Principles of Treatment

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The good news for people with social phobia who are able to seek help for their problem is that there are a myriad of treatment options available. The drug therapies are beyond the scope of this talk. Those who are interested in these treatments should speak with their physicians. Today's talk will focus on psychotherapies or treatments that involve the "talking cure". In particular, we will look at cognitive behavioural therapy, one of the psychotherapies that is best supported by the research literature as working well with social phobia. Roughly three in four people with social phobia respond to treatment with cognitive behavioural therapy, and treatment effects have been found to last for up to five years.

Cognitive behavioural therapy is actually a combination of therapies. Its active therapeutic ingredient is a behavioural technique based on systematic desensitization, called *exposure*. Exposure is a method of experiencing a feared social situation in one of three relatively controlled and manageable ways. One way is to imagine the social interaction as vividly and in as much detail as possible. A second is to role play the social interaction with a therapist or fellow client, and a third is to encounter the actual social situation, in-vivo. Exposure is usually done in a progressive manner, starting with the least troublesome situation from a fear and avoidance hierarchy. It is arguably the single most effective approach to treating many anxiety problems, including social phobia.

The other therapeutic ingredient to cognitive behavioural therapy is called *cognitive restructuring*. It is a method of identifying and replacing fear-promoting, irrational beliefs with more realistic and functional ones. Alone, it probably doesn't work as well as exposure, and opinion is mixed about whether cognitive restructuring and exposure together work better than exposure alone. In studies where the combination has worked better than exposure alone, the difference has emerged on follow up. That is, people who receive the combined treatment tends to continue making therapeutic gains long after the active treatment has concluded.

Cognitive Theory

Cognitive behavioural therapy is based on Beck and Emery's (1985) cognitive theory. This theory describes the role of faulty thinking in making us anxious, and suggests a way to recover from it through cognitive restructuring. According to Beck and Emery, the way we process information is governed by structures called *schemata*. These schemata are made up of rules for explaining incoming information, and for retrieving what we have already learned. They are capable of exerting powerful effects on how we experience and relate to the world. For example, the schemata of a person with a social phobia cause them to become anxious and avoidant by explaining incoming information and memories in terms of social threat. Treatment consists of correcting faulty or illogical thinking by repeatedly confronting cognitive schemata with

discrepant information from role-playing and homework assignments. The entire procedure is carried out in four steps described below.

Step 1: Elicit automatic thoughts
Automatic thoughts are habitual ways of thinking. Together with images, dreams and memories they form the *cognition* part of social phobia. The other two components of social phobia are avoidant behaviour and anxious *mood*. An example of an automatic thought, in the case of a secretary who is having trouble speaking up to her boss, might be, "If I say the wrong thing, she will think I am incompetent and fire me." As in this example, the automatic thoughts of people with social phobia tend to contain cognitive distortions.

behaviour consist of overt motor activity, physiological responses, and verbal responses. Examples of behaviour, in the case of the secretary, might be taking sick days, palpitations, and sweating. Mood is the subjective emotional experience of a person, and can include physical sensations. The secretary's mood is probably fearful and angry. As a result of the cognition, behaviour and mood components being interdependent, a change in one is expected to produce a change in the other two.

Automatic thoughts usually occur spontaneously. When they do not any one of the following techniques may be used to elicit them.

1. Focus on the other components of the problem (i.e., mood, behaviour), and ask for associated thoughts.
2. Focus on an image and ask for whatever words come to mind.
3. Use imagination in mentally recreating the situation, perhaps with someone else in the role of client. Ask what thought comes to mind, or what they might be thinking.

Step 2: Identify underlying irrational beliefs
Examine the automatic thoughts for any cognitive distortions that may be present. These cognitive distortions usually occur as one of the twelve unrealistic or irrational beliefs described below. These irrational beliefs are all based on flawed or faulty logic, and have the potential to be highly maladaptive for the person who holds them. One of the typical maladaptive consequences of these irrational beliefs is a negative mood state such as anxiety, depression or anger. Other maladaptive consequences are the fact that these beliefs often interfere with our ability to solve problems, and may lead to behaviours that get us into trouble or create other difficulties.

Two techniques commonly used to help identify irrational beliefs are the *downward arrow* technique and the use of *thought records* to find common themes. The downward arrow technique consists of challenging statements people make about what they think is causing their negative mood states by repeatedly asking the question, "If that were true, why would it be so upsetting?" Thought records are a common from of homework given to people in cognitive behavioural therapy that requires they record their automatic thoughts associated with problem situations (e.g., social avoidances or fears) during the week.

1. Emotional reasoning is mood-state dependent thinking based on the assumption that feeling something strongly necessarily makes it true. e.g., "If I am feeling anxious, I must be doing a poor job."

2. Over generalization is the use of a single negative event as evidence for a never-ending pattern of negative events. e.g., "Lisa said she didn't have time for coffee with me yesterday ... I'll never get a date with her."

3. Arbitrary inference involves drawing unwarranted connections between ideas that are either not logically related or are related in a much different way than is being suggested. e.g., "I've had so many bad relationships with men, I always seem to pick the same type. There must be something wrong with me."

4. All-or-nothing (black and white) thinking is seen in statements that use absolute terms such as always, never, completely, totally or perfectly to suggest you are a failure if your performance falls short of these standards. e.g., "You're nobody as a writer until you've won a Pulitzer Prize."

5. Should statements are statements that suggest a desire to change some reality when the only real choice is between accepting or not accepting it. e.g., "The boss should show greater appreciation for the hard work I do."

Note: Not all should statements contain the word "should". e.g., "Why does Jake always have to arrive late for appointments?"

6. Jumping to conclusions happens when negative interpretations are made of events without sufficient supporting evidence.

- Fortune telling occurs as unfounded, usually dire predictions that are made as if they are already fact. e.g., A student who is overwhelmed with registering for her first year of college says, "I probably won't get any of my course selections."
- Mind-reading is a prediction about other people's thoughts or behaviours that is made without checking it out. It sometimes represents the projection of one person's thoughts/feelings onto another person. e.g., "He must think I'm lazy for cutting the class."

7. Selective negative focus is focusing on the negative aspect of a situation while ignoring the positive. e.g., A student who fails the oral part of an exam but passes the written with an 'A' says, "I really messed up that exam."

8. Disqualifying the positive is a rejection of positive experiences by insisting they "don't count". e.g., A student who fails the oral part of an exam but passes the written with an 'A' says, "I usually do well on written exams, that's not what is important to me."

9. Magnification and minimization is also referred to as the "binocular trick" because it happens when we enlarge our shortcomings or someone else's accomplishments while shrinking our accomplishments or someone else's shortcomings. e.g., "I'm not half the man my brother is. Everything he touches seems to turn to gold."

10. Catastrophizing is a building up of consequences to an event so that they seem insufferable or particularly horrible. e.g., "This is the second time I've been turned down for a date with Tom. At this rate I'm going to end up a lonely old maid."

11. Personalization happens when we interpret an event or a situation as having

special meaning (usually negative) for only ourselves. e.g., "If I hadn't hired on with this company, they never would have gone bankrupt."

12. Labeling is an extreme from of Over generalization whereby a negative and usually emotionally charged label is attached to a person on the basis of a relatively isolated or insignificant behaviour. e.g., A person who says something offensive after having a few drinks is called a "drunk".

Step 3: Challenge the irrational beliefs
Once the irrational belief underlying an automatic thought has been identified from the list above, it is important to refute these beliefs by examining the evidence for them, and by looking for alternative explanations. Generic questions called "dispute handles" originally developed by Sank and Shaffer (1984) can be used to refute irrational beliefs in two ways. Questions about how certain we are a particular outcome will occur are referred to as probability dispute handles. Questions about the worst thing that could happen, and how bad that is are called coping dispute handles. Refer to the lists below for examples.

Probability Dispute Handles

1. What are the other possible outcomes?
2. What evidence do we have that _____ will happen?
3. Does _____ have to equal or lead to _____?
4. What has happened in the past? Any exceptions?
5. What are the chances of it happening/happening again?

Coping Dispute Handles

1. What is the evidence to suggest the consequences will be disastrous?
2. Could there be any other explanation?
3. Is _____ really so important that my whole future depends on it?
4. Does _____'s opinion reflect that of everyone else?

Step 4: Replace the irrational beliefs with suitable alternatives
Often the replacements for automatic thoughts become evident in the course of refuting the irrational beliefs on which they are based. The following excerpt from a fictional case illustrates how this might happen.

Jim is a 25-year-old male with a fear of negative evaluation and rejection from females he would like to approach for a date. The therapeutic contract he negotiated with his therapist established the following goals.

1. Increase the number of opportunities for meeting women by joining a health club, taking a course, and by participating in some functions of a local singles' club.
2. Initiate conversations and engage in small talk with women he hasn't met before.
3. Initiate follow-up conversations with women he met previously.
4. Ask a woman to join him in a social outing.

The following automatic thoughts were reported by Jim in response to anticipating a

role play of initiating a conversation with a woman. Listed below his automatic thoughts are the underlying irrational beliefs, the rebuttal he used to challenge these beliefs, and the alternative beliefs he substituted.

- Automatic Thought: I won't be able to talk.
- Irrational Belief: Fortune telling
- Rebuttal: I'm able to talk to men and women for whom I have no attraction.
- Alternative Beliefs: I have been able to talk just fine in other situations.

References

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