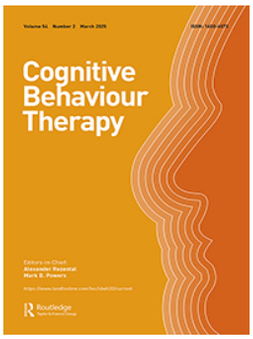

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Understanding change from the patient perspective in a transdiagnostic Internet-based intervention for emotional disorders: a qualitative content analysis

Carmen Schaeuffele [a], Christine Knaevelsrud [a], Babette Renneberg [a] and Johanna Boettcher [b]

[a]Department of Education and Psychology, Freie Universität Berlin, Berlin, Germany; [b]Department of Clinical Psychology, Psychologische Hochschule Berlin, Berlin, Germany

ABSTRACT

Qualitative investigations that openly explore changes and facilitators of changes from the patient's perspective might offer valuable insights on impacts of therapy and helpful and hindering aspects. Our aim for this study was to explore the perspective of patients on a transdiagnostic Internet-based intervention to understand (1) which changes (positive as well as negative effects) responders and non-responders experienced, and (2) which aspects of the intervention they found helpful or hindering in facilitating those changes. We interviewed 21 patients that showed response or non-response to treatment using the Change Interview Schedule following a 10-week Internet-based intervention based on the Unified Protocol. Interviews were analyzed using qualitative content analysis. Both responders and non-responders reported positive changes, with few negative changes mentioned. Across both groups, increased positive affect was reported most frequently (81%). Both groups reported helpful factors, with guidance mentioned most frequently across both responders and non-responders (85.7%). Mainly, aspects of the specific framework were perceived as hindering (e.g. lack of personalization) (66.7%). Overall, patients reported mostly positive impacts, even if they did not respond to treatment. Results highlighted that what patients find helpful or hindering is individual.

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Unified protocol; Internet-based intervention; qualitative content analysis; helpful events; hindering events

Transdiagnostic treatments target a wide range of disorders (Sauer-Zavala et al., 2017; Schaeuffele et al., 2020). They show promising effects in treating the most common emotional disorders like anxiety and depression, with comparable effects when delivered over the Internet (Kolaas et al., 2024; Schaeuffele et al., 2024). Transdiagnostic treatments facilitate change by targeting shared mechanisms between disorders (Schaeuffele et al., 2020). One proponent of this „shared mechanism approach" is the Unified Protocol (UP) (Barlow, 2011; Carlucci et al., 2021). A meta-analysis across 21 randomized controlled trials found that the UP is effective in treating anxiety and depression (Carlucci et al.,

CONTACT Carmen Schaeuffele carmen.schaeuffele@fu-berlin.de Department of Education and Psychology, Freie Universtität Berlin, Habelschwerdter Allee 45, Berlin 14195, Germany
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2021). At the same time, other meta-analyses on depression and anxiety report that about 35% of patients do not improve following treatment and 5% even deteriorate, both in face-to-face as well as Internet-based settings (e.g. Cuijpers et al., 2021; Rozental et al., 2019).

A better understanding of factors contributing to change may help to improve treatment responses. The UP postulates that participants need to change their dysfunctional reaction towards emotions to experience an alleviation of symptoms (Barlow et al., 2016; Wilamowska et al., 2010). To achieve this, the UP fosters patients' mindful emotion awareness and cognitive flexibility as well as decreases their avoidance tendencies. In addition to these treatment targets, the importance of working alliance and expectation as putative change mechanisms has been highlighted (Sauer-Zavala et al., 2018). These proposed change mechanisms tie in with the literature, where common factors like alliance and expectation as well as a whole range of treatment specific factors are discussed (Cuijpers et al., 2019).

The use of qualitative studies that openly explore changes and facilitators of changes from the patient's perspective may offer valuable additional insights (Elliott, 2010; Maxwell & Levitt, 2023). In this line of research, the emphasis is on the patient's perspective on change and potential pathways to change: Patients are asked which changes they experienced and what they believe to be facilitators and barriers of change (Cooper & McLeod, 2015).

Established measures to capture helpful and hindering aspects of therapy is the Client Change Interview, usually conducted at the end of treatment, as well as the Helpful Aspects of Therapy (HAT) form usually collected each therapy session (Elliott, 2010). Such qualitative investigations have mostly been conducted within face-to-face therapies and a humanistic/experiential background (Ladmanová et al., 2021). While to our knowledge, no study on standalone Internet-based interventions (IBIs) used the client change interview to collect impressions on changes by patients, several studies report on the facilitators and barriers of the acceptability and usability of IBIs: Patel et al. (2020) conducted a qualitative meta-synthesis on patients' perspectives on the acceptability and usability of IBIs. They had three aims: Understand how users perceive the acceptability and usability of digital health interventions, identify the aspects that users find effective and beneficial, as well as areas that require improvement or modification and explore the reasons why users decide to start, continue, or discontinue using digital health interventions. Across 24 studies, Patel et al. (2020) identified three key themes as determinants of the success of IBIs: Participants' initial expectations and preferences around IBIs were identified as key determinants of their perceptions regarding the acceptability and usability of these interventions. Personalization was emphasized by the interviewees, suggesting that tailoring IBIs to individual circumstances can be of high value to the participants. The meta-synthesis also highlighted the importance of personal support, whether through direct human interaction or other forms, in boosting user commitment and engagement.

It may be especially informative to conduct qualitative investigations into patients' perspectives on change as well as hindering and helpful aspects of IBIs with patients who either responded or did not respond to treatment. Non-response refers to a lack of clinically meaningful improvement over the course of therapy, e.g. based on established thresholds like a value of less than 1.96 on the reliable change index (RCI) (Jacobson & Truax, 1991). Comparing responders and non-responders may help to shine light on

what may help to foster beneficial outcomes and prevent treatment failures. Contrasting different outcome cases with each other may help to identify differential factors contributing to treatment successes and failures. This is in the tradition of comparative case studies (Fishman, 2011; see Schulz et al., 2017 for an applied example with an Internet-based intervention) but has been sparsely applied in qualitative investigations on helpful and hindering factors (e.g. McElvaney & Timulak, 2013). While quantitative research has often focused on baseline factors, such as initial severity, as predictors of non-response (e.g. Cross et al. 2022), there is growing evidence that in-therapy processes may be more informative. For instance, Hammelrath et al. (2023) demonstrated that fair prediction of non-response in an IBI for depression could only be achieved when information from early treatment, like initial symptom improvement or therapeutic alliance, was included. This suggests that understanding the dynamics within therapy, rather than solely relying on baseline characteristics, is crucial for understanding and addressing non-response. Qualitative interviews with non-responders could provide valuable insights into these helpful and hindering factors in treatment, offering a deeper understanding of the personal and contextual factors that contribute to their lack of improvement.

Our aim for this study was to explore the perspective of patients on a transdiagnostic IBI based on the UP to understand (1) which changes (positive as well as negative effects) responders and non-responders experienced, and (2) which aspects of the intervention they found helpful or hindering in facilitating those changes.

Method

Procedure

Participants for this sub study were participants of a randomized controlled trial on the efficacy of an Internet-based adaptation of the UP (Schaeuffele et al., 2022). The RCT compared an Internet-based version of the UP with a wait-list control in $N = 129$ patients with depressive, anxiety, or somatic symptom disorders. Participants were self-referred and recruited through mental health online forums as well as via online advertising. The intervention group showed significantly greater improvements in symptom distress, anxiety and depression. Patient selection for the qualitative interview was based on responder status. Responder status was decided based on a comparison between baseline and post-treatment scores of our primary outcome measure, the Brief Symptom Inventory, capturing symptom distress (Franke et al., 2011): We classified participants as responders if their BSI-18 scores decreased by equal to or larger than 9.43 according to the RCI of the German validation of the BSI-18 (see Schaeuffele et al., 2022). After the post-assessment, we extended an email invitation to participants to participate in a change interview. The email provided detailed information on the study and procedure. Interviews were conducted via telephone and transcribed and analyzed using qualitative content analysis (Kuckartz, 2018). We determined sample size based on recommendations by Elliott (2010) who states that 6 to 12 participants may be sufficient for conducting change interviews. As we aimed to exploratively compare responders and non-responders, we aimed for this number in both groups. Finally, we included 21 participants in the interview study (see Table 1 for an overview of their demographic characteristics).

Table 1. Demographic characteristics of participants at baseline.

Demographic Variable	Total RCT Sample	Interviewed Responders ($n = 12$)	Interviewed Non-Responder ($n = 9$)
Gender			
Male	41 (31.8%)	4 (33.33%)	3 (33.33%)
Female	88 (68.2%)	8 (66.67%)	6 (66.67%)
Age			
Mean (SD)	37.31 (12.47)	42.7 (11.7)	42.0 (12.6)
Range	18-67	27-54	18-57
Relationship			
in a relationship	70 (54.3%)	8 (66.67%)	5 (55.56%)
single	59 (45.7%)	4 (33.33%)	4 (44.44%)
Highest Education			
up to 9 years of school education	9 (7%)	1 (8.33%)	0 (0%)
Secondary school	21 (16.3%)	3 (25%)	1 (11.11%)
College entrance qualification	41 (31.8%)	3 (25%)	2 (22.22%)
College/university degree	56 (43.3%)	5 (41.67%)	6 (66.67%)
other	2 (1.6%)	0 (0%)	0 (0%)
Employment status			
employed	62 (48.1%)	8 (66.67%)	5 (55.56%)
self-employed	9 (7%)	1 (8.33%)	1 (11.11%)
in education	29 (22.5%)	1 (8.33%)	1(11.11%)
pensioned	8 (6.2%)	0 (0%)	0 (0%)
unemployed	15 (11.6%)	1 (8.33%)	1 (11.11%)
other	6 (4.7%)	1 (8.33%)	1 (11.11%)
Currently on medication			
yes	32 (24.8%)	2 (16.67%)	1 (11.11%)
no	97 (75.2%)	10 (83.33%)	8 (88.89%)
Prior Psychotherapy			
yes	95 (73.6%)	6 (50%)	6 (66.67%)
no	34 (26.4%)	6 (50%)	3 (33.33%)
Primary Diagnosis			
Agoraphobia	7 (5.4%)	0 (0%)	0 (0%)
Generalized Anxiety Disorder	14 (10.8%)	1 (8.33%)	0 (0%)
Panic Disorder	10 (7.8%)	2 (16.67%)	2 (22.22%)
Social Anxiety Disorder	29 (22.5%)	3 (25%)	1 (11.11%)
Major Depressive Disorder	31 (24%)	2 (16.67%)	4 (44.44%)
Persistent Depressive Disorder	27 (20.9%)	2 (16.67%)	1 (11.11%)
Somatic Symptom Disorder	5 (3.9%)	2 (16.67%)	0 (0%)
Illness Anxiety Disorder	6 (4.7%)	1 (8.33%)	1 (11.11%)
Comorbidity			
1 comorbid diagnosis	99 (76.7%)	9 (75%)	6 (66.67%)
2 comorbid diagnoses	55 (42.6%)	5 (41.67%)	2 (22.22%)
3 comorbid diagnoses	36 (27.9%)	3 (33.33%)	1 (11.11%)
4 comorbid diagnoses	22 (17.1%)	3 (33.33%)	0 (0%)
5 comorbid diagnoses	9 (6.9%)	1 (8.33%)	0 (0%)

Treatment

The IBI was developed based on the UP and was delivered over the course of ten weeks. Following the UP's treatment principles, the intervention contained ten modules that participants worked through at their own pace: Module 1 focused on motivation and goal-setting. Module 2 covered understanding emotions, and Module 3 introduced mindfulness. Modules 4 and 5 addressed cognitive flexibility, while Module 6 dealt with countering emotional avoidance. Module 7 focused on confronting physical sensations, and Modules 8 and 9 covered confronting emotions through emotion exposures. Finally, Module 10 emphasized relapse prevention. Online therapists guided participants through the interventions and provided personalized semi-standardized feedback once a week over the course of the intervention. On average, interviewees who responded to

treatment completed 9.42 modules (range 6–10) and interviewees who did not respond to treatment completed 8.44 modules (range 5–10).

Interview

We used the Client Change Interview schedule (Elliott, 1996; Elliott et al. 2001) to collect patient's perceptions. The Client Change Interview is a semi-structured interview schedule that is conducted following treatment to collect client-reported changes. We translated the interview to German and adapted the instructions to fit the Internet-based context. The German translation is provided in the supplementary material. The Client Change Interview explores the clients' perspective and experiences on (1) changes since treatment started, (2) unfulfilled hopes for changes, and (3) causes and influences of those changes including helpful and hindering aspects of treatment. The interviews were conducted by two female master's students of clinical psychology as well as by the first author, psychotherapist in training. All interviewers also provided guidance in the IBI to participants and were thus, very familiar with the treatment and had some understanding of the patients' perspective based on their interactions with the patients who they provided guidance for. In coordinating the interviews, the first author ensured that the interviewers did not interview participants who they had provided guidance for. The interviewers were instructed to explore patients' experiences in depth, utilizing prompts such as "Is there anything else that comes to mind?" to encourage further elaboration. Although the master students had some prior experience with interviews from their studies, this was their first exposure to conducting more open-ended qualitative interviews. To ensure quality and consistency, the first author who has experience with conducting qualitative interviews was present during their initial interviews to provide feedback and guidance following the interviews.

Ethics

Prior to conducting the study, ethical approval was sought from and granted by the University Ethics Committee of Freie Universitaet Berlin (186/2018).

Data analysis

We employed a deductive-inductive qualitative content approach to analyze the interview data (Kuckartz, 2018). We chose qualitative content analysis for its systematic exploration and categorization of nuanced experiences of patients, while allowing for a descriptive comparison between responders and non-responders in frequencies of categories. Initially, we established deductive categories based on the interview schedule and the valence of responses (positive, negative, no change, as well as helpful and hindering). We then employed an inductive approach to identify themes in the participants' responses. The inductive categories were then organized into main themes, which were further refined based on deductive considerations from the literature on IBIs and transdiagnostic treatments (e.g. themes relating to the UP were captured in the main category UP skills). For the development of the initial coding system, we selected the two longest interviews. We followed recommendations on a consensual coding technique (Kuckartz, 2018). We chose this approach to enhance reliability and validity by involving multiple coders and using a systematic

approach to develop and refine the coding system. The collaborative nature allowed for in-depth exploration of the data, capturing a wide range of themes and subcategories, while maintaining consistency and adaptability in the coding process. First, two raters independently familiarized themselves with the material and extracted occurring themes. Then, the two raters discussed the emerging themes and drafted an initial, consensual coding system that organized themes into subcategories and subsequently subcategories into main categories. The initial coding system was discussed between the two raters and the first author, incorporating additional insights and expertise. This collaborative process helped refine the categories and ensured that they were grounded in the data while being theoretically informed by existing literature on IBIs and transdiagnostic treatments. The refined coding system was tested on the third longest interview to assess its applicability and comprehensiveness. Any discrepancies or new themes were discussed, leading to further refinement of the coding system. This iterative process continued until a consensus was reached, ensuring that the coding system was both robust and reflective of the data. Coders then moved on to coding the rest of the material. During the coding of the remaining interviews, if a new theme emerged, it was integrated into the coding system, necessitating re-coding of previous interviews to maintain consistency.

To mitigate biases, the transcribers and coders were blind to responder status. Qualitative content analysis was aided by qualitative content analysis software MAXQDA (VERBI Software, 2021). The inter-rater reliability was calculated by double coding 10% of the material by two coders independently. Cohen's kappa showed a good inter-rater reliability ($\kappa = .72–.78$).

Results

First, we will describe what changes patients experienced during the treatment with the transdiagnostic IBI and outline similarities and differences between responders and non-responders. We will then report in more detail the attributions of these changes: What do patients think has contributed to or hindered change?

Changes

The coding scheme for the patients' perspective on the changes they experienced is shown in Table S1 in the Supplementary Materials. Patients reported both positive and negative changes as a result of treatment. As interviewees also emphasized that they had noticed stagnation in several areas where they had expected change, we also included "no change" as a valence of reported change. Overall, we identified 5 higher-order categories with 16 subcategories. Table 2 shows the frequency with which responders and non-responders reported experiencing positive changes, negative changes, or no changes in the respective subcategories. As interviewees mostly reported positive changes due to treatment, we will follow the coding scheme to highlight subcategories in which positive changes were mentioned. Mentions of no or negative changes will be summarized less fine-grained.

Table 2. Patients' perspectives on positive, negative, and no changes.

	Positive Change				Negative Change				No Change			
	Responders (n = 12)	%	Non-Responders (n = 9)	%	Responders (n = 12)	%	Non-Responders (n = 9)	%	Responders (n = 12)	%	Non-Responders (n = 9)	%
Emotional Experiences												
Positive Affect	11	92%	6	67%	0	0%	0	0%	2	17%	1	11%
Negative Affect	5	42%	0	0%	1	8%	1	11%	2	17%	2	22%
Hopefulness/Optimism	6	50%	3	33%	0	0%	1	11%	1	8%	0	0%
Negative Thinking	5	42%	0	0%	0	0%	0	0%	1	8%	1	11%
Drive & Activity Level	5	42%	1	11%	0	0%	0	0%	0	0%	3	33%
Somatic Aspects	3	25%	1	11%	1	8%	0	0%	0	0%	1	11%
Emotion Regulation												
Cognitive Flexibility	7	58%	7	78%	0	0%	0	0%	1	8%	1	11%
Behavioral Avoidance	8	67%	5	56%	0	0%	0	0%	1	8%	2	22%
Experiential Avoidance	8	67%	4	44%	0	0%	0	0%	1	8%	2	22%
Mindfulness	7	58%	3	33%	0	0%	0	0%	1	8%	1	11%
Dysfunctional Behaviors	3	25%	3	33%	0	0%	1	11%	0	0%	0	0%
Psychological Awareness & Growth												
Self-Compassion & Self–Efficacy	8	67%	3	33%	0	0%	1	11%	0	0%	1	11%
Psychological Mindedness	5	42%	5	56%	0	0%	0	0%	0	0%	1	11%
Mental Health Literacy	3	25%	3	33%	0	0%	0	0%	0	0%	0	0%
Participation												
Relationships	7	58%	7	78%	0	0%	0	0%	0	0%	1	11%
Work	8	67%	1	11%	0	0%	0	0%	1	8%	0	0%
Global & Miscellaneous Changes	3	25%	2	22%	0	0%	1	11%	2	17%	2	22%

Positive changes—"the online therapy has positively turned my entire life upside down"

Emotional experiences—"I laugh more"

Interviewees reported a positive impact on a range of different emotional experiences, from changes in affect, cognition, drive/activity to somatic aspects. For responders, the most frequent positive change was reported in the subcategory positive and negative affect (42%–92%), including more emotional stability ("I feel more grounded and emotionally stable" (R8)) and less anxiety ("I simply don't have panic attacks any more" (R7)). While 44% of non-responders also reported changes in positive affect, none of the interviewed non-responders (0%) reported any improvement in negative affect.

Both responders and non-responders reported changes in relation to hopefulness/optimism (responders: 50% vs. non-responders: 33%). For negative thinking, 42% of responders reported positive changes ("I am quite surprised that the basic problem, the focus on negative thoughts, has turned around by almost one hundred and eighty degrees" (R12)), but 0% of non-responders did. Responders also reported more positive changes in their drive/activity level (42%) ("I am full of energy and eager to take action" (R7)) and somatic aspects (25%) ("I used to have an upset stomach [when visiting new places]. I don't have that all anymore" (R2)) than non-responders (11% respectively).

Emotion regulation—"I accept it when symptoms appear"

Interviewees reported a positive impact on a range of emotion regulation strategies, with an increase in cognitive flexibility and a decrease in behavioral avoidance mentioned most frequently. The majority of responders (58%) and non-responders (78%) reported a positive impact on how they deal with thoughts: "My thoughts are not so intertwined with my emotions anymore. More free, more flexible." (NR1). Both responders and non-responders also reported positive changes in behavioral avoidance (67% of responders vs. 56% of non-responders): "And [I notice positive changes] also with avoidance. I am more aware of where I avoid situations or where I tend to avoid them. I realize this more in everyday life and then I can deal with it better. Not in every case, of course. Sometimes I still avoid things. But I would say: Yes, yes. That's better."(NR6). Responders (68–67%) as well as non-responders (33–44%) also reported changes in emotion acceptance ("I don't feel so much pressure anymore, for example when [I have texted someone and] I want a clear answer within a week. Now I can relish my feelings" (R12)) and mindfulness ("I accept it when the symptoms appear. It could be the thyroid, it could be menopause. So, I don't suspect any fatal or other diseases that harm me. I accept it like that. It's mindfulness. I just notice it and it is there." (NR1)).

Psychological awareness and growth—"I am much more compassionate with myself"

Interviewees reported changes in different areas of psychological awareness and growth. Most frequently responders (67% vs. 33% non-responders) reported feeling more compassionate towards themselves as well as more self-confident and self-efficacious: "I have a certain strength. I can trust myself. Yes, that's it: Strength, confidence, optimism." (R8). Both groups (42% of responders vs. 56% of non-responders) stressed they noticed an

increase in their psychological mindedness and insight into their problems as positive changes due to the intervention ("Without this [online] therapy, it was a reaction to these feelings and this [online] therapy has allowed me to take this story apart, to really think about it and to perceive this disorder or these negative feelings in a different way. So now I can say, ok, the emotions are there, I can partly explain why they are there and I can suddenly deal with it." (NR2)).

Participation—"I found a job"

In terms of participating more in work and social life, the majority of patients in both groups (58% of responders vs. 78% of non-responders) reported positive changes in their interpersonal relationships. This applied both to their significant others being positively impacted by their progress ("And it's great for my husband too, of course. He no longer has to drop me off, leave his car, walk home and pick me up again later. It's better for him now." (R4)) and in how they relate to others ("I approach people in a more positive way. And then I might get positive feedback, which encourages me again. That then becomes a kind of cycle." (NR7)). More responders (42%–67%) than non-responders (11%) reported positive changes in their work: "Well, the online therapy has positively turned my entire life upside down and I am currently no longer suffering from any complaints, I have found a job and am active in working life again, my health is very good, no more depressive episodes and so on" (R7).

Global changes—"I am better than before starting online therapy"

25% of responders and 22% of non-responders reported global changes in their overall (mental) health that were too unspecific to be included in other categories ("I am better than before starting online therapy, despite the current situation." (NR3)).

Negative changes—"I felt a bit worse, or I became aware of things that were not going well"

Overall, interviewees reported comparably few negative effects. Individual responders reported negative changes in the area of their physical health and negative affect, while individual non-responders reported negative changes in the areas of negative affect, expectations/optimism, self-compassion/self-efficacy, and their global state. One non-responder alluded to the fact that engaging with the intervention made them more aware of their problems which led to in an increase in their negative affect: "So in the meantime, I felt a bit worse or I became aware of things that were not going well in some places or that didn't work out. And that occupied me a lot. Yes, that made me a little sadder and a little more depressed." (NR4).

No changes—"social situations will probably always be unpleasant"

In contrast to negative effects, participants more frequently reported areas of no change. For example, two responders (17%) and non-responders (22%) reported that aspects of their negative affect remained unchanged ("I think what will be difficult to get rid of is a discomfort in certain social settings. Even among friends and acquaintances. Whether it's strangers or certain distant acquaintances who I just don't get on well with, these

[social situations] will probably always be unpleasant moments." (R12)). Two responders and non-responders reported that they had not experienced any global changes ("I had perhaps hoped that therapy would give me a different perspective on life, on things, on my mindset, but that is NOT the case." (NR9).

Helpful and hindering aspects

The coding scheme for patients' perspective on helpful and hindering aspects is provided in Table S2 in the supplements. Interviewees reported aspects driving or hindering change in 5 higher-order categories and 12 subcategories. Table 3 shows how frequent responders and non-responders mentioned a subcategory.

What was perceived as helpful?

Guided self-help format—"yes, the feedback was always great"

In terms of helpful aspects, responders and non-responders found the guided self-help format of the intervention generally helpful, particularly emphasizing the aspect of guidance (92% responders vs. 78% non-responders). Interviewees found the guidance encouraging and empowering ("Yes, these feedbacks from the psychologist or therapist were helpful. She always summarized what I did. She also regulated the downward spiral. Yes, that was exactly right. I did not miss such an exchange [that you usually have in face-to-face therapy], sitting in a therapist's office for an hour and then nothing happens for a week. This [format] led me to take the initiative." (NR1)) and appreciated its corrective experience ("Yes, the feedback was always great. I was

Table 3. Patients' perspective on helpful and hindering aspects of treatment.

	Helpful Factors				Hindering Factors			
	Responders (*N* = 12)	%	Non-Responders (*N* = 9)	%	Responders (*N* = 12)	%	Non-Responders (*N* = 9)	%
Guided self-help format								
General framework	9	75%	7	78%	7	58%	6	67%
Therapist guidance	11	92%	7	78%	3	25%	3	33%
Textualization	7	58%	4	44%	0	0%	0	0%
Intervention-specific Aspects								
Specific framework	9	75%	7	78%	8	67%	6	67%
Content	12	100%	9	100%	2	17%	5	56%
UP skills								
Cognitive flexibility	10	83%	5	56%	0	0%	0	0%
Experiential avoidance	7	58%	4	44%	1	8%	4	44%
Mindful self-perception	7	58%	3	33%	0	0%	0	0%
Other self-related aspects								
Openness to experiences	2	17%	2	22%	0	0%	0	0%
Psychological/ emotional state	5	42%	0	0%	1	8%	6	67%
Sense of achievement	10	83%	3	33%	1	8%	3	33%
Insight	10	83%	6	67%	1	8%	1	11%
External reasons	6	50%	4	44%	3	25%	6	67%

looking forward to having my own exercises analyzed and being told what I could do better" (R6)). 75% of responders and 78% of non-responders also appreciated that the intervention gave them a concrete framework to work on their mental health ("the structured approach of the online therapy from week to week with exercises that build on each other, was helpful, like a guideline, like a rope which you can follow" (NR")), independent of an appointment with a therapist ("So I always need a little time to process things. Because if I had been sitting directly opposite someone, i.e. a therapist, and had then processed it in this way, I wouldn't know whether the really important things would have occurred to me in that moment. That's why I thought it was good, because in the end, how should I say, for answering or processing, there was always this in-between time to let the whole thing sink in and to think about it again, or to think about it in peace." (R9)). What was helpful for 58% of responders and 44% of non-responders was that the intervention encouraged them to write things down: „What was most helpful was actually writing things down in concrete terms" (NR1).

Intervention-specific aspects—"it helped me to give a name to things"

All interviewed responders (100%) and non-responders (100%) felt that the content of the intervention was helpful. This included the concepts that were taught ("It helped me to give a name to things. For example, the term 'thinking trap' is now anchored into my brain. Even now, when one of my friends thinks badly about themselves, then I say 'that's a thinking trap!'" (NR9)) as well as the case examples that several interviewees emphasized as particularly helpful: ("just the existence of this avatar [...] who represented the hypochondriac. This has helped me a lot because I could identify, a sort of counterpart with similar symptoms to me. To see I am not alone and that he thinks exactly or similarly to me, was very helpful to me." (NR3)).

UP skills – "I consciously accept that symptoms may appear"

Overall, a higher percentage of responders reported facilitating qualities of the UP skills (responders: 58%-83% vs. non-responders: 33–56%), with cognitive flexibility being mentioned most frequently: "I can now deal with the build-up of strong feelings and also thoughts, especially negative thoughts, much more quickly. Not push them away but perhaps look at them differently. I feel much more flexible in my thoughts and the consequence is simply that I now have a much more relaxed life and positive things happen." (R12). Participants particularly reported applying different UP skills together: "Of course, I am still afraid of heights but I just don't avoid bridges anymore, you know? I can deal with it, I anchor myself and maybe it takes a while to cross but I do cross the bridge". Non-responders seemed to report more cautiously, but very much in line with the UP principles: "Sometimes I want to go somewhere, for example into a bookstore or into town. And sometimes I don't dare to do that because I feel so dizzy and so faint. [A success was] that sometimes I dared to go there and consciously accepted that these symptoms may appear." (NR4).

Self-related aspects—"I can be proud of myself again"

In terms of self-related aspects, more responders (83%)—in contrast to non-responders (33%)—emphasized a sense of achievement and empowerment as helpful to stick with

the intervention and facilitate positive impacts: "It was just this permanent feeling that when I faced difficult situations, I was so unbelievably proud of myself afterwards. And that is definitely something new through the online therapy, because in the last few years I was no longer proud of myself. Now I can be proud of myself again and that is also one of the most significant moments for me" (R7) and "That made me realize that I could do something. And the therapist only gives me ideas." (NR1). 83% of responders and 67% of non-responders also felt that a greater reflection on and insight into their feelings, thoughts, and behaviors was helpful: "What was helpful was gaining insight. It was about finding out how this triad works with me, with feelings, actions and thinking." (R5).

External reasons—"winter is over"

50% of responders and 44% of non-responders mentioned external reasons, including a change of season ("Winter is over. Winter is always a burden" (R12)) or using other resources in addition ("In addition, I attended a one-day workshop on happiness at the adult education center. That was also very, very helpful" (R9)).

What was perceived as unhelpful?

Guided self-help format—"I have nobody by my side, except this online person"

In terms of hindering aspects, both responders and non-responders reported hindering aspects of the general framework (responders: 58% vs non-responders: 67%) of the guided self-help format, e.g. in terms of technical issues and guidance. A proportion of participants emphasized that they think they could have benefitted from more personal contact ("I just noticed that I have trouble doing things for the first time when I have to them by myself. It just means I have nobody by my side, except this online person" (NR6)) and that they found the anonymity of the format impeding ("To entrust such intimate things to a person I've never seen before, a person I'll probably never get to know. Almost as anonymous as a machine. So that was difficult" (R5)).

Intervention-specific aspects—"far too little personalized and far too standardized"

In terms of the specific framework of this IBI, 67% of responders and non-responders reported barriers. They especially emphasized that they felt pressured by the fixed weekly sequence of modules ("The pressure to complete it in ten weeks [was hindering]. I think I could have allowed myself a little more time with a few things." (R1)) and that some concepts were not that clearly explained ("That was too UNCLEAR to me. What exactly do you mean by avoidance? Yes, well, if you say the word to a layperson, they have thousands of ideas and everyone has a different one." (NR5)).

More non-responders (responders: 17% vs. non-responders: 56%) mentioned content-related aspects as hindering, especially emphasizing that the module focusing on interoceptive exposures was not helpful ("you have to run in place or breathe through a straw. I did it, but then I thought: So what? So what?" (NR5)) and that the intervention lacked tailoring and personalization ("For me, it is actually far too little personalized and far too standardized."(NR5)).

UP skills—"oh, I'm already anxious. I can't do it now. Else I can't keep it together."

Regarding UP skills, only experiential avoidance was mentioned as hindering, with non-responders (44%) emphasizing this aspect more than responders (8%). Non-responders both shared that they did not see the exercises related to experiential avoidance as useful as well as them having too much fear to engage in these exercises: "I was very nervous and tense. And then you should practice these things yourself [engaging in interoceptive and emotional exposures] and then I realized: Oh, I'm already anxious. I can't do it now. Else I can't keep it together. But I didn't know whether I was anxious because of these exercises or whether I was just anxious in general" (NR6).

Self-related aspects—"I somehow have the feeling that I haven't accomplished anything at all."

This ties in with non-responders also reporting their emotional state (67% vs. 8% of responders) ("I gave up half-way through because I did not have the energy to continue" (NR9)) and (lack of) sense of achievement (33% vs. 8% of non-responders) as unhelpful ("I somehow have the feeling that I haven't accomplished anything at all" (NR4)).

External reasons—"time was the biggest issue"

67% of non-responders also reported hindering external reasons (vs. 25% of responders), particularly a lack of time to work on the intervention ("Unfortunately, I often didn't have as much time as I would have liked. Simply because of my life, so to speak, because of work, children, because I also work at home a lot. My day is very structured and then also because of certain unpredictability like children being sick, I didn't get to work [on the intervention] as often as I would have liked." (R8)).

Discussion

With this interview study, we shed light on the patients' perspective on changes as well as helpful and hindering aspects of a transdiagnostic IBI based on the UP. Uniquely, we aimed to give insight into the perspectives of responders and non-responders of treatment on these aspects.

Responders mentioned positive impacts in positive affect, behavioral avoidance, and experiential avoidance most frequently. Although non-responders did not show clinically significant changes on the BSI-18, they also reported positive changes in the interview, with positive changes in dealing with thoughts and interpersonal relationships mentioned most frequently. Overall across categories, however, more responders than non-responders seem to report on positive changes. Negative changes were reported very infrequently by both responders and non-responders. Instead, more areas of no change were reported by non-responders (although in small numbers). In the RCT, we also collected negative effects quantitatively and found 80% of patients reporting negative effects due to treatment, primarily an increase in negative emotions (Schaeuffele et al., 2022). However, when openly exploring changes, only a handful of patients reported any negative effects across categories. The difference between those responding and those not responding seems to lie more in the changes that those not responding would have liked to see happen, but which failed to materialize. Both responders and non-responders identified helpful factors in the treatment, with content being a universally acknowledged

helpful aspect by all participants. However, responders also frequently highlighted self-related aspects as helpful, such as a sense of achievement or insight, which were less prominent among non-responders. In contrast, non-responders reported overall higher percentage of hindering factors, notably citing their own psychological/emotional state and external reasons as obstacles.

While helpful and hindering aspects identified in qualitative research are not change mechanisms per se, they can hint at processes that facilitate or hinder change, particularly when patients emphasize a causal relationship in their experience. The hindering and helpful factors that emerged in our analysis mirror processes discussed as change mechanisms in CBT, the Internet-based setting, and specifically the UP. In McElvaney and Timulak (2013)'s comparison of bad and good outcome cases, their identified categories reflect the face-to-face setting with aspects relating to the therapeutic alliance and opening up in sessions. While some aspects like alliance were also identified in our study, the majority of categories reflect unique aspects of the Internet-based setting (e.g. the self-help format, textualization) and the UP skills. Patients specifically found the guided self-help format to be supportive, while at the same time empowering them to be to work through the content and react to their symptoms/emotions in a more adaptive way. Empowerment and self-efficacy are discussed as potential mechanisms of change in IBIs (Behr et al., 2024). Notably, our study participants highlighted the uniqueness of the experience of empowerment in the context of the Internet-based self-help format. Several patients specifically contrasted this experience with traditional therapy, where a greater reliance on the therapist for problem-solving would have been typical. Participants' language when describing the helpful and unhelpful events also reflected the language of the intervention and patients seemed to have adopted its phrases into their vocabulary, which might have been facilitated by the text-based IBI setup. Our findings also add to the discussion on the relationship and overlap of transdiagnostic processes (Mansell & McEvoy, 2017; Schaeuffele et al., 2020). Interestingly, interviewees in our study often highlighted several transdiagnostic processes in the same statement (e.g. anchoring themselves mindfully before counteracting behavioral avoidance). This integration of different emotion regulation skills is very much in line with what the UP is teaching but makes it apparent how difficult it is to study these processes in isolation, as patients experience them intertwined and apply them together.

As a clinical implication, it may be especially worthwhile to consider the experience of hindering factors reported to prevent treatment failures. Research indicates that adherence to or engagement with IBIs is often correlated with better outcomes. Conversely, low adherence or dropout may be linked to poorer outcomes, potentially due to unmet needs or barriers within the therapeutic process. Both responders and non-responders in our interview study showed comparable and rather high rates of module completion. In this vein, an interview study with patients who dropped out could be particularly insightful. This population may reveal underlying reasons for disengagement and identify specific factors that hinder adherence. Understanding these aspects could inform the development of strategies to improve retention and tailor interventions to better support patient needs. For example, Fernández-Álvarez et al. (2017) conducted interviews with dropouts in a transdiagnostic IBI and reported insufficient support due to the absence of a therapist and the lack of specificity of the contents to their own problems as main reasons for dropout. Our findings also highlight that what is helpful to some, can be

hindering to others. For example, in terms of guidance most responders and non-responders found guidance helpful and "just right" but some interviewees felt it was too little contact and too anonymous which is in line with the meta-synthesis by Patel et al. (2020) who have also found that a proportion of patients wished for more responsive contact. Similarly, other aspects were also found to possess dual characteristics, serving as both helpful and hindering, like the length of the intervention texts (some finding them just right, some finding them too short, some finding them too long) or the setup of the weekly modules (some finding all modules and the weekly schedule helpful, some wanting to deepen their work on some modules but skipping others). Since those hindering factors can be very individual, the application of the intervention as a tailored and personalized intervention is promising to boost effects and prevent treatment non-response. While the UP lends itself well to treatment adaptations, as it is modular (Sauer-Zavala, Cassiello-Robbins, et al. 2017), and the digital setting offers many opportunities to personalize treatments, there is currently no empirical basis on how to decide how to personalize treatments. Our results suggest that since the helpful and hindering aspects can be so individual, it may be beneficial to put more emphasis on patient preferences as a decision basis for tailoring. Accommodating patient preferences are associated with better treatment satisfaction and adherence (Eigenhuis et al., 2024), and potentially also outcomes (Delevry & Le, 2019). While these meta-analyses investigate patients choosing a treatment, involving patients' choices in the therapeutic process may also present an option: First studies have started to investigate patient-driven adaptations in IBIs on several levels, including selection, order, and frequency of modules and aspects of the guidance (Nissling et al., 2021). Our findings suggest that this could be a fruitful possibility to personalize this intervention as well. This may also be facilitated by a blended therapy setup which allows for a more personalized and responsive guidance.

The following limitations contextualize our findings. We interviewed 21 out of 31 invited patients, from a total of 42 patients who provided post-treatment data. As we were interested to compare good and bad outcome cases, we only invited patients that provided baseline as well as post-treatment data. It is possible that those who agreed to be interviewed were more positive or less disappointed with the treatment than those who declined, a bias that may be particularly pronounced among non-responders. As outlined above, interviewing patients who drop out of treatment may have also provided additional insights. The recruitment procedure of the general study—self-selection of patients who were recruited through online forums and advertisements—may have also influenced the range of experiences and perspectives captured in our study, potentially limiting the diversity of insights into helpful and hindering factors. It would be interesting to see whether similar qualitative interviews conducted in routine clinical care settings would yield comparable findings.

We also conducted our interviews post-treatment. However, it might be worthwhile to collect post-module assessments to gain insight into more immediate impacts instead of retrospective accounts, as argued by a recent meta-analysis on helpful and hindering aspects (Ladmanová et al., 2021). The identified categories mirror the conceptual structure of the UP treatment. While we aimed for reflexivity and a consensual coding system that evolved iteratively with the emergence of new themes, we recognize the potential for bias introduced by the coders' preconceptions,

including their background in (Internet-based) CBT and the UP. Future analyses could include independent coding by researchers with different backgrounds to mitigate this bias.

The present study reveals important insights on how a transdiagnostic IBI impacts patients and which factors they perceive as helpful or hindering. We found that both responders and non-responders reported positive changes. Overall, patients rarely reported negative changes but instead put more emphasis on aspects that stagnated. Our results also highlighted that what patients find helpful or hindering can be highly individual. As many of the reported helpful and hindering aspects we identified were in relation to the specific treatment rationale this IBI was based on, conducting client change interviews with patients receiving other IBIs is warranted to gain insights into more overarching as well as specific helpful and hindering aspects.

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ORCID

Carmen Schaeuffele https://orcid.org/0000-0001-5902-0725
Christine Knaevelsrud https://orcid.org/0000-0003-1342-7006
Babette Renneberg https://orcid.org/0000-0003-2177-3566
Johanna Boettcher https://orcid.org/0000-0002-8220-9291

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