Behaviour Research and Therapy 81 (2016) 21–34

Contents lists available at ScienceDirect

Behaviour Research and Therapy

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

The desire to belong: Social identification as a predictor of treatment outcome in social anxiety disorder

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ARTICLE INFO

Article history:
Received 6 July 2015
Received in revised form
11 March 2016
Accepted 30 March 2016
Available online 2 April 2016

Keywords:
Social identification
Stigma
Personality
Cognitive behavioral therapy
Social anxiety disorder
Predictor

ABSTRACT

Objective: Perception of personal identity cannot be separated from the perception of the social context and one's social identity. Full involvement in group psychotherapy may require not only the awareness of personal impairment, but also social identification. The aim of the current study was to examine the association between social identification and symptom improvement in group-based psychotherapy.
Method: 169 participants received 12 sessions of group-based cognitive behavioral therapy for social anxiety disorder. Social identification, the extent to which a person identifies with those who suffer from the same psychological problem as themselves and/or with those lacking psychopathology (non-sufferers), and clinical outcome were assessed at baseline, mid-and posttreatment, and 1, 3, and 6-months follow-up.
Results: At baseline, patients aspired for closeness with non-sufferers, and viewed themselves as distant from fellow sufferers and non-sufferers. After treatment, participants viewed not only themselves, but also other individuals with social anxiety, as closer to both non-sufferers and fellow sufferers. These ratings were related to clinical outcomes.
Conclusions: The increase in closeness to both sufferers and non-sufferers across treatment may reflect a movement towards a more tolerant, less dichotomous and rigid, separation of ill and healthy that occurs with successful social anxiety treatment.

Psychological disorders not only cause significant personal impairment (Schneier et al., 1994), they also pose a potential threat to one's identity. Social identity refers to one's construal of self through the lens of group membership (Turner & Onorato, 1999). According to social identity theory, the tendency to divide the social world into two categories, the ingroup (i.e., the group with which one identifies) or outgroup (i.e., any group other than the one with which one identifies) is an attempt to enhance one's self-esteem. This tendency is only successful if the ingroup members perceive their group as superior to competing groups (Tajfel & Turner, 1986). Consistent with stigma against mental disorders, membership in a group of individuals suffering from psychopathology may be perceived as belonging to an inferior group. Despite intensive efforts in public health education over the past decades, attitude surveys reflect an increase in such prejudice against mental disorders (Jorm & Oh, 2009; Link, Yang, Phelan, & Collins, 2004; Phelan, Link, Stueve, & Pescosolido, 2000; Schomerus et al., 2012). Individuals with mental illnesses are thus confronted on one hand, with a dual challenge of clinical symptoms and personal suffering and on the other, the potential of inclusion in a publically stigmatized group, the mentally ill. Consequently, self-stigmatization, or the acceptance of the legitimacy of negative social attitudes towards an ingroup, is common in patients with a mental disorder

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http://dx.doi.org/10.1016/j.brat.2016.03.008
0005-7967/

(Alonso et al., 2009; Corrigan & Watson, 2002; Hinshaw & Stier, 2008; Rüsch, Angermeyer, & Corrigan, 2005; Watson, Corrigan, Larson, & Sells, 2007).

One way to cope with stigma-related threat is to view oneself as dissimilar and refuse to identify with the devalued social group (Allport, 1954; Quinn & Chaudoir, 2009; Smart & Wegner, 2000). While it is easier to distance oneself from the devalued group when group membership is not obvious and can be hidden, "concealable stigma", (Goffman, 1986; Clair, Beatty, & MacLean, 2005), denial of a devalued identity has also been shown to be associated with aggravated distress (Barreto, Ellemers, & Banal, 2006; Crocker, Major, & Steele, 1998; Jacoby, Snape, & Baker, 2005; Smart & Wegner, 1999) and reduced treatment compliance (Fung, Tsang, & Corrigan, 2008; Sirey et al., 2001). Furthermore, strong accentuation of the dichotomy between "normal" and "abnormal" may increase perceived illness stigma in individuals who identify themselves as "mentally ill." Identification with a devalued group may only be empowering if individuals believe that the distinctions between their devalued group and a more valued outgroup is small and the perceived status differences between groups (and the legitimacy of socially constructed differences) are questionable (Campbell & Jovchelovitch, 2000). Thus, the subjective "distance" of the self to the ingroup and to a relevant outgroup may be highly relevant to treatment progress, particularly in group-based therapy. Because the perception of personal identity cannot be separated from the perception of the social context and one's social identity (Mischel & Shoda, 1995; Mendoza-Denton, Ayduk, Mischel, Shoda, & Testa, 2001; Onorato & Turner, 2004), psychotherapy engagement may not only require awareness of personal impairment, but also acceptance of this social identification (Petersen, van den Berg, Janssens, & Van den Bergh, 2011).

Notably, identification with groups is not completely stable and can change over time as a person accumulates new information, moves to new contexts, and adds more positively valenced content to the group identity (Quinn & Chaudoir, 2009). Therefore, it is reasonable to hypothesize that group identification can change over the course of therapy, and such change could relate to progress during treatment. In support of this notion, a recent study on substance abuse found that identity transition (change in identification from a "user identity" to a "recovery identity") accounted for a substantial amount of variance in post-treatment drinking behavior change, even when controlling for traditional factors (e.g., session attendance, substance use severity/duration) (Dingle, Stark, Cruwys, & Best, 2015).

Identification with a low status group as one's ingroup has been shown to reduce self-stigmatization and lead to empowerment (Rosenthal & Crisp, 2006), including in mental disorders (Crabtree, Haslam, Postmes, & Haslam, 2010; Rüsch, Lieb, Bohus, & Corrigan, 2006). Similarly, Cruwys et al. (2014) found that members of a group-based CBT program for depression who more strongly identified with other group members showed superior improvements compared to those who did not. A robust body of research examining the impact of connectedness and social identification on mental and physical health, indicates that group identification is advantageous in general. For example, Sani, Madhok, Norbury, Dugard, and Wakefield (2015) showed that the greater the number of groups an individual identifies with, the lower their level of depression (Sani et al., 2015). Likewise, stronger national identification is linked to lower rates of posttraumatic stress disorder for individuals living in a region with ongoing violence and conflict (Muldoon & Downes, 2007). Further evidence comes from Wakefield, Bickley, and Sani (2013) who demonstrated that higher degrees of subjective group identification (i.e., one's sense of belonging to a group) was associated with decreased depression and anxiety, as well as increased life satisfaction in multiple sclerosis (MS) patients. Moreover, change in perceived norms in young women undergoing a body acceptance group program (e.g., members arguing against distorted weight ideals), indicated greater identification with the other members of the group and mediated reductions in disordered eating (Cruwys, Haslam, Fox, & McMahon, 2015). Taken together, these studies indicate that social/group identification could be an important, yet largely neglected, factor influencing therapeutic change.

The aim of the current study was to examine group identification as a time-varying predictor of symptom improvement in patients undergoing 12-sessions of group CBT for social anxiety disorder (SAD). We hypothesized that increases in identification with the ingroup and a reduction of accentuation between the categories "health" and "disease" would be associated with therapeutic success, although the direction of this relation is unclear at this time. To assess social identification we used an adapted version the Overlap of Self, Ingroup, and Outgroup (OSIO) scale, a validated measure used in social psychology (Schubert & Otten, 2002).

1. Methods

1.1. Participants

The sample consisted of 169 outpatients with a diagnosis of social anxiety disorder (SAD). The sample was part of a larger study examining the efficacy of d-cycloserine as an augmentation strategy of cognitive behavioral therapy for SAD (Hofmann et al., 2013). Patients were primarily white (61.5%), male (56.8%), and single (66.9%), with the majority having a college degree. The mean age was 32.6 years ($SD = 10.36$) (see Hofmann et al., 2013 for more details). Inclusion criteria were current DSM-IV diagnostic criteria for generalized SAD (First, Spitzer, Gibbon, & Williams, 1996; DiNardo, Brown, & Barlow, 1994),[1] a score 60 or higher on the Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987), age 18–65, and agreement not to initiate concurrent psychotherapy or psychotropic medication. Exclusion criteria included: 1) major medical or cognitive illness, 2) drug abuse/dependence, eating disorder or PTSD diagnosis, clinically significant suicidal ideation or behavior in past 6 months, and 3) pregnancy, lactation, or not using medically accepted forms of contraception when of childbearing age. The study was approved by institutional review boards and written informed consent was obtained from all participants.

1.2. Study design and treatment

Eligible participants at three sites (Boston University, Massachusetts General Hospital, and SMU) received identical 12-session CBT protocols. Patients were randomized to receive either 50 mg of DCS ($N = 87$) or an identical looking placebo pill ($N = 82$) during sessions 3–7. The protocol and timing (12 weekly 2.5-h sessions) followed Heimberg's cognitive behavioral group therapy approach (Heimberg & Becker, 2002), with modified emphasis on exposure strategies (Hofmann, 2007). Session 1 educated patients about the nature and treatment of SAD. Session 2 introduced patients to cognitive restructuring. Session 3–7 focused on exposure therapy where patients were led through repeated and prolonged confrontation of feared situations. Session 8–12 combined the use of cognitive restructuring strategies with exposure practice. Each treatment group was led by two therapists and was comprised of 4–6 patients. In-depth training and close monitoring through

[1] Integrity and reliability of diagnoses was ensured by certification training and weekly supervision and feedback based on approximately 20% of the audio recorded assessment interviews (see Hofmann et al., 2013 for more details).