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# Effectiveness of a six session stress reduction program for groups



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Design

## Abstract

This study set out to determine the effectiveness of a 6-week cognitive-behavioral stress reduction course for groups. Two groups (intervention group  $N=47$ ; matched control group  $N=47$ ) completed questionnaires on stress, depression, anxiety, worrying, and stress management skills pre and post-intervention, at 6 months and at 1 year follow-up. Results showed decline for all symptoms in the intervention group (linear trends  $ps < .05$ ), whereas stress management skills remained stable. Clinically significant and reliable change for almost 30% of participants confirmed these findings. No such change was found for the control group. Overall, the data showed small but reliable, long-lasting effects.

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## Introduction

Lazarus and Folkman (1984) defined psychological stress as "... a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being." Almost three decades later, chronic stress is considered a major burden in modern society, compromising

both physical and mental health (American Psychological Association). High levels of self-perceived stress are, for example, closely related to several adverse health conditions like metabolic syndrome (Chandola, Brunner, & Marmot, 2006) and coronary heart disease (Jood, Redfors, Rosengren, Blomstrand, & Jern, 2009; Rosengren et al., 2004; Xu, Zhao, Guo, Yanhong, & Gao, 2009). There is also a clear link between high levels of stress and the subsequent onset of mental disorders such as depression (van Praag, 2004; Wang, 2005).

Considering the scope of the burden of stress, no health service will ever be able to provide adequate treatment for all, even in more affluent countries (van't Veer-Tazelaar et al., 2009). This emphasizes the need for large scale

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prevention, for example by reducing stress in the general population. In mental healthcare, prevention can be situated within a stepped-care approach. This represents an attempt to maximize the efficiency of resource allocation in therapy: low threshold and low cost interventions are offered first, and more intensive and costly interventions are reserved for those who are not sufficiently helped by the initial intervention (Haaga, 2000). A recent meta-analysis including a variety of programs confirmed that the average participant of a stress reduction program obtains a significant reduction of perceived stress. When long-term changes are considered, however, results are less clear. The limited number of studies that include follow-up for up to 6 months or less find mixed results (Van Daele, Hermans, Van Audenhove, & Van den Bergh, 2012).

The current study therefore aims at consolidating the evidence base for stress reduction programs, both in the short and long term. In the present case, we are interested in how the intervention performs in the real-life context of communities, resembling common practice. This provides a more accurate view of intervention effectiveness in everyday life. The intervention itself is a stress reduction program, developed within the cognitive-behavioral therapy (CBT) tradition as an adaptation of a program by White (2000) that was originally developed to reduce anxiety. It is being offered to large groups of self-registering community dwellers. Since they self-register, participants may have various initial complaints and motivations constituting a heterogeneous group of participants with 'typical' elevated stress symptoms, but also participants with low levels of stress whose main interest is to learn more about stress and how it may affect them. Whereas White's course was more focused on curing participants with elevated complaint levels, the current course has therefore more characteristics of a selective preventive intervention.

The goal of the program is to reduce stress by altering the relationship between the person and the environment. More specifically, stress reduction is intended to occur through two main routes. One focuses on strengthening the participants' resources through developing social and self-management skills. The other attempts to change cognitive representations through targeting negative appraisals and unhelpful perseverative thinking, such as worrying and ruminating which may mediate the relationship between stressors and psychopathology (Brosschot, Gerin, & Thayer, 2006). Because the program aims to initiate a learning process, the reduction of stress-related symptoms is expected to occur gradually and to continue in the months following the intervention.

Changes were assessed through self-report questionnaires. Stress scores were considered as the primary outcome measure, depression and anxiety as secondary outcome measures, and reduction in worrying and increase in stress management skills as the means for stress reduction. We used a pre-post matched control design with two follow-up moments, one after 6 and one after 12 months. Because participants needed time to process all the information and practice the skills taught during the course, it was hypothesized that in the months following the intervention, a steady, gradual decline in worrying and a gradual increase in stress management skills would be accompanied by a decline in stress and depression and anxiety. The strongest effect is expected to occur for those participants who present themselves with higher levels of initial symptoms.

## Method

### Recruitment and screening

In order to participate, respondents had to reside in one of three regions in Flanders (Belgium). In each region, local organizations were contacted to help distribute information leaflets through their own networks and communication channels, including general practitioners, (sports) clubs, libraries and local press. Exclusion criteria were defined and potential participants who met at least one of these were informed that the current intervention might not completely suit their needs and that additional professional help might be necessary. Subsequently, they could decide to continue following the course or not, but they were always advised to contact the local centre for ambulatory mental healthcare. The centers were informed about these potential contacts and agreed to give these requests priority. If participants continued to follow the course, they were removed from the study sample. The exclusion criteria were the answers on (1) question 15 of the Web Screening Questionnaire (Donker, Straten, van Marks, & Cuijpers, 2009) indicating suicidal tendencies (Answering 'I would do it given the opportunity' on the question whether the idea of harming yourself or taking your life, recently came into their mind), (2) the General Anxiety Disorder Questionnaire-7 (Spitzer, Kroenke, Williams, & Löwe, 2006) showing they suffered from a severe generalized anxiety disorder (15+ on a 21 point scale), (3) three questions of the Alcohol Use Disorders Screening Test (Saunders, Aasland, Babor, de la Puente, & Grant, 1993) pointing to problematic substance abuse (which could lead to alcohol induced violence, endangering fellow participants). During the course, participants could also be excluded if the teacher-therapist noticed signs of psychotic disorders or severe deviant behavior.

To study long-term effects, the original goal was to randomly allocate participants to a stress management course or to a 1-year non-intervention control group. This, however, raised practical and ethical concerns in local partners endangering course implementation: local partners were reluctant to advertise the study when half of the participants would be denied treatment for 12 months or would receive some kind of placebo treatment. A matching procedure was therefore used to collect control data instead of using randomized non- or pseudo-intervention controls. In the matching procedure, a large sample was recruited from the general population through local newspapers, answering an advertisement to participate in a questionnaire study concerning their general well-being. Subsequently, a selected number of them were matched one-on-one to the course participants according to predetermined criteria: stress scores, depression and anxiety, as well as age, socioeconomic status and gender. Participants in this control group were not aware of the intervention and had not expressed an explicit desire to participate in the stress course. This design proved to be acceptable for local partners. It was subsequently also approved by the ethics committee of the Faculty of Psychology and Educational Studies of the University of Leuven. Controls received €10 per data collection wave for participating.

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