



## Shorter communication

## Imagery-enhanced cognitive behavioural group therapy for social anxiety disorder: A pilot study

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## ABSTRACT

Cognitive behavioural group therapy (CBGT) for social anxiety disorder (SAD) is efficacious and effective, however a substantial proportion of patients remain in the clinical range so treatment innovations are required. Research suggests that working within the imagery mode may be more emotionally potent than traditional verbal-linguistic strategies. This study piloted an imagery-enhanced CBGT (IE-CBGT) protocol for SAD. It was hypothesised that IE-CBGT would be acceptable to patients, demonstrate large effect sizes, and compare favourably to historical controls who completed CBGT without the imagery-enhancements. Patients ( $N = 19$ ) were consecutive referrals to a community clinic specialising in anxiety and mood disorders. Primary outcomes were self-reported performance and social interaction anxiety. IE-CBGT was highly acceptable to patients with high attendance and completion rates. Effect sizes were large by mid-treatment and very large at post-treatment and follow-up. A high proportion of patients achieved reliable change. Outcomes compared favourably to published group and individual treatments for SAD but larger randomised controlled trials are now required.

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## Introduction

Social anxiety disorder (SAD) is characterised by significant and persistent fear or anxiety in situations where an individual is exposed to possible scrutiny by others, such as interacting socially, being observed, or performing in front of others (American Psychiatric Association, APA, 2013). SAD is common, chronic, debilitating, and is one of the earliest onset anxiety disorders (Andrews, Henderson, & Hall, 2001; McEvoy, Grove, & Slade, 2011). Cognitive behavioural therapy for SAD has demonstrated efficacy within randomised controlled trials (RCTs, Rapee, Gaston, & Abbott, 2009) and effectiveness within real world community clinics (Lincoln et al., 2003; McEvoy, Nathan, Rapee, & Campbell, 2012). However, a substantial proportion of patients completing gold-standard treatments remain symptomatic so treatment innovations are required.

Cognitive theories suggest that negative images are important maintaining factors of emotional disorders in general (Holmes &

Mathews, 2010) and SAD in particular (Rapee & Heimberg, 1997). According to Clark and Wells' (1995) model of SAD, self-focused attention results in the construction of negative self-images viewed from the perspective of others. Rather than being an accurate impression, these negative images reflect the individual's feared outcome (Hackmann, Clark, & McManus, 2000) and are imbued with a threatening meaning, such as "I look like an idiot and will be rejected" (Chiupka, Moscovitch, & Bielak, 2012). Consistent with these theories, studies of SAD (e.g., Hackmann et al., 2000) and high social anxiety (Chiupka et al., 2012) have demonstrated that between 90% and 100% of individuals report experiencing negative social images. Experimental studies have also found that holding a negative image in mind is associated with greater anxiety, higher self-ratings of anxiety visibility, more negative self-cognitions and performance appraisals, increased safety behaviours, poorer performance ratings by conversational partners, increased self-focus, and more negative post-event processing (e.g., Hirsch, Meynen, & Clark, 2004). Contemporary CBT protocols incorporate video-feedback to correct distorted self-images and associated meanings (e.g., Rapee et al., 2009).

Hackmann et al. (2000) found that recurrent intrusive images in their SAD sample were often associated with early traumatic social experiences occurring around the time of disorder onset. Imagery rescripting (IR) targeting past traumatic events has been

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incorporated in comprehensive manuals or as a stand-alone treatment for a range of clinical problems, including post-traumatic stress disorder (Grunert, Smucker, Weis, & Rusch, 2003), depression (Brewin et al., 2009), and more recently in SAD (Wild, Hackmann, & Clark, 2008). One CBT trial for SAD found that a protocol including IR was superior to in vivo exposure with applied relaxation (Clark et al., 2006). Subsequent small clinical trials have found that IR in SAD is associated with significant improvements in negative social beliefs, the vividness and distress of negative images and early memories, fear of negative evaluation, and social anxiety symptoms (Frets, Kevenaar, & van der Heiden, 2014; Lee & Kwon, 2013; Nilsson, Lundh, & Viborg, 2012; Wild, Hackmann, & Clark, 2007, 2008). These studies provide proof of concept and suggest that IR may be a powerful technique for treating SAD. However, to date IR has only been conducted individually, so it is unknown whether it could potentiate greater improvements within cognitive behavioural group therapy (CBGT).

Imagery is characterised as sensory-perceptual representations that may have visual, somatic, auditory, olfactory, and/or gustatory elements, and which have particularly strong links to both positive and negative emotions (Holmes & Mathews, 2010). For instance, one study found that compared to verbal processing instructions, cognitive bias modification training involving imagery was more powerful at changing emotion and interpretations (Holmes, Lang, & Shah, 2009). Compared to verbal thoughts, images are more potent in triggering emotional responses because they share similar neural mechanisms as the perceptual experiences one obtains from direct sensory experiences (Brewin, Gregory, Lipton, & Burgess, 2010). These findings have been replicated and extended to naturalistic settings (e.g., Holmes, Mathews, Dalgleish, & Mackintosh, 2006). A review by Holmes and Mathews (2010) concluded that "...images appear to act as 'emotional amplifiers' for both positive and negative information" (p. 353), and speculated that cognitive restructuring using imagery, rather than verbal representations, would have greater impacts on therapeutic outcomes. It may be that integrating imagery-based techniques into all treatment components (e.g., behavioural experiments, attention retraining) could enhance emotional change, and there is evidence that imagery facilitates access to negative core beliefs (Pratt, Cooper, & Hackmann, 2004).

The main aim of this study was to pilot a new, imagery-enhanced CBGT protocol (IE-CBGT) for SAD. In addition to including video-feedback and IR, the IE-CBGT protocol exploits the strong relationship between imagery and emotion by using imagery-based techniques in all components of the program. The first hypothesis was that IE-CBGT would be acceptable to patients and thus attrition would be low. The second hypothesis was that effect sizes on symptoms of social interaction and performance anxiety would be large. The third hypothesis was that the IE-CBGT would compare favourably to historical controls, who completed a gold standard CBGT protocol, in terms of attrition, effect sizes, and reliable and clinically significant change.

## Method

### Participants

Participants comprised 19 consecutive referrals by health professionals (General Medical Practitioners, Psychiatrists, Psychologists) with a diagnosis of SAD to a specialist community mental health clinic. Mean age was 29.7 (SD = 11.6), 10 (53%) were women, and most were born in Australia or New Zealand ( $n = 14$ ), with the remainder from Britain ( $n = 2$ ), Asia ( $n = 2$ ), and North America ( $n = 1$ ). Inclusion criteria were (a) a Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; APA, 1994) SAD diagnosis, (b)

not currently actively suicidal, self-harming, or experiencing psychosis, and (c) a level of substance use judged by the assessing clinician as unlikely to significantly interfere with engagement in treatment. The Mini International Neuropsychiatric Interview (MINI PLUS 5.0; Sheehan et al., 2001) was administered by masters- or doctorate-level clinical psychologists to establish Axis I disorders. The MINI has good validity and converges with other structured interviews (e.g., Sheehan et al., 1997). The most common comorbid disorders were major depression and/or dysthymia ( $n = 10$ ) and generalized anxiety disorder ( $n = 6$ ). Patients and assessing clinicians made a collaborative decision to attend IE-CBGT if SAD was considered to be the most debilitating problem. Written informed consent was provided for de-identified data to be used for evaluation purposes.

### Outcome measures

*Social Phobia Scale (SPS) & Social Interaction Anxiety Scale (SIAS; Mattick & Clarke, 1998)*. The SPS and SIAS are widely used, 20-item measures of performance and interaction anxiety, respectively. The SPS describes situations in which the person is the focus of attention and observed by others, such as eating, drinking, and writing. The SIAS contains items reflecting cognitive, affective, and behavioural reactions to interaction situations, such as nervousness when speaking to authority figures or mixing with people. The 5-point response scale for both scales is *Not at all, Slightly, Moderately, Very, or Extremely* characteristic of me. Internal reliabilities for the SPS ( $\alpha = .89$ ) and SIAS ( $\alpha = .93$ ) are high within clinical samples and these scales have been shown to be sensitive to change (Cox, Ross, Swinson, & Drenfeld, 1998; Mattick, Peters, & Clarke, 1989). Twelve-week test-retest reliabilities are high for both the SPS ( $r = .93$ ) and SIAS ( $r = .92$ , Mattick & Clarke, 1998).

### Procedure & treatment

IE-CBGT comprised 12 weekly, 2-h sessions plus a one-month follow-up. Questionnaires were completed prior to the initial assessment (T0) and at treatment sessions 1 (T1), 4 (T4), 8 (T8), 12 (T12), and the one-month follow-up (T13). Treatment integrity was encouraged by the use of a 187-page treatment manual with detailed therapist instructions, patient handouts, and worksheets (McEvoy & Saulsman, 2013). The co-authors facilitated the first group ( $n = 8$ ) and the first author co-facilitated the second group with another clinical psychologist ( $n = 11$ ). The IE-CBGT protocol was modified from a manual demonstrated to be efficacious (Rapee et al., 2009) and effective (McEvoy et al., 2012). The same treatment model and principles were followed in the IE-CBGT protocol with the modifications detailed below. Table 1 summarises some of the key differences between the IE-CBGT and historical control treatments (see Rapee et al., 2009, and McEvoy et al., 2012 for more detail about the historical control treatment). Many imagery-based strategies in the IE-CBGT manual were modified for a group setting from those described in Hackmann, Bennet-Levy, and Holmes (2011).

Session 1 involved socialising patients to identifying and working with negative past, present, and future social images. Patients were instructed to transform negative thoughts into images with the rationale that (a) imagery often encourages more specificity than verbal descriptions, which allows for more targeted cognitive modification, and (b) research suggests that imagery has stronger associations with emotions than thoughts. Patients monitored thoughts and images and their multisensory qualities between sessions 1 and 2.

Session 2 involved imagery challenging, including a description of negative social imagery, rating associated Subjective Units of

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