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RESEARCH ARTICLE

Internet-delivered emotion regulation therapy for adolescents engaging in non-suicidal self-injury and their parents: A qualitative, online focus group study

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Abstract

Objectives: We explore adolescents' and their parents' experiences of internet-based emotion regulation therapy for non-suicidal self-injury (NSSI).

Design: A qualitative study nested within a controlled feasibility trial.

Methods: Online, semi-structured focus group interviews were conducted with outpatient adolescents with NSSI aged 13–17 years ($n = 9$) and their parents ($n = 8$) who had received therapist-guided Internet-delivered Emotion Regulation Individual Therapy for Adolescents (IERITA). Transcripts were analysed using reflexive thematic analysis.

Results: Three main themes were generated: (1) Fatigue – barriers to and during treatment, comprised of two sub-themes 'Arriving to services exhausted, needing motivation, and leaving feeling abandoned' and 'the burden of IERITA and the consequences of fatigue', (2) inter- and intrapersonal insights as facilitators of change and (3) Online, written contact with the therapist is beneficial and contributes with less pressure, comprised of three sub-themes 'the therapist behind the screen is essential', 'less pressure sitting alone: the physical absence of a therapist' and 'engaging on your own terms, in your own tempo'. Themes were consistent among adolescents and parents.

Conclusion: Fatigue due to therapeutic engagement and previous help-seeking processes created barriers for engagement. Emotion regulation therapy was experienced as beneficial leading to inter- and intra-personal insights, facilitating change of maladaptive patterns. Therapists were regarded as indispensable, and the internet-based format did not hinder therapeutic alliance. The written format allowed for reflection and alleviated the pressure of relating to the therapist. Further research should explore experiences of other online treatment formats (e.g. synchronous or video-based) with regard to benefits, fatigue and therapist interaction.

KEYWORDS

emotion regulation therapy, family, online focus group, online treatment, qualitative study, self-harm, youth

BACKGROUND

Non-suicidal self-injury (NSSI), for example, cutting or burning oneself, is becoming increasingly prevalent in young people (Plener et al., 2015) with an estimated lifetime prevalence of 22.9% in non-clinical samples of adolescents (Gillies et al., 2018; Swannell et al., 2014). The prevalence increases when investigating young psychiatric populations with estimates up to 75% among patients with borderline personality disorders and interpersonal problems (Andrewes et al., 2019). Previous self-harm, including NSSI, is the most significant risk factor for suicidal behaviour (Muehlenkamp & Brausch, 2012; Victor & Klonsky, 2014) and dying by suicide (Ribeiro et al., 2016; Whitlock et al., 2013). It is well documented that youth engaging in NSSI have poor prognoses and a higher risk of adverse outcomes, such as need for mental health treatment and poorer educational performance (Bjureberg et al., 2019; Mars, Heron, Crane, Hawton, Kidger, et al., 2014; Mars, Heron, Crane, Hawton, Lewis, et al., 2014).

Evidence-based treatment for NSSI specifically is sparse within mental care and is most often handled within specialties, for example, eating or psychotic disorders, hence not specifically addressed or treated (Kiekens & Claes, 2020), despite the inherent risk and poor prognosis (Bjureberg et al., 2019; Mars, Heron, Crane, Hawton, Kidger, et al., 2014; Mars, Heron, Crane, Hawton, Lewis, et al., 2014). There is evidence in favour of Dialectical Behaviour Therapy for Adolescents (DBT-A), however DBT-A is an intensive, resource-demanding treatment usually not offered at early stages of NSSI (Kothgassner et al., 2021).

To meet the need for early, short-term, effective and easily accessible treatment, digital interventions have been suggested (Arshad et al., 2020). Recent meta-analyses of the effectiveness of apps and digital interventions to prevent self-harm do not provide sufficient empirical evidence to provide treatment recommendations, however these tools are evaluated as safe and appealing to young populations (Arshad et al., 2020; Stefanopoulou et al., 2020).

An internet-delivered intervention specifically for adolescents with NSSI has been developed by Bjureberg et al. (2017, 2018), named *Internet-delivered Emotion Regulation Individual Therapy for Adolescents* (IERITA). IERITA is developed from emotion regulation group therapy based on elements of Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT) and Acceptance and Commitment Therapy (ACT) (Bjureberg et al., 2017) and teaches emotion regulation skills. Improvement in emotion regulation ability is the treatment target and mediator in IERITA (Bjureberg et al., 2023). There is consistent reporting that NSSI temporarily reduces negative emotions such as anxiety, anger, loneliness, guilt and shame (Klonsky, 2007, 2009; Nock et al., 2009) with estimates of 66–81% of NSSI engaging youth stating emotion regulation as their motive for this behaviour (Taylor et al., 2018). Emotion regulation has been investigated as a moderator and predictor of treatment outcome in IERITA, however

with non-significant results (Ojala et al., 2024). The adolescent can access a new online module every week for 11 weeks (parents receive a new module every second week) supported by written dialogue with an individual IERITA therapist (Morthorst et al., 2022).

IERITA was tested in pilot and feasibility studies warranting safety and large scale investigations of the internet-delivered format (Bjureberg et al., 2017, 2018; Morthorst et al., 2022). The Danish feasibility trial was a two-armed design comparing 11 weeks of IERITA added to treatment as usual (TAU) versus TAU showing a 53% (95% CI 39.9–66.8) eligibility-to-randomisation rate, 87% (95% CI 58.4–97.7) completion rate and most importantly 90% (95% CI 72.3–97.4) follow-up rate at 12 weeks follow-up (Morthorst et al., 2022). A recent large-scale trial investigating the effect of IERITA in addition to TAU compared to TAU ($n = 166$) found a significantly larger reduction in NSSI episodes for IERITA compared to controls (82% vs. 47%) (Bjureberg et al., 2023). IERITA has also been shown to be cost-effective (Bjureberg et al., 2024).

As digital interventions are still a developing field, how these interventions are experienced by users is an area of research similarly in need of advancement, and this is especially so for adolescents (Valentine et al., 2022). Insights into experiences of internet-based treatment specifically for NSSI are limited. A subsample of participants (nine adolescents and 11 parents) from the Swedish IERITA feasibility study were interviewed about their experience of IERITA (Simonsson et al., 2021). The results indicated that IERITA is an acceptable method of acquiring news skills and understanding of NSSI, though also perceived stressful to adhere to for some. A mixed-method study of a mood supporting app for children and adolescents, the BlueIce app as add-on to face-to-face treatment, was experienced as easy to use, facilitating new strategies as well as catalysing difficult conversations. However, lack of motivation with both app engagement and reluctance to stop self-injuring were emerging themes (Grist et al., 2018). In a German study investigating needs and potential design implications for digital apps, the included adolescents expressed interest in smartphone interventions in management of NSSI, however, the participants had no direct experience of such interventions to draw on. This meant that the suggestions for future interventions were purely proposals (Cus et al., 2021).

The aim of the present study was thus to further explore adolescents' and parents' experiences of receiving IERITA (e.g. the internet delivery of the treatment and the focus on emotion regulation skills), to add to the still sparse evidence base and to contribute knowledge to the future provision of e-mental health programmes in child and adolescent mental health services (CAMHS). The study is part of a sequence of studies, from a quantitative feasibility trial to a qualitative study, followed by initiation of the large-scale TEENS (Treatment Effect of ERITA for Non-suicidal Self-injury) Multi-site trial, which the findings of the study have informed, to create a complementary study complex, as recommended by Sørensen et al. (2023).

METHOD

This study applied a qualitative design. We conducted semi-structured, online focus groups with adolescents and parents who had received IERITA. We followed the consolidated criteria for reporting qualitative research (Appendix S1: COREQ) (Tong et al., 2007).

Participants and recruitment

During winter 2021 to spring 2022 adolescents and parents receiving IERITA in a nested qualitative study within the TEENS Feasibility trial were recruited through convenience sampling. Participants were adolescents, fulfilling the inclusion criteria of at least one NSSI episode in the past month and five episodes the last year, outpatient within CAMHS in the Capital Region of Denmark, or an IERITA participating parent of one such adolescent. In this study NSSI was defined as 'deliberate self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned' (Hooley

et al., 2020). Eligible participants were contacted by phone by the research team and invited to participate if dates and times were convenient for them. IERITA engagement was presented by adolescents ranging from actively following all modules including exercises, to almost no recognition of IERITA content and terms and close to no logins to the platform.

Participants were all provided oral and written study information, and informed consent was obtained from both adolescents and custody holders, and explicit from the participating parent prior to inclusion. During the focus group sessions additional consent to video record was obtained.

We conducted five online focus groups, three with adolescents ($n = 9$) and two with parents ($n = 8$) in total covering 15 IERITA adolescent participants since two parent–child dyads participated. We have described the psychopathological profile of the entire adolescent sample including for the adolescents represented by their parents in the focus group interviews, since their NSSI behaviour and strain to the family was also the question of interest and the reason for the IERITA engagement among parents. Hence, in Table 1, demographics are presented for the 15 adolescents represented either by themselves or by a parent. Information on parent marital status is also provided.

The adolescents were aged 14–17 years, all identified as female, and the majority attended middle-school (Table 1). Current diagnostic status was based on clinical assessment obtained from medical records. The most prevalent diagnoses were personality disorders and autism spectrum disorders. Comorbid mental disorders were frequent (Table 1).

The IERITA intervention

IERITA is an 11-module intervention for adolescents based on principles from CBT, DBT and ACT, teaching emotion regulation skills and strategies (Bjureberg et al., 2017). The modules consist of texts to read, exercises to engage in, and videos and audios to watch and listen to. A new module is opened every week and is estimated to take approx. 60 min. to complete (with great variation due to, e.g. potential dyslexia, exercises and module content). The intervention is closely guided by an individual IERITA therapist through on-going, written dialogue. The therapists respond to messages from the participants several times a week, but not in a pre-set structure or immediately when receiving a message, hence through asynchronous support. IERITA also entails a six-module parent programme with new modules opening every second week. The IERITA therapist provides support for both the adolescent and the parents, undisclosed to the counterpart (Morthorst et al., 2022).

All IERITA therapists were experienced clinicians within CAMHS with therapeutic experience of the target group. They were all trained in the intervention, IERITA, by the Swedish developers and supervised by experts in the field of NSSI.

Procedures

Due to the COVID-19 lock-down, and to mirror the internet-based aspect of the intervention, we conducted online focus groups during winter 2021 to spring 2022. Focus groups in our study were chosen both because they are time efficient in terms of interviewing several people together, rather than in separate interviews, and are particularly suitable to facilitate interaction between participants that stimulates participants' answers regarding opinion or experience beyond the habitual (Balch & Mertens, 1999; Katz-Buonincontro, 2022; Macun & Posel, 1998). Focus groups can also mitigate power differentials between researchers and participants, in case of for instance age differences between adult researchers and young participants, by creating a supportive forum for participants (Macun & Posel, 1998). The inclusion of sensitive themes as topics in focus groups has been debated, and researchers have contested the argument of sensitive topics as unfit for focus groups, finding that precisely the interaction between participants holds a potential for mutual comfort (Woodyatt et al., 2016). We chose real-time, virtual focus groups where adolescents or parents

TABLE 1 Baseline demographic and clinical characteristics of participants participating in qualitative interviews after intervention ($n = 15$).

Variables	
Age, years, mean (SD) (range 14–17)	15.6 (1.1)
Gender (%)	
Female	15 (100)
Nationality (%)	
Danish	14 (93.3)
Other European nationalities	1 (6.7)
School (%)	
Boarding school	1 (6.7)
High school	2 (13.3)
Middle school	8 (53.3)
No School	2 (13.3)
Other (prep school)	2 (13.3)
Psychiatric disorders (ICD-10, A-diagnosis) (*n*, %)	
F30-39 (Affective disorders)	2 (13.3)
F40-49 (Anxiety disorders)	1 (6.7)
F50-59 (Eating disorders)	1 (6.7)
F60-69 (Personality disorders)	3 (20.0)
F80-80 (Development and autism spectrum disorders)	3 (20.0)
F90-98 (Behavioural disorders)	1 (6.7)
DF999 (Other mental disorders)	1 (6.7)
Co-morbid psychiatric disorders (ICD-10, B-diagnosis) (*n*, %)	
F40-49 (Anxiety disorders)	3 (20.0)
F50-59 (Eating disorders)	1 (6.7)
F60-69 (Personality disorders)	2 (13.3)
F80-80 (Development and autism spectrum disorders)	3 (20.0)
F90-98 (Behavioural disorders)	1 (6.7)
Parental status (%)	
Divorced	6 (40.0)
Married	8 (53.3)
Other	1 (6.7)

participated simultaneously, as synchronous, audio-visual focus groups have been shown to produce data richness comparable to face-to-face groups (Abrams et al., 2015). Comparisons of quality of data generated through in-person and online focus groups on a sensitive topic (e.g. intimate partner violence) similarly found online focus groups to have equal potential for generating data of high quality to that of in-person focus groups (Woodyatt et al., 2016). Three focus groups with adolescent participants and two with participating parents were held separately with three to five participants per group. For all three adolescent interviews, four participants were invited, with only three attending each interview. Non-attendees were not further investigated. Though recommendations for focus group sizes differ, there is largely consensus that online focus groups should be smaller, approximately three to six participants (Katz-Buonincontro, 2022; Poynter, 2010). None of the participants or the interviewers had previously met. The focus groups took place in the late afternoons, after traditional work or school hours and had a duration of 1.5–2 h. Participants participated in only one focus group each. Participants received a link to a secure Teams meeting room in a personal

digital mailbox. All interviews were video recorded using Microsoft® Teams. As preparation for the interviews, we distributed envelopes containing post-its, writing materials, images to facilitate and support statements and reflections, as well as snacks, as would have been offered if the participants had participated *in vivo*. Interviews were facilitated by two female researchers, an independent anthropologist (Christensen) with experience facilitating focus groups and semi-structured interviews, and a PI and associate professor (Morthorst et al., 2022) with experience conducting clinical interviews. The researchers took turns being the observer or facilitator of different interviews. At the beginning of the focus groups, additional oral consent was obtained to record the session as video and audio. All focus groups began with an introduction of the two researchers sharing names and brief personal features such as motherhood and age of children plus professional experience within the field of NSSI.

We used semi-structured interview guides including open-ended questions exploring the participants' experiences of (1) the internet-based format, (2) general experience of the therapy and (3) emotion regulation as a core target in the IERITA intervention. During the introduction, we underlined that the focus was experiences of receiving IERITA, not the personal history of NSSI or child's NSSI. Interview sessions began with an introduction with all participants and researchers visible on the screen. Open-ended questions were supplemented by exercises (see Table 2) to initiate discussion. Exercises are commonly used in focus groups to encourage discussion, facilitate interaction between participants and to set participants at ease (Fielding et al., 2017; Kitzinger, 1995). Exercises and moments to reflect individually were prioritised to ensure that viewpoints of all participants are captured, thereby avoiding that some participants omit sharing their considerations due to, for example, feeling shy (Krueger, 1998), as well as to facilitate dynamic discussions among participants, and finally due to the potentially sensitive nature of the topic of NSSI treatment. The observer made field notes during all interviews. New focus group sessions were conducted until the two researchers assessed that information power was reached, with consideration to the double perspective of both adolescents and parents (Guest et al., 2006), the relatively narrow study aim and the sample specificity obtained through convenience sampling as suggested by Malterud et al. (2016) in assessment of information power. Information power was considered at two-time points (a) during familiarisation process (b) re-coding phases (Castleberry & Nolen, 2018).

Transcription and analysis

Reflexive thematic analysis was applied through five hierarchical steps: All interviews were transcribed and closely read (compiling), transcripts were then inductively coded, re-read and re-coded constructing themes (disassembling and reassembling), followed by interpretation of themes, including thematic mapping, and conclusion (Castleberry & Nolen, 2018; Clarke & Braun, 2018), all performed by the two researchers conducting the interviews using NVivo 11 (QSR) (Dhakal, 2022). Reflexive thematic analysis was chosen as it allows for analysis focused on broad thematic patterning, and with flexibility for participant discussions to guide analysis in unexpected directions (Braun & Clarke, 2006), in line with focus group discussions that allow for the group to focus on experiences not predicted by the facilitators. The researchers performing the analysis were the primary investigator (PI) (Morthorst et al., 2022) in the feasibility trial and an independent anthropologist (Christensen), the latter without any prior connection to or specific insights into the intervention, allowing for focus group facilitation and coding with limited preconceived expectations of findings regarding the experiences of participants. The coding-re-coding process was conducted jointly, in a process where differences in meaningful units and codes were continuously explored and discussed, leading to reflexive re-coding and development of initial themes and subsequent thematic refinement. The collaborative coding created a fruitful interaction between the independent researcher's narrow focus on the generated data, contextualised by her research with other patient groups in CAMHS, and the PI's broader scope containing in-depth insights into the IERITA intervention and target group, which led to new discoveries within the material. Neither transcripts nor codes or analysis were returned to participants for correction or feedback; instead, to give the

TABLE 2 Focus group exercises.

Exercise	Purpose	Exemplar quote
Exercise 1: Pictures of public or fictive figures, for example, cartoons were presented as examples. The participants were asked to choose one or more figures and explain why they resembled their IERITA therapist	Opening question to set participants at ease by highlighting the shared experience of having a therapist and to facilitate discussion regarding experiences of therapeutic alliance and online relationship	Eva (adolescent)*: She reminds me of Winnie the Pooh. Because she is like, very kind […] she reminds me to do stuff, but in a caring way*
Exercise 2: Participants were asked to individually write down five positive and negative aspects of the IERITA programme, followed by discussion	To make room for all participants to individually formulate their initial response before being influenced and/or inspired by the joint discussion	Anja (adolescent)*: What the others said, but also… I really liked that it* [IERITA] *was in writing*
Exercise 3: Participants were given pictures to indicate the different formats of the IERITA programme, for example, text to read, drag-and-drop exercises, and asked to choose what provided the most and least benefits	Worked as a basis for discussion of the formats of IERITA	Eva (adolescent)*: For me, it* [the least beneficial] *was text to read. […] I quickly lost concentration, because it is so much text, and it's just like… I don't really want to read this, because it's so long. So, I was like, the last maybe 10 lines, that's it, I'm not reading any more, next page. […] then, it's not really useful*
Exercise 4: Participants were given pictures to indicate the different content elements of the IERITA programme, for example, understanding their feelings and distraction techniques, and asked to choose what provided the most and least benefits	To facilitate discussion regarding experiences of the therapeutic focus of the IERITA programme	Interviewer*: Okay, you have all chosen "understanding your feelings" […] can you tell me why that part in particular was good?* Anja (adolescent)*: I think for me, it has been because I have often felt that I didn't really feel my feelings, because I just avoided them*
Exercise 5: Participants were asked to write a piece of good advice to adolescents or parents just starting IERITA	Wrapping-up question, referred to as an 'all things considered' question (Krueger, 1998), to help participants reflect on their own process and crystallise those experiences into retrospective insights	Tanja (adolescent): *I just wrote "Give it time and trust the process"*

participants the possibility to give feedback, the moderator ended each focus group by summarising the discussion to ensure alignment. Pseudonyms are used to protect participant confidentiality.

Ethical considerations

The feasibility study was reported to the Regional Ethical Committee which waived the need for approval (H-19042904). Under Danish law, interview-based health research is exempt from ethical approval by the Committee (Videnskabsetik.Dk/Ansoegning-Til-Etisk-Komite/Overblik-over-Anmeldelsespligten, n.d.). Permission was granted from the Danish Data protection agency (reference id.: P-2020-113, Pactius). The data security of collected data and intervention platform was handled and granted by the Center for IT, Medico, and Technology within hospital services. Since all interviews were conducted online, there was no inconvenience related to travel logistics or expenses. Specific focus on NSSI behaviour in groups of adolescents is advised against due to the risk of social contagion, hence refrained from in the interviews. At the start of all focus groups, the researchers verbally introduced group agreements on confidentiality, as recommended by Katz-Buonincontro (2022). At the end of each interview, participants were asked about their

well-being, and invited to contact the PI if subsequent discomfort was experienced, as recommended by Pope (2020).

RESULTS

From the analysis of the focus groups, three main themes were generated: (1) Fatigue – barriers to and during treatment, (2) Inter- and intrapersonal insights as facilitators of change and (3) Online, written contact with the therapist is beneficial and contributes with less pressure (Table 3).

Fatigue – Barriers to and during treatment

This theme was generated from emic codes on especially scepticism, motivation for participation and therapy as homework. It encapsulates participants' experiences of exhaustion and fatigue and the consequences for their therapy processes, before, during and at the end of intervention.

Arriving exhausted, needing motivation and leaving feeling alone

Especially the parents described long-lasting help-seeking processes before starting IERITA. For most of them, it had been a back-and-forth movement between services characterised by false starts and unfruitful outcomes. Some families felt overlooked, that their needs had not been met, and that they had lost hope. This is how they encounter the IERITA intervention: exhausted and dubious about yet another intervention:

TABLE 3 Themes and sub-themes.

Theme	Sub-themes	Examples of codes	Exemplar quotes within the theme
Fatigue – barriers to and during treatment	Arriving exhausted, needing motivation, and leaving feeling alone	Preceding exhaustion, scepticism	Line (parent)*: How will this be any better than all the other things you have been through?*
	The burden of IERITA and the consequences of fatigue	IERITA as homework, hastily flipping through the modules	Eva (adolescent)*: I quickly lost concentration, because it is so much text […] then, it's not really useful*
Intra- and interpersonal insights as facilitators of change		Language, self-care, stepping back	Mia (adolescent)*: The thing about having a dialogue with my parents. That my parents could see if I got into a bad situation. Then my mother could say: "okay, what kind of ERITA-tool are you going to use now?"*
Online, written contact with the therapist is beneficial and contributes with less pressure	The therapist behind the screen is essential	Alliance, being supported	Laura (parent): *It's really crazy, that you can have a completely bodily, emotional experience through language, that there is someone standing there, taking care of you*
	Less pressure sitting alone: the physical absence of a therapist	Lessened interaction pressure, writing to the therapist	Line (parent): *I felt set free by not having a person I had to relate to physically*
	Engaging on your own terms, in your own tempo	Flexibility, writing to the therapist	Nadja (adolescent): *I was surprised by how nice it was to reflect in writing. […] through that process, I found out what was important and what wasn't*

Line (parent): *I probably approached this with a certain scepticism because you've been through rather a lot, before you land in that project* [IERITA], *and you think: 'How will this be any better than all the other things you have been through and all the other psychologists and professionals you have talked to?'*
Anja: *When I first heard about it* [IERITA] *I thought… I was just really sceptical* […] *I think because I like felt that I have tried so many things already. And I couldn't see how this would be any different.* […] *what could you say that was different from… what I had already heard.*

When asked what motivated them to participate in a research project with internet-based therapy, parents described a desperate need for help. It was as such not a question of choosing between NSSI-therapy in different forms, but rather getting any help at all, being the driving factor. The high level of psychiatric burden and comorbidity of the adolescents, and previous health care contacts because of this, contributed to many adolescents and parents feeling desperate to receive effective treatment. Parents described previous treatment offers as insufficient, ineffective, or too narrowly focusing on a singular aspect (e.g. eating disorder) rather than the general ill-being of their child, highlighting a need for a more holistic approach to treatment. For the parents, this was reflected in statements like "finally some help", and descriptions of several previous help-seeking attempts not meeting their needs. These previous experiences influenced how they initially perceived the IERITA intervention, that is, with a certain amount of scepticism, as for instance Line's comment above. This scepticism decreased their motivation and made them (at least initially) hesitant to engage in the intervention. The prior experiences of exhaustion due to insufficient support also influenced the experience of ending IERITA. The parents all to some degree felt unsure whether they were truly ready to not be supported by the IERITA therapist, echoing the unmet need for support experienced before IERITA:

Laura (parent): *We* [her and the daughter] *talked about it* [IERITA ending]*: 'How on earth are we going to make it?'. We also wrote to the therapist 'I'm not sure we can make it without you'* [laughs]. *And she was like 'Sure, it's going to be fine', but what else could she say?!* [laughs]. *But… actually, I think it was a bit tough, you have these 12 weeks concentrated, and then it's over. If you could phase it out somehow, that would be nice.*

The burden of IERITA and the consequences of fatigue

Though the experiences preceding participation in IERITA left especially parents exhausted, IERITA itself was also described by both adolescents and parents as burdensome. Most experienced the intervention tasks as 'homework' that had to be remembered and done by a deadline. Moreover, the amount of text was experienced by the adolescents as insurmountable. This at times led to a certain experience of fatigue.

Mia (adolescent): *It's a bit difficult being in 2.g* [high school] *and having assignments and school, a job, and friends, and then also having to do this* [IERITA] *plus other treatment offers. Maybe it would have worked if I didn't have anything else to do but… in the end it got a bit stressed, and I didn't feel that I got as much out of it because I didn't have time for all of it.*

Several participants mentioned how the fatigue negatively impacted the potential benefit of the intervention. Especially the adolescents recounted quickly paging through the module the evening before the next one opened, and not truly paying attention to the content. This meant that although the participants had technically completed the modules, the understanding of how to implement concepts and learnings were at times abandoned in favour of superficial readings due to the fatigue.

Helle (adolescent): *sometimes, when you perhaps read too much, you just read it like a text, not something you can really use […] sometimes, when it got a bit too much for me, I just wanted to read it quickly, but not really understand how this could affect me.*

For some participants the burden of IERITA also impacted their relationship with their parent or child, with some adolescents and parents struggling to motivate the counterpart. For some, the motivational struggle became a barrier for engagement leading to resignation.

Line (parent): *My daughter was just not motivated for it to be an online process. […] Besides I'm a single parent and have been alone helping her through this process, so it has been hard to compel this… […] I mean, it simply felt like the worst kind of homework to her […] it also felt a bit stressful to me because there were of course things I wrote that she* [the therapist] *asked about etc. and that's good, that's her job, but it could feel all stressful to me.*

The burden of the programme was also reflected in the advice participants would give to others (exercise 5), which often included advice of taking the time to engage with the programme and not give up. For instance, Jakob's advice to parents whose child is starting IERITA:

Parent Jacob: *Be forgiving, because it is difficult to get it all done and there is a lot. Like Tobias* [another participating parent] *says, it is a lot, both in amount and in the heart.*

The notions of accepting that the intervention was demanding and staying with it despite fatigue mirrors acceptance and validation, which are central elements of the IERITA programme.

Intra- and interpersonal insights as facilitators of change

Besides barriers and hardships, participants spoke of several benefits derived from IERITA. In descriptions of the therapeutic process, acquisition of language emerged as a prominent theme. The IERITA intervention focuses on providing an understanding and handling of difficult emotions through a theoretical framework of emotion regulation including specific concepts and terms, and participants described how this facilitated both a focus on underlying issues, rather than solely on NSSI, and an understanding of one's action patterns:

Tobias (parent): *I mean, there was a lot of focus on this thing about emotions […] it was those underlying things which were in focus, and I thought that was very good.*
Helle (adolescent): *I'm starting to understand a whole lot of things in my everyday life. Why I do certain things. […] Now I can almost express what actually happens… instead of not really knowing how to explain it. […] there are actual terms for it. […] I wanted to avoid having these feelings, by self-injuring. Um, and by knowing that it is an evasion [IERITA term] […] and that it's better perhaps just doing a diversion [IERITA term].*

Helle describes gaining insight into her pattern of behaviour, enabling her to understand why she at times had the urge to self-injure and how to act differently. Likewise, Mia articulates the connection between acquiring concepts, understanding one's own actions and, through that insight, changing one's action patterns:

Mia (adolescent): *When I had words for it, it was easier to grasp in my brain, figuring out which strategy I should use. Because I had a name and an explanation of what I was really doing.*

These insights were not solely intrapersonal. As the language applied for NSSI and emotion regulation became shared between parent and adolescent, this enabled both interpersonal insights and dialogue within the parent–child dyad:

Mia (adolescent): *The thing about having a dialogue with my parents. That my parents could see if I got into a bad situation. Then my mother could say: 'okay, what kind of ERITA tool are you going to use now?'*

One type of such interpersonal insight was an understanding of how action patterns within the family could lead to detrimental outcomes and how those patterns could be changed. These insights included the need for legitimate self-care and temporarily withdrawing from the situation. Especially the premise of helping oneself before being truly able to help the child dealing with severe distress, including the urge to self-injure, was a recurring topic for parents:

Nadja (parent): *So about breaking the vicious circle through activities […] to say* [to myself] *'it's okay that I say 'now I just need half an hour as well' […] It is actually valuable, to gain a language, to tell my daughter that 'right now, this* [NSSI behaviour] *is so all encompassing, and I can feel that I am getting totally confused myself. I want to take care of you, but I also must take care of myself'.*

Nadja describes the necessity of breaking a negative circle with self-care and how the language gained through IERITA helps her articulate this need. The need for and impact of these new action patterns were echoed by several parents. One mother described how the therapist helped her keep calm in the face of her panic regarding her daughter's misery, and Tobias recounted how the new action pattern was crucial for re-establishing dialogue with his daughter:

Tobias (parent): *It's unbearable as a parent being unable to reach her* [daughter]. *So, you fall into this solution-mode. Whereas in this program, you practiced stepping back. When we chose that approach, she came back and started automatically sharing more and more.*

The examples highlight how gaining a language was experienced as a catalyst for inter- and intrapersonal insights into behavioural patterns and emotions, the articulation thereof and ultimately for change. In Figure 1 we illustrate the interconnections between these experiences, with the new language leading to new insights and then either directly to experiences of change, or with the new insights being communicated utilising the gained, shared language, which then becomes not only the catalyst for change, but also the mode through which change is actualised.

Online, written contact with the therapist is beneficial and contributes with less pressure

In the participants' descriptions of the IERITA therapeutic process, the novel experience of internet-based therapy emerged as a major theme. All adolescent participants and their parents had experienced one or more psychotherapeutic treatment interventions previously and highlighted contrasts and similarities between the face-to-face and internet-based formats, particularly the consequence in terms of therapeutic alliance, a lessened interaction-pressure, the tempo giving room for reflection, and the flexibility of online-delivered therapy.

The therapist behind the screen is essential

Gitte (adolescent): [the most beneficial format was] *writing with a therapist. I don't know if you could, like, do it without. […] if you feel unsure about some things, or need it explained. Then, it's very nice to know that there is someone who can explain it.*

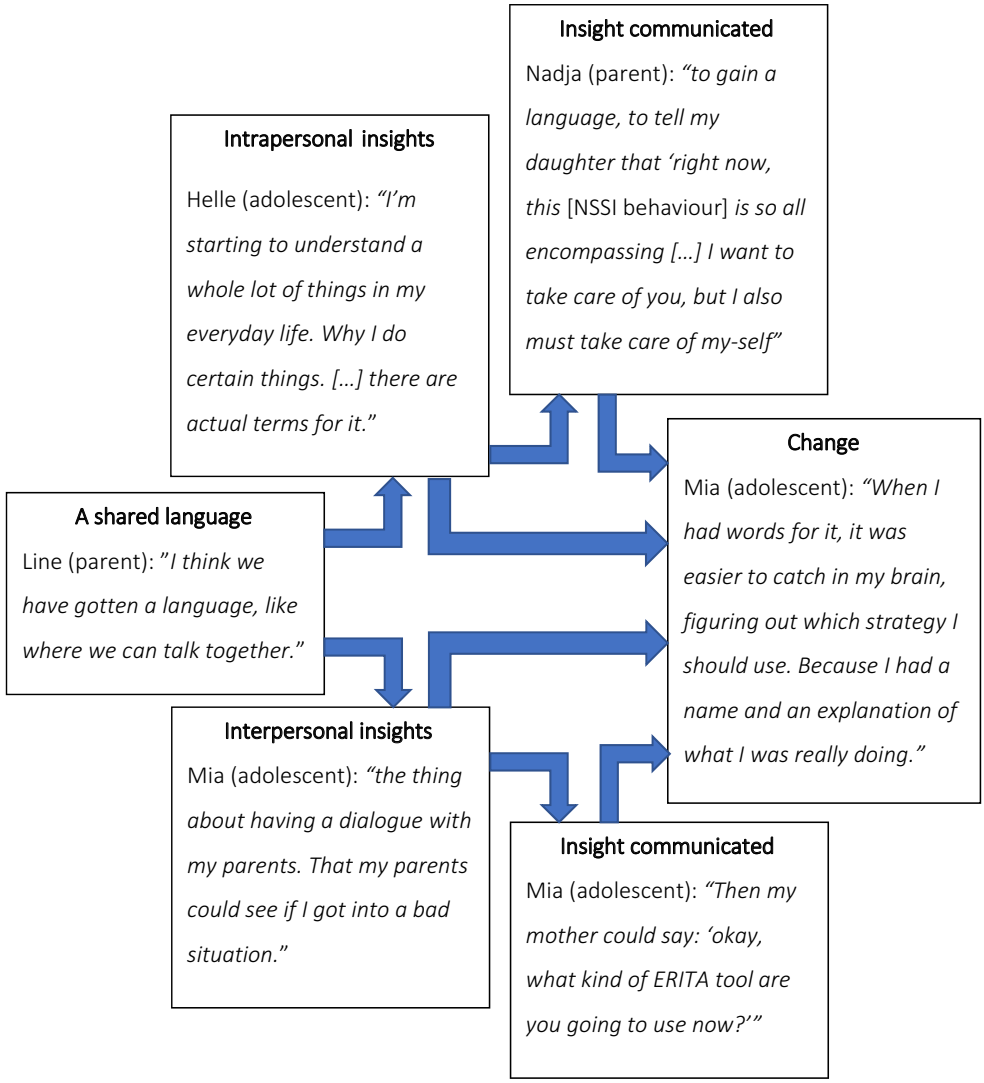

FIGURE 1 Model of interconnections between language, insights, language as a facilitator of change, and experienced change.

> ***Helle (adolescent):*** *I also* [like Gitte] *chose the therapist. That thing about having a person who sometimes would write you back* […] *that you didn't feel like you were just… doing exercises like in school. There was actually something behind.*

Throughout the interviews, there was a clear consensus that the therapist was a central part of the intervention, offering guidance, care, feedback, and validation. For parents, the therapists also provided crucial support and calming assurance during desperate and sometimes panic-inducing situations. Additionally, for some parents, having contact with an online therapist made them feel like they no longer carried the burden of their child's troubles alone.

> ***Line (parent):*** *that freedom I had for a while, where the responsibility wasn't mine […] being able to lean into something, where someone minimum once a week was helping us.*

Notably, with the exception of one adolescent participant, alliance was not hindered by the internet-based format; indeed, as one parent commented, she had truly not realised that she had not been having physical meetings with her therapist.

> ***Laura (parent):*** *It's funny, because it's just during this talk that I realized that it* [IERITA] *was in writing* [laughs]. *[…] I mean, it felt like 'we have been sitting right here. You [the therapist] were right there'. I have never seen her, but I have pictures of her in my mind. It's really crazy that you can have a completely bodily, emotional experience through language, that there is someone standing there, taking care of you.*

For Laura, the internet-based format did not even register until brought up in the focus group. The written correspondence alone offered her an embodied, emotional experience of support. The experience of having support 'behind' the programme was thus both central and achievable. Though participants were online assessed at baseline by their IERITA therapist, some reflected that writing with an individual you hadn't met was 'a bit weird' and made them initially nervous. They also speculated that alliance could perhaps have been established earlier if they had had a physical meeting with their therapist prior to the online dialogue.

Less pressure sitting alone – The physical absence of a therapist

> ***Line (parent):*** *I felt set free by not having a person I had to relate to physically. […] it* [internet therapy] *has been free of having to deal with how the person responds to what is very difficult for me.*

Both parents and adolescents were relieved that the internet-based format entailed less energy spent on considerations of the reactions of the therapist. This was especially appreciated, as the therapeutic process was experienced as both time consuming and emotionally exhausting. The internet-based format thus reduced the extra burden of having to relate to a therapist, while disclosing difficult emotions or situations. It also provided a contrast to previous experiences of therapy and psychiatric assessments, where the presence of a therapist could inhibit or compel disclosure:

> ***Helle (adolescent):*** *I have a tendency to hold back more when it is face-to-face. I struggle to say things which are easier for me to write down. […] It is easier opening up a bit.*
> ***Anja (adolescent):*** *I don't have to sit all the time and look them* [therapist] *in the eye and be pressured to tell them all kinds of stuff. And if I have a really bad day, I'm not forced to talk to that person. That's why it feels less like a forced relationship.*

Several parents also highlighted that the internet-based format, *through* the absence of a physically present therapist, ameliorated a challenge they otherwise faced in getting help to their children, due to the façades their children would put up, both in school and during consultations within services.

> ***Jacob (parent):*** *I don't know how many conversations with psychologists and psychiatrists I have attended with her* [daughter] *and thought 'I hope they are good enough to see through this', because I could just hear her project exactly what she expected the listener wanted to hear. Smiling and well-spoken, and I just know it has nothing to do with the reality, but that's what she does, and that was a part of her problem […] when that was peeled off, all that was left were the thoughts.*
> ***Laura (parent):*** [my daughter] *is exactly the same* [as Jacob's]. *I mean, she stands there looking so friendly, and then she goes and 'cut, cut, cut' because she feels so awful. And that thing, that no one saw her, it didn't matter if she smiled. She could just focus on whatever she had to think about.*

The parents were frustrated by the perceived façades obscuring their children's struggles to teachers and health care assessors, and by how their children's focus on maintaining the façade had inhibited previous therapeutic attempts. IERITA was experienced as a contrast, where the façade was 'peeled off' and the adolescent could focus on the therapy. The internet-based format thus had the potential of creating a space where the participants did not have to put up a façade or pay attention to their therapist, not unlike a confessional where one can say potentially shameful or private revelations out loud without being confronted with the recipient's bodily reaction.

Ronja (adolescent): *it's cool that you can like, write, because sometimes I think it's really difficult to say it out loud. […] It sounds wrong coming out of my mouth or perhaps it's embarrassing. It's just a bit easier to write.*

For one participant however, this experience was not necessarily instant. Gitte's advice to an adolescent starting IERITA was to let go of the fear of "writing something wrong".

Gitte (adolescent): *In the beginning, I thought a lot about whether I like… wrote something wrong. […] I thought a lot about what they wanted me to write […] if there was a right way to write it.*

Gitte's experiences mirror the parental frustration of their child's focus on the recipient eclipsing their focus on the therapy in itself. In her case, the written form did not immediately yield the benefit of lessened interaction-pressure, perhaps due to the delay in alliance mentioned above.

Engaging on your own terms, in your own tempo

Jacob (parent): *you can do things […] through writing that can be difficult to do face-to-face […] there was some kind of lingering in that that made it so you actually wrote it all out.*

Beyond the internet-based format removing the face-to-face therapist interaction, writing responses to the therapists both created a space where participants could reflect on their responses and make corrections while writing, which allowed for a different tempo to linger and take time for reflection.

Nadja (adolescent): *I was surprised by how nice it was to reflect in writing. […] writing down my thoughts, deleting and writing them again, you could say I got more into the core of it […] through that process, I found out what was important and what wasn't.*

In contrast to weekly appointments with a therapist, participants could in their own time engage with the programme, writing and re-writing paragraphs and lingering in the process until new insights emerged. The internet-based format also made it possible for the participants to engage with the intervention when they simply found it convenient or when they would otherwise have been too impacted to attend, for example, a regular therapy session:

Helle (adolescent): *I think it's nice that I can do it at home […] if there are days when I can't get up or do anything […] even if I have a bad day, I can still do some of it.*

Even though the fatigue at times caused participants to rush through the programme, the flexibility and especially the process of writing enabled participants to choose when and on what to spend time and energy. The internet-based, written format thus created room for the participants to engage with both the therapist and the programme on their own terms and in their own tempo in ways that weekly, time-limited, face-to-face appointments did not.

DISCUSSION

This qualitative study investigating adolescents' and parents' experiences of receiving IERITA, contributes to insights regarding both NSSI treatment and internet-delivered interventions. Three main themes were generated covering (1) the impact of exhaustion and fatigue due to preceding help-seeking processes and demands of the intervention, (2) inter- and intrapersonal insights as facilitators of change and (3) the impacts of internet-based intervention on the therapeutic process. These findings highlight (1) that the intervention, and especially the impact thereof, does not exist in a vacuum, but is continually influenced by preceding and concurrent circumstances of the participants, (2) that the potential for change is at least partly catalysed by emotion regulation language acquisition and (3) that the contact with an immaterial therapist, mediated through written language, holds the potential for greater agency, especially in terms of disclosure.

The results indicate how previous experiences of not receiving sufficient help creates scepticism that influences the participants' engagement with the IERITA intervention. In Denmark, there has recently been an increased focus on the process prior to children and adolescents receiving psychiatric treatment. For instance, Hansen et al. (2021) showed that parents seeking help for their child's mental health encounter numerous barriers such as unavailability of services and professionals refusing to initiate interventions or to provide referral to services, and a report on experiences of parents with children in assessment or treatment in Danish CAMHS describes the system as labyrinthian and slow with many dead ends (Hansen & Poulsen, 2021). The preceding processes were experienced as the reason for exhaustion and scepticism, which in turn must be considered as part of the circumstances for motivation and engagement in IERITA.

Similarly to Simonsson et al. (2021), who found that emotion regulation training was experienced as supportive, we found that the IERITA therapy shifting focus from self-injuring behaviour towards the understanding of difficulties in emotion regulation is indeed experienced as relevant and helpful. The benefits include a focus on underlying issues that parents articulated as previously lacking in treatment approaches, an issue which has been raised in critiques of CBT as being too mechanistic and lacking a holistic focus (Gaudiano, 2008). Moreover, the analysis has shown how a language regarding especially emotion regulation facilitated insights into detrimental action patterns of both adolescents and parents. These insights in turn were able to catalyse changes of action patterns mentioned above. Haydicky et al. (2017) found behaviour regulation as catalysed by action pattern recognition, when investigating mechanisms of therapeutic action in parent–child mindfulness training for adolescents with ADHD. The training provided a shared vernacular that enabled parent–child dialogue, which in turn was instrumental in improving interpersonal relationships. The BlueIce app (in conjunction with face-to-face therapy) for adolescents engaging in self-harm was likewise found to be helpful in terms of facilitating conversations about feelings (Grist et al., 2018).

Considering the multitude of internet-based therapeutical interventions without therapist guidance (Berger, 2017) the participants' insistence on the indispensability of the therapist is of particular interest. The idea that online treatment cannot stand alone was likewise emphasised by Cus et al. (2021) in a sub-theme titled Apps Cannot Replace People, and is in line with both a systematic review by Palmqvist et al. (2007) showing a strong association between therapist input and outcome, and with the findings of a meta-synthesis of guided computer- and book-based self-help, where all included studies consistently highlighted the helpfulness of guidance (Yim & Schmidt, 2019). Therapeutic alliance is known to play a role in treatment effect, though the precise importance is still indeterminate. A bonding and caring relationship with mutual trust and respect has previously been emphasised (Ardito & Rabellino, 2011). Aspects which were all similarly highlighted by IERITA participants. Therapeutic alliance is seldom a primary outcome of interest in psychotherapy trials, limiting the knowledge of importance thereof (Henson et al., 2019). However, previous feasibility studies of the ERITA programme, both face-to-face and internet-delivered, proved strong therapeutic alliance and treatment adherence (Bjureberg et al., 2017, 2018). We found that, for some participants, alliance with a therapist through written communication took some time to establish, which mirrors studies of the relevance of a therapeutic alliance as a dynamic process (Ardito & Rabellino, 2011). This is furthermore in line with the conclusion of a

narrative review by Berger (2017) stating that, from a client perspective, therapeutic alliance can be formed in guided internet-based CBT, though the timing may differ, but importantly, alliance was not hindered by a lack of face-to-face-meetings, as has otherwise been hypothesised. In a meta-synthesis of studies with adult populations Flückiger et al. (2018) argued that alliance in internet-based therapy is of less importance compared to in-person therapy, contradictory to our findings of consistent appreciation of the therapist guidance and support.

We found that the absence of face-to-face interaction may lead to lessened emotional burden and greater agency in terms of disclosure. This was similarly an aspect of the written correspondence, lending participants time for reflection, and a space where they focused less on the reactions of the therapist. Simpson (2009) similarly found that internet-based treatment can lead to disinhibition and openness, though her findings focused on patients with avoidant personalities, and King et al. (2006) conclude that internet-based counselling is experienced as providing a private and safe environment when related to sensitive topics with emotional pressure, compared to face-to-face options in adolescents.

Interestingly, these experiences are not easily attributed to the internet-based or the written format exclusively. It may be that an online therapeutic programme where participants make small recordings of themselves instead of writing, or an intervention where participants write passages which are then shared with a therapist face-to-face, might equally offer some of these benefits.

Strengths and limitations

This qualitative study embedded in a quantitative feasibility trial was conducted exclusively online including the focus group interviews during COVID-19 lockdown, which is a proof of a consistent online concept. The study investigated a novel intervention format not previously provided within CAMHS in Denmark, but considered an innovative future strategy within mental health services. The nested design meant the study has informed adjustments and adaptations of the TEENS Multi-site trial, which is now in process, achieving a complementary synergy between quantitative and qualitative research strategies as recommended by Sørensen et al. (2023). Conducting the focus groups online meant that participants who might otherwise be difficult to include could add their perspectives on the intervention and thereby directly impact the development of future treatment in CAMHS. The adolescents themselves commented on the accessibility of online meeting compared to physical meetings, and though this was not mentioned by parents, the report Family Life under Cross Pressure highlights how parents with children in child and adolescent psychiatry are overwhelmed by the logistics of assessments and treatment, and are difficult to recruit for research (Hansen & Poulsen, 2021). Despite the online nature of the focus group causing participants to have more limited contact with one another, the atmosphere was characterised by laughter and mutual support. A clear synergy emerged between the participants, who clearly both cared for and inspired each other during the conversations – a primary goal of the focus group method. NSSI can be a sensitive topic not easily shared or disclosed with strangers. However, the mirroring potential of focus groups emerged during all interviews, for instance among parents sharing their frustration and fears, and adolescents confirming each other's experiences of struggling with the material. Though encouraged, no participants contacted the PI following an interview due to discomfort from participation; indicative of no adverse reactions following the interviews.

Representativity was good with respect to a wide range of IERITA engagement and participation, by families covering the entire capital region, Denmark, and differing co-morbid profiles among the adolescents. Some participants had been fully engaged in the programme including homework assignments, while others had hardly been active and expressed unfamiliarity with the IERITA content. Convenience sampling could potentially have created selection bias towards more satisfied IERITA participants.

In this qualitative study nested in the TEENS feasibility trial all participants were exposed to IERITA with no comparison group hence no quantitative measures of NSSI progression or responder calculations were performed. A further study limitation is the lack of male and non-binary adolescent participants as well as a lack of demographic information on the parents. However, it is a consistent

finding that NSSI is more frequent in females than males, even more so in clinical samples, mirroring our participants (Bresin & Schoenleber, 2015). Additionally, information bias cannot be excluded due to group interviews for some participants potentially hindering disclosure. Furthermore, we cannot ignore that certain families, even more burdened by mental illness and cross-sectional service use, may not have had the capacity to even engage in online focus group, thus skewering our findings towards a relatively less burdened group of adolescents and parents.

CONCLUSION

This study provides nuanced insights into the experience of emotion regulation internet-based therapy for NSSI among adolescents and their parents. The constructed themes underline the ambivalence of initiating treatment in the context of long, prior help-seeking processes, but also emphasise the importance of the therapist guidance in internet-based therapy. The internet-based emotion regulation therapy shifting from a narrow focus on self-injuring behaviour towards a broader understanding of difficulties in emotion regulation is indeed experienced as relevant and helpful. However, the internet-based therapy is also experienced as demanding to engage in, even though it allows for more flexibility and less pressure from interacting directly with a therapist. Further research should focus on the experience of other online treatment formats (e.g. synchronous, or video-based) with regard to experienced benefits, fatigue, and therapist interaction. The experiences of IERITA support further implementation and development of internet-based therapy within CAMHS.

AUTHOR CONTRIBUTIONS

Sofie Heidenheim Christensen: Conceptualization; investigation; writing – original draft; methodology; validation; visualization; writing – review and editing; formal analysis. **Michella Heinrichsen:** Visualization; writing – review and editing; data curation; project administration. **Bo Møhl:** Writing – review and editing; conceptualization. **Lotte Rubæk:** Writing – review and editing; conceptualization; validation; project administration. **Katherine Krage Byrialsen:** Data curation; writing – review and editing; project administration. **Olivia Ojala:** Writing – review and editing; conceptualization. **Clara Hellner:** Writing – review and editing; conceptualization. **Anne Katrine Pagsberg:** Writing – review and editing. **Johan Bjureberg:** Writing – review and editing; conceptualization. **Britt Morthorst:** Conceptualization; investigation; writing – original draft; methodology; validation; visualization; writing – review and editing; formal analysis; project administration; resources.

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CONFLICT OF INTEREST STATEMENT

All authors report no potential conflict of interest.

DATA AVAILABILITY STATEMENT

The data supporting the findings of this study can be made available upon reasonable request from the corresponding author. Data such as full, un-pseudonymised transcripts may not be made publicly available due to privacy considerations.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

Appendix S1.

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