



Cognitive behavioral group therapy for social phobia with or without attention training: A controlled trial

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ABSTRACT

The Self-Regulatory Executive Function model [S-REF; Wells, A., & Matthews, G. (1996). Modelling cognition in emotional disorder: the S-REF model. *Behaviour Research and Therapy*, 34, 881–888] proposes that metacognitive beliefs, inflexible self-focused attention, and perseverative thinking (rumination and worry) play an important role in maintaining emotional dysfunction. Attention training [ATT; Wells, A. (1990). Panic disorder in association with relaxation induced anxiety: an attentional training approach to treatment. *Behavior Therapy*, 21, 273–280] is a technique designed to increase attentional control and flexibility, and thereby lessen the impact of these maintaining factors. The main aim of this study was to determine whether or not supplementing cognitive behavioral group therapy (CBGT) with ATT could potentiate greater changes in social anxiety, depression, attentional control, metacognitive beliefs, and anticipatory and post-event processing in a clinical sample with social phobia. Patients ($N = 81$) were allocated to CBGT with ATT or relaxation training (RT). ATT did not potentiate greater change on any outcome variable, with both groups achieving significant improvements on all measures. Exploratory correlational analyses (pre-treatment and changes scores) showed that some metacognitive beliefs were associated with attentional control, anticipatory processing, and symptoms of social anxiety and depression. However, attentional control was more consistently associated with anticipatory processing, post-event processing, and symptoms of social anxiety and depression, than with metacognitive beliefs. Results are discussed with reference to cognitive behavioral models of social phobia. It is tentatively concluded that while supplementing CBGT with ATT does not improve outcomes, increasing attentional control during CBGT is associated with symptom relief.

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1. Introduction

Social phobia is a common and disabling anxiety disorder characterized by a fear of negative evaluation in performance situations or social interactions (Andrews, Henderson, & Hall, 2001). Cognitive behavior therapy (CBT) delivered individually (CBIT) or in groups (CBGT) has proven effective within research and 'real world' settings (e.g. Clark et al., 2006; McEvoy, 2007). However, the fact that a significant proportion of patients remain symptomatic following best practice interventions highlights the need for clinical researchers to continue developing and evaluating theory-driven treatment innovations. This study was an attempt to

evaluate whether supplementing standard CBGT with attention training (ATT) would potentiate greater symptom change for a clinical sample with social phobia.

Clark and Wells' (1995) cognitive behavioral model suggests that people with social phobia engage in anticipatory processing prior to encountering a social event, the content of which includes negative self-statements and reflections on past social failures. This anticipatory processing primes a series of negative thoughts about the person's inability to present a favourable impression when social situations are encountered (e.g. by showing signs of anxiety such as shaking and blushing, and by acting incompetently). Importantly, these thoughts are associated with heightened self-focused attention and adoption of the 'observer perspective', which involves the creation of a mental image (or feeling) of how other people are perceiving them. However, because self-focused attention creates a closed system, whereby more objective external information (e.g. positive cues from others) is not as readily incorporated, this mental image is negatively biased and thus increases the perception of

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social threat. In an attempt to ameliorate this threat, people with social phobia engage in avoidance or rely on safety behaviors, which prevent fears from being directly tested and modified. Safety behaviors can also be self-fulfilling by increasing the likelihood of social difficulties (e.g. if the use of alcohol as a social lubricant results in severe intoxication). This dysfunctional pattern of in-situation processing also biases information processing after the social situation, because negative cues are extensively processed during the interaction. Thus, post-event rumination is also negatively biased and the individual's initial fears are reinforced.

Clark and Wells' (1995) model was informed by Wells and Matthews (1994, 1996) transdiagnostic Self-Regulatory Executive Function (S-REF) model, which places attentional control as an important contributing factor in emotional disorders. The S-REF model specifies a dysfunctional pattern of cognitive processing (Cognitive Attentional Syndrome, CAS), consisting of inflexible self-focused attention, perseverative thinking (rumination and worry), threat monitoring, and coping behaviors that prevent disconfirmation of negative beliefs. The effect of the CAS is to maintain self-focused attention in a way that perpetuates psychological disturbance. Specifically, activities like worry and threat monitoring usurp cognitive and attentional capacity, which prevents the individual from attending to sources of information likely to facilitate belief modification, and from coping in effortful but ultimately more adaptive ways. Wells (2007) argues that "excessive and inflexible self-focused attention is a surface marker of..." the CAS (p. 135).

Positive and negative metacognitive beliefs are considered to be important factors driving dysfunctional S-REF activity (Wells, 2000). Metacognition has been defined as "psychological structures, knowledge, events and processes that are involved in the control, modification and interpretation of thinking itself" (p. 386, Wells & Cartwright-Hatton, 2004). The metacognitions questionnaire (MCQ; Cartwright-Hatton & Wells, 1997) measures several dimensions of metacognitive beliefs, including positive beliefs about worry (e.g. Worrying helps me cope), negative beliefs about thoughts concerning uncontrollability and danger (e.g. When I start worrying I cannot stop), confidence in attention and memory (e.g. I have a poor memory), negative beliefs about the consequences of not controlling thoughts (e.g. I should be in control of my thoughts all of the time), and the tendency to focus attention on thought processes (e.g. I am constantly aware of my thinking). The S-REF model suggests that these beliefs will increase the likelihood of selecting coping strategies that promote self-focused attention, such as threat monitoring, thought suppression, worry, and rumination, which, in turn, maintain emotional disorder. Metacognitive beliefs have been found to be associated with rumination and depression (Papageorgiou & Wells, 2001), obsessive compulsive symptoms (Myers & Wells, 2005; Wells & Cartwright-Hatton, 2004), and worry (Cartwright-Hatton & Wells, 1997). There is also some evidence that metacognitions are more strongly endorsed by high than low socially anxious individuals (Dannahy & Stopa, 2007).

Consistent with Clark and Wells (1995) and the S-REF model (Wells & Matthews, 1994, 1996), evidence is also accumulating that self-focused attention is associated with emotional disorders in general and social anxiety in particular (Bögels & Mansell, 2004; Mansell, Clark, & Ehlers, 2003; Mellings & Alden, 2000; Mor & Winquist, 2002; Pineles & Mineka, 2005; Woody, 1996; Woody & Rodriguez, 2000). For instance, self-focused attention has been found to be associated with negative biases in self-related judgments and poorer recall of external information (Mellings & Alden, 2000). In a clinical sample with social phobia, using path analysis Rapee and Abbott (2007) found that orientation to internal social threat (i.e. memories of past negative social experiences,

physical symptoms of anxiety, and hypotheses about how others were seeing them) mediated the relationships between social anxiety and the probability and consequence of negative evaluation, as well as perceived social performance. Importantly, group CBT for social phobia that includes a component encouraging patients to attend to external stimuli during social situations has been associated with reductions in self-focused attention and symptom relief (Woody, Chambless, & Glass, 1997). Following group CBT for social phobia, Hofmann (2000) also found a reduction in negative self-focused thoughts, which were associated with reductions in social anxiety. In addition to self-focused attention, there is evidence that social anxiety is associated with orientation to external social threat (see Schultz & Heimberg, 2008, for a review), which is consistent with Rapee and Heimberg's (1997) model.

The S-REF model postulates that attentional inflexibility, such as an inability to shift attention from threat, contributes to emotional disorders. Consistent with this notion, evidence from experimental studies of high and low trait anxious individuals have found that while high trait anxious individuals orient toward moderate and high threat stimuli (e.g. pictures), low trait anxious individuals only orient to high threat stimuli (e.g. Koster, Crombez, Verschuere, & De Houwer, 2006). Importantly, Koster et al. found that the attentional bias in high trait anxious individuals was mostly a result of difficulty in disengaging from threat, which likely leads to elaborated threat processing at the expense of neutral or positive material. Derryberry and Reed (2002) found that anxiety-related attentional biases at a short cue presentation duration (500 ms) were only found in high trait anxious individuals with poor attentional control.

A clinical implication of the S-REF model is that treatment strategies should aim to modify unhelpful metacognitions and related coping strategies that (a) direct controlled processing systems towards self-focused attention, worry, and rumination, (b) maintain inflexible control over processing, and (c) limit the collection of corrective information to modify dysfunctional beliefs (Wells, 2000, 2007). To this end, interventions such as attention training (ATT; Wells, 1990, 2000) have been designed to shift attention more externally and increase attentional flexibility and control. As the name suggests, ATT is designed as a training exercise only. Participants are not instructed to do ATT when they are in a threatening situation, but rather to practice it for a discrete period every day. It comprises of three auditory attentional phases involving selective attention, attention switching, and divided attention. The selective attention phase involves focusing on one sound to the exclusion of all others for approximately 30 s, before shifting to another sound. For the attention switching phase participants are again instructed to focus on one sound to the exclusion of all others, but they are required to shift their attention to a new sound approximately every five seconds. The divided attention phase involves patients simultaneously focusing on as many sounds as possible. The entire procedure typically takes around 15 min.

Wells (2000) argues that ATT can result in positive effects by attenuating self-focused attention, disrupting rumination and worry, increasing executive control over attention and processing, and strengthening metacognitive processing, which involves identifying thoughts as objects open to scrutiny rather than as facts. ATT has been trialled in single case interventions for panic disorder and social phobia (Wells, 1990; Wells, White, & Carter, 1997), hypochondriasis (Papageorgiou & Wells, 1998), major depression (Papageorgiou & Wells, 2000), and more recently with auditory hallucinations (Valmaggia, Bouman, & Schuurman, 2007). These studies have found evidence that ATT is associated with symptom improvement and modification of maladaptive beliefs.

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