

## EFFECTIVENESS OF COGNITIVE-BEHAVIORAL THERAPY IN TREATMENT OF SOCIAL PHOBIA

Social phobia is often referred to as social anxiety disorder, it is include by marked and persistent fear and anxiety with exposure to social or performance situation. The lifetime prevalence of SAD in Western countries ranges between 7% and 12% of the population. Two thirds of patients with generalized SAD and one third of patients with nongeneralized SAD have never been married. Generalized SAD is associated with a significantly earlier age of onset (mean = 10.9) than nongeneralized SAD (mean = 16.9). There is little evidence to suggest that traumatic speaking experiences play a dominant role in the onset of social fears. A number of effective treatments for SAD exist, including cognitive therapy, CBT, exposure treatment, and social skills training. According to Barlow's (2002) model of anxiety, perception of low emotional control is a crucial aspect of all anxiety disorders. In fact, social anxiety is closely tied to the social norms of a culture. Negative self-perception plays a central role in the development and maintenance of social phobia.

**Social phobia** - Social phobia is often referred to as social anxiety disorder to make it more consistent with how other anxiety disorders are described (McNillie 2000) according to DSM-IV-TR (2000), social anxiety disorder is include by marked and persistent fear and anxiety with exposure to social or performance situation (e.g., public speaking, writing or eating in public, meeting strangers or author figures), in which the person believe he or she will be scrutinized, negatively judged, or thought of negatively by others, or that person will do or say something to embarrass or humiliate himself or herself. This social anxiety can be found in bout specific and circumscribed situations, such as for public speaking only and more broadly across many social situations, when anxiety reactions are found to be more pervasive and spanning most situations, it is often referred to as "generalized social phobia. (Rosqvist 2005)

### Disorder Prevalence and Characteristics

Social anxiety is the third largest psychological problem in the United States today. This type of anxiety affects 15 million Americans in any given year 90% of the time (3).

Based on a review of the epidemiological literature, the lifetime prevalence of SAD in Western countries ranges between 7% and 12% of the population (Fur mark, 2002; Kessler et al., 2005). The disorder affects females and males fairly equally, with the average gender ratio (female: male) ranging between 1:1 (Moutier & Stein, 1999) and 3:2 (Kessler et al., 2005) in community studies. SAD often begins in the midteens but can also occur in early childhood.

During childhood, SAD is often associated with overanxious disorder, mutism, school refusal, separation anxiety, behavioral inhibition, and shyness. If untreated, the disorder typically follows a chronic, unremitting course and leads to substantial impairments in vocational and social functioning (Davidson, Hughes, George, & Blazer, 1993; Liebowitz, Gorman, Fyer, & Klein, 1985; Schneier et al., 1994; Schneier, Johnson, Hornig, Liebowitz, & Weissman, 1992; Stein & Kean, 2001; Stein, Torgrud, & Walker, 2000; Stein, Walker, & Forde, 1996) (Stefan G. Hofmann Michael W. Otto).

### **Demographics**

Two thirds of patients with generalized SAD and one third of patients with nongeneralized SAD have never been married (Mannuzza et al., 1995). Moreover, some studies have reported that individuals with generalized SAD tend to have a lower socioeconomic status than the residual subgroup of individuals (Brown et al., 1995; Heimberg, Hope, et al., 1990; Levin et al., 1993). However, other studies have found no differences between subtypes with respect to age, gender, and socioeconomic status (Herbert, Hope, et al., 1992; Hofmann & Roth, 1996; Holt, Heimberg, Hope, & Liebowitz, 1992; Mannuzza et al., 1995; McNeil et al., 1995; Stemberger et al., 1995). (Stefan G. Hofmann Michael W. Otto 2008)

### **Developmental Characteristics**

Generalized SAD is associated with a significantly earlier age of onset (mean = 10.9) than nongeneralized SAD (mean = 16.9), with half of the former group developing the disorder before age 10 (Mannuzza et al., 1995). With early onset of social fears and avoidance behavior, one can imagine the developmental challenges faced by these children. With impairments in opportunities for social success, early onset may be one driving force in the generalization of social fears and avoidance patterns. (Stefan G. Hofmann Michael W. Otto 2008).

### **Etiology of SAD**

There is little evidence to suggest that traumatic speaking experiences play a dominant role in the onset of social fears. Of the few studies addressing this issue, Stemberger et al. (1995) examined the presence of traumatic social experiences among 22 individuals who met criteria for generalized SAD, 16 participants who met criteria for a specific subtype, and 25 healthy control participants. The study reported that 56% of individuals with specific SAD and 40% of those with generalized SAD, but only 20% of normal controls, reported the presence of these traumatic social-conditioning experiences. Only the difference between the specific subtype and the control group reached the level of statistical significance. Contrary to this finding, a previous study found that traumatic external events, as well as vicarious and informational learning, were notably uncommon among individuals anxious about public speaking. Instead, individuals tended to attribute their fear most often to panic attacks (Hofmann, Ehlers, & Roth, 1995). Although 89% of the speech phobics in the study

reported traumatic experiences in the past, which is consistent with those of Öst and Hugdahl (1981, 1983), none of them developed SAD after they experienced these traumatic speaking situations. The study further showed that only 15% reported that the traumatic experience occurred at the same time as the onset of SAD. The traumatic experience occurred on average 21.5 years after the onset of SAD. Stemberger et al. (1995) did not examine the temporal relationship between the traumatic event and the onset of the disorder. Therefore, the existing data question the hypothesis that traumatic experiences play a significant role in the etiology of SAD. (Stefan G. Hofmann Michael W. Otto 2008).

Evidence for a genetic contribution to social anxiety comes from family studies, twin studies, and high-risk studies (Fyer, Mannuzza, Chapman, Liebowitz, & Klein, 1993; Horwarth et al., 1995; Kendler, Neale, Kessler, Heath, & Eaves, 1992; Mancini, van Ameringen, Szatmari, Fugere, & Boyle, 1996; Reich & Yates, 1988; Skre, Onstad, Torgersen, Lygren, & Kringlen, 1993). For example, the results of a direct family interview study showed that the risk for developing SAD was approximately 3 times higher for relatives of individuals with SAD than for relatives of never mentally ill controls (Fyer et al., 1993). Similarly, the twin study by Kendler et al. (1992), which was based on over 1,000 female twin pairs, found substantial concordance rates for SAD in identical (24%) and fraternal (15%) twin pairs. Another study by Mancini and colleagues (1996) reported that 23% of the children (with the mean age of 11 years) of adults with SAD met diagnostic criteria for SAD. (Stefan G. Hofmann Michael W. Otto 2008).

### **Contemporary Psychological Treatments**

A number of effective treatments for SAD exist, including cognitive therapy, CBT, exposure treatment, and social skills training (e.g., Heimberg, Salzman, et al., 1990, 1998; Heimberg, Holt, et al., 1993; Heimberg, Salzman, Holt, & Blendell, 1993; Hofmann, 2007; Hofmann & Scepkowski, 2006; Mattick & Peters, 1988; Turner, Beidel, Cooley, Woody, & Messer, 1994; Turner, Beidel, & Cooley-Quille, 1995)

The cognitive therapy protocol by Clark and colleagues (2003, 2006) is an individual approach consisting of 16 sessions. Treatment efforts are directed toward the systematic teaching of an alternative cognitive frame for understanding social situations, social performance, and social risk. Interventions are richly cognitive, asking patients to examine their expectations about social situations and the social costs of imperfect social performances, and then to specifically examine the veracity of these expectations as valued by logical evaluation and, particularly, specific "behavioral experiments" that are designed to test anxiogenic expectations. As compared with more behavioral treatments emphasizing

Exposure alone, the Clark and colleagues protocol devotes more attention to the testing of assumptions in select, carefully arranged—but often exposure-

based—social experiments. What then, is the distinction between cognitive therapy using behavioral experiments to aid therapeutic learning versus a standard exposure protocol? One answer is that cognitive protocols try to substitute in specific learning moments for what may be more nonspecific learning of safety in social situations that come from repeated exposure assignments that may rely on less cognitive preparation or testing of specific anxiogenic predictions. Regarding the performance of this approach, an abbreviated version of the Clark and associates' protocol was developed by Wells and Papa Georgiou (2001). The Clark et al. (2003) trial randomly assigned 60 patients with generalized SAD to one of three conditions: (1) cognitive

Therapy alone, (2) fluoxetine combined with self-exposure, or (3) self-exposure combined with placebo. Treatment efficacy was measured by calculating a SAD composite score that was based on six frequently used self-report measures of SAD and a rating based on a structured clinical interview. The results at post treatment and 12-month follow-up assessments showed that cognitive therapy was superior to the other two conditions, which did not differ from one another. Several authors have suggested that treatment for SAD should include a focused approach on changing dysfunctional beliefs about social situations using logical evaluation on specific behavioral experiments that use experience in social situations to challenge these thoughts (Heinrichs & Hofmann, 2001; Stopa & Clark, 1993, 2000; Wells, Clark, & Ahmad, 1998; Wells & Papa Georgiou, 1998) {Stefan G. Hofmann Michael W. Otto 2008}.

### **The General Treatment Model**

Figure 2.1 provides an overview of the maintaining factors of SAD. This model also includes important mediators of treatment change. Briefly stated, the treatment model indicates that social apprehension is associated with unrealistic expectations regarding social standards and a deficiency for selecting specific and attainable social goals. When confronted with challenging social situations, people with SAD typically shift their attention toward the negative aspects of themselves and their social performance. Depending on the individual patient, this then leads to an overestimation of the negative consequences of a social encounter, perception of low emotional control, negative self-perception as a social being, and/or perception of poor social skills. As a consequence of this attentional shift and perception of poor coping strategies in socially challenging situations, individuals with SAD anticipate and attend to social errors and perceive these errors catastrophically. In the face of this deluge of social threat, maladaptive coping strategies abound, most prominently including social escape, avoidance, and safety behaviors, followed by post-event rumination. The rumination, accordingly, feeds social apprehension in the future.

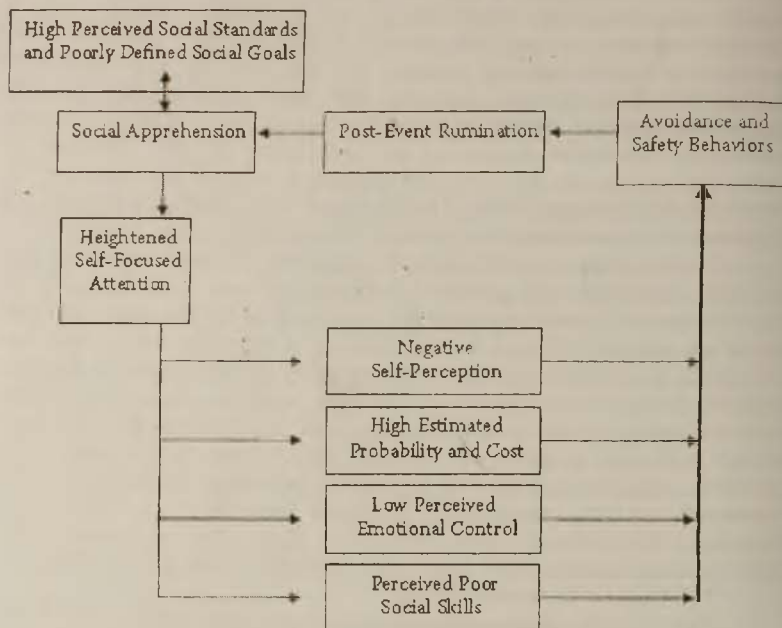


Figure 2.1 CBT model of SAD. From: Hofmann, S.G. (2007) Cognitive factors that maintain social anxiety disorder: A comprehensive model and its treatment implications. *Cognitive Behavior Therapy*, Vol. 36:4, pp. 195–209. Taylor & Francis Ltd., <http://www.informaworld.Com>, reprinted by permission of the publisher.

This model of treatment is not only useful to therapists, but also helps patients understand the purpose of the various treatment strategies. Figure 2.1 is provided to patients at Session 1. The treatment techniques that specifically target the various elements of the model are provided next.

### Perception of Emotional Control

According to Barlow's (2002) model of anxiety, perception of low emotional control is a crucial aspect of all anxiety disorders. During treatment, perceived emotional control is elevated through repeated and prolonged exposure to physiological symptoms of anxiety in social situations while encouraging patients to experience and accept the feeling of anxiety to its fullest. This approach is similar to the acceptance technique in acceptance and commitment therapy, as advocated by Hayes and colleagues (1999).



**Social Standards** - Several models of social anxiety assume that anxiety arises in social situations when individuals wish to convey a desired impression but are unsure about their ability to do so (Clark & Wells, 1995; Leary, 2001; Trower & Gilbert, 1989). In fact, social anxiety is closely tied to the social norms of a culture (Heinrichs et al., 2006). Studies have further demonstrated that individuals with SAD show a discrepancy between perceived social standards and their perceived social abilities (Alden, Bieling, & Wallace, 1994; Alden & Wallace, 1991, 1995; Wallace & Alden, 1991, 1995). This discrepancy was found to be largely due to the individuals' underestimation of their ability level in relation to the perceived social standards and desired goals.

A recent study by Moscovitch, Hofmann, Suvak, and In-Albon (2005) provided individuals with generalized SAD with cues indicating that standards for their performance were high, low, or ambiguous. Individuals with SAD rated their performance as being worse only in the high and ambiguous conditions as compared to nonanxious controls. The results suggest that information about social standards moderates retrospective self-appraisals of social performance. Emotions may also shift these standards (affect-as-information model; Cervone, Kopp, Schaumann, & Scott, 1994), with the notion that experiencing negative effects can implicitly influence people to set higher minimal standards for their performance (Scott & Cervone, 2002).

**Goal Setting** - Leary and colleagues (Leary & Kowalski, 1995; Schlenker & Leary, 1982) offer that social anxiety occurs if individuals doubt that they are able to make a desired impression on other people and if they feel that they are unable to attain their goals in a social situation.

### **Self-Focused Attention**

The cognitive model assumes that when confronted with social threat, socially anxious individuals shift their attention inward and engage in a process of detailed monitoring and observation of themselves, which is consistent with some of the information processing literature (e.g., Heinrichs & Hofmann, 2001). Recent studies show that under conditions of high self-focused attention, individuals with SAD experience spontaneous, recurrent, and excessively negative self-images, which they believe to be accurate at the time they occur (Hackmann, Clark, & McManus, 2000; Hackmann, Surawy, & Clark, 1998; Hofmann & Heinrichs, 2003). These negative self-images are causally related to social anxiety (Hirsch, Clark, Matthews, & Williams, 2003).

**Self-Perception** - Socially anxious or phobic individuals under social threat experience self-discrepancies that are characterized by an underestimation of their abilities relative to others' standards (Alden, Bieling, & Wallace, 1994; Wallace & Alden, 1991).

Negative self-perception plays a central role in the development and maintenance of social phobia (e.g., Hook & Valentiner, 2002). Cognitive

theories (e.g., Beck & Emery, 1985; Clark & Wells, 1995; Rapee & Heimberg, 1997) posit that on the basis of early learning experiences,

individuals with social phobia develop a number of distorted, negative assumptions about themselves (e.g., "I'm stupid," "I'm unattractive"; Clark & Wells, 1995) that become reinforced over time by selective information processing errors that occur both within and between social encounters (see Bögels & Mansell, 2004; Clark & McManus, 2002;

**Estimated Social Cost** - One of the most popular accountings of the crucial change processes in Cognitive Behavioral Therapy (CBT) is that alternations in cognitiveschemata account for therapeutic benefits. This notion has been studied primarily in investigations of major depression (Barber & DeRubeis, 1989; Evans & Hollon, 1988; Hollon, Evans, & DeRubeis, 1990; Whisman, 1993). Likewise, researchers of anxiety disorders believe that effective psychotherapy either directly modifies the patient's irrational beliefs or deactivates them while making other schemata available.

Clark and Wells (1995) argue that individuals with SAD believe that "(1) they are in danger of behaving in an inept and unacceptable fashion, and (2) that such behavior will have disastrous consequences in terms of loss of status, loss of worth, and rejection" (pp. 69-70). Consistent with this model are the results from studies showing that socially anxious individuals believe that negative social events are more likely to occur than positive social events (Leacock & Salkovskis, 1988),

#### **Comparison medical therapy with CBT:**

Basically social phobia is in foundation a disorder of misperception, guided by faulty thinking and flawed reasoning, the first therapeutic step involved cognitive interventions aimed at teaching to clients to better evaluate just whom they thinking and reasoning. Not surprisingly, it was quick discovered they engage in a variety of common thinking errors, such as all-or nothing, fortune telling, catastrophizing emotional reasoning, labeling and mind reading

Medical treatment usually includes anti anxiety and beta blockers such as Inderal. Drugs absolutely can decrease the patients' anxiety but cannot change their beliefs. Therefore, if it is supposed to prescribed drug to treat SAD, it must be associated with CBT unless selective treatment for SAD is CBT.

**Conclusion:** - Social anxiety disorder (ASD) is one of anxiety disorders, often referred to as social phobia.

Basically social phobia is in foundation a disorder of misperception, guided by faulty thinking and flawed reasoning, the first therapeutic step involved cognitive interventions aimed at teaching to clients to better evaluate just whom they thinking and reasoning. There are different treatments methods to the disorders. Studies point out CBT in comparison others methods are effective. As mention, some factors like, Perception of Emotional Control, Social Standards, Goal Setting, Self-Focused Attention, Self-Perception and Estimated

Social Cost, within all of them there are kind of cognitive distortions for example, Individuals with SAD believe that "(1) they are in danger of behaving in an inept and unacceptable fashion, and (2) that such behavior will have disastrous consequences in terms of loss of status, loss of worth, and rejection. CBT by given opposed these maladaptive schemas treat the ASD. Drugs absolutely can decrease the patients' anxiety but cannot change their beliefs. Therefore, if it is supposed to prescribe drugs to treat SAD, it must be associated with CBT unless selective treatment for SAD is CBT.

#### Reverences:

- 1-Stefan G. Hofmann & Michael W. Otto "Cognitive Behavioral Therapy for Social Anxiety Disorder" © 2008 by Taylor & Francis Group, LLC Routledge is an imprint of Taylor & Francis Group, an Informa business.
- 2-(Rosqvist johan "Exposure treatment for anxiety disorders "BY Taylor & francis group 2005 new york.
- 3-<http://www.socialphobia.org/whatis.html#top>
- 4- Rosqvist johan "exposure treatment for anxiety disorders "Routledge 2005 New York and Hove.

#### Ճանաչողական-վարվեցողական բուժման արդյունավետությունը հասարակական ֆոբիայի բուժման հարցում

«Հասարակական ֆոբիան» սովորաբար ընդունվում է որպես հասարակական հուզմունքային խանգարումներ, որոնք դրսևորվում են հասարակական իրավիճակներին հանդիպման ժամանակ կայուն վախի տեսքով: Արևմտյան երկրներում այս խանգարումների տարածումը կազմում է ընդհանուր բնակչության 7-12 տոկոսը: Ընդհանրացված տեսակի «հասարակական ֆոբիայով» տառապող հիվանդների երկու երրորդը երբեք չի ամուսնանում, իսկ ոչ ընդհանրացված տեսակի դեպքում՝ մեկ երրորդը: Ընդհանրացված տեսակի հասարակական հուզմունքային խանգարումները սկսվում են փոքր տարիքից (միջին ցուցանիշը՝ 10.9), իսկ ոչ ընդհանրացված տեսակի դեպքում այդ ցուցանիշը կազմում է 16.9: Այդ խանգարումների վերացման հարցում գոյություն ունեն մի շարք արդյունավետ բուժումներ, ինչպիսիք են՝ ճանաչողական-վարվեցողական բուժումը (CBT), ամերեանյան բուժումը եւ հասարակական հմտությունների ուսուցումը: Հուզմունքների վերաբերյալ Բարլոյի (2002) տեսության համաձայն, հուզմունքների զսպման մասին ցածրամակարդակ ընկալումն էական դերակատարություն ունի հուզմունքային բոլոր խանգարումների հարցում: Իրականում հասարակական հուզմունքային խանգարումները սերտ կապ ունեն մշակույթի եւ այլ օրինաչափությունների հետ: Բացասական ինքնաընկալումը հիմնական դերակատարություն ունի «հասարակական ֆոբիայի» զարգացման եւ շարունակման հարցում: