



The efficacy of Imagery Rescripting (IR) for social phobia: A randomized controlled trial



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ABSTRACT

Background and objectives: There is a need for brief effective treatment of social phobia and Imagery Rescripting (IR) is a potential candidate. The purpose of this study was to examine the efficacy of IR preceded by cognitive restructuring as a stand-alone brief treatment using a randomized controlled design.

Methods: Twenty-three individuals with social phobia were randomly assigned to an IR group or to a control group. Participants in the IR group were provided with one session of imagery interviewing and two sessions of cognitive restructuring and Imagery Rescripting. Those in the control group had one session of clinical interviewing and two sessions of supportive therapy. Outcome measures including the Korean version of the Social Avoidance and Distress Scale (K-SADS) were administered before and after treatment, and at three-month follow-up. The short version of the Questionnaire upon Mental Imagery and the Traumatic Experience Scale were also administered before treatment.

Results: Participants in the IR group improved significantly on K-SADS and other outcome measures, compared to the control group. The beneficial effects of IR were maintained at three-month follow-up. It was also found that mental imagery ability and the severity of the traumatic experience did not moderate the outcome of IR.

Limitations: Further studies are needed to replicate the findings of our study using a large sample.

Conclusions: The efficacy of IR as a stand-alone brief treatment was demonstrated for social phobia. The findings indicate that IR could be utilized as a cost-effective intervention for social phobia.

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1. Introduction

Social phobia is a common and enduring anxiety disorder in which images of the self play an important role in maintaining social anxiety. According to the cognitive model developed by Clark and Wells (1995), when individuals with social phobia feel threatened by social situations, they switch their attention from external stimuli to their internal state and construct distorted self-images based on their increased perceptions of bodily sensations. Further, they are convinced that others will see them as they appear in these images, and that this will lead to negative evaluation. Hackmann, Surawy, and Clark (1998) demonstrated that socially phobic individuals were more likely than controls to report experiencing visual images when anxious in social situations. Their images were significantly more negative and more likely to involve seeing themselves from an observer perspective. It was also found

that their negative self-images were recurrent and associated with memories of traumatic early social experiences (Hackmann, Clark, & McManus, 2000).

Negative self-image has adverse effects on individuals with social phobia in many ways. First, holding a negative image in mind increases anxiety, self-focused attention, and safety behaviors, and thus undermines effective social performance (Hirsch, Clark, Mathews, & Williams, 2003; Vassilopoulos, 2005). Second, individuals with social phobia will judge their performance based on covert information such as bodily sensations and the negative self-imagery that is activated in anxiety-provoking social situations (Clark & Wells, 1995; Rapee & Heimberg, 1997). Third, negative self-images can also play a role in post-event processing. James (2005) found that highly socially anxious individuals had more negatively valenced images during post-event processing than did less socially anxious individuals. Finally, as their negative self-images repeatedly emerge, individuals are likely to accept those images as accurate representations of their present selves (Butler, Fennell, & Hackmann, 2008). In sum, negative self-image, which increases self-focused attention, negative interpretation bias, and safety behaviors, is central to the maintenance cycle of social phobia.

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One of the key components of the successful treatment of social phobia, therefore, is to help sufferers to view themselves in a more realistic way through replacing their negative self-imagery with a realistic alternative. In cognitive behavior therapy (CBT), guided discovery, the surveying of other people's observations and behavioral experiments have all been used to challenge negative self-image and self-beliefs in socially anxious individuals. Video feedback has proved a particularly powerful way of restructuring distorted self-imagery. Most techniques rely heavily on verbal processing with less emphasis having been placed on imagery. However, emerging evidence has encouraged a renewed interest in the use of imagery as a therapeutic strategy. For example it was demonstrated that, in comparison with verbal processing, imagery had a greater impact on anxiety (Holmes & Mathews, 2005). Pratt, Cooper, and Hackmann (2004) showed that imagery provides a rapid way to access deeper levels of beliefs, including assumptions and core beliefs, when compared to information obtained via verbal cognitions.

The use of Imagery Rescripting (IR) with traumatic memories was inspired by the seminal work of Arntz and Weertman (Arntz & Weertman, 1999; Weertman & Arntz, 2007). They devised a therapeutic procedure in which patients revisit adverse early events with an adult perspective. It aims to update the meaning of these events through the use of imagery. First, it involves identifying a childhood memory laden with negative schematic meaning, asking patients to relive the memory from the child's perspective. Then they relive it at their current age, watching what happens to their younger self and may intervene. Finally they relive it from the perspective of the younger self with the adult self present. This time the younger self is often asked what else he/she might need to happen in order to feel better, and receives further interventions from the adult self. The powerful effects of the procedure have been reported for personality disorders (Giesen-Bloo et al., 2006; Weertman & Arntz, 2007), post-traumatic stress disorder (Arntz, Tiesema, & Kindt, 2007; Grunert, Weis, Smucker, & Christianson, 2007), ophidiophobia (Hunt & Fenton, 2007), and depression (Wheatley, Brewin, Patel, & Hackmann, 2007).

The first attempt to use IR for social phobia was made by Wild, Hackmann, and Clark (2008) and was built on the Arntz and Weertman (1999) three-stage procedure, but differed in that cognitive restructuring was included. The results indicated that IR decreased distress in response to the image and allow individuals to modify the self-beliefs encapsulated in the image. It also produced significant decreases in social anxiety and fears of negative evaluation, thus indicating the potential role of IR as a therapeutic method. Although this study was seminal in demonstrating the substantial benefits of IR for social phobia, it had methodological limitations because it used a within-subject design and a small sample size. Following from this pioneering study, Nilsson, Lundh, and Viborg (2012) tested the efficacy of IR without cognitive restructuring using an experimental between-groups design. Similar to the findings of Wild et al. (2008), IR led to significant improvements in memory and image distress. Decreases in social anxiety and fears of negative evaluation were also demonstrated. These findings suggest that IR by itself can be a powerful intervention tool for social phobia. However, in both studies IR was not regarded as a viable stand-alone treatment option and so its long-term effect was not examined.

The current study was designed to examine the efficacy of IR as a stand-alone intervention for social phobia using a randomized controlled trial. Previous research has shown that IR can reduce both the vividness of the early traumatic memory and the distress it causes, and allow changes in beliefs encapsulated in the image. It has also been found to lead to significant decreases in

social anxiety and fears of negative evaluation. As was earlier discussed, negative self-imagery is a key maintaining factor in the persistence of social phobia. We propose that IR will be able to bring about changes in negative self-imagery and self core-beliefs, and thus lead to clinical improvement in social phobia. In our preliminary clinical trial, social phobic individuals showed very positive responses to IR including decreases in social anxiety symptoms, fears of negative evaluation, and avoidance behaviors, and did not feel the need for additional treatment after IR. Yoon and Kwon (2010) reported that short-term IR led to dramatic improvement in a Korean socially phobic patient who had not received benefit from group CBT. Recent research examining the efficacy of IR for other disorders has also indicated the therapeutic potential of IR as a stand-alone treatment (Brewin et al., 2009).

According to an internet-based survey, only one third of respondents with social phobia had received treatment, despite the severity of their disorder (Erwin, Turk, Heimberg, Fresco, & Hantula, 2004). In the absence of treatment, this disorder is very likely to run a chronic course (Dewit, Ogborne, Offord, & MacDonald, 1999). Therefore, one of the clinical issues which needs to be addressed in the treatment of social phobia is the accessibility and affordability of evidence-based psychological treatments. In Korea, the availability of CBT has thus far been limited by its cost and the lack of trained practitioners, and therefore there is a great need for an effective and brief therapeutic intervention.

In the current study we aimed to examine the efficacy of IR as a stand-alone intervention for social phobia. This study followed the procedure used by Wild et al. (2008), which enhanced the usual IR with cognitive restructuring.¹ We further attempted to strengthen the efficacy of IR by adding one more session. In our preliminary trial, it was found that patients were better able to consolidate the benefits of the intervention when they had at least two sessions of IR. We predicted that IR would, as compared to the control condition, result in fewer symptoms of social anxiety, reduced fears of negative evaluation, less memory distress, and reduced image vividness and frequency. We also tried to improve some of the methodological limitations of previous studies. First, we used a randomized controlled trial to improve the internal validity of the study. Second, we investigated whether the therapeutic effects were maintained at three months after treatment instead of using a short follow-up period of one week. Third, we also examined the relationship between imagery ability and the outcome of the intervention. There are individual differences in people's ability to use an imagery-based technique, and some individuals may experience difficulty with the task of recalling and creating images. At the moment there is not enough evidence to determine whether imagery ability moderates the efficacy of IR or not. It was found that imagery ability did not affect the efficacy of IR for simple phobia (Hunt & Fenton, 2007). We examined whether imagery ability would moderate the efficacy of IR for social phobia. In addition, we examined whether the severity of traumatic experience would affect the efficacy of IR. When IR was used as a brief stand-alone treatment for depressed patients, it was shown that patients reporting additional memories tended to have more treatment sessions and a larger drop on the BDI (Brewin et al., 2009). Unfortunately, the relationship between the severity of traumatic experience and the outcome was not examined in this study. Therefore our study attempted to explore how the severity of traumatic experience will affect the treatment effect of IR.

¹ The intervention could be described precisely as IR with cognitive restructuring, but the term IR was used for brevity.

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