

Mindfulness and Acceptance-Based Group Therapy for Social Anxiety Disorder: An Open Trial

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Mindfulness and Acceptance-Based Group Therapy (MAGT) for Social Anxiety Disorder (SAD) is based largely on Acceptance and Commitment Therapy (ACT; Hayes et al., 1999), with enhanced mindfulness mostly from Mindfulness-Based Cognitive Therapy (MBCT; Segal et al., 2002). The purpose of this study was to assess the feasibility and initial effectiveness of MAGT for the treatment of SAD. Forty-two SAD patients were invited to take part in an open trial of MAGT. Participants completed measures of social anxiety, mindfulness and acceptance, depression, and rumination at pretreatment, midtreatment (6 weeks), posttreatment (12 weeks), and at a 3-month follow-up session. Twenty-nine participants completed the treatment and these participants reported that the treatment was helpful. Effect sizes for treatment completers ranged from 1.00 to 1.17 for the social anxiety symptom measures at follow-up. Intent-to-treat analyses revealed significant reductions in social anxiety, depression, and rumination and significant increases in mindfulness and acceptance, with effect sizes ranging from .65 to .76 on the social anxiety measures. This study demonstrates that MAGT is feasible and acceptable to SAD patients and provides further support for the use of mindfulness and acceptance-based interventions for the treatment of SAD.

SOCIAL anxiety disorder (SAD) is a chronic condition characterized by a persistent fear of negative evaluation in social and/or performance situations, as well as avoidance of and/or distress in the feared situations, and it is a very common disorder, representing the fourth most common mental health diagnosis (Kessler, Berglund, Demler, Jin, & Walters, 2005). Despite considerable evidence for the efficacy of Cognitive Behaviour Therapy (CBT) for SAD, there is significant room for improvement (Heimberg, 2002; Huppert, Roth, & Foa, 2003; Rodebaugh, Holaway, & Heimberg, 2004; Rowa & Antony, 2005). Hofmann and Bögels (2006) estimated that 40% to 50% of SAD patients treated with conventional CBT show minimal improvement. A recent study found that following treatment with Cognitive Behavioral Group Therapy (CBGT; Heimberg & Becker, 2002), patients with SAD still reported considerable dissatisfaction with their lives (Eng, Coles, Heimberg, & Safren, 2005). Refinement of existing CBT interventions is one current approach to improving psychological treatment for SAD (e.g., Clark et al., 2006; Hofmann & Scepkowski, 2006; Huppert et al., 2003; Voncken & Bögels, 2006), while another current approach is the exploration of

mindfulness and acceptance interventions (Bögels, Sijbers, & Voncken, 2006; Herbert & Cardaciotto, 2005). The present research focuses on the latter approach, as has been done in other areas of psychopathology (e.g., Roemer & Orsillo, 2005; Segal, Williams, & Teasdale, 2002; see Baer, 2003; and Hayes, Luoma, Bond, Masuda, & Lillis, 2006, for reviews).

The primary aim of the present study was to evaluate the feasibility and initial effectiveness of a new group intervention for SAD that utilizes acceptance, mindfulness, and exposure strategies adapted from Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) and from Mindfulness-Based Cognitive Therapy (MBCT; Segal et al., 2002). There are similarities and overlap in ACT and MBCT. Being present (or mindful) is one of the core processes of ACT, and the developers of ACT suggested a homework assignment of “practicing awareness of experience” (Hayes et al., 1999, pp. 178–179), although they also referred to mindfulness training as one of “a number of techniques other than ACT” (p. 62). More recently, others have increased the emphasis of mindfulness within ACT, notably Eifert and Forsyth (2005), who also adapted exercises from MBCT for use in the area of anxiety disorders. They suggested 5 minutes of practice in most sessions and recommended assigning acceptance practice (similar to mindfulness practice) based on written instructions, rather than audio-

recordings. In the present study, mindfulness training played a much larger role in the treatment sessions and homework assignments.

Therapeutic strategies from ACT and MBCT were chosen to target the core attentional, cognitive, and behavioral processes that have been shown to maintain SAD. Although these processes were originally identified within a cognitive behavioral model (Clark & Wells, 1995; Rapee & Heimberg, 1997), they can also be conceptualized within a mindfulness and acceptance framework. Attentional processes include heightened *self-focus* on public aspects of the self such as visible physical symptoms of anxiety (e.g., blushing, sweating, trembling, etc.) and social performance, as well as *external focus* on potential threat (such as signs of disapproval from others) (see Bögels & Mansell, 2004, for a review). Cognitive processes include anxious rumination before (i.e., anticipatory processing), during, and after (i.e., post-event processing) social situations with a tendency to dwell on the likelihood of being negatively evaluated by others. Behavioral processes include overt and subtle avoidances (i.e., safety behaviors) that are engaged in to reduce anxiety and negative evaluation. These processes interact to maintain social anxiety.

Mindfulness and Acceptance Approach to Social Anxiety

Within a mindfulness and acceptance framework the narrow and evaluative attentional processes in SAD can be seen as the antithesis of paying “mindful attention,” which has been defined as “paying attention in a particular way—on purpose, in the present moment and nonjudgmentally” (Kabat-Zinn, 1994, p. 4). Mindfulness practice in SAD patients involves focusing not just on how one is coming across in the situation, but to the full range of experience in the moment. Instead of judging one's experience, mindfulness practice encourages an attitude of acceptance and allowing towards physical sensations, feelings, and thoughts.

Within the ACT model of psychopathology, the concept of cognitive fusion addresses cognitive processes in SAD. Cognitive fusion is “the tendency of human beings to get caught up in the content of what they are thinking so that it dominates over other useful sources of behavioural regulation” (Luoma, Hayes, & Walser, 2007, p. 13). In SAD, fusing with thoughts about negative evaluation can be seen to fuel avoidance behaviors. Cognitive defusion strategies are employed to help clients see thoughts as what they are—events in the mind—so that they can be responded to in terms of their workability given the client's values, rather than in terms of their literal meaning (Luoma et al.).

Finally, the concepts of experiential avoidance and lack of valued actions within the ACT model can be seen to

address the behavioral processes in SAD. Experiential avoidance is “the attempt to control or alter the form, frequency, or situational sensitivity of internal experiences (i.e., thoughts, feelings, sensations, or memories), even when doing so causes behavioral harm” (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996, as cited in Luoma et al., 2007, p. 11). In SAD, experiential avoidance is manifested in avoidance and subtle avoidance behaviors, which lead to impairment in all aspects of life for SAD individuals (e.g., relationships, career, health, etc.). Further, acceptance can be viewed as a moderator of the relationship between social anxiety and behavioral disruption, with low levels of acceptance leading to attempts to control the anxious thoughts and feelings, with significant behavioral disruption (Herbert & Cardaciotto, 2005). Conversely, with high levels of acceptance of social anxiety, a person would simply note any anxious thoughts and feelings and not try to control or avoid them, thus leading to minimal behavioral disruption. In the mindfulness and acceptance approach, the emphasis is on reversing the costs of avoidance and living a richer, more meaningful life. This is accomplished by making commitments to work toward valued goals, while choosing willingness to accept anxiety in the moment.

Empirical Support for the Use of Acceptance and Mindfulness Interventions for SAD

There is empirical support for the use of ACT with a variety of conditions, including depression and anxiety disorders (Hayes et al., 2006). ACT has been tailored for use with patients with anxiety disorders (Eifert & Forsyth, 2005) and for SAD in particular (Herbert & Dalrymple, 2004), and there is preliminary evidence for the use of ACT in SAD as an individual intervention (Dalrymple & Herbert, 2007) and as a group intervention (Ossman, Wilson, Storaasli, & McNeill, 2006). Dalrymple and Herbert conducted an open trial of an individual ACT intervention for SAD in a sample of 19 patients and obtained large effect sizes on measures of social anxiety, quality of life, valued living, and experiential avoidance, and had low attrition, supporting the continued investigation of ACT for SAD. Using an ACT group intervention, Ossman and colleagues (2006) also found significant improvements in social anxiety, experiential avoidance, and valued living, but had a high rate of attrition (i.e., only 12 of 22 participants attended at least 7 of 10 group sessions). Data on reasons for dropping out were not collected; however, among the several reasons speculated by the authors was their liberal inclusion criteria, namely that participants could meet criteria for either generalized or discrete SAD and they only needed to have a score on the Social Phobia and Anxiety Inventory (Turner, Beidel, Dancu, & Stanley, 1989) in the mild range. As such, it is difficult to compare this study with other SAD

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