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Clinical Psychology Review 24 (2004) 421–440
CLINICAL PSYCHOLOGY REVIEW

Cognitive causes of social phobia: A critical appraisal

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Received 17 March 2003; received in revised form 10 December 2003; accepted 14 January 2004

Abstract

This review examined critically studies issuing from the cognitive therapy (CT) model claiming to have unveiled cognitive causal factors of social phobia. Additionally, it examined outcome studies of CT-inspired interventions and other treatments having included measurements of cognitive constructs. Overall, we found no evidence consistently supporting the claim that social phobics are characterized by typical cognitive processes. Moreover, we found neither corroborating evidence for a controlling effect of such cognitive processes on social phobic conduct, nor consistent indications that cognitive therapies or techniques effect cognitive changes differently than other approaches. The evidence suggests rather, that cognitive factors change concurrently with other features of psychopathology as part of an overall improvement during or after effective therapy, regardless of therapeutic approach.

Keywords: Social phobia; Cognitive therapy; Causal factors; Cognition

1. Cognitive causes of social phobia

Social phobia is a clinical pattern of self-protective social behavior characterized by an intense concern over evoking negative reactions, for example, criticism, being made fun of, found unsuitable or in the wrong, in dealing with others. Typical is a dread of and a desire to avoid social situations in which the individual is to perform in front of an attentive audience—be it formal or not. Generally, the most feared situations are those in which one is being assessed (formally or informally) by those holding considerable power over one's fate, like people in position of authority or a prospective lover (e.g., Dixon, De Monchaux, & Sandler, 1957). Typically, such performances include public presentations or interviews, or activities, such us eating, writing, and engaging in conversation that would highlight that

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0272-7358/$ - see front matter © 2004 Published by Elsevier Ltd.
doi:10.1016/j.cpr.2004.01.006

individual's state of fearfulness. The main concerns are of being incoherent or speechless, visibly distressed (e.g., blushing, trembling, and sweating), and being socially awkward. Such patients' ultimate fears are of drawing unfavorable attention to themselves, to be overpowered, and feeling embarrassed and diminished; such prospects are anticipated and dreaded above all (see Greist, 1995). The long-standing experience of distress and the various stratagems employed to avoid it, have cumulatively serious adverse consequences on functioning in the social, interpersonal, and occupational spheres of life (Schneier et al., 1994) of social phobic individuals.

Various explanatory schemes have been proposed to account for this socially anxious pattern of behavior (see Hofmann & DiBartolo, 2001). One of the most popular at the present is a cognitive therapy (CT) model. Its rise is tied to the advent of cognitive psychotherapy (Beck, 1976) that aims at correcting certain faulty hypothetical structures or operations of the mind of patients. This analysis of psychopathology was first applied generally and in the abstract to a broad range of abnormal phenomena, but has been subsequently refined and extended to social phobia as well (Beck, Emery, & Greenberg, 1985, pp. 146–164).

Despite numerous statements of the CT outlook usually emphasizing its therapeutic implications, a definition of the term cognition is hard to find (see Beck et al., 1985). Conceptually, it is used either as a label for a hypothetical "information-processing" system or the product of such a process or both. It is often spoken of as a "thing," seemingly impervious to context and contingency. A lay interpretation of the word might be that it refers to a kind of thinking that may be put into words, thus excluding the ineffable or tacit knowledge. Some of the theorizing in this area however, is suggestive of unconscious processes, for example, "automaticity" (McNally, 1995).

Proponents of the CT school hold the view that faulty thinking results in emotional distress (anxiety) and inadequate behavior, which in turn generates more distress. Although they take pains to point out that "the cognitive model does not postulate a sequential unidirectional relationship in which cognition always precedes emotion. . ." (Clark & Steer, 1996, p. 76), it is plain that for all intents and purposes, the cognitive perspective is mostly interested in precisely this sort of causal relationship. Fodor (1983), a foremost proponent of a "cognitive science," puts it unequivocally: ". . .the structure of behavior stands to mental structure as an effect stands to its cause." (p. 8). The assertion that ". . .social phobics become anxious when anticipating or participating in social situations *because* they hold beliefs (dysfunctional assumptions) which *lead them* to. . ." (Stopa & Clark, 1993, p. 255, italics added) illustrates this point.

Cognition as a generic description of mental structures with *agency* is at the center of the theoretical universe of CT—hence, the name. It is for this reason that cognitive factors are considered as "maintaining" social phobia (see Amir, Foa, & Coles, 1998, p. 956; Hackmann, Surawy, & Clark, 1998, p. 9). They are therefore regarded as its linchpin and as such, are assumed to provide the necessary leverage for therapeutic change (see Wells & Papageorgiou, 1999, p. 86).

On the simplest level, faulty thinking or "cognitions" (see Clark & Steer, 1996, p. 79) implies various kinds of irrational inferences, for example, exaggerating and ignoring counterevidence as gathered from the justifications patients offer for what they did or felt. On a somewhat loftier plane, inadequate thinking implies broad beliefs ("schemas") expressing a whole outlook (e.g., the dangerousness of impropriety). Finally, various additional cognitive processes are said to be operative: for example, focus on self and self-blame, presumably driven by the overarching cognitive structures (schemas).

"According to this [the CT] model, social phobics become anxious *when* anticipating, or participating in, social situations *because* they hold beliefs (dysfunctional assumptions) which *lead*