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Social phobia : examining the empirical shortcomings of the most prevalent anxiety disorder

Randall P. Schultz

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Abstract

Social phobia, which is notably the fear of being negatively evaluated, humiliated, or embarrassed by others in social situations, has become the most prevalent anxiety disorder and the third most diagnosed mental disorder in the nation (Orsillo & Hammond, 2001). Although social phobia is no longer considered to be the "neglected" anxiety disorder (Liebowitz, Gorman, Fyer, & Klein, 1987), it remains an often undertreated, misunderstood, and understudied anxiety disorder (Cuthbert, 2002). The purpose of this paper is to examine the numerous discrepancies and shortcomings within social phobia literature in regards to defining, diagnosing, measuring, and treating social phobia. Recommendations are also noted regarding future directions of social phobia research.

Social Phobia: Examining the Empirical Shortcomings of the Most Prevalent Anxiety Disorder

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by

Randall P. Schultz

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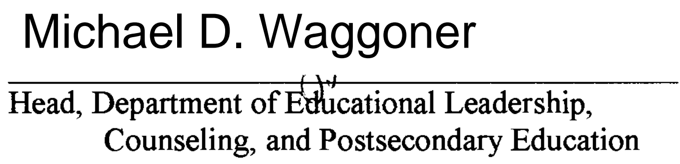

Head, Department of Educational Leadership, Counseling, and Postsecondary Education

Abstract

Social phobia, which is notably the fear of being negatively evaluated, humiliated, or embarrassed by others in social situations, has become the most prevalent anxiety disorder and the third most diagnosed mental disorder in the nation (Orsillo & Hammond, 2001). Although social phobia is no longer considered to be the "neglected" anxiety disorder (Liebowitz, Gorman, Fyer, & Klein, 1987), it remains an often undertreated, misunderstood, and understudied anxiety disorder (Cuthbert, 2002). The purpose of this paper is to examine the numerous discrepancies and shortcomings within social phobia literature in regards to defining, diagnosing, measuring, and treating social phobia. Recommendations are also noted regarding future directions of social phobia research.

Social Phobia: Examining the Empirical Shortcomings
of the Most Prevalent Anxiety Disorder

Once described as the most "neglected" anxiety disorder (Liebowitz, Gorman, Fyer, & Klein, 1985), social phobia has become the most prevalent anxiety disorder and the third most diagnosed mental disorder in the nation (Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996). In fact, about 13.3% of adults (11.1% of men and 15.5% of women, respectively) will meet the criteria for social phobia at some point in their lives (Kessler, Stein, & Berglund, 1998). Nevertheless, despite the high prevalence and significant degree this disorder can interfere with an individual's life, social phobia has only recently become the focus of academic and clinical research (Hofmann & Barlow, 2002), most of which has come since its inception into the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III; American Psychiatric Association, APA) in 1980. Unfortunately, the nature of this research has not always assisted in helping counselors to better understand this anxiety disorder. Therefore, although social phobia may be on the rise diagnostically, this disorder remains highly fragmented and relatively poorly defined conceptually speaking.

For example, inconsistencies and controversy abound from researchers in their use of multiple terms they use to describe this anxiety disorder. Within social phobia literature, several terms often get synonymously used when describing social phobia, such as, social anxiety disorder, shyness, social anxiety,

speech anxiety, social withdrawal, social introversion, as well as many more (McNeil, 2001). However, many researchers and clinicians have come to believe that the label "social anxiety disorder" better encapsulates the essence and pervasiveness of the symptoms of this anxiety disorder in comparison to the label "social phobia" (Liebowitz, Heimberg, Fresco, Travers, & Stein, 2000). In fact, the term, social anxiety disorder, has risen in such popularity amongst researchers, that it was formally introduced in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; APA, 1994). Nevertheless, even though more researchers are now beginning to use the label, social anxiety disorder, when discussing this anxiety disorder, most of the existing research still centers upon the label, social phobia (Heimberg & Becker, 2002). Therefore, as the controversy over what to name social phobia rages forward, so will the confusion felt by many counselors in regards to the exact nature of this anxiety disorder.

Just as confusing it seems, is differentially diagnosing social phobia from other psychological disorders, in particular, trying to distinguish between the criteria of generalized social phobia and that of avoidant personality disorder. For instance, when juxtaposing the criteria of both generalized social phobia and avoidant personality disorder, each disorder's criteria appear to overlap considerably. This overlap in criteria has led many researchers and clinicians to conclude that these two disorders might be conceptually the same and only differ on the severity of the symptoms, with avoidant personality disorder simply being

a more severe form of generalized social phobia (McNeil, 2001). In fact, Turner, Beidel, and Townsley (1992, as cited in Heimberg & Becker, 2002, p. 40) contend, "The diagnostic criteria are just too similar." In any event, although Heimberg and Becker (2002) agree with the hypothesis that avoidant personality disorder is merely a more severe form of social anxiety in comparison to generalized social phobia, there is only a scant of empirical data to support these hypotheses. Therefore, more research is needed to elucidate the relationship between these two similar DSM disorders.

Finally, just as controversy is apparent in defining and diagnosing social phobia, discrepancies loom in the measurement and treatment in social phobia. For example, given that social phobia has been adopted by top researchers as having a strong cognitive component (Beck & Emery, 1985; Clark & Wells, 1995; Rapee & Heimberg, 1997; Stopa & Clark, 1993), it is ironic that there are few valid social phobia instruments that are available for counselors to use in measuring the cognitive domain of this disorder. In fact, Heimberg (1994) found that more than 25% of the studies he reviewed did not employ any type of cognitive assessment. Likewise, there seems to be inconsistent results being reported in regards to some of the more popular cognitive-behavioral treatments being developed and researched, most notably, Cognitive Behavioral Group Therapy (CGBT; Heimberg & Becker, 2002). For instance, two major problems with some of these treatment outcome studies, including CGBT studies, include

researchers repetitively having used small sample sizes in these studies as well as there being frequent differences among how researchers have operationally-defined the generalized subtype in these studies (Hofmann & Barlow, 2002). Therefore, in spite of the progress being made in the measurement and treatment of social phobia over the past three decades, social phobia continues to remain one of the most misunderstood anxiety disorders, partly because it remains one of the leading understudied and undertreated psychiatric disorders in general (Cuthbert, 2002).

Keeping this in mind, the purpose of this paper is to briefly define social phobia and to critically examine and review some of the current discrepancies and shortcomings of social phobia research in regards to how researchers have (and are) defining, measuring, and treating social phobia, as well as to provide recommendations for researchers to heed in their future research of social phobia. In short, the goal of this paper is not to re-define or discuss an exhaustive history of social phobia, but rather it is to lay a foundation to assist counselors in developing a better conceptualization of social phobia, particularly so they can be more adept in "thinking critically" about social phobia and its research in regards to diagnosing, assessing, and treating individuals with this anxiety disorder.

Features of Social Phobia

Defining Social Phobia. Social phobia has become widely accepted by researchers and clinicians as a cognitive-based disorder, which seems to support

(or be based upon) the numerous cognitive and cognitive-behavioral theories that have burgeoned in the last two decades (Beck & Emery, 1985; Clark & Wells, 1995; Leary, 1995; Rapee & Heimberg, 1997; Stopa & Clark, 1993). Although many of these theories are well-documented and are becoming more well known among counselors and other clinicians, one such theory–Self-Presentation Theory (Schenkler & Leary, 1982)–still unfortunately remains relatively obscure to counselors in comparison to the other notable theories of social phobia. Thus, attention will be focused upon how this social-cognitive theory explains the nature of social anxiety in regards to social phobia.

Over the past two decades, self-presentation theory has significantly added in helping researchers better understand the nature of social anxiety. In essence, the underlying principle of self-presentation theory is that people will experience social anxiety, because they are motivated to make a particular impression (i.e., usually a favorable impression), but they doubt their ability of being able to achieve such an impression (Leary & Kowalski, 1995a, 1995b). Furthermore, Leary (2001) posits that individuals within our society are often socially devalued based upon four principle themes: (a) When people appear incompetent, inept, or unskilled; (b) When people appear poorly groomed and physically unattractive; (c) When people violate minor and major group social rules or norms; and (d) When people appear as being socially undesirable, such as, projecting themselves as abrasive or boring individuals. Therefore, individuals with social phobia often

will unrealistically strive to project positive images in wanting to been seen as being attractive, competent, moral, or social desirable in trying to gain social approval and acceptance, simply because they have come to learn that society often devalues and rejects people primarily on the basis of the these four themes (Leary, 1995b).

Conversely, Leary (2001) further suggests that since individuals have an evolutionary "need to belong", people are generally motivated not only to avoid relational devaluation and social exclusion, but also people generally strive for social inclusion and relational acceptance. However, he cautions that although people generally wish to convey positive social messages, they also can be motivated to project negative messages. In any event, regardless of whether a desired impression is positive or negative, social anxiety will often occur in those situations in which a person doubts their social skill abilities (i.e., perceived social self-efficacy beliefs) in being able to achieve their desired impression (Leary & Kowalski, 1995a).

Social Phobia Subtypes. Even though most people who are diagnosed with social phobia often avoid more than one type of social situation (Holt, Heimberg, Hope, & Liebowitz, 1992; Turner, Beidel, Dancu, & Keys, 1986), there continues to be a debate about how best to categorize or subtype individuals with social phobia into discrete subtypes, based upon the number of social fears they possess. Currently, the DSM-IV-TR (APA, 2000) only adopts the

generalized subtype (i.e., fearing numerous or most types of social situations) as the only specifier of social phobia, but some researchers have proposed that rather than having only one subtype of social phobia that there should be two additional distinct categories or subtypes–a nongeneralized subtype (i.e., fearing a few types of social situations) and a circumscribed subtype (i.e., fearing one or two distinct types of social situations) (Heimberg, Holt, Schneider, Spitzer, & Liebowitz, 1993).

The problem with this proposal is that there continues to be no substantial quantitative evidence confirming the validity of either the nongeneralized or the circumscribed subtypes; thus, neither subtype has been adopted as an official social phobia subtype in conjunction with the generalized subtype. Even so, the nongeneralized and circumscribed terms continue to be frequently mentioned by researchers throughout the social phobia literature, which regrettably gives the false impression to counselors that these categories are "official" subtypes of social phobia. Moreover, although most people diagnosed with social phobia are diagnosed with the generalized subtype, there is little agreement upon how best to operationally define "most social situations" (Hofmann & Barlow, 2002). Since this same argument can be made of how best to operationally define "few social situations" in reference to the nongeneralized subtype of social phobia, more research is required before either the nongeneralized and circumscribed specifiers can be formally adopted as social phobia subtypes. In short, the lack of

consistency among researchers in operationally defining social phobia subtypes more clearly has added both to the conceptual fragmentation of social phobia as well as to an increased misunderstanding on the exact structure of how distinct social situations fall within each social phobia subtype.

Finally, although public speaking has been found to be the most prevalent feared social situation (Kessler et al., 1998), little is currently known about the range and structure of social situations that are used in categorizing or subtyping people with social phobia (Hofmann & Barlow, 2002). In addition, although most researchers agree that the varying types of social situations generally fall within two broad categories, social performance situations (i.e., performing in front of others) and social interaction situations (i.e., engaging in interactions with others), it appears that only one study to date, (Holt et al., 1992), has attempted to formally investigate the range and structure of these two types of social situation domains.

After analyzing the prevalence and overlap of social anxiety across different types of social situations, Holt et al. (1992) were able to identify four distinct social situation domains: formal speaking and interaction, informal speaking and interaction, assertive interaction, and observation by others (Hofmann & Barlow, 2002). Examples of social situations that generally fall within these four domains include public speaking, eating and/or drinking in public, using a public restroom, exercising at a health club, asserting oneself,

initiating conversations, asking someone out on a date, answering or talking on the telephone, sending food back in a restaurant, and so forth. Nevertheless, although there is some research purporting that these domains can be beneficial in developing discrete subtypes of individuals with social phobia (Hofmann & Roth, 1996), there is no conclusive empirical evidence supporting that these domains be formally adopted in regards to subtyping social phobia. Therefore, more empirical investigations are sorely needed in further scrutinizing these social situations and their potential domains in regards to developing specific social phobia subtypes.

Conversely, the intensity and severity of fear and anxiety experienced appears not to be cued by the social situation itself, rather it is cued by the individual's interpretation of the specific social situational features unique to the individual's "perceived audience", which is defined as the notable characteristics of the other person or other people within the social situation (Beck & Emery, 1985). For example, although two people who both fear public speaking may escape the same public speaking situation if presented with it, both individuals may escape the situation for entirely different reasons, based upon how (and to what degree) each person will interpret these situational features as being socially threatening. Therefore, although the degree of anxiety an individual with social phobia experiences in a social situation seems to be associated with the frequency and saliency of these situational features, the degree to which the individual interprets these situational features as being socially threatening seems to be the

primary factor that contributes to the degree of anxiety a person will experience in a social situation (Rapee & Heimberg, 1997).

With this in mind, Anthony and Swinson, (2000) as well as McLean and Woody, (2001), have both noted some situational features of a "perceived audience" that appear to mediate the degree of anxiety experienced among individuals with social phobia within a particular social situation. These include the: (a) Age level of perceived audience, (b) Gender of perceived audience, (c) Relationship status of perceived audience (i.e., single, married, etc.), (d) Physical attractiveness of perceived audience, (e) Nationality or ethnicity of perceived audience, (f) Confidence level of perceived audience, (g) Degree of assertiveness or aggressiveness shown by perceived audience, (h) Intelligence level of perceived audience, (i) Education level of perceived audience, (j) Socioeconomic status of perceived audience, (k) Reputation and popularity of perceived audience, (l) Type of relationship held with the perceived audience, (m) Group size of perceived audience, (n) Whether the social situation is either formal or informal, (o) Whether the person is being formally evaluated or graded, and (p) The degree of success one has had in similar social situations.

In summary, although it is important for counselors to be aware of *what* types of social situations and situational features an individual with social phobia typically responds to, more importantly, counselors should be cognizant of *how* a person with social phobia responds within these social situations. In other words,

it is not enough for counselors to understand the *content* of the social situation in which a person experiences anxiety, but they must understand the *process* in which the person displays this social anxiety. Keeping this in mind, one good way for counselors to develop this understanding of the *process* or *how* individuals with social phobia respond within socially threatening situations is from valid instruments that purport to measure the different social phobia response domains.

Measurement of Social Phobia

Major contemporary theories of social phobia (Beck & Emery, 1985; Clark & Wells, 1995; Leary, 1995; Rapee & Heimberg, 1997; Stopa & Clark, 1993) have identified several response domains of how individuals with social phobia display their social anxiety in situations that they fear negative evaluation. Most agree that individuals with social phobia often display these social anxiety symptoms cognitively, behaviorally, physiologically, emotionally, and/or socially. However, although these symptoms of anxiety are not exhaustive in regards to *how* an individual with social phobia responds within socially threatening situations, they have become widely adopted by social phobia researchers as being a solid basis in defining the social phobia response. Nevertheless, when perusing the social phobia literature, it appears that the cognitive and behavioral response domains have become the "center of attention" in social phobia research.

Although top social phobia researchers have recently called upon the rest of their research peers to construct more instruments that measure the cognitive domain of social phobia (Arnkoff & Glass, 1989; Heimberg, 1994), there are only four instruments that currently purport to tap this response domain. These include the Fear of Negative Evaluation Scale (FNE; Watson & Friend, 1969), the Brief Fear of Negative Evaluation Scale (B-FNE; Leary, 1983), the Social Interaction Self-Statement Test (SISST; Glass, Merluzzi, Biever, & Larsen, 1982) and the Self-Statements made During Public Speaking Scale (SSPS; Hofmann & DiBartolo, 2000).

Fear of Negative Evaluation Scale. According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-TR (DSM-IV-TR; American Psychiatric Association, APA, 2000), "The essential feature of social phobia is a marked and persistent fear of social situations in which embarrassment may occur" (p. 450). In other words, the core feature of social phobia is a fear of being negatively evaluated by others. With this in mind, the FNE (Watson & Friend, 1969) is an instrument that was constructed to measure the degree of fear of negative evaluation a person possesses in regards to different types of social situations. Although the FNE has been one of the most frequently employed social anxiety measures in studies of individuals without social phobia (Heimberg, 1988), there appears to be some problems that exist with the FNE. For example, although the FNE has shown that it is sensitive to decreases in fear

of negative evaluation and in the negative thoughts in these studies, these changes have been minute at best and the meaning of these changes remains ambiguous, as they may be due to changes in cognition, anxiety, or both (Heimberg, 1994).

Brief Fear of Negative Evaluation Scale. The BFN-E (Leary, 1983) is an abbreviated version of the FNE, which also claims to measure fear of negative evaluation in regards to different types of social situations. Nonetheless, even though Leary (1983) reported that the B-FNE had shown to have high reliability in its initial development (r = .96), few studies have been conducted since to establish the B-FNE as a valid abbreviated version of the FNE. Therefore, since the FNE is over three decades old and the B-FNE is nearly two decades old, as well as the FNE having suspect validity and the B-FNE having little research supporting its validity, new instruments need to be constructed in regards to measuring the essential feature of social phobia.

Social Interaction Self-Statement Test. The SISST (Glass et al., 1982) is a structured questionnaire that purports to measure positive and negative self-statements made during male-female interaction situations. Although the SISST has become the best known and most frequently used cognitive endorsement instrument (Herbert, Rheingold, & Brandsma, 2001), some studies (e.g., Beidel, Turner, Jacob, & Cooley, 1989; Turner, Beidel, & Larkin, 1986) have misused the SISST by attempting to measure self-statements in other types of situations (e.g.,

impromptu public speaking), rather than in hetero-social situations for which the SISST was originally developed to measure (Hofmann & DiBartolo, 2000).

Keeping this in mind, even though Beidel et al. (1989) concluded that using a modified or "trait" version of the SISST is appropriate in measuring self-statements made in other types of situations (e.g., public speaking), her position appears both psychometrically and ethically suspect. As most psychometric experts would now agree, modifying any instrument (especially without first validating the modified instrument) to measure a variable that is different from what the instrument was intended to measure, clearly violates many of the fundamental rules of psychometrics, not to also mention many ethical principles. Therefore, this brings into question the external validity of these studies, which used a modified version of the SISST.

Self-Statements made During Public Speaking Scale. Finally, the SSPS (Hofmann & DiBartolo, 2000), which is an instrument that was modified from the SISST, has been suggested to be a promising cognitive endorsement method in measuring positive and negative self-statements during public speaking situations. However, when scrutinizing the development of this instrument and the results of the initial validation study, the final verdict of this scale's overall validity also appears questionable. In general, the major critique of endorsement instruments, such as the SISST and SSPS, is that these measures may actually measure how the individual *feels* rather than how he or she *thinks* during a socially threatening

situation (Heimberg & Becker, 2002). This critique seems applicable (and plausible) to the SSPS, especially given that even Hofmann and Dibartolo (2000) summarized that they were not clear of whether their scale measures self-statements made or whether it measures negative affect felt during a public speaking situation. For this reason alone, more validation studies need to be conducted on the SSPS, before researchers and clinicians recognize the SSPS as a valid and clinically useful instrument.

In summary, it remains unfortunate that only a few instruments have been developed to specifically measure the cognitive response domain of social phobia, especially since most of the research used to define social phobia has centered upon cognitive and cognitive-behavioral theories. Moreover, is the fact that with some of these instruments being suspect in validity and utility (e.g., FNE, SSPS), as well as some of them being over two decades old (e.g., FNE, SISST), one must question the continuing use of these instruments by researchers. Therefore, it seems logical that before social phobia researchers purport that cognitive-based treatments do demonstrate clinical utility, valid cognitive-based instruments will be necessary to confirm the effect sizes or the clinical utility of these treatments.

Treatment of Social Phobia

As a result of probably continuously escaping and avoiding perceived socially threatening situations, there often exists significant impairment socially, interpersonally, occupationally, and educationally in those with social phobia. In

fact, individuals with social phobia typically achieve less education, work in lower-income jobs, work in jobs that are generally below their ability level, have fewer social supports, marry less frequently, and marry at a much later age in comparison to those without social phobia (Magee et al., 1996). Nevertheless, in spite of the suffering and impairment that is often associated with social phobia, social phobia continues to remain an undertreated anxiety disorder in comparison to other anxiety disorders (Cuthbert, 2002), simply because individuals with social phobia typically do not seek treatment (Heimberg & Becker, 2002), and if treatment is sought, it is more likely to be for other psychological problems (e.g., depression) rather than for social phobia (Davidson, Hughes, George, & Blazer, 1993, as cited in Heimberg & Becker, 2002). Keeping this in mind, great attention has been given by researchers over the past two decades in developing quality treatments to treat social phobia more effectively and efficiently.

With the social phobia research community having adopted the premise that social phobia is defined as having a strong cognitive component (Beck & Emery, 1985; Clark & Wells, 1995; Rapee & Heimberg, 1997; Stopa & Clark, 1993), cognitive and cognitive-behavioral treatments have subsequently risen in popularity. In fact, Heimberg (2002) has noted that cognitive-behavioral therapy (CBT) is currently the most thoroughly investigated approach to psychotherapy for individuals with social phobia. Keeping this in mind, attention will be given to research associated with treating individuals with social phobia using CBT.

According to Heimberg (1994), "Cognitive-behavioral treatments are purported to produce changes in emotions and behavior via their effect on these cognitive variables" (p. 269). Currently, there are several cognitive-based and cognitive-behavioral treatments that have been developed and adopted by researchers over the past two decades in treating individuals with social phobia (see Heimberg, 2002 for a full review of CBT).

Some of the more notable treatments include: (a) Cognitive therapy that includes restructuring distorted cognitive assumptions and dysfunctional core beliefs (e.g. Beck & Emery, 1985); (b) Behavior therapy that includes using mostly *in vivo* or imaginal exposure (e.g., Social Effectiveness Therapy; Turner, Beidel, Cooley, Woody, & Messer, 1994); (c) Individual cognitive-behavioral therapy that includes both cognitive restructuring, exposure, and teaching social skills (e.g., Comprehensive Cognitive-Behavioral Therapy; Foa, Herbert, Franklin, & Bellack, 1995, as cited in Foa, Franklin, & Kozak, 2001); and (d) Group cognitive-behavioral therapy that includes cognitive restructuring, exposure techniques, and homework assignments in a group setting of usually six members, which is usually co-facilitated over a 12 week period (e.g., Cognitive-Behavioral Group Therapy for Social Phobia, CGBT, Heimberg, Dodge, et al. 1990; Heimberg & Becker, 2002). Keeping these in mind, only CBGT has been officially recognized by the Society of Clinical Psychology's (Division 12 of the American Psychological Association, APA) Task Force on Promotion and

Dissemination of Psychological Procedures as an empirically supported treatment for social phobia (Chambless et al., 1996, as cited in Hofmann & Barlow, 2002, p. 468). Nevertheless, researchers are now beginning to question the overall efficacy and validity of CBGT based upon some of the CBGT validation studies conducted during the past decade.

Although Heimberg and Becker (2002) reported that the efficacy of CGBT has been demonstrated in a number of studies (e.g., Heimberg, Dodge, et al. 1990; Heimberg, Salzman, et al., 1993), inconsistencies have recently begun to appear in regards to both the external validity (Chambless, Tran, & Glass, 1997) and the overall treatment efficacy (Erwin, Heimberg, Juster, & Mindlin, 2002) of CBGT. For example, Erwin et al. (2002) reported that a sizable percentage of clients have not shown clinically significant improvement by the end of CBGT treatment. In addition, Chambless, Tran, and Glass (1997) noted that one major criticism of Heimberg's and colleagues' CBGT research concerns how they excluded those individuals with both social phobia and depression in their CBGT research trials. Chambless et al.'s (1997) findings are important, especially since comorbidity rates of social phobia with depression appear to range from 14.6%, (Davidson et al., as cited in Wenzel & Holt, 2001, p. 137) to 70.2% (Van Ameringen, Mancini, Styan, & Donison, 1991, as cited in Wenzel & Holt, 2001, p. 137).

Therefore, since individuals who present with both social phobia and depression appear to endure greater impairment than those who present with only

social phobia (Erwin et al., 2002), and because the most salient predictor of poor treatment outcome for individuals with social phobia is often associated with self-reported depression (Chambless et al. 1997), the treatment-outcome efficacy and external validity of CBGT research begins to appear dubious. In short, despite the demonstrated efficacy of CGBT across many of Heimberg's own studies (Heimberg, Dodge, et al. 1990; Heimberg, Salzman, et al., 1993), and despite being recognized by APA's Division 12 Task Force as the only empirically supported treatment of social phobia, more evidence is needed to support the overall treatment efficacy of this often used social phobia treatment.

Future Directions of Social Phobia Research

Although research has provided some clear answers of why people feel socially anxious (e.g., Self-Presentation Theory; Schenkler & Leary, 1982; Leary & Kowalski, 1995a, 1995b; Leary, 2001), there still remains no clear empirical understanding of why some individuals with social phobia will avoid some social situations and remain (and even pursue) others. For example, although it is known that specific features of situations actually cue the degree of physical anxiety experienced in people during these situations (Beck & Emery, 1985), little is known about the specific factors associated with these situational features that contribute to *why* a person will endure such physical anxiety symptoms during perceived socially threatening situations. Likewise, since there have been few studies empirically investigating whether the "nongeneralized" and

"circumscribed" social phobia subtypes should be formally adopted as valid subtypes along with the generalized subtype, more research is necessary to better understand both of these prospective social phobia subtypes.

Further investigation is also warranted about *how* individuals with social phobia display the symptoms of their anxiety within socially threatening situations (i.e., social phobia response). One such recommendation is for researchers to formulate and adopt a theoretically inclusive model that holistically defines the response domains of social phobia, rather than for researchers continuing to develop distinct theories. First, an inclusive model will help reduce the theoretical fragmentation that has been evident in social phobia research during the past two decades. Second, and most importantly, an inclusive model will provide a more solid framework in assisting counselors to better conceptualize social phobia, so they can improve upon their skills in choosing and using the most relevant and valid measurement in assessing social phobia as well as them implementing the most efficacious treatment in treating individuals with social phobia.

In addition, even though there has been a plethora of cognitive and cognitive-behavioral theories developed in conceptualizing social phobia and the social phobia response (Beck & Emery, 1985; Clark & Wells, 1995; Leary, 1995; Rapee & Heimberg, 1997; Stopa & Clark, 1993), more attention needs to be directed towards the role emotional processes play in the etiology and

maintenance of social phobia. Although some researchers have noted several different emotions and feelings, which are often associated with social phobia (e.g., shame, fear, worthlessness, and inferiority; Greenberg & Paivio, 1997), to date, no theory has been constructed to explain the emotional response domain of social phobia.

Finally, although it appears logical to consider social phobia as being an interpersonal disorder, especially since the distinguishing criterion of social phobia centers upon the fear of being negatively evaluated by others in social situations, no substantial research to date has been conducted on the interpersonal dimension of this disorder. Furthermore, for decades many prominent researchers and clinicians have stressed how valuable the therapeutic relationship is to achieving a successful treatment outcome (Horney, 1950; Rogers, 1957; Sullivan, 1951; Yalom, 1980). Nevertheless, there is surprisingly no research demonstrating to what extent the therapeutic relationship affects treatment outcome when treating individuals with social phobia. Therefore, since this disorder seems to have a strong interpersonal component to it, more studies need to investigate how the therapeutic relationship affects treatment outcome.

Conclusion

Social phobia (social anxiety disorder) has steadily grown into the third leading diagnosed psychological disorder and the leading diagnosed anxiety disorder in the United States, since its inception into the DSM-III (APA) in 1980.

Nevertheless, even though social phobia is no longer dubbed as the "neglected" anxiety disorder (Liebowitz, Gorman, Fyer, & Klein, 1985), it certainly continues to be one of the most misunderstood anxiety disorders, because it remains one of the most undertreated and understudied psychological disorders (Cuthbert, 2002).

With this in mind, the purpose of this paper was to illuminate the problems, discrepancies, and controversies prevalent in social phobia literature, provide recommendations for researchers to heed in their continued quest of investigating social phobia, and to instigate counselors to begin "thinking critically" about social phobia research regarding defining, diagnosing, assessing, and treating social phobia. In short, even though researchers have provided a valuable framework during the last three decades in outlining social phobia for today's counselors, this theoretical framework continues to remain conceptually fragmented and poorly defined. Therefore, it is critical that for counselors to better understand, diagnose, and treat this widespread anxiety disorder, researchers must continue to incrementally add not only both breadth and depth to the conceptual framework of social phobia, but also they must continue to be audacious in their efforts to critically examine and re-define this framework.

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