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Internet-delivered cognitive behavioural therapy with and without an initial face-to-face psychoeducation session for social anxiety disorder: A pilot randomized controlled trial

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ABSTRACT

Background: Guided Internet-delivered cognitive behavioural therapy (ICBT) is an effective treatment of social anxiety disorder (SAD). However, the treatment is not effective for all. The amount and type of therapist contact have been highlighted as a possible moderator of treatment outcome.
Objective: The aim of this study was to examine whether treatment effects of ICBT are enhanced with an initial 90 min face-to-face psychoeducation (PE) session for university students with SAD.
Method: University students with SAD ($N = 37$) were randomized into one out of two conditions: 1) an initial therapist-led face-to-face PE session followed by guided ICBT, 2) guided ICBT without an initial PE session. Data was analysed with an intent-to-treat approach.
Results: Eight participants (21.6%) dropped out of treatment. A statistically significant reduction in symptoms was found for all outcome measures for both groups. There were no significant additional effects of adding the initial face-to-face PE. Moderate to large within-group effect sizes on self-rated social anxiety symptoms were found at post-treatment ($d = 0.70$–0.95) and at a six month follow-up ($d = 0.70$–1.00). Nearly half of the participants were classified as recovered.
Conclusions: Notwithstanding limitations due to the small sample size, the findings indicate that guided ICBT is an effective treatment for students with SAD. Adding an initial face-to-face PE session to the guided ICBT did not lead to enhanced outcomes in the present study.

1. Introduction

Social anxiety disorder (SAD) is the most frequent anxiety disorder with a lifetime prevalence of 12–14% (Kessler et al., 2005; Kringlen et al., 2001). Considering the negative impact of anxiety disorders on well being and quality of life (Mendlowicz and Stein, 2000), and the economic burden on the society (Smit et al., 2006), it is important to provide adequate health care interventions at an early stage. Population-based surveys, however, indicate that more than half of those with anxiety symptoms may never seek treatment (Roness et al., 2005; Wang et al., 2005), and only a few get evidence-based treatment (Shafran et al., 2009).

Guided Internet-delivered cognitive behavioural therapy (ICBT) has been shown to be an effective treatment for a variety of anxiety disorders (e.g. Haug et al., 2012; Hedman et al., 2012), including SAD (Andersson et al., 2006; Boettcher et al., 2013; Carlbring et al., 2007; Furmark et al., 2009; Hedman et al., 2014). Patients also consider guided ICBT to be a credible and suitable alternative to face-to-face treatment (Gun et al., 2011; Mohr et al., 2010; Spence et al., 2011; Wootton et al., 2011). However, some patients do not improve from ICBT and an average of 31% drop out of treatment (Melville et al., 2010). It is therefore important to identify factors related to improved outcomes from ICBT. Increased therapist contact is suggested as a factor that may enhance treatment effects (Palmqvist et al., 2007; Haug et al., 2012).

The question about what constitutes the optimal amount and modes of therapist contact (e.g. e-mail, telephone, face-to-face meetings) has been addressed in several studies (e.g. Andersson et al., 2006;

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Carlbring et al., 2006; Carlbring et al., 2007). The findings in these studies support the use of guided ICBT but give no clear indication on what might be the optimal way of providing therapist guidance. The degree of therapist support has been examined on ICBT for other disorders (Johansson and Andersson, 2012) but little work has been done on the effects of support on ICBT for SAD specifically. Boettcher et al. (2012) examined whether an initial diagnostic interview would increase treatment effects and found no effect on their primary SAD outcomes. Also Titov et al. (2010) compared ICBT with and without motivational enhancement strategies. This included lessons in managing ambivalence, developing and resolving discrepancy between values and symptoms and enhancing self-efficacy for change. Although there were less drop-outs in the motivationally enhanced group, there were no between-group differences in outcome measures at the end of treatment or at the 3 month follow-up.

Psychoeducation interventions based on CBT-principles as a stand-alone treatment have been found to significantly reduce symptoms for anxiety, depression, and psychological distress, but with small effect sizes (Donker et al., 2009; Rummel-Kluge et al., 2009). Psychoeducation interventions usually consist of information about the development and maintenance of a particular mental disorder, the principles behind the treatment of that disorder, and suggestions for coping strategies. In accordance with the arguments that therapist support is a critical component in ICBT treatments (Johansson and Andersson, 2012), psychoeducation is thought to be a common factor that may enhance the patient's experience of accountability to the therapy and the therapist (Newman et al., 2003), stimulating the development of the therapeutic alliance (Horvath and Luborsky, 1993), and facilitate the process of entering a change promoting role (Ogrodniczuk et al., 2005). All together, these factors are thought to increase satisfaction, use, and treatment outcome among patients seeking help for anxiety disorders (Taylor et al., 2012). One can argue that while the ICBT treatment offers psychoeducation as a part of its treatment, it does not add the same gravitas and accountability as a face-to-face psychoeducation. Thus, the aim of the present study was to examine whether an initial face-to-face psychoeducation session would enhance outcomes and reduced drop-out in guided ICBT for SAD.

2. Method

2.1. Procedure

A total of 37 students with SAD were included in the study, and randomized to the psychoeducation + ICBT condition ($n = 17$) or the ICBT only condition ($n = 20$). Participants were recruited at the Student Psychological Health Services, a low-threshold psychological service where students at the University of Bergen can self-refer for treatment. The SPH does not required student to fulfil diagnostic criteria for a mental disorder to receive treatment, and they are not excluded from treatment if they do. Possible participants were screened for SAD and those who affirmed at least two of the three main screening questions for SAD in the Mini-International Neuropsychiatric Interview (MINI; Sheehan et al., 2009) were informed about the study and invited to the face-to-face inclusion assessment. To be included, participants had to fulfil the following inclusion criteria: a) between 18 and 65 years of age; b) fulfilling MINI criteria for SAD for at least one month; c) SAD as the primary psychological disorder; d) a Clinician Severity Rating (Brown et al., 1994) score of at least 3, indicating a severity which warrants a diagnosis (Brown et al., 2001); e) willingness to be randomized; f) Internet access; g) a signed written informed consent. Exclusion criteria were: a) major reading difficulties; b) in immediate need of other treatment; c) drugs or alcohol dependence syndrome; d) regular use of benzodiazepines; e) psychosis, major depressive disorder, or suicidal ideation. Use of selective reuptake inhibitors was accepted, if medication had been stable over the last three months and the patient was willing to remain stable during the intervention period. Previous psychological treatment, including CBT and exposure treatment, was not an exclusion criterion but ongoing psychological treatment was.

Participants were randomized to one out of two treatment conditions: 1) psychoeducation + ICBT: a therapist-led face-to-face 90 min psychoeducation session before starting guided ICBT or 2) ICBT: guided ICBT without an initial psychoeducation session. The therapists who delivered the psychoeducation also administrated assessment and guided their respective patients through the ICBT programme. Both conditions had a weekly 10 min telephone contact during the ICBT intervention. The randomisation was done by an online true random-number service.

Participants were assessed at pre-treatment, post-treatment, and at 6 months follow-up. The Social Phobia Scale (SPS; Mattick and Clarke, 1998) was administrated via Internet after the third and sixth module. Participation in the study was based on written, informed consent. The Regional Committee for Medical and Health Research Ethics, Western Norway, approved the study.

2.2. Treatment

2.2.1. Psychoeducation session

The psychoeducation session lasted 90 min, comprising an introduction to the cognitive, physical, emotional, and behavioural symptoms of SAD. During this session the therapist and the patient made use of the CBT model for SAD (Clark and Wells, 1995) in order to understand the symptoms of the patient. In addition, the participant was given advice to change focus from themselves to their environment as well as general advice on how to master the physical symptoms that accompany anxiety. At the end of the session, the participants were given a leaflet with a brief summary of the topics covered in the session.

2.2.2. Guided ICBT

The ICBT-programme for SAD was developed in Sweden and has been used in several randomized controlled clinical trials (e.g. Andersson et al., 2006; Andersson et al., 2012; Carlbring et al., 2006, 2007; Furmark et al., 2009) and has been shown to be effective in routine care (El Alaoui et al., 2015). It has also been demonstrated to be as effective as cognitive behavioural group therapy (Hedman et al., 2011). The programme is informed by Clark and Wells' (1995) cognitive model for SAD. Professional translators and psychologists translated the programme into Norwegian. The nine modules comprised written information about central symptoms of SAD, the etiological and maintaining factors of these symptoms, and how to change these. Main themes in the modules were identifying and changing negative thought patterns, improving information processing in social situations, identifying and reducing safety behaviours, mastering physical anxiety symptoms, and social exposure (Andersson et al., 2006).

At the end of each module, patients were given homework assignments, i. e. setting goals for treatment recording thoughts, feelings, and behaviour, and to plan and evaluate behavioural experiments. Participants were recommended to spend 4–6 h working on the programme each week.

2.2.3. Therapist support

Due to Norwegian legislation at the time of development of the web-platform (2007) no online storage of sensitive information or electronic was included. Therefore, guidance was provided in pre-scheduled weekly phone call from their therapist, in line with procedures used by Carlbring et al. (2007). The phone call was expected to last around 10 min and therapists were instructed to answer questions about the current module or the treatment in general and to encourage progress and completion.

The therapists ($N = 6$) were clinical psychologists (female = 4), all certified specialists with between 5 and 15 years of experience in psychological treatment of students. The therapists attended a one-day workshop focusing on information about the ICBT-programme and