The goal of this chapter is to provide the therapist with background information on social anxiety and its treatment beyond that provided in the Client Workbook. We begin this chapter with a brief overview of the epidemiology and psychopathology of social anxiety disorder. We then present our model of social anxiety in greater detail than in the Client Workbook to more thoroughly introduce the theoretical underpinnings of our treatment.

**Epidemiology and Psychopathology**

In the National Comorbidity Survey (NCS), over 8,000 noninstitutionalized individuals throughout the United States were interviewed about various mental health problems. This study found that 13.3% of people suffer from clinically significant social anxiety at some point during their lives (Kessler et al., 1994). In fact, social anxiety disorder was the third most common psychiatric disorder, with only major depressive disorder and alcoholism having a higher lifetime prevalence rate. Social anxiety most commonly begins during early childhood or adolescence (Schneier, Johnson, Hornig, Liebowitz, & Weissman, 1992) and typically follows a chronic and unremitting course (Chartier, Hazen, & Stein, 1998; Reich, Goldenberg, Vasile, Goisman, & Keller, 1994).

Unfortunately, most individuals with social anxiety disorder do not seek treatment unless they develop an additional disorder (Schneier et al., 1992). Approximately 70% to 80% of individuals with social anxiety disorder meet criteria for additional diagnoses, and, in most cases, social anxiety disorder predates the onset of these comorbid conditions (Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996; Schneier et al., 1992). In
community samples, the most common additional diagnoses include simple (specific) phobia, agoraphobia, major depression, and alcohol abuse and dependence (Magee et al., 1996; Schneier et al., 1992). Among treatment-seeking clients, comorbidity with depression is associated with more severe impairment before and after cognitive-behavioral treatment (e.g., Erwin, Heimberg, Juster, & Mindlin, 2002). However, individuals with and without comorbid conditions make similar gains. These findings suggest that socially anxious individuals with comorbid mood disorders may benefit from more extended treatment for their social anxiety or supplemental treatment directed at the comorbid disorder. Comorbid mood disorders appear to be more strongly associated with greater pre- and posttreatment impairment than comorbid anxiety disorders (Erwin et al., 2002).

Subtypes of Social Anxiety Disorder and Avoidant Personality Disorder

Both clinical experience and research suggest that individuals presenting for treatment of social anxiety are a heterogeneous group in terms of pervasiveness and severity of their social fears. In the current diagnostic system, the generalized subtype of social anxiety disorder is specified if most social situations are feared. Social interaction fears (e.g., dating, joining an ongoing conversation, being assertive), performance fears (e.g., public speaking, playing a musical instrument in front of others), and observation fears (e.g., working in front of others, walking down the street) are common among these clients.

The Diagnostic and Statistical Manual of Mental Health Disorders, fourth edition (DSM-IV), also classifies clients with limited fears into the nongeneralized subtype of social anxiety disorder, “a heterogeneous group that includes persons who fear a single performance situation as well as those who fear several, but not most, social situations” (American Psychiatric Association [APA], 1994, p. 413). For example, clients who fear public speaking but otherwise feel comfortable interacting with and being observed by others would be assigned to the nongeneralized subtype.

Clients with generalized social anxiety disorder improve as much as nongeneralized clients do with cognitive-behavioral treatment (Brown, Heim-
berg, & Juster, 1995; Hope, Herbert, & White, 1995; Turner, Beidel, Wolff, Spaulding, & Jacob, 1996). However, because clients with generalized social anxiety disorder begin treatment with greater impairment, they remain more impaired after receiving the same number of treatment sessions. These findings suggest that clients with generalized social anxiety may require a longer course of treatment to achieve outcomes similar to those of clients with nongeneralized social anxiety.

The generalized subtype of social anxiety disorder has many features in common with avoidant personality disorder (APD). In the current diagnostic system, APD is characterized by a long-standing pattern “of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation…” (APA, 1994, p. 664). Given the similarity between the descriptions of the two disorders, it is not surprising that many clients who meet diagnostic criteria for social anxiety disorder also meet criteria for APD. However, there is little scientific evidence to suggest that some individuals meet criteria for APD without also meeting criteria for social anxiety disorder (Widiger, 1992). The most parsimonious description of the relationship between social anxiety disorder and APD is that they are not different disorders and that individuals meeting criteria for both disorders are simply the most severely impaired persons with social anxiety disorder (Heimberg, Holt, Schneier, Spitzer, & Liebowitz, 1993). With regard to treatment outcome, some studies have found that clients with and without comorbid APD make similar gains (Brown et al., 1995; Hofmann, Newman, Becker, Taylor, & Roth, 1995; Hope, Herbert, et al., 1995), although others have found comorbid APD to be associated with a poorer treatment response (Chambless, Tran, & Glass, 1997; Feske, Perry, Chambless, Renneberg, & Goldstein, 1996). Nevertheless, the effects of APD on treatment have been smaller than anticipated, and a substantial number of clients no longer met criteria for APD following 12 weeks of cognitive-behavioral treatment for social anxiety (Brown et al., 1995). The remediation of APD within such a brief time frame further calls into question the conceptualization of this symptom cluster as representing a distinct personality disorder. As with individuals meeting criteria for generalized social anxiety disorder, clients with APD may require a longer course of treatment to achieve an optimal outcome.
Beliefs

Through a complex interaction of genetics, family environment, and important life experiences, socially anxious individuals develop fundamental, negative beliefs about themselves, others, and the social world. One common belief among socially anxious individuals is that they lack important social skills and that their social behavior is likely to be inadequate or inappropriate. Research has repeatedly demonstrated that socially anxious individuals are more critical of their own social behavior than are objective observers (Rapee & Lim, 1992; Stopa & Clark, 1993). Therefore, many socially anxious individuals may give a description of their social behavior that is more reflective of their negative beliefs than of their actual performance. Although some research has suggested that socially anxious individuals exhibit deficient social behavior (Halford & Foddy, 1982; Stopa & Clark, 1993), other research suggests that their social behavior is satisfactory (Glasgow & Arkowitz, 1975; Rapee & Lim, 1992).

We believe that it is important to clarify the difference between “performance deficits” and “social skills deficits.” We believe that the term *social skills deficit* should be applied only when a person cannot perform the behavior in question or cannot perform it up to a certain standard because he or she does not know how. Therefore, even when performance deficits are observed among socially anxious individuals, it is difficult, if not impossible, to tease apart whether these deficiencies are a function of a lack of social knowledge, of behavioral inhibition produced by anxiety, or of some combination of these and other factors. Nevertheless, we have observed that the behavior of most socially anxious individuals during in-session exposures is within the normal range and that social behavior improves as anxiety declines. This may happen for several reasons. For example, a reduction of negative thoughts through cognitive restructuring may improve an individual’s ability to attend to the social task at hand and improve performance. Eliminating subtle avoidance behaviors such poor eye contact through exposures may also have a positive impact upon performance. In fact, research has shown that exposure and cognitive restructuring alone (i.e., with no explicit social skills training) has a positive impact upon quality of social behavior according to the ratings of objective observers (e.g., Heimberg, Salzman, Holt, & Blendell, 1993). Thus, our approach is to work from the as-
assumption that, in most cases, performance deficits may be remedied by exposure and cognitive restructuring and do not require explicit training in social skills. Of course, when assessment of a specific client suggests otherwise, social skills training can easily be added to our program.

Another set of commonly held beliefs among socially anxious individuals is that they will display noticeable anxiety symptoms (e.g., blushing, trembling, or sweating) and that others will interpret these symptoms as reflecting intense anxiety or mental illness (Roth, Antony, & Swinson, 2001). In contrast, nonanxious persons are more likely to think that others would judge these symptoms to reflect a normal physical state such as being cold, tired, or hungry. Although socially anxious individuals have been shown to display more symptoms of anxiety than their nonanxious counterparts, they routinely overestimate the visibility of their anxiety symptoms relative to ratings by objective observers (Alden & Wallace, 1995; Bruch, Gorsky, Collins, & Berger, 1989; McEwan & Devins, 1983).

Socially anxious individuals may also believe that social relationships are inherently competitive and hierarchical in nature (Gilbert, 2001; Trower & Gilbert, 1989; Walters & Hope, 1998). Socially anxious persons often doubt that they will be able to successfully compete for dominant positions in the social hierarchy. Thus, instead of making dominance a primary goal during interactions, they may adopt secondary goals such as remaining affiliated with the group, retaining current social status, and avoiding harm. These goals require that they remain hypervigilant so that they can quickly detect signals of threat from others and that they behave in a manner that communicates a subordinate position to others perceived as dominant. If these strategies for remaining affiliated with others are perceived as failing, escape and avoidance behaviors are likely. In contrast, nonanxious individuals tend to view social relationships as cooperative and supportive most of the time. For example, a socially anxious individual may view a conversation with a new coworker as some sort of competition in which each person looks for weaknesses in the other (e.g., who is more attractive, well educated) and as a potential threat to his or her status and self-esteem. A nonanxious person would be more likely to view the same conversation as an opportunity to pleasantly pass the time, make a new friend, get input on a project, etc.
Information Processing

Research has shown that socially anxious persons exhibit biases in the allocation of attention that favor the detection of social threat cues in the environment (e.g., Asmundson & Stein, 1994; Hope, Rapee, Heimberg, & Dombeck, 1990; Mattia, Heimberg, & Hope, 1993; see review by Hirsch & Clark, 2004), a phenomenon referred to as “wearing amber-colored glasses” in the Client Workbook. In a study by Veljaca and Rapee (1998), socially anxious participants detected significantly more negative than positive reactions from audience members during a presentation, suggesting an attentional bias for threatening social information. In contrast, nonanxious participants detected significantly more positive than negative reactions, suggesting that they were biased toward detecting social cues indicative of safety and acceptance.

Such biased attention holds the potential for several negative consequences. A bias for negative social information may interfere with the socially anxious individual’s ability to process information contrary to existing beliefs. Therefore, the one audience member who yawns is attended to and the other audience members who may be smiling or nodding are largely ignored. A negative attentional bias may also magnify the importance of threatening social information such that one’s trembling voice is equated with weakness of character and not knowing the answer to a question is taken as a reflection of one’s incompetence. Lastly, hyper-vigilance for social threat may drain cognitive resources and interfere with the individual’s ability to attend and respond appropriately to the social task at hand. For example, one may lose one’s place during a speech or have difficulty responding to questions during a conversation.

An Integrated Cognitive-Behavioral Model of Social Anxiety Disorder

We now present the model of social anxiety that provides the conceptual framework for the procedures used in our treatment (Heimberg & Becker, 2002; Rapee & Heimberg, 1997; Roth & Heimberg, 2001; Turk, Lerner, Heimberg, & Rapee, 2001). Our model focuses on how social anxiety is maintained rather than on how it develops (see Chapter 3 of the Client Workbook for a discussion of etiology). Specifically, it portrays what hap-
pens when socially anxious individuals face a situation that they perceive as holding the potential for negative evaluation.

The cognitive-behavioral model presented here is more sophisticated than is the more generic model presented to clients (see Chapter 2 of the Client Workbook). We believe that an understanding of the more complex model can facilitate case conceptualization for therapists. However, we believe that the scaled-down model presented in the Client Workbook is sufficient to help clients begin to reconceptualize their social anxiety and understand the rationale behind treatment. Little benefit will be derived from overwhelming already anxious clients with too much detail.

Figure 2.1 illustrates what takes place when a socially anxious individual confronts a social situation that he or she perceives as holding the potential for negative evaluation. When confronted with another person or persons (i.e., “the audience”), he or she forms a mental image of how he or she appears to the audience. This mental image is formed using information from long-term memory, current internal cues such as one’s face feeling hot, and external cues such as the other person’s gestures or facial expressions. These images may include spontaneous, recurrent images of events that occurred around the time of the onset of the disorder, the content of which centered around feared social situations and was stable over time (Hackmann, Clark, & McManus, 2000). Socially anxious persons are more likely to form images and memories of threatening social situations in which they see themselves from an external point of view (e.g., Hackmann, Surawy, & Clark, 1998; Wells, Clark, & Ahmad, 1998). This phenomenon is not surprising in that socially anxious individuals are most concerned with how they appear to others and whether anything in their appearance might elicit a negative reaction. In contrast, nonanxious individuals are more likely to remember threatening social situations from a field perspective, in which they recall people and things in the environment as seen through their own eyes (e.g., Coles, Turk, Heimberg, & Fresco, 2001).

The mental representation of the self as seen by others is likely to be distorted in a manner consistent with the individual’s negative beliefs about his or her behavior and appearance. For example, a recent client with a slight Australian accent described his speech as “muttering,” “mumbling,”
Figure 2.1

and “hard to understand.” Role players during his in-session exposures described him as “charming,” “pleasant,” and “not at all difficult to understand.” Another client became tearful and described herself as “ugly” and “unacceptable,” because she perceived her jaw line as protruding grossly from her face, despite the fact that this feature objectively appeared to be well within the normal range.

During the social encounter, the socially anxious individual constantly monitors and adjusts the mental representation of the self on the basis of internal and external cues. For example, a socially anxious person giving a lecture would be likely to detect the slightest hand tremor when writing on the blackboard and would then include (and probably exaggerate) this information in the mental image of the self. As previously noted, this individual would also preferentially allocate attentional resources to quickly detect feedback suggestive of negative evaluation from the audience (e.g., frowns). Therefore, the person attempts to simultaneously monitor his or her appearance and behavior for anything unacceptable, monitor the environment for evidence of negative evaluation, and engage in the ongoing social task. This division of attentional resources may disrupt social performance, which may elicit actual negative feedback from others (which in turn would provoke a downward adjustment of the mental representation of the self as seen by others and an increase in anxiety symptoms). Complex social tasks, which require more processing resources, may be more likely to result in disrupted performance than simpler ones.

The socially anxious individual takes his or her (distorted) mental self-representation and compares it with what he or she perceives to be the standard held by the audience. Characteristics of the audience (e.g., education level, attractiveness) and features of the situation (e.g., whether it is a brief or extended social task, whether the situation is structured or unstructured) influence how lofty the audience's standards are judged to be. Given the negative bias present in the mental self-representation, in many instances, the individual will judge himself or herself as falling short of the audience's expectations. In the instances in which the individual perceives himself or herself as appearing and behaving in a manner consistent with or exceeding the estimated standards of the audience, anxiety will be minimal. For example, an individual may feel relatively comfortable giving weekly reports to subordinates but extremely anxious
giving the same report to a supervisor, who may hold higher standards for performance.

Lastly, predictions that the likelihood of negative evaluation is high and the consequences of negative evaluation are catastrophic lead to cognitive, behavioral, and physiological symptoms of anxiety. These cognitive, behavioral, and physiological symptoms interact with each other and eventually feed back into and further bias the mental representation of the self, perpetuating the cycle of anxiety.

The model suggests several points of intervention in the treatment of social anxiety disorder. It also highlights several aspects of the disorder that should be addressed in treatment. These include (Heimberg & Becker, 2002):

- Negative beliefs about social situations and other people
- Negative beliefs about oneself
- Negative predictions about the outcomes of social situations
- Avoidance associated with these negative predictions
- Attentional focus on social threat cues while engaged in the social situation
- Negative evaluation of performance after the situation has passed.

Our treatment works to break the vicious cycle of anxiety described in the model through the use of cognitive interventions before, during, and after in-session and in vivo exposures. Chapter 3 of the Client Workbook provides a rationale for the use of cognitive restructuring and exposure as well as the importance of in-session exposures and homework.