

## Residential cognitive therapy versus residential interpersonal therapy for social phobia: A randomized clinical trial

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### Abstract

Eighty patients meeting DSM-IV criteria for social phobia were randomly assigned to 10 weeks of residential cognitive therapy (RCT) or residential interpersonal therapy (RIPT). Subjects were assessed at pretreatment, midtreatment, posttreatment, and 1 year after end of treatment. The patients reported chronic, highly comorbid social phobia. Most had tried other treatments without success. Existing individual treatment protocols for cognitive therapy and interpersonal therapy were extensively modified for an integrated group, individual, and residential format. The RCT and RIPT patients improved significantly on the primary outcome measures from pre- to posttreatment. No significant differences were observed between treatments. Patients also completed three weekly secondary outcome measures; on one, *social role security*, RCT was superior to RIPT. The entire sample reported continued improvement from posttreatment to 1-year follow-up, indicating that improvements were robust. RCT in the present trial was associated with less improvement compared to individual CT in other recent trials.

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### 1. Introduction

Social phobia is characterized by fear of behaving ineptly and unacceptably in social or performance situations. It is a common disorder: epidemiological studies (Fresco, Erwin, Heimberg, & Turk, 2000; Kessler et al., 1994; Kringlen, Torgersen, & Cramer, 2001) have found lifetime prevalence rates of about 13%. Left

untreated, the disorder has a chronic course (DeWit, Ogborne, Offord, & MacDonald, 1999; Keller, 2003), and severely impairs social role functioning and career progression (Wittchen & Fehm, 2003). It also represents an influential risk factor for suicidal behavior (Keller, 2003). Given its prevalence, severity, and chronicity, effective treatments are greatly needed. Traditional psychological and pharmacological treatments have statistically significant but clinically limited effects (Davidson et al., 2004; Heimberg & Juster, 1995; Taylor, 1996), and relapse rates for pharmacological treatments have been high (Haug et al., 2003; Liebowitz et al., 1999).

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In the search for more effective treatments, Clark and Wells (1995) developed a cognitive model based on an empirical analysis of the cognitive processes in social phobia. The model posits that social anxiety and avoidance are maintained by: (a) beliefs characterized both by overestimation of the *probability* of negative social events (e.g., shaking in front of others) and by overestimation of their *cost*; (b) an increase in self-focused attention and monitoring, with a corresponding reduction in observation of other people and their responses; (c) the use of internal information (anxious sensations and spontaneously occurring, distorted self-images) misleading the individuals to make excessively negative inferences about how they appears to others; (d) extensive use of safety behaviors, which are intended to prevent feared catastrophes but have the consequence of maintaining negative beliefs, increasing feared symptoms, and making patients come across to others in ways that are likely to elicit less friendly responses; (e) the use of negatively biased anticipatory and postevent processing, and (f) underlying assumptions of excessively high standards for social performance (e.g., “I must not show any signs of weakness”), conditional beliefs concerning social evaluation (e.g., “If I show feelings or make mistakes, others will reject me”), and unconditional beliefs about own defectiveness (e.g., “I am odd/peculiar,” “I am inferior”).

An individual cognitive therapy program that targets the maintaining factors specified in the cognitive model has been evaluated in four randomized controlled trials. The first trial (Clark et al., 2003) improved fear of negative evaluation by 9.9 points (FNE; Watson & Friend, 1969) and found individual cognitive therapy superior to treatment with a selective serotonin reuptake inhibitor (fluoxetine). In the second trial (Stangier, Heidenreich, Peitz, Lauterbach, & Clark, 2003), an individual treatment similar (but not identical) to the treatment in the first trial was superior to group cognitive therapy. In the third study, the original individual treatment was superior to individual exposure therapy combined with applied relaxation training (Clark et al., 2006). In the fourth trial, a similar individual treatment was superior to intensive group cognitive therapy, and to routine psychiatric treatment involving medication and emotional support (Mörtberg, Clark, Sundin, & Wistedt, 2007). Taken together, these trials strongly support the efficacy of individual cognitive therapy for outpatients.

Persons suffering from social phobia show impaired and restricted interpersonal relations (Stein & Kean, 2000; Wittchen, Fuetsch, Sonntag, Muller, & Liebowitz, 1999). Symptoms of social phobia may therefore be

viewed as a part or a result of more general interpersonal impairment. Thus, interpersonal psychotherapy (IPT) may be considered a plausible alternative for treating social phobia. The interpersonal model posits that social anxiety both creates and is maintained by *social role insecurity*. This denotes that individuals with social phobia feel unsure about and have difficulties socializing with others, disclosing personal matters, asserting their interests, and experiencing positive aspects of social interactions and performance, even though they demonstrate these abilities when they feel safe (Lipsitz, Markowitz, & Cherry, 1997). As a consequence of such insecurity, they develop a variety of “self-protective” strategies. They refrain from expressing wishes and feelings, hide anxiety, try to exhibit a polished social performance, and withdraw as soon as possible. Thus, others are kept unaware of the person’s wishes and feelings and cannot respond to the actual self. Furthermore, these self-protective behaviors may make the social phobic person appear aloof and uninterested in others. This stance may lead others to feel rejected and uninteresting, and subsequently to withdraw. Hence, individuals with social phobia engage in *self-perpetuating interactional cycles*, in which they unwittingly produce the very response they fear, a lack of interest and warmth and even negative evaluation from others (Alden & Taylor, 2004). By alienating and by eliciting negative reactions from others, the self-protective behaviors maintain and consolidate social role insecurity, social anxiety, and a self-view as defective. In turn, self-observation of fearing and avoiding social activities and of failing to perform adaptive social skills strengthens their role insecurity and sense of defectiveness, and thus serves to maintain the disorder (Lipsitz et al., 1997).

Interpersonal therapy (IPT) has proven efficacious for major depression (Elkin et al., 1989; Weissman, Markowitz, & Klerman, 2000) and for bulimia (Fairburn et al., 1995). IPT has been shown to help patients utilize the sorts of social performance skills that individuals with social phobia need. Efficacy for social phobia has yet to be proven in randomized controlled trials. A clinical case series indicates that social phobic patients improve during individual interpersonal psychotherapy designed for social phobia (FNE improvement = 4.7; Lipsitz, Markowitz, Cherry, & Fyer, 1999), but superiority to a control condition has yet to be demonstrated.

IPT was devised to provide an effective short term, focused treatment for depression to mirror ambulatory community psychotherapy treatment in a randomized controlled trial of antidepressant pharmacotherapy

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