



Adherence to a web-based pre-treatment for phobias in outpatient clinics



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ABSTRACT

Background: Non-adherence in Internet interventions is a persistent and multifaceted issue and potentially limits the applicability and effectiveness of these interventions. Factors that influence non-adherence are poorly understood, especially in outpatient samples with more complex symptoms.

Objective: The current study is a secondary analysis of data from a randomised controlled trial that examined the cost-effectiveness of offering an Internet-based exposure treatment to phobic outpatients on a wait-list to receive face-to-face psychotherapy.

Methods: We collected baseline demographic and clinical information, and adherence data of the Internet-based intervention and conducted regression analyses to predict non-adherence to the intervention.

Results: The adherence to the intervention was low, with only 13.3% of 105 patients completing all five lessons of the intervention. The median number of exercises completed (out of a possible 8) was 3. In a multi-predictor model, a higher baseline score of anxiety (OR = 0.94, 95% CI 0.90–0.99) was a risk factor for low adherence. Higher age (OR = 1.05, 95% CI 1.00–1.09) was a protective factor against non-adherence. Participants who adhered to the intervention were more likely to complete post-test assessments, further biasing results. However, overall participant attrition was high. The results are based on a small subset of participants and should be interpreted with caution.

Conclusions: Poor baseline clinical status and age are factors to consider when deciding whether to offer an Internet-based intervention to outpatients. Low adherence among those patients might be related to intrinsic motivation and might even be lower in outpatient settings where participants expect to receive face-to-face treatment. It might be worthwhile to develop a concise instrument to assess intrinsic motivation and treatment expectations for using Internet-based interventions, and for the therapist to review the range of possible (Internet-based) intervention options to suit personal preferences and expectations.

Trial registration: Netherlands Trial Register, NTR2233.

1. Introduction

The use of the Internet to deliver mental health interventions has been increasing almost exponentially in the past decade. The flexibility and easy implementation of Internet-based mental health interventions makes it possible to deliver therapies to a large number of people in their own environment, at a convenient moment. Furthermore, these interventions have the potential to reach populations hitherto unreachable, due factors such as distance to healthcare providers or stigma. Internet interventions in the form of Internet-based cognitive behavioural therapy (iCBT) have been shown to be as effective as face-to-face (FtF) psychotherapy for a number of common mental disorders

(Andersson et al., 2014). Additionally, preliminary evidence suggests that these interventions may be cost-effective when compared to alternative treatments or wait-list control groups (Donker et al., 2015).

One of the main challenges of offering Internet-based interventions is premature discontinuation of the intervention (Christensen and Mackinnon, 2006; Eysenbach, 2005). Participants who discontinue prematurely are non-adherent to the intervention, as they do not experience the content of the intervention as it was intended. Non-adherence estimates in Internet interventions range from 2% to 83%, with an average of approximately 31% (Melville et al., 2010). It has been found that adherence to an intervention tends to be higher when the intervention has some of guidance by a professional (Christensen et al.,

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2009; Richards and Richardson, 2012). The non-adherence to guided Internet-based interventions is comparable to discontinuation of FtF psychotherapy (van Ballegooijen et al., 2014), as a recent large meta-analysis found that approximately 26.2% of patients discontinued FtF psychotherapy prematurely (Fernandez et al., 2015). Although the non-adherence to guided Internet-based interventions seems comparable to FtF treatments, the effects of these psychological interventions might be increased when the problem of non-adherence can be reduced. This makes it important to examine factors that influence non-adherence to psychological treatments.

Previously found factors associated with treatment non-adherence in FtF psychotherapy were a lower educational level (Keijsers et al., 2001), higher baseline depression scores, or being in specialised (out-patient) rather than in primary care, although the latter may be indicative of worse clinical status. Research on the influence of gender on adherence has produced equivocal results, with some indicating higher adherence in men (Issakidis and Andrews, 2004), some in women (Herbert et al., 2005; McEvoy, 2007), and others reporting no differences (Erwin et al., 2002; Hofmann and Suvak, 2006; Santana and Fontenelle, 2011).

With regard to Internet interventions, several categories of adherence predictors can be identified. Broadly, these are divided into socio-demographic variables, psychological problems (e.g., duration and severity of problems, comorbid anxiety and depression) and treatment-related variables such as e.g., treatment credibility, expectations and presentation and motivation to participate (Melville et al., 2010). In Internet-based interventions, sociodemographic variables that were associated with non-adherence in unguided Internet-based therapy included, as in FtF treatment, a low educational level. Furthermore, male gender, and younger age were also associated with non-adherence (Karyotaki et al., 2015). Psychological problems associated with lower online adherence are also similar to FtF psychotherapy, including higher pre-treatment symptoms and comorbidity (Christensen et al., 2009). Treatment-related variables include expectations of whether the intervention will work (Boettcher et al., 2013), feeling accountability to the therapist (Mohr et al., 2011) or a sense of duty to researchers carrying out the intervention and being able to identify with the programme (Donkin and Glozier, 2012). Additionally, persuasive design features – which explicitly motivate a user to keep using the intervention – also play a part. For example, more frequent intended usage, more frequent updates and more extensive use of dialogue support (e.g., an online coach), significantly predicted better adherence (Kelders et al., 2012).

However, one shortcoming of previous research on predictors of adherence is that it was mostly based on either non-clinical samples, self-selected samples who were offered no other treatment other than an Internet-based treatment (i.e., studies with wait-list control conditions), or samples from unguided Internet-based interventions (e.g., Karyotaki et al., 2015). Currently, we are not aware of any research on predictive variables of adherence to an Internet-based intervention in patients that are actively awaiting outpatient psychological treatment. The upcoming face-to-face psychological treatment may influence the attitudes of patients towards Internet-based treatment, or may influence attitudes or behaviours. For example, outpatients might have different clinical profiles (e.g., worse symptom severity) which influence adherence. Additionally, knowing that one is guaranteed to receive face-to-face psychotherapy could lower the threshold to discontinue the Internet-based intervention. Information on predictors of adherence can help therapists and healthcare workers to identify different patient profiles, e.g. those likely to complete an Internet-based treatment relatively independently, patients for whom an Internet-based intervention should be more closely monitored e.g. in form of extra guidance, and perhaps patients best directly referred to FtF treatment.

In short, treatment dropout and its causes remain a research priority. To add to currently available information, the current study uses data from a previously conducted RCT (Kok et al., 2012, 2014),

which investigated the potential cost-effectiveness of offering an Internet-based guided pre-treatment to outpatients during wait-list for FtF psychotherapy. In short, the rationale was that offering an Internet-based pre-treatment might reduce the number of FtF sessions by relegating routine tasks to guided self-help.

In the current study, we investigate predictors of adherence in this clinical sample of phobic outpatients. We will examine prognostic variables related to intervention adherence in an outpatient sample of phobic patients. As Internet-based interventions increasingly find their way into clinical practice, it is necessary to identify predictive variables for adherence to these interventions in clinical samples.

2. Method

2.1. Design

This study is a secondary analysis from a randomised controlled trial examining the cost-effectiveness of guided Internet-based treatment for phobic patients waiting for face-to-face treatment (Kok et al., 2012, 2014). In this trial, 212 outpatients from eight Dutch outpatient clinics were randomised to either 1) a 5-week wait-list control group ($n = 107$) or 2) a 5-week Internet-based guided intervention ($N = 105$) based on exposure homework exercises. After wait-list control group or the Internet-based intervention, all participants were scheduled to receive face-to-face-psychotherapy; all but 4 participants (2 in either condition) did continue to face-to-face psychotherapy.

For this secondary analysis on intervention adherence, data from the 105 participants receiving the Internet-based intervention were used.

The study from which these data originated has been approved by the Medical Ethical Committee of the VU University Medical Centre (registration number 2010/77).

2.2. Participants and recruitment

Phobic patients were referred to the research team by outpatient clinic staff. If eligible for inclusion, the mood and anxiety sections of a diagnostic interview (CIDI; World Health Organization, 1990) were administered by telephone, informed consent was sought and baseline measurements were recorded. We included computer-literate, Dutch-speaking patients, 18 years or older, with a DSM-IV-TR diagnosis of any phobia (social phobia, agoraphobia or specific phobia). Stable psychotropic medication use was allowed. Patients with psychotic disorders or at elevated risk for suicide were excluded and received care as usual at the outpatient clinic.

2.3. Intervention

Intervention patients were offered a five-week Internet-based intervention, based on exposure therapy. This intervention comprised 8 exercises, which were to be completed in 5 weeks; the average time spent waiting for face-to-face psychotherapy. In the first week, patients were offered psychoeducational information on phobias and reviewed the treatment rationale for exposure therapy. Additionally, patients had to assess motivation for treatment and were asked to affirm they were ready to start confronting their fear by self-exposure. In the second week, patients categorised their fears and avoidance behaviours, constructed a fear hierarchy (ranking fear-inducing situation from 'no fear' to 'complete terror') and started planning to complete this fear hierarchy in the coming weeks by planning gradual exposure homework exercises. During week 3, 4 and 5 patients were asked to complete their planned exposure exercises. This means that patients needed to expose themselves to situations or objects that elicited fear. They had made a fear hierarchy and were supposed to expose themselves to fearful situations in a gradual way starting with the least fearful situation and increasing levels of intensity each week. After each lesson, patients

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