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Commentary on Identifying and Targeting Idiosyncratic Cognitive Processes in Group Therapy for Social Phobia: The Case of Vumile

The Case Of Vumile: Breathing Life Into a Manual and Model

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ABSTRACT

Vumile represents an individual with social phobia who experienced a successful outcome after being treated with a manualized treatment based on Clark and Wells' (1995) theoretical model (Edwards & Kannan, 2006). This commentary reviews issues in the debate regarding manualized treatments, with an emphasis on how the case of Vumile represents the best of what manualized treatments and empirically based approaches to clinical practice have to offer. Additionally, the fit of the case of Vumile with Clark and Wells' (1995) theoretical model is considered.

Key words: social phobia; manualized treatment; evidence based practice; randomized control trials (RCTs)

A large body of research supports the efficacy of cognitive behavioral treatments for social phobia (see Rowa & Antony, 2005 for a recent review). Clark's (1997) version of cognitive behavioral treatment for social phobia has yielded large effect sizes and appears promising (Clark et al., 2003; Stangier, Heidenreich, Peitz, Lauterbach, & Clark, 2003). Clark's (1997) protocol includes cognitive restructuring and exposure elements like most efficacious treatments for social phobia. However, his treatment also emphasizes procedures derived from his theoretical work and basic research such as identification of safety behaviors, shifting focus of attention away from the self (to the social situation), behavioral experiments in which safety behaviors are dropped, and video feedback on social performance. Edwards and Kannan (2006) present an application of Clark's (1997) manualized treatment for social phobia to the case of Vumile. This commentary will tie elements of Vumile's case into issues involving manualized treatments and theoretical models of social phobia.

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CURRENT ISSUES IN THE USE OF MANUALIZED TREATMENTS

Manualized treatments have been the subject of much interest and controversy since the Division 12 (Clinical Psychology) Task Force on Promotion and Dissemination of Psychological Procedures published a list of treatments that they considered empirically supported for certain populations (Chambless et al., 1996; 1998). These treatments were identified based upon evidence from randomized controlled trials (RCTs) implemented using a treatment manual. Clark's (1997) particular treatment approach for social phobia is relatively new but does employ a manual, allowing for its dissemination. The Division 12 Task force emphasized the importance of manuals so that treatments can be operationalized in terms of what they are and are not and the treatments can be replicated by other clinicians and researchers. Moreover, therapy manuals typically provide a description of theoretically grounded treatment principles and techniques and give directions with regard to how to best implement them.

In their review of the criticisms of manualized treatments, Chambless and Ollendick (2001) identified a number of arguments against their use. One argument against the use of manuals involves concerns that therapists will lack the flexibility to adapt a standardized treatment protocol to a specific individual. Another argument suggests that therapy programs designed for the individual case are superior to a standardized treatment approach. Another criticism is that studies have examined the efficacy of manualized treatments, not their effectiveness. That is, little is known about how effective manualized treatments are when implemented by clinicians without extensive training in the manual's theoretical underpinnings and procedures. Furthermore, little is known about how effective manualized treatments are with clients who present with comorbidities that would exclude them from most RCTs or who are diverse in race, ethnicity, and culture. Overall, Chambless and Ollendick (2001) conclude that more research is needed to sufficiently understand and address these issues. However, the limited data available are not consistent with the above criticisms.

CONTRIBUTION OF THE CURRENT CASE STUDY TO UNDERSTANDING MANUALIZED TREATMENT

The case of Vumile, which ultimately had a successful outcome, can be considered from the perspective of the issues that have been raised in the debate about manualized treatments. The therapists in Clark's (2003) initial efficacy study were clinicians who had experience treating anxiety using cognitive behavioral therapy, who treated at least two practice patients with the protocol before the start of the trial, and who had regular supervision with the developer of the treatment during the trial. In the Vumile case study, the lead therapist was the first author (Edwards). In a personal communication to the PCSP editor in response to a question about his background, Edwards wrote the following:

> My cognitive-behavioral credentials were well established before the study began. I am a highly experienced cognitive therapist trained by one of the founders of cognitive therapy, Aaron Beck. In conjunction with my work with Dr. Beck, I was a founding member of Beck's well-known Academy of Cognitive Therapy (http://www.academyofct.org), and I am

> accredited by that Academy. As the primary therapist of the group, I was able to ensure that the intervention followed the general principles of contemporary cognitive-behavioral group therapy (White & Freeman, 2000) as well as the manual-based steps described by Clark (1997). The second author and additional assistants involved in the therapy were students who presented some of the educational material, attended to the data collection and video and audio equipment, and participated in the group. (Edwards, 2005, personal communication).

On the other hand, in their case study, Edwards and Kannan point out that, although they had Clark's support, they received no training or supervision from anyone involved in the development or implementation of the Clark model and worked at a site in South Africa where this approach is largely unknown. Thus, in this case, dissemination of a treatment via a manual and employing an experienced cognitive behavior clinician as the lead therapist appears to have been successful both in terms of the description of the treatment interventions employed and the outcomes obtained with Vumile and the other patients in the group.

(Of relevance here and on a personal note, I found the case of Vumile particularly engaging, in part because I have found it interesting to compare my past experience as a therapist working with manualized treatments as they are done in highly quality controlled RCTs (with highly trained therapists who receive a good deal of supervision) versus a more "real world" application as I do now as a trainer of Master's level clinical psychology students. These students obtain weekly individuals supervision with me on the manual that they are using with their clients. However, they don't have as much background training in psychopathology and cognitive behavior therapy, they often don't get as much supervision time per patient, and they often see clients who are very diverse in terms of cultural and comorbidity issues. Nevertheless, their clients generally do well. I frequently wonder how far one can push the envelope in terms of manualized treatments.)

Vumile also represents a patient quite different from those included in Clark et al.'s (2003) efficacy trial in terms of diversity variables. Vumile is identified as a 19 year old, single, Black, male college student in South Africa. Clark et al's (2003) sample consisted of 60 patients (52% women) treated in the United Kingdom. No information is provided with regard to race or ethnicity, but the average age was 33 years. Half of the sample was married, and the majority of the participants were employed. In this way, the treatment appears to have been successful with a client quite different from those patients in Clark et al.'s (2003) sample. In addition to noting this success, it would have been interesting and helpful if the authors would have commented on the "fit" of the treatment with their unique patient population and culture and whether any adaptations of the treatment were made or could be recommended in hindsight in light of diversity issues.

The case of Vumile also challenges the notion that therapists lack the flexibility to adapt a standardized treatment to the individual. Rather, the case of Vumile, and other case studies based on manualized treatments (e.g., Turk, Hope, & Heimberg, 2001), provide opportunities to showcase how therapists "breathe life into a manual" (Kendall, Chu, Gifford, Hayes, & Nauta, 1998). That is, when a manualized treatment is skillfully utilized, the therapist is continually

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refining the conceptualization of the client within the framework of the theoretical model on which the treatment is based as more data become available over the course of therapy. The manual provides a set of procedures designed to target factors important in maintaining symptoms according to the model. For these techniques to be effective, an adequate case conceptualization guides exactly how these techniques should be applied to any given patient. In the case of Vumile, the authors walk the reader through the process of conceptualizing his symptoms in the context of Clark and Wells' (1995) model early in therapy. Later in therapy, more dramatic progress is made by the client when the case conceptualization is further refined and the treatment's interventions are targeted toward aspects of Vumile's psychopathology that had not yet been addressed (i.e., negative images of women looking at him with pity that were maintained by the safety behavior of not looking at their faces; this safety behavior prevented him from seeing their true expressions, which could disconfirm his beliefs and modify his internal imagery). In a way that is not possible in research reports summarizing the response of a group of patients to a treatment, the case study provides the opportunity to demonstrate that manualized treatments are not just a set of procedures applied in a blanket fashion to each patient irrespective of individual characteristics and needs. Rather, even when a manual is used, successful treatment is characterized by an integration of the case conceptualization, the treatment techniques, the unique characteristics of the patient, and the therapeutic relationship.

With regard to the therapeutic relationship, Kendall et al. (1998) have pointed out that, because some manuals do not specifically address the process of the therapeutic relationship, some critics seem to assume that the therapeutic relationship is not considered relevant to a successful outcome and therefore not attended to during treatment. It would have been helpful if the role of the therapeutic relationship in the case of Vumile had received more attention, since the role of Vumile's relationship with his therapists was undoubtedly important to his progress. More information was provided with regard to how the therapeutic relationship among group members furthered Vumile's progress. For example, Tabelo encouraged Vumile to engage in a behavioral experiment with him out of session, female group members engaged in role-plays in session with Vumile and gave him feedback about his performance, and Lindiwe offered observations about the reaction of women to Vumile's changes with therapy which served as the catalyst for new therapeutic homework assignments. Edwards and Kannan (2006) also noted the respectful and supportive atmosphere among group members.

One issue facing manualized treatments is that it is unclear to what extent one may take liberties with the original manual and still expect outcomes similar to those obtained with the original manual during efficacy studies. Edwards and Kannan (2006) actually used a variation of Clark's (1997) manual which had been adapted to a group therapy format (Kannan, 2002). Strangier et al. (2003) also adapted Clark's (1997) manual to a group format, but their adaptation differed from Kannan's in several ways. For example, Strangier et al. (2003) developed idiosyncratic models of factors maintaining social anxiety in an individual session with each client and reviewed the model in group. In contrast, Edwards and Kannan (2006) spent the first five therapy sessions deriving the idiosyncratic model of each patient through group exercises in pairs, through homework, and through assistance by the therapists. It appears that other aspects of treatment, such as video feedback, may have been handled differently as well. It is reassuring

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that therapists working from the same theoretical model and using the same treatment elements appear to be able to present the concepts and techniques of the protocol in a variety of ways and still achieve successful outcomes (Edwards & Kannan, 2006; Strangier et al., 2003). That said, more research is needed to understand the range of outcomes that might be expected depending upon how the manual is implemented. For instance, preliminary research suggests that the individual version of Clark's (1997) treatment is superior to the group version (Strangier et al., 2003). Similarly, for Heimberg's cognitive behavioral treatment of social phobia, recent data suggest larger effect sizes for the individual version of the treatment relative to the group version (Zaider et al., 2003). Other adaptations of Clark's (1997) manualized treatment are certainly possible, such as self-help versions that could serve as an adjunct to pharmacotherapy or marital therapy in which one or both members of the couple experiences clinically significant social anxiety. Alternatively, for patients with primary problems with other disorders (e.g., substance abuse, depression), it may be possible for therapists to integrate aspects of the manualized treatment into an overall treatment plan that emphasizes the primary disorder. However, research is needed to understand how well such adaptations might perform.

CONTRIBUTION OF THE CURRENT CASE STUDY TO UNDERSTANDING CLARK & WELLS' (1995) MODEL

In addition to breathing life into a manual, the case of Vumile also breathes life into a theoretical model by showing its application to a particular patient. Edwards and Kannan (2006) depict how Vumile's social anxiety is maintained according to Clark and Wells' (1995) model in figure 1. Vumile feared a variety of social situations that are common among individuals with generalized social phobia. These social situations reliably elicited certain beliefs about the self (e.g., "I'm boring") and others (e.g., "They will feel pity for me"). During social interactions, Vumile also experienced negative images of himself (e.g., puny, shaking with anxiety). He engaged in safety behaviors in an attempt to minimize the chances of experiencing feared negative outcomes such as others looking at him with pity (e.g., by avoiding eye contact). However, these avoidant behaviors increased the likelihood that he would not receive the response he desired from others, and any negative reactions from others reinforced his negative beliefs and imagery. His negative beliefs and focus on internally generated negative images of himself led to anxiety symptoms (e.g., perspires freely). Vumile's perception of these anxiety symptoms fed back into the negative beliefs and imagery.

Largely inspired by the theoretical models of Clark and Wells (1995) and Rapee and Heimberg (1997), research on the role of imagery in social phobia has grown exponentially in recent years. Unlike their nonanxious counterparts, individuals with social phobia have been shown to recall anxiety-provoking social situations as if looking at the self from an external point of view (e.g., Coles, Turk, Heimberg, & Fresco, 2001; Coles, Turk, & Heimberg, 2002). These observer-perspective images also occur during ongoing social situations and are negative in nature (Hackman, Surawy, & Clark, 1998). In one study, when individuals with social phobia held their usual negative self-image in mind during a conversation, they were rated as more anxious and as engaging in less positive behaviors by a blind observer than when they held a less negative self-image in mind (Hirsch, Clark, Mathews, & Williams, 2003). These negative self-

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images images seem to be linked to memories of criticism, bullying, and other adverse social events from earlier in life (Hackmann, Clark, & McManus, 2000). A recent study found that more than one-third of patients with social phobia actually manifested a PTSD-like symptom pattern in connection with adverse social events from earlier in life (Erwin, Heimberg, Marx, & Franklin, in press).

Consistent with Clark and Well's model (2005) and previous research, Vumile experienced distorted, negative, observer-perspective self-images in social situations, and these self-images played a role in maintaining his social anxiety (Edwards & Kannan, 2006). However, he also experienced distorted, negative images of others that functioned in a similar manner. Specifically, during social interactions, Vumile experienced internally generated images of women looking at him with pity and ridicule. These images could not be disconfirmed during exposures because he engaged in the safety behavior of avoiding looking at women's faces. Overall, Clark and Wells' (1995) model and subsequent research have emphasized the importance of self-focused imagery rather than images of others. Similarly, Rapee and Heimberg's (1997) model speaks to the importance of the individual's potentially distorted perception of other people (e.g., as critical, as having high standards) in the maintenance of social anxiety but imagery of others is not emphasized. As Edwards and Kannan (2006) suggest, it would be interesting to study the role of negative, distorted imagery of others among social phobia to see whether Vumile is a unique case or whether his experiences are typical of individuals with social phobia. If negative, distorted imagery of others is common among individuals with social anxiety, the possibility that these images are derived from early life experiences involving social traumas also warrants investigation.

UNDERSTANDING THE RELATIVE MERITS OF RCTS AND CASE STUDIES

Moreover, the current case study is a valuable complement to data from RCTs, not a substitute (which, of course, the authors never suggested). In most RCTs, more experimental control would be provided in a number of ways. With random assignment to groups, a comparison group can control for variables such as maturation, history, patient expectancies, and nonspecific aspects of treatment, allowing for stronger statements regarding causality to be made. In an RCT, participants most likely would have completed a structured clinical interview to give more confidence in the primary diagnosis of social phobia and to document comorbidity. Although some of the same assessment instruments targeting social anxiety may have been used in a RCT, others probably would have been included as well because they are more well-established in the literature. For example, most RCTs in the area of social phobia utilize one or more of the following instruments: the Social Interaction Anxiety Scale (Mattick & Clarke, 1998), the Social Phobia Scale (Mattick & Clarke, 1998), the Social Phobia Anxiety Inventory (Turner, Beidel, Dancu, & Stanley, 1989), and the Liebowitz Social Anxiety Scale (Liebowitz, 1987). Given their wide use, these measures facilitate comparisons across treatment outcome studies. Additionally, the best RCTs assess treatment outcome using at least one clinician-administered measure such as the Clinical Global Impression scale (Guy, 1976), which is ideally completed by a clinician who is blind to treatment condition. Data collected by the therapists

providing treatment are subject to a variety of biases. The best RCTs also typically provide some sort of assessment of treatment adherence, which is ideally completed by someone familiar with the treatment protocol but blind to the treatment condition of the patient in the session being reviewed.

Since the current case study lacks the above features, the positive findings in terms of outcome must be interpreted in an appropriately circumspect manner. For example, Vumile's case description certainly appears to be consistent with the theoretical stance that cognitive change is critical for symptom reduction (e.g., "…exposure is only effective if it modifies the cognitive processes and structures that maintain the phobia. Vumile's case provides strong evidence for this claim." [Edwards & Kannan, 2006]). However, being a case study with the limitations described above, it is impossible to definitively say that Vumile would not have responded just as well to a treatment consisting of exposure exercises accompanied by a habituation rationale. Alternatively, it is impossible to say whether the mechanism of change in this case was indeed cognitive change or the change in some other variable such as experiential avoidance. Indeed, the issue of whether cognitive therapy (with or without an exposure component) is superior to exposure alone has been a topic of much debate in the literature, with data on this topic being mixed (Rowa & Antony, 2005). Of course, it is also not possible to make statements about the relative effectiveness of therapist-guided exposure alone versus Clark's (1997) protocol based on the RCTs that have been conducted to date (Clark et al., 2003; Strangier et al., 2003). Additional case studies and RCTs designed for the purpose of understanding mechanisms of change and the performance of Clark's (1997) treatment relative to exposure alone are needed before any strong conclusions on this issue can be drawn.

CONCLUSION

The case of Vumile adds to the growing literature supporting Clark and Well's (1995) model and Clark's (1997) treatment manual. The value of the case study lies largely in its ability to breathe life into a theoretical model and manual in a way that is not possible in efficacy studies that must collapse data into groups. Commendably, in addition to providing evidence-based treatment, Edwards and Kannan (2006) supplemented their qualitative clinical observations with quantitative data derived from standardized questionnaires, providing a realistic model of sound clinical practice in which assessment and treatment are integrated. Edwards and Kannan (2006) also demonstrate how clinical practice can feed research with their suggestions about investigating negative, distorted imagery of others among individuals with social phobia. Edwards and Kannan (2006) reported that the follow-up appointments included questionnaires and interviews that targeted what each patient found valuable in the group and to elicit criticisms and suggestions for improvement. It would be interesting to know what, if any, modifications of the treatment approach they might suggest based on the information they obtained in these follow-ups– with such suggestions having the potential to fuel additional research.

In conclusion, the case of Vumile provides an excellent model for clinicians who strive to engage in empirically based practice. Ultimately, it is my hope that cases studies such as this

one will make treatments with research support more understandable and accessible to a broader range of clinicians – inspiring them in a way that a rather sterile RCT report may not. It is also my hope that case studies such as this one will give us insights that help spur new directions in research, so that we might further improve our models and treatment. In these ways, we may make further progress in alleviating the suffering of those with social phobia, a disorder that is both impairing and associated with a very poor quality of life (Hambrick, Turk, Heimberg, Schneier, & Liebowitz, 2003).

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