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Social Mishap Exposures for Social Anxiety Disorder: An Important Treatment Ingredient

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Conventional cognitive-behavioral therapy for social anxiety disorder, which is closely based on the treatment for depression, has been shown to be effective in numerous randomized placebo-controlled trials. Although this intervention is more effective than waitlist control group and placebo conditions, a considerable number of clients do not respond to this approach. Newer approaches include techniques specifically tailored to this particular population. One of these techniques, social mishap exposure practice, is associated with significant improvement in treatment gains. We will describe here the theoretical framework for social mishap exposures that addresses the client's exaggerated estimation of social cost. We will then present clinical observations and outcome data of a client who underwent treatment that included such social mishap exposures. Findings are discussed in the context of treatment implications and directions for future research.

Social anxiety disorder (SAD) is one of the most common anxiety disorders in the U.S., with a lifetime and 12-month prevalence of 12.1% and 7.1%, respectively (Kessler, Chiu, Demler, Merikangas, & Walters, 2005). It is defined by a persistent fear of negative evaluation by others in social or performance situations (American Psychiatric Association, 2000) and is associated with significant impairment in occupational, academic, and interpersonal functioning (Hofmann & Otto, 2008; Ruscio et al., 2008). SAD is a heterogeneous condition, as individuals with SAD may vary in the kinds of people, places, and situations that cause fear. However, common fears include formal public speaking, speaking up in a meeting or class, and meeting new people (Ruscio et al.). It also appears that while these situations may differentially provoke anxiety for each individual, most clients with SAD share similar underlying core fears, such as being rejected, looking stupid or unintelligent, expressing disagreement or disapproval, and being the center of attention.

Theoretical Models of SAD

There is strong empirical evidence supporting a cognitive-behavioral model of SAD (Davidson et al., 2004; Heimberg, Dodge, Hope, & Kennedy, 1990; Heimberg et al., 1998). The cognitive-behavioral model proposes that SAD develops and is maintained by maladaptive cognitive and behavioral processes, which negatively reinforce avoidance strategies and contribute to a cycle of anxiety and avoidance (Clark & Wells, 1995; Rapee & Heimberg, 1997). The following discussion is based on the maintenance model developed by Hofmann (2007), which emphasizes the importance of social cost and social mishap exposures. A more detailed explanation of this model is described elsewhere (Hofmann, 2007). According to this model, an individual with SAD experiences apprehension upon entering a social situation because they perceive the social standards to be excessively high and experience doubt about being able to meet those standards. Once confronted with social threat, individuals with SAD experience heightened self-focused attention, in which attention is turned inwardly toward one's internal physical sensations and anxious thoughts (Brozovich & Heimberg, 2008; Clark & McManus, 2002; Hofmann, 2000a). Self-focused attention simultaneously triggers a variety of other cognitive processes, including a negative self-perception (e.g., "I am such an inhibited idiot"), high estimated social cost (e.g., "It will be a catastrophe if I mess up this situation"), low perceived emotional control (e.g., "I have no way of controlling my anxiety"), and perceived poor social skills ("My social skills are inadequate to deal with this situation"). These processes, in turn, lead the client to anticipate a social mishap in which one actually does something to embarrass oneself, cause negative evaluation, or otherwise violate social norms. This expectation

[1] Video patients/clients are portrayed by actors.

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contributes to the use of avoidance strategies and safety behaviors to cope with the anxiety and to avoid the feared outcome, which leads to post-event rumination about one's performance in a social situation (Clark & Wells, 1995). The rumination and avoidance behaviors ultimately feed back into continued apprehension in social situations.

An important reason why SAD is maintained in the presence of repeated exposure to social cues is because individuals with SAD engage in a variety of avoidance and safety behaviors to reduce the risk of rejection (e.g., Wells et al., 1995). These avoidance tendencies, in turn, prevent patients from critically evaluating their feared outcomes and other catastrophic beliefs, leading to the maintenance and further exacerbation of the problem. Social mishap exposures directly target the patients' exaggerated social cost by helping patients confront and experience the actual consequences of such mishaps without using any avoidance strategies.

Social Mishap Exposures

Consistent with the notion that clients with SAD overestimate the social costs associated with social mishaps, high estimated social costs have been proposed to be an important mediator of treatment change (Hofmann, 2000b). This hypothesis has been subjected to empirical testing, and substantiated in a treatment outcome study that compared cognitive-behavioral group therapy, exposure therapy (without explicit cognitive intervention), and a wait-list control group (Hofmann, 2004). It was found that changes in estimated social costs mediated treatment change between pre- to posttreatment in the two active treatment conditions (Hofmann, 2004). These empirical findings therefore support the utility of social mishap exposures in addressing this overestimation of costs associated with a social mishap. This is accomplished by having the client behave in a way that causes a social mishap by purposefully violating the client's perceived social norms (e.g., singing in a subway).

The difference between social mishap exposures and exposure practices that have been typically used in cognitive-behavioral therapy protocols for SAD is that social mishap exposures cause clients to experience the feared outcomes that they try so hard to avoid by clearly appearing incompetent, crazy, obnoxious, and so on. Standard exposure practices of patients with SAD are typically designed to make patients realize that social catastrophes are unlikely to happen, and that patients are able to handle socially challenging situations despite their social anxiety (e.g., Heimberg et al., 1990, 1998). In contrast, the goal of the social mishap exposures is to purposely violate the patient's perceived social norms and standards in order to break the self-reinforcing cycle of fearful anticipation and subsequent use of avoidance strategies. Patients are asked to intentionally create the feared negative consequences of a feared social situation. As a result, patients are forced to reevaluate the perceived threat of a social situation after experiencing that social mishaps do not lead to the feared long-lasting, irreversible, and negative consequences. A more detailed description of this model is presented in Hofmann (2007).

Early data suggest that treatment protocols that incorporate social mishap exposures show considerably greater efficacy than traditional CBT protocols, which are typically associated with only moderate effect sizes (e.g., Hofmann & Smits, 2008). Other, more recent studies that include social mishap exposures (among other techniques) report considerably larger efficacy rates. For example, Clark and colleagues (2003) reported effect sizes ranging between 1.41 (pretest to posttest) and 1.43 (pretest to 12-month follow-up; Clark et al.). Similar efficacy data (pre-post effect size of 1.54) have been found in an early pilot trial (Hofmann & Scepkowski, 2006).

Obviously, social mishap exposures are not the only aspect that distinguishes traditional CBT protocols from more modern approaches (Hofmann, 2012). Depending on the specific treatment protocol, other aspects include strategies for attention retraining, changes in self-perception, and post-event rumination. However, in-vivo social mishap exposures are the most obvious differences to traditional CBT approaches, which have primarily employed in-session role-play situations with the goal to identify and replace maladaptive general automatic thoughts. The purpose of the current paper is to present a case example from a group cognitive-behavioral therapy protocol that emphasizes social mishap exposures, and to discuss the benefits and challenges associated with its successful implementation. The case that follows discusses a treatment-seeking individual who presented to an outpatient clinic specializing in the treatment of mood and anxiety disorders.

Method

The Anxiety Disorders Interview Schedule (ADIS-IV; DiNardo, Brown, & Barlow, 1994) was administered at the intake evaluation. The ADIS-IV is a semistructured clinical interview that assesses mood and anxiety disorders according to *DSM-IV* (American Psychiatric Association, 1994) criteria. The Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987) is a 24-item clinician-administered measure that assesses fear and avoidance of social situations (each rated on a 0- to 3-point scale with a range of total scores from 0 to 144) in the past week. The LSAS has been validated in clinical samples, and has high internal consistency (Heimberg et al., 1999). The LSAS was administered at every session throughout the course of treatment, and also at six major time points: baseline, Week 8, posttreatment, 1-month follow-up, 3-month follow-up, and 6-month follow-up.