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A Case Study Illustrating Therapist-Assisted Internet Cognitive Behavior Therapy for Depression

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Randomized controlled trials show that therapist-assisted Internet cognitive behavior therapy (ICBT) is efficacious in the treatment of depression. Given that this is a novel way of delivering cognitive behavior therapy, however, clinical service providers may have questions about how to provide therapist-assisted ICBT in clinical practice, particularly with respect to therapist assistance. To exemplify this approach, we present a case study of an older adult male who received 12 modules of therapist-assisted ICBT for depression over the course of 5 months. Highlights of the therapeutic exchanges that occurred over email are provided to illustrate the type of information clients may share with therapists and the nature of therapist assistance. Treatment progress was assessed via self-report questionnaires measuring depression, anxiety, and adjustment. Consistent with the research evidence, significant improvement was observed on all symptom measures at posttreatment. Satisfaction with the therapist-assisted ICBT program and a strong therapeutic alliance was also reported. The case will expand clinician understanding of therapist-assisted ICBT and may serve to stimulate clinician interest in the provision of therapist-assisted ICBT. Future research directions stemming from this case are presented.

A growing body of research has emerged on therapist-assisted Internet cognitive behavior therapy (ICBT) for depression (Johansson & Andersson, 2012). This treatment involves the client working through modularized psychoeducational and cognitive behavioral treatment materials over the Internet (Barak, Klein, & Proudfoot, 2009). Off-line therapeutic homework exercises are often assigned to assist clients with applying core cognitive and behavioral skills into their daily lives. A primary component of therapist-assisted ICBT is a therapist who provides encouragement, guidance, and feedback to the client, typically via email (Andersson, 2009). Despite the growing literature on therapist-assisted ICBT, the delivery of this form of treatment in routine clinical practice remains limited. Perhaps one explanation for this incongruence lies with the minimal literature focusing on the therapist's role in therapist-assisted ICBT. We identified only one qualitative study, by Paxling and colleagues (2013), that examined email correspondence between therapists and clients participating in therapist-assisted ICBT for generalized anxiety disorder. Through content analysis, these authors found that therapist email correspondence involved the following: task reinforcement, self-efficacy shaping, alliance bolstering, psychoeducation, empathetic utterance, deadline flexibility, and self-disclosure. This type of research is useful as it provides further clarification regarding the nature of therapist-assistance in ICBT.

In an effort to assist with dissemination of information on therapist-assisted ICBT in clinical practice and to enhance understanding of client communication and the therapist's role, we begin by providing a brief description of therapist-assisted ICBT and follow with a case study of an older adult male client who received therapist-assisted ICBT via email for depression. Emailed therapeutic exchanges between the client and therapist and outcome measures are provided to illustrate the approach. Given the paucity of case studies related to therapist-assisted ICBT in the literature, this case has the potential to stimulate clinician interest in this approach to treatment.

Therapist-Assisted ICBT

Like many mental health problems, depression is suboptimally treated for reasons such as limited access to providers, mobility difficulties due to the severity of the disorder or a co-occurring health condition, and stigma associated with seeking treatment (Collins, Westra, Dozois,

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& Burns, 2004). Therapist-assisted ICBT has the potential to reduce logistical barriers associated with receiving face-to-face treatment in that it is cost-effective and more accessible to clients than face-to-face treatment (Griffiths et al., 2006). Another major advantage of therapist-assisted ICBT is that it can be offered to clients as an initial step in preventing clinical problems (Calear & Christensen, 2010) or to treat subthreshold to moderate clinical disorders prior to complex, time-intensive, and costly treatments (Cuijpers, Donker, van Straten, Li & Andersson, 2010). The contemplative process of writing about one's thoughts, feelings, and problems may in and of itself be therapeutic for some clients Mitchell, D.L., & Murphy, L.M. (1998). Confronting the challenges of therapy online: A pilot project. Proceedings of the Seventh National and Fifth International Conference on Information Technology and Community Health, Victoria, British Columbia, Canada. Indeed, previous research provides empirical evidence that writing about emotional experience is generally helpful (Pennebaker, 1997). Another advantage of Internet therapy is the option to use the power and technology of the Internet to facilitate supplementary material to clients quickly and easily. As described by Rochlen, Zack, and Speyer (2004), "Whereas traditional therapy takes place in the therapist's office, limiting the therapist to whatever resources he or she has on the bookshelf, online therapy always takes place in a context with limitless resources" (p. 272). From a clinician perspective, therapist-assisted ICBT is advantageous as it can prevent therapeutic drift from evidence-based treatment protocols (Andersson, 2010) and allows therapists to seek supervision or take time to reflect on their thoughts prior to responding to client concerns or questions via email (Shandley et al., 2011).

Considerable evidence indicates that therapist-assisted ICBT results in significant improvements in depression. In a recent meta-analysis, the overall effect size of 15 Internet-based and computerized treatments for depression was reported to be $d = 0.41$ (95% CI: 0.29–0.54; Andersson, 2009); this represents a significant and respectable improvement in symptoms. Of importance, this effect size was significantly moderated by therapist support, with greater effect sizes found for therapist-assisted treatments compared to unguided treatments. Adding to this meta-analysis, a recent review showed that the more human contact involved in Internet therapy resulted in larger effect sizes (Johansson & Andersson, 2012). With respect to maintaining treatment gains, in a recent meta-analysis it was reported that therapist-assisted ICBT treatment gains for depression and anxiety were maintained with no evidence of relapse, even after 1 year (Andrews et al., 2010). Therapist assistance also appears to be very important in terms of attrition rates and treatment satisfaction, with research showing lower attrition and greater satisfaction in clients in receipt of therapist-assisted ICBT compared to self-directed ICBT (Christensen, Griffiths, & Farrer, 2009).

In reviewing the literature, the nature of therapist contact ranges from instant messaging and posting comments on a private forum to providing guidance over email or telephone (Andrews et al., 2010). Often, an Internet therapist will contact their client on a weekly basis, although research has yet to establish the ideal frequency of therapist-client contact to achieve the greatest symptom reduction. However, evidence suggests that people diagnosed with panic disorder require one email a week (Klein et al., 2009). Researchers have also investigated the impact of varying therapist expertise in therapist-assisted ICBT. Titov and colleagues (2010) compared clinicians to technicians in the delivery of therapist-assisted ICBT for the treatment of depression. Technicians in this case were nonclinically trained individuals who provided support and responded to general questions via email, but did not offer clinical advice. They were, however, supervised by clinical psychologists. In both treatment groups, the authors found large effect sizes and clinically significant improvements comparable to those associated with face-to-face treatment.

In terms of client reactions to therapist-assisted ICBT, clients consistently report enjoying the multimedia features and that they prefer this approach as much as, if not more than, other forms of treatment for depression or anxiety (Proudfoot et al., 2003). Further, clients who received written therapist-assisted ICBT for depression report developing a strong therapeutic alliance with their Internet therapist comparable to face-to-face CBT (Preschl, Maercker, & Wagner, 2011).

While there is growing research on therapist-assisted ICBT and multiple benefits associated with its use, there are barriers to delivering therapist-assisted ICBT to clients with depression. For instance, access to a website that allows for secure communication between therapist and client is required (Andersson, 2010). Furthermore, clinicians need to be careful about limiting ICBT to clients within the province or state where they are licensed. Even though Internet therapy dissolves geographical boundaries, within North America, psychologists and other mental health professionals are licensed to practice within a particular province or state. Most provinces and states are ambiguous about whether treating clients online from other regions is appropriate (Kanani & Regehr, 2003). Another limitation of Internet therapy is that therapists must manage the limited nonverbal information exchange, aside from what can be conveyed through text (e.g., emoticons to convey emotions, such as ☺). If using asynchronous email (i.e., a time lag between emails), therapists must consider not being able to spontaneously clarify the meaning of text, which has the potential to amplify problems associated with