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Efficacy of Therapist Guided Internet Based Cognitive Behavioural Therapy for Depression: A Qualitative Exploration of Therapists and Clients Experiences

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Abstract

Depression is an incapacitating mood disorder that is present among 20 million Pakistanis. About 3.4% of annual deaths in Pakistan are due to depression. CBT has been proven a successful treatment module for depression in Pakistan. However, whether individual therapist-guided internet-based Cognitive Behavioral Therapy (iCBT) practiced widely during the pandemic COVID-19 has been effective remains unclear. It was during this time that the educational institutions and government hospitals of Pakistan widely experienced tele-psychotherapy. Therefore, to generate evidence on the efficacy of iCBT and to maximize the benefits of adopting it, the present study was carried out. Semi-structured interviews were conducted from *N*=10 participants (5=Therapists, 5=Clients) experiencing iCBT via Zoom. The data was coded using NVivo software version 12 pro. An inductive approach to thematic analysis was used to form meaningful themes and subthemes. Analysis resulted into two major themes – (1) Similarities in Perspective of Therapists & Clients, consisting of three subthemes: (a) Clinical Efficacy of iCBT, (b) Ease of Use & Perceived Usefulness of iCBT, and (c) Additional Therapist Support & Extra-Therapeutic Influence; (2) Differences in Perspective of Therapists & Clients, consisting of two subthemes (a) Therapy Environment (b) Structure of Therapy. It was concluded that individual therapist-guided iCBT was experienced as effective by both therapists and clients. It was suggested that large scale experimental studies on iCBT be carried out in future to quantitatively test the efficacy of iCBT. The perceived benefits attached with tele-practice must be maximized to reduce disease burden and fill mental health treatment gap.

Keywords: Depression, Pakistan, Internet-based Cognitive Behavior Therapy, Telepsychotherapy, Telepsychology, Online Therapy

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Introduction

Before the pandemic of COVID-19, many traditional psychotherapists and clients were opposed to the idea of therapy out of an in-person clinical setting. Some people did practice online therapy even before the pandemic, but it was during this time that the internet-based practice of psychotherapy, for the first time, was adopted and promoted by academic institutions, government hospitals and other private practices and organizations. Due to a severe lack of mental healthcare professionals, the existing mental healthcare gap was already huge in Pakistan, but with a crisis like COVID-19 pandemic, these statistics skyrocketed. As a need of time and duty to service, many renowned mental healthcare professionals developed online content to reach out to people and reduce their stress and depression. Out of necessity, an opportunity for growth and improvement, and as the

only way forward, therapists and clients inevitably adopted internet-based psychotherapy. Though many studies have been conducted in the West on internet-based psychotherapies but there is hardly any evidence found for the efficacy of such practices in our culture. Furthermore, internet-based psychotherapies are becoming rapidly acceptable and widely practiced. Even though it is highly unlikely that the traditional paradigm of therapy will ever fully go away, the recent conditions have mobilized the way forward for tele-psychotherapy and this new format is likely to stay in practice (Zur, 2012). This is why it is pertinent to empirically research the most commonly practiced psychotherapy in Pakistan that has been properly taught, trained for, and adapted according to our culture, i.e., Cognitive Behavioral Therapy (CBT). CBT has been proven effective for treating the most common and incapacitating illness, depression. Depression alone is a leading cause of disability worldwide and is a major contributor of overall global burden of disease (WHO, 2021). The present study, therefore, aimed to explore the experiences of individual therapist-guided internet-based Cognitive Behavioral Therapy (iCBT) for mild to moderate depression from the therapists and clients' perspective.

Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest or pleasure. It can abnormally increase or decrease appetite and sleep, and can cause hopelessness, helplessness, haplessness, and suicidal thoughts. It can weaken one's immunity, making them more vulnerable to diseases (Gilbert, 2007). Depression has been projected by the World Health Organization to be the leading cause of disease burden worldwide by 2030 (Kraepelien et al., 2018). Over 700,000 people die each year by suicide due to depression (WHO, 2021). Prevalence of depression is quite high in Pakistan. About 20 million i.e., around 10% of the population of Pakistan suffers from depression (Nisar et al., 2019). During COVID-19 pandemic, there has been a surge in the number of depression cases in Pakistan. Studies have revealed about 3.4% of annual deaths in Pakistan due to depression (Khaliq et al., 2021). Despite alarming statistics, many Pakistanis do not believe depression to be an illness.

Reasons for depression vary. It could be biological, psychological, or due to environmental factors. It could be genetic, it could be because of medicinal side-effects or drug-interactions, or as a secondary disorder due to a primary disease (Bruce, 2008). It could be because of one's faulty thinking patterns, inability to manage stress, or difficulty regulating emotions (Gabbey, 2020). Depression is possible if one has prolonged exposure to stressful environments or has experienced interpersonal issues, abuse, trauma or even a change of seasons (Nisar et al., 2019). A family history of depression can also result into a person suffering from this disease. Pakistan has a majority of people with lower- and middle- socioeconomics. The per capita income of Pakistan is just $1,798 (Pakistan Economic Survey 2021-2022, 2022). Poverty being a major cause of depression is also the reason patients do not seek help as they cannot afford it (Malik et al., 2015).

Most people acknowledge depression as a natural feeling of sadness rather than a mental health disorder making seeking treatment for it a challenge in low-middle income countries, like Pakistan. Due to a high illiteracy rate and lack of awareness about depression, people often believe depression to be a result of evil eye "nazar" or black magic "kaala jaadu". Hence, instead of going to a mental health professional, they pursue traditional and spiritual remedies like changes in diet, or "dam" or other homeopathic treatments (Naeem et al., 2015).

While seeking help for treatment of depression from trained psychiatrists and psychologists is often the last resort for many people in Pakistan, those who do desire to see a mental health professional

are further bounded by their lack of availability. Pakistan has about 400 psychiatrists (Javed et al., 2020) and about 2 to 3 psychotherapists per 100,000 of its population making psychotherapy even harder to avail (Taj, 2015). People aware of their problems often avoid seeking professional help due to the fear of stigmatization and discrimination. There is a strong shame attached to discussing depression publicly in Pakistan as there is little to no understanding of the disease or of mental illnesses in general. Most people do not seek help due to the fear of being labelled as "crazy". This way the society complicates the illness by not acknowledging it or preferring it stays hidden and it ends up causing more damage to the individual beset by it (Hyder, 2020). The burden of such untreated conditions affects the productivity of individuals consequently affecting the economy of the nation (Hussain et al., 2017).

Treatment for depression based on its severity and cause is possible through medicines or psychotherapy. Cognitive Behavioral Therapy (CBT) is one such psychotherapeutic treatment that has been widely researched, implemented, and adapted for cultural efficacy (Naeem et al., 2021). CBT treats underlying maladaptive thoughts leading to disruptive behaviors (Katon, 2022). It aims to alter the cognitive distortions, thoughts, beliefs, and attitudes, and form a coping mechanism to subdue future emergence of unwanted feelings or behaviors (Goldman et al., 2006). CBT differentiates itself from the traditional psychotherapies by being "action-oriented" as it is used to treat a specific problem linked to the disorder and has been found as effective a treatment as with psychotropic medications (Gartlehner et al., 2017).

Cultural adaptation of CBT is required for its effectiveness in non-western cultures (Laungani, 2004). Pakistan is a predominant Muslim nation where religion strongly shapes people's way of life. Therefore, experienced psychologists modify CBT to address the individual needs of patients in Pakistan taking into consideration their cultural and religious believes as part of therapy (Naeem et al., 2021).

Implementation of CBT in its structured form is quite limited in Pakistan. Having to attend at least 6-8 therapy sessions becomes an expensive treatment for people to follow through (Naeem et al., 2015). With such a large number of patients to address, CBT becomes a very time-consuming treatment and often the time possible to give each patient in person lasts from 15-20 minutes only. Activities such as identifying cognitive distortions, doing thought balancing exercises, engaging in stress-reduction activities, and tracking progress are all usually done within the session as patients have poor compliance with homeworks (Royal College of Psychiatrists, 2013). Many psychologists predict that it might be due to illiteracy but the psychologists working in the private sector with usually educated and wealthy patients, also complain that the patients are not willing to comply with homeworks. An estimated of only 40% of the patients adhere to the homeworks given (Naeem et al., 2010). This lack of treatment adherence could be because of a lack of motivation and belief in the efficacy of the homeworks. A psychologist assistant support system that could follow-up with the patients and provide the necessary help that the clients might need with doing homeworks is often missing**.** Another major reason for poor compliance with homeworks could be peoples' lack of motivation and belief in the efficacy of doing homeworks. Moreover, Pakistan is a pill-oriented society. Patients are more interested in getting medicines than resolving underlying psychological issues. Despite all these difficulties, under controlled conditions, CBT has been proven highly effective treatment for depression in Pakistan (Naeem et al., 2015).

Internet-based Cognitive Behavioral Therapy (iCBT) is the provision of therapy (CBT) through a telecommunication device (phone/laptop) with internet access,

diminishing in-person direct contact of therapist and client. iCBT can be delivered in three forms, (1) standalone self-help software-based therapy program, (2) guided self-help software-based therapy program, and (3) therapist-guided synchronous or asynchronous audio/video-based therapy program (Cerga-Pashoja et al., 2020).

With integration of technological advances into healthcare, iCBT has become a fast-growing intervention modality compared to conventional in-person psychotherapy especially during the pandemic of COVID-19. Due to the need to maintain physical distance for personal safety, many therapists, and clients experienced therapy virtually. Many seasoned therapists developed web-based self-help videos based on CBT principles to help people deal with their anxieties and combat depression (Ajmal, 2019). Ideally, iCBT would have made therapy easy for both the patient and the therapist while being relatively cheaper for the patient as a few small-scale studies suggested (McCrone et al., 2004). However, considering factors like low incomes resulting into lack of electronics, laptops, or mobile phones etc., and no internet connections rendering iCBT inaccessible, it was important to explore if this method of delivering psychotherapy in Pakistan was beneficial. As, even for the populous that could afford and access internet facilities, the internet connection is subpar in comparison to the western, more developed, countries making iCBT difficult to practice on a regular basis. Furthermore, since iCBT is a teaching module, it required a well-educated audience, however, Pakistan's literacy rate is around 60%, and many literates are not digital literates, meaning they are unable to manoeuvre through the vicarious world.

For present study, efficacy of individual therapist-guided iCBT was explored taking therapists and clients experience-based perspectives in account.

Method

Research Design

A qualitative research design was used to understand the in-depth experiences of therapists and clients on iCBT for depression.

Sample Size and Technique

A sample of *N*=10 participants (5 therapists, 5 clients) having delivered/received iCBT for mild to moderate depression were recruited. Participants were selected through criterion-based sampling. Criterion-based sampling involved identification of a pre-established criterion of importance that narrowed down to some specifications and allowed the researcher to understand the implications and weaknesses of a system for improvement (Palinkas et al., 2011).

Inclusion Criteria

- Therapists having relevant qualifications, 3 years of minimum work experience and certifications to deliver CBT.
- Therapists having at least six months of experience with delivering iCBT sessions for depression.
- Clients, 18 years and older experienced with iCBT for mild to moderate depression.

Exclusion Criteria

- Clients with severe depression, comorbid disorders, or suicidal ideation.
- Clients and therapists not having access to laptops/smart phones or lacking basic digital skills.

Sample Characteristics

Table 1 shows the characteristics of the research participants.

Table 1
Characteristics of the Sample Participants N=10 (5 Therapists, 5 Clients)

Sr No.	Participant	Pseudonyms	Gender	Age	Education	Experience with iCBT
1	Therapist	Ajmal	Male	57	PhD	8 months
2	Therapist	Khan	Male	48	PhD	1 year
3	Therapist	Sidrah	Female	41	PhD	13 months
4	Therapist	Sadaf	Female	33	MS/ADCP	6 months
5	Therapist	Rabia	Female	48	PhD	6 months
6	Client	Haya	Female	21	BS	4 weeks
7	Client	Reyha	Female	25	MPhil	12 weeks
8	Client	Muhammad	Male	21	BA	5 weeks
9	Client	Zain	Male	20	MSc	8 weeks
10	Client	Naima	Female	26	MPhil	7 weeks

Note. To maintain privacy of information, each participant was given an assumed pseudo name. These pseudonyms have been used only to represent the data, keeping discreet the real identities of the research participants.

Instruments

Semi-structured interviews were conducted to collect in-depth data on the experiences of therapists and clients on the efficacy of individual therapist-guided internet-based CBT for mild to moderate depression.

Main question asked was:

1. What is your view on the efficacy of individual therapist-guided iCBT?

Analysis

An inductive approach to thematic analysis was taken for extracting the themes. Induction approach was suitable as it allowed open observation of data in order to search for similarity between different perspectives to reach towards a flexible conclusion that could be generalized (Creswell, 2013). This provided an in-depth understanding of participants' view of therapist-guided iCBT within Pakistani context. Thematic analysis was used as it provided a more flexible, detailed, and comprehensive understanding of participant's experiences. The six-step framework for thematic analysis (Clarke et al., 2015) was used as follow:

1. Familiarization with Data

The researcher familiarized herself with the data through reading and re-reading all the transcribed data, cohesively understanding the viewpoint of all participants.

2. Generating Initial Codes

Using NVivo software 12 Pro, the researcher started coding the data for importance of ideas, similarities and differences of opinions and relevant data matching the study objectives. NVivo allowed for the codes to be stored, indexed, and easily retrieve associated textual material identifying illustrative quotations. Initial coding was performed by the first author and cross-checked by the second author (supervisor) to reduce research bias and improve reliability.

3. Searching for Themes

Redundant codes were discarded, and similar codes were merged. The codes were then arranged into clusters of similar looking patterns/sub-themes that matched an idea of convergence or divergence by the participants on an area of inquiry.

4. Generating Initial Themes

The initial themes were revised and verified across latent codes by giving meaning units to the codes. The subthemes were then aligned with the main research questions.

5. Defining and Naming Themes and subthemes

The subthemes were clustered after discussion and with agreement between the two researchers. After reviewing the subthemes, a major theme was finalized. A comprehensive thematic table with major

theme, subthemes, and codes was then drawn.

6. Report Generation

Results and discussion were drawn based on major theme and subthemes supported by participant's verbatim, general discussion and past research. It was ensured that the final framework was representative of the entire dataset and at least one quote from every participant was presented.

Procedure

Therapists and clients fulfilling sampling criterion were approached through personal and professional contacts via email. Those who agreed to participate (response rate 90% for therapists – one declined due to professional commitments, and 70% for clients – no reasons were given by those who did not respond) were interviewed online using Zoom meetings at a mutually agreed date and time. Interviews were conducted in English/Urdu languages as per the convenience of the participant. However, all transcripts were carefully translated and transcribed into English without losing the meaning and emotions behind what was said. All interviews were audio-recorded and lasted about 25-30 minutes.

Ethical Considerations

Information about the purpose of the study and the interviews was disclosed to the participants and their consent was obtained via an email. Confidentiality of the data was promised to the participants and were assured that all their information would be treated as sensitive. Pen names were used for the participants to ensure anonymity. Participants were made aware of their right to withdraw from the study at any time without any explanation. Permission to audio-record the interviews was sought.

Results

After analyses, the data was condensed into two major themes: (1) Similarities in Perspective of Therapists & Clients, (2) Differences in Perspective of Therapists & Clients. The first major theme consisted of three subthemes namely: (a) Clinical Efficacy of iCBT, (b) Ease of Use & Perceived Usefulness of iCBT, (c) Additional Therapist Support & Extra-Therapeutic Influence. The second major theme consisted of two subthemes namely (a) Therapy Environment, (b) Structure of Therapy. Relevant codes falling under these subthemes have been given in Table 2.

Table 2

Main Themes, sub-themes, and Relevant Codes Showing Efficacy of iCBT (N=10)

Main Theme	Sub-Themes	Codes
Similarities in Perspective of Therapists & Clients	Clinical Efficacy of iCBT	Symptom Reduction/Improved well-being
		Improved learning of clinical & technological skills
		Satisfaction with treatment and services
	Ease of Use & Perceived Usefulness of iCBT	Increased accessibility & scalability of services
		Reduced money, wait-time, travel, lodging expense
		Client empowerment/Flexible scheduling/rescheduling
		Overcoming therapeutic barriers (communication, comprehension, context, culture)

	Additional Therapist Support & Extra-Therapeutic Influence	Out of session therapist support instills motivation in clients Maximizing treatment adherence and compliance Use of self-help resources
Differences in Perspective of Therapists & Clients	Therapy Environment	Interrupted vs. uninterrupted environment Comfort of home vs. difficulty finding space in shared household Audio vs. video environment for communication
	Structure of Therapy	Work-time control Long-term vs. short-term therapy modules

Major Theme 1

Similarities in Perspective of Therapists & Clients

This theme consisted of three subthemes explained below:

Subtheme 1

Clinical Efficacy of iCBT

CBT is an evidence-based approach to treat underlying maladaptive thoughts. Under the subtheme, Efficacy of iCBT, it was found that both therapists and clients found individual therapist-guided internet-based CBT to be clinically effective as iCBT reduced symptom intensity and yielded positive results. Despite scepticism for the viability of iCBT, therapists and clients were overall satisfied with the services delivered and received via the internet.

In my experience, if we were to compare CBT for the depressed patients for online and the face-to-face sessions, there has been no difference at all in patients' therapeutic achievements or the pace of the treatment. The improvement rate was the same (Therapist - Khan).

I really feel good about it (iCBT). The patient satisfaction level has also been appropriate and even sometimes better than in person sessions (Therapist – Sadaf).

I felt at ease and safe. My therapist did a really good job in identifying and explaining my problem (Client – Muhammad).

By adopting iCBT, the clinical and technical skills of therapists and clients to effectively deliver/receive therapy via the internet improved. Clients were able to practice the clinical skills for resolving their underlying thoughts related to depression.

Before therapy, my mind only thought and catered for my perspective. With online therapy, I changed. I would now take account of other people's narrative. I started accepting their story. I also started changing my narrative to make it more positive and that is something iCBT really helped me with (Client – Haya).

Previously (before experiencing CBT online), I thought only face to face sessions could work. The eye contact, the presence of the therapist plays a very important role in rapport building, empathic listening, and especially in collaborative empiricism that is the heart of CBT, but now (after experiencing iCBT) it is not the whole story. We can build up all these skills during our online sessions (Therapist – Rabia).

With Zoom, you can do so much. You can open a classroom within your videoconference. To practice therapy online, you need to learn about a few apps and be up to date (Client – Reyha).

Subtheme 2

Ease of Use and Perceived Usefulness of iCBT

Under this subtheme, iCBT was experienced as easy and useful by clients and therapists alike. iCBT provided real-time and quick solutions, thus reducing the long-term trauma and unresolved

psychological issues. iCBT was cost-effective and reduced wait-time, travel, and lodging expenses.

With this (iCBT), I have saved 4 hours of traveling time, money, fuel, and my energy. I feel like I can do a lot more and give a lot more (resources) to my client (Therapist – Khan).

iCBT has increased the scalability of services. For therapists, it increased the potential clientele. For clients, choice and access to expert care improved. Not only locally but internationally, clients were able to seek help. Moreover, iCBT empowered the clients to choose a therapist and manage the pace and direction of their therapeutic progress.

Homemakers, who previously had no access for therapy, now have access and are going for therapy. Mothers and grandparents, for whom it is not really convenient going for a therapy outside of home without being accompanied are now going for online sessions (Therapist – Rabia).

When I shifted to internet-based interventions, I quickly started to get international clients…All I had to do was press a button and I would be connected with my clients (Therapist – Khan).

I did not have to wait for my therapist to get answers to my problems (Client – Zain).

iCBT sessions allowed therapists and clients to overcome communication, comprehension, contextual, and cultural barriers. Internet-based intervention made it possible for the clients to reach out to therapists who spoke the same language as them. It further facilitated the therapists to accurately comprehend clients' problems keeping their cultural values and background in mind.

Sometimes we have clients who speak 'Siraiki' language, but the psychologist speaks "Pahari" language. Though these languages are mutually intelligible but the differences between them are enough to cause difficulty in understanding. Due to this language barrier, the client is unable to understand what the psychologist is saying. Therefore, iCBT allows you to see a psychologist from your region who speaks the same language and knows your culture. (Therapist – Khan).

Clients' fear of being labelled 'crazy' for seeing a therapist, all went away as nobody else had to know that they were taking therapy except for their therapist. (Therapist – Rabia).

Subtheme 3

Additional Therapist Support & Extra-Therapeutic Influence

The additional support received by the therapists other than the therapy session time for providing clarification on assigned homework tasks or help with any other exercises provided motivation to the client and increased their adherence to treatment. Similarly, for therapists, the ability to provide/send out free inexpensive reading materials, or trusted links of educational videos related to the client's problems or treatment for their better understanding became easy. Such out-of-therapy session influences helped clients.

The role of therapist support is far more necessary in iCBT than in traditional in-person CBT. One reason for this was that most clients coming to hospital/clinic settings were accompanied by family, friends, or someone close whom they trusted. This person gave the social support and motivation to the client to stick to therapy. However, with this kind of social support often being missing for iCBT sessions as the clients could independently seek it, this support and motivation to adhere to treatment now had to come from the therapist. The out-of-therapy supportive session time that the therapist gives to the client helps them to better understand the therapy contents and feel motivated to adhere and comply with the treatment goals.

I would send voice notes to the therapist if I did not understand anything. Had my therapist not replied, I would not know what to do. I would have probably not come back (Client – Zain).

Over the internet, we have some way of getting back to the client which is not quite possible for most of our in-person patients as no one keeps a record of patient's number or residence. The patient is just told a day when to visit again. It is up to the patient if he wants to show up again or not. There is no way to encourage him for it (therapy) or send reminders to set an appointment for their therapy sessions (Therapist – Sadaf).

Generally, Pakistanis are reluctant in doing assigned CBT based homework tasks. However, iCBT facilitated therapists to easily follow up on homework with clients.

Most people in in-person sessions used to have excuses for not doing the homework or forgetting the worksheets at home. Through online sessions getting the patients to do their homeworks and returning them in before the sessions has become easier. For patients, it is generally difficult to do homework tasks, they desire therapists help and are reluctant in doing homeworks by themselves. But as a therapist, for me, giving patients homeworks and worksheets, supporting them with bibliotherapy has become a lot easier (Therapist – Ajmal).

iCBT practice distributed the load of the therapists towards the available plentiful self-help CBT material. Informational care received through reading material and videos made exercising CBT techniques easier as it catered for client's forgetfulness due to depression and made it available to be viewed multiple times.

Sometimes I use bibliotherapy and recommend books. Share pamphlets and articles, or what I do is, I recommend YouTube videos. At times, I put up a video on my feed for clients to be able to relate and understand a problem. Sometimes, I send them memes or cartoons that resonate with their situation, all as a part of treatment based on CBT (Therapist – Rabia).

With iCBT, the colorful worksheets keep clients more engaged with therapy related work (Therapist – Khan).

Unlike England where I previously worked, the hospital supplied a huge chunk of pamphlets on how one could help himself. CBT allows you to do that. Online medium has allowed me to provide those things again. For these things to be practiced in-person in Pakistan, either laziness or lack of resources is to be blamed (Therapist – Sadaf).

Major Theme 2

Differences in Perspective of Therapists & Clients

This theme consisted of two subthemes explained below:

Subtheme 1

Therapy Environment

Under this subtheme, the differences in perspectives of therapists and clients were seen based on the environment in which therapy was conducted. While therapists saved time and energy through work-from-home, whether their environment at home or at office was more interruption-free, concluded their likeability and acceptability towards iCBT. Similarly, whether a client was able to find a private space within their home where they felt a sense of privacy or not, influenced their satisfaction and preference of iCBT. Unlike in-person therapy, with iCBT, the virtual environment for therapy provided an option to therapists and clients to provide/seek treatment in audio-video or audio only format.

The distractions in environment for therapy influenced the efficacy, choice, and satisfaction with iCBT for therapists and clients. iCBT allowed physical and mental comfort of providing/seeking therapy from home. Whether a therapist had additional tasks at home or at hospital/clinic influenced their attention towards the client in therapy and hence the satisfaction with the environment for effectiveness of iCBT.

You have a better chance of getting distracted, since you are at your own home, which I would not consider ideal therapy environment (Therapist – Sadaf).

My therapist was vice CEO of the company…At times during the call there would be a knock on the door, which she

would then go and check. It disrupted my flow of conversation (Client – Reyha).

My therapist used to take the sessions from her home. Sometimes her kids would come by, and her daughter would be crying but I would not mind that because I am a mother myself (Client – Naima).

Most clients would take iCBT sessions from the solace of their beds. While it allowed some people to have the mental peace and a sense of safety and security, others sharing rooms with siblings or family, found it difficult to find private space to talk and even if they did find some private space, they feared being overheard. Overall, most clients felt satisfied with sharing their problems via the internet and had no major privacy concerns.

For clients, the environment of their home for therapy is far more comfortable as they can lay down and openly share their problems than sit straight in an upright stature. Laying back just allows free flow of thoughts (Therapist – Sidrah).

I used to quietly close the door to my room and take sessions as no one in my family knew that I was taking therapy…I sometimes feared being overheard (Client – Haya).

Therapist's perspective on seeking treatment from home was that for depressed patients with psychomotor retardation and lethargy, it is actually more beneficial and helps the clients to continue treatment without physical barriers.

Clients sitting at home did not have to put a lot of effort. They did not have to take a bath or wear nice clothes or travel. When you are depressed, such tedious tasks seem too much and often are the reason clients are reluctant in continuing treatment (Therapist – Rabia).

Clients with depression tend to have low self-esteem and often prefer that they take audio therapy sessions than video sessions. Most clients for iCBT sessions have insight into their problem. They are less hesitant in an audio session over the internet as it provides them with a one-on-one uninterrupted safe environment. Despite having issues in finding a private space to take the online session, something common for collectivistic cultures with a combined family system, clients felt comfortable sharing their problems online. Acknowledging the limitations in therapeutic environment, the lack of physical proximity and limited body language cues, therapists allowed their new clients extra time to understand them better.

Initially, we did a video session, later on, it was just more comfortable to do audio sessions (Client – Zain).

Online sessions were extremely comfortable. I have body image issues so he (my therapist) could not see my whole body, he (my therapist) could not figure out if I were fidgeting or not, so yes, that was comfortable. I was able to communicate my more pressing issues without being conscious of being judged on my looks (Client – Muhammad).

Subtheme 2

Structure of Therapy

The structure of iCBT sessions greatly depended upon the work-time control. Whether the therapists and clients were able to manage the time of sessions for collaboratively working towards the solution of problems, affected their satisfaction with the efficacy of internet-based CBT. Though appointment-based scheduling allowed therapists and clients to prepare for sessions in advance, the possibility to extend time within therapy sessions catering for therapist/client demands versus drift impacted the structure of treatment provided/received. Furthermore, while some therapists and clients appreciated the possibility of continuing long-term therapy, others believed that the entire purpose of reaching out for help via the internet was to seek short-term immediate help for pressing problems.

Internet-delivery has given more structure to practicing CBT. The sessions being appointment-based have allowed therapists to plan therapeutic tasks for their clients, unlike in-person practice where the

therapists are unaware of who the next client will be or what his problems were (due to a lack of electronic medical record and appointment system). Work-time control was rendered significant in maintaining a structured approach to iCBT sessions. iCBT reduced therapist/client drift as the client and therapist could both account for the time spent in therapy.

During online sessions, even the clients can see on screen how much time has gone by. You do let the client spit what he wants to, but you cannot just let that go on for too long. In the first 15 minutes, you can build the rapport and gather information, then in the next 15 minutes you must produce a solution so that in the last 15 minutes you can get some feedback on what is being done. Structuring your therapy sessions is far easier in online therapy (Therapist – Sidrah).

Online was difficult due to network/internet issues, and the inability to schedule appointments according to the therapist's time. Sometimes when she was available, I would be busy. Sometimes, our sessions would get delayed. Sometimes the sessions would not happen. There was just no structure to the sessions (Client – Haya).

While some therapists and clients believed that adherence to treatment for long-term structured CBT sessions improved with internet-delivery of services; Others believed that for online sessions quicker short-term structured solutions must be present to address the pressing mild to moderate level of problems.

In online sessions, client's adherence to the treatment improved. If initially clients took 6-8 sessions, that improved to about 10-12 sessions (Therapist – Sadaf).

The purpose of online therapy is to become available for client at his/her convenience (Therapist – Khan).

I would only contact my therapist when I really needed a session (Client –Zain).

Discussion

Before COVID-19 pandemic, many therapists and clients disregarded the idea of online therapy due to a lack of belief in its effectiveness, however, after experiencing it and with trial-and-error method, they found it to be quite easy and useful. The similarities and differences that therapists and clients experienced with iCBT have been discussed below.

In terms of similarities of experiences, for clients, access to effective treatment increased with iCBT as it promoted active self-care, perceived control, and empowerment in therapy. Clients getting extra support from therapists believed that iCBT helped them to continue treatment by strongly adhering to the therapy modules (Lippke et al., 2021). Therapists also believed that compliance to homeworks was better with iCBT. Literature suggested low adherence to homeworks for unguided iCBT programs, and high adherence for therapist-guided iCBT. This was because either traditionally, in in-person settings, the therapists did not have enough time to stress upon the importance of these exercises or explained in detail how clients were to go about them. However, factors identified for poor adherence with homeworks in iCBT were challenges in understanding content, skills being cognitively or emotionally draining, contextual challenges, forgetfulness, and lack of familiarity with the skill (Peynenburg et al., 2022).

Sometimes people due to their busy work schedules and unavailability of a private space for therapy were unable to seek treatment for their prevailing issues despite having an insight for it. However, iCBT overcame such geographical and contextual barriers and allowed clients to seek therapy as per their convenience from the comfort of their homes. With the delivery of therapy (CBT) via the internet seeking therapy at odd hours also became possible. While some senior therapists strongly discouraged this practice, paradoxically, others believed that this was an advantage that iCBT offered to its clients i.e., the autonomy to schedule/re-schedule a session according to clients' needs and convenience. Since the time set by the therapist and the client for

therapy was always mutually agreed upon, this flexibility of time was regarded as a benefit. Consistent with these results, research suggested benefits of iCBT as geographic flexibility, customizability, time-effectiveness, consistency, high availability, and rapid dissemination of treatment (Lau et al., 2017).

The differences in experiences with iCBT according to therapists and client's perspective were that in the Western countries often pamphlets/brochures are present in psychiatric offices for clients to better educate themselves or their loved ones about mental illnesses. This practice due to a lack of structure, finances, and literacy rate is often absent in Pakistani hospitals and clinical practices. With iCBT, therapists were able to provide clients with free extra-therapeutic CBT based resources that helped them visualize and better understand their problems. Clients could revisit the material and use the self-help material to get better. This is something missing in most in-person practices. Many depressed clients often tend to forget what was taught and discussed during sessions, so with the extra out-of-session help present, they are often able to retain their teachings. In a study on exploring the necessary competencies for an effective tele-practice of therapy in Pakistan, it was found that with access to evidence-based self-help material, many clients understood their problems better and felt more skilled to manage their problems (Khan et al., 2022).

Environment for the therapy greatly influenced the efficacy of iCBT. For therapists, if they had additional administrative or/and teaching tasks at their physical workplace along with seeing clients, then they were likely to prefer iCBT as it allowed them to be more focused on the patient and minimize other distractions. Likewise, if they had more duties towards family and other household chores, where they felt they could or they just had to multitask, then they felt that iCBT was distractive and not as efficient as in-person therapy. Similarly, for clients, whether or not they found a quiet and private space at home for therapy affected their involvement and experience with iCBT. A warm, safe, and supportive environment for therapy is very important for the treatment to effectively work. Studies have also shown that therapeutic atmosphere directly affects treatment outcome (Siegel et al., 2020). In a meta-study by Pihlaja et al. (2018), six studies showed the environment of iCBT to be feasible for therapeutic alliance resultantly affecting the treatment outcome.

The structure of CBT delivered via the internet was mostly offered as a brief therapy for clients with mild to moderate depression. Since the people seeking treatment online were often well aware of having a problem, they were willing to change, and came with an expectation for the received treatment (iCBT) to work; Brief CBT helped enhance their adjustment and resolved problems. Culturally adapted brief CBT was found as effective as Treatment as Usual for Pakistanis (Naeem et al., 2015). Many clients seeking online treatment (iCBT) were equipped with skills to manage their problems, they often desired a single session therapy to deal with their acute anxieties or mild to moderate depression (Naeem et al., 2015). iCBT made it convenient for clients to easily schedule a session with a therapist reducing wait-times, resources exhaustion, and shortage of trained professionals (Newby et al., 2021).

Based on the results of the professional and personal experiences of therapists and clients on the efficacy of individual therapist-guided internet-based Cognitive Behavioral Therapy (iCBT) for mild to moderate depression, iCBT was found effective. Recent meta-analysis of twelve randomized controlled trials (RCTs) comprising of evidence-based iCBT for depression and anxiety during COVID-19 also found iCBT to be clinically effective in significantly lowering the assessment scores (Komariah et al., 2022).

Conclusion

The study qualitatively explored the similarities and differences in perspectives of therapists and clients on efficacy of individual therapist-guided iCBT for mild to moderate depression in Pakistan. iCBT was found to be clinically effective and easy to use. Moreover, the additional support and extra-therapeutic materials from therapists made iCBT a preferable choice by both clients and therapists. However, the virtual environment in which therapy was conducted, whether or not was interruption free influenced greatly the satisfaction of therapists and clients with their experience of iCBT. iCBT unlike traditional CBT gave empowerment to the clients to control the pace and progress of their treatment. Since the therapist and clients would set appointments for therapy, the structure of therapy in iCBT greatly based on the clients need, whether they just wanted a short one-session treatment for immediate problems or a long-term treatment for eradicating the root of their issue. iCBT could be safely used as an alternative or additional tool for delivering in-person therapy across various languages and cultures, and on a global scale. Therapists and clients have been satisfied with the experience of iCBT and appreciated the increase in variety that it brought to their schedules. Considering the efficacy of iCBT, its benefits must be maximized to extend and receive professional psychological care.

Limitations

This study focused on the perceived efficacy of individual therapist-guided iCBT for mild to moderate depression. More studies are required to see if iCBT can be useful for chronic or severe depression cases in Pakistan. Experiences of only educated participants residing in urban areas with easy access to internet and sufficient digital literacy were explored. Sample of clients was community-based and not clinical. Therefore, the results might be different for a clinic-based sample or for people who are uneducated and uncomfortable with the use of technology.

Implications

The results of the study paves way for academicians to develop courses and training focused on effectively delivering digital therapy. Practitioners can adopt iCBT for scalability of their services to people in remote areas and abroad. Evidence for efficacy of iCBT, will allow more clients to pursue treatment for their psychological needs as it can significantly increase the number of clients who desire effective and accessible treatment.

Suggestions

Despite the efficacy of iCBT, on a public level, its reach is still very small. The benefits of iCBT must be maximized at a larger scale and be implemented in routine mental healthcare settings. Indigenous studies establishing the effectiveness of iCBT as an alternative psychotherapy tool are needed. More therapeutic modules that can be adapted for digital delivery of therapy must be studied.

Contribution of Authors

Kanza Faisal: Conceptualization, Investigation, Data Curation, Formal Analysis, Writing - Original draft

Afsheen Masood: Methodology, Writing-Reviewing & Editing, Supervision

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