

CBT Intensity and Outcome for Panic Disorder in a Primary Care Setting

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A hybrid efficacy-effectiveness design in which participants ($n = 91/93$) were retained in the study regardless of whether or not they received treatment enabled evaluation of CBT intensity in relation to panic disorder in the primary care setting. CBT intensity was operationalized as number of cognitive-behavioral therapy sessions, number of follow-up booster phone calls, and secondarily, as number of cognitive behavioral coping and exposure strategies. Baseline psychosocial and demographic predictors of CBT intensity were analyzed first. Severity of anxiety sensitivity predicted number of cognitive behavioral sessions, but no baseline variables predicted number of follow-up booster phone calls or number of coping and exposure strategies. Multivariate logistic and linear regressions were used to evaluate the degree to which treatment intensity predicted 3-month and 12-month outcomes (anxiety sensitivity, phobic avoidance, depressive symptoms, disability, and medical and mental health functioning) after controlling for potential confounding baseline variables. Number of cognitive behavioral therapy sessions predicted lower anxiety sensitivity at 3

and 12 months, and number of follow-up booster phone calls predicted lower anxiety sensitivity, less phobic avoidance, and less depression at 12 months. These findings indicate that “dose” of psychotherapy was an important predictor of outcome. The significance of follow-up booster phone contact is discussed as an index of continued self-management of panic and anxiety following acute treatment.

COGNITIVE BEHAVIORAL THERAPY and medication regimens have become well recognized as efficacious treatments for panic disorder. Typically, cognitive behavioral therapies involve 12 sessions over a 3-month interval, after which significant improvements generally maintain for up to 2 years (e.g., Craske & Barlow, 2001), with little evidence for substantial relapse despite individual profiles of waxing and waning of symptoms (Brown & Barlow, 1995). Similarly, medication treatments, particularly the selective serotonin reuptake inhibitors (SSRIs), yield significant improvements for the majority of panic disorder patients (e.g., Ballenger, Wheadon, Steiner, Bushnell, & Gergel, 1998), and relapse rates among treatment responders are relatively small with continued medication and substantially less than rates following randomization to placebo (e.g., Mavissakalian & Perel, 2002).

However, these results mostly derive from samples of patients who actively seek treatment in specialized mental health settings or are part of clinical research trials. Hence, they possess limited

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generalizability to primary care practices in real-world settings, where the majority of individuals with anxiety disorders seek treatment (e.g., [Harman, Rollman, Hanusa, Lenze, & Shear, 2002](#)). In addition, randomized controlled trials of psychotherapeutic interventions typically exclude individuals who fail to attend a minimum number of treatment sessions, thus obscuring the relationship between amount of treatment received (i.e., “dose”) and treatment outcome.

In our hybrid effectiveness-efficacy study of panic disorder ([Roy-Byrne et al., 2005](#)), we evaluated the outcomes for individuals randomized to a collaborative care treatment (CC) involving cognitive behavioral therapy (CBT) and expert-based guidelines for psychotropic medication compared to treatment as usual (TAU), all conducted in the primary care setting. Patients randomized to CC achieved lower symptom severity and higher functioning that was sustained for a period of 12 months ([Roy-Byrne et al., 2005](#)). Our manualized, CC treatment was comprised of up to six in-person visits with a behavioral health specialist (BHS) over a 3-month interval, followed by up to six follow-up booster phone contacts over the next 9 months. The variation in attendance and amount of treatment received enabled us to investigate (a) baseline predictors of “treatment intensity” and (b) the effects of treatment intensity upon outcome.

Extant research on treatment intensity derives from pharmacological studies in which intensity is typically operationalized as dosage level and duration ([Leon et al., 2003](#); [Schoenbaum et al., 2002](#)). To evaluate the effects of treatment intensity upon outcome, preexisting variables (particularly degree of distress) that influence treatment intensity as well as treatment outcome must be taken into account. For example, severity of panic disorder may influence amount of treatment received as well as outcomes, and thus the relationship between treatment intensity and outcome may be obscured by panic disorder severity. As an example, without control of preexisting variables, there is no consistent evidence that pharmacological dosage positively predicts treatment outcome (e.g., [Schweizer et al., 2001](#)), whereas when preexisting variables are controlled, the evidence suggests superior outcomes with more intense pharmacologic regimens for depression ([Leon et al., 2003](#); [Schoenbaum et al., 2002](#)).

A handful of studies have evaluated CBT intensity effects in terms of the number of treatment sessions attended (alternatively coined adherence or compliance). However, none have fully adjusted for preexisting influences upon treatment intensity or treatment outcome ([Bowen, South, Fischer, & Looman, 1994](#); [Taft, Murphy, Elliott, & Morrel, 2001](#)). The current

study evaluated treatment intensity, operationalized as number of sessions and number of follow-up booster contacts received for patients with panic disorder who were diagnosed and assigned to an intervention in the primary care setting. Secondarily, we analyzed the number of coping strategies and exposure strategies delivered in session as another index of CBT intensity. We chose not to examine pharmacological intensity given that rates of “adequate” pharmacotherapy were not significantly enhanced by our collaborative care intervention ([Roy-Byrne et al., 2005](#)). We hypothesized that initial symptom severity would predict CBT intensity. Also, after controlling for baseline variables, a positive relationship was hypothesized between treatment intensity and treatment outcome.

Method

SETTING AND PARTICIPANTS

Participants were recruited from university-affiliated primary care clinics in Seattle, San Diego, and Los Angeles that included internal medicine and family medicine. Eligible subjects were patients who (a) were between 18 and 70 years old, (b) met *DSM-IV* criteria for panic disorder (PD) with at least one panic attack in the prior week, (c) were English speaking, (d) had access to a telephone, and (e) were willing to accept a combined treatment of anti-anxiety medication and CBT. Psychiatric and medical comorbidities were not reasons for exclusion, except those that were potentially life threatening (i.e., suicidal ideation, terminal medical illness) or those expected to severely limit patient participation or adherence (e.g., psychosis, unstable bipolar disorder, current substance abuse, dementia, pregnancy). Patients receiving psychiatric disability benefits or those already seeing a psychiatrist or cognitive behavioral therapist were excluded. Subjects were recruited in clinic waiting rooms using a validated 2-question PD screener ([Stein et al., 1999](#)) and diagnosed using the Composite International Diagnostic Interview (CIDI: [World Health Organization, 1997](#)) administered over the phone. Details of recruitment are described in [Roy-Byrne et al. \(2005\)](#). Two hundred thirty-two individuals who met criteria for PD and all other eligibility criteria were randomized to either CC ($n = 119$) or TAU ($n = 113$) groups. This analysis focuses only on the 119 patients randomized to the CC. Patient outcomes were assessed at baseline and every 3 months for 12 months. Only the 3- and 12-month follow-up results are presented here. Nonresponse (i.e., attrition) at 3 months was predicted by study site (Site 1 $X^2[3] = 32.11, p < .001$; Site 2 $X^2[3] = 14.40, p < .001$) and frequency of full panic attacks in the past week, $X^2(3) = 4.82, p < .05$. Nonresponse at 12

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