Edited by
Justin W. Weeks

THE WILEY BLACKWELL HANDBOOK OF
Social Anxiety Disorder

WILEY Blackwell

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Justin W. Weeks

Center for Evaluation and Treatment of Anxiety (CETA)
Ohio University

WILEY Blackwell

*To my parents, for setting me on the scholarly path,
and for their continued inspiration.*

John and Jeanne Weeks

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Part VI Treatment

Notes on the Contributors

Lynn E. Alden is a Professor of Psychology at the University of British Columbia and a former president of the Society for Interpersonal Theory and Research. Her research addresses the interplay of cognitive and interpersonal processes in the anxiety disorders. She has published numerous papers on social anxiety disorder and, with Ray Crozier, has published several volumes on shyness and social anxiety.

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Professor Eni S. Becker is chair of Clinical Psychology and the director of the research program "Experimental psychopathology and treatment" of the Behavioural Science Institute at the Radboud University Nijmegen. She is also chair of Nij-CARE (Nijmegen Centre of Anxiety research and Expertise). Her research interests are cognitive processes in anxiety and depression, approach and avoidance behaviour as well as cognitive bias modification.

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Carlos Blanco, MD, PhD, is a Professor of Clinical Psychiatry at the New York State Psychiatric Institute/Columbia University. The focus of his research is the epidemiology and treatment of mood, anxiety and addictive disorders. His research has been supported by NIH, the New York State Psychiatric Institute and several private foundations.

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Laura B. Bragdon is a research coordinator at The Anxiety Disorders Center at Hartford Hospital's Institute of Living. She received her MA degree in clinical psychology from Columbia University in 2011. Most recently she coauthored the article "The evidence-based pharmacotherapy of social anxiety disorder." (*International Journal of Neuropsychopharmacology*, 21, 1–15. E-pub ahead of print).

Julia D. Buckner, PhD, is a licensed clinical psychologist and assistant professor in the Department of Psychology at Louisiana State University. She directs the LSU Anxiety & Addictive Behaviors Research Laboratory and Clinic. Her research efforts aim to understand factors that contribute to the co-occurrence of anxiety and problematic substance use. She also works to improve treatment outcomes for patients with anxiety disorders, with particular focus on patients with co-occurring substance use.

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Wieke de Vente is an Assistant Professor at the Research Institute of Child Development and Education, University of Amsterdam. Her research focuses on

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Samantha G. Farris, BA, is a clinical psychology doctoral student at the University of Houston. She received her BA in psychology from Rutgers University, while working at the Center of Alcohol Studies. After completing her degree, Ms. Farris worked as a research coordinator at the Center for the Treatment and Study of Anxiety, at the University of Pennsylvania. Her research primarily addresses the interrelations between emotional and stress vulnerabilities and substance use disorders.

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Evan M. Forman, PhD, is Associate Professor and Director of Graduate Studies at Drexel University. Research interests include the development and evaluation of acceptance-based behavioral interventions for health behavior change (especially obesity) as well as mood and anxiety disorders; neurocognitive contributors to, and interventions for, overeating; and remote treatment.

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Joel Gelernter, MD, is Foundations Fund Professor of Psychiatry and Professor of Genetics and of Neurobiology at Yale University where he is Director, Division of Human Genetics (Psychiatry). He is also staff psychiatrist at the VA Connecticut Healthcare Center in West Haven, CT. Dr. Gelernter has been conducting genomic research in the areas of substance use disorders and anxiety disorders for the past 25 years.

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Dina Gordon, MA, is a clinical psychology doctoral candidate at Temple University working under the mentorship of Dr. Richard Heimberg. She was trained in cognitive-behavioral therapy for adults with social anxiety disorder at the Adult Anxiety Clinic of Temple. Her research interests lie in the nature and treatment of anxiety disorders, specifically, in the roles of emotion regulation, mindfulness, distress tolerance, and experiential avoidance in the anxiety cycle and as moderators of treatment outcome.

Elizabeth A. Gordon, MA, is a clinical psychology doctoral candidate at Temple University working under the mentorship of Dr. Richard Heimberg. Her primary research interests include interpersonal processes among those who suffer with high social anxiety, such as communication within intimate relationships. She is also interested in how evolutionary and social psychological models can inform conceptualization and treatment of anxiety disorders and other mental health problems.

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Amie E. Grills-Taquechel is an Assistant Professor of Counseling Psychology in the School of Education at Boston University. She has published in the areas of childhood anxiety and related disorders, trauma, and evidence-based assessment and treatment of children for the past 10 years. She has also given numerous conference presentations, secured grants, and received prestigious awards, including selection as a 2011 American Psychological Society Rising Star.

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Richard G. Heimberg, PhD, is the Director of the Adult Anxiety Clinic of Temple University. He is well known for his efforts to develop cognitive-behavioral treatments for social anxiety and examine their efficacy in comparison to (or in combination with) medication treatments. He has published 11 books and more than 350 papers on this and related topics. His research has been supported by a number of grants from the National Institute of Mental Health.

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Justin W. Weeks, PhD, is the Director of the Center for Evaluation and Treatment of Anxiety (CETA) at Ohio University. He is the author of a number of scientific publications and book chapters—the majority of these publications focus specifically on social anxiety and social anxiety disorder. Dr. Weeks is well known for his work on fear of positive evaluation as a proposed core element of social anxiety disorder, as well as on the enhancement of objective assessment of social anxiety symptoms.

Judy Wong, MA, is a clinical psychology doctoral candidate at Temple University working under the mentorship of Dr. Richard Heimberg. Her primary research interests include the influence of culture, ethnic minority status, and immigration on mental health. Specifically, she is interested in looking at attitudes and factors associated with culture and ethnicity that influence treatment-seeking behavior. She is also interested in examining cultural competence in therapy.

I
Theoretical Overview
Social Anxiety Disorder

1

Cognitive-Behavioral Models of Social Anxiety Disorder

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Cognitive-Behavioral Models of Social Anxiety Disorder

Since its recognition as a mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (American Psychiatric Association, 1980), social anxiety disorder (SAD, also known as social phobia) has received increasing attention in the field of psychology as a complex, debilitating disorder that, left untreated, is often unremitting. In the last few decades, many theorists have contributed significantly to our understanding of this disorder, subsequently informing approaches to treatment. In this chapter, we review and compare aspects of the two preeminent cognitive behavioral models of SAD, as well as more recently proposed models of SAD.

Clark and Wells (1995): A Cognitive Model of SAD

Clark and Wells (1995) put forth a cognitive[1] model of SAD to explain why exposure to feared situations alone was not enough to extinguish fear in socially anxious individuals. According to their model, SAD develops as a result of an interaction between innate behavioral predispositions and life experiences, leading individuals to perceive the social world as a dangerous one which they have little ability to navigate. A core feature of this model, derived from self-presentational models described below, is "a strong desire to convey a particular favorable impression of oneself to others and marked insecurity about one's ability to do so" (p. 69). These beliefs contribute to the sense that the person with SAD is at substantial risk of behaving in an inept and unacceptable fashion and that such behavior will have catastrophic consequences involving loss of status, loss of value, or rejection. The following is a brief overview of the model—a discussion of the empirical support for specific aspects of the model is beyond the scope of this chapter, but interested readers are referred to reviews of research by Clark and Wells (1995) and Clark (2001).

Dysfunctional Processes

Clark and Wells (1995) describe the dysfunctional pattern of social anxiety as being comprised of four interactive processes. The first process begins when people with SAD enter a feared situation and judge that they may be in danger of being negatively evaluated. They then turn their attention inward and use interoceptive information as the main source of feedback about their performance. Often, their internal experiences appear to provide confirmation of their social ineffectiveness, which is believed to be obvious to those around them (e.g., "I feel nervous, therefore everyone must realize I am nervous"). Compounding this negative self-perception, people with SAD often imagine themselves as others see them (the "observer perspective"), though these images are likely to be quite distorted. Clark and Wells refer to this attentional inward bias and distorted images as a *processing of the self as a social object*, and this is the putative reason why exposure alone to feared situations is insufficient to reduce social anxiety. They write:

> Clinically, the importance of this processing bias is that it prevents social phobics from getting maximum benefit from their everyday experience with social situations or from the exposure exercises used in behavior therapy treatment programs. When in feared social situations, social phobics process the negative feelings generated by their fear of the situation, but they do not check out what is really happening. (p. 72)

The second dysfunctional process relates to behaviors that socially anxious individuals engage in to prevent negative evaluation by others. Clark and Wells (1995) refer to these behaviors as *safety behaviors*. For instance, a person concerned with others noticing his profuse sweating may wear an extra layer of dark clothing. Ironically, safety behaviors often make the feared behavior or outcome more likely to occur: the extra layer of clothing may cause the person to sweat more. Safety behaviors also serve to maintain anxiety because they prevent the person from experiencing unambiguous, disconfirming evidence of their negative beliefs about feared consequences. So, although the feared outcome may not have occurred (e.g., people did not express disgust about the person's sweating), the person with SAD may attribute this to the fact that he or she engaged in this safety behavior.

The third dysfunctional process described by Clark and Wells (1995) is that individuals with SAD often overestimate how negatively others evaluate their performance and predict the consequences of social failures to be far worse than is realistic. As a result of these cognitive distortions, they are hypervigilant in monitoring their behavior and performance, which may further impair their ability to fully engage in social interactions. Real performance deficits may result, which could lead to others perceiving them to be socially unskilled, aloof, or unfriendly.

The final dysfunctional process delineated by Clark and Wells (1995) occurs either before or after a social situation is encountered. Prior to engaging in a social event, many individuals with SAD frequently experience a period of anticipatory anxiety in which previous negative experiences are recalled, and expectations of failure and images of the self performing poorly are evoked. This can lead to complete avoidance of the

situation. However, if the situation is not avoided, anticipatory anxiety can lead the person to enter the situation with a self-focused processing mode and reduced capacity for noticing positive reactions from others. Following a social interaction, people with SAD frequently review their performance in detail (referred to by Clark and Wells, p. 74, as a "postmortem" review or "post-event processing"), often recalling events and their outcomes to have been more negative than they really were, as their perceptions are colored by their attentional biases and cognitive distortions. Ultimately, this helps maintain negative self-schemas and increases the likelihood that the person will avoid feared situations in the future.

Rapee and Heimberg (1997): A Cognitive-Behavioral Model of SAD

Along with Clark and Wells' (1995) and Rapee and Heimberg's (1997) model is the other most widely cited and applied model of SAD in the literature. According to Rapee and Heimberg, social anxiety exists along a continuum, with individuals with SAD representing the higher end of the continuum. Similarly, the degree of dysfunctional patterns can be represented along a continuum. Thus, according to the model, the difference between those with SAD and those without is "the extent to which [individuals with SAD] appraise cues as predictive of threat and the extent of threat predicted by a given cue" (Rapee & Heimberg, 1997, p. 751).

   A number of different factors are thought to influence the development of dysfunctional processes, which in turn lead to the development of SAD. A genetic tendency toward preferential attention to threat may be one factor, which interacts with early childhood family environment and/or other experiences (e.g., being teased or bullied) to create a perception of the social world as being dangerous and unforgiving. Consequently, a defining characteristic among those with SAD is the assumption that others are likely to evaluate them negatively. Additionally, individuals with SAD attach fundamental importance to being accepted by others. The result is a set of expectations and goals that the person feels unable to reach, accompanied by predictions of very negative consequences of this failure. The discrepancy between the mental representations of the self as seen by others and others' perceived expectations, according to Rapee and Heimberg (1997), lies at the heart of SAD. Below, we provide an overview of the model, including its recent update (Heimberg, Brozovich, & Rapee, 2010). As with the Clark–Wells model, a discussion of the empirical support for the Rapee–Heimberg model is beyond the scope of this chapter. Interested readers are referred to the original theoretical articles for reviews of empirical research; see also Roth and Heimberg (2001) and Turk, Lerner, Heimberg, and Rapee (2001).

Dysfunctional Processes

In this model, "social situations" are defined broadly and may include situations in which no social interaction actually occurs, as the presence of a *perceived* threat may be enough to evoke anxiety. Thus, the stranger walking down the street may become

an audience for and potential judge of the socially anxious person's appearance and behavior. For individuals with SAD, the prospect of an audience activates a mental representation of the self as they imagine they are perceived by that audience. This mental representation of the self is a distorted image that is shaped by a number of inputs. Rapee and Heimberg (1997) proposed that individuals form a "baseline image" (p. 745) that may be derived from past experiences and actual images of the self as seen by an audience (e.g., from mirrors or photographs) and which is consistent with negative self-schemas and core beliefs. It is modified in any given situation by internal (i.e., interoceptive) and external feedback. For instance, sensations of warmth may cause the person to imagine herself to be blushing noticeably, or a passing and ambiguous comment by another person in a group interaction may lead the person to think she has said something contrary to group opinion, and she thus imagines that she "looks stupid."

According to the model, one reason this mental representation of the self as seen by the audience is distorted is that individuals with SAD have a bias toward attending to external cues in the social environment that signal threat or negative evaluation. This orientation to threat is consistent with other anxiety disorders. However, Rapee and Heimberg (1997) also hypothesized that individuals with SAD also preferentially allocate attentional resources to monitoring and adjusting the mental representation of the self as perceived by the audience. This is in addition to the attentional resources needed to engage in the social task at hand. Consequently, social performance suffers as attentional resources are taxed, and the poor performance only serves to confirm negative mental representations of the self (e.g., that one is socially unskilled, awkward, etc.).

The model proposes that a key dysfunctional process is the comparison of the mental representation of the self with the perceived expectations of the audience. Socially anxious individuals typically believe that others hold extremely high standards for their performance, and the greater the perceived failure to live up to this standard, the greater the likelihood of negative evaluation, and the greater the anxiety. Socially anxious individuals anticipate the cost of such failure to be high, and this anticipation activates behavioral, cognitive, and physical symptoms of anxiety, which feed back into the mental representation of the self as seen by the audience in a most deflating way, renewing the vicious cycle, which continues until the situation comes to a natural end or is terminated by the anxious person. It is therefore not surprising that socially anxious individuals often engage in avoidance or escape from feared situations, as it seemingly provides respite from this cycle. However, behavioral avoidance becomes yet another source of shame and frustration and contributes to an increasingly negative mental representation of the self as seen by the audience.

In 2010, Heimberg et al. published an updated version of the model to incorporate knowledge from new findings about the processes that occur in SAD. For instance, a growing body of research has shown that individuals with SAD frequently engage in negative self-imagery (e.g., Hackman, Surawy, & Clark, 1998). In addition, compared with non-anxious individuals, the images of socially anxious individuals are often from the observer's perspective (Hackman et al., 1998). These findings are consistent with the theory that those with SAD formulate a mental representation of

the self as seen by the audience. The updated model highlights the role of negative imagery in influencing the mental representation of the self, and ultimately serving to maintain SAD.

A significant change to the model addresses what is thought to be the core fear in SAD, typically characterized as a fear of negative evaluation. However, recent research suggests that socially anxious individuals fear *any* evaluation, whether it is negative or positive (e.g., Weeks, Heimberg, Rodebaugh, & Norton, 2008; see **Chapter 20** of this volume). Fear of positive evaluation (FPE) may arise when successful social performance activates the belief that others will expect continued success in future social interactions, but the person may doubt his or her ability to meet these increased expectations. However, the construct of FPE is derived from an evolutionary model of SAD, which posits that socially anxious individuals work to maintain their (low) social status by not drawing attention to themselves (Gilbert, 2001; see **Chapter 2** of this volume). In this way, they do not risk losing status, nor will they have to engage in conflict with more powerful others to defend any elevated social status they may have achieved. The update to the Rapee–Heimberg model reflects this line of thinking, and the model now posits that those with SAD fear and attend to cues of evaluation, regardless of valence.

Lastly, another significant addition to the Rapee–Heimberg model is the inclusion of post-event processing (PEP) as a maintaining factor of SAD. As discussed by Clark and Wells (1995), PEP refers to the phenomenon of a person's review and recall of a situation after it has occurred. Often, the recall is biased and distorted, which then fuels fear and avoidance of future situations. PEP can therefore be conceptualized as the ongoing process that links the experience of one social situation to the next.

Comparisons Between the Models

As acknowledged by both teams of researchers, there is substantial common ground between the two models, with more points of agreement than difference. Both models highlight the excessive application of attentional resources to identifying threat cues, maladaptive avoidance behaviors, and the dysfunctional cognitions held by socially anxious individuals. These dysfunctional cognitions include distorted mental representations of the self as seen by others, unrealistic standards of performance, and unrealistically negative expectations of the consequences of a discrepancy between the two. According to both models, a lack of social skills is not a fundamental or universal difficulty among individuals with SAD. Rather, they suggest that social skills may be intact in socially anxious people, but anxiety, negative cognitions, or avoidance/safety behaviors may impede social interaction and give the appearance of social skill deficits (see **Chapter 17** in this volume for further discussion of social skills deficits in SAD).

A primary but subtle difference distinguishes the two models, and it concerns the nature of attentional focus that occurs among individuals with SAD. Clark and Wells (1995) assert that the core attentional bias in SAD is the person's shift to monitoring

internal cues, which prevents the person from attending to the actual reactions from others:

> Instead of observing other people more closely in order to gain clues about what they think about him or her, the social phobic appears to turn attention inwards, notice how he or she feels, and then automatically assume that this information is relevant to others' evaluation. (p. 71)

In contrast, Rapee and Heimberg (1997) emphasize that, although there is an increase in self-focused attention with increased anxiety, attention is directed externally in search of threat cues:

> [S]ocial threat takes the form of potential negative evaluation from others. Thus, individuals with social phobia will scan the environment for any signs of impending negative evaluation, will detect such signs rapidly, and will have difficulty disengaging attention from them. (p. 746)

Clark (2001) asserts that processing of external social cues *does* occur—and is negatively biased—but that this processing is reduced due to the direction of the person's attention toward internal cues. In contrast, Rapee and Heimberg describe a more interactive relationship between self-monitoring of internal cues and monitoring of the environment for external threat (Schultz & Heimberg, 2008)—persons with SAD essentially vacillate between searching for threat in the external environment and "looking" internally to evaluate the resources that they can marshal to defend against the threat.

In addition, the two models differ in the degree to which safety behaviors are featured as a core dysfunction in SAD. Rapee and Heimberg (1997) recognize in their model that socially anxious individuals are likely to engage in subtle avoidance behaviors aimed at reducing negative outcomes (e.g., joining a group conversation but remaining at the periphery), otherwise known as safety behaviors. Safety behaviors are not described as necessarily more problematic than overt avoidance in the Rapee–Heimberg model. In contrast, safety behaviors are seen as a core problem in the Clark–Wells model and are featured prominently in the illustrated diagram of the model (as revised by Clark, 2001).

Unsurprisingly, these differences are evident in the treatments associated with each theoretical model. In the treatment based on the Clark–Wells model, a central strategy is to help clients identify their safety behaviors and to compare their experiences using them and dropping them (Clark, 2001; Clark & Wells, 1995). In the second phase of treatment, clients are encouraged to shift to an external focus of attention while also dropping safety behaviors. As with other cognitive-behavioral treatments, behavioral exposures are coupled with cognitive restructuring to challenge distorted thinking and predictions of negative outcomes.

The basic cognitive-behavioral tenets of the treatment associated with the Rapee–Heimberg model are similar (Hope, Heimberg, & Turk, 2010). However, treatment is aimed at training socially anxious individuals to direct their attention away from the mental representation of the self and from indicators of evaluation in the