

A Treatment-Refractory Case of Social Anxiety Disorder: Lessons Learned From a Failed Course of Cognitive-Behavioral Therapy

Faith A. Brozovich
Richard G. Heimberg
Temple University

Over the past 25 years researchers have made enormous strides in the implementation of cognitive-behavioral therapy (CBT) for social anxiety disorder (SAD), although considerable work remains to be done. The present paper discusses a treatment refractory case seen in our clinic. The young man presented numerous interrelated obstacles, such as low treatment expectations, poor homework compliance, and comorbid depression and alcohol dependence. We highlight the challenges presented by this complex presentation, as well as issues that arose over the course of treatment. We then elaborate on techniques that could have improved his outcome. The promise of motivational interviewing and behavioral activation techniques for these complex clients is discussed. Future research and treatment directions for refractory cases are considered.

SOCIAL anxiety disorder (SAD) is a highly prevalent mental disorder, occurring at some time during the lives of 12.1% of the U.S. population (Kessler et al., 2005). It is a chronic condition associated with elevated risk for later onset of serious comorbid disorders, such as major depression and alcohol and substance use disorders (Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996; Schneier et al., 2010) as well as functional impairment (Schneier et al., 1994) and personal and societal economic burden (Acarturk et al., 2009; Greenberg et al., 1999). Clearly, it is important to develop effective treatments for SAD and to disseminate them broadly, and much has been accomplished in that direction. However, whereas many clients show positive response to both pharmacological and psychosocial treatments for SAD, a substantial subset does not respond to these treatments, and others, even those who have made dramatic improvements, are often left with significant residual anxiety and impairment. In this paper, we focus on issues related to inadequate response to cognitive-behavioral therapy (CBT) for SAD.

CBT for SAD has made significant strides in the past 25 years, and efficacious treatments are now available. CBT for SAD began with the work of Beck and Emery (1985), which was then extended by Heimberg and colleagues, who developed cognitive-behavioral group therapy (CBGT), the most widely studied CBT for SAD. CBGT

has been identified as the treatment of choice for SAD by cognitive-behavioral experts (Chambless & Ollendick, 2001).

Heimberg and colleagues also developed an individualized CBT for SAD, which will be the focus of the present paper.¹ The individual treatment, which builds upon the successes of the group protocol, is typically completed in 16 to 20 weeks. It consists of five phases: (a) psychoeducation, (b) cognitive restructuring training, (c) in vivo and in-session exposure, (d) advanced core beliefs work, (e) treatment consolidation and termination. The client receives a workbook (Hope, Heimberg, & Turk, 2010) before treatment or during the first session, reads the appropriate chapter prior to each session, and completes homework assignments appropriate to each chapter's content. The first four sessions (psychoeducation) provide information about the nature of social anxiety, etiological and maintaining factors, as well as the cognitive-behavioral model underlying the treatment of SAD. Clients also develop a personalized hierarchy of feared social situations for use as a roadmap for later exposures and to provide an index for later evaluation of treatment efficacy. In the next phase (2 to 3 sessions),

¹ Many other investigators have dedicated themselves to the development of cognitive-behavioral and other psychosocial treatments for SAD, most notably David M. Clark (see Clark et al., 2003, 2006). Our focus on our own work does not in any way suggest its superiority or diminish the efforts of others. The reader is directed to both qualitative reviews (e.g., Ponniah & Hollon, 2007) and meta-analyses (Powers et al., 2008) of CBT for SAD, which provide a broader perspective than is possible in the current context.

clients learn cognitive restructuring (CR) techniques. CR in CBT helps individuals identify their automatic thoughts (ATs) and develop coping skills. ATs can be defined as negative maladaptive thoughts that are activated in anticipation of, during, or when recalling socially stressful events and thus contribute to the maintenance of an individual's social anxiety. Clients are then taught cognitive coping skills that include recognizing thinking errors in ATs (e.g., all-or-nothing thinking, catastrophizing, fortune telling), interrogating the logical basis of these ATs, and developing rational responses to them (Heimberg & Becker, 2002). The goal of CR training is to have clients reach a point at which they are able to refute negative ATs and incorporate rational responses into their internal dialogue while encountering anxiety-provoking situations.

The next several sessions of treatment focus on exposure to feared social situations, incorporating CR skills. Guided by their fear and avoidance hierarchy, clients begin work with less anxiety-provoking situations and then move onto more anxiety-provoking ones later in treatment. Exposure is conducted in session as well as in vivo for homework between sessions. In-session exposures, often role-plays of real-life situations orchestrated by the therapist, allow clients to test the logical basis of ATs they have in anticipation of the situation, practice CR skills under the watchful eye of the therapist, and receive feedback on various aspects of their behavior from the person(s) involved in the role-plays. In vivo exposures allow clients to apply their new learning in their everyday environments, outside the therapy room, with less reliance on the therapist. Homework exposures typically involve self-administered CR exercises both before and after exposure to the assigned situations to increase the chances that clients' distorted thinking will lead them to discount successes or "turn victory into defeat."

After several weeks of CR and exposure, a few sessions are devoted to core beliefs work, in which the client and therapist work to identify the maladaptive and sometimes extremely painful beliefs that clients hold about themselves and which provide the underpinnings for ATs that are often expressed across situations. Further exposures or behavioral experiments are conducted to test the validity of these core beliefs. The final session provides clients with a summary of their work in treatment and emphasizes the consolidation of treatment gains.

A core element of CBT for SAD is the collaborative relationship between client and therapist (Heimberg & Becker, 2002). The client is the expert on his or her social anxiety and personal experience. The therapist is an expert on social anxiety in a broad sense. Together, they work to maximize the client's therapeutic experience. In CBT, the therapist teaches the client to think like a scientist and examine his or her beliefs as hypotheses.

Also, socially anxious individuals must develop a sense of trust in their therapist so that they can fully participate and succeed in role-played and *in vivo* exposures to feared social situations. The main goal of therapy is to equip clients with all of the necessary tools to "be their own cognitive therapist" once treatment is completed. As a result, the therapeutic alliance is extremely important in CBT. Hayes, Hope, VanDyke, and Heimberg (2007) demonstrated that a strong alliance was associated with clients' ratings of engagement with therapy sessions and of session helpfulness.

There is a substantial evidence base for the treatment. Heimberg et al. (1990) provided the first demonstration that CBGT was more efficacious than a credible educational supportive (ES) psychotherapy control in a randomized controlled trial. Heimberg et al. (1998) conducted a large randomized control trial examining the efficacy of CBGT compared to pharmacotherapy. One hundred thirty-three individuals were randomized to one of four 12-week treatment conditions: CBGT; the monamine oxidase inhibitor phenelzine; pill placebo; or the ES control psychotherapy. Independent assessors administered the Liebowitz Social Anxiety Scale and the social phobia section of the Anxiety Disorder Interview Schedule. Participants also completed a variety of self-report measures (e.g., Social Interaction Anxiety Scale, Social Phobia Scale).

After the 12 weeks of treatment, both CBGT and phenelzine were associated with greater improvements than pill placebo and ES. In intent-to-treat analyses, 58% of individuals in CBGT and 65% of individuals receiving phenelzine were classified as treatment responders compared to 33% of individuals receiving pill placebo and 27% of individuals receiving ES treatment. Phenelzine was superior to CBGT on some measures after 12 weeks.

Individuals who responded to CBGT or phenelzine in the Heimberg et al. (1998) trial entered into the second phase of the study, which tracked the individuals' progress through a 6-month maintenance phase and a 6-month follow-up period (Liebowitz et al., 1999). A greater proportion of individuals who had received phenelzine relapsed, compared to individuals receiving CBGT (50% versus 17%, respectively). Individuals who received CBGT were about as likely to respond to 12 weeks of treatment as those receiving phenelzine; importantly, they were more likely to maintain their gains in the long term compared to individuals who had received phenelzine. A recently published trial suggests that the combination of phenelzine and CBGT may be more effective than the component treatments (Blanco et al., 2010), although other studies of concurrent combinations of CBT and pharmacotherapy treatment have been equivocal (e.g., Davidson et al., 2004; see also Pontoski & Heimberg, 2010).

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