochondria, panic disorder, sleeping difficulties, social phobia	Anxiety, OCD	6 years	3 years
2	Psychiatry	Depression, panic disorder, sleeping difficulties, social phobia	Addiction, anxiety, depression, overweight	2 ½ years	3 years
3	Psychiatry	Depression	Anxiety, bipolar disorder, depression, impulse control disorders, psychosis	14 years	10 years
4	Psychiatry	Social phobia	Anxiety, depression, GAD, OCD, panic disorder, social phobia,	5 years	6 years
5	Primary care	Anxiety, depression, sleeping difficulties	Anxiety, depression, sleeping difficulties, stress	2 ½ years	6 years
6	Psychiatry	Depression, IBS, panic disorder, social phobia	DSM-IV axis 1 and 2 disorders	3 years	6 years
7	Child and young adult psychiatry	Depression, panic disorder, sleeping difficulties, social phobia	Anxiety, depression	1 ½ years	3 years
8	Child psychiatry	Depression, hypochondria IBS, OCD, pain, panic disorder, social phobia	Borderline, burnout, depression, social phobia, GAD, hypochondria, IBS, OCD, pain, panic disorder, PTSD, sleeping difficulties, specific phobia	10 years	10 years
9	Primary care	Depression	Anxiety, burnout, depression, panic disorder, personality disorders	1 year	9 years
10	Clinical research	Pain, sleeping difficulties (Note: Two treatments)	Anxiety, depression, fear of labour, pain, sleeping difficulties	2 treatments	5 years
11	Psychiatry	Eating disorders, pain, promoting physical activity, tinnitus	Anxiety, depression, eating disorders, pain, promoting physical activity, tinnitus	8 years (On and off)	8 years

Data collection

Participants were recruited via an email, explaining the research project. The email informed the participants that their partaking in the project was completely voluntary, and could be cancelled at any time without neither consequences, nor a need for them to give a reasons for the cancellation. It also stated that the interview data would be handled in accordance with research regulation (Vetenskapsrådet, 2002) and confidentially presented in the finished report, so that no individuals could be identified. Finally the participants were informed that the data would be used for this research project only.

Those who gave their written consent to partake were interviewed over the phone. The information contained in the email was repeated verbally before the interview began. The interviews lasted about 30 to 50 minutes and were recorded to be transliterated later on. When the last two interviews provided no new themes or perspectives, the data collection was concluded. Thus, saturation in the data was achieved.

Interview guide

A semi-structured interview guide (see Appendix 1) was constructed in accordance with the method of abductive thematic analysis. This was done by starting the interview with a few broad questions designed to make the participants give individual spontaneous answers to be analysed inductively, and followed specific questions about working alliance and motivation, to be analysed theoretically in relation to existing research (Braun & Clarke, 2006). The interview guide was complemented with follow up-questions. These were derived from how the participants answered the questions in the interview guide, and were not asked in the same order or manner across interviews (Lantz, 2007). A pilot interview guide was tested two times with two psychology students who had worked as internet therapists in a research project and with face-to-face-therapy as part of their education. The interview guide was revised after each testing.

Analysis

The interviews were transliterated verbatim. Colloquial expressions were rewritten to standard-written language and hesitations markers, laughs and pauses were marked. This work was done by two outside transliterators and myself. The quotes presented in the results have been translated from Swedish and processed as to become more readable while still keeping the participants' original formulation. The thematic analysis (Braun & Clarke, 2006) of the data commenced parallel with the transliteration and the other interviews. It was conducted by myself alone. Firstly, the raw data was read through several times as to familiarise myself with it and obtain a holistic view of it. Secondly, all the interviews were coded and a number of quotes collected under each code. Thirdly, these codes where gathered under overarching themes. The entire data set and codes were reviewed as to find everything that could potentially fit under each theme, and to make sure the themes would still reflect the data itself. Finally, these themes where refined and defined as clearly as possible, and quotes from the raw data were selected to show the relation to the themes in this presentation.

Reflexivity

Lantz (2007) states that the relationship between the interviewer and the interviewee will always influence the data material, so the interviews conducted for this thesis are no exception. My position as a final semester-student of psychology with knowledge of the topic has absolutely had an impact on what came up in the interviews, and especially on the way it was expressed. The conversation became more that of professional associates discussing the subject, and less of the participants explaining the subject to an unaware interviewer. The fact that I am younger than all the participants may also have influenced how they related to me, as well as the fact that I am male.

As I have my own subjective opinions on CBT conducted over the internet and face-to-face, my pre-understanding of these therapy forms should also be discussed in relation to my role as researcher. I myself have had experience as a therapist, both face-to-face and via internet. My experience as an internet therapist came through the research project "Actua!". I worked with a total of two clients, none of whom actually finished the therapy. I experienced it as frustrating, boring and non-rewarding. My opinions on ICBT as a whole, however, are quite positive. I think it is a viable complement or alternative to face-to-face-therapy, and reason that my own experience is due to the lack of motivation from my clients. My experience of face-to-face-therapy, which I have obtained though my education, has been a lot more rewarding and enjoyable. In this form I have also had two clients. However, both completed the therapy and expressed their satisfaction with it. This has made me feel much more "at home" in conducting face-to-face-therapy.

Ethics

In accordance with current research ethics (Vetenskapsrådet, 2002) the participants were informed on the purpose of this research project on forehand. They were also informed that their participation was completely voluntary, and could at any time be discontinued without clarification or consequences. Informed consent was granted by all participants. They were also told that their interview data wold be treated as confidential, stored in accordance with current requirements and inaccessible for unauthorized individuals. They were also promised that no individuals would be directly identifiable in the written thesis. Lastly, the participants were informed that their interview data was to be used for this study only. See Appendix 1 for further details.

Results

Analysis revealed seven large themes, each with two to three subthemes. The seven larger themes were named "Face-to-face-therapy as a stronger experience than online therapy", "Manualised ICBT or individually tailored face-to-face-therapy", "ICBT and work-time control", "Working alliance", "Motivation", "Blended therapy" and finally "Both therapy forms fit different people differently". These are presented in Table 2, and described in more detail below.

Table 2. *Themes and subthemes.*

Theme	**Subthemes**
Face-to-face-therapy is a stronger experience than ICBT	Face-to-face-therapy is more reinforcing than ICBT Face-to-face-therapy brings more focus to the therapist Face-to-face-therapy is more demanding than ICBT
Manualised ICBT or individually tailored face-to-face-therapy	ICBT is manualised and more focused than face-to-face-therapy Face-to-face-therapy is easier to adapt to the client than ICBT
ICBT and work-time control	Face-to-face-therapy is dependent on time and space ICBT offers more flexible work-time
Working alliance	Advantages of creating a working alliance in face-to-face-therapy Working alliance differs in both therapy forms
Motivation	The clients take more responsibility for their own treatments in ICBT Similar and different motivators in both therapy forms
Blended therapy	Internet and face-to-face-therapy are complementary to each other Blended therapy offers better working alliance than pure ICBT
Both therapy forms fit different people differently	Both forms of therapy fit different clients Both forms of therapy fit different therapists

Manual-based ICBT or individually tailored face-to-face-therapy?
Generally, this theme can be described as the participants' experience of ICBT being manualised, focused and structured, while face-to-face-therapy was seen as more flexible. This flexibility seemed to stem from of a greater possibility for the therapists to adapt and tailor the therapy to the client's individual needs. Several of the participants talked about difficulties in achieving focus in face-to-face-therapy. They reported that the clients "floated away", "ran off", "lost their train of thought" and "talked about things 'around' the therapy" to a much greater extent than in ICBT. One of them remarked that it was easy to "lose yourself in the client's mess" (#5). ICBT, on the other hand, made it easier to achieve focus, according to several participants.

> The manual is clearer and easier to follow when you have it in text form, which the patient reads. The risk is smaller that you do something else than what you really should do, like, instead you focus on what you really have agreed to focus on. If it is depression – or whatever it is – and not get stuck on all the little things which can pop up in a conversation between... between people. (#2)

As indicated in the quote above, this stricter focus was sometime attributed to the manual or structure of the therapy. Having the treatment material and communication fixed in writing seemed to make them clearer and more available for both the therapist and the client. The manual was also often seen as a safety measure for the therapists and made them feel secure in their work. It made them believe in the treatment and in the fact that they provided the clients something evidence-based that yielded results for them.

A disadvantage from working with a strict manual was that the therapy became increasingly difficult to adapt to the individual. However, some argued that they had the opportunity to "make some additions", "add some personal things" and adapt their answers and interventions to the client even via the internet. A few therapists remarked that some of the clients needed a more caring therapy style where the client was allowed to "float away as they pleased". It would seem that the structure of ICBT does not fit everyone.

> When you work with complete treatment packages (in ICBT), then it becomes a little bit "one size fits all". Then it does not fit anyone really well. (…) But for me in the primary care, it is more like I want several different sizes, so that I can find you a slimmed suit that fits *you*. (#5)

Contrasting this opinion on ICBT, face-to-face therapy was described as providing this flexibility. This flexibility meant a larger opportunity to tailor and adapt the therapy according to the needs of each client. Participants described face-to-face-therapy as offering more possibilities for reading and meeting the client. They described it as having more "tools" to work with, meaning the direct feedback, the option to ask direct follow-up questions, body language, voice and tone as well as subconscious communication.

> There is great room to individualise each treatment, and that does not exist in internet therapy in the same way. Instead… the individualisation increases, and it becomes more like maybe… it becomes more work doing a behaviour analysis, which is fun. Uh, so that you can really bury yourself in a case and think a little more and, uh, shape it after a specific patient. And it does not have to be diagnose-specific either. It can be, like… yes, compulsion or depression in a mix, like that, yeah? It becomes an individual behaviour analysis of the one you are going to treat. (#3).

> You can look each other in the eye and validate in another way, because you see, maybe, that they are feeling bad, even though it would not have emerged through what they say or what the write for example. Uh, so you can catch things in another way. You do not have… you have access to body language and such. So that is an advantage. You can also… another advantage is that the treatment becomes more adaptable. (#2)

According to some, this opened face-to-face-therapy for addressing broader problems as well as more unspecified ones, compared with ICBT. It was assumed that ICBT offered a broader range of competence and with several different areas at the same time.

Face-to-face-therapy is a stronger experience than ICBT

> Face-to-face-therapy is a, well, more, both more rewarding and more punishing in some way, it is like a strong, a stronger experience (than ICBT). When it is going well and going forwards for the patients, then you become happier, and when it does not go as well or when it goes badly with, with the patient work, then you become frustrated and self-critical. Meanwhile, in internet therapy, you might be more lukewarm all the time. (#11)

As expressed in the above quote, a common theme that emerged in the data was that the therapists experienced face-to-face-therapy as a "stronger" experience than ICBT. This was expressed in several different ways. Overall, many of the therapists expressed that they felt "more reinforced" as therapists by face-to-face-therapy. They also speculated that this reinforcement came from the direct feedback they got from their clients, because they could see how their interventions were received.

> (ICBT) is not as reinforcing for the therapist as it is to meet a person face-to-face. (…) There are some reinforcing aspects missing, which exists in face-to-face. (…) You do not see how that which you, what you deliver, you do not really see how it affects the person in the moment. (#4)

Some therapists reported that they felt that ICBT lacked the "aha" or "wow-moments" or "breakthroughs" which might occur face-to-face-therapy. Lastly some of the participants described face-to-face-therapy as "fun", "exiting", "interesting" and ICBT as "boring" and "less loaded". It should be noted that all therapists found

ICBT a working and satisfactory treatment form, even though it seemed that several of them found the experience as inferior to face-to-face therapy. Lastly, some of the participants also talked about how they perceived the working alliance as stronger in face-to-face-therapy, however this will be elaborated upon further ahead, under the headline "Working alliance".

Many therapists discussed how ICBT gives the clients more of the responsibilities for their own treatment. This seemed to coincide with a larger focus being brought onto the therapists' work in face-to-face-therapy. In turn, the increased focus on the therapists can make them feel "helpful" and better about their work done face-to-face, than their work in ICBT.

> There is more focus on me, that is also… uh, could actually be a disadvantage in live-therapy, that there is less focus on the therapy. Progress is also attributed more to me as therapist than to the therapy itself and what the patient does. (#10)

> (Face-to-face-therapy) can sometimes also make us (therapists) feel pretty capable and good, that I have met someone, and I have helped someone and I have been able to treat someone who was sad. (#4)

Contrasting this, a picture of face-to-face-therapy as more demanding for the therapists also emerged. Firstly, face-to-face was described as "frustrating" and emotionally "demanding" or "exhausting". One therapist expressed the larger efforts put in face-to-face-therapy, in spite of acquiring an appropriate reward. Secondly, several of the participants also described the experience of a more strained work load in face-to-face, due to much more work "around" the actual therapy, such as booking and rebooking therapy sessions as well as handling cancellations. Several of them also reported that more time in the actual therapy sessions is spent on themes that did not concern the goals of the treatment itself. One therapist noted however that these feelings could be a result of "heavier cases" and different clients in face-to-face-therapy, and thus not only from the modality itself.

> I think that is has been both, well, fun and occasionally also very, like, demanding. (…) You feel very much less burdened by (ICBT) than in regular outpatient care. It does not get as, like… heavy in the moment, as it can get when you are sitting with someone who become like that really sad or really angry or dissatisfied or – you become protected by the screen in some way. (#7)

As displayed in this quote, the participants often remarked not only that face-to-face-therapy gives a "stronger" experience, but also that ICBT provides weaker reinforcement. Thus, some of the participants pursued alternative forms of reinforcement when working in ICBT. They could, for example, rather than focus on the direct reinforcement get their reinforcement from clients' slow improvement over time or by acknowledging their gradual achievements. Another

possibility is to share achieved progress with their colleagues. However, the weaker experience of ICBT could also be seen as something positive.

> I think it is good that you, you are protected and you will last a little longer and you do not get tired and you will not, like, you will not be negatively impacted. Uh, you do not get run down. I think you will last longer as an internet therapist. (#7)

ICBT and work-time control

A recurring theme in the data centred on the flexibility of work-time for the therapists. Many of the participants felt that face-to-face-therapy made the work days feel "compartmentalised" and "booked up". Face-to-face-therapy was depicted as very dependent on a certain time and place to function. This can also be taken into context with the previously mentioned themes of more time in face-to-face-therapy being put on administrative work, as scheduling appointments, side-lines and work "around" the actual therapy. A few therapists also mentioned that these tasks could often become disarrayed with cancelled therapy sessions and meetings and full schedules.

> You are usually completely dependent on time and space. Uh, you got to have a certain venue, got to be at a certain place. The patient and you have to be there on a certain time. Uh, it is… uh… and that is like technical for the both of you. (…) uh, but in internet ther- or face-to-face-therapy there are cancelled appointments and you mess up the patients schedule, and the likes. (#8)

> Yeah, well, the only disadvantage that I have experienced – which is not inconsiderable – is that you are very booked up in time. You have your appointments, where you are very booked up, and those you have to make and follow very carefully in that way. So for me it fits extremely well with the internet therapy where I can decide when I want to do what. And rearrange a day if I want. Swap the order of things. I am not so fond of regulated schedules, no [laughs]. So I think this is a disadvantage of face-to-face. A very regulated day. (#1)

Illustrated by the latter quote above, an even more common theme was the flexibility that therapists perceived when working with ICBT. Many of the therapists experienced that they could be in control of their work-time in a variety of ways. For example they could decide not only when they would do their work, but also where. A few of the therapists brought the work home with them. Some of them also mentioned that they could control their work pace and that they were able to do all of their client work in one concentrated effort if they wished. In short, the participants experienced that therapy conducted over the internet became unbound by time and space.

Other work-time advantages concerning ICBT that emerged from the data was that the participants perceived it as being unaffected by illness (either their own or their children's), emergencies or meetings at the work place. For some it even

meant that colleagues could take over their clients for them if needed. This also coincides with the previously mentioned theme of the nuisance of having much more administrative work "around" the therapy face-to-face. The technical solutions often did much of the work for the therapists themselves, for example reminding clients to do their homework or to write to their therapists.

This flexibility in time has made it possible for several of the therapists to do other work on the side of their ICBT, such as research or face-to-face-therapy. Many of them also mentioned how this made it possible for them to work with many more clients at one given time than face-to-face allows them. Some of the therapists remarked that this gave them the opportunity to "work all the time" and increase their work load. Participant #8 said that this also made it easier to down-prioritise her internet clients and it was thus required of her to be more structured, although she saw this flexibility as something basically positive in the end.

Working alliance

When asked about how they experience creating a working alliance with a client in each therapy form, many therapists answered that they thought it was definitely possible in both media. Some therapists had expectations that it would be much more difficult to achieve a working alliance in ICBT, but were surprised to find it easier than they previously thought.

> Eh, over the internet this was a, uh, a misgiving I had when I started working here, that, that how are you going to, like, get a personal relationship, uh, with patients that you never meet. But, uh, I do not think- there can be very personal meetings even over the net. (…) I have seen very, very good, fantastic alliances, even with patients over, over the internet surprisingly good. (#6)

However, even though almost all therapists maintained and emphasised that creating a working alliance over the internet is possible, they also stated that it might be done easier and faster in face-to-face-therapy. A few speculated that this was because of the broader spectrum of communication available in face-to-face-therapy.

> Yes, I think that, uh, I myself have probably… had it easier to do it face-to-face. But it is, it can be done well enough via internet, to create an alliance there too. (#3)

> It is very different in the live contact, but generally it might take longer to get that personal (contact in ICBT) maybe, even if I think it comes with time anyway. So it is seldom you can get that immediate thing, like, that you can get with some (clients) live. (#2)

> In some way maybe it is easier (to create a working alliance), that is, when you are sitting in the room, because you have access to the body in some way. And then you have gestures and like… yes, but, facial expressions and gaze and the likes. You do not have that (in ICBT). (#7)

However, opinions on whether the working alliance itself had the same quality in both forms of therapy were diverse. Many stated that it felt different in both media. Some argued that the working alliance usually felt "stronger" and "richer" in face-to-face-therapy. However, most of these still maintained that this did not make the ICBT working alliance inferior.

> It becomes another, yes, it becomes like another type of alliance, but at the same time it becomes a different alliance. It might be equally good, but it is not really the same. (#5)

> You can say that… you have… a contact with these people that is of another quality, you, you… uh… it is probably a notch… better, or no, not better, but it is a notch… a notch richer. (#3)

One therapist argued that this discrepancy in working alliance was because he had worked with both therapy forms and could therefore compare.

> I experience that you get a stronger alliance in face-to-face, but at the same time I know (laughs) that there are studies that show that it is not always that big a difference when you assess it, so it is simply relative, that… we who go for both parts, we might experience a greater difference than patients who only experience the one. (#11)

Others, in contrast, speculated that it was rather the clients that differed. A few participants even thought that ICBT and writing as communication creates better working alliances than face-to-face therapy when dealing with clients with social phobia, because ICBT is less "charged" and threatening than face-to-face-therapy. Finally, two participants thought that adolescents and young adults open themselves up more in ICBT.

> I think that many times, for some patients, it can be an advantage that you have not… met live because it feels a little more threatening and revealing to sit face-to-face and tell someone things that are shameful, anxious. (#6)

> I rather think that (…) clients have opened themselves more (in ICBT) than what you can do in the room (…) It could be because they are adolescents, but also that you, that sometimes it can be easier when you express something in writing instead of sitting together with a person you do not know so well in a room. That… if you write you, you do not see the person in front of you so that, uh… that you dare to expose yourself a little more. (#10)

Motivation

As previously mentioned, many therapists experienced a better focus on themselves and their own work in face-to-face-therapy as opposed to ICBT. A similar theme was that they also felt that the client took on more responsibility for their own treatment in ICBT.

> I think that (…) in both (forms of treatment), I have succeeded in motivating the patient. I think that in face-to-face-treatment I attribute, uh, the motivation of the patient to a much larger extent to myself. That is: "If I had not been there, the patient surely could not have done this!" But in internet treatment, uh, I probably attribute much more of the motivation to the entire treatment structure (…) So that in both forms I am convinced that the patients become encouraged by the treatment to do certain changes… in their lives. But I connect them much stronger to myself in face-to-face-treatment. (#8)

> It is a difference, now that you say it, that ICBT is seldom frustrating, because you have put much of the responsibility on the patient. Meanwhile, in… in face-to-face-therapy you, I experience that you take on more of that responsibility yourself. (#11)

Some participants also mentioned a "social pressure" on the clients that motivate them face-to-face. A few of them thought that it was easier for a client to terminate an internet treatment where they had not met the therapist.

> Therapist: It is a little harder (to terminate)… face-to-face. Sure, they can decide not to show up at a meeting, but… you have to give a little more than refrain from a program on the net.
> Interviewer: Yes, what (sic) do you, uh, think that is?
> Therapist: No, I think it is easier to avoid it. (…) There is no one there who sits and waits for you and you have to actively call if you are not going to come. (#10)

> Therapist: It might be a bit worse, like, harder (in ICBT), specifically because you cannot… I think it is for better or worse, like, what you, what you do as patient or client do for the therapist's sake, like. So that it sometimes might be a good thing if you, like, make and extra effort to be good, like. Uh, it is a li- it is a little, little bit easier to loiter here, like. There are many who I have treated whom end up in a total avoidance, like, stop staying in touch and like cannot be reached even if we call or text. Uh. I guess it is harder than meeting live.
> Interviewer: Uh, what, what do you think causes it, that it is easier to do so via the Internet?
> Therapist: No, but, it does not get as, uh, it does not get as like, like this, personal. There is no one who sees. (…) The contact does not get as personal and then it is easier to terminate. (#7)

When it came to their own motivational work, almost all therapists thought that they worked very similarly in internet and face-to-face-therapy. One difference was the technological utilities made available by ICBT. For example, the assessment scales filled in by the clients helped one therapist to show the client their progress. The technology can also be seen as an obstruction. Some therapists had had clients who experienced technical difficulties with the web page, internet connection or hardware in ICBT, something that they thought drastically decreased their motivation.

Blended therapy

A few of the participants worked or had worked in some form of blended therapy, that is, therapy conducted over the internet featuring one or more meetings face-to-face. For example, some of the participants met their clients for one or two opening sessions face-to-face before starting the therapy online. All who had worked this way had many positive things to say about blended therapy, for example that it is efficient, that both forms of treatment complement each other when used together, that the working alliance improves when client and therapist get to meet at least once, and that this makes it easier for the client to confide in the therapist. Even some of the therapists who had not worked in blended therapy expressed that they thought it would have these advantages.

> It would be good to be able to mix (therapy forms) too. And I have had the benefit of being able to work with a bit of both, both face-to-face and internet parallel, and getting to feel (…) (that) they complement each other, they are fun in different ways. (#3)

> I met the patients live too, uh, initially so we get to meet them twice first live and, uh, through that it felt like we already had a pretty good contact with them. (…) I thought the live meetings were good. I think it would have been harder if I had not had them. (#10)

> It is like (the patients) would feel that it is easier to confide in someone they met, and they meet psychiatrists or doctors with us, but not the psychologists themselves, uh… live. That it would feel easier to meet on the internet when you have met live, so to speak. I think that we therapists can feel that too, that the times we met someone you get a little bit different relation to the person, and that it gets… but you get like more flesh on the bones with the individual, and it feels worthwhile and you feel that it affects the therapy. And then maybe it does not affect treatment outcomes, but that is a whole other matter. (#1)

Both therapy forms fit different people differently

A final theme revolved around the opinion that both forms of therapy could fit and attract different kinds of clients as well as different therapists. As mentioned, some of the participants thought some clients preferred the contact over the internet, such as people with social phobia, young adults and adolescents. Some thought that the clients they worked with face-to-face were more demanding than those in

ICBT, who they perceived as more well-functioning. Sometimes, these clients also lacked the motivation needed for taking responsibility for their own treatment in ICBT. Lastly, a few therapists mentioned that clients who are not accustomed to computers and internet might have difficulty motivating themselves to an internet treatment

> The patients we meet here (in ICBT) are more well-functioning from the start than the ones I have met before (in face-to-face-therapy). (#7)

> There are different types of patients we are dealing with. Uh, and that naturally affects the, uh, motivation. I would like to say that the ones I saw on the internet, they are the ones wh- they have so small problems that they would not have sought help normally. The ones who are pretty well-functioning really, and the ones who are so bad that they do not get away to the health care center. So, it is the extremes in a way. Uh, that is my view anyway. Uh, and the ones in between are the ones I get in the room, if I am generalising. (#9)

Most of the participants thought that both therapy forms required similar things from the therapist since both treatments make use of the same therapeutic methods. What differed was that the participants thought that the therapists required the ability to express themselves in the relevant medium, i.e. text messages in ICBT and respectively speech and interpersonal skills in face-to-face-therapy. Many referred to the themes mentioned above, such as that an internet therapist should agree with more manual-based, structured and focused way to work with lesser reinforcement. On the other hand, the participants thought that a face-to-face-therapist should be able to individualise the treatment and be able to focus more during the current therapy session than throughout the length of the treatment process.

> (For internet therapists) the obvious is that you have to be good at expressing yourself in writing, uh, that is a high demand. I think that you have to, if you do not have this non-verbal (communication), then you have to convey yourself clearly and empathically in writing instead. And that is not always entirely easy. (#6)

> (Face-to-face-therapy) probably demands much more. (…) It demands that, uh, you have a good capability for conversation, it demands good interpersonal skills. (#8)

These differences directed the participants to prefer one or the other form of therapy. This is related to their own predisposition, for example concerning through which medium they thought they best could communicate in (writing or by talking). It also relates to much reinforcement they needed through their client work or if they preferred a manual as support or rather the possibility to personalise the treatment.

Discussion

Manual-based therapy vs. individually tailored therapy

As shown in the results, many participants viewed ICBT as focused, structured, evidence based, clear and safe. This was often attributed to the treatment manual. Contrasting this view, face-to-face-therapy was depicted as easier to individualise, providing more "tools" to work with and opening up for working with broader, unspecified or multiple problems. This contrast taps into a larger debate about whether psychotherapy in general benefits more from being manual-based or tailored to fit the individual.

The results of this thesis have many similarities with the advantages and disadvantages that Wilson (1995) stipulates with manual-based treatments. Firstly, my results and Wilson (1995) both highlight that the manual supports the therapist achieve a clearer focus in the therapy. Wilson (1995) argues that this is partly because of the demarcation in time that a manual-based treatment requires. Secondly, the participants of this thesis mention that the heavily manualised ICBT makes it easier for them to maintain a certain quality in the treatment, keep it evidence-based and be able to conduct research on the therapy. These advantages are also emphasised by Wilson (1995). A few therapists thought of this as a safety measure, and that they can lean on the manual in their treatment.

Further, Wilson (1995) stipulates disadvantages arise from the use of a manual. Many of these coincide with these results in that they concern an increasing difficulty with individualising therapy. Wilson (1995) writes that even treatment manuals designed for a specific psychiatric disorder are not always applicable since these disorders vary in their symptoms and causes. Therefore a manual might miss individual differences and focus on treating conditions that might be irrelevant for the specific client. The participants seem to be aware of this disadvantage since they talk about both the difficulty of individualising ICBT and the freedom in treatment methods that they experience face-to-face, which helps them tailor the treatment to the clients' needs. With this, Wilson (1995) also supports the notion from the participants that less manual-based face-to-face-therapy might be better suited for working with broader, more unspecified and multiple problems, and that ICBT is not suitable for everyone.

Lastly, Wilson (1995) argues that it might be necessary to assess the client's problems in person. Since the therapists reported it more difficult to "read" the client over the internet, this seems to be a valid point and important for the recruitment of clients in ICBT. It also gives support to the praxis of blended therapy, where the client and therapist have a few introductory sessions face-to-face, and then continue working online if it suits the clients' needs.

However, it should be argued that the dichotomy of manual-based and individualised treatments is not an absolute. There exist many highly manualised face-to-face-treatments, which allow several advantages of manualisation to actually be achieved face-to-face. More flexible forms of ICBT does not seem to

exist to the same extent, however. This suggests a few alternate routes for the future of the latter therapy form.

Firstly, ICBT could remain manualised. This would mean that ICBT would not be suitable for clients with more unspecific, broader or even multiple problems, as stated by the participants. Secondly, another option is to facilitate individualisation in ICBT. This could be done either by merging more face-to-face-elements into ICBT, making it more of a blended therapy, or as Wilson (1995) suggests, allow the treatment manual to become more individualised. According to Wilson, this can be done by timing the intervention, using multiple techniques and using the manual more flexibly.

Can ICBT buffer therapist exhaustion?
Some participants stated that they felt that face-to-face-therapy was more reinforcing, but on the other hand a more exhausting experience than ICBT. According to some participants, this exhaustion stemmed from the stronger emotional experience and higher levels of frustration as well as the heavier work-load in form of more administrative work "around" the actual therapy. This theme might also be related to a major problem in Swedish health care. Health care workers, such as psychologists, continue to be one of the groups with the largest amount of sick leave in Sweden, despite that the number of sick days has decreased overall over the years. Swedish psychologists and social workers are among the occupational groups who have been shown to be most inclined to take sick leave from work on account of stress reactions or depressive episodes, which in turn are some of the most common diagnoses for sick leave in Sweden (Försäkringskassan, 2011). The fact that the participants in this study talk about emotional exhaustion and a heavier work load in face-to-face-therapy fits well with the pattern shown in reports from Försäkringskassan published in 2011 and 2012.

Many of the participants also stated that ICBT provided a less exhausting, more "lukewarm" experience. One therapist even stated that she felt "protected by the screen", and she thought that ICBT can prevent the therapist from exhaustion. Could that be the case? Studies with larger samples are required to give a conclusive answer, but the data given in this study give several affirming indications. These assumptions are also in line with previous research done by Reynolds et al. (2013), who measured lower levels of arousal in both therapists and clients in ICBT as opposed to face-to-face-therapy. They hypothesise that the online environment is "more comfortable and less threatening" (p. 375) than its face-to-face-counterpart, alternatively that this is because of the time-delay in the communication. Even though this thesis focuses on the therapists and Reynolds et al. (2013) on the clients, there are similarities. For example, the time delay in internet communication mentioned by Reynolds et al. (2013) and the direct feedback of face-to-face-therapy reported as a reason in this study could very well be seen as two sides of the same coin. This thesis also supports Reynolds et al.'s (2013) posed implications, such as ICBT being suitable for clients (or perhaps even therapists) with anxiety disorders or social phobia, which the participants report in the interviews.

Apart from the previously mentioned themes of ICBT providing less exhaustion for the therapist and less administrative work, there is also a common theme of ICBT facilitating work-time control. This is reflected by the participants as the possibility to decide when and where to do the work, how much of it to do at one time, and opening up for other flexibilities such as working in spite of sickness. This fits the criteria for work-time control stipulated in a meta-study on the subject by Nijp, Beckers, Geurts, Tucker and Kompier (2012), which is "an employee's possibilities of control over the duration, position, and distribution of work-time" (s. 299). The results of this study suggests that many of the participants felt that they were able to control all of these aspects while working with ICBT. The effects of work-time control are positive, according to Nijp et al. (2012). The studies reviewed it as a positive effect on work-non work balance – i.e. how hard employees experience combining their roles at work and in their private life (Greenhaus & Beutell, 1985) – as well as job-related outcomes, such as job satisfaction and job performance. Even more importantly, work-time control also positively affected health and wellbeing, including stress, burnout, depression, anxiety and sick leave (Nijp et al., 2012).

Considered that the work-time control described by the participants of this study does have the effects that Nijp et al. (2012) suggests, this could mean that ICBT could serve a clinical purpose in the Swedish health care system. Maybe such a feature could work as a first step for exhausted therapists returning to work or as a buffer for therapists on the verge of burning out? As stated, better targeted research is needed to answer whether a relation exists between ICBT, work-time control and positive health effects, but the results of this study indicate that such an assumption is not farfetched.

It is worthy to mention that Mathieu, Barratt, Carter and Jamtvedt (2012) find the same experiences of perceived ease and flexibility with patients of ICBT.

Working alliance

The results of this study can both corroborate and challenge existing research. Most importantly, the participants' views that creating a working alliance in ICBT is possible – despite prejudices that it would not be – has been confirmed by the previously mentioned reviews done by Klasen, Knaevelsrud and Böttche (2012) and Sucala et al. (2012). Although working alliance is possible, Sucala et al. (2013) and Calero-Elvira et al. (2014) suggest that therapists' experience it as stronger and better in face-to-face than over the internet, which is also brought forth in the results of this study. The working alliance was also put forth along with and the therapist's work as less important than the client's own work in ICBT, a theme that is confirmed by Sucalas et al.'s (2013).

As stated earlier, some participants thought the relationship was equivalent in both modalities. Indeed, other research examined in the two reviews by Klasen, Knaevelsrud and Böttche (2012) and Sucala et al. (2012) does not find any significant difference from the client's point of view. One possible explanation is

the relative difference discussed by one of the participants, where he commented that maybe the therapists experience working alliance as better face-to-face since they have experience of both. On the other hand, clients usually only have experience from one treatment form, and therefor the different working alliances might be assessed as the same. Should this be the case, it could very well explain the findings of Sucala et al. (2013) and Calero-Elvira et al. (2014).

The results from this study suggests that whereas more modalities of communication are available, working alliance might be created more easily and faster, and thereto be experienced as stronger by the therapist. This is supported by Sucala et al. (2013), who argue that clinicians experienced negative impact on the working alliance related to fewer modalities of communication (mail, chat, video chat) accessible. This theme also emerges in this data, as the participants talk about working alliance being easier to create when they have access to more "tools" and broader forms of communication in face-to-face-therapy. The participants point out that fewer means of communication also means that the assessment of the client becomes more difficult. One of them pointed out a crucial consequence of this, namely that suicide assessment becomes more difficult – which also provides another stressor for the therapist. This is also corroborated by SBU's (2013) assessment of the disadvantages of psychotherapy. Along with Sucala et al. (2013), I would like to suggest more research on how working alliance is affected by more or fewer means of communication.

Motivation

My results underline the importance of clients' intrinsic motivation in ICBT, stipulated by Bendelin et al. (2011), Donkin and Glozier (2012) and Gerhards et al. (2011). The apparent shift in focus from the therapist in face-to-face-therapy to the client and treatment modules in ICBT, which the participants discussed, could very well explain or at least reinforce the need for clients to be more internally motivated. The external motivators, suggested by Donkin and Glozier (2012), can also be found in the results when the therapists were asked to describe their motivational work with clients. For example, one therapist used assessment scales in the program to show the clients their progress.

While the therapists in this thesis speculate that social pressure on clients and them having a sense of duty toward the therapist can be stronger motivators in face-to-face-therapy than in ICBT, results from Donkin and Glozier (2012) report that this phenomenon also exist in the latter modality. Some of their client interviewees expressed the obligation to finish their therapy because of their commitment to the therapist and the research project in which they partook. The question on how much the presence of a therapist affects client motivation seem to be an important and complex one, and further client focused research could benefit from operationalising social pressure and sense of duty as mediators in this relationship. As highlighted by Reynolds et al. (2013) above, some of my interview participants also experienced that clients who had more symptoms and were difficult to encourage face-to-face were even harder to motivate over the internet.

The future of blended therapy
As shown in the results, several of the participants had an appreciation of blended therapy, thinking it might comprise the best of both therapy modalities and possibly even enhance the working alliance. There is not yet any existing research to confirm or disprove these hypotheses, so blended therapy opens up a large area of future research.

Existing research is positively inclined towards blended therapy. A recent study by Månsson, Skagius Ruiz, Gervind, Dahlin and Andersson (2013) is the first to utilise internet and face-to-face-therapy combined, by their own say. Their study yielded good results and the therapists found many advantages of using the modalities together, such as bridging or even replacing face-to-face-sessions.

As suggested above, merging more face-to-face-elements into ICBT might also make it less dependent on a treatment manual and easier to individualise. This might also make it more open to new types of clients, and make it available for a broader clientele.

ICBT might not fit everyone
There exist some research that potentially corroborate the themes emerging from this data suggesting that ICBT would be suitable for certain client groups such as adolescents and clients with social phobia. Reynolds et al. (2013) has already been mentioned – supporting ICBT as a medium appropriate for social phobia. This since it seems to be a less threatening and more relaxing environment. Hanley (2009) and King, Bambling, Reid and Thomas (2006) show the possibility to create a working alliance with adolescents with good treatment outcome.

Yet there is also evidence to support the participants' notion that ICBT does not fit all clients. As previously noted, Reynolds et al. (2013) show that heavily symptomatic clients show less motivation and satisfaction in treatment. This supports the assumption from the therapists that ICBT is more suitable for clients who are relatively well-functioning. Moritz, Schröder, Meyer and Hauschildt (2013) also display similar results. Their study shows that as depression deepens, the worse the attitude towards treatment got. Still, a participant in this study indicates, in line with SBU (2013), that ICBT might fill an important function of reaching clients that are so symptomatic that they do not even seek out help at all. While ICBT might not be quite appropriate as a form of treatment for them, it can on the other hand help them to seek out a therapy modality better adapted to their needs.

As of today there exists no research on how therapists' own preferences affect treatment. Since the participants clearly have different inclinations to one or the other form of therapy, perhaps future studies could tackle this question. Important mediators derived from my results could be how reinforced the therapists feel by their work, their own reliance on worktime control or their assessment of working alliance.

Limitations

This study faces a number of limitations. First and foremost, the analysis was done by a single researcher. Even though it was possible for me to test ideas and reasoning with my supervisor and colleagues, having one or more partners that were more familiar with the data would surely have made a positive difference for the stringency, analysis and not least the validity of the results. This also indicates that this thesis would benefit from a reanalysis of the data, with the explicit approval of the participants. Preferably such an undertaking would be done by someone with a different pre-understanding of the subject than the one I had.

Other limitations relates mainly to with the selection of participants. The partaking therapists were still active internet therapists, which would imply that they felt comfortable in their use of ICBT. As a result, the data has probably become one sided in favour of therapists who actually enjoy and see advantages with ICBT. Future studies might instead also recruit internet therapists who were not as pleased with their experiences. In spite of this limitation disadvantages and advantages of both therapies have been highlighted and neither should not be overlooked.

Related to the limitation above is the fact that there are very few ICBT projects active in Sweden today. Many of these were approached concerning participation in the study. Since all did not responded and some declined, along with limited time and resources, the conclusive sample chosen for this study had to be based on availability. Thus, the Internet Psychiatry Unit in Stockholm was overrepresented among the participants of this study. This means that some of the similarities in the data might stem from the participants' shared workplaces, as well as all of them working in an urban environment.

Another liable limitation emerged from the data itself, namely that the participants speculated that different clients were attracted to face-to-face-therapy and ICBT respectively. This has consequences for the validity of the results, in that the differences expressed by the participants might not derive from working with different modalities of therapy, but rather with different people.

As previously stated, his study focuses on ICBT with therapist support, but as stated in the introduction, there are several different types and forms of ICBT ranging from pure self-help to blended therapy. This means that there are many forms of ICBT that are not explored in this thesis, and even more forms of face-to-face-therapy, although this study attempted to keep the experiences as diverse as possible.

The fact that the interviews were conducted over the phone has implications, especially for the transliteration and in turn for the interpretation of the data. No non-verbal information except tone of voice could be collected from the situation, which made aspects such as sarcasm and subtleties in the language difficult to capture. It might have impacted the relationship between the interviewer and

interviewee, especially taking into consideration the results regarding modalities of communication and working alliance.

Further research

I have already mentioned several areas where this thesis calls for further research. Below I will confine myself to a few others. Firstly, to confirm or disprove the questions and speculations raised by this thesis, more quantitative studies can be of use. For example, a design where therapists' level of stress, burnout and work-family conflict is correlated and compared with respect to work face-to-face versus ICBT can further clarify whether work-time control is a factor in ICBT that determines these variables. Another suggestion could be to delve further into the experience of the strength of the working alliance in ICBT. More studies focused on a relative difference in working alliance between internet and face-to-face-therapy might answer whether working alliance actually becomes stronger with the non-verbal communication provided by face-to-face-therapy and what part, if any, it actually plays in ICBT.

Another area that call require more research is blended therapy. According to my results there might be some strong advantages in this therapy form. Many of the participants found their experience positive, and both the two therapy forms seemed to complement each other as well as improve the contact with the client. This can be a very important step in the future of psychotherapy, when researched more thoroughly. As mentioned in the introduction, the amount of qualitative research on the subject of ICBT is still scarce; qualitative research with a therapist perspective even more so. This study can with benefit be replicated in other contexts or redesigned to differentiate the data collected here. With time and resources, maybe a study with joint therapist and client-perspective might be preferable, to examine the reciprocal relationship between the two.

Conclusions

Even though there is plenty of quantitative research on internet-based CBT, there are still uncertainties that need explaining if the therapy is to be implemented on a larger scale in health care. Among other areas, there are a deficit of qualitative research, as well as studies that compares face-to-face and internet-based CBT or done from a therapist viewpoint. That is why this thesis has aimed to explore therapists' experiences of conducting CBT online and face-to-face. Eleven therapists partook in semi-structured interviews, which were thematically analysed using an abductive approach. The results showed that the therapists viewed face-to-face-therapy as a stronger experience than ICBT, and the latter as more manualised and providing more work-time control. They also showed that working alliance may be easier and faster created in face-to-face-therapy and that ICBT is heavily reliant on the clients' intrinsic motivation. The final themes concerned the advantages of blended therapy and that both therapy forms appealed to different people. Clinical implications are that ICBT might buffer therapist exhaustion and that it might have to become less manual dependant in order to be easier to individualise.

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Appendix 1: Interview guide

Ethics

This study is done as part of a thesis written for the psychology program at Umeå University. The purpose of this study is to examine the experiences of therapists who have performed both face-to-face-therapy and internet therapy, to thus obtain a deeper insight into their strengths and weaknesses as well as similarities and differences. Participation in the study is completely voluntary. You may at any time without clarification discontinue participation without consequences. The interview will be recorded for later transliteration. All interview data will be stored in accordance with current requirements and will be treated as confidential. No unauthorized individuals will have possibility to access them. The study results will be presented in the exam paper in such a way so that no individuals can be directly identified. Interview data will be used for this research study only. If you want, feel free to take part of the essay afterwards.

Background Information

- How old are you?
- How much experience do you have with computers and the internet?
- What kind of experience do you have with internet treatment?
  - What kinds of psychological problems have you treated?
- What kind of experience have you had with face-to-face treatment?
  - What kinds of psychological problems have you treated?

Opening questions

- How do you perceive working with a client over the internet as a therapist?
  - Do you think that this experience may have impacted on the treatment?
  - What disadvantages have you experienced with internet treatment? Have you had difficulties with anything? What was challenging for you?
  - What benefits have you experienced with internet treatment? What did you think was easy? What did you think was fun?

- How have you experienced working with a client face-to-face as a therapist?
  - Do you think that this experience may have impacted on the treatment?
  - What disadvantages have you experienced with face-to-face treatment? Have you had difficulty with anything? What has been challenging for you?
  - What benefits have you experienced with face-to-face treatment? What did you think was easy? What did you think was fun?

- What do you think a therapist needs to perform a good internet treatment?
  - What qualities should a therapist have to carry out a good treatment do you think?
  - Is there any kind of therapist that it fits more or less well?

- What do you think a therapist needs to perform a good face-to-face treatment?
  - What qualities should a therapist have to carry out a good treatment do you think?
  - Is there any kind of therapist that it fits more or less well?

Specific questions

- How do you communicate with the client in face-to-face treatment or treatment internet?
  - What are the advantages and disadvantages of the respective methods of communication?

- How do you think it was to create a working alliance with the client in face-to-face treatment or treatment internet?
  - How do you show yourself empathetic, genuine and warm?
  - How do you feel that it is possible to connect to the client? How do you feel that it is possible for the client to connect with you?

- How do you think it was to motivate the client in face-to-face treatment or treatment internet? (Commitment, perseverance and determination to stay in treatment)
  - What can you do to motivate clients in each therapy form?