



Mindfulness and acceptance-based group therapy versus traditional cognitive behavioral group therapy for social anxiety disorder: A randomized controlled trial



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ABSTRACT

Recent research has supported the use of mindfulness and acceptance-based interventions for Social Anxiety Disorder (SAD).

Objective: The purpose of the present study was to compare mindfulness and acceptance-based group therapy (MAGT) with cognitive behavioral group therapy (CBGT) with respect to outcome. It was hypothesized that MAGT and CBGT would both be superior to a control group but not significantly different from one another.

Method: Individuals ($N = 137$, mean age = 34 years, 54% female, 62% White, 20% Asian) diagnosed with SAD were randomly assigned to MAGT ($n = 53$), CBGT ($n = 53$) or a waitlist control group ($n = 31$). The primary outcome was social anxiety symptom severity assessed at baseline, treatment midpoint, treatment completion, and 3-month follow-up. Secondary outcomes were cognitive reappraisal, mindfulness, acceptance, and rumination. Depression, valued living, and group cohesion were also assessed. **Results:** As hypothesized, MAGT and CBGT were both more effective than the control group but not significantly different from one another on social anxiety reduction and most other variables assessed. **Conclusions:** The present research provides additional support for the use of mindfulness and acceptance-based treatments for SAD, and future research should examine the processes by which these treatments lead to change.

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There is extensive support for the use of traditional cognitive behavior therapy (CBT) for social anxiety disorder (SAD; see Heimberg, 2002 for a review). However, in recent years more attention is being paid to the minimal improvement (Hofmann & Bögels, 2006) and continued dissatisfaction with life (Eng, Coles, Heimberg, & Safren, 2005) experienced by many patients following traditional CBT. This has led to refinement of traditional CBT approaches (e.g., Clark et al., 2006) and exploration of other CBT approaches such as acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999) that may serve as alternative treatment options.

ACT is a contextual behavioral treatment that uses mindfulness, acceptance and behavioral strategies to promote behavior change

consistent with personal values (Hayes, Villatte, Levin, & Hildebrandt, 2011). There is growing empirical support for the effectiveness of ACT for a wide range of psychological conditions, including anxiety disorders (see Ruiz, 2010 for a review). A major process targeted by ACT is *experiential avoidance*, “the phenomenon that occurs when a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, behavioral predispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them” (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996, p. 1154). In SAD, experiential avoidance is thought to manifest in overt and subtle avoidance behaviors that interfere in values-based behavior (Herbert & Cardaciotto, 2005). An intervention aimed at explicitly targeting experiential avoidance may be particularly helpful in the treatment of SAD.

Our efforts have focused on an ACT-based group approach for SAD, mindfulness and acceptance-based group therapy (MAGT; for

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a more detailed theoretical rationale for our approach, see Kocovski, Fleming, & Rector, 2009), as an alternative to traditional CBT. In MAGT, mindfulness and other strategies are used to promote acceptance (“actively contacting psychological experiences – directly, fully, and without needless defense – while behaving effectively”, Hayes et al., 1996, p. 1163) of unwanted physical symptoms (e.g., sweating, shaking), and anxious thoughts (e.g., about embarrassing oneself, or being negatively evaluated by others) in order to reduce overt and subtle avoidance of anxiety-provoking situations, and increase values-based action. Exposure exercises (conducted with an acceptance rationale) provide opportunities to practice acceptance while engaging in values-based behaviors (Hayes et al., 2011). In a pilot study of MAGT ($N = 42$), we found medium to large effect sizes on social anxiety reduction and 43% of the intent-to-treat sample achieved clinically significant change (Kocovski et al., 2009). Our findings were consistent with those from two previous open trials of individual (Dalrymple & Herbert, 2007; $N = 19$) and group ACT (Ossman, Wilson, Storaasli, & McNeill, 2006; $N = 22$) for SAD.

No published randomized controlled trials (RCTs) for SAD have compared ACT-based treatments with traditional CBT, the most evidence-based psychotherapy for SAD. Hence, the main purpose of the present study was to compare MAGT with cognitive behavioral group therapy (CBGT; Heimberg & Becker, 2002), the most empirically-supported group CBT intervention for SAD. Further, both treatments were compared with a waitlist control group, and as such, this study represents the first RCT for any anxiety disorder to compare an ACT-based treatment to both active and inactive control groups.

Present study

Based on the pilot study that found effect sizes for MAGT similar to those found for CBGT, it was hypothesized that MAGT and CBGT would both be superior to a waitlist control group (WAIT) but not significantly different from one another. This pattern was hypothesized for the primary outcome variable of social anxiety, as well as depression. Further, given the strong focus on values in MAGT, it was hypothesized that MAGT would result in greater increases in valued living compared to CBGT.

Secondary outcomes were cognitive reappraisal, mindfulness, acceptance, and rumination. Cognitive reappraisal, an emotion regulation strategy in which the interpretation of a situation is changed in order to reduce the emotional impact (Gross & John, 2003), is closely related to cognitive restructuring, one of the main elements of treatment for CBGT. As such, it was hypothesized that cognitive reappraisal would increase for the CBGT group, as has been found in other studies (e.g., Moscovitch et al., 2012). Further, given that MAGT includes mindfulness as an element of treatment and focuses on cultivating acceptance, significant increases in mindfulness and acceptance were expected for MAGT, as was found in our pilot study (Kocovski et al., 2009). Finally, given that rumination is targeted directly or indirectly in both forms of treatment, and there is evidence that mindfulness treatments (e.g., Ramel, Goldin, Carmona, & McQuaid, 2004; as well as our pilot study, Kocovski et al., 2009) and CBT (Price & Anderson, 2011) can reduce rumination, both treatments were expected to result in decreased rumination.

Method

Participants

Participants ($N = 137$) were recruited via advertisements in local newspapers, letters sent to physicians informing them of the study,

and flyers posted in clinics and other public places in the Greater Toronto Area. Inclusion criteria were: principal diagnosis of SAD, Generalized (based on criteria from the Diagnostic and Statistical Manual of Mental Disorders, 4th ed., text revision [DSM-IV-TR]; American Psychiatric Association, 2000 assessed using the Structured Clinical Interview for DSM-IV [SCID-IV]; First, Spitzer, Gibbon, & Williams, 1996); English fluency; and age between 18 and 65 years. Exclusion criteria were: current major depressive disorder (MDD); current alcohol or substance abuse or dependence; lifetime psychosis; lifetime mania; current suicidal intent; and past ACT or CBT for SAD. Psychotropic medications were allowed if doses were stable in the 3 months prior to the study and there was agreement to remain stable for the study duration.

There were no significant differences across conditions on demographics or comorbid diagnoses (see Table 1; effect sizes [d] ranged from .07 to .35). Ages ranged from 18 to 62 years. Ethnicities included White (62%), Asian (20%), Black (3.6%), Hispanic (3.6%) and other (10.9%). Most completed college or university (63.5%) or at least some postsecondary education (27.0%). Religious status was as follows: none (38.0%), Catholic (16.1%), Protestant (12.4%), Buddhist (8.0%), Muslim (5.1%), Jewish (3.6%), Hindu (.7%), and other (16.1%).

Materials

All self-report measures described below (with the exception of the Group Cohesion Scale) were completed at baseline, midtreatment (6 weeks), and posttreatment (12 weeks) by all groups. MAGT and CBGT also completed these measures at the 3-month follow-up. WAIT participants were offered treatment at the end of the waiting period and did not take part in the follow-up assessment.

Primary outcome. The primary outcome measure was the *Social Phobia Inventory* (SPIN; Connor et al., 2000), a 17-item self-report measure of fear and avoidance of a range of social situations and of physiological symptoms of anxiety. The SPIN has been validated for use in clinical populations, has strong convergent and discriminant validity, and good internal consistency and test–retest reliability (Antony, Coons, McCabe, Ashbaugh, & Swinson, 2006; Radomsky et al., 2006). Alphas ranged from .88 to .92 across the four assessment points in the present study.

Clinician-administered measures. There were two clinician-administered measures at baseline, posttreatment and follow-up (but not at midtreatment). The 24-item *Liebowitz Social Anxiety Scale* (LSAS; Liebowitz, 1987) assesses fear and avoidance of

Table 1
Demographics and comorbidities across conditions.

Variable	CBGT	MAGT	WAIT	F or χ^2	p
Demographics:					
Mean age (years)	32.66	34.94	36.55	1.30	.28
(SD)	(9.07)	(12.52)	(11.58)		
SAD duration (years)	18.55	22.17	23.84	1.99	.14
(SD)	(10.84)	(13.94)	(13.22)		
% Female	52.83	49.06	64.52	1.93	.38
% Single	58.49	62.26	67.74	.71	.70
% White	52.83	69.81	64.52	3.35	.19
% Current psychotropic medications	28.30	47.17	38.71	4.02	.13
Comorbidities (%):					
Past major depression	45.28	49.06	45.16	.19	.91
Dysthymic disorder	3.77	3.77	9.68	1.72	.42
Lifetime alcohol	11.32	20.75	25.81	3.12	.21
Lifetime substance	15.09	15.09	19.35	.32	.85
Other anxiety ^a	16.98	22.64	16.13	.76	.68

Note: F(2,134) values reported for age and duration; χ^2 (2) values for all other variables. CBGT = cognitive behavioral group therapy; MAGT = mindfulness and acceptance-based group therapy; WAIT = waitlist control condition; SAD = social anxiety disorder.

^a Participants may have met criteria for more than one other anxiety disorder.

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