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# Predicting who benefits from psychoeducation and self help for panic attacks

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## Abstract

Self-help and psychoeducation have been identified as effective methods for delivering treatment, yet not everyone benefits from these brief interventions. Therefore it is clinically and economically useful to identify who is likely to require more intensive assistance. This paper develops a prognostic scale which predicts who will recover from panic attacks and who will require more assistance.

*Method:* Random regression models were used to evaluate the relationship between predictive variables, baseline severity, and the rate of improvement in 117 people with DSMIV panic attacks who participated in a trial of a psycho-educational booklet, a self-help workbook, and brief group CBT over a 9-month period. ROC analysis was used to choose cut-off points on a scale made up of significant predictors.

*Results:* Panic disorder and agoraphobia symptom measures were predicted by baseline social anxiety, and general mental health. There was no significant effect on the outcome for baseline depression or anxiety sensitivity. While general mental health (SF12 Mental Component scores) was predicted by the age at first panic attack, neuroticism, panic disorder and/or agoraphobia symptoms and a positive screen for alcohol use disorders. A prognostic scale based on simple additive scoring was equivalent to standard scores and significantly better than chance at predicting who would recover and who required face-to-face therapy.

*Conclusions:* The prognostic scale may be used to guide the choice of psychoeducation, self-help or face-to-face therapy as the first step in stepped care.

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*Keywords:* Panic attack; Self-help; Psychoeducation; Prognosis; Stepped care

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## 1. Introduction

Self-help has been demonstrated to be as effective as face-to-face therapy in recruited samples suffering panic disorder (Febbraro, Clum, Roodman, & Wright, 1999; Gould, Clum, & Shapiro, 1993; Lidren et al., 1994; Wright, Clum, Roodman, & Febbraro, 2000). In addition, the drop out rate in recruited samples who were offered self-help is argued to be no different from that of samples offered face-to-face assistance (Gould & Clum, 1993). However, studies of self-help in clinically referred samples describe significantly higher drop out or no significant effect (Hecker, Losee, Fritzler, & Fink, 1996; Holden, O'Brien, Barlow, Stetson, & Infantino, 1983). A trial of stepped care (SC) for bulimia nervosa showed that those who did not recover following self-help, improved faster in the second step of face-to-face therapy than those who did not receive self-help as the first step (Treasure, Schmidt, Troop, & Todd, 1996). However, 36% of those who were offered face-to-face therapy at the second step did not take up the offer. Similarly, Hecker et al. (1996) reported that 38% of a referred clinical sample with panic disorder and agoraphobia (PDA) dropped out from a trial of self-help. It may be that people drop out from self-help because they have achieved their goals for treatment, or because they have become demoralised and are less likely to take up subsequent treatment. Thus there are pressing reasons to predict who benefits from self-help and other brief interventions and who is likely to require more help.

There is a large literature searching for variables predictive of outcome following specialist cognitive behavioural therapy and pharmacotherapy for panic disorder and agoraphobia (Mennin & Heimberg, 2000; Pollack, Rappaport, Clary, Mardekian, & Wolkow, 2000; Steketee & Shapiro, 1995). Gender, duration of disorder, age at onset of disorder, comorbid axis I disorders (depression, social anxiety, alcohol abuse and dependence), personality and its disorders, and motivation have been studied and found to predict outcome in at least one of the many studies. The aim of many studies has been to predict who does not benefit from the recommended 'standard' treatments. As both CBT and pharmacotherapy are very effective (e.g. Gould, Otto, & Pollack, 1995), there is arguably little point in searching for predictors. So, while this line of research may provide some pointers to potentially useful variables, predictors of outcome are of much greater value for the selection of briefer interventions which are likely to be less effective. In this way, predictors can be used to triage people into the briefest treatment likely, to achieve an acceptable result.

This paper evaluates predictors of benefit from psychoeducation and self-help provided as part of stepped CBT intervention for people experiencing panic attacks (Baillie & Rapee, 2001). The focus is on panic attacks rather than on panic disorder because panic attacks may act as risk markers for depression and other mental disorders (Baillie & Rapee, 2003; Kessler et al., 1998; Reed & Wittchen, 1998). Panic attacks may also bring people into contact with health services (Kessler, Olson, & Berglund, 1998); so attacks may be a good cue for preventive intervention.

The present paper has two aims: (a) to identify factors that are easily assessed before brief intervention, and combine them into a scale to inform the choice of psycho-education, self-help, or face-to-face therapy as the first step of intervention; and (b) to develop significant predictors into a prognostic scale.

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