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Is internet-based CBT for panic disorder and agoraphobia as effective as face-to-face CBT?

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Abstract

This study compared Panic Online (PO), an internet-based CBT intervention, to best-practice face-to-face CBT for people with panic disorder with or without agoraphobia. Eighty-six people with a primary diagnosis of panic disorder were recruited from Victoria, Australia. Participants were randomly assigned to either PO ($n = 46$) or best practice face-to-face CBT ($n = 40$). Effects of the internet-based CBT program were found to be comparable to those of face-to-face CBT. Both interventions produced significant reductions in panic disorder and agoraphobia clinician severity ratings, self reported panic disorder severity and panic attack frequency, measures of depression, anxiety, stress and panic related cognitions, and displayed improvements in quality of life. Participants rated both treatment conditions as equally credible and satisfying. Participants in the face-to-face CBT treatment group cited higher enjoyment with communicating with their therapist. Consistent with this, therapists' ratings for compliance to treatment and understanding of the CBT material was higher in the face-to-face CBT treatment group. PO required significantly less therapist time than the face-to-face CBT condition.
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1. Introduction

Panic disorder (PD) is characterized by chronic fear of the experience of unpredictable, and seemingly spontaneous, panic attacks which occur without any obvious cause. Surveys in several Western countries have consistently reported the incidence of PD to be between 2.2 and 5% (Andrews, Hall, Teeson, & Henderson, 1999) and the incidence of PD among primary care patients has been estimated at approximately 8% (Roy-Byrne et al., 1994).

Cognitive behavioral therapy (CBT) is acknowledged as the 'gold standard' psychological treatment approach (American Psychological Association, 1993, 1995) used for PD and includes provision of information about panic and anxiety, instruction in self-monitoring of panic symptoms, controlled exposure to panic symptoms and feared situations, and cognitive therapy designed to have the patient re-interpret the causes and consequences of panic symptoms. Results from numerous clinical trials around the world have provided evidence that multi-element panic treatment protocols, which are grounded in cognitive behavioral principles, achieve a 75–95% patient panic-free status

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following treatment, with improvements being maintained for at least two years (e.g., Brown & Barlow, 1995; Craske, Brown, & Barlow, 1991; Margraf, Barlow, Clark, & Telch, 1993).

CBT is a well-established treatment for PD (with or without agoraphobia) especially when accompanied with a treatment manual. The most commonly used treatment manual is the 'Mastery of Anxiety and Panic' workbooks (Barlow & Craske, 2000) and numerous treatment studies (e.g., Brown & Barlow, 1995; Sanderson, Raue, & Wetzler, 1998; Stuart, Treat, & Wade, 2000; Wade, Treat, & Stuart, 1998) have demonstrated the efficacy of this manualized treatment program.

Although CBT is effective for people with PD, it typically requires 12–15 h of manualized face-to-face treatment with a mental health specialist. The major barriers to accessing expert assistance include scarcity of skilled therapists, long waiting lists, cost and consumer fears regarding the stigma of a mental health referral (National Institutes of Health, 1991). A major challenge, therefore, is to increase the accessibility of evidence-based treatments for high-prevalence disorders such as anxiety disorders and depression (Walker, Norton, & Ross, 1991).

Internet-based treatments offer a solution to the problems of accessibility and affordability. There has been enormous growth in mental and physical health internet-based treatments in the last 10 years and its efficacy has been established for treating a variety of conditions including depression (e.g., Andersson et al., 2005; Christensen, Griffith, & Jorm, 2004), social anxiety disorder (Carlbring, Furmark, Steczko, Ekselius, & Andersson, 2006), post traumatic stress symptoms (Lange et al., 2003), eating problems (Tate, Wing, & Winett, 2001), insomnia (Ström, Pettersson, & Andersson, 2004), tinnitus (Andersson & Kaldo, 2004), encopresis (Ritterband et al., 2003), and headache (Ström, Pettersson, & Andersson, 2000).

Numerous clinical trials have demonstrated that PD can be effectively treated via internet. These trials have been conducted in a variety of countries including Australia (Klein & Richards, 2001; Klein, Richards, & Austin, 2006; Richards & Alvarenga, 2002; Richards, Klein, & Austin, 2006), Sweden (Carlbring, Ekselius, & Andersson, 2003; Carlbring, Westling, Ljungstrand, Ekselius, & Andersson, 2001), and United Kingdom (Kenwright, Marks, Gega, & Mataix, 2004; Schneider, Mataix-Cols, Marks, & Bachofen, 2005).

Although these panic programs differ on a variety of dimensions (e.g., type and quantity of therapist assistance provided, duration of treatment program, etc.), the results of controlled trials demonstrate efficacy of this treatment modality. Nevertheless, none of these studies compared an internet-based program to the 'gold standard' treatment (i.e., 12–15 sessions of face-to-face CBT treatment using an evidence-based manualized treatment protocol). Rather, comparison conditions have typically included waitlist controls, information-only controls, or manualized telephone-based CBT treatment. Although Carlbring et al. (2005) compared their internet-based treatment program for panic disorder to a 10-week face-to-face CBT condition the manual used did not have a substantial evidence-base. By contrast, the face-to-face CBT condition used in the present study is the accepted 'gold standard' evidence-based protocol of 12 one hour weekly sessions with a psychologist using the Mastery of Panic and Anxiety III program (Barlow & Craske, 2000).

Therefore, this study aimed to compare an internet-based treatment program for PD to the accepted 'gold-standard' treatment approach. To our knowledge, there have been no other randomized controlled trials involving comprehensive assessment of participants' clinical status, with a structured clinical interview, and comparison of an internet-based treatment program to the evidence-based 'gold standard'. As PO has already been compared to an information-only control condition in previous trials and demonstrated its superiority (Klein et al., 2006; Richards et al., 2006), we did not include a control condition in this RCT.

2. Methods

2.1. Participants

Sixty-two women (72.1%) and 24 men (27.9%) diagnosed with PD, with or without agoraphobia, were recruited through the PO website, via search engines, hyper-links established with other Australian mental health websites and through local and national media releases. Inclusion criteria for this study were that participants were Australian residents and living in Victoria, Australia and had a Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) primary diagnosis of PD (with or without agoraphobia) as assessed with the anxiety disorders interview schedule (ADIS-IV) (Brown, Di Nardo, & Barlow, 1994). PD (with or without agoraphobia) was considered to be the primary diagnosis when the severity was estimated to be two points greater than any secondary diagnosis on the clinician's nine-point severity rating scale in the ADIS-IV. Exclusion criteria were presence of a seizure

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