



A demonstration of the efficacy of two of the components of cognitive therapy for social phobia

Freda McManus^{a,*}, David M. Clark^b, Nick Grey^c, Jennifer Wild^b, Colette Hirsch^b, Melanie Fennell^d, Ann Hackmann^d, Louise Waddington^b, Sheena Liness^c, John Manley^e

^a University of Oxford, Department of Psychiatry & Oxford Cognitive Therapy Centre, Warneford Hospital, Oxford OX3 7JX, UK

^b Department of Psychology, Institute of Psychiatry at Kings College London, DeCrespigny Park, London SE5 8AF, UK

^c Centre for Anxiety Disorders and Trauma, South London and Maudsley NHS Trust, 99 Denmark Hill, London SE5 8AF, UK

^d University Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX, UK

^e West London Mental Health NHS Trust, Department of Psychology, 2 Wolverton Gardens, Hammersmith W6 7DY, UK

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ABSTRACT

Cognitive-behavioral treatments have demonstrated efficacy in the treatment of social phobia. However, such treatments comprise a complex set of procedures, and there has been little investigation of the effects of individual procedures. The current study investigates the effects of two single session procedures that form part of cognitive therapy for social phobia [Clark, D., Ehlers, A., McManus, F., Hackmann, A., Fennell, M., Campbell, H., et al. (2003). Cognitive therapy vs fluoxetine in the treatment of social phobia: A randomised placebo controlled trial. *Journal of Consulting and Clinical Psychology*, 71, 1058–1067; Clark, D., Ehlers, A., McManus, F., Fennell, M., Grey, N., Waddington, L., et al. (2006). Cognitive therapy versus exposure and applied relaxation in social phobia: A randomised controlled trial. *Journal of Consulting and Clinical Psychology*, 74, 568–578], namely the “self-focused attention and safety behaviors experiment” and the “video feedback experiment.” Results suggest that both procedures are effective in achieving their aims, which are: (i) demonstrating to patients the role of self-focused attention, safety behaviors, and excessively negative self-impressions in maintaining social phobia and (ii) reducing the symptoms of social phobia.

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Social phobia is a common and disabling condition, which in the absence of treatment typically follows a chronic and unremitting course (Bruce et al., 2005; Kessler, Berglund, et al., 2005; Kessler, Chiu, Demler, & Walters, 2005) and is associated with marked social and occupational handicap (Stein & Kean, 2000). Considerable progress has been made in developing effective treatments for social phobia. Within psychological approaches, the best-validated treatments are behavioral and cognitive-behavioral. Five meta-analytic reviews have summarized studies comparing behavioral and cognitive-behavioral conditions with various control conditions and concluded that both are effective treatments for social phobia (Chambless & Hope, 1996; Fedoroff & Taylor, 2001; Feske & Chambless, 1995; Gould, Buckminster, Pollack, Otto, & Yap, 1997; Taylor, 1996). Furthermore, individual studies have reported excellent maintenance of gains after the end of psychological treatment (e.g., Heimberg, Salzman, Holt, & Blendell, 1993; Liebowitz et al., 1999).

Although cognitive-behavioral treatments have been shown to be effective in social phobia, these treatments consist of a complex set of procedures and it is not clear which procedures are responsible for the good outcome. It is important to evaluate efficacy of individual treatment components independently of the overall treatment program for two reasons. First, while cognitive-behavioral therapies have been shown to be effective in social phobia, there remains room for improvement. All trials of cognitive-behavioral treatments have found that a proportion of patients remain symptomatic at the end of treatment and fail to reach an optimal level of functioning. Hence, evaluating individual treatment components may help to show how the efficacy of the treatment could be improved. A second reason for evaluating efficacy of individual treatment components is to make treatments as cost-effective as possible by eliminating any unnecessary procedures. Evaluations of individual treatment components may help identify which procedures should be included and which may be omitted from briefer, more cost-effective, versions of the treatment.

The aim of the present study is to evaluate the effects of two of the components used in Clark et al.'s (2003, 2006) version

* Corresponding author. Tel.: +44 1865 223986.

E-mail address: freda.mcmanus@psych.ox.ac.uk (F. McManus).

of cognitive therapy for social phobia. Four randomized controlled trials have shown this cognitive therapy protocol to be effective in treating social phobia (Clark et al., 2003, 2006; Mortberg, Clark, Sundin, & Wistedt, 2007; Stangier, Heidenreich, Peitz, Lauterbach, & Clark, 2003). The treatment involves carrying out a series of maneuvers in a given order. In the first session, the therapist and patient collaboratively derive a personal version of Clark and Wells' (1995) model of the maintenance of social phobia using the patient's own thoughts, images, anxiety symptoms, safety behaviors and attentional strategies. The following two sessions involve behavioral experiments that aim to demonstrate to the patient specific aspects of the model. It is the effects of these behavioral experiments that are the focus of investigation in the present study.

The first behavioral experiment, which is termed the "self-focused attention and safety behaviors experiment," is usually carried out in the second treatment session and aims to demonstrate to patients the dysfunctional nature of the self-focused, evaluative attention and the safety behaviors that they normally engage in. This particular behavioral experiment involves two enactments of a difficult social task. During one enactment patients focus evaluative attention on themselves and use their safety behaviors. During the other enactment, they are encouraged to focus externally and non-evaluatively while dropping their safety behaviors. Afterwards, self-ratings of anxiety and performance are reviewed in order for the patient to draw conclusions about the effects of self-focus and safety behaviors in social situations.

The second behavioral experiment is the "video feedback experiment," which is usually carried out in the third treatment session. This experiment involves showing patients the video of the enactments from the first experiment in order to evaluate whether their impressions of their own performance are excessively negative. More specifically, patients were asked to watch a video recording of the two enactments that they engaged in during the previous session (the self-focus and safety behaviors experiment), and to make ratings of how they expect to appear on the video and to compare these ratings with how they actually appeared. These ratings are reviewed by the patient and therapist in order to draw conclusions about the accuracy of their self-impression and thus demonstrate this component of the cognitive model of social phobia.

Previous research has shown that both the self-focus and safety behaviors experiment (McManus, Sacadura, & Clark, 2008) and the video feedback experiment can produce therapeutic effects in analogue populations (Harvey, Clark, Ehlers, & Rapee, 2000; Kim, Lundh, & Harvey, 2002) but their specific effects have not been evaluated in a clinical group. The present paper investigates whether the experiments have their intended effects in terms of:

- (i) demonstrating to the patient that self-focused attention, safety behaviors, and excessively negative self-impressions serve to maintain social anxiety) and,
- (ii) reducing patients' symptoms of social anxiety in the following week.

A common way of identifying whether a treatment procedure contributes to the overall effectiveness of a treatment program is to compare the effectiveness of the complete program with or without that particular procedure. This design, which was successfully used to decompose systematic desensitization (Teasdale, 1977), is most appropriate for treatments in which several components are delivered in parallel (e.g., exposure with and without cognitive restructuring) but cannot easily be applied to treatments, such as cognitive therapy for social phobia, that

comprise specific maneuvers that are implemented in sequence rather than in parallel. For the treatment procedures evaluated in this study, it is not possible to remove them from the full treatment program and then evaluate its impact without them as subsequent procedures in the treatment program explicitly build on the lessons that patients learn during these two procedures. We therefore adopted an alternative approach in which the short-term effects of the target procedures are evaluated before additional procedures have been implemented. This strategy has previously been successfully employed to evaluate components of other cognitive-behavioral treatment programs (Fennell & Teasdale, 1984; Salkovskis, Clark, Hackmann, Wells, & Gelder, 1999; Salkovskis, Thorpe, Wahl, Wroe, & Forrester, 2003).

1. Method

1.1. Participants

Participants were 34 patients receiving cognitive therapy for social phobia either as part of the randomized controlled treatment trial ($n = 20$) reported in Clark et al. (2006) or, if they were not suitable for inclusion in the trial, as part of the routine clinical service at the Centre for Anxiety Disorders and Trauma at the Maudsley Hospital in London ($n = 14$). All participants received individual cognitive therapy following the protocol outlined in Clark et al. (2006). Any patients who were taking psychotropic medication had been maintained on a stable dose of medication for at least two months prior to beginning cognitive therapy.

All participants met Diagnostic and Statistical Manual for Mental Disorders-IV (DSM-IV; American Psychiatric Association, 1994) criteria for social phobia. Fifty percent of participants also met DSM-IV criteria for avoidant personality disorder and 52.9% were currently taking psychotropic medication. Diagnostic interviews used a combination of the Anxiety Disorders Interview Schedule (ADIS; Brown, Di Nardo, & Barlow, 1994) for DSM-IV and the Structured Clinical Interview for DSM-IV; Axis-I (SCID-I; First, Spitzer, Gibbon, & Williams, 1995) and Axis II disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997). Clinical psychologists who had received extensive training in the ADIS and SCID conducted the interviews. Interviewer reliability was good ($Kappa = .93$) for the diagnosis of social phobia and moderate ($Kappa = .74$) for the diagnosis of avoidant personality disorder.

Participants' mean age was years 31.3 years. 44.1% were female, 61.8% were working full-time, and 29.4% were married or cohabiting. All participants completed the following standardized measures at intake: the Liebowitz Social Anxiety Scale, Self-Report Version (LSAS-SR; Fresco et al., 2001), the Social Phobia Scale (SPS; Mattick & Clarke, 1998), the Social Interaction Anxiety Scale (SIAS; Mattick & Clarke, 1998), the Social Phobia and Anxiety Inventory-Social Phobia (SPAI; Turner, Beidel, Dancu, & Stanley, 1989), Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979) and Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988). Means and (standard deviations) were as follows: SPS 30.9 (14.9); SIAS 41.2 (18.7); SPAI social phobia subscale 118.8 (37.0); LSAS 77.1 (28.1); BDI 11.7 (9.41) and BAI 15.18 (8.53).

1.2. Measures

1.2.1. Standardized measure of social anxiety

Participants completed the Social Phobia Weekly Summary Scale (SPWSS; Clark et al., 2003), prior to each treatment session throughout therapy. The SPWSS has good internal consistency (Cronbach's $\alpha' = .81$) and has been shown to be sensitive to the effects of treatment (Clark et al., 2003, 2006; Mortberg et al., 2007). The SPWSS consists of 0–8 ratings of social anxiety, social

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