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Stepped Care Versus Direct Face-to-Face Cognitive Behavior Therapy for Social Anxiety Disorder and Panic Disorder: A Randomized Effectiveness Trial

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The aim of this study was to assess the effectiveness of a cognitive behavioral therapy (CBT) stepped care model (psychoeducation, guided Internet treatment, and face-to-face CBT) compared with direct face-to-face (FtF) CBT. Patients with panic disorder or social anxiety disorder were randomized to either stepped care (n = 85) or direct FtF CBT (n = 88). Recovery was defined as meeting two of the following three criteria: loss of diagnosis, below cut-off for self-reported symptoms, and functional improvement. No significant differences in intention-to-treat recovery rates were identified between stepped care (40.0%) and direct FtF CBT (43.2%). The majority of the patients who recovered in the stepped care did so at the less therapist-demanding steps (26/34, 76.5%). Moderate to large within-groups effect sizes were identified at posttreatment and 1-year follow-up. The attrition rates were high: 41.2% in the stepped care condition and 27.3% in the direct FtF CBT condition. These findings indicate that the outcome of a stepped care model for anxiety disorders is comparable to that of direct FtF CBT. The rates of improvement at the two less therapist-demanding steps indicate that stepped care models might be useful for increasing patients' access to evidence-based psychological treatments for anxiety disorders. However, attrition in the stepped care condition was high, and research regarding the factors that can improve adherence should be prioritized.

Keywords: stepped care; effectiveness; social anxiety disorder; panic disorder

Cognitive Behavioral Therapy (CBT) is well documented as an effective treatment for panic disorder (PD) and social anxiety disorder (SAD) (Stewart & Chambless, 2009), both of which are highly prevalent disorders that are associated with chronic courses if left untreated (Furmark et al., 1999; Kringlen, Torgersen, & Cramer, 2001). However, access to CBT is limited (Shafran et al., 2009). Less therapist-demanding treatment formats, such as guided Internet-based CBT (ICBT), have therefore been developed, and these therapies have produced results similar to those of face-to-face CBT in direct comparisons (Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014).

Stepped care models have been suggested as effective methods of organizing psychological interventions with increasing amounts of therapist-patient contact (Bower & Gilbody, 2005; National Institute for Health and Care Excellence, 2011). Stepped care models begin with interventions that involve the lowest levels of therapist input that are assumed to lead to successful treatment outcomes and include monitoring at each step to detect and act on cases of nonimprovement (Bower & Gilbody, 2005; Haaga, 2000). Stepped care models are well recognized as a method for organizing interventions in health care in general. For example, patients with Type 2 diabetes receive additional medication only if meal plans and insulin are insufficient to control blood glucose levels (McFarland, 1997). The use of stepped care models to organize psychological interventions, however, is relatively new, but models have been developed for addictions (Brooner et al., 2007), anxiety and depression (Seekles, van Straten, Beekman, van Marwijk, & Cuijpers, 2009; Tolin, Diefenbach, & Gilliam, 2011), obesity and weight loss (Carels et al., 2009), and chronic low back pain (Von Korff & Moore, 2001). However, stepped care models are heterogeneous regarding type of interventions, number of interventions, and the stepping-up criteria used. Following the main principle of increasing therapist input throughout the stepped care process, some stepped care models in primary care start with monitoring alone, so-called "watchful waiting." The first psychological intervention may be psychoeducation and/or self-help, and high-intensity psychological treatments such as face-to-face therapy are offered as the next step. Stepped care studies in primary care often have referral to specialist care as the final step (van Straten, Hill, Richards, & Cuijpers, 2015). Although stepped care models comprising ICBT have received some support in efficacy studies (van Straten et al., 2015) and are implemented in the large-scale initiative "Improving Access to Psychological Therapies" in the U.K., the evidence for stepped care models in mental health is sparse (van Straten et al., 2015). First, it is unclear which interventions to include and how the interventions should be administered. Second, we do not know about the effectiveness of stepped care models for clinical samples in ordinary public mental health clinics (Richards, 2012; van Straten et al., 2015). Patients in these clinics often have more severe and complex problems and are treated by therapists with less training and competence in terms of diagnosis-specific treatments compared with those in typical conditions specialized

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