Behaviour Research and Therapy 50 (2012) 258–265

Contents lists available at SciVerse ScienceDirect

Behaviour Research and Therapy

journal homepage: www.elsevier.com/locate/brat

Cognitive behavioural group therapy for social phobia: Evidence of transportability to community clinics

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ARTICLE INFO

Article history:
Received 16 September 2011
Received in revised form
15 January 2012
Accepted 29 January 2012

Keywords:
Social phobia
Cognitive behaviour therapy
Group
Effectiveness
Benchmarking

ABSTRACT

Cognitive Behavioural Group Therapy (CBGT) for social phobia has been shown to be efficacious within research units and effective within a variety of real world clinical settings. However, most effectiveness studies of CBGT for social phobia have (a) used protocols without demonstrated efficacy, (b) not included direct comparison groups, and/or (c) contained features of efficacy trials. This study addressed these limitations by using a benchmarking strategy to compare outcomes from the same CBGT protocol used in both a research unit and a community clinic. Research ($N = 71$) and community ($N = 94$) patients completed the same 12-session protocol, which resulted in significant reductions in social anxiety and life interference at post-treatment. Compared to research unit patients, community patients had more severe symptoms and life interference at pre-treatment, and were more likely to be male, use medication, have comorbid disorders, and have lower educational attainment. Importantly, degree of improvement on social anxiety symptoms and life interference did not differ across the treatment settings for either completer or intention-to-treat analyses. There was some evidence that being younger, single, and having a depression diagnosis were associated with dropout. Pre-treatment symptoms and number of diagnoses predicted post-treatment symptoms. Consistent with previous uncontrolled trials, it is concluded that CBGT is effective within community mental health clinics.

Introduction

Social phobia is characterised by a fear of negative evaluation within social or performance situations, where individuals believe that they are under scrutiny and may be embarrassed (American Psychiatric Association, 1994). Social phobia is common, persistent, debilitating, and has one of the earliest onsets of all anxiety disorders, resulting in it being temporally primary to many subsequent comorbid anxiety, affective and substance use disorders (Andrews, Henderson, & Hall, 2001; McEvoy, Grove, & Slade, 2011; Wittchen & Fehm, 2003). Cognitive behavioural individual (CBIT) and group (CBGT) therapy have been shown to be efficacious for social phobia in randomised controlled trials (RCTs, Butler, Chapman, Forman, & Beck, 2006; Jørstad-Stein & Heimberg, 2009; Rapee, Gaston, & Abbott, 2009). However, RCTs are difficult to conduct within real world clinics and the transportability of efficacious treatments to community populations cannot necessarily be assumed.

Efficacy trials prioritise internal validity and are a crucial first step to establishing the credentials of treatment protocols. However, there are a number of potential threats to the generalisability (i.e., external validity) of outcomes from well-controlled efficacy trials to community clinics. Research trials typically select patients based on strict inclusion criteria, use highly trained and closely supervised specialist clinicians, and closely follow manualised treatment protocols. In contrast, effectiveness studies, which examine whether efficacious treatments result in comparable outcomes in naturalistic settings, use clinically representative patients (e.g., highly comorbid, severe, referred by health practitioners rather than through advertisements or self-referral), therapists (e.g., not formally trained or supervised by the protocol developers, broad caseload rather than specialising in the target disorder, various levels of experience, unmonitored protocol adherence), and services (e.g., private practice, community mental health clinics, primary care; Stewart & Chambless, 2009). Dissemination of evidence-based treatments has probably been impeded by the perception that RCTs are not representative of real world

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doi:10.1016/j.brat.2012.01.009

circumstances (Barlow, Levitt, & Bufka, 1999), so it is important to demonstrate that efficacious treatments are robustly effective across various treatment settings.

Evidence for the transportability of CBT for social phobia to community clinics is accumulating for CBIT (Lincoln et al., 2003) and CBGT (Marom, Gilboa-Schechtman, Aderka, Weizman, & Hermesh, 2009; McEvoy, 2007), and there is evidence that CBGT is equally effective in research and private practice settings (Gaston, Abbott, Rapee, & Neary, 2006). Moreover, some effectiveness researchers have found that applying exclusion criteria used in efficacy trials has no effect on treatment outcomes (Lincoln et al., 2003; McEvoy, 2007), thus supporting the generalisability of efficacy trial outcomes. In contrast, two meta-analyses of CBT for social phobia across research and naturalistic settings have found an association between the number of laboratory treatment conditions and effect sizes, with studies using an array of efficacy trial restrictions having better outcomes (Lincoln & Rief, 2004; Stewart & Chambless, 2009). This finding suggests that treatment within clinically representative settings may be less effective than within well controlled research settings, and reinforces the need to directly compare outcomes across settings to demonstrate equivalence.

The evidence for the transportability of CBT for social phobia is promising, but limitations in the existing effectiveness literature remain. One limitation is that some effectiveness studies have failed to directly compare outcomes to previous benchmarks (e.g., Haug et al., 2000), so it is unclear whether outcomes vary across settings. A second limitation is that some effectiveness studies have used protocols without demonstrated efficacy within well controlled trials. Whilst modifying evidence-based protocols to better fit patient or service requirements (e.g., inpatient vs. outpatient, session duration, program length, clinician availability) is consistent with the philosophy of effectiveness research, it nonetheless makes it difficult to directly attribute treatment gains to the strategies in the manual. For instance, McEvoy (2007) used a benchmarking strategy to compare effect sizes from an uncontrolled study in a community mental health clinic (CMHC) to previous efficacy and effectiveness trials of both CBIT and CBGT. This study found that effect sizes were within the range of previous efficacy and effectiveness studies for both treatment formats. However, while the treatment protocol in McEvoy's (2007) study contained similar core components to efficacious CBGT protocols, the manual had not been previously evaluated within an efficacy trial and no comparison group was used. Likewise, Marom et al. (2009) found that effect sizes from CBGT in a naturalistic setting compared well to previous studies and meta-analyses, with gains maintaining at one-year follow-up. While a theory- and evidence-guided protocol was used (i.e., cited as being *based on* an efficacious manual), it was unclear whether the protocol had been previously evaluated in an RCT. A third limitation is that many effectiveness studies contain efficacy trial qualities, such as excluding individuals with comorbidities or recruiting via self-referral or newspaper advertisements (e.g., Haug et al., 2000; Marom et al., 2009). In addition to these limitations recent research has demonstrated that combining theory-driven components with more traditional CBT strategies (referred to as enhanced-CBGT) led to somewhat stronger effects than use of a more traditionally-based CBGT only (Rapee et al., 2009). However, this enhanced protocol is yet to be evaluated within a naturalistic setting. The current study sought to address these limitations by using a benchmarking strategy to directly compare outcomes in community and research settings when the same efficacious, CBGT protocol was used.

The first aim of this study was to compare treatment outcomes across research and community samples using a CBGT manual with demonstrated efficacy (Rapee et al., 2009). Patient, clinician and service factors within a CMHC may reduce treatment effects (Lincoln & Rief, 2004; Stewart & Chambless, 2009). Alternatively, consistent with benchmarking studies conducted to date (Lincoln et al., 2003; Marom et al., 2009; McEvoy, 2007), it may be that CBGT is robustly effective despite differences that exist across service settings. The second aim of this study was to identify sociodemographic and clinical factors associated with (a) treatment attrition, (b) any observed differences in outcomes between the two settings, and (c) post-treatment symptoms. In addition to basic demographic variables (age, gender), other factors previously found to be associated with treatment outcome were examined, including pre-treatment symptoms, pre-treatment impairment, medication use, and comorbid depression.

Method

Participants

Participants in the research unit (RU) comprised the 71 individuals from an RCT comparing the "enhanced" CBGT protocol that was used in this study to standard CBGT and non-specific treatment (Rapee et al., 2009). Five participants did not provide pre-treatment data, so were excluded from all subsequent analyses in this study (total $N = 66$). All patients had been allocated to the enhanced-CBGT condition and all had a principal diagnosis of social phobia (see Table 1). Most were born in Australia or New Zealand (81.8%). The RU specialises in the assessment and treatment of anxiety disorders, and the assessment was subsidised and treatment was free in return for participating in an RCT. The RU recruited participants via media stories, self-referrals, or referrals from other professionals. A maximum of four disorders were coded in the database. Additional diagnoses included generalised anxiety disorder (23%), major depressive disorder (12%), specific phobia (8%), dysthymia (6%), panic disorder (6%), obsessive compulsive disorder (8%), and bipolar affective disorder (2%).

Participants in the CMHC comprised 94 consecutive admissions with a diagnosis of social phobia, which was listed as the principal diagnosis for 79 patients (84.0%). Principal diagnoses for the

Table 1
Demographic characteristics of the RU and CMHC samples.

	RU ($N = 66$) (mean or %)	CMHC ($N = 94$) (mean or %)	df	t/χ^2	p
Sociodemographic variables (adjusted $p < .01$)					
Age (years)	35.82 (12.25)	32.77 (11.41)	158	$t = 1.62$	.11
Gender (% women)	58	40	1	$\chi^2 = 4.57$	.03
Marital status (%)			2	$\chi^2 = 1.62$	.45
Single	59	61			
Married/de facto	36	30			
Separated/divorced	5	9			
Educational status (%)			3	$\chi^2 = 9.02$	.03
Less than high school	5	20			
High school	31	33			
Technical/trade	31	19			
Tertiary qualifications	34	29			
Employed (%)	64	50	1	$\chi^2 = 3.14$	.08
Clinical variables (adjusted $p < .006$)					
Problem medicated (%)	27	62	1	$\chi^2 = 18.43$[a]	<.001
Number of diagnoses (%)			2	$\chi^2 = 11.72$[a]	.003
1	56	31			
2	23	46			
3+	21	23			
Depressive disorder (%)	18	57	1	$\chi^2 = 24.67$[a]	<.001
Number of sessions	9.47 (3.33)	9.14 (3.47)	158	$t = -.60$	.55

Note. RU = research unit, CMHC = community mental health clinic.
[a] Statistically significant using a Bonferroni-adjusted alpha.