

Study Shows Cognitive Therapy Superior to Fluoxetine for Social Phobia

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A randomized clinical trial compared cognitive therapy to fluoxetine (Prozac) for treatment of generalized, social phobia, and the findings are striking (Clark, Ehlers, et al., 2003). The cognitive therapy tested in this study involved 16 week 75-minute individual therapy sessions followed by 3 monthly booster sessions. It was compared with self-exposure instructions combined with fluoxetine or pill placebo. Patients in the self-exposure groups got several new exposure assignments each week which were reviewed with the therapist during the next session. These patients received no therapist accompanied or in-session exposure assignments. Patients receiving cognitive therapy showed larger and clinically significant improvements (over 2 standard deviations) on several social phobia measures. Moreover, their scores were superior to both the fluoxetine plus self-exposure group and the placebo plus self-exposure group at each measurement point: mid-treatment, posttreatment, end of booster phase, and at 12-month follow-up. The fluoxetine plus self-exposure and placebo plus self-exposure groups did not differ.

Given the impressive findings from this clinical trial, the theoretical underpinnings and technical aspects of the treatment are of particular interest. The cognitive therapy in this study was based on a model of social phobia developed by David M. Clark and Adrian Wells (Clark & Wells, 1995). Drawing on earlier writings of Beck, Emery, and Greenberg (1985) among others, Clark and Wells extended cognitive theory to explain the persistence of generalized social phobia despite (apparently) repeated disconfirmation of patients' anxious predictions in daily life. The model highlights phobia- maintaining

factors. One such factor involves self-focused attention and the associated development of a negative social self-image.

Social phobics show a significant increase in self-focused attention when they enter a social situation. They start to closely monitor themselves, which increases their awareness of their own (feared) anxiety response and interferes with processing the situation and other people's behavior. Their heightened awareness of their internal distress contributes to a negative impression of themselves. They then assume this impression is what other people notice and think about them. They assume they are the center of attention and that they are leaving a very negative impression. On the contrary, although performance anxiety and safety behaviors do have some negative interpersonal consequences, social phobics frequently over estimate how negatively other people evaluate their performance and the consequences of such evaluation.

Another prominent phobia-maintaining factor is in-situation safety behaviors. Clark and Wells (1995) cite the example of a woman who was concerned about the possibility that her hand might shake while drinking. Her in-situation safety behaviors included only filling her wine glass half way and then gripping the glass tightly while drinking. Such behaviors are reinforced because they lead to an immediate (if only partial) reduction in anxiety. They are problematic because they prevent social phobics from experiencing a clear disconfirmation of their unrealistic beliefs about feared behaviors (e.g., shaking) or the consequences of these behaviors (e.g., being humiliated and rejected). Some safety behaviors can even make the feared behavior more likely. Clark and Wells (1995) noted that the woman who grasped her wine glass tight discovered during therapy that this made her hand more likely to shake. Many in-situation safety behaviors are actually cognitive strategies, such as constantly evaluating and censoring what they might say in a conversation, escaping through distraction, or dissociation.

In the treatment provided by Clark and colleagues, the adverse effects of patient's safety behaviors were demonstrated with an experiential exercise in which patients first role-played a difficult social situation while focusing attention on themselves and using their safety behaviors. They then role-played the same situation while focusing attention externally and attempting to drop their safety behaviors. The following exercise might be set up for a socially anxious patient who fears saying something "dumb" in social conversation and has in-situation safety behaviors of staying quiet, averting her gaze, and judging her opinions as uninteresting or stupid. For the first role-play, she might be instructed to focus on herself, imagine the impression she thinks she is making on the other person (the therapist) and judge this impression, not make eye contact, and only say things that are highly interesting and insightful. In the second role-play, she might be asked to try to shift her focus from herself to the other person, make eye contact, and say whatever she thinks the current event being discussed regardless of how interesting or insightful it may be. The differences between these two role-play experiences could then be discussed to highlight the impact of her safety behaviors on her performance and on her self-image.

Patients were next encouraged to focus their attention externally in social situations outside of sessions so as to reduce self-monitoring and to obtain more accurate information about how they are responded to by other people. Anticipatory and post-event automatic thoughts were identified and discussed, particularly with regard to the costs and (perceived) benefits of this processing. As patients started to see that the disadvantages greatly exceeded any advantages, they were encouraged to drop the processing. Extensive use was made of behavioral experiments in which patients specified their feared outcomes for various social situations and then tested out whether these outcomes actually occurred during planned exposures to the situations. Underlying dysfunctional assumptions were identified and tested using similar behavioral experiments and cognitive restructuring.

The treatment protocol also included video feedback to modify distorted self-imagery. Patients viewed videotapes of themselves engaging in feared social tasks, such as the above role-play. To enhance the therapeutic effects of the video feedback, patients were provided with an instructional set. They were asked to 1) predict what they would see in the video, 2) form an image of their own performance, and 3) watch the video as if they were watching the video as if they were watching a stranger. Previous research has shown that socially anxious subjects who have been given this cognitive preparation make higher ratings of their performance compared to subjects who have not been given these instructions, and compared to their own “expected” ratings prior to watching the video (Harvey, Clark, Ehlers, Rapee, 2000). In the treatment study, therapists helped patients objectively evaluate their performance while viewing the videotapes.

The strong findings from this clinical trial should make the study and the associated treatment of particular interest to practicing clinicians. The individual therapy format fits well with most practice settings. However, most clinicians will need to modify the approach to fit within a 50-minute therapy hours. The procedures are described in detail in a therapist manual (Clark, 1997).

References

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