The behavioral and cognitive therapy for social phobia
Mersch, Peter Paul Alois

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Conclusions and discussion

In this chapter the results of the studies described in the preceding chapters will be discussed in a broader perspective. Also, some critical remarks will be made about the clinical and diagnostic state of the art in social phobia. Finally, suggestions for future research will be made.

Discussion of the results

In general, it can be concluded that three treatments have shown to be effective: social skills training, cognitive therapy and exposure in vivo, while the effectiveness of applied relaxation is, at this stage, questionable and awaits further study (see chapter 1). Although these treatments are effective, it is generally felt that, in comparison to other anxiety disorders (e.g., agoraphobia, panic disorder and simple phobia) their effectiveness is less. Follow-up studies show that too many patients need additional treatment and of the patients that did not need additional treatment a considerable percentage shows a relapse (see chapter 8 and 9). The most important hypothesis for this state of affairs is that in social phobia individual differences are large (e.g., Marzillier & Winter, 1983; Scholing & Emmelkamp, 1990). Therefore, from the first studies on social phobia on (e.g., Kanter, & Goldfried, 1979: high vs. low social anxious; Trower, Yardley, Bryant, & Shaw, 1978: unskilled vs. social phobic patients), the influence of subtype of social phobia and treatment effectiveness has been an important topic in research. A somewhat different approach in this context is the classification of patients on the basis of disturbances in one of three response systems, the psychophysiological, the cognitive and the behavioral system (Lang, 1971; Rachman and Hodgson, 1974). Öst, Jerremalm, & Johansson (1981) found some support that a treatment matched to the specific response system deficiency was more effective than a treatment that was not. A study by Jerremalm, Jansson, & Öst (1986) was not able to replicate these findings.

The Mersch, Emmelkamp, Bögels, and Van der Sleen (1989) study (chapter 4) applied more rigid criteria, in order to create more extreme patient groups. However, this study also failed to confirm the hypothesis that treatments matching patient characteristics are more effective than treatments that do not. One of the fundamental issues in these three studies is the choice of assessment instruments to divide patients in the respective reactor group. Often, these instruments are not psychometrically studied and developed for the study at hand. Whether or not these instruments are valid with respect to their purpose is questionable. For the Mersch et al. (1989) study both the cognitive criteria variable (the Rational Behavior Inventory; Sanderman, Mersch, Van der Sleen, Emmelkamp, & Ormel, 1987) as well as the behavioral variable (the Simulated Social Interaction Test; Mersch, Breukers, & Emmelkamp, 1992; see chapter 3) were analyzed. The behavioral test (SSIT; Curran, 1982) was translated in Dutch and adapted for use on both male and female subjects. This did not affect the reliability of the test. The SSIT appeared to have high reliability coefficients, which were comparable with figures from studies in the USA. The Mersch et al. (1992) study confirmed the hypothesis that social behavior is largely situation specific (Bellack, 1983; Nelson, Hayes, Felton, & Jarre, 1985; Westberg, Curran, Monti, Corriveau, Coyne, & Dziadosz, 1981). The consequences of this result will be discussed in the subjects, with a per...
tudies in the USA. The Mersch et al. (1992) study confirmed the test. The SSIT appeared to have high reliability coefficients, but all researchers, & Emmelkamp, 1992; see chapter 3) were analyzed. The social characteristics are more effective than treatments that do not. One subgroup of social phobia has recently received growing attention, namely patients with an additional personality disorder. An important question is whether the presence of a personality disorder has influence on the effectiveness of treatments for social phobia. Several authors have emphasized that social phobics may be hard to treat with cognitive-behavioral or pharmacological treatments (Heimberg, Dodge, & Becker, 1987; Greenberg & Stravynski, 1983). According to Heimberg et al. (1987) a patient with APD ‘...has little desire to confront the phobic event and has adopted avoidance as a comfortable if unfurling life-style...' and ‘...the avoidant personality would appear to be a poor risk for treatments such as our multicomponent group program’ (p.302). The one study performed so far seems to confirm this notion. Turner (1987) compared the effectiveness of a cognitive-behavioral group treatment for social phobic patients without personality disorder (n=6) and for social phobic patients with personality disorder (n=7). At the posttest two patients were diagnosed as avoidant, three as schizotypal, one as borderline, while one patient had two Axis II diagnoses, avoidant and borderline. On most anxiety and avoidance measures, the patient group without personality disorder improved significantly more than the group with personality disorder.

Results of the Mersch, Jansen, and Arntz (1993) study are much more encouraging. Although patients with a personality disorder had more severe complaints at the pretest, this did not influence treatment outcome.
(chapter 6). Both groups appeared to benefit equally from the treatments on all variables. Nevertheless, the functioning of personality disorder patients at the first follow-up was on most variables significantly worse than that of patients without personality disorder. This means that although patients with personality disorder benefit from a relatively short structured behavioral treatment, this is not enough to reach an acceptable end-state functioning. On most variables the end-state functioning of personality disorder patients is about equal as the pretreatment functioning of patients without personality disorder. It may be hypothesized that for patients with a personality disorder the treatment, although effective, must be considerably longer.

Little is known about the long-term effectiveness of cognitive-behavioral treatments for social phobia. In a review of the literature (chapter 8) the reasons for this state of affairs are discussed. In the first place, the follow-up periods are relatively short. Only six studies, of which two were case-studies, published so far (Alström, Nordlund, Persson, Harding, & Ljungqvist, 1984; Biran, Augusto, & Wilson, 1981; Stravynski, 1983; Wizalo, Schroeder-Hartwig, Hand, Kaiser, & München, 1990; Scholing & Emmelkamp, 1993a,c) reported follow-up periods of more than six months. These generally short follow-up periods prevent conclusions about relapse. More serious, however, are the methodological flaws in the designs. Especially the lack of information on additional treatments and medication, the inclusion of booster sessions or homework between posttest and follow-up and the undocumented omission of variables are violations of a sound methodology of this phase of the studies and tend to exaggerate maintenance of treatment effect. Therefore, a more creative use of the possibilities of follow-up research was proposed.

The results of the follow-up study (Mersch, Emmelkamp, & Lips, 1991) of the patients of the Mersch et al. (1989) study, show the merits of a more elaborate approach (chapter 9). In general there was a clear maintenance of treatment effect. If the different groups of patients are analyzed separately, however, the results were less favorable. Of the 57 patients who participated in the follow-up assessment no less than 25 (44%) had received additional treatment between follow-up I and follow-up II. Furthermore, of the 32 patients that did not receive additional treatment, 9 showed a significant relapse. Overlooking the consequences of these findings, it appears that of the 74 patients starting the treatment, for only 23 patients (31%) the treatment was successful. The main reason for this finding may be that the treatments were too short (cf. Scholing, 1993). Another important finding of this study is that a short follow-up period (in our study the first follow-up was after 6 weeks) does not seem to give additional information. Finally, it appeared that level of social skill may be an important outcome predictor. From a methodological point of view this study shows how a more thorough data analysis may give important additional information.

Critical remarks and suggestions for future research.

Clinical considerations

In the treatment of social phobia, there seems to be a group of patients that is hard to treat, no matter what treatment is given. This group seems to be delineated by more serious initial psychopathology and may benefit from prolonged treatment. Another indication for the importance of treatment duration is the number of additional treatments. Comparison of the results of four long-term follow-up studies (Mersch et al., 1991; Mersch, 1993; Scholing & Emmelkamp, 1993a,c) of treatment and number of additional treatment in the (1989) study, it seems that duration of treatment (Scholing, 1993), maybe even more so than whether more treatment time is needed to deal with the target phobia.

Subgroups in social phobia

As mentioned, social phobic patients are composed of different subgroups. This point of view was expressed by the DSM-III-R (1987) (type) of social phobics. The question is which subgroup is the most problematic?

Most research has focused on the distinction between social phobia and personality disorder. Results from several studies (Mersch et al., 1991; Turner, Opes, & Hope, 1992; Mersch et al., 1993; Turner, 1992) show that the differences that are found in these subgroups in social phobia. It is possible that this is not the case. It is likely that when patients with an Axis II disorder are diagnosed and treated, who are severely disturbed the outcome will be worse. In other words, it is likely that a study comparing patients with agoraphobic patients who fear supermarkets with agoraphobic patients who fear leaving homes and restaurants, would find more severe pathology than the 'generalized social phobics' reported in the (Heimberg et al., 1990) study. A problem with the division of social phobia is that the diagnosis of specific or discrete or two social situations (e.g., speaking in public) is given to patients who fear most social interactional anxiety, like going to parties, supermarkets with agoraphobic patients who fear leaving homes and restaurants, would find more severe social phobic patients diagnosed with the specific subtype (Scholing & Emmelkamp, 1993) with less severe pathology than the 'generalized social phobics' reported in the (Heimberg et al., 1990) study. Also, patients with the specific subtype (Scholing & Emmelkamp, 1993) with less severe pathology than the 'generalized social phobics' reported in the (Heimberg et al., 1990) study. It is likely that when patients with any Axis II disorder are diagnosed and treated, who are severely disturbed the outcome will be worse. In other words, it is likely that a study comparing patients with agoraphobic patients who fear leaving homes and restaurants, would find more severe pathology than the 'generalized social phobics' reported in the (Heimberg et al., 1990) study. A problem with the division of social phobia is that the diagnosis of specific or discrete or two social situations (e.g., speaking in public) is given to patients who fear most social interactional anxiety, like going to parties, supermarkets with agoraphobic patients who fear leaving homes and restaurants, would find more severe social phobic patients diagnosed with the specific subtype (Scholing & Emmelkamp, 1993) with less severe pathology than the 'generalized social phobics' reported in the (Heimberg et al., 1990) study. Also, patients with the specific subtype (Scholing & Emmelkamp, 1993) with less severe pathology than the 'generalized social phobics' reported in the (Heimberg et al., 1990) study.
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of patients that is hard to treat, no matter what serious initial psychopathology and may benefit important of treatment duration is the number of long-term follow-up studies (Mersch et al., 1991; Mersch, 1993; Scholing & Emmelkamp, 1993b,c) suggests a negative relationship between duration of treatment and number of additional treatments. Considering these studies and the Scholing and Emmelkamp (1989) study, it seems that duration of treatment is an important variable in the treatment of social phobia (cf. Scholing, 1993), maybe even more so than treatment technique. Future research should study the question whether more treatment time is needed to do full justice to an integration treatment.

Subgroups in social phobia

As mentioned, social phobic patients are considered a heterogeneous group, consisting of different subtypes. This point of view was expressed by the DSM-III-R that distinguishes two subgroups (specific and generalized type) of social phobias. The question is whether there is evidence for the existence of these subgroups.

Most research has focused on the distinction between specific and generalized social phobia and avoidant personality disorder. Results from several studies (Heimberg, Hope, Dodge, & Becker, 1990; Holt, Heimberg, & Hope, 1992; Mersch et al., 1993; Turner, Beidel, Dancu, & Keys, 1986; Turner, Beidel, & Townsley, 1992) show that the differences that are found are in the level of severity. These results show the problem with subgroups in social phobia. It is possible that these studies are merely comparing severity of psychopathology. It is likely that when patients with any Axis I diagnosis who are lightly disturbed are compared with patients who are severely disturbed the outcome will be that the latter group has more severe symptoms. In other words, it is likely that a study comparing agoraphobic patients who only become anxious in and avoid supermarkets with agoraphobic patients who become anxious and avoid streets, public transportation, waiting rooms and restaurants, would find more severe symptomatology in the latter group. There is a possibility that social phobic patients diagnosed with the subtype 'specific' have a shorter duration of complaint to account for less severe pathology than the 'generalized' subtype. In one study this indeed is the case (Holt et al. 1992), non-generalized social phobics reported a mean duration of complaint of 15.3 years, while the generalized subgroups (with or without APD) reported a mean of 24.2 years. The two other studies (Turner et al., 1992; Heimberg et al., 1990) did not report duration of complaint.

A problem with the division of social phobia in subgroups are the criteria to which the distinction takes place. The diagnosis of specific or discrete social phobia is given to a person with social anxiety in only one or two social situations (e.g., speaking in public or using public restrooms). The diagnosis of generalized subtype is given to patients who fear most social situations. These latter patients are characterized by more severe social interactional anxiety, like going to parties and talking to co-workers. Sometimes, patients are diagnosed with a specific social phobia if they do not fulfill the criteria of generalized social phobia (Schneier, Spitzer, Gibbon, Fyer, & Liebowitz, 1991). Also, patients with predominant somatic symptoms have been diagnosed with the specific subtype (Scholing & Emmelkamp, 1993). It can be said that the confusion concerning the distinction is considerable. Although, acknowledged by several researchers (e.g., Holt, Heimberg, Hope, & Liebowitz, 1992; Widiger, 1992) the inclusion of a non-generalized subgroup to fill the gap between a specific and generalized social phobia (Holt et al., 1992; Heimberg, Holt, Schneier, Spitzer, & Liebowitz, 1991, cited by Holt et al., 1992), does not seem to be a practical solution. This merely creates two grey areas instead of one and leads Widiger (1992) to state that 'One is still left with the ambiguity of what is meant by many,
some, and most social situations, the definitions of which are likely to vary across studies. (p. 341).

Another question is whether the distinction of subgroups has clinical relevance. Although, according to Scholing (1993), this is indeed the case, it remains to be seen whether there is a differential treatment effectiveness between the different subgroups of patients. Comparisons in treatment effectiveness between subgroups awaits investigation. Scholing and Emmelkamp (1993) were the first to study the treatment effectiveness of cognitive-behavioral therapies on generalized social phobics, but since no comparison group of specific social phobics was used nothing can be said about differential effects.

The conclusion from the above is that the subgroups of social phobia may only differ with respect to the severity of the complaint. Whether this distinction has consequences for treatment outcome is thusfar unknown. A problem with these subgroups is that the diagnosis is left to clinical judgement, which will undoubtedly differ across researchers. This means that in future research agreement should be reached about the boundaries of the subgroups. The inclusion of another subtype by Heimberg et al., 1991, cited by Holt et al. 1992, the non-generalized subtype does merely seem to add to the boundary conflict. Also, the considered inclusion in DSM-IV (APA, 1991) of a third subtype (performance type) next to a limited situational type and a generalized type seems premature.

In addition to a sub-group approach, the study of individual differences and treatment-outcome in social phobia will undoubtedly profit from a retrospective approach as well. Therefore, the neglected area of the study of long-term effectiveness should be considered less as a time consuming obligation and should be approached with more enthusiasm and creativity. The analysis of follow-up data offers an opportunity for a more individual approach and, if possible, should include an analysis of "failures" and "successes".

**Personality disorders**

Personality disorders seem to be more prominently present in social phobia in comparison to other anxiety disorders (Klass, Dinardo, & Barlow, 1989; Alnaes & Torgersen, 1988). Percentages vary from 20% to 100% personality disorder (Mersch et al., 1993). In all studies on this subject, avoidant personality disorder (APD) is the predominant personality disorder in social phobia (Van Velzen & Emmelkamp, 1993).

Although APD is not a subgroup of social phobia but often an additional DSM-III-R, Axis-II disorder, the relationship between social phobia and APD resembles the state of affairs with respect to the subgroups of social phobia. The introduction of Personality Disorder (PD) as a distinct diagnostic category separate from the symptom disorders in the DSM-III (APA, 1980), has stimulated the study of the relationship between Axis I and Axis II disorders. Two developments have influenced the study of personality disorders in social phobia. First, the above discussed distinction in DSM-III-R (APA, 1987) between specific social phobia and generalized social phobia led to studies with the purpose to delineate subtypes of social phobia. The second development was the consequence of an influential article by Marks (1985). In line with results of a study in which social phobics showed less adequate social skills than patients with APD (Greenburg & Stravynski, 1983), Marks (1985) differentiated between two types of social anxiety: pure social phobics (SP) and patients with social skills deficits (SSD), the latter group being identical to avoidant personality disorder. Marks (1985) characterized both groups as follows: "In brief, SPs have fears more limited to particular social situations which is more like a trait of shyness in etiological terms, and avoidant personality disorder resembles a personality disorder."

It may be, however, that an artefactual difference in the criteria of APD and of (generalized) social phobia is due to the fact that APD is a side-effect of social dysfunction (e.g., neuroticism, introversion). In fact, APD was the most common personality disorder in a large sample of social phobics (cf. Widiger, 1985). If APD is a side-effect of social dysfunction, the criteria of APD and of (generalized) social phobia should overlap with each other and be descriptive of the same personality disturbance. This is also the case with SPs and SSDs. The latter two groups show the same set of symptoms (e.g., avoidant personality disorder and social phobia or panic disorder, obsessive-compulsive personality disorder, social phobia). APD extends the observation of a severe form of social phobia, which is more like a trait of shyness in etiological terms, and avoidant personality disorder resembles a personality disorder. The frequently observed APD in social phobia may be a result of the presence of social phobia or panic disorder, obsessive-compulsive personality disorder, social phobia. Another hypothesis is that APD patients have indeed a social phobia (Marks, 1985). Marks may have had this difference. Since exploratory study by Turner et al. (1986) and social phobics with APD, the latter hypothesis, however, failed to find significant differences. Bellack, 1992; Turner et al., 1992; Holt this stage, a skills deficit explanation for the hypothesis. In this respect, it is interesting to note that the criteria of APD and SPs are identical. An alternative hypothesis is that APD patients are indeed less socially skilled (Marks, 1985). In line with results of a study in which social phobics showed less adequate social skills than patients with APD (Greenburg & Stravynski, 1983), Marks (1985) differentiated between two types of social anxiety: pure social phobics (SP) and patients with social skills deficits (SSD), the latter group being identical to avoidant personality disorder. Marks (1985) characterized both groups as follows: "In brief, SPs
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Assessment of social skills

A major difficulty in the social skills debate in social phobia is the assessment of social skills. Not two of the abovementioned studies that employed behavioral tests used the same test situation. Also, the rating levels (molecular, intermediate or molar) differed, as well as the measures (qualitative or quantitative). One study used subjective measures only (Holt et al., 1992), which are not comparable to more objective measures by independent raters. Another study (Heimberg et al., 1990) used different individualized situations, making comparisons between groups impossible. All these differences are the more problematic, since the reliability and validity of these tests are unknown. All behavioral tests used in research in social phobia are used only once in the involved studies, and are hardly ever evaluated psychometrically. These methodological flaws which would invalidate all assessment instruments are even more troublesome in the assessment of social behavior, which is to a great extent related to specific situations (Bellack, 1983; Mersch et al., 1992; Nelson et al., 1985; Weissberg et al., 1981). In other words, someone's performance on a test is to a large extent dependent on the situation represented by the test. Furthermore, social behavior rated by higher class judges in behavioral tests may be sensitive to educational level (Mersch et al., 1992). In view of these considerations interpretation of the results of the different studies is an hazardous affair.

Therefore, in order to pursue this issue further, the development of reliable and valid assessment instruments to measure a complex phenomenon like social skills is a basic requirement. Preferably, the study of social skills should take place in a more embracing context in which the simultaneous measurement of physiological arousal, subjective anxiety and cognitive aspects is included. The importance of the inclusion of these variables is shown by the preliminary results of a recent study (Mersch, van der Wijngaart, Hofman, & van Hout, 1993) which are in contrast to the Beidel, Turner, and Dancau (1985) study. In a multidimensional study, Beidel et al. (1985) studied physiological reactivity, cognitive variables and social skills of 26 social phobic patients and 26 non-social phobics in different social situations. The conclusion from their study was that both groups differed from each other on all three systems. Social phobics showed higher physiological arousal, more negative self-statements and less skillful behavior than non-social phobics. Since Beidel et al., (1985) used subjects that rated above a cut-off score on a questionnaire and not social phobic patients, this study was replicated by Mersch et al. (1993) comparing social phobic patients with 'normals'. Conclusions from this study are that both groups did not differ on physiological arousal during a behavioral task (a conversation with two confederates). As expected, the social phobics showed highly increased heart rate and blood pressure, indicating that the situation was indeed anxiety arousing. The 'normals', however, showed an identical increase in arousal on both variables. The social phobics showed both before, as well as immediately after the behavioral test significantly more negative self-statements. Although both groups showed the same physiological arousal, the patients were judged as significantly more anxious and less skillful by the confederates than the 'normals'. Subjectively, the social phobics did not judge themselves as significantly less skillful than the 'normals' judged themselves. An interesting finding in this study is the high negative correlation between negative self-statements and the subjectively experienced skillfulness for the social phobics (r = .78) in contrast to the 'normals' (r = .04). This result may be an indication that lack of social skills may be a consequence of the believe by the patient that he or she does not behave as competent as other people.

In other words, this lack of social skill (Bandura, 1977). The differences in our variables at all levels of measurement and the importance of this area is called for.

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Herbert, J.D., Hope, D.A., & Bellack
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The assessment of social skills is a basic requirement. Preferably, the study context in which the simultaneous measurement of skills is included. The importance of the inclusion of social skills in the assessment of social phobia (Bellack, 1983; Mersch et al., 1992; Nelson et al., 1992) is the assessment of social skills. Not two of the studies used the same test situation. Also, the rating levels and measures (qualitative or quantitative) used in research in social phobia are used only for descriptive purposes. These methodological flaws are even more troublesome in the assessment of social phobia (Bellack, 1983; Mersch et al., 1992; Nelson et al., 1992). In view of these considerations, the development of reliable and valid assessment scales is a hazardous affair.

The lack of social skills may be a consequence of low efficacy and outcome expectations (Bandura, 1977). The differences in outcome between the two studies shows the complexity of behavior on all levels of measurement and the important role that situational context may play on behavior. More research in this area is called for.

REFERENCES


