



Imagery enhancements increase the effectiveness of cognitive behavioural group therapy for social anxiety disorder: A benchmarking study



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ABSTRACT

Emerging evidence suggests that imagery-based techniques may enhance the effectiveness of traditional verbal-linguistic cognitive interventions for emotional disorders. This study extends an earlier pilot study by reporting outcomes from a naturalistic trial of an imagery-enhanced cognitive behavioural group therapy (IE-CBGT, $n = 53$) protocol for social anxiety disorder (SAD), and comparing outcomes to historical controls who completed a predominantly verbally-based group protocol ($n = 129$). Patients were consecutive referrals from health professionals to a community clinic specialising in anxiety and mood disorders. Both treatments involved 12, two-hour group sessions plus a one-month follow-up. Analyses evaluated treatment adherence, predictors of dropout, treatment effect sizes, reliable and clinically significant change, and whether self-reported tendencies to use imagery in everyday life and imagery ability predicted symptom change. IE-CBGT patients were substantially more likely to complete treatment than controls (91% vs. 65%). Effect sizes were very large for both treatments, but were significantly larger for IE-CBGT. A higher proportion of the IE-CBGT patients achieved reliable change, and better imagery ability was associated with larger symptom change. Outcomes compared very favourably to published group and individual treatments for SAD, suggesting that IE-CBGT may be a particularly effective and efficient mode of treatment delivery.

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Social anxiety disorder (SAD) is characterised by significant and persistent anxiety when exposed to possible scrutiny by others (American Psychiatric Association, APA, 2013). SAD is one of the most common anxiety disorders, has an early age of onset (median 12 years), and can be highly debilitating (Andrews, Henderson, & Hall, 2001; McEvoy, Grove, & Slade, 2011). Cognitive behavioural therapy (CBT) is highly efficacious within research settings (Clark et al., 2003, 2006; Rapee, Gaston, & Abbott, 2009) and effective within community clinics (McEvoy, Nathan, Rapee, & Campbell, 2012). However, a significant minority of patients remain symptomatic after CBT (McEvoy et al., 2012), so further treatment innovations are required. A recent pilot of an imagery-enhanced group CBT protocol (IE-CBGT) found high attendance rates and very large effect sizes

(McEvoy & Saulsman, 2014). The aims of this study were to extend these pilot data by including a larger clinical sample, examining weekly trajectories of change, and examining whether general imagery use and imagery ability moderate outcomes from IE-CBGT.

Cognitive theories of emotion (Holmes & Mathews, 2010) and SAD in particular (Heimberg, Brozovich, & Rapee, 2014; Ng, Abbott, & Hunt, 2014) suggest that negative imagery contributes to the maintenance of emotional disorders. Imagery has been defined as multisensory-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). Rapee and Heimberg's (1997) cognitive behavioural model suggests that individuals with SAD construct a mental representation of the self as seen by others (i.e., the observer perspective), which is guided by a "pre-existing image, stored in long-term memory and based on feedback from others, actual images of the self (e.g., from mirrors, photographs, etc.), and

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prior experiences in a given situation. (p. 744).” An individual’s mental representation of the self is also guided by preferential attention on both internal experiences (e.g., physical sensations of blushing) and perceived external indicators of evaluation (e.g., others’ non-verbal and verbal behaviour). The model argues that individuals with SAD attempt to formulate the audience’s performance standard and then determine whether or not this standard is being met, with any discrepancy being used to guide the perceived likelihood and costs of evaluation. The anticipation of evaluation then results in a range of physiological, cognitive, and behavioural effects that reinforce the individual’s negative mental representation of the self (Heimberg et al., 2014). Rapee and Heimberg (1997) argue that the process is the same whether the situation is being experienced, anticipated or reflected on. Therefore, images about the self and the consequences of evaluation can be present before, during, and after social situations.

Research has shown that negative imagery is common in high socially anxious individuals (Moscovitch, Garvric, Merrifield, Bielak, & Moscovitch, 2011), ubiquitous in individuals with SAD (Hackmann, Clark, & McManus, 2000), and features in both anticipatory and post-event processing in relation to social stressors (Chiupka, Moscovitch, & Bielak, 2012). Importantly, these negative social images reflect the individual’s feared outcomes rather than being reality based, and they serve to reinforce negative self-appraisals and expectations of negative evaluation from others (Hackmann et al., 2000). Experimental studies have found that negative imagery exacerbates anxiety, increases the use of avoidant behaviours, increases self-focused attention, results in more negative self-appraisals, and interferes with social performance (Hirsch, Clark, Mathews, & Williams, 2003; Hirsch, Meynen, & Clark, 2004). These findings suggest that negative imagery is an important treatment target for SAD.

There is also evidence that imagery is a more potent facilitator of cognitive and affective change more generally compared to verbal-linguistic activity (Holmes, Lang, & Shah, 2009; Holmes & Mathews, 2010). Cognitive interventions within the imagery mode may therefore potentiate greater affective shifts in treatment compared to verbal techniques. McEvoy and Saulsman’s (2014) pilot study (N = 19) found an imagery-enhanced cognitive behavioural group therapy protocol (IE-CBGT) for SAD to be associated with high retention (95%), large effect sizes, and a high proportion of patients achieving reliable improvement. The main components in the IE-CBGT protocol were based on those in existing efficacious and effective group (Rapee et al., 2009) and individual (Clark et al., 2003) treatments, with adaptations to ensure each component was delivered in imagery mode. For example, imagery was used prior to cognitive restructuring and behavioural experiments to elicit specific beliefs, and afterwards to envisage more realistic conclusions. Metaphorical (‘coping’) imagery was developed to assist patients with tolerating anxiety during behavioural experiments, and positive imagery was used to develop and road-test new core beliefs. Video-feedback was used to modify negative self-images (Harvey, Clark, Ehlers, & Rapee, 2000), and past imagery rescripting was used to modify negative core beliefs.

Past imagery rescripting involves revisiting and modifying recurrent memories, associated images, and meanings of past traumas within imagery to alter the encapsulated meanings of the original event. Several small clinical trials with SAD patients have found that imagery rescripting alone 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 (e.g., Nilsson, Lundh, & Viborg, 2012; Wild & Clark, 2011). To our knowledge, other than the pilot study (McEvoy & Saulsman, 2014), past imagery rescripting has not previously been evaluated within a group format.

Identifying treatment moderators can aid clinical decision-making. It is plausible that individuals who naturally tend to operate within an imagery mode in their day-to-day life, and who have a greater capacity to elicit vivid imagery, would benefit more from an imagery-enhanced treatment. However, a consistent relationship between imagery ability and treatment outcomes has not been reported in the literature. Hunt and Fenton (2007) found that whilst imagery ability was associated with avoidance during an imagery induction procedure, it was unrelated to the efficacy of imagery rescripting for snake phobias. The authors note that their measure of imagery ability was suboptimal in terms of non-standard administration and only marginally acceptable internal consistency. In a small sample with SAD (N = 23), Lee and Kwon (2013) also failed to find a significant association between mental imagery ability and outcomes from imagery rescripting. Although poor imagery ability may not necessarily be an impediment to benefiting from imagery-based techniques, it is plausible that a comprehensive treatment protocol emphasising imagery within each component would be more beneficial for individuals who are able to evoke more vivid images.

The first aim of this naturalistic benchmarking study was to evaluate an IE-CBGT protocol for SAD. The current study extends an earlier pilot (McEvoy & Saulsman, 2014) by including larger IE-CBGT (N = 53, henceforth referred to as the ‘imagery-enhanced’) and historical control (N = 129) samples, and by more comprehensively assessing treatment completion and symptom change. Imagery-enhanced outcomes were compared to historical controls who attended a predominantly verbally-based CBGT protocol in three ways: (a) the proportion of patients completing treatment and mean number of sessions attended, (b) trajectories of weekly change and effect sizes, and (c) the proportion of patients achieving reliable and clinically significant change. It was hypothesised that the imagery-enhanced group would demonstrate higher attendance rates, more rapid change, larger effect sizes, and higher rates of reliable and clinically significant change, compared to the historical controls.

The second aim was to examine whether (a) self-reported tendencies to operate within an imagery mode and (b) imagery ability were associated with outcomes in the imagery-enhanced group. It was hypothesised that individuals with a stronger natural tendency to operate within the visual mode and with greater ability to evoke vivid images would benefit more from imagery-enhanced treatment.

Method

Participants

Inclusion criteria were (a) a Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; APA, 1994) SAD diagnosis, (b) no current suicidal intent, (c) no psychotic illness, and (d) 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). A maximum of three diagnoses were coded in the database. Patients and assessing clinicians made a collaborative decision for the patient to attend the social anxiety program if SAD was the most debilitating problem. Written informed consent was provided from all patients for de-identified data to be used for evaluation purposes and approval for this study was received from the health service’s Human Research Ethics Committee (QI 2014_05).

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