

Strengths and
limitations of cbt for
social phobia
psychology essay



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Social phobia, also known as Social Anxiety Disorder (SAD) is considered as one of the most common psychological disorders on its own, and also as a comorbid disorder (Kessler, McGonagle, Zhao, et al., 1994). Current research literature suggest Cognitive Behaviour Therapy (CBT) as the first treatment choice for social phobia, unless in the case where the client opt for medication or if the client is suffering from comorbid depression or another psychological disorder that makes medication essential (Veale, 2003; Social Anxiety Disorder, 2006; NICE guideline, 2004c).

The aim of this paper will be to discuss the application of CBT in the treatment of Social Phobia. However, it is important to emphasise that it will not attempt a detailed discussion on the historical development, or theoretical frameworks of CBT. These aspects of therapy will be emphasised, discussed and analysed where necessary, to comprehend its practicality in the treatment of social phobia. Furthermore, the scope of this paper will be limited to examining the use of CBT for treatment of adults with social phobia but, it will not focus on treatment of social phobia in children and adolescent groups.

CBT was initially developed by Aaron T. Beck as a structured, short-term, present-oriented psychotherapy for depression, directed toward solving current problems and modifying dysfunctional thinking and behaviours (Beck, 1995). The basic assumptions of cognitive model suggest that distorted or dysfunctional thinking that influence the patient/client's mood and behaviour is common to all psychological disturbances (Beck, 1995). CBT is a collection of therapies that are designed to help clients suffering from phobias, depression, obsessions & compulsions, stress disorders, drug

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addictions and/or personality disorders. CBT attempts to help people identify the situations that may produce their physiological or emotional symptoms and alter the manner in which they cope with these situations (Smith, Nolen-Hoeksema, Fredrickson, & Loftus. 2003).

The effectiveness of CBT has been widely tested since the first study on treatment success in 1977 (Beck, 1995). Westbrook, Kennerley and Kirk (2007) stated that CBT has many features common to other therapies. However, they acknowledged that CBT is different from the other psychotherapies with some distinguishing characteristics. This therapeutic approach is a combination of Behaviour Therapy (BT) and Cognitive Therapy (CT). However, these will not discuss in detail. However, as a result of having been evolved from a combination of both BT and CT, modern CBT consist important elements of them both. Westbrook, et al. (2007) presents the CBT model of viewing problem development.

For instance, individuals develop cognitions (thoughts & beliefs) through life experiences (mostly based on childhood experiences, but sometimes with later experiences). These can be functional (ones that allow making sense of the world around and deal with life issues), as well as dysfunctional beliefs. Most of the time, functional beliefs permit individuals to reasonably cope well with life situations. Whereas dysfunctional beliefs may not cause problems unless/until encountered with an event or a series of events (also known as critical incident) that violates the core beliefs or the assumptions, to the extent of being unable to handle one's positive/functional beliefs. This situation may activate the negative/dysfunctional thoughts over the positive thoughts resulting or provoking unpleasant emotional status such as anxiety

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or depression. Thus, Westbrook et al. (2007) highlighted the interactions between negative thoughts, emotions, somatic reactions, and behaviours as responses to different life events. These dysfunctional patterns lock the individual into vicious cycles or feedback loops resulting in the perpetuation of the problem.

Focussing on the effectiveness of CBT as a therapy, the UK National Institute for Clinical Excellence (NICE) guideline recommends CBT for several major mental health problems including depression (NICE, 2004a), generalised anxiety and panic (NICE, 2004c), and post-traumatic stress disorder (PTSD) (NICE, 2005). Furthermore, Westbrook et al. (2007) highlighted the findings of Roth and Fonagy (2005) in their book 'What works for whom?' a landmark summary of psychotherapy efficacy. This book presents evidence on the success of CBT as a therapy for most psychological disorders.

However, though there is evidence supporting the successfulness of CBT for numerous psychological disorders, CBT has some limitations as well. Firstly, it is not suitable for everyone. One should be committed and persistent in finding a solution to the problem and improving oneself with the guidance of the therapist (Grazebrook & Garland, 2005).

Secondly, it may not be helpful in certain conditions. Grazebrook & Garland (2005) mentioned that there is increasing evidence of the successful therapeutic use of CBT in a wide variety of psychological conditions.

However they pointed that there is a great need for further research to gather evidence on the therapeutic success of CBT in these different types of psychological disorders.

Social Phobia

Social Phobia is categorised as an Anxiety Disorder in the Diagnostic and Statistical Manual-IV-TR (DSM-IV-TR) of the American Psychiatric Association (2000). This disorder is characterised by persistent excessive anxiety and fear of scrutiny by others, often accompanied by anxiety symptoms such as tremulousness, blushing, palpitations, and sweating (Social Anxiety Disorder, 2006). The DSM-IV-TR (2000) presents the following diagnostic criteria for social phobia (SAD).

Marked and persistent fear of social or performance situations in which the person is exposed to unfamiliar people or to perceived scrutiny by others.

This includes the fear of embarrassment or humiliation

Exposure to feared social or performance situations that almost invariably provoke anxiety. This may even take the form of a panic attack. In the case of children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.

The person recognises that the fear is unreasonable and that it is excessive. However, this fear and knowledge may be absent in children.

The feared social situation or the performance is avoided or else it is endured with intense anxiety or distress.

The avoidance, anxious anticipation, or fear causes significant distress or impaired functioning.

Fear or avoidance are not due to another psychological, or physiological condition (e. g., a personality disorder such as paranoid personality disorder, a specific phobia, or due to the influence of substance use/abuse)

Specify ‘ generalised’, if the fears include most social situations (e. g., these may range from initiating or maintaining conversations, participating in small groups, dating, speaking to authority figures, or attending parties hindering most parts of a personal social life)

According to the criteria stated above, social phobia can be generalised or non-generalised, depending on the breadth of social and performance situations that are feared. While generalised social phobia hinders a vast range of social and performance situations, non-generalised social phobia may hinder/restrict only performance of some social activities or engagements.

According to health statistics from year 2002, social phobia affects 3% of the Canadian adult population (Social Anxiety Disorder, 2006). In USA 13. 3% of the population suffer from social phobia at some point in their life (Kessler et al., 1994). Statistics indicate a life time prevalence of about 8% to 12% making social phobia one of the most common anxiety disorders (Social Anxiety Disorder, 2006; Kessler, et al., 1994). Apart from being a high prevalence disorder, social phobia is also known to have a high comorbidity, specially substance abuse and/or alcohol dependency (Schadé, A., Marquenie, L., Van Balkom, et al., 2008; Amies, Gelder, & Shaw, 1983; Schneier, Johnson, Hornig, Liebowitz, & Weissman, 1992).

Kessler et al. (1994) stated that while the lifetime prevalence of social phobia is as high as 13.3%, the prevalence reported in a 30-day period is between 3% – 4.5%. In addition, other similar conditions, such as shyness, behavioural inhibition, self-consciousness, selective attention and embarrassment are seen to be correlated with social phobia (Beidel & Morris, 1995; Beidel & Randall, 1994; Leary & Kowalski, 1995; Rosenbaum, Biederman, Pollock, & Hirshfeld, 1994; Stemberger, Turner, Beidel, & Calhoun, 1995). According to Schneier, Johnson, Hornig, et al. (1992), comorbidity of two or more psychological disorders, is also fairly common with social phobia. Research has also indicated that social phobia is also characterised with a higher frequency of suicide attempts (Schneier et al., 1992).

Focusing on the impact of the disorder on the quality of life, social phobia is described as an “illness of missed opportunities”, because its early onset hinders future social progression such as marital success and career growth (Social Anxiety Disorder, 2006). The authors of this article stated that these individuals were less likely to be well educated, belong to lower socioeconomic status, and are possibly unmarried. In addition, they also suffer greater functional, health, and physical impairments than individuals without social phobia (Social Anxiety Disorder, 2006). Thus the disorder has a significant impact on the quality of life, in particular, socially and emotionally. Emphasising on this point, the authors of this article highlighted that in a community health survey in Canada, people with social phobia were twice as likely to report at least one disability day in the past two weeks, compared to people without social phobia (Social Anxiety Disorder, 2006).

Aetiology of social phobia can be traced to Bio-Psycho-Social factors (Smith, Hoeksema, Fredrickson, et al., 2003). Looking at the neuro-biologic factors, research data up to date, provides evidence of dopaminergic, serotonergic, and noradrenergic systems (Stein, Tancer, & Uhde, 19992; Tancer, Stein, Uhde, 1993; Yeragani, Blalon, Pohl, 1990). However, Stein, Tancer, & Uhde (1995) stated that the evidence for these neuro-biological factors in the predisposition, precipitation, and perpetuation is far from clear. The authors also present the same regarding the effect of antidepressants on social phobia stating that further work is warranted, although preliminary evidence indicates that antidepressants are not entirely effective on social phobia.

From a cognitive-behavioural perspective, a person with social phobia develops a series of negative assumptions about themselves and their social world based on some negative experience (Kessler, et al., 1994). These assumptions of behaving inappropriately and being evaluated negatively and/or being humiliated will give rise to anticipatory anxiety that precedes the social situation adding an extra source of concern and perceived danger. Preoccupied with these fears, clients with social phobia have difficulty focussing their attention on the social cues or their own strengths that help them to effectively cope in the phobic situations. In addition, biased memory and focused attention towards negative signs will prevent the individual from perceiving the positive signs (e. g., acceptance, success, admiration) giving rise to performance deficiencies. These may contribute towards producing patterns of negative interactions that may further contribute to the perpetuation of the phobic condition experienced at the time (Elting & Hope, 1995). These explanations are similar to the generic CBT model, of problem

development. Thus the research by Kessler et al (1994) has provided supporting evidence to the general CBT explanation and theoretical framework of problem understanding, assessment and treatment.

Another dimension of the aetiology of social phobia is the lack of social skills and/or the lack of awareness of one's own social skills. According to Hill (1989), clients with social phobia vary widely in their knowledge of socially appropriate behaviour skills. Many of these individuals seem to have adequate social skills when assessed in a non-threatening environment such as the clinician's office, but they fail to use these skills when laden with anxiety in an unfamiliar social situation that is perceived as threatening. Hill (1989) further described that there is another group of individuals suffering with social phobia who may be unaware of socially appropriate behaviours in certain situations and therefore encounter repeated failures and disappointments. Thus, Hill (1989) suggest that apart from medication and/or conventional CBT, individuals in this group will benefit more from specific training in social skills either through role playing or modelling as appropriate.

In addition to the above dimensions, there are developmental and psychodynamic issues associated with the aetiology of social phobia as well. In this view, children who are rejected, belittled, and censured by their parents, teachers or peers may develop feelings of low self-esteem and social alienation (Arrindell, kwee, & Methorst, 1989). The authors of this article further stated that clients with social phobia tend to report, having had hypercritical parents. The article further examine the condition of social phobia from a psychodynamic perspective hypothesising that avoidant
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behaviour may be caused by an exaggerated desire for acceptance, an intolerance of criticism, or a willingness to constrict one's life to maintain a sense of control. Furthermore, they claim that traumatic embarrassing events may lead to loss of self-confidence, increased anxiety, and subsequent poor performance, resulting in a vicious circle that progress to social phobia.

Concentrating on treatment seeking behaviours for social phobia, Hill (1989) highlighted that clients rarely see a physician for symptoms relating to social anxiety. More often seeking help will be for conditions such as substance abuse, depression or any other anxiety disorder (e. g. panic attack).

Treatment for Social Phobia

As mentioned above, social phobia is the result of biopsychosocial factors. Thus, the treatment choices may also vary which may include pharmacotherapy, and/or different types of psychotherapy. Veale (2003) stated that treatment choice for social phobia is up to the client to decide. Medication is indicated if it is the client's first choice, or if CBT has failed or if there is a long waiting list for CBT. Similarly, pharmacotherapy becomes the choice of treatment when social phobia is comorbid with depression (Veale, 2003). Considering the first treatment choice, UK National Institute for Clinical Excellence (NICE) does not have a specific guideline specific for social phobia. However, in its guidelines for anxiety disorders (NICE, 2004), it recommends pharmacotherapy as treatment if the client opts for medication, or if the client opts for psychological treatment, CBT is given as the first choice of therapy. NICE guidelines (2004) too recommend CBT as the first choice of psychological therapy for generalised anxiety disorder and other

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anxiety disorders. The National Institute for Clinical Excellence provides evidence that CBT is more effective than no intervention and that CBT has been found to maintain its effectiveness when examined after long term follow up of eight to fourteen years. This can be used as a cost and time effective therapeutic intervention in group settings and most clients have maintained treatment gains at longer terms (NICE 2004). It further stated that CBT is more effective than psychodynamic therapy and non-specific treatments. Apart from CBT, clients who receive anxiety management training, relaxation and breathing therapy have been proven to be effective compared to having no intervention.

Apart from CBT, Veale (2003) also discusses Graded self-exposure as a psychological therapy for social phobia. This therapeutic intervention which is based on the learning theory hypotheses has been the treatment of choice for social phobia for many years. However, as this method of therapy using exposure to previously avoided situations in a graded manner until habituation occurs was only successful with limited amount of clients, alternative approaches such as CBT have become a more frequent therapy choice.

NICE guidelines (2006) on ' computerised cognitive behaviour therapy' (CCBT) for depression and anxiety recommend CCBT for mild depressions and anxiety disorders, including social phobia. With reference to two Randomised Controlled Trials (RCTs) and two non-RCTs comparing CCBT (programme for panic/phobic disorders – FearFighter) with therapist led CBT (TCBT) the NICE guidelines recommend the use of CCBT for mild

phobic/panic disorders. When results of CCBT and TCBT were compared after <https://assignbuster.com/strengths-and-limitations-of-cbt-for-social-phobia-psychology-essay/>

a three month period of therapy for global phobia, both groups showed statistically significant improvement. Similar results were shown in two non-RCT studies too. When these scores were compared with a group who received relaxation techniques as therapy, this third group did not show statistically significant improvement while the other two groups (CCBT & TCBT) did. However, it must be noted that the RCT and the non-RCT studies does not report clinically significant improvement. Nevertheless, the dropout rate of FearFighter group was twice as many as the TCBT dropout rate. However, from a positive point of view on the practicality of CCBT on phobias, delivery of FearFighter programme at the clinical setting for one group, and the other group having access to the programme at home over a 12 week period showed that both groups showed statistically significant improvement in all measures (NICE guidelines, 2006). In terms of client satisfaction too there was no statistically significant difference between TCBT and CCBT (NICE guidelines, 2006). Thus, though further research is warranted to evaluate the clinical significance of CCBT for social phobia specifically, the NICE guidelines recommend CCBT as a choice of therapy for mild levels of depression and anxiety disorders. In addition to the observed effectiveness of CCBT, NICE guidelines also recommend it as a cost effective therapy alternative. Thus, CCBT for social phobia at mild levels could be useful at a practical level too.

In a study by Rosser, Erskine & Crino (2004), the researchers studied the treatment success of CBT with antidepressants and CBT on its own as treatment for social phobia. The results did not show a statistically significant difference in the treatment progress between the two groups allowing the

researchers to conclude that pre-existing use of antidepressants did not enhance or detract from the positive treatment outcome of a structured, group-based CBT programme for social phobia. Application of ' medication' and ' CBT' is common practice in treatment for social phobia (Rosser et al., 2004). Yet, there are not many studies that have studied the combined effectiveness for social phobia. Citing Heimberg (2002) Rosser et al., (2004) describe that there are three possible outcomes from combining medication and CBT. Combined treatment may produce a better outcome than each treatment alone, by potentiating the gains achieved by CBT and also reducing relapse rates following the discontinuation of medication. Alternatively, there may be no difference between the combined approach and each approach individually, if both therapies (pharmacotherapy and CBT) are sufficiently powerful on their own. Also, depending on how individual clients attribute treatment success, effectiveness of CBT might be detracted by medication in a combined approach of treatment. Referring to literature on treatment success for social phobia Rosser et al., (2004) highlighted that combination treatment (CBT and pharmacotherapy) or pharmacotherapy alone has not been found to be of significant advantage. CBT has mostly been successful in overcoming symptoms, minimising relapses and also effective in terms of cost minimisation (Rosser et al., 2004). Focussing on the conclusions Rosser et al. (2004), there were no significant differences between the combination treatment (CBT & antidepressants) and CBT alone could be interpreted in different ways. It is possible that since antidepressants and CBT are both reasonably powerful treatments individually, and thus a combination of the two did not contribute to a significantly to improve the outcome. Alternatively it may be that the <https://assignbuster.com/strengths-and-limitations-of-cbt-for-social-phobia-psychology-essay/>

group who were already taking antidepressants may have been prescribed with the medication because they were more severe in terms of social phobic or depressive symptoms prior to commencing treatment programme. Thus, it may be possible to argue that the combined therapy may not have contributed to a significant improvement compared to the group that only received CBT, because there was a difference in symptom severity between the two groups. In addition there was no control in allocating (randomly) participants and or having a control over the medication dosage. Thus, the research findings of the study are subjected to the limitations of these variables that were out of the researchers' control. However, it has to be noted that it does not devalue the comparative treatment success on the CBT (alone) group. The researchers of this study therefore emphasise the need for further research on combined therapy for social phobia as in real life clinical settings most clients are on medication while receiving CBT.

Moreover, Rodebaugh & Heimberg (2005) recommends CBT combined with medication as a widely used successful treatment method for social phobia. However, while recommending the above, they also emphasise the need for further research in this regard as the current data reveals mixed results. According to available evidence and theoretical considerations they suggested that some methods of combination could provide short-term benefits, but long-term decreases in efficacy compared to either treatment alone. In this paper Rodebaugh & Heimberg (2005) emphasised that most research on the effects of CBT combined with medication had the common research gap of failing to control the medication dose and the allocation of participants in to random samples. However, the authors of this paper

emphasised that in most studies combined therapy for social phobia had not shown significant evidence of treatment success compared to either pharmacotherapy or CBT.

Rodebaugh & Heimberg (2005) highlighted that there is supporting evidence to the treatment success of combining CBT with relaxation training. While mentioning this, they also noted that relaxation training alone has not proven to have any clinically significant benefit for the clients. Thus, it is when combined with CBT that clients have had a successful experience with relaxation training. Rodebaugh & Heimberg (2005) stated that all forms of CBT aim to reduce the experience of fear through modification of avoidance and other maladaptive behaviours, thoughts, and beliefs (e. g. through exposure with cognitive restructuring). Thus, in the process of therapy most clients may experience an increase in stress and negative affect and distress in the short-term, but the modification of these earlier components of these earlier components of a behavioural-emotional chain leads to reduction of symptoms over time.

In regard to combining treatment methods with CBT as treatment for social phobia, Rodebaugh & Heimberg (2005) highlighted the fact that all treatment methods have its own limitations and strengths. Thus when combining two therapies (either pharmacological and CBT or CBT with another psychotherapy), the strengths as well as the weaknesses of the two approaches could be magnified, depending on the nature of the combination. Hence, Rodebaugh & Heimberg (2005) stated that an empirically supported method of combining medication and CBT for social anxiety disorder is yet to be established, although under varied circumstances clinicians use different <https://assignbuster.com/strengths-and-limitations-of-cbt-for-social-phobia-psychology-essay/>

combinations of CBT along with other psychotherapies and medication to maximise effectiveness on a case by case level.

Concluding Remarks

As discussed in this paper, social phobia may literally be a common mental disorder and it is categorised as an anxiety disorder under the DSM-IV classification system (DSM-IV-TR, 2000). While being highly prevalent, it is also a disorder that may have a large impact on a person's quality of life, hindering opportunities for personal growth and/or social interaction/relationships. Therefore, it is an important area of study and clinical practice in mental health, which has the aim of improving the lives of people suffering from this disorder, and minimising its effect on the society.

Research literature on social phobia recommends certain types of medication, and CBT as a psychotherapeutic intervention as the first choice of treatment for this debilitating condition. As it is out of our scope, this paper did not pay detailed attention to the types of pharmacotherapeutic interventions that may successfully be used to control symptoms of this disorder and enable clients live a healthy life.

From a psychological perspective, CBT is widely recommended through evidence based research as the first choice of psychotherapeutic treatment for social phobia. As discussed in this paper, evidence on the successful combinations of therapeutic methods at present denotes the need for further research in order to determine the best combinations for successful treatment. Another area that needs similar attention is combining different types of psychotherapies with CBT as treatment for social phobia.

Focusing on CBT for social phobia, although there is supporting evidence for therapy success, and though it is widely considered as the first choice of psychotherapy for this disorder, it is not always successful with all individuals. Thus, from a practical point of view, it is important that clinicians are able to tailor and combine different therapeutic methods (pharmacotherapy and psychotherapy), not only to maximise treatment success, but also to make it useful with different types of clients/clients from different background and life-experiences. Furthermore, although CBT is recommended as the first therapy choice, there are practical issues regarding meeting the demand for services. This becomes an issue in terms of finance as well as in terms of the limited amount of professionals available to deliver treatment. Some successful methods of overcoming these difficulties would be ' Group CBT' for social phobia and CCBT.

However, it must be emphasised that these issues become a much grave problem in countries where psychotherapists trained in CBT are rare, and even methods such as CCBT could be unaffordable and inaccessible for certain groups. In addition, there are also limitations in being able to use programmes such as CCBT in countries where English is not used, or it not the first language. Thus, from a global perspective, the use of CBT as a therapy choice is practically challenged due to limitations of resources and trained personals, leavening pharmacotherapy as the most practical mode of therapy for a large numbers of people suffering from social phobia.

To conclude, it must be stated that continued research on the successful use of CBT as a therapeutic tool for social phobia and other disorders should be continued as it proves to be a successful therapy for many psychological

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disorders (Westbrook et al., 2007). Thus, it can be stated that CBT is a useful and successful therapeutic intervention for social phobia. The practical use of it could be further improved through continued research, and through therapist training programmes to meet the demands for therapy, as it would further increase the effectiveness of CBT as a therapy for social phobia.