



Outcome predictors in guided and unguided self-help for social anxiety disorder

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ABSTRACT

Internet-based self-help with therapist guidance has shown promise as an effective treatment and may increase access to evidence-based psychological treatment for social anxiety disorder (SAD). Although unguided self-help has been suggested primarily as a population-based preventive intervention, some studies indicate that patients with SAD may profit from unguided self-help. Gaining knowledge about predictors of outcome in guided and unguided self-help for SAD is important to ensure that these interventions can be offered to those who are most likely to respond. Utilizing a sample of 245 patients who received either guided or unguided self-help for SAD, the present study examined pre-treatment symptoms and program factors as predictors of treatment adherence and outcome. The results were in line with previous findings from the face-to-face treatment literature: namely, the intensity of baseline SAD symptoms, but not depressive symptoms, predicted treatment outcomes in both unguided and guided self-help groups. Outcomes were unrelated to whether a participant has generalized versus specific SAD. Furthermore, for the unguided self-help group, higher credibility ratings of the treatment program were associated with increased treatment adherence. The findings suggest that guided and unguided self-help may increase access to SAD treatment in a population that is more heterogeneous than previously assumed.

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Introduction

Social anxiety disorder (SAD) has a lifetime prevalence of approximately 13% (Kessler, Berglund, Demler, Jin, & Walters, 2005; Kringlen, Torgersen, & Cramer, 2001) with an unremitting course if left untreated (DeWit, Ogborne, Offord, & MacDonald, 1999). Cognitive behavior therapy (CBT) is an effective treatment for SAD (Clark & Wells, 1995; Heimberg, 2002; Hofmann & Smits, 2008). However, access to such treatment is limited (Shafran et al., 2009). A shortage of trained personnel (Barlow, Levitt, & Bufka, 1999), the relatively few mental health services in rural areas (Griffiths & Christensen, 2007), and the lower tendency for people with SAD to seek help (Newman, Erickson, Przeworski, & Dzus, 2003; Olfson et al., 2000) may explain the low use of CBT to treat SAD.

Self-help CBT-based interventions have been suggested as a means to improve access to evidence-based treatment for SAD. So far, a consensus has not been reached on the definition of self-help (Andersson, 2009; Barak, 1999; Gellatly et al., 2007), but one definition states that self-help is “a psychological treatment in which the patient takes home a standardized psychological treatment protocol and works through it more or less independently” (Cuijpers & Schuurmans, 2007, p. 284). Self-help interventions have a strong educational component as they provide information, explanations, tasks, and exercises relevant for the actual problem, with the aim of managing the symptoms and the consequences of these symptoms (Barlow, Ellard, Hainswoth, Jones, & Fisher, 2005; Munoz, 2010). Guided self-help involves minimal professional guidance provided by means of weekly scheduled email contact or telephone calls (Gartner & Riessman, 1977; McKendree-Smith, Floyd, & Scogin, 2003; van't Hof, Cuijpers, & Stein, 2009). In contrast, unguided self-help involves no professional guidance, although it may include assessments, including reminders through e.g., email or SMS to complete the assessments. During the last

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10–20 years, self-help treatment has moved from being primarily based on self-help books and bibliotherapy to being increasingly administered through software programs on hand-held computers or the Internet (Marks & Cavanagh, 2009), with the Internet featuring in the majority of self-help interventions for SAD.

In recent years, several research groups (e.g., Abramowitz, Moore, Braddock, & Harrington, 2009; Andersson et al., 2006; Berger, Hohl, & Caspar, 2009; Rapee, Abbott, Baillie, & Gaston, 2007; Titov, Andrews, Johnston, Schwencke, & Choi, 2009) have developed and studied the effects of CBT-based self-help programs that require reduced or no therapist contact.

Adherence and effect sizes reported by researchers examining guided self-help for some disorders have been similar to those for studies of face-to-face therapy (Andersson, 2009). Therapist guidance and assessment seem to be crucial, as suggested by studies on unguided self-help for SAD, which reported small effect sizes (ES ; 0.28–0.38) (Rapee et al., 2007; Titov, Andrews, Choi, Schwencke, & Mahoney, 2008) and high attrition rates (67–98%) (Farvolden, Denisoff, Selby, Bagby, & Rudy, 2005; Titov et al., 2008). Such findings raise concerns as to whether unguided self-help should be offered as a standard psychological treatment or whether it should be perceived as a preventive population-based intervention (Andersson & Carlbring, 2011). However, unguided self-help for SAD have yielded moderate to large effects and low attrition rates in other studies (Furmark et al., 2009; Titov et al., 2008). One explanation of the discrepancies across studies of unguided self-help programs for SAD may relate to the ways in which symptoms and treatment effects were monitored. For example, the unguided condition in Furmark et al. (2009) included weekly assessments on the Internet whereas the “pure” self-help condition in Rapee et al. (2007) included only pre- and post-assessments. At the same time, a substantial proportion of SAD patients have reported positive outcomes after receiving “pure” self-help (Christensen, Griffiths, & Farrer, 2009; Farvolden et al., 2005; Rapee et al., 2007). Thus, further research is required to identify these patients. It is important to identify predictors of treatment adherence and outcomes for both guided and unguided self-help so that these interventions can be offered to the patients who are most likely to respond and so that these interventions can be modified for those who are unlikely to respond (Andersson, Carlbring, & Grimund, 2008; Nordgreen et al., 2010).

In the present study, we evaluated a series of factors, including baseline SAD symptoms, comorbid depressive symptoms, and program factors (e.g., credibility and adherence), as potential predictors of diagnosis-free status and reliably reduced symptoms in the context of guided and unguided self-help for SAD.

In the research literature on face-to-face CBT, the baseline level of the targeted SAD symptoms has consistently been reported to affect treatment outcomes in SAD (Eskildsen, Hougaard, & Rosenberg, 2010). Specifically, generalized SAD has been suggested to be more difficult to treat than specific SAD (Eskildsen et al., 2010). However, empirical data supporting such a hypothesis is lacking (Lincoln et al., 2005). Comorbid depressive symptoms, which are highly prevalent in patients with SAD, have been suggested to negatively affect the outcome of SAD treatment, but the reported findings have also been inconclusive (Eskildsen et al., 2010). Moreover, several groups of researchers have argued that program credibility and adherence may be of special relevance to self-help treatment outcomes (Geraghty, Wood, & Hyland, 2010; Ritterband, Thorndike, Vasques, & Saylor, 2010; Titov et al., 2008). Specifically, there have been concerns regarding whether self-help is viewed as a “less credible” treatment among both patients (Waller & Gilbody, 2009) and therapists (Nordgreen & Havik, 2011). For example, reported treatment credibility of guided self-help for panic disorder has been associated with treatment outcomes in the case of panic disorder symptoms

(Carlbring et al., 2005). However, the role of credibility with regard to both guided and unguided self-help is unclear (Ritterband et al., 2010) and was, therefore, included as a predictor in this study. Finally, a patient’s adherence to the program, operationalized as the number of modules completed, has been found to relate to self-help treatment outcomes (Rapee et al., 2007). However, the association between program adherence and self-help treatment outcomes may be difficult to determine. For example, users of an unguided self-help program may adhere to the program until they feel “better enough”, regardless of the length of the program (Farvolden et al., 2005).

In addition to the analyses of treatment outcomes, we also wanted to investigate the predictors of treatment adherence. Although treatment adherence has been found to positively relate to treatment outcomes (Rapee et al., 2007), further examining the baseline factors related to the level of adherence may help to identify patients at risk of low adherence or dropout. Yet, few studies have included analyses of predictors of adherence in self-help treatments (Christensen et al., 2009). This lack of research is somewhat surprising given that low adherence and attrition are described as main barriers to the effectiveness of self-help treatments (Eysenback, 2005). Research on comparing face-to-face CBT and self-help has suggested that, disease-related factors and, to a lesser degree, comorbid depressive symptoms, may be of importance to adherence (Christensen et al., 2009; Eskildsen et al., 2010).

Taken together, and on the basis of the existing literature, we hypothesized that higher baseline symptom levels of SAD, generalized SAD, and depressive symptoms would be associated with less favorable treatment outcomes. Moreover, we expected treatment adherence to relate to better outcomes. However, the relationship between credibility and treatment outcomes was less predictable. Finally, we hypothesized that pre-treatment SAD symptoms and treatment credibility would relate to treatment adherence in guided and unguided self-help programs.

Method

Outline of the original studies

Participants were selected from four previously published studies on self-help for SAD (Carlbring, Furmark, Steczkó, Ekselius, & Andersson, 2006; Carlbring et al., 2007; Furmark et al., 2009). Furmark et al. (2009) reported two randomized controlled trials: Trial 1 compared Internet-based guided self-help to bibliotherapy and to a waitlist control whereas Trial 2 compared guided self-help to bibliotherapy alone, bibliotherapy with a chat forum, and a waitlist control. Carlbring et al. (2007) compared a guided self-help group with a waitlist control group in a randomized control trial. Moreover, Carlbring et al. (2006) conducted an open study that examined the effects of guided self-help for SAD (Carlbring et al., 2006). These studies found large within-group effect sizes (Cohen’s $d = 0.85–2.04$) (Carlbring et al., 2006, 2007; Furmark et al., 2009). Unguided self-help showed moderate to large within-group effect sizes ($d = 0.65–1.20$; Furmark et al., 2009). Furthermore, guided self-help and unguided self-help compared with the waitlist control had moderate between-group effect sizes ($d = 0.63/0.64$; Furmark et al., 2009). The between-group effect sizes for both guided self-help and unguided self-help were small ($d = 0.09$ at post and $d = 0.16$ at follow-up). Study designs and results are described in greater detail elsewhere (Carlbring et al., 2006, 2007; Furmark et al., 2009).

Measures

Diagnostic assessment

Pre-treatment SAD was assessed with the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV; American Psychiatric

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