

Social Phobia: The Effects of Attention Training Technique and Situational Attentional

Refocusing

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Forord

Denne hovedoppgaven har tatt for seg behandling av sosial fobi ved bruk av to ulike intervensjoner. Vi har også sett på hvordan dataene forholder seg til to ulike modeller av sosial fobi. Den er skrevet på engelsk for å kunne gi den et bredere publikum og en mulig publisering. En hovedoppgave setter større krav på en teoretisk bakgrunn samt utvidet diskusjon enn hva en vitenskapelig artikkel gjør, derfor er hovedoppgaven i sin nåværende form noe lengre enn om den var skrevet for publisering uten omskrivninger.

Hovedoppgaven baserer seg på data som er blitt innsamlet tidligere og data som forfatterne selv har samlet inn på *Sosial fobi-prosjektet* ved psykologiske poliklinikker, NTNU Dragvoll. Vi vil takke Professor Patrick A. Vogel og Førsteamanuensis Roger Hagen for utmerket veiledning. Arbeidet med å skrive hovedoppgaven har vært svært lærerik. Veiledernes samarbeidsvilje og entusiasme har gjort arbeidsprosessen fornøylig og engasjerende. Vi vil også takke studentterapeutene som hjalp til med behandlingen av klientene slik at data kunne genereres til prosjektet. Sist men ikke minst vil vi takke Vegard Larsen, Jenny Konecny og Per G. Burhol for god hjelp i forhold til korrektur lesing.

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Abstract

The present study investigates the effectiveness of the attention training technique (ATT) and the situational attentional refocusing (SAR) in decreasing the maintaining factors of social phobia identified in Clark and Wells (1995). Also, the study examines the effect ATT and SAR have on comorbid symptoms often associated with social phobia. A convenience sample of twelve participants meeting the Diagnostic and Statistical Manual of Mental Disorders' (DSM-IV) (American Psychiatric Association, 1994) criteria for social phobia were assigned to ATT and SAR treatment. Assessments were conducted pre-, mid-, and post-treatment, and during treatment. At post-treatment 58% of the participants no longer met the criteria for social phobia and 50% had achieved reliable change on self report. Significant differences were found on most measures, with strong effect sizes (ranging from 0.97 – 2.54). ATT and SAR seem to be effective interventions for social phobia and comorbid symptoms. ATT and SAR are relatively brief interventions that could easily be included in a step-care treatment approach.

Social Phobia: The Effects of Attention Training Technique and Situational Attentional Refocusing

Social phobia was introduced as a diagnosis with the publication of the Diagnostic and Statistical Manual of Mental Disorders third edition (DSM-III) (American Psychiatric Association, 1980). Clinically, it has been described long before that date (e.g., Marks, 1969; Shaw, 1979). In the DSM-IV social phobia is characterized by a fear of being evaluated when exposed to social situations. The afflicted individual is afraid of exhibiting anxiety symptoms and/or acting in a humiliating or embarrassing way. The result is avoidance of social situations or social situations are endured under great stress. To qualify for a diagnosis, the anxiety must be perceived as irrational. The anxiety must cause significant disturbances in the individual's social and/or occupational life. The duration of the anxiety symptoms must have lasted at least six months and not be caused by other mental disorders (e.g. panic disorder, agoraphobia) substances, injuries or organic disorders (American Psychiatric Association, 1994).

Individuals suffering from social phobia often feel embarrassed and afraid of being judged by others for being stupid, anxious, etc. Common situations they might fear are writing, eating, speaking, etc., in front of others because they fear others will for instance notice them shaking or being inarticulate. Their anxiety is in almost every case accompanied by autonomic symptoms like gastrointestinal discomfort, muscle tension, blushing, sweating, tremor, etc. (American Psychiatric Association, 1994).

Social phobia is one of the most common mental disorders in the world, with a lifetime prevalence of at least 5%. In treatment settings, the gender ratio is equal, but in epidemiological surveys the female predominance is 3:2. Despite the fact that social phobia is prevalent it is frequently not diagnosed or effectively treated (Veale, 2003).

Onset of social phobia is reported from early (Rapee, Sanderson, & Barlow, 1988; Thyer, Parrish, Curtis, Nesse, & Cameron, 1985) to late adolescence (Amies, Gelder, & Shaw, 1983). Extreme shyness can be observed early, sometimes even in children as young as two-three years old (Kagan, 1994). Social phobia onset is often gradually. Individuals often report that symptoms have been present as long as they can remember (Sutker & Adams, 2001).

Comorbid disorders are a major problem in social phobia. In an extensive survey on lifetime social phobia, the comorbidity rate ranged from about 60 to 90%, depending on the impairment and the severity of the social phobia (Ruscio et al., 2008). Interestingly, several studies have suggested that comorbid disorders are often secondary to social phobia (e.g., Brunello et al., 2000; Fehm, Beesdo, Jacobi, & Fiedler, 2008; Stein et al., 2001; Van Ameringen, Mancini, Styan, & Donison, 1991; Weiller, Bisserbe, Boyer, Lepine, & Lecrubier, 1996). Also, individuals with social phobia often do not receive treatment, until after they have developed a comorbid disorder (Kessler, Stang, Wittchen, Stein, & Walters, 1999). Ruscio et al. (2008) found that only one third of individuals with social phobia, who had received treatment for a mental disorder in their life-time, had also undergone treatment for social phobia.

Unfortunately, it appears that social phobia is a long lasting and chronic disorder (e.g., Bruce et al., 2005; Yonkers, Dyck, & Keller, 2001). For instance, Bruce et al. (2005) found a 62% probability of still qualifying for the diagnostic criteria of social phobia after a twelve year follow-up period. However, when recovered, the likelihood of recurrence is profoundly lowered (39%). This emphasizes the need for early intervention in individuals with social phobia (e.g., Bruce et al., 2005; Brunello et al., 2000).

The Challenges of the Social Phobia Diagnosis

According to DSM-IV, a generalized subtype of social phobia can be applied when an individual fears many social situations (e.g. speaking with authority figures, participating in groups, eating in public, etc.) (American Psychiatric Association, 1994). DSM-IV does not divide the social phobia diagnosis into further subtypes. The National Comorbidity Survey indicated that a limited number of fears, such as fear of public speaking, could be regarded as a subtype, whereas, the other subtype involved fears of many social situations. The latter subtype was characterized by being more persistent, having more impairments, and higher comorbidity rates (Kessler, Stein, & Berglund, 1998). In contrast, Stein, Torgrud, and Walker (2000) found that the functional impairment of social phobia is linear with no clear cut-off between possible subtypes.

Since the inclusion of social phobia and Avoidant Personality Disorder (APD) in DSM-III (American Psychiatric Association, 1980), there has been an ongoing debate regarding whether social phobia and APD are separate disorders. This is in fact suggested in DSM-IV, where DSM-IV states that APD and generalized social phobia might be different conceptualizations of identical or similar disorders (American Psychiatric Association, 1994). DSM-IV characterizes APD as: *“pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts”* (p. 664, (American Psychiatric Association, 1994)).

Many believe that APD seems to reflect a more severe and impaired form of social phobia (e.g., Chambless, Fydrich, & Rodebaugh, 2008; Herbert, Hope, & Bellack, 1992; Holt, Heimberg, & Hope, 1992). This has developed into the continuum hypothesis, where social phobia with APD presents a more severe mental disorder (Cox, Pagura, Stein, & Sareen, 2009). An extensive national mental health survey, with 43,093 respondents, could

shed some light on the relationship between social phobia and APD. In support of the continuum hypothesis, the survey found that generalized social phobia with comorbid APD often represent more severe cases of generalized social phobia. Conflicting with the continuum hypothesis is the finding that nearly two-thirds of individuals with APD did not have a comorbid generalized social phobia, and clients presenting with APD were more likely to have a comorbid major depression disorder (65%) than a generalized social phobia disorder (40%). Additionally, the study revealed that two-thirds of people diagnosed with generalized social phobia did not have comorbid APD (Cox et al., 2009).

Evidence-based Psychotherapy

The most common psychotherapy used in treating social phobia is different variants of cognitive behavioral treatment (CBT), cognitive restructuring, exposure treatment, relaxation training and social skills training (SST) (Roth & Fonagy, 2005). All these treatments, except for applied relaxation training, have been recommended by the Norwegian Board of Health Supervision's guidelines for social phobia treatment. The guidelines are developed by experts on anxiety disorders, and they are recommended as good treatments for social phobia (Martinsen, 2000). Interestingly, very few if any studies have been conducted on psychodynamic approaches to the treatment of social phobia (Roth & Fonagy, 2005).

Cognitive behavioral therapy, cognitive restructuring and exposure therapy in the treatment of social phobia. Cognitive restructuring is often accompanied with exposure therapy in an overall CBT approach. CBT varies depending on the treatment manual, but the most frequently used are Ellis' rational emotive therapy (RET) (Ellis & Dryden, 1997), Heimberg's cognitive-behavioral group therapy (CBGT) (Heimberg, Juster, Hope, & Mattia, 1995), and cognitive treatment, which is based on Clark and Wells' cognitive model of social phobia (Clark & Wells, 1995).

In the cognitive treatment, based on Clark and Wells' cognitive model (Clark & Wells, 1995), a variety of interventions are used to reverse the maintaining factors of social phobia. The maintaining factors are as follows (will be described in detail later): increased self-focus, use of internal information on how he or she is being perceived by others, use of safety behaviors to prevent feared catastrophes, and use of pre- and post-event processing (Clark et al., 2006). CBGT aims at helping individuals with social phobia overcome their anxiety in social situations, through exposure therapy, and alter beliefs that maintain the social phobia, through cognitive restructuring (Heimberg et al., 1995). Ellis' RET teaches clients to identify their beliefs, behaviors and thoughts that are self-defeating, and replace them with more rational alternatives. RET employs a variety of cognitive, emotive and behavioral techniques to dispute irrational beliefs (Ellis & Dryden, 1997).

Exposure therapy has for long been a major part in the treatment of phobic disorders (Turner, Beidel, Cooley, Woody, & Messer, 1994). Exposure therapy gets the phobic person to face feared situations to allow the conditioning of fear reduction, and eventually giving rise to habituation and extinction. Exposure therapy usually starts with the least or moderately feared situations. As mastery is gained the clients are encouraged to face more difficult situations until one reaches the top of the client's idiosyncratic anxiety hierarchy. Exposure can be imagined, role played, real life situations or a combination of all three (Heimberg, 2002). The clients should stay psychologically involved, pay full attention and be fully emerged in the situation. Clients' experiences of anxiety and arousal are an important part of getting the desired results in exposure therapy (Foa & Kozak, 1986).

There are mixed results indicating whether exposure alone, cognitive restructuring alone, or the combination of both are the best treatment for social phobia (Roth & Fonagy, 2005). Hofmann (2004) compared CBGT, group exposure therapy and wait-list, and found

that the two active treatment interventions did not differ from each other at post-test on self-reported social anxiety. However, CBGT produced larger effect sizes (0.72 and 0.92) on self-report than group exposure therapy (0.52 and 0.49). At the six month follow-up, only the CBGT group continued to show improvements marked with significantly reduced social anxiety scores compared with the exposure group. Hope, Heimberg, and Bruch (1995) investigated if the cognitive restructuring intervention is necessary, and if it produced greater improvements on fear and avoidance symptoms. They found that exposure alone produced somewhat larger effect sizes on the self-report measures and on the fear and avoidance hierarchy compared with CGBT. In contrast, Mattick and Peters (1988) found superior effects of a combined treatment of exposure and cognitive restructuring over exposure alone, although both treatments had an effect on social phobia symptoms. Also, in Clark et al. (2006) cognitive therapy with exposure treatment produced better results than exposure and applied relaxation. Controlled effect size for cognitive treatment was $ES=2.63$, and for exposure and applied relaxation were $ES=1.46$. On the other hand, results showing no differences between exposure alone and cognitive restructuring have been found in a couple of studies (e.g., Emmelkamp, Mersch, Vissia, & van der Helm, 1985; Scholing & Emmelkamp, 1993).

Meta-analytic studies have not found a difference in effectiveness between cognitive restructuring and exposure treatment in treating social phobia (e.g., Chambless & Gillis, 1993; Feske & Chambless, 1995; Taylor, 1996). However, (Gould, Buckminster, Pollack, Otto, & Massachusetts, 1997) found larger effect sizes for exposure alone ($ES=0.89$) and for cognitive restructuring incorporated with exposure ($ES=0.80$) than for cognitive restructuring alone ($ES=0.60$).

According to Beck's theory, in order to achieve cognitive change, cognitive restructuring is necessary. The cognitive restructuring is thought to lead to change by rational analysis and challenging dysfunctional beliefs. Exposure treatment is thought to aid cognitive restructuring, by providing contrary evidence to dysfunctional beliefs, and provide access to dysfunctional thoughts and beliefs when the client is anxious, which would not be reported by the client otherwise (Beck & Emery, 1985, cited in Hope et al., 1995). Thus, according to Beck's theory, cognitive restructuring is essential in order to achieve cognitive change, and exposure contributes to this process. This is supported by Butler, Cullington, Munby, Amies, and Gelder (1984) and Emmelkamp et al. (1985). Butler et al. (1984) found that exposure integrated with a limited cognitive restructuring program was more effective in improving cognition than exposure alone. In Emmelkamp et al. (1985), exposure alone did not influence the clients' irrational beliefs. Cognitive restructuring treatment on the other hand, resulted in a decrease of irrational beliefs. Surprisingly, some studies have actually found a tendency toward subjects receiving exposure alone, actually lead to more cognitive change than integrated exposure and cognitive restructuring (e.g., Hope et al., 1995; Scholing & Emmelkamp, 1993). In Hope et al. (1995), there were indications that exposure alone was able to achieve more cognitive change than CBGT. Scholing and Emmelkamp (1993) showed that a pure exposure group achieved more change in their cognitions than a group receiving integrated cognitive restructuring and exposure therapy.

Also, patients dropping out or refusing treatment is an issue concerning CBT. For example, Lincoln et al. (2005) rated 56% of their clients as improved at post assessment, when accounting for the clients who dropped out during diagnostic screening and treatment, and those who completed treatment, but did not benefit from the treatment. The results from Lincoln et al. (2005) are in line with Turner, Beidel, Wolff, Spaulding, and Jacob (1996). In

Turner et al. (1996), only 52% of their clients profited from the treatment, when including individuals who either dropped out or refused treatment.

There are probably many explanations why studies report mixed results regarding the effectiveness of exposure, cognitive restructuring and integrated treatment of exposure and cognitive restructuring. For instance, cognitive restructuring is not just based on one theory, but have been based on different theories (e.g., Ellis' RET, cognitive treatment based on Clark and Wells model, Heimberg's CBGT, etc.). Thus, different cognitive restructuring approaches can therefore lead to different results.

Social Skills Training. SST consists of many components and different researchers use different components. SST components used in research ranges from psycho-education, modeling of behaviors, behavioral rehearsal, exposure, practicing social skills, giving and receiving feedback, assertiveness training, refusing requests, asking for favors, role-playing, etc. (e.g., Herbert et al., 2005; Liberman, 1975; Mersch, Emmelkamp, Bogels, & Van der Sleen, 1989).

Adding SST to a treatment package or using it as an individual treatment intervention, implies that people with social phobia have deficits in social skills. Observer ratings have in fact indicated that people with social phobia have deficits in social skills (e.g., Baker & Edelman, 2002; Norton & Hope, 2001). However, Herbert et al. (2005) have pointed out that it is unclear whether persons with social phobia actually have deficits in their social skills. Instead, others have proposed alternative explanations for their awkward behaviors (e.g., safety behaviors (Wells, 2007), and/or the interfering effects of anxiety (Rapee, 1995)). This was illustrated by Öst, Jerremalm, and Johansson (1981), where subjects responded better to treatment matched to the individual subjects response to anxiety situations. Öst et al. (1981) divided the subjects based on responses to a social interaction

test, into a behavior group and a physiological group. The results indicated that the behavior group responded better to the SST than the applied relaxation treatment, while the physiological group achieved better results with the applied relaxation treatment than the SST. Others (Mersch et al., 1989; van Dam-Baggen & Kraaimaat, 2000) have failed to replicate the results of Öst et al. (1981).

Mersch (1995) found no additional benefits for including an integrated treatment of Rational Emotive Therapy (RET), SST and exposure in vivo, over the exposure alone therapy. Herbert et al. (2005) found that adding individualized SST to CBGT produced larger effect sizes on self-report ($ES = 1.94$), than CBGT alone ($ES = 0.61$). The results from the studies mentioned above should be interpreted with caution. Many of them do not have control groups or wait-list groups, and some have selected subjects based on their skill deficits and not on their social phobias (Roth & Fonagy, 2005).

Many of the SST programs have exposure incorporated in their treatment. This makes it hard to decide whether the SST treatment interventions (e.g., psycho-education, role-play, modeling, etc.) show beneficial gains in the treatment of social phobia, or results from studies investigating SST could be attributed to the exposure component in the SST programs.

Applied relaxation training. The few studies on the effectiveness of applied relaxation training have not found promising results compared to other interventions. Mostly used is Öst's applied relaxation technique, which consists of different relaxation instructions and techniques (Öst, 1987).

Clark et al. (2006), described above, compared cognitive treatment with exposure and applied relaxation, where cognitive treatment achieved better outcome and had more treatment responders. In Bogels (2006), applied relaxation was effective in treating social phobia, but applied relaxation was inferior to task concentration training, which teaches

clients to focus their attention on the social task and away from bodily symptoms. In another study applied relaxation produced significant changes on pre- to post-scores on two of the eight measures used in the study, when applied on individuals who react physiologically in social situations (Öst et al., 1981). However, as highlighted by Öst et al. (1981), there were changes in pre- to post-scores on all the measures, but most failed to reach significance.

Influence of Severity and Comorbidity on Therapy Outcome

There are indications that comorbid APD may affect the treatment outcome in individuals with social phobia, but the findings are mixed. Hofmann, Newman, Becker, Taylor, and Roth (1995) reported that individuals with social phobia with or without APD responded to exposure treatment. They found no significant differences between the two groups. However, Hofmann et al. (1995) believes the lack of significant differences is due to the small sample size. Feske, Perry, Chambless, Renneberg, and Goldstein (1996) treated people with generalized social phobia with and without comorbid APD with exposure treatment. Although the clients suffering from social phobia and APD benefited from the treatment, they were more severely impaired at the end of the treatment and at the follow-up. Feske et al. (1996) points out that depression might partly explain the worse outcome for the clients with social phobia and APD, because a removal of clients with comorbid depression diagnosis, lead to a non-significant difference between the groups. Chambless, Tran, and Glass (1997) investigated predictors of treatment outcome in clients with social phobia receiving CBGT. Chambless et al. (1997) found few client characteristics with strong predictability. Depression scores measured with BDI turned out to be the strongest negative predictor of treatment outcome. The clients who scored higher on BDI before treatment were less likely to improve or remain improved on self-reported anxiety scores and self-reported

skills in conversation role plays. In a review, a tendency of a few pre-treatment variables were found to be predictors of treatment outcome: depression, APD, symptom severity and generalized subtype were negative predictors of end-state functioning, but apparently not influencing the improvement in therapy. These findings can be interpreted as clients with depression, APD, high symptom severity and/or generalized social phobia do benefit from psychotherapy with the same amount of improvement, but they begin treatment with greater impairments and end treatment with greater impairments compared to clients without these characteristics and/or lower scores on these characteristics (Eskildsen, Hougaard, & Rosenberg, 2010).

Rapee and Heimberg's Cognitive Model of Social Phobia

Two cognitive behavioral models of social phobia emerged in the 1990s, and have since been the foundation for much of the social phobia research (Schultz & Heimberg, 2008), including many of the treatment studies mentioned above. The models stress the importance of attentional processes in the maintenance of social anxiety (Clark & Wells, 1995; Rapee & Heimberg, 1997).

According to Rapee and Heimberg's model of social phobia, people suffering from social phobia assume that people observing them are critical and evaluative. In addition, they believe being positively assessed by others are important. In a social situation they form a mental representation of their behavior and appearance that is based on how they think others perceive them. At the same time, they are also highly attentive to threat cues from the environment, e.g., yawns, laughter, etc., that they may interpret as signs of boredom from others, that they are stupid, etc. The mental representation is probably based on an image in the long-term memory, developed from the person's mirror image, photographs, etc., and the person's previous experiences in similar social situations. Internal cues (e.g., physiological

symptoms) and external cues (e.g., yawning from the others) modify the mental representation. The perceived performance of their own behavior and appearance is compared with beliefs about other people's standards of performance. A discrepancy between their own perceived performance and the believed standards of others is likely to lead to perceived negative evaluation from others. Perceived negative evaluation is believed to elicit anxiety in the individual (Rapee & Heimberg, 1997).

Clark and Wells' Cognitive Model of Social Phobia

Clark and Wells' model has been divided into two parts. First, when a person with social phobia enters a feared social situation, the person activates assumptions (e.g., "I should always have something intelligent to say", "I must not come across as boring") that are based on previous experiences. As a consequence of these assumptions, the person might fear that he or she will behave in an unacceptable manner, and that such behavior might lead to loss of status, rejection, etc. This triggers a shift in attention from external attention to internal attention, where the person processes the self as a social object. The internal attention is unfortunate, because it leads to increased attentiveness to feared responses (Clark & Wells, 1995).

To prevent feared catastrophes and reduce the likelihood of negative evaluation, safety behaviors are used. Safety behaviors can be both internal mental acts (e.g., memorizing and checking everything that is said), and observable behaviors (e.g., gripping a coffee mug tightly to prevent spilling). Safety behaviors are problematic for several reasons. For instance, when a feared social situation goes well, an individual with social phobia attributes the success to the safety behaviors, and not to the fact that the feared catastrophe was unlikely to happen in the first place (Wells, 2007). In order to investigate the effects safety behaviors have in maintaining anxiety and negative beliefs, Wells et al. (1995) compared exposure

alone with exposure with the banning of safety behaviors. The exposure condition with decreased safety behaviors resulted in significantly greater reduction in anxiety and belief scores, compared to exposure without the banning of safety behaviors. Social anxiety often occurs with heightened arousal (e.g., sweating, tremor, etc), and these are often interpreted as a failure to meet their standards for social interaction. Therefore, the person with social phobia is often hyperattentive towards symptoms of arousal, and the hyperattentiveness will most likely increase the intensity of the arousal symptoms (Clark, 2001).

The second part of the model consists of anticipatory and post-event processing. Anticipatory processing is when the individual with social phobia experiences anxiety before a feared social situation, and scrutinizes in detail what might happen. Although, a person with social phobia will most likely experience a decrease in anxiety when leaving a challenging social situation, it is common to review the event. This is called post-event processing. As mentioned above, persons with social phobia usually experience internal attention in problematic social situations. Because of the internal attention, dysfunctional beliefs held by individuals with social phobia will not be disconfirmed, since they do not perceive any disconfirming cues from the environment. Therefore, post-event processing will most likely focus on their negative feelings, and the impression they think others have of them (Clark & Wells, 1995).

Empirical Support for the Models

Several studies have shown that individuals with social phobia or socially anxious individuals have more negative thoughts when they are in social situations compared to people with low social anxiety and without social phobia (e.g., Beidel, Turner, & Dancu, 1985; Daly, Vangelisti, & Lawrence, 1989; Stopa & Clark, 1993). These thoughts are often more self-focused. For instance, Stopa and Clark (1993) found a higher number of negative

self-focused thoughts among persons with social phobia, such as “I’m boring”, than negative thoughts about what the interaction partner presumably thinks about the individual, like “she thinks I’m boring”. Stopa and Clark (1993) speculate that the negative thoughts are not based on information from the environment, which support Clark and Wells’ model, which presumes that the observer perspective they have on themselves is not being modified by external information (Clark & Wells, 1995).

Hackmann, Surawy, and Clark (1998) investigated whether individuals with social phobia experience themselves as social objects, meaning that they hold an observer perspective on themselves. Hackmann et al. (1998) found that many reported to experience imagery of themselves in an observer perspective when they were anxious in a social situation, with images often being negative and displaying their worst fears. Coles, Turk, Heimberg, and Fresco (2001) asked participants with social phobia to recall social situations of different anxiety levels, and rate which perspective (observer or field perspective) they had in the recalled situations. In highly anxious social situations the participants were more likely to recall the situation from an observer perspective. The low social anxiety situations were more likely to be recalled from a field perspective.

Anxiety is not a disease in itself, it has important survival functions. Anxiety sharpens our attention toward potential threats, so instead of walking toward a moving vehicle, the anxiety causes us to jump out of the way. Successful means to reduce the danger, usually lead to reduced anxiety. Anxiety becomes a problem when there is a misperception and/or exaggeration of danger, because then the individual is unable to reduce it (Beck, 1985). According to the proposed mechanisms of anxiety, vigilance toward social threat cues should be found in participants with social phobia. Several studies have been conducted on social phobia clients and socially anxious individuals to investigate if they have an attentional bias

toward threat cues. Many have found that individuals who are socially anxious have slower response time to socially threatening words in modified Stroop tasks (e.g., Hope, Rapee, Heimberg, & Dombek, 1990; Maidenberg, Chen, Craske, Bohn, & Bystritsky, 1996; Mattia, Heimberg, & Hope, 1993). Holle, Neely, and Heimberg (1997) argues that the increased response time to socially threatening words can be explained partly by semantic relatedness of the words in the categories, and that one category of words have been presented in a blocked format. Holle et al. (1997) used semantically related threat words, semantically related neutral words and unrelated neutral words, also, they presented the words in both blocked- and randomized-format to test this prediction. Participants with social phobia were significantly slower at naming colors in social threat words than related neutral words, and significantly slower to name the colors in related neutral words compared with unrelated neutral words in the blocked-format. No significant differences were found in the randomized-format. This study indicates that other studies might have overestimated the vigilance for social threat words (Holle et al., 1997).

Amir, Freshman, and Foa (2002) used a modified Stroop task with social threat words, positive words and non-words, and presented the real words in high ratio and low ratio. As expected, the participants with social phobia showed an increase in Stroop interference for social threat words when they were presented in a low ratio condition compared to a high ratio condition. The findings indicate that individuals with social phobia are vigilant toward threat cues, but use avoidance strategies in the high ratio condition (Amir et al., 2002), which is consistent with the “vigilance-avoidance” hypothesis. The hypothesis states that anxious individuals are more likely to notice threat cues, and immediate avoidance prevents accurate evaluation or habituation of the potential threat (Mogg, Mathews, & Weinman, 1987).

Mansell, Clark, Ehlers, and Chen (1999) used a dot-probe with emotional faces to determine if highly socially anxious individuals are more attentive or show more avoidance to negative facial expressions. They split their participants into two groups, both groups did the dot-probe task, but one of the groups were told that they would be assessed on their social skills on public speaking after they finished the dot-probe task. The results showed that in the presence of a social-evaluative threat highly socially anxious participants reduced the attention toward both positive and negative emotional facial expressions. There were no differences between the participants low in social anxiety and the participants high in social anxiety in the absence of social-evaluative threat. In another dot-probe study conducted on individuals with social phobia, vigilance toward negative emotional facial expressions was found when the stimulus was present for 500 ms. When the stimulus was present for 1250 ms both the control group and the group consisting of individuals with social phobia showed a vigilance towards negative emotional faces, although, this failed to reach significance (Mogg, Philippot, & Bradley, 2004). Vassilopoulos (2005) used a modified probe detection task to investigate the vigilance-avoidance hypothesis. The probe was presented for either 200 ms or 500 ms. The 200 ms condition is thought to be too short to allow a shift in gaze, which is an indication of avoidance. In addition, the participants were told that they would have to give a speech after the probe detection task. The results were that highly anxious participants showed vigilance toward all the emotional words (social threat and physical threat words, and positive words) when the probe was presented at 200 ms. In the 500 ms condition the highly anxious participants turned their attention away from the emotional words. Thus, the study partly supports the “vigilance-avoidance” hypothesis (Vassilopoulos, 2005).

Both Rapee and Heimberg (1997) and Clark and Wells (1995) assert that self-focused attention is crucial in maintaining social anxiety. Empirical research provide support for an

increased self-focused attention in individuals with social phobia or individuals who are socially anxious when they are in social situations (e.g., Daly et al., 1989; Stopa & Clark, 1993). In addition, there are empirical support for the internal mental representation (e.g., Coles et al., 2001; Hackmann et al., 1998) as suggested by Rapee and Heimberg (1997) and Clark and Wells (1995). Unlike Clark and Wells (1995), Rapee and Heimberg (1997) emphasize the vigilance to socially relevant threat stimuli in the environment, that is, cues of potentially negative judgment from others. Consistent with Rapee and Heimberg's model, Hope et al. (1990), Mattia et al. (1993), Maidenberg et al. (1996), and Mogg et al. (2004) have found an attentional bias toward threat cues in the environment. Thus, there seems to be empirical support for attentional bias toward threat cues. However, there are studies that have found avoidance of threat cues. For example, Mansell et al. (1999), Amir et al. (2002) and Vassilopoulos (2005) have found that socially anxious individuals use avoidance strategies for social threat cues when they are presented over a long enough period or frequently enough, which supports Clark and Wells (1995). In addition, the vigilance effect found in studies using the modified Stroop task, might not be so strong as initially thought as shown by (Holle et al., 1997).

Treatment Implications

Both Rapee and Heimberg's model and Clark and Wells' model have implications for the treatment of social phobia (Clark & Wells, 1995; Rapee & Heimberg, 1997). A successful shift from internal attention to external attention can hinder the processing of self as a social object or as a mental representation. This can be achieved through an exercise called attention training technique (ATT) (Wells, 2009). Situational attentional refocusing (SAR) is another technique that can be used to alter the clients' internal focus of attention and their dysfunctional beliefs about their performance. However, SAR asks the client to explicitly

focus their attention on the environment when he or she is being exposed to a social situation (Wells, 2009). According to Rapee and Heimberg (1997) this could potentially have detrimental effects on the clients, since the model states that individuals with social phobia are vigilant to social threat cues from the environment. In contrast, Clark and Wells (1995) do not include the theory about vigilance toward threat cues, instead they state that internal attention is the main problem. Therefore, turning the attention outward will give clients information from the environment that is inconsistent with their dysfunctional beliefs.

Attention training technique. ATT involves listening to auditive stimuli consisting of diverse sounds with instructions before each of the three components. First, the auditive stimulus guides the client's attention between individual sounds. This is called selective attention. Second, during the "rapid attention switching" part, the tape instructs the client to shift his or her attention between individual sounds, with increasingly higher speed. Third, during the "divided attention" part, the tape instructs the client to broaden his or her attention and listen to as many sounds as possible simultaneously. Wells highlights the fact that ATT is not developed as a distraction technique, and therefore it should only be rehearsed when the client is not in a state of anxiety (Wells, 2000, 2009; Wells, White, & Carter, 1997). Studies have found the ATT technique to be promising in treating social phobia, panic disorder, auditory hallucination and depression (e.g., Papageorgiou & Wells, 2000; Valmaggia, Bouman, & Schuurman, 2007; Wells et al., 1997). McEvoy and Perini (2009) found that ATT accomplished a shift toward external attention in the subjects as consistent with the ATT rationale. Also, subjects who achieved greater attentional flexibility while doing ATT achieved better control over their attention throughout the treatment. However, despite the fact that ATT showed promising results during treatment, McEvoy and Perini (2009) did not

find any additional advantage of including ATT in standard CBGT in terms of symptom change in social phobia and depression, attentional control, and meta-cognition.

Situational attentional refocusing. Instead of training the client's executive control of attention as ATT does, SAR tries to enhance the client's processing of information that conflict with the client's dysfunctional beliefs. This is achieved by focusing attention outward in a stressful and problematic situation (Wells, 2000, 2009). Wells and Papageorgiou (1998) have compared exposure alone with exposure plus external attention focus, finding that both conditions produced a decrease in anxiety. However, the exposure plus external attention focus condition produced significantly greater reductions in anxiety scores. On a scale ranging from 0 "*not at all anxious*" to 100 "*the most anxious I have ever been,*" the mean decrease in anxiety was 10 points for the exposure alone condition and a 37.5 points decrease for the exposure with external attention focus. In an effort to decrease anxiety, Woody, Chambless, and Glass (1997) used diaphragmatic breathing and instructions to aid external attention. Woody et al. (1997) were able to decrease the self-focused attention, which did not influence the external attention of the subjects. This is not in agreement with Clark and Wells (1995), where they propose a proportional view on internal and external attention. The decrease of self-focus attention during CBGT was found to be related to lower anxiety in social situations. An alternative explanation for these findings is that the diaphragmatic breathing succeeded in reducing anxiety which in turn reduced the self-focus attention, and the external attention instructions did not accomplish an increase in the subjects' external attention.

Causal mechanisms in situational attentional refocusing and attention training technique. In support of the SAR intervention, Heeren and Lievens (2011) revealed, with use of a cognitive experiment, that training individuals with social phobia to either direct their

attention away from threat cues (stimuli in the form of faces and words), or do this and additionally re-engage their attention towards non-threat cues, resulted in lower anxiety in a stress test (giving a speech) compared to a control group and those only trained to direct their attention towards non-threatening cues. This finding has also been supported by Klumpp and Amir (2010), where subjects trained to re-direct their attention away from threatening faces towards neutral faces, achieved lower levels of anxiety in a subsequent speech exposure. Surprisingly, the condition where subjects were instructed to attend to threatening faces, subjects experienced lowered anxiety in the speech exposure. Impaired attentional control can explain why attention training toward threat stimuli can lessen the anxiety experienced in challenging social situations. Impaired attentional control has been shown to be unique to social phobia (Moriya & Tanno, 2008). The mechanisms, which probably maintain the impaired attentional control, are hypothesized by Derryberry and Reed (2002). Their research suggests that highly anxious subjects have difficulty disengaging from threatening stimuli instead of having a bias towards threatening cues, which is in contrast to the vigilance and avoidance studies mentioned above (e.g., Mansell et al., 1999; Mogg et al., 2004). Additionally, subjects with good attentional control were better able to shift their attention from threatening stimuli. The implication from this is that if anxious individuals train their attentional control they will be better able to shift their attention towards stimuli they choose consciously (Derryberry & Reed, 2002). For example, the ability to direct attention toward a set goal can decrease anxiety, because the training will increase the person's control over their attention. In case this hypothesis is true, the direction of the attention training should not matter. ATT reflects as an example of an intervention that tries to achieve greater control over the attention.

Hypothesis

The fact that up to half of the clients treated do not benefit from many of the CBT approaches, due to refusal of treatment, dropping out of treatment, or do not show improvements (e.g., Lincoln et al., 2005; Turner et al., 1996), highlights the need of more research on the treatment models that might increase their efficacy. Both Rapee and Heimberg (1997) and Clark and Wells (1995) suggest that the attention training can alter the processing of an internal mental representation or the processing of the self as a social object, this can contribute to a decrease in anxiety, which is supported with research described above. In the SAR intervention clients are given instructions to focus on the environment, they are not given explicit instructions to focus only on positive cues from the environment, this might be detrimental to the clients if Rapee and Heimberg's model is correct (Rapee & Heimberg, 1997). However, studies do not seem to support this (e.g., Wells & Papageorgiou, 1998; Woody et al., 1997). Instead, as mentioned above Wells and Papageorgiou (1998) found that exposure therapy with external attention instruction achieved better results than the exposure therapy without this instruction.

Therefore, based on the research findings described above the present study will examine if ATT and SAR are effective in decreasing the maintaining factors, identified in the cognitive model of social phobia by Clark and Wells (1995), in clients with social phobia, and if additional symptoms that often follow social phobia also decreases. In addition, because of the debate concerning if APD and social phobia lies on a common continuum the present study wants to explore if an association between APD measures and social phobia measures can be found. This study will also investigate if APD is affecting the recovery from social phobia, since studies have shown that APD influence recovery from social phobia (e.g., Eskildsen et al., 2010; Feske et al., 1996). Operationalized, the hypotheses are: 1)

Expect that ATT and SAR are effective in decreasing the maintaining factors of social phobia as illustrated in Clark and Wells' model (Clark & Wells, 1995), measured by the Social Phobia Rating Scale (SPRS). 2) Expect that ATT and SAR will decrease symptoms of social phobia, general anxiety and depression, measured by Clinical Severity Rating (CSR) of Anxiety Disorders Interview Schedule (ADIS-IV), Fear of Negative Evaluation (FNE), Becks Anxiety Inventory (BAI) and Becks Depression Inventory (BDI). 3) Expect that sum scores on APD in the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID II) assessment will correlate positively with symptoms of social phobia and depression, measured by ADIS-IV CSR, and BDI. 4) Expect that comorbid APD will affect treatment outcome, measured by ADIS-IV CSR and BDI.

Method

Design

A single case longitudinal crossover (A-B, B-A) design was chosen (Jones & Kenward, 2003). The participants were randomly assigned to one of two conditions. Treatment consisted of ATT and SAR (Wells, 2009), administered in session ranging from 45-60 min. Baseline was recorded before treatment. Data collection was done mid-treatment and post treatment and certain measurements were collected every session. Treatment in both conditions was administered in one session per week in four weeks, with a minimum of one week between treatments.

Participants

The participants were recruited using a convenience sample primarily among clients who sought treatment at Studentsamskipnaden in Trondheim's psychosocial health service. Participants were also recruited from individuals who sought treatment at local general practitioners. Table 1 shows the demographic variables of the sample.

Table 1

Age, sex, diagnoses and level of education of the sample

Variable	Intention to treat (n = 16)
Age (Mean, SD)	34.0 (SD = 15.34)
Sex	
Women	6
Men	10
Diagnoses	
Social phobia	16
Other anxiety disorders	2
Depression	6
APD	5
Highest completed education	
High school	14
College/University	2

Note. APD = Avoidant personality disorder

Figure 1 presents the participants' progress through the trial. A total of 25 participants were referred for treatment, all of which were of Caucasian ethnicity. 1 was excluded before ADIS-IV interviews because of medication use. 24 underwent ADIS-IV screening. 5 were excluded right away and 1 participant was excluded later on because it was discovered that the participant suffered from agoraphobia not social phobia. Of the 18 meeting the inclusion criteria and given the opportunity to begin the treatment, 2 participants refused treatment and 4 participants dropped out during treatment.

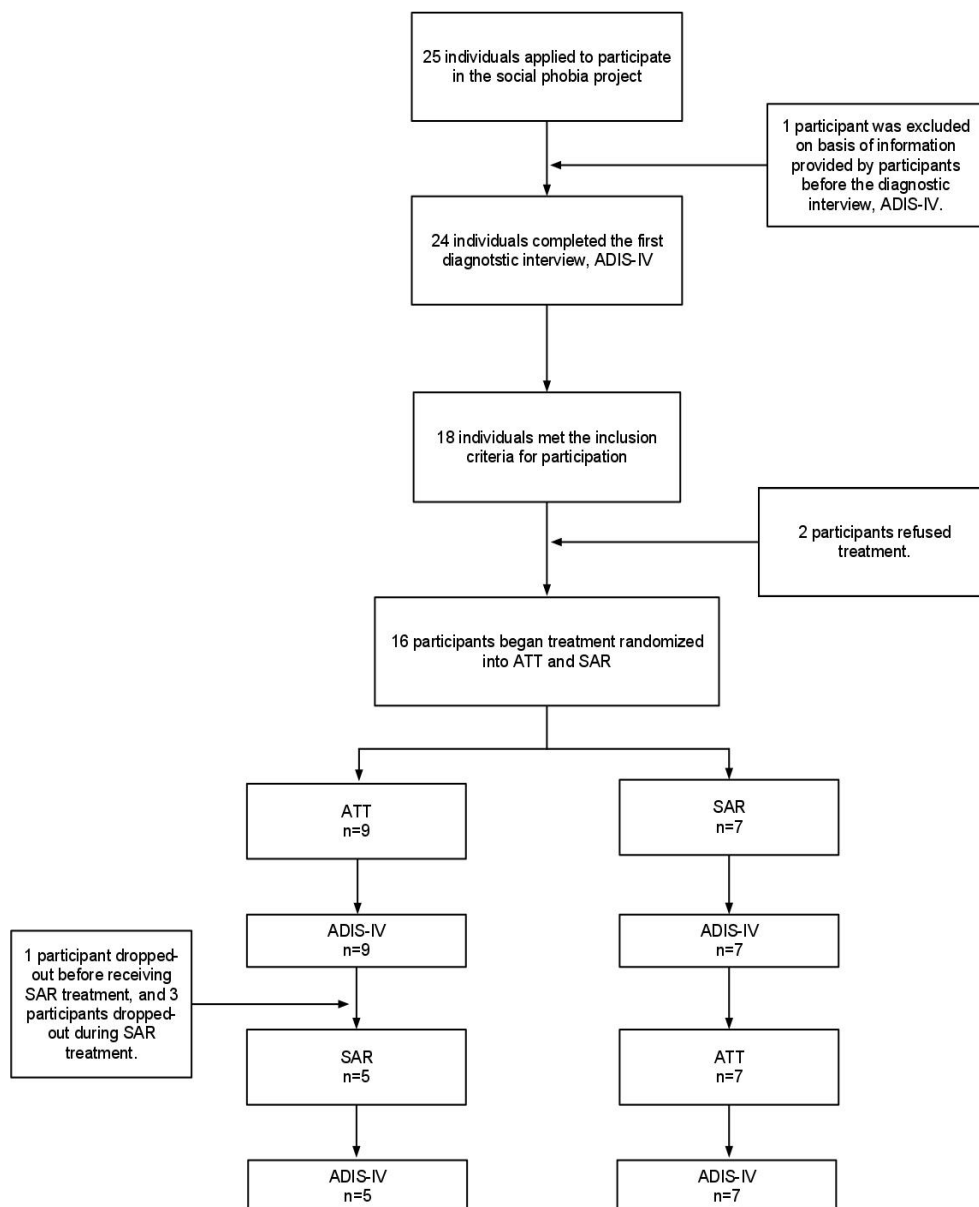


Figure 1. Flowchart of participants' progress through phases of the trial. ATT = attention training technique, SAR = situation attentional refocusing. ADIS-IV = Anxiety Disorders Interview Schedule.

The mean age of those who completed treatment ($n = 12$) was 25.2 years ($SD = 7.0$). 25% were women, 17% were married or living with a partner, 8% had a higher education, and the remaining had completed high school. 25% of the sample had a comorbid major depressive disorder and 17% met the criteria for another anxiety disorder. One third of the completing participants met the criteria for APD. Inclusion criteria for this study was a

primary diagnosis of social phobia according to criteria from DSM-IV (American Psychiatric Association, 1994) assessed with the ADIS-IV (Brown, 1994). The assessments were done by graduate students in clinical psychology. All pre-treatment interviews were recorded.

Exclusion criteria were: social phobia not being the main diagnosis, being involved in other treatment, taking antidepressant drugs, being psychotic, having clear suicidal intent, severe substance abuse or dependence, or having previously received an adequate trial of CBT that included ATT or SAR treatment. APD was not an exclusions criterion.

Instruments

Self-report instruments. An extensive test battery of frequently used and standardized self-report measures were employed. These tests assess different dimensions and aspects of social phobia. The tests were: a modified version of the Social Phobia Rating Scale (SPRS: Wells, 1997), Fear of Negative Evaluation (FNE: Watson & Friend, 1969), Beck Anxiety Inventory (BAI: Beck, Epstein, Brown, & Steer, 1988), and the Beck Depression Inventory (BDI: Beck, Rush, Shaw, & Emery, 1979).

The SPRS consists of six rating scales assessing key components of the Clark and Wells' cognitive model of social phobia (Clark & Wells, 1995) in current social situations which are anxiety-provoking. These subscales include: (1) "*distress*", (2) "*avoidance*", (3) "*self-consciousness*", (4) "*frequency of safety-seeking behaviors*", (5) "*negative beliefs*". An additional item, (6) "*ruminating about social situations*", was added at the suggestion of the author, Adrian Wells. Question 1, 2, 3 and 6 is graded from 0-8. Question 4 lists 15 common safety behaviors and the respondent is asked to indicate the frequency (0 - 8) each safety behavior is practiced during anxiety provoking situations. Question 5 list 14 common negative beliefs which the respondent is asked to indicate from 0 – 100 regarding how much they believe in the negative assumption, when experiencing social anxiety.

The FNE is a 30 item self report questionnaire which employs a true or false response set. The FNE is a widely used measurement and it assesses a person's expectations towards being evaluated by others negatively (McNeil, Ries, & Turk, 1995). The psychometric properties of FNE have been investigated with samples using undergraduate students. Internal reliability is excellent (Cronbach's alpha ranging from 0.94 – 0.98) and test retest reliability with a one month retention was 0.78 (Watson & Friend, 1969). No agreed upon cut-off scores of the FNE were found. Normative data on a sample of patients diagnosed with social phobia found a mean score of 21.9 (SD = 5.8) (Oei, Kenna, & Evans, 1991). As cut off, based on Oei et al. (1991) data, we chose to use a score of 10, that roughly constitutes a 2 SD drop in score. This is in line with Jacobson and Truax (1991) suggestion on clinical significance.

BAI is a 21 items self-report questionnaire which closely represents common criteria for panic disorder. Participants rated their discomfort on a particular symptom from 0 to 3. In line with the 1993 revision of the BAI manual a score between 0 - 7 "*minimal level of anxiety*", 8 - 15 "*mild anxiety*", 16 - 25 "*moderate anxiety*" and a score of 26 - 63 indicate "*severe anxiety*" (Beck & Steer, 1993). Studies of BAI have reported excellent internal consistency (Cronbach's alpha ranging from 0.90 - 0.92), and test-retest reliability of 0.75 (Beck, Epstein, et al., 1988; Kabacoff, Segal, Hersen, & Van Hasselt, 1997).

BDI is a 21 items multiple choice self-report inventory which was used to assess depressive symptoms. Persons rate their depressive symptoms on a 0 to 3 scale (Beck et al., 1979). Following recommendations, scores on the BDI was interpreted in the following way: 0 - 9 "*normal*", 10 - 20 "*mild level of depression*" 20 - 30 "*moderate level of depression*" and 30 and above "*severe level of depression*" (Kendall, Hollon, Beck, Hammen, & Ingram, 1987). Studies of BDI have found high internal consistency (Cronbach's alpha = 0.91) (Ambrosini, Metz, Bianchi, Rabinovich, & Undie, 1991), high content validity and high

validity in differentiating between depressed and non-depressed subjects (Beck, Steer, & Carbin, 1988; Richter, Werner, Heerlein, Kraus, & Sauer, 1998). Test-retest reliability of 0.69 has been reported (Yin & Fan, 2000).

Clinical interviews. All participants were assessed with ADIS-IV, which includes a 9 point clinical severity rating. The scale addresses clinical severity and level of functioning. According to ADIS-IV CSR a rating of 4 is the minimum for a diagnosis. A higher rating indicates greater symptom distress and a higher level of functional impairment (Brown, 1994). ADIS-IV was administered pre-, mid-, and post-treatment. The same interviewer made all the ratings for each participant. In addition, participants were screened with the Avoidant Personality Disorder section of SCID-II at pre-treatment (First, Gibbon, Spitzer, Williams, & Benjamin, 1997). The ADIS-IV and the Avoidant Personality Disorders section of SCID-II interviews were conducted by four graduate students under supervision of a clinician with extensive experience with ADIS-IV evaluations. The ADIS-IV interviews, which incorporated SCID-II, were administered in session ranging from 1.5 to 7 hours.

Time of assessments

Participants completed an extensive test battery (BAI, SPRS, and FNE) pre- mid- and post-treatment. At pre- and post-treatment, participants also completed the BDI questionnaire. In addition, at the beginning of each session participants completed the SPRS and BAI questionnaires to gain insight into the treatment progress.

Treatment

Each treatment was administered weekly over a four week period. The two treatment conditions consisted of ATT and SAR, as outlined in Wells (2009), with a minimum of one week between each session. One group received ATT first then SAR, this group was counterbalanced with a group receiving SAR first then ATT.

Treatment was given according to a formal protocol (Appendix A: SAR protocol, Appendix B: ATT protocol). One common feature of both conditions was creating an individualized anxiety hierarchy for social situations in the first session (Appendix C). The protocol was monitored on a self-report form filled out by therapists after each session to maintain standardization of treatment.

The ATT protocol consisted of an initial psycho-educational part where the rationale behind ATT was explained (Appendix D). The rationale emphasizes the fact that ATT is supposed to be an attention training technique and not another way to avoid anxiety provoking stimuli. A CD was introduced, lasting about eleven minutes, and obtained from the Metacognitive Therapy Institute. The instructions of ATT were read by Adrian Wells on a standardized recording of diverse sounds in accordance with the principles for conducting ATT (Wells, 2009). Before ATT commenced, the participants were asked if they understood the rationale and to rate from 0 - 100 how much they believed in the rationale, i.e. if they believed the treatment would be helpful for their problems, a score of 0 being no faith in the rationale, and 100 being complete faith in the rationale. The aim of ATT is to train the participants control over their attention. Participants were given homework in the form of performing ATT training twice a day at home and to register this on a form (Appendix E). They were asked to rate their external or internal focus of attention before and after on a 7 point scale ranging from +3 “*maximum external focused*” to -3 “*maximum internal focused*”.

The SAR treatment started with an initial session with an explanation of the rationale (Appendix F). During SAR exposures participants were given the task of focusing on features of the social environment (e.g. hair color, clothes, eye color etc.) in the exposure situation. The situations were arranged in accordance with situations that the participants had described in their anxiety hierarchy. As with ATT, the participants was asked to rate from 0 - 100 how

much they believed in the rationale. The participants' homework was to expose themselves to feared social situations while using the SAR technique and register them on a self-report form to monitor each participant's progression (Appendix G).

Therapists and supervision

Therapists were recruited among 3rd and 4th year graduate students in psychology at the Norwegian University of Science and Technology (NTNU) in Trondheim. They received training in both ATT and SAR regarding the logic behind the rationale and the "selling" of the rationale to the participants. They were also given training in the precise execution of ATT and SAR according to the treatment protocol.

Statistical Analysis

Participants who refused treatment or did not complete post-treatment assessment (i.e., dropouts) were excluded from further analyses. Due to a small n in the present study, just limited analyses were possible. For example, no formal test on order effect was possible. Descriptive statistics on ADIS-IV CSR and the self-report measures were calculated. Changes in symptom levels were measured using three different scales; ADIS-IV CSR, FNE and SPRS questions: 1 "*distress*", 2 "*avoidance*", 3 "*self-consciousness*", 5 "*negative beliefs*" and 6 "*ruminatation*". To identify possible differences between pre- and post-treatment, a Bonferroni correction for 6 paired samples t-test, with $p < .008$, was employed. BDI and BAI, which measures symptoms commonly associated with social phobia, pre- and post-treatment scores were analyzed with a Bonferroni corrected 2 paired samples t-test with $p < .025$. Effect sizes were calculated using Cohen's d .

Additionally, the ADIS-IV CSR, FNE, BAI, and BDI scores were analyzed with regards to how many participants scored beneath each assessments lowest cut-off score. On ADIS-IV CSR, this means no longer meeting the DSM-IV criteria for social phobia. FNE,

BAI and BDI scores were also analyzed in terms of the reliable change index (RCI: Jacobson & Truax, 1991).

To investigate if there were an association between APD symptoms and severity of the social phobia disorder, correlations were conducted between pre-treatment SCID II scores on APD and pre-treatment ADIS-IV CRS scores and pre-treatment BDI scores. Also, pre-treatment SCID-II scores on APD were correlated with post-treatment ADIS-IV CSR scores and post-treatment BDI scores, to examine whether APD symptoms could be associated with treatment outcome.

Results

Dropouts

Dropout of treatment was 25%, (4 out of 16 participants), where 3 of the dropouts were women. The mean age among dropouts was 34.0 (SD = 15.34). There was no significant difference in age between dropouts and completers. There was no significant difference at pre-treatment in the ADIS-IV CSR between dropouts and completers. Also, no significant differences were found between dropouts and completers in anxiety scores, depression scores, and SCID-II scores on APD.

Effects of Treatment on Social Phobia

Effect of treatment on group level. ADIS-IV CSR, FNE and SPRS are the main instruments used in this study to measure symptom reduction. Table 2 shows the effect of treatment on symptom reduction on a group level. Table 2 also presents the results from BAI and BDI, which are used as secondary symptom variables, since they measure symptoms commonly occurring in individuals with social phobia.

Table 2

Outcome measures at pre-treatment and post-treatment

Assessment	Pre n = 12		Post n = 12		Sig.	Cohen's <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
ADIS-IV	6.08	0.79	3.58	1.62	.001	1.33
BAI	25.25	12.29	6.33	4.75	.000	1.93
BDI	14.67	7.82	5.50	4.95	.001	1.34
FNE	27.00	2.82	18.2	7.31	.001	1.29
SPRS 1: Distress	5.08	1.08	2.25	1.14	.000	2.54
SPRS 2: Avoidance	4.08	2.19	1.25	1.22	.001	1.33
SPRS 3: S.c. ^a	5.42	0.90	3.00	1.48	.002	1.17
SPRS 5: N.b. ^b	56.73	19.58	22.44	11.44	.000	1.73
SPRS 6: Rumination	6.00	1.73	2.91	1.81	.009	0.97

Note. M = mean, SD = Standard deviation, Sig = Significance level, ^aSelf-consciousness.

^bFrequency of safety seeking behaviors. Cohen's *d* effect sizes were calculated as follows. Cohen's $d = (\text{Pre mean scores} - \text{post mean scores}) / \text{pooled standard deviation of pre and post scores}$

At post-treatment the paired samples t-test showed a significant reduction in symptoms on a group level. According to Cohen (1988), all our effect sizes are high.

To show the pattern of anxiety scores, mean BAI scores were plotted across treatment. Figure 2 show this pattern. The small spike in session 5 scores was also found on an aggregated score on the SPRS questions 1, 2, 3, and 6.

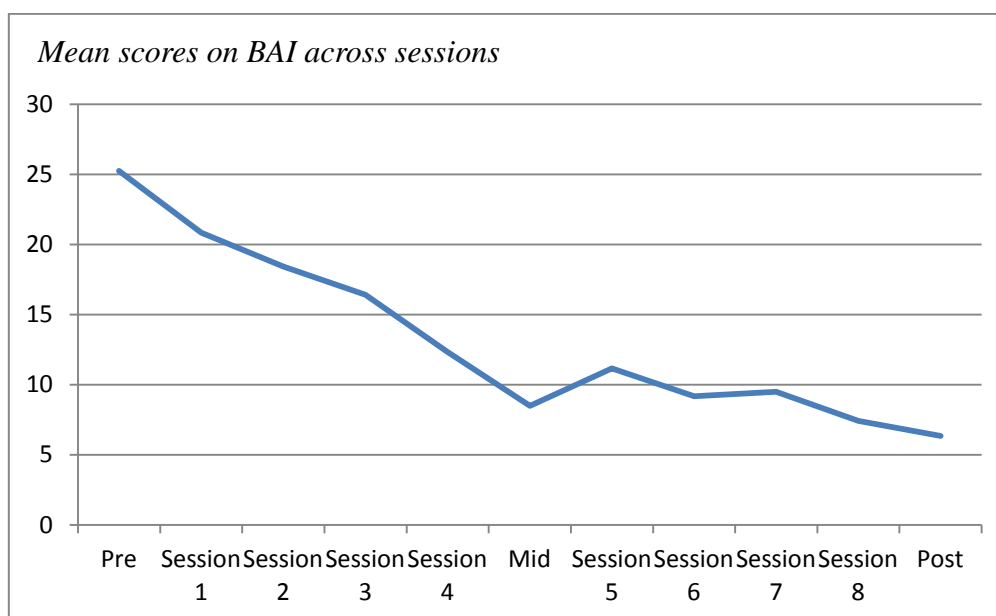


Figure 2: Mean BAI scores across therapy sessions.

From dysfunctional range to functional range and reliable change index. Table 3 shows the overall movement from the dysfunctional to the functional end of measurements for each participant. 1 means a successful change based on the RCI (Jacobson & Truax, 1991). On self report a score of 1 means that the participant is below the lowest cut off on the scale. On the ADIS-IV CSR a score of 1 means that the participant no longer meets the diagnostic criteria for social phobia. Table 3 shows that 58% of the participants after treatment did not meet the diagnostic criteria for social phobia. On the FNE 25% of the participants were below cut off score, but 66% had made a reliable change. On the BAI 58% of the participants were below cut off score, with half of the participants having a reliable change. On BDI 75% of the participants were below cut off score, and 33% had a reliable change. Overall, this shows that 59% of possible movements from the dysfunctional range into the functional range were achieved on ADIS-IV CSR, FNE, BAI and BDI. Table 3 also shows that 50% of possible reliable change was achieved on FNE, BAI and BDI.

Table 3

Movement from dysfunctional range to functional range, with corresponding RCI movement

Participant	ADIS	FNE	RCI FNE	BAI	RCI BAI	BDI	RCI BDI
1	0	0	0	1	1	0	1
2	1	0	1	1	0	1	0
3	0	0	1	0	1	1	0
4	0	0	0	1	0	1	0
5	1	0	1	1	0	1	0
6	1	1	1	1	1	1	0
7	1	1	1	1	1	1	1
8	1	0	0	0	1	1	1
9	0	0	1	0	0	0	0
10	1	0	1	0	1	1	1
11	1	0	0	1	0	0	0
12	0	1	1	0	0	1	0
Sum	7	3	8	7	6	9	4

Note. ADIS = ADIS-IV Clinical severity rating, FNE = Fear of Negative Evaluation, BAI = Beck Anxiety Inventory, BDI = Beck Depression Inventory. RCI = Reliable Change Index.

The Impact of APD

A Pearson product-moment correlation between SCID II scores on APD and pre-treatment ADIS-IV CSR score showed a positive correlation, $r = 0.67$, $n = 12$, $p < .05$. No significant correlation was found between SCID II scores and post-treatment ADIS-IV CSR scores. A positive correlation was found between SCID II scores and pre-treatment BDI scores, $r = 0.66$, $n = 12$, $p < .05$, but there was no significant correlation between SCID II scores and post-treatment BDI scores.

Discussion

The overall results indicate that the combination of ATT and SAR, irrespective of order, were effective treatments for social phobia, with significant differences between pre- and post-treatment on symptom severity and cognitive change, which is shown in table 2. The

strong effect sizes are somewhat surprising, since the sample was heterogeneous, with some clients having comorbid axis I disorders and comorbid axis II APD.

The results are in line with Wells et al. (1997), lending further support for ATT being an effective intervention in the treatment of social phobia. Unlike McEvoy and Perini (2009), which did not find any additional benefit of adding ATT to other interventions, our results suggest that ATT with SAR may be effective treatments of social phobia. In agreement with Wells and Papageorgiou (1998), the present study also found promising results regarding SAR as a successful intervention for the social phobia disorder. Unfortunately, unlike Wells and Papageorgiou (1998), the present study cannot state if the inclusion of the external attention instruction in SAR is able to achieve better results than exposure therapy alone, since the study did not include a comparison group that received exposure alone therapy.

SPRS was used to measure whether ATT and SAR were able to decrease the symptoms (distress, avoidance, self-consciousness, negative beliefs and rumination) as described in Clark and Wells' cognitive model of social phobia (Clark & Wells, 1995). The results from the SPRS show that there was a significant decrease in all subscales, except for rumination which became non significant following a Bonferroni correction. This, coupled with the strong effect sizes, indicates that ATT and SAR are useful treatment interventions for many of the aspects of the social phobia disorder.

ATT and SAR seem to have influenced cognition. They seem to have significantly reduced negative beliefs in the clients. Even though ATT and SAR are not considered to be cognitive restructuring interventions, results are in agreement with previous studies that have indicated that interventions who do not specifically targets cognitions, actually can achieve cognitive change (e.g., Hope et al., 1995; Scholing & Emmelkamp, 1993).

According to Rapee and Heimberg (1997), the re-direction of attention away from internal sensation, could improve social anxiety. Therefore, the ATT intervention could also be used by therapists endorsing Rapee and Heimberg's model. However, a study by Klumpp and Amir (2010) found that the direction of attention does not matter, when the participants had gone through an attention training. Rather impaired attentional control is hypothesized to be the problem in social phobia, which is in contrast to Rapee and Heimberg (1997), where vigilance toward threat cues is thought to partly maintain the social phobia disorder.

In addition, according to Rapee and Heimberg (1997), noticing others reactions in an exposure situation, which is done in SAR, could potentially lead to more anxiety, since the individual being exposed would probably also notice threat cues from others (e.g., others laughing of them). The results from the present study do not indicate that the participants deteriorated under the SAR intervention, instead they improved. Therefore, this study supports Clark and Wells (1995), because shifting from internal to external attention in exposure lead to improvement not deterioration.

The order of the interventions might have yielded different results. Unfortunately, the sample size was too small to conduct analyses on possible sequence effects. Therefore, the study cannot make inferences about the sequence order, but the tendency throughout the treatment was that scores decreased independently of intervention sequences. Visual inspection of figure 2 shows an example of the general reduction in BAI scores. This tendency is evident for both those participants that started therapy with ATT and those who started with SAR. There might be several reasons for the tendency. First, this might mean that ATT and SAR are equally effective in decreasing social phobia symptoms. Second, nonspecific therapy effects may have played a role. Third, demand characteristics might have influenced the participants' self-report.

ATT and SAR are two very different interventions. ATT involves training the clients' attention to be more flexible, giving clients the ability to intentionally choose the direction of attention. In SAR the client exposes him- or herself to feared situations, and is given explicit instruction to direct the attention outward (e.g., notice each person's hair color, clothes, etc.). The attention re-direction is not rehearsed before the exposure. A logical inference from this is that the ATT intervention could function as a training intervention for SAR, since ATT teaches executive control of attention. Consequently, participants who were randomized to ATT first, could have mastered SAR better than the others randomized to SAR first, but there seems to be no evidence supporting this.

Measures of Mood

An analysis of the mood measurements BDI and BAI demonstrated significant differences between pre- and post-treatment with corresponding strong effect sizes. On BAI a moderate rate of reliable change occurred, with a moderate number of participants below lowest cut off at post-treatment. On BDI the majority scored beneath cut off, but only with a moderate rate of reliable change, making way for a possible flooring effect. Overall, the results are good on group level and within group level.

The significant decrease in depressive mood, measured by BDI, might be due to nonspecific therapy factors, or that the depressive mood is secondary to the social phobia. In fact, many have shown that comorbid disorders often are secondary to social phobia (e.g., Brunello et al., 2000; Fehm et al., 2008; Stein et al., 2001; Van Ameringen et al., 1991), which lend support to the hypothesis that treating social phobia could also improve depressive symptoms. The present study used only ATT and SAR in the treatment of social phobia. Therefore, this study cannot state if the decrease in depressive mood are a result of nonspecific therapy factors, or that the interventions used are also effective in decreasing

depressive symptoms. However, the protocol emphasized motivating the participants to be more sociable and challenge themselves in naturally occurring social situations, and this could have meant increased behavioral activation, which is a well supported intervention for treating depression (Jacobson, Martell, & Dimidjian, 2001).

Social Phobia in Relation to Avoidant Personality Disorder

Significant positive correlations were found between pre-treatment SCID-II scores on APD and pre-treatment ADIS-IV CSR ($r = 0.67$), and between pre-treatment SCID-II scores on APD and pre-treatment BDI scores ($r = 0.66$). SCID-II scores on APD failed to reach significance when correlations were conducted on post-treatment data. The results indicate that the degree of APD symptoms seems to be associated with the severity level of the social phobia. As correlations did not reach significance between SCID II scores on APD and post-treatment scores, no inferences from present data can be made with regards to the degree of APD symptoms' influence on end state functioning. These results fail to replicate other studies that have suggested that the severity of the social phobia disorder, in terms of generalized social phobia and axis II APD are associated with the treatment outcome (Eskildsen et al., 2010). A small sample size and not controlling for subtype of social phobia may have contributed to this discrepancy. However, Eskildsen et al. (2010) found that the severity does not seem to be associated with inferior improvement during therapy. This means that individuals with social phobia with or without generalized social phobia, which either have or does not have a comorbid APD disorder, do respond to the usual therapy given to individuals with social phobia. However, they begin treatment being more severely affected and end treatment at a more severe level, but they achieved the same amount of improvement compared with individuals who score lower on these characteristics. Consequently, persons with social phobia with the generalized subtype with or without APD

most likely need more extensive therapy, combined interventions, and a more individualized therapy, that are based on a thorough case conceptualization.

Strengths and Weaknesses

The present study used both self-report measures and observer ratings. The self report measures used have excellent psychometric properties. The study was not able to find research on the psychometric properties of SPRS, probably because this is a relatively new questionnaire.

There are some limitations that are worth mentioning. An important limitation is that the assessors were not “blind” to treatment condition, or how long the clients had been in therapy. This could have influenced mid-treatment assessments and post-treatment assessments of ADIS-IV CSR in a more favorable direction. Another major limitation with the study is the lack of a control group. With no control group, it is not possible to determine if the decrease in symptoms is due to chance or that the interventions are effective. The study could have used a control group that had received treatment-as-usual (TAU) to control for nonspecific therapy factors.

A small sample size affects the statistical power in the study. Also, the study uses a convenience sample. This poses a problem with the generalization of the sample, and might lead to difficulties in replicating the study.

Follow-up data was not collected, because of the limited scope of the paper. This is unfortunate, since follow-up data could have provided valuable information about the durability of treatment effects.

The study used 3rd and 4th year graduate students as therapists; it is possible that this could have hampered the standardization of the treatment package, making it harder to compare clients with each other. On the other hand, this study makes a great pilot study for

low-threshold services. Therefore, using many graduate students as therapists can be seen as a strength as-well, because many therapists with less clinical experience is probably more comparable to how low-threshold operates.

Future Directions

Toward a step-care treatment approach. Along with previous studies (e.g., Herbert et al., 2005; Scholing & Emmelkamp, 1993), the present study had a high drop-out rate, which means that there were many clients with social phobia who did not receive help for their mental illness in our clinic even though they were offered alternative treatment if they did not want to participate in the study.

A step-care approach to treatment could be a solution for the clients who do not benefit or complete the treatment offered to them. In addition, the model could suggest at which step each client should begin therapy based on the severity of the mental disorder, comorbid disorders, client's treatment preferences, etc. To our knowledge there are no suggested step-care treatment models for social phobia. The intention of the model is to reduce the number of persons who refuse treatment, dropping out of treatment, not responding to treatment or have to complete a rigorous treatment when they experience a significant drop in symptom severity making the cost of completing therapy higher than quitting. In order for the model to achieve this ambitious goal, the model needs to be flexible, and interventions should be tailored to each individual. Clark and Wells offer a detailed model that can be used for an individualized case conceptualization for each client (Clark & Wells, 1995). Other benefits with a step-care model is that it could potentially close some of the gaps between research and implementation of research in ordinary clinical practice, because the model encourage research on severity of each client's individual

diagnosis, clients preferences of treatment, treatment conducted in different settings, such as low versus high threshold, low expertise versus high expertise, etc.

A general step-care model is suggested, to act as a step-care treatment approach of social phobia. This does not mean that it is suited for every client to begin treatment at step 1. For example, clients with comorbid disorders, long duration of the social phobia disorder, etc. might have better effects of their treatment if they begin therapy at step 2 or 3. Although, some of the clients in the present study's sample had comorbid disorders (e.g., APD, depression), all the clients went through the same treatment program.

Step 1. A first step in a step-care model could begin with short interventions which could be offered at low threshold clinics. The interventions conducted in the present study represent therapy at a first step, because of the short duration (4 weeks for each intervention). The clinic was considered to be low threshold, and the therapists used were graduate students, and not specialist in clinical psychology or psychiatry which is usually the case in specialist mental health services. Another way of conducting exposure therapy in a cost effective way is by group therapy. However, a major issue with exposure therapy alone or combined with cognitive restructuring is that many (up to half) of the clients do not benefit from the treatment, refuse the treatment or drop out during treatment (e.g., Lincoln et al., 2005; Turner et al., 1996).

Step 2. The next step is for those who did not benefit, refused or dropped-out from the therapy offered at step 1. The clients who are offered step 2 interventions are in need of increased intensity in the treatment. Instead of group treatment, individualized treatment may be needed.

Step 3. This step is for those who did not benefit from the interventions they went through in the previous steps. Here, a referral to a specialist mental health service, where a

thorough case conceptualization is conducted might be necessary. The case conceptualization could be based on various CBTs, (e.g., cognitive treatment (Clark & Wells, 1995), RET (Ellis & Dryden, 1997)). Interventions can then be individually tailored according to each client's case conceptualization. The interventions will vary depending on the model the therapist uses.

Conclusion

The study indicates that ATT and SAR are effective in decreasing the maintaining factors of social phobia, which supports Clark and Wells' cognitive model (Clark & Wells, 1995). However, given the small sample size an ascertainment on whether or not ATT or SAR is superior or inferior to one another cannot be made, nor can any inferences about the order of intervention be made.

The study also suggests that a relatively short and simple intervention have the potential of effectively treating clients suffering from social phobia with and without comorbidity. This gives optimism for the future development of step care models, by minimizing suffering while maximizing utility of available resource interventions.

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Appendix A

Sjekkliste for SAR

Dato:	Sesjon nr:	Behandler:	Pasientnr:
Oppgave:	Eventuelt:	Sjekk:	
Forberedt Eksponering: - Første time: Lage hierarki	Beskrivelse av eksponering:		
Ta imot testpakke	Hvis ikke levert, fyll ut før timen		
Kontrollere eksponerings registrering	Viktig at de øver hjemme. Se derfor over registrering og oppfordre til videre trening		
Teste forventning til eksponering (0-100)	Score og beskrivelse:		
Eksponering m/ytre fokus (registrer hårfarger, øyne, smil osv) Minne på ytre fokus (under eksponering) (ca 5min)	Hva fikk pasient med seg:		
Teste opplevelse av eksponering (0-8) angst og (0-8) selvopphengt (som på SPRS).	Score og beskrivelse:		
Teste rasjonale av eksponering	Forstår vedkommende treningen?		
Teste tro på eksponering (0-100)	Score:		
Dele ut testpakke! (SPRS, BAI, og registrerings skjema)	Minne på å fylle ut til neste gang		

Appendix B

Sjekkliste for ATT

Dato:	Sesjon nr:	Behandler:	Pasient nr:
Oppgave:	Eventuelt:	Sjekk:	
Forberede ATT og <i>lage frykt hierarki for sosialfobi</i> . (bare første time)	Beskrivelse:		
Ta imot testpakke	Vis ikke levert, fyll ut før timen		
Kontrollere ATT registrering	Viktig at de øver hjemme. Se derfor over ATT/eksponerings registrering og oppfordre til videre trening		
Teste rasjonale av ATT	Forstår vedkommende treningen?		
Teste forventning til ATT (0-100)	Score og beskrivelse:		
Teste eksternt/internt fokus (pre)	Skala -3 - +3		
ATT			
Teste eksternt/internt fokus (post)	Skala -3 - +3: normalisere opplevelse		
Kontrollere om pasient har brukt ATT i dagliglivet (ble tatt med i opprinnelig prosjekt, men er en missforståelse)	Hvordan:		
Dele ut testpakke! (SPRS, BAI og registrerings skjema)	Minne på å fylle ut til neste gang		

Appendix C

Hierarki

For lettere å arbeide og overvinne angsten, skal du lage et *frykthierarki*. Hierarkiet skal bestå av ca 7 situasjoner som du finner angst skapende. Målet er å trene på disse situasjonene, og merke hvordan angsten reduseres.

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Det er viktig at du utfordrer deg selv utenom timene. Prøv å oppsøke situasjoner som ligner på de du har vært med på. Husk å registrer dem.

Appendix D

ATT rasjonale

I løpet av en dag har vi alle mange tanker. Noen tanker husker vi ikke å ha tenkt. Andre tanker bruker vi mye tid på. Ingen av oss har helt kontroll over hva vi tenker på, det er heller ikke meningen. Om du får beskjed om å ikke tenke på en blå kanin, er det sannsynlig at du tenkte på nettopp en blå kanin. Vår hjerne fungerer slik. Det vi har mulighet til å kontrollere, er hva vi skal rette fokuset vårt mot. Du skal nå få lære en teknikk kalt Oppmerksomhetstrening (OT) som skal hjelpe deg til å få mer kontroll over oppmerksomheten din.

OT er en auditiv oppmerksomhetsøvelse. Den innebærer trening av selektiv oppmerksomhet, raske skift av oppmerksomhet og delt oppmerksomhet. Alle delene trenes i løpet av en OT sesjon. Du vil få med deg en CD som gir instruksjoner.

Det er viktig å teste din forståelse av denne teknikken, og hvor mye du tror den kan hjelpe deg. Du blir derfor spurt "Hvor mye tror du denne prosedyren vil hjelpe deg med å overvinne dine problemer? Kan du uttrykke det på en skala fra 0-100

Før og etter treningen, vil du bli spurt på en skal fra -3 - +3 om grad av selvfokus. Det er viktig at du forstår hva som menes med selvfokus.

-3	-2	-1	0	+1	+2	+3
Helt			Lik			Helt
eksternt			mengde			selvfokusert
fokusert						

Selvfokus øker intensiteten i indre reaksjoner. Det avdekker flere slike reaksjoner, og er med på å opprettholde dem etter hendelse negative antakelser og emosjoner. Målet er ikke å skyve bort alt annet fra bevisstheten, men å trene på å rette oppmerksomheten i en bestemt retning. De negative tankene og emosjonene skal få lov til å utfoldes seg som de må.

Prosedyren er ikke enkel og krever trening. Om det dukker opp distraherende tanker, kan dette sees på som ekstra trening. Det er viktig at du fortsetter å trene, spesielt når det er vanskelig. Som alle andre ting du har lært deg, var det sjelden du fikk det til med en gang. Teknikken vil bli enklere om du fortsetter å trene. Det anbefales at du trener min 2 ganger daglig.

Appendix F

SAR rasjonale

De fleste har opplevd og kommer til å oppleve angst eller anspenthet i spesielle situasjoner som når man står overfor mange fremmede, skal prestere noe, blir kritisert eller evaluert av viktige e.l. Dette er normal sosial engstelse og må ikke betraktes som sykelige. Sosial angst er derimot en psykisk lidelse/diagnose og innebærer langt sterkere angst av mer handikappende karakter som blir utløst i sosiale situasjoner. Dette kan være situasjoner hvor man må møte, hilse på eller snakke med mennesker man ikke kjenner særlig godt, mennesker som man skal spise sammen med, eller på andre måter bli utsatt for andres observasjon eller vurdering. Rent psykologisk handler sosial angst om frykt for å bli vurdert negativt, å bli kritisert, ydmyket eller å bli latterliggjort av andre.

Eksposering er en kognitiv adferdsterapeutisk behandlingsteknikk for å redusere angst og fryktresponser. Den innebærer å trene på situasjoner som skaper ubehag.

I fryktskapende situasjoner, er den normale reaksjonen å søke bort. Velger du å gjøre det du alltid har gjort, kan du også forvente det samme resultatet. Ved å bryte mønstret av flukt fra situasjonen, som styrker frykt responsen, kan situasjonen etter hvert oppleves som mindre frykt skapende.

Hvis du fortsetter å unngå situasjoner som bringer angst, blir det bare hardere å komme over den. Når du starter med å gjøre eksponeringsoppgaver, dvs å oppsøke de situasjonene som du frykter, vil du begynne med merke angst og ubehag. Det er viktig at du da ikke rømmer situasjonen eller bruker tryggingstrategier da dette vil ødelegge eksponeringen og forhindre deg i å utfordre din angst. Du vil oppdage at hvis du står ut og holder deg i situasjonen over tid så vil angsten etter hvert reduseres (allerede etter 15-20 minutter).

Alle er engstelig når de går inn i nye situasjoner. Hvordan angsten håndteres er forskjellig. Det har tatt lang tid å utvikle angsten og du har hatt den lenge. Vær derfor beredt på at det vil ta tid å mestre den. Det finnes ingen tryllestav som fjerner angsten din. Vær også forberedt på tilbakefall og vær forberedt på å hankses med dem. Den ene dagen kjennes det helt fint, mens du i en annen dag igjen kan kjenne angsten komme. Når dette oppstår er det lett å bli skuffet. Innse at tilbakefall er en del av hele innlæringsprosessen. Som alle andre ting vi lærer oss, kreves det repetisjon for å bli dyktig. Ingen fikk til å gå ved første forsøk, og ikke alle dager var like enkle. Hvis du derimot trener regelmessig, er sjansen stor for at du lykkes. Angst er ubehagelig, men ikke farlig. Ikke steng angsten ute eller løp fra den når den kommer. Vær i situasjonen, og la opplevelsen utfolde seg. Om du lærer deg å leve med angsten, så forsvinner den.

Appendix G

For å kjenne at du kan mestre angsten, er viktig at du trener på det du har gjort i timen. Situasjonene du har opplevd, gjør at det kan føles vanskelig til å begynne med. Det er derfor lurt å skrive opp sosiale situasjoner som du opplever. Det er viktig at du forsøker å gjøre noe som ligger opp mot det du har gjort i timen.

Forventning: (0-100)	Situasjon: (beskriv)	Opplevelse etterpå (0-100)	Eksternt fokus: Hva la jeg merke til)

Samarbeid om hovedoppgave

Hovedoppgaven er blitt gjennomført som et samarbeid mellom Asgeir Riseth og Anne Cecilie Burhol. I henhold til *Retningslinjer for utforming av PSYPRO4100 hovedoppgaven på profesjonsstudiet i psykologi Psykologisk institutt* må det framkomme en beskrivelse av hver kandidats bidrag.

Hovedoppgaven har vært et kontinuerlig samarbeid mellom hver kandidat. Spesielt gjelder dette for utviklingen av hypoteser, hvilke statistiske analyser som ble gjort, redigering, korrektur.

Følgende punkter har blitt gjort i fellesskap:

- Innsamling av data
- Forord
- Abstract
- Hypoteser
- Konklusjon
- Referanser

Det er vanskelig å skille hver kandidats bidrag, men følgende punkter har Anne Cecilie Burhol hatt hovedansvaret for:

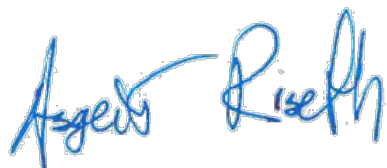
- Introduksjon
- Diskusjon

Følgende punkter har Asgeir Riseth hatt hovedansvar for:

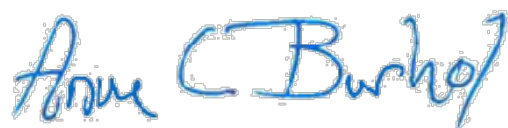
- Metode
- Resultat

Avslutningsvis vil vi understreke at det har vært svært lærerikt å samarbeide med hverandre. Dette er noe vi kommer til å dra nytte av i vår framtidige karriere.

Trondheim, 8. desember 2011



Asgeir Riseth



Anne Cecilie Burhol