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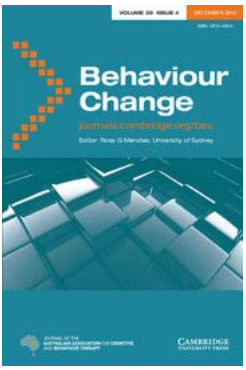

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Which Client Characteristics Contribute to Good and Poor Cognitive-Behavioural Treatment Outcome for Social Anxiety Disorder? A Survey of Clinicians

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The aim of the study was to survey a group of clinicians who identify themselves as experienced in treating social anxiety disorder using cognitive behavioural treatment (CBT) with regard to the characteristics of clients which they think, based on their experience, are predictive of poor or good CBT outcome. Fifty-four practising clinicians responded to an email inviting participation in a research study of clinicians' opinions about client characteristics that may be important in CBT outcome for social anxiety. Participants completed open-ended questions about, and made ratings of the importance of, client characteristics that they believed impact upon the outcome of CBT for social anxiety disorder. Motivation for seeking treatment, comorbidity, and intellect or reasoning ability were nominated most frequently by clinicians as having an effect on CBT outcome. Acceptance of the CBT rationale/model, ability to take responsibility for change, motivation/reason for seeking treatment, and ability to develop an alliance were all rated by participants as being important in contributing to CBT outcome. The results provide direction for future empirical research on client characteristics as predictors of CBT outcome.

■ *Keywords:* client characteristics, clinician views

Social anxiety disorder (or social phobia) is defined as a marked and persistent fear of social or performance situations in which embarrassment may occur (DSM-IV; American Psychiatric Association, 2000). It is estimated that 4.7% of adult Australians have experienced social anxiety disorder within the past 12 months (Australian Bureau of Statistics, 2007). Social anxiety disorder can be a debilitating disorder that markedly affects individuals' lives across occupational, social, and medical domains. Social anxiety disorder has been estimated to provide a major burden on both the individual and society (Norton et al., 1996) and Australian estimations of the impact of social anxiety disorder indicate that it is one of the worst 30 diseases in terms of disability adjusted life years lost (Mathers, Vos, Stevenson, & Begg, 2000).

Since the first trials of cognitive behavioural treatment (CBT) for social anxiety disorder conducted over 20 years ago (Mattick & Peters, 1988, Mattick, Peters, & Clarke, 1989) there has been extensive evaluation of treatments for social anxiety

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disorder. As a result, a variety of empirically supported treatment packages have been developed, with good efficacy (see Rodebaugh, Holaway, & Heimberg, 2004, for a review). Most supported treatments follow CBT principles and have resulted in mean effect size changes of around 0.8 (Fedoroff & Taylor, 2001). More recent developments in treatments that are closely linked with recent psychological models of social anxiety disorder (Clark & Wells, 1995; Rapee & Heimberg, 1997) have increased these effects.

Despite empirical evidence for the effectiveness of CBT, not all clients who complete a program of CBT for their social anxiety disorder will have optimal levels of improvement. For example, Rapee, Gaston, and Abbott (2009), showed, in a randomised controlled trial (RCT), that an enhanced CBT package produced significantly greater changes post-treatment than a standard CBT program. Despite this significant change at the group level, however, 59% of participants in the enhanced CBT group still met diagnostic criteria for social anxiety disorder at the end of treatment. While this was better than the 66% meeting criteria in the standard CBT condition, optimum benefit from CBT programs is still not being achieved by over half of participants in treatment. Research focused on improving CBT outcomes is needed.

Research examining the factors which account for individual differences in CBT outcome may lead to enhanced CBT efficacy by allowing tailoring of CBT to account for such factors. In a review of participant or client factors that predict treatment outcome for social anxiety disorder Newman, Crits-Cristoph, Gibbons, and Erickson (2006) found that several client characteristics are important in predicting CBT outcome in social anxiety disorder; for example, functional impairment, severity and duration of the disorder, expectations for change, and perceived credibility of the treatment. A more recent review of predictors of treatment outcomes for social anxiety disorder (Eskilsden, Hougaard, & Rosenberg, 2010) draws similar conclusions regarding the impact of client characteristics. While these reviews draw consistent conclusions regarding the importance of client characteristics in predicting treatment outcome, both also point to the fact that there is a paucity of research on such factors.

One of the resources that has been under-utilised in research for identifying potential client characteristics that might predict poor or good CBT outcome is the clinicians who use CBT in daily practice to treat social anxiety disorder. There has been a call for including clinicians in the research effort (e.g., American Psychological Association Division 12 Committee on Building a Two-Way Bridge Between Research and Practice, 2010) in order to bridge the scientist–practitioner gap. The aim of the present study was to survey a group of clinicians who identify themselves as experienced in treating anxiety disorders (and especially social anxiety disorder) and who are using CBT with regard to the characteristics of clients they have assessed, based on their experience, are predictive of poor or good CBT outcome. If there are characteristics clinicians can identify as predictive of poor or good CBT outcome, these characteristics may suggest features that may be targeted in further empirical research on client characteristics. There is some research which suggests that considering characteristics that may hinder or enhance treatment outcome might be a fruitful endeavour. For example, the work of Pollard and colleagues (VanDyke & Pollard, 2005; Pollard, 2007) in the area of obsessive-compulsive disorder focuses on identifiable behaviours that are likely to interfere with treatment ('Treatment Interfering Behaviours'; TIBs) once a client has reported for treatment. Pollard and his colleagues have generated a list of such TIBs for OCD that a clinician can check for each client. (A similar measure has been developed for clients with depression [Safran et al., 1990].) If the client has TIBs, it is then recommended that the treatment for

OCD be stopped until the TIBs are addressed. VanDyke & Pollard (2005) report on a treatment approach for such TIBs in OCD and provide preliminary evidence in a small sample ($n = 11$) that such an approach improves outcomes overall for OCD. While such research is encouraging, it is not clear that the TIBs identified for OCD are the same as those that might be identified for all anxiety disorders. Thus, the present study asks clinicians to identify characteristics which might hinder or enhance CBT outcome for clients with social anxiety disorder.

Method

Participants

Participants were 54 (45 female) practising clinicians who responded to an email inviting participation in a research study of clinicians' opinions about client characteristics that may be important in CBT outcome for social anxiety. The email was sent by the coordinator of the Anxiety Practitioners Network (APN) which 'is a non-profit association and has as its aim the advancement of the treatment of anxiety disorders. Members of the APN are individuals who have an interest in assessing and treating anxiety in its various forms' (http://anxietypractitionersnetwork.org.au/). All of the participants had a tertiary education in psychology or psychiatry.

Measures

Participants completed a purpose-built questionnaire that gathered demographic details (gender, age, highest level of attained education, psychology qualifications, and qualifications attained not in the area of psychology) and details about their experience with CBT and Social Anxiety Disorder (SAD); that is, how many years they had been using CBT, the total number of clients suffering SAD they had treated in their career, and the current number of SAD clients they are treating. Participants then responded to two open-ended questions, which asked them to provide at least three characteristics that they believe contribute to (1) a client doing well in cognitive-behaviour therapy ('We have all had a client who, after the first session, we think will do well in treatment. Please tell us three characteristics a client may have that make you think they will DO WELL at Cognitive Behavioural Therapy.'); and (2) a client doing poorly in CBT ('Similarly, we have all had a client who, after the first session, we think will do poorly in treatment. Please tell us three characteristics a client may have that make you think they will DO POORLY at Cognitive Behavioural Therapy.') Participants were then asked to give a rating of the importance to CBT outcome of 14 client characteristics on a 5-point Likert scale (where 1 = *Not important*, and 5 = *Extremely important*). The 14 characteristics listed were those included in previous clinician checklists of client characteristics (e.g., Safren et al., 1990; Pollard, 2007; VanDyke & Pollard, 2005) that were likely to be relevant to social anxiety disorder as well as those identified in literature reviews of client characteristics as predictive of CBT outcome for social anxiety disorder (Eskildsen et al., 2010). The included characteristics were: problem-solving ability, self-efficacy for change, acceptance of CBT rationale/model, self-awareness of emotions, locus of control, personality/temperament, ability to take personal responsibility for change, expectations about treatment, ability to acknowledge the existence of alternative viewpoints, interpersonal style, motivation/reason for seeking treatment, willingness to experiment with new ways of thinking and behaving, intellect, and ability to develop an alliance with the therapist.

Procedure

Participants responded to an email sent to them by the coordinator of the APN inviting them to consider the research by following a link to the survey which was delivered online via a secure online questionnaire server (SurveyMonkey).

Results and Discussion

Preliminary Analysis

Integrity of the dataset was checked and any partial responses were eliminated so that analyses would be sound. The final number of respondents in the dataset was $N = 49$ for the analysis of the open-ended responses, and $N = 48$ for analysis of the multiple-choice responses. The final dataset had no missing items except for one participant who omitted one response (one of the three open-ended questions that asked for a variable which may be related to poorer outcome after cognitive-behavioural therapy).

Analysis of Responses to Open-Ended Questions

A total of 331 responses were provided, which were coded by two independent raters into the following categories: (1) problem-solving ability; (2) self-efficacy for change; (3) acceptance of the CBT rationale or model or unsuccessful CBT in the past; (4) awareness of own emotions and/or thoughts; (5) locus of control; (6) personality or temperamental features (not including a comorbid personality disorder); (7) ability to take personal responsibility for change; (8) expectations about treatment or change; (9) ability to acknowledge the existence of alternative viewpoints; (10) interpersonal style; (11) motivation or reason for seeking treatment (including ambivalence); (12) willingness to experiment with new ways of thinking and behaving; (13) intellect or thinking style (e.g., abstract vs. concrete); (14) ability to develop an alliance with the therapist; (15) insight; (16) aspects of social anxiety (e.g., severity, duration, tolerance for anxiety, avoidance); (17) comorbidity (including personality disorder); (18) social support; (19) psychological mindedness; and (20) other (including cultural or language barriers, chaotic lifestyle, medication, age). Inter-rater reliability was assessed for coding of the open-ended responses. Very good perceived agreement between raters was found (observed percentage agreement = 85%; $k = .79$). Where there were disagreements these were resolved by discussion between raters and the analysis was based on the agreed ratings.

The number of times each characteristic was nominated as likely to contribute to good or poor CBT outcome for social anxiety disorder is presented in Table 1. The most frequently nominated response (20.24% of all of the responses) with regard to both good and poor CBT outcome for social anxiety disorder focused on motivation, the reasons for seeking treatment and ambivalence regarding treatment. Motivation was nominated 1.5 times more often as a contributing factor for good outcome than for poor outcome. This, however, may be an artefact of the fact that clinicians were asked to provide characteristics for good outcome prior to characteristics for poor outcome. Nevertheless, it seems that there is a general opinion among clinicians that clients who attend for CBT with good motivation for change and who are not ambivalent are likely to respond well to CBT.

Comorbidity was nominated frequently as a factor contributing to poor CBT outcome (8.46% of all responses were related to comorbidity; where comorbidity is listed in the "good CBT outcome" column, the comment referred to lack of comorbidity as

TABLE 1

Client Characteristics Nominated by Clinicians as Contributing to Good or Poor CBT Outcome for Social Anxiety Disorder

Client characteristic	Good CBT outcome (*f*)	Poor CBT outcome (*f*)	Total (%)
Motivation/reason for seeking treatment/ goals/ambivalence	40	27	67 (20.24)
Intellect/thinking style/reasoning ability	19	9	28 (8.46)
Comorbidity	5	23	28 (8.46)
Features of the anxiety disorder	7	15	22 (6.65)
Psychological mindedness	15	5	20 (6.04)
Insight	12	6	18 (5.44)
Personality	12	5	17 (5.14)
Understanding/acceptance of CBT model	9	7	16 (4.83)
Willingness to experiment with new ways of thinking and behaving	9	7	16 (4.83)
Social support	9	5	14 (4.23)
Interpersonal style/features	4	9	13 (3.93)
Locus of control	2	9	11 (3.32)
Awareness of emotions/thoughts	6	4	10 (3.02)
Expectations about treatment/change	3	5	8 (2.42)
Ability to develop an alliance with the therapist	5	3	8 (2.42)
Able to take personal responsibility for change	3	4	7 (2.11)
Other	8	20	28 (8.46)
Total	168	163	331

contributing to good outcome). This observation made by clinicians is consistent with the research literature on social anxiety which points to comorbidity as a consistent predictor of poorer CBT outcome (Eskilsden et al., 2010). Also consistent with the research showing that features like severity and duration of the disorder contribute to CBT outcome, specific clinical features of social anxiety disorder were relatively frequently (6.65% of responses) nominated as contributing to CBT outcome.

Intellect and reasoning ability were nominated frequently as factors contributing to good CBT outcome (8.46% of all responses). This opinion is at odds with the very few empirical studies which have examined intelligence in general and found that it is not a predictor of CBT outcome for those with anxiety disorders (see Newman, et al., 2006 for a review). The empirical research on intellect and reasoning ability, however, is scarce and it may well be that the construct of intellect or reasoning ability as nominated by clinicians in this survey has not been well operationalised in empirical research. Rather than measuring intelligence in general and examining IQ scores as predictors of treatment outcome, it may well be that there is a particular kind of reasoning, that is predictive of better CBT outcome. Perhaps this sort of reasoning is captured by another category of response provide by clinicians, namely, psychological mindedness which was nominated in 6% of responses as contributing to CBT outcome. The construct of psychological mindedness, although originally coined

TABLE 2
Mean Rating of Importance of Client Characteristics

Client characteristic	*M*	*s*
Willingness to experiment with new ways of thinking and behaving	4.31	.72
Acceptance of CBT rationale/model	4.25	.67
Ability to take responsibility for change	4.13	.70
Motivation for seeking treatment	4.08	.82
Ability to form an alliance with the therapist	4.08	.82
Self-efficacy for change	3.94	.93
Ability to acknowledge the existence of alternative view points	3.88	.87
Locus of control	3.65	.89
Expectations about treatment	3.52	.90
Self-awareness of emotions	3.40	.74
Problem-solving ability	3.08	.74
Personality/temperament	3.06	.91
Intellect	2.92	.90
Interpersonal style	2.85	.77

and examined within the psychodynamic literature has more recently been proposed as an important factor to examine for all psychotherapies, including CBT (e.g., Grant, 2001).

Analysis of Responses to the Checklist of Client Characteristics

Besides nominating characteristics that they thought were important in contributing to good or poor CBT outcome, clinicians also rated the importance of 14 characteristics in contributing to CBT outcome. The mean ratings for each of the characteristics are presented in Table 2. As the characteristics were rated on a 5-point Likert scale, any characteristics with a mean equal to or greater than 4 was identified as being important to the CBT outcome. Of the 14 characteristics that were rated by each participant, willingness to experiment with new ways of thinking and behaving, acceptance of CBT rationale/model, ability to take responsibility for change, motivation/reason for seeking treatment, and ability to develop an alliance with the therapist have mean ratings over 4. Self-efficacy for change and ability to acknowledge the existence of alternative viewpoints had mean scores close to 4. The characteristic rated as most important in contributing to good CBT outcome was willingness to experiment with new ways of thinking and behaving. This is a client characteristic that has not been directly addressed in the empirical research examining predictors of CBT outcome and may well provide an avenue for future research. The second most important characteristic as rated by clinicians was acceptance of the CBT model or rationale. Together, the two characteristics rated as most important by the clinicians (willingness to experiment and acceptance of the CBT model) are specific to CBT rather than characteristics that might be important in treatment in general (e.g., motivation). The higher mean importance ratings for these characteristics may be related to the fact that the clinicians participating in the study were recruited based on their interest in CBT. Nevertheless, the importance of acceptance of the CBT rationale is consistent with

the empirical literature which suggests that acceptance of the treatment rationale (often opeartionalised as credibility of the treatment) is an important predictor of CBT outcome (e.g., Safren, Heimberg, & Juster, 1997).

While the results of this survey are important because they include the clinician perspective in research, they should be interpreted in the light of at least one caveat — while clinicians were asked to provide their opinions based on their clinical experience, it may be that they were reporting characteristics that they were aware of as being important, based on the empirical literature examining predictors of CBT outcome. Nevertheless, the opinions of clinicians in this survey provide avenues for future research into client characteristics that have yet to be examined empirically as predictors of treatment outcome. Future research examining specific client characteristics, such as willingness to experiment with new ways of thinking and behaving and motivation, may lead to enhancements to CBT programs that provide better outcomes for clients with social anxiety disorder. The research also has some clinical implications; namely, when assessing clients with a view to embarking upon CBT with them, it may be useful for clinicians to focus on specific characteristics of the client in order to evaluate whether there are factors that may be capitalised upon to enhance outcomes (e.g., motivation) or factors which may need to be addressed prior to CBT (e.g., comorbidity).

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders*. Washington, DC: American Psychiatric Association.

American Psychological Association Division 12 Committee on Building a Two-Way Bridge Between Research and Practice. (2010). Clinicians' experiences in using and empirically support treatment (EST) for panic disorder: Results of a survey. *The Clinical Psychologist*, *63*, 10–20.

Australian Bureau of Statistics. (2007). *National Survey of Mental Health and Wellbeing: Summary of results* (Cat. no. 4326.0). Canberra, Australia: Author.

Clark, D., & Wells, A. (1995). A cognitive model of social phobia. In R. Heimberg, M. Liebowith, D.A. Hope, & F.R. Schneier (Eds), *Social phobia: Diagnosis, assessment and treatment* (pp. 69–73). New York: Guilford.

Eskildsen, A., Hougaard, E., & Rosenberg, N.K. (2010). Pre-treatment patient variables as predictors of drop-out and treatment outcome in cognitive behavioural therapy for social phobia: A systematic review. *Nordic Journal of Psychiatry*, *64*, 94–105.

Federoff, I., & Taylor, S. (2001). Psychological and pharmacological treatments of social phobia: A meta-analysis. *Journal of Clinical Psychopharmacology*, *21*, 311–324.

Grant, A.M. (2001). Rethinking psychological mindedness: Metacognition, self-reflection, and insight. *Behaviour Change*, *18*(1), 8–17.

Mathers, C., Stevenson, C.E., & Begg, S.J. (2000). The Australian Burden of Disease study: Measuring the loss of health from disease, injuries and risk factors. *Medical Journal of Australia*, *172*, 592–596.

Mattick, R.P., & Peters, L. (1988). Treatment of severe social phobia: Effects of guided exposure with and without cognitive restructuring. *Journal of Consulting and Clinical Psychology*, *56*, 251–260.

Mattick, R.P., Peters, L., & Clarke, J.C. (1989). Exposure and cognitive restructuring for social phobia: A controlled study. *Behavior Therapy*, *20*, 3–23.

Newman, M.G., Crits-Christoph, P., Gibbons, M.B.C., & Erickson, T.M. (2006). Participant factors in treating anxiety disorders. In L.G. Castonguay & L.E. Beutler (Eds.), *Principles of therapeutic change that work*. New York: Oxford University Press.

Norton, G., McLeod, L., Guertin, J., Hewitt, P.L., Walker, J.R., & Stein, M.B. (1996). Panic disorder or social phobia: Which is worse? *Behaviour Research and Therapy*, *34*, 273–276.

Pollard, C.A. (2007). Treatment readiness, ambivalence, and resistance. In M.M. Antony, C. Purdon, & L.J. Summerfeldt (Eds.), *Psychological treatment of obsessive-compulsive disorder: Fundamentals and beyond*. Washington, DC: APA.

Rapee, R., Gaston, J., & Abbott, M. (2009). Testing the efficacy of theoretically-derived improvements in the treatment of social phobia. *Journal of Consulting and Clinical Psychology*, *77*, 317–327.

Rapee, R., & Heimberg, R. (1997). A cognitive-behavioural model of anxiety in social phobia. *Behaviour Research and Therapy*, *35*, 741–756.

Rodebaugh, T., Holaway, R.M., & Heimberg, R.G. (2004). The treatment of social anxiety disorder. *Clinical Psychology Review*, *24*, 883–908.

Safran, J.D., Segal, Z.V., Shaw, B. F., & Vallis, T.M. (1990). Patient selection for short-term cognitive therapy. In J.D. Safran & Z.V. Segal (Eds.). *Interpersonal process in cognitive therapy*. New York, NY: Basic Books.

Safren, S.A., Heimberg, R.G., & Juster, H.R. (1997). Client expectancies and their relationship to pretreatment symptomatology and outcome of cognitive-behavioral group treatment for social phobia. *Journal of Consulting and Clinical Psychology*, *65*, 694–698.

Van Dyke, M.M. & Pollard, C.A. (2005). Treatment of refractory Obsessive-Compulsive Disorder: The St Louis model. *Cognitive and Behavioral Practice*, *12*, 30–39.

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