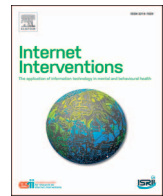




Contents lists available at ScienceDirect

## Internet Interventions

journal homepage: [www.elsevier.com/locate/invent](http://www.elsevier.com/locate/invent)

## Patient's experience with blended video- and internet based cognitive behavioural therapy service in routine care

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### ARTICLE INFO

#### Keywords:

Blended therapy  
Patient's experience  
Depression  
Routine care  
Video-based psychotherapy  
Internet-based self-help

### ABSTRACT

**Introduction:** Internet-based guided self-help and face-to-face CBT have shown to be effective in the treatment of depression, but both approaches might not be an available treatment option for all patients. A treatment which blends internet-based guided self-help with video-based psychotherapy might reduce potential disadvantages of both approaches, while maintaining major advantages such as being location-independent. Additionally, it could provide a stronger focus on patient empowerment and lower resource use compared to traditional face-to-face treatment.

**Aim:** The aim of this study is to evaluate patient's experiences with blended internet- and video-based CBT (blended iCBT) treatment and to derive suggestions for the improvement of such services.

**Methods:** Semi-structured interviews were conducted with 15 participants of the blended iCBT treatment as part of the European MasterMind trial. Participants included adults suffering from Major Depressive Disorder. The interview guide assessed patient's experiences regarding the four treatment components program, 1. face-to-face diagnostic interviews, 2. video-based synchronous therapy sessions (VTS), 3. online self-help treatment modules (OTM) as well as 4. behaviour diaries and symptom monitoring. Interviews were analyzed using the framework method and outcomes regarding connections within and between participants and categories were generated by counting the statements within relevant themes.

**Results:** Overall, patients indicated to have been satisfied with all components of the treatment, highlighting the option to independently work from home in their own pace. While the OTMs allowed for a deeper reflection of the content, the VTS with the therapist were mentioned to provide the personal character of the service. The working alliance with the therapist was experienced as fostering the individual fit of the treatment. Patients reported a high self-perceived treatment effectiveness. Negative effects included that some patients felt overwhelmed by the service, e.g. by working with the content of the OTM as they forced them to address their problems. Within the combination of OTM and VTS, both components were rated as equally important and patients felt that the combination depicted a treatment at least equal to regular face-to-face treatment regarding the perceived effectiveness. Other identified themes included patient's individual factors, reactions in their social environment and suggestions for improvement of the service.

**Discussion:** Predominantly, patients reported positive experiences with the blended iCBT service and rate the treatment as adequate and effective to treat their condition. The importance of the VTS is highlighted. Following this approach might be an option to make affordable and effective evidence-based CBT available independent from regional barriers.

### 1. Introduction

Despite the proven effectiveness of psychotherapy in the treatment of depression, the provision of evidence-based treatments depicts a constant challenge given barriers such as the shortage, uneven distribution of trained providers, delayed treatment provision and inadequacy of treatment (Kessler et al., 2001; Mack et al., 2014; Wang

et al., 2007; Wittchen et al., 2011).

Using the internet to provide guided self-help interventions may help overcome some of the limitations of traditional treatment services (Andersson, 2009; Ebert et al., 2017c). Such approaches (a) provide high accessibility at any time and place, (b) may attract people who do not make use of traditional mental health services, and (c) are easily scalable. Recent research suggests internet-based CBT (iCBT) to be

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<https://doi.org/10.1016/j.invent.2018.01.003>

Received 7 August 2017; Received in revised form 1 December 2017; Accepted 8 January 2018

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effective for the prevention (Ebert et al., 2017b; Sander et al., 2016) and treatment of a wide variety of mental health conditions (Andrews et al., 2010; Hedman et al., 2012; Königbauer et al., 2017; Richards and Richardson, 2012; Zachariae et al., 2015) as well as the maintenance of treatment effects (Ebert et al., 2013; Holländare et al., 2011). Studies were also able to show comparable effects to face-to-face treatments in adults (Andersson et al., 2016, 2014; Olthuis et al., 2015).

However, internet- and mobile based interventions (IMIs) with a strong focus on self-help might not be an attractive treatment option for all patients (Apolinário-Hagen et al., 2017; Baumeister et al., 2014; Ebert et al., 2015; Musiat et al., 2014). Moreover, patient's adherence to the treatment constitutes a challenge to some patients, especially in pure self-guided treatment, while for other patients the transfer of what they have learned can be low in these interventions (Gerhards et al., 2011; Sharry et al., 2013).

Telephone- and video-based treatments have also been proven to be an effective medium in the delivery of psychological care (Mohr et al., 2008, 2005; Osenbach et al., 2013; Simpson, 2009), and being acceptable to patients (Richardson et al., 2009). While the combination still requires professionals to administer the services (Mohr et al., 2013), there is no necessity for patient and practitioner to be in the same place thus providing the option to overcome the obstacles of regional barriers, delayed treatment provision and inadequacy of treatment. However, telephone- and video-based treatments (Gros et al., 2013; Kotb et al., 2015; Shore, 2013) do require a comparable amount of human resources of trained clinicians. Additionally, they entail disadvantages such as the limitation of material use such as worksheets and other therapeutic material.

The concept of blending face-to-face and iCBT components into an integrated depression treatment has been discussed as an innovative way to overcome obstacles of stand-alone IMIs (Erbe et al., 2017; Kooistra et al., 2014; van der Vaart et al., 2014), especially in the treatment of more severely depressed patients (de Graaf et al., 2009; Richards and Timulak, 2012), but conclusive results of the efficacy and (cost-)effectiveness of these treatments are still pending.

Combining telephone- and video-based interventions in the treatment of psychological disorders with IMIs may increase the utilisation of treatments as well as adherence to treatment by reducing logistical disadvantages such as travel time and cost and allowing practitioners to monitor symptoms more effectively and provide for closer treatment intervals if needed (Pruitt et al., 2014). Moreover, patient's satisfaction could be increased by these factors (Richardson et al., 2009) and such services may help to reduce drop-out (Lovell et al., 2006; Mohr et al., 2008) and increase patients autonomy in dealing with their mental health (Samoocha et al., 2010). Furthermore, combining telephone- and video-based interventions with IMIs may also help to overcome some patient's concerns about privacy and stigmatisation associated with seeking care in a local facility (Pruitt et al., 2014). Lastly, such services could lower associated resource use, although there is yet no evidence supporting such an assumption.

As part of the European “MasterMind” trial (Vis et al., 2015), the aim of this study is to evaluate patient's experiences of a new blended iCBT service under routine care conditions and based on this to derive suggestions for the improvement of the service. Patient's experience with the implemented iCBT service is considered to be an important factor for the evaluation of the implementation of a telemedical service (Kidholm et al., 2012) and there is an additional value of qualitative research in evaluating trial processes (Donovan, 2002; Oakley et al., 2006). Using qualitative methods can be helpful in investigating potential benefits and disadvantages of the treatment and foster the understanding of mechanisms of change during the treatment (Andersson et al., 2009; Bendelin et al., 2011; Khan et al., 2007). Additionally, recommendations for the further optimization of the treatment can be derived. To our knowledge, no study has to date investigated the patient's experience with a blended internet- and video-based iCBT (blended iCBT) service.

## 2. Methods

### 2.1. Participants

The current study was part of an evaluation of the implementation of a newly developed blended iCBT treatment for depression (“Depression Online”) in routine care practice. For the overall study, inclusion criteria comprised the presence of any form of Major Depressive Disorder assessed by semi-structured standardized interviews (SCID; First et al., 2002), not having any other primary psychiatric condition being the primary treatment reason (e.g. eating disorder being in the fore), suffering from psychotic symptoms, acute or chronic suicidality or not having stable and private internet access. In addition, the participants had to be insured with a specific public health insurance company or self-paying and patients could not participate in another psychological treatment when starting the blended iCBT treatment. Patients were recruited for the service by informational letters send out by the health insurance company to selected clients known to be suffering from depression, being without psychological treatment and reporting a significant number of sick days with a focus on clients living in rural areas.

In total, 25 patients were deemed eligible for the inclusion to the interviews, of which one was excluded due her therapist's concerns as the patient was too burdened by his depressive symptoms to participate. Patients were contacted via the program integrated messaging system if they had completed more than six video-based therapy sessions with a therapist. We received informed consent to participate in the study by 15 of the remaining 24 patients and included all of them. A weighting of participants by qualitatively measured perceived satisfaction (CSQ8; Boß et al., 2016; Larsen et al., 1979), as initially intended was not possible, as CSQ8 values were very high (95% of overall agreement). Study participants did not differ from those patients that did not react on the invitation to take part in the study regarding symptom severity (measured with the QIDS; Rush et al., 2003), perceived satisfaction with the program (CSQ8) and working alliance (WAI; Bordin, 1979; Busseri and Tyler, 2003; Fuertes et al., 2007; Hatcher and Gillaspay, 2006; Horvath and Greenberg, 1989; Horvath and Symonds, 1991).

### 2.2. Treatment

The blended video- and internet-based intervention is based on principles in CBT. The treatment consisted out of four core components, 1) a face-to-face diagnostic interview 2) video-based synchronous therapy sessions (VTS) 3) online self-help treatment modules (OTM) 4) online and smartphone based monitoring of behaviour and symptoms (BSM). The face-to-face diagnostic interview took place in one of three clinics across Germany. This was necessary, as it is mandatory by German professional regulations for psychotherapists and psychiatrists, that mental health diagnoses are established face-to-face. A SCID interview (First et al., 2002; Wittchen et al., 1997) was conducted by an experienced diagnostician and was scheduled to take 100 min. Also, general information about the service were provided and the decision about the patient's fit to the program was communicated. Afterwards, an introduction to the online platform and the use of the video-conferencing tool was offered by an IT specialist. Subsequently, the patient participated in the intervention from his or her home. Synchronous psychotherapy sessions were conducted via video-conferencing between the patient and his or her therapist. The VTS were structured equal to CBT outpatient psychotherapy in Germany with a maximum number of 25 sessions of 50 min duration. Sessions were planned on a weekly basis, and on rare occasions twice a week when indicated. Therapists were provided with a “library” of OTM on the platform based on modules of the Get.On interventions, which have been adapted to various target groups and evaluated in several randomized controlled trials in various samples (Buntrock et al., 2017, 2016, 2015,

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