

Approach-Avoidance Attitudes Associated with Initial Therapy Appointment

Attendance: A Prospective Study

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Background: Initial therapy appointments have high nonattendance rates. Few studies examine psychological predictors and theory-based studies are scarce.

Aims: This study aimed to identify positive and negative attitudes towards therapy that predicted initial attendance, informed by a perceptual control theory account of approach-avoidance conflicts in help-seeking. **Method:** A prospective study was used to identify predictors of first (n = 96) and second appointment (n = 85) attendance in a primary care mental health service. Measured factors included attitudes towards therapy, depression and anxiety scales, and demographic variables. **Results:** The results showed that endorsement of a negative attitude item representing concern about self-disclosure was independently predictive of nonattendance. Positive attitudes predicted increased attendance, especially endorsement of motives for self-reflection, but only among less depressed individuals. A shorter time interval between appointments predicted second appointment attendance. **Conclusions:** These results show that self-disclosure concerns may contribute to therapy avoidance. They also suggest that approach motivation for therapy includes having goals for self-reflection; however, this has less impact among more highly depressed people.

Key words: Nonattendance, cognitive behavioural therapy, IAPT, attitudes, control theory

Introduction

Depression and anxiety have high prevalence rates, estimated at 1 in 6 among UK adults (Singleton et al., 2001), yet few receive therapy (Bebbington et al., 2000). The UK's 'Improving Access to Psychological Therapies' (IAPT) programme (Department of Health, 2008) represents a major initiative to increase availability of evidence-based interventions such as cognitive-behavioural therapy (CBT), but for people to benefit, they need to at least attend an appointment. However, nonattendance is a common problem across therapy services (Barrett et al., 2008) including IAPT settings (K. Grant et al., 2012). Initial appointments have the highest nonattendance rates, estimated at 40% (Hampton-Robb et al., 2003) and therefore warrant specific study. Despite decades of research, the reasons for nonattendance remain poorly understood (Barrett et al., 2008). Demographic factors are often studied (Wierzbicki and Pekarik, 1993), therefore the lack of progress may reflect the paucity of psychological research. Moreover, theory-based studies are scarce (Wills and Gibbons, 2009).

This paper draws on an account of the motivational processes underlying nonattendance, termed the loss of valued control (LVC) model (see Schauman and Mansell, 2012) based on perceptual control theory (PCT, Powers, 1973). PCT posits that the purpose of behaviour is to maintain control over our experiences to bring them in-line with internal goals, but that goal conflict disrupts this process. The LVC model thus conceptualises nonattendance as ambivalence due to approach-avoidance goal conflicts between wanting help to regain control over a problem, yet anticipating that accessing therapy will conflict with another goal. Previous authors have considered nonattendance as an approach-avoidance conflict (Kushner and Sher, 1989) but have not tested this directly (Paige and Mansell, 2013). The LVC model also provides a hierarchical account of goal conflict, highlighting that conflicts with personal avoidance goals which are part of the psychological problem itself,

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such as a need to avoid further negative emotional experiences, are most problematic (Schauman and Mansell, 2012). Practical issues, such as having other commitments, or forgetting the appointment, also conflict with therapy attendance (Barrett et al., 2008). Practical solutions are potentially easier to identify if the need for help can be prioritised, but conflicts are less easily resolved when they involve the psychological problem itself e.g. transportation issues plus agoraphobic concerns (Schauman and Mansell, 2012).

This study aimed to identify approach and avoidance therapy attitudes, beliefs and goals (hereafter referred to as attitudes) associated with attendance and is the follow-up to a pilot study (Murphy, Mansell, Craven, Menary and McEvoy, 2013). It was hypothesised that positive and negative attitudes would predict increased and decreased attendance respectively, and that an interaction effect would emerge based on competing approach-avoidance tendencies. Based on the LVC model, anxiety was hypothesised to amplify the effect of negative attitudes on nonattendance. This was because anxiety is specifically characterised by avoidance goals to prevent aversive experiences (Dickson, 2006; Mansell, 2005) and endorsement of negative attitudes may represent anticipated conflict with existing anxiety-related avoidance goals. Depression was hypothesised to moderate the relationship between approach attitudes and attendance, due to depression-related deficits in approach motivation (Dickson and MacLeod, 2004).

Methods

Design and setting

A prospective study was conducted of first and second appointment attendance; the former being the main outcome of interest and latter as consistent with previous studies (Murphy and Mansell, 2012). One group completed questionnaires at the time of referral by

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their general practitioner (GP) (Sample 1) and another group completed forms at the first appointment (Sample 2).

Setting

The primary care mental health team were based in general practices in Salford. Salford is among the 10% most deprived local authority areas in England (Department of Communities and Local Government, 2011) and 92% of its population of 225,100 are of white ethnicity (Office for National Statistics, 2011). As part of the IAPT programme (Department of Health, 2008), trained therapists provided low-intensity cognitive behavioural therapy (CBT), for an average of six to eight, 30 minute sessions.

Inclusion criteria

The service inclusion criteria were individuals aged 16 years and over, registered with a general practitioner (GP), with mild to moderate anxiety or depression. Exclusion criteria were high risk to self or others, significant alcohol dependency or psychosis.

Ethical approval

The research was approved by the North West National Research Ethics Committee.

Participants

The Sample 1 participants were referred from nine participating general practices, selected on the basis that they were agreeable to participation. The overall study period was 16th June 2011 to 31st March 2012; however, practices participated for varying periods, with an average of 3.8 months. The Sample 2 participants were individuals who attended their first

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appointment at 20 participating practices over a two-month period (15th January to 15th March 2012).

Data collection

Patients who were offered an appointment for low-intensity CBT during their GP consultation were invited to schedule an appointment via the receptionist. Whilst booking the appointment, reception staff offered patients a questionnaire pack, including an information sheet and consent form. Those agreeing to participate completed the questionnaires in the waiting room and returned them via reception.

Measures

Depression. The Patient Health Questionnaire (PHQ-9) is a brief measure of depression (sensitivity, 88%; specificity, 88%, Kroenke, Spitzer and Williams, 2001).

Anxiety. The Generalised Anxiety Disorder Assessment (GAD-7) is a brief measure of GAD (sensitivity, 89%; specificity, 82%, Spitzer et al., 2006).

Functioning. The Work and Social Adjustment Scale (WSAS) is a five-item measure of functional impairment (Cronbach's alpha ranges from 0.70 to 0.94, Mundt, Marks, Shear and Greist, 2002).

Attitudes towards therapy. The Initial Appointment Questionnaire (IAQ) (Mansell, 2011) is a 26-item measure of beliefs, goals and attitudes towards therapy. It combines positive approach items and negative avoidance items, and was developed as earlier measures did not fulfil this two-dimensional purpose. Items were based on previous literature and clinical experience, and rated on visual analogue scales from 0 (not true) to 100 (completely true). Previous versions were piloted in student and clinical samples (Murphy et al., 2013). Cronbach's alpha for the positive and negative subscales were 0.90 and 0.89 in the current study.

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Attendance outcome. Data on first appointment attendance were collected from electronic patient records. For cancelled appointments, attendance was recorded for the rescheduled appointment.

Analysis

Principal components analysis was used to identify the subscales of the IAQ using SPSS version 16.0 (SPSS Inc., 2008). The outcomes of first (Sample 1) and second appointment attendance (Sample 2) were then analysed separately. Firstly, differences in categorical variables by attendance status were examined using odds ratios (OR), and for continuous variables using independent t-tests or the Mann-Whitney U test. Secondly, IAQ item ratings were standardised and examined as univariate predictors using logistic regression. Any significant items were entered into a multivariate model to adjust for distress and demographic factors. Thirdly, summed and standardised IAQ subscale scores were examined as predictors of attendance. Finally, moderation analysis (Aiken and West, 1991) was used to test the interaction hypotheses.

Results

Sample size

There were 198 individuals who completed the questionnaires (Sample 1: n = 96, Sample 2: n = 102).

Principal components analysis

The IAQ items loaded onto two subscales (Table 1) thus supporting the intended factor structure. Factor 1 was labelled 'Positive attitudes' and factor 2 was labelled 'Negative attitudes'.

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Table 1. Descriptive data on each attitude rating, and factor loadings from the rotated component matrix

Questionnaire items	Item rating:	Factor loadings (n = 189)*:	
	Median (IQR)	Factor 1	Factor 2
Positive items			
I have a significant problem to talk about	80 (63-100)	0.43	0.22
I want someone to listen to my problem	90 (68-100)	0.68	0.11
I feel comfortable with the idea of talking to a therapist about my problem	85 (53-100)	0.65	-0.25
Talking to a therapist will help me understand how my mind works	80 (60-100)	0.76	-0.19
Seeking suggested therapy will help me make a positive change in my life	65 (85-100)	0.76	-0.24
If I share my thoughts and feelings with another person it will help me get to know myself better	80 (50-95)	0.81	-0.14
I think I might be ready for some self-improvement	85 (70-100)	0.72	-0.06
It is important to me to try and understand what my feelings mean	90 (75-100)	0.72	0.07
I have started working on my problem but I would like help	85 (55-100)	0.63	-0.18
I am very interested in examining what I think about	80 (50-100)	0.75	-0.04
Accessing appropriate help when I need it shows that I am a capable person	80 (58-100)	0.63	-0.18
It is important that I turn up to an appointment that I have booked	100 (95-100)	0.54	-0.15
It was my choice to book the appointment	95 (75-100)	0.45	-0.14
I know what to expect from therapy	55 (45-85)	0.53	-0.13

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Negative items			
The therapist seeing me might think I am wasting their time when others have more important problems	50 (5-80)	-0.14	0.56
I might feel too depressed to attend the appointment	35 (0-65)	0.01	0.66
I am worried that the therapist will think I am a bad person if I tell them everything I have been thinking/feeling	25 (0-60)	0.00	0.73
Nothing can ever help me	10 (0-50)	-0.12	0.68
I would feel vulnerable if I disclosed something very personal I had never told anyone before to a therapist	45 (0-70)	-0.13	0.75
I am worried that talking about my problems will make them worse	20 (0-50)	-0.12	0.77
If I attended therapy I would be burdening the therapist with my problems	10 (0-40)	-0.09	0.73
It is easier for me if I stay unwell	0 (0-15)	-0.08	0.59
I am worried that I will be pressured to do things in therapy that I don't want to do	10 (0-43)	-0.16	0.73
I am worried that I will be pressured to make changes in my lifestyle that I feel unable to make right now	15 (0-50)	-0.15	0.79

* One person completed questionnaires for both samples. The duplicate response was deleted. Smaller 'n' due to missing data, variables were 95 to 99% complete. Bold indicates the highest factor loading. Two negative items: 'Another arrangement could be more important than the appointment' and 'My friends and family can help me more than a therapist can' were excluded due to low correlations with other items. Repeating the analyses on log transformed data produced the same results. The 8th and 10th items of the positive scale were from Grant et al. (2002). The 3rd, 9th and 10th items of the negative scale were adapted from Kushner and Sher (1989).

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First appointment attendance

Demographic and clinical predictors

Sixty of the 96 participants attended the first appointment (62.5%); thus the nonattendance rate was 37.5%. Sixty percent were female, 96% were of white ethnicity and 54% were employed. No demographic or clinical factors differed significantly by attendance status: female gender (OR vs. males 1.7 (95% CI 0.7, 3.9), $p = 0.24$); other ethnicity (OR vs. white 1.9 (95% CI 0.9, 19.5), $p = 0.57$), unemployment (OR vs. employed 0.5 (95% CI 0.2, 1.3), $p = 0.13$); receiving benefits (OR 0.5 vs. no benefits (95% CI 0.2, 1.3), $p = 0.11$); age (nonattenders M 30.5 (IQR 24.3, 50.5) vs. attenders 36.0 (28.0, 49.0), $p = 0.28$); Index of Multiple Deprivation (M 30.3 (IQR 24.6, 51.1) vs. 24.4 (14.2, 43.8) $p = 0.10$); anxiety (M 17.0 (IQR 12.0, 20.3) vs. 15.0 (10.0, 19.0), $p = 0.24$); depression (\bar{x} 17.4 (s 7.2) vs. 15.7 (5.1), $p = 0.25$); functioning (\bar{x} 16.1 (s 9.8) vs. 17.5 (9.1) $p = 0.52$) and waiting time in days (M 30.3 (IQR 24.6, 51.1) vs. 24.4 (14.2, 43.8), $p = 0.39$).

IAQ items

One item predicted attendance (OR 0.5 (95% CI 0.3, 0.8), $p = 0.007$, inverse association): 'I would feel vulnerable if I disclosed something very personal I had never told anyone before to a therapist'. After controlling for age, employment and distress measures the finding remained significant (OR 0.5 (95% CI 0.3, 0.9), $p = 0.01$).

IAQ subscales

The subscale scores did not predict attendance (positive attitudes OR 1.1 (95% CI 0.7, 1.7), $p = 0.58$; negative attitudes OR 0.7 (95% CI 0.5, 1.1), $p = 0.14$) and there was no evidence of an interaction between them (interaction OR 0.9 (95% CI 0.6, 1.4), $p = 0.56$).

Interactions between attitudes and distress measures

There was no interaction between negative attitudes and anxiety (OR 1.1 (95% CI 0.7, 1.9), $p = 0.58$), or between the self-disclosure item and anxiety (OR 1.0 (95% CI 0.7, 1.7), $p = 0.80$). However, we did confirm an interaction between positive attitudes and depression (OR 0.3 (95% CI 0.1, 0.7), $p = 0.007$, see Figure 1).

Figure 1. Interaction of positive attitudes and depression on attendance

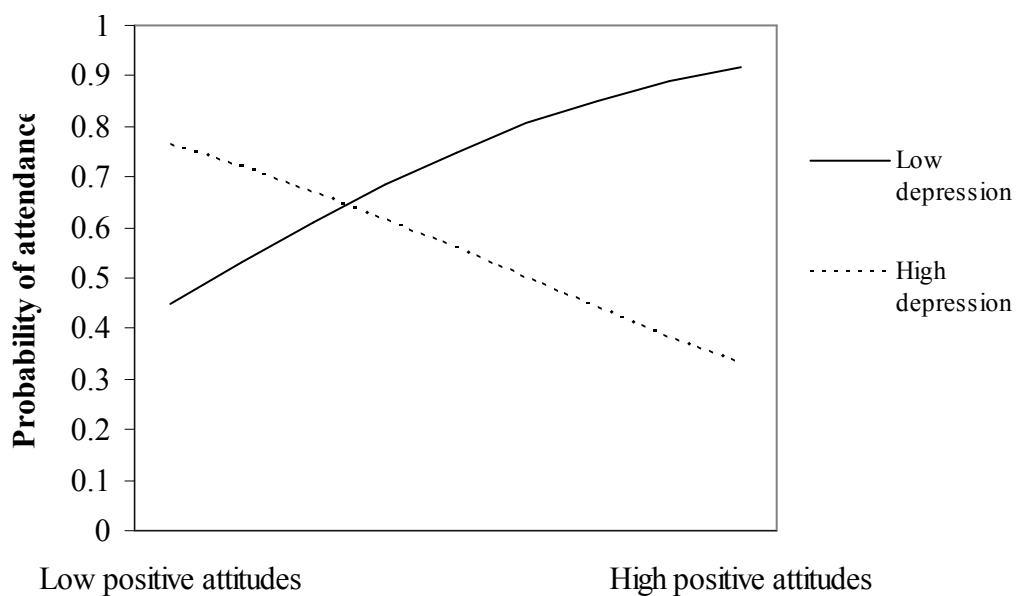


Figure 1 shows that positive attitudes predicted increased attendance when depression was low. At low depression (scores below the median), the positive attitudes OR was highly significant at 4.1 (95% CI 1.5, 11.7, $p = 0.008$). At high depression, positive attitudes appeared to be associated with lower attendance, however the OR was of a smaller magnitude and non-significant 0.6 (95% CI 0.3, 1.3, $p = 0.18$). Examination of individual positive items at low depression showed the largest effects for: ‘I am very interested in examining what I think about’ (OR 6.6 (95% CI 1.9, 23.3), $p = 0.003$), ‘If I share my thoughts and feelings with another person it will help me to get to know myself better’ (OR 3.9 (95% CI 1.4, 10.7), $p = 0.009$) and ‘It is important to me to try and understand what my feelings mean’ (OR 3.5

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(95% CI 1.4, 8.8), $p = 0.009$). Two of these items were from the Self-Reflection and Insight Scale (SRIS) (Grant, Franklin and Langford, 2002).

Second appointment attendance

Of the 102 individuals who participated, 17 were excluded from the prospective analysis due to being assessed as unsuitable for the service, hence $n = 85$. Of these, 53 (62.4%) attended their second appointment. The nonattendance rate of 37.6% did not differ from that of first appointments. The only significant predictor of second appointment attendance was the median time interval between appointments which was 14 days among attenders versus 21 days among nonattenders ($p = 0.007$).

Discussion

Main findings

Endorsement of an item measuring concern about self-disclosure predicted nonattendance, whereas positive attitudes predicted increased attendance among less depressed individuals. Positive versus negative attitudes did not interact to predict attendance, and the hypothesis that anxiety would amplify the effect of negative attitudes was also disconfirmed.

Strengths and limitations

Few psychological studies have examined first appointment attendance as an outcome (Sheeran et al., 2007) and the prospective design provides external validity. Also, previous research has not examined first and second appointments in a single study. Although data were not available for calculation of a true questionnaire return rate, a conservative estimate based on total referrals over each study period shows that the proportions completing a

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questionnaire were 18% and 27% for Samples 1 and 2 respectively. Therefore the sample may have been selective and may not have been representative of the whole cohort, thus potentially limiting its generalisability. However, the service first appointment nonattendance rate of 35.3% is similar to the sample rate of 37.5%, and there were no age or gender differences (60 vs. 63% female, $p = 0.6$; median age 35 vs. 36 years, $p = 0.6$) suggesting some comparability between the sample and the overall cohort. The reasons for non-response include practice staff forgetting to offer the questionnaires, or patients declining the offer for reasons such as not having time to complete them; and thus reflects the challenges of administering measures at the time of referral. However, the return rates are comparable to a previous study of initial appointments (Sheeran et al., 2007) which achieved a 29% response rate from a postal questionnaire. Finally, the study was based in a low-intensity CBT service in a deprived urban area, therefore caution is needed in generalising the findings to other settings.

Findings in relation to previous studies

Nonattendance rate. The first appointment nonattendance rate of 35% was similar to that of 40% quoted by Hampton-Robb et al. (2003) as well as reported in another low-intensity IAPT service (K. Grant et al., 2012) where one-third of referred individuals did not opt-in, and a further quarter did not attend (K. Grant et al., 2012). The nonattendance rate in the pilot study (Murphy et al. 2013) was slightly higher at 45%, though the pilot study was only conducted in one general practice.

Self-disclosure concern. The item 'I would feel vulnerable if I disclosed something very personal I had never told anyone before to a therapist' was adapted from the Disclosure Expectations Scale (Vogel and Wester, 2003) which measures self-disclosure concerns. The finding should be interpreted cautiously as it was based on one item. However, studies have shown self-disclosure to be associated with help-seeking attitudes (Komiya, Good and

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Sherrod, 2000) and intentions (Vogel and Wester, 2003). Furthermore, anticipating feelings of shame, embarrassment and exposure predicted nonattendance in a study by Sheeran et al. (2007), which to our knowledge is the only previous psychological study of first appointments. This finding may also represent self-disclosure concerns, as a qualitative study revealed clients' anxieties about self-disclosure to include anticipating vulnerability, shame and exposure (Farber, Berano and Capobianco, 2004).

Positive attitudes. Positive attitudes predicted attendance among less depressed individuals. Previous studies have not found positive attitudes to directly predict attendance (Murphy and Mansell, 2012). The difference may reflect the measure used, which was designed to capture a broader range of approach attitudes. The most important items were those measuring self-reflection motives, based on the "Need for self-reflection" subscale of the SRIS (Grant et al., 2002). This is consistent with the pilot study (Murphy et al., 2013), which found a main effect for a self-reflection item. Self-reflection has been described as a facet of psychological mindedness (Grant et al., 2002). Psychological mindedness was highlighted in the Barrett et al. (2008) review of dropout, although the quoted studies lacked a clear definition of the construct. However, the present study suggests that having motives for self-reflection may capture an important approach goal to pursue via accessing therapy.

Conflict. The hypothesis that the effect of negative attitudes on nonattendance would be amplified by anxiety levels was not supported. More precise interactions may require examination in future. For example, it could be hypothesised that self-disclosure concerns might interact with social anxiety more specifically, as the latter is known to involve particular motives to avoid embarrassment and negative evaluation (Wells, 1997). The reasons for avoiding therapy may therefore vary by the type of psychological problem, due to the avoidance goals involved.

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The hypothesis that positive and negative attitudes would interact, based on approach-avoidance conflicts, was also rejected. Conscious awareness of ambivalent attitudes might not measure lasting conflict. Perceptual control theory describes how conscious awareness of goal conflict may result in reorganisation processes such as a decision to prioritise a goal, whereas unconscious goal conflict is more problematic (Powers, 1973).

Depression. More highly depressed individuals who endorsed positive items were not more likely to attend their appointment. Their attendance rates were slightly lower, although not significantly so. A study by Dickson et al. (2011) found that although depressed individuals were able to identify and endorse approach goals, they were pessimistic about their ability to attain them. This may reflect deficits in approach motivation processes. Approach motivation problems identified in depression include deficits in reward responsiveness (Bijttebier, Beck, Claes and Vandereycken, 2009) and approach perseveration due to difficulty in disengaging from unattainable goals (Pyszczynski and Greenberg, 1987). These may be linked, as retaining unmet goals can result in negative expectations and pessimism, which may contribute to further approach deficits in reward responsiveness (Trew, 2011). Also, depressed individuals may have difficulty in flexibly shifting from abstract goals to making concrete goal-action plans (Watkins, 2011). Therefore if people with more severe depression have planning difficulties and are more pessimistic about achieving their goals, then their positive goals and attitudes towards therapy may have less impact on their actual attendance at the appointment.

Second appointment attendance. The only predictor of second appointment attendance was a shorter time between appointments. The LVC model (Schauman and Mansell, 2012) posits that factors trigger nonattendance if they conflict with a personal preference, therefore those clients might have preferred to be seen again sooner. For example, a qualitative study (Snape et al., 2006) described how clients felt frustrated even by short

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waiting times and consequently sought help elsewhere. Psychological predictors of second appointment attendance were not identified, perhaps because of not accounting for the experience of meeting the therapist. For example, people may fear self-disclosure yet find the therapist to be warm and non-judgemental; or may desire self-reflection but perceive that this need will be unmet. Therefore the degree of perspective convergence (Reis and Brown, 1999) or match between client and therapist goals (Carey, Kelly, Mansell and Tai, 2012) may be an important influence on subsequent dropout after initial attendance.

Clinical implications

Openly talking with clients about their comfort with disclosure (Vogel and Wester, 2003) or providing brochures to allay feared misconceptions (Barrett et al., 2008) may improve attendance. The amount of self-disclosure involved in low-intensity CBT is likely to be lower than in longer term therapy; therefore clarification about this to clients may be helpful. Promotional material which highlights opportunities for self-reflection may encourage attendance among those with these motives. To address individual concerns, referrers and therapists could ask clients what they personally value as important for them to have control over in therapy (Schauman and Mansell, 2012). For more depressed individuals, encouraging them to make clear plans or implementation intentions regarding attendance (Sheeran et al., 2007) or exploring pessimism about pursuing therapy goals (Dickson et al., 2011) may be of benefit. Finally, the results suggest that a time interval between initial contacts that does not exceed two weeks may be preferable.

Conclusion

These results show that self-disclosure concerns contribute to therapy avoidance and that having goals for self-reflection may represent approach motivation for therapy, although the latter has less impact among more highly depressed people.

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