



Low implicit self-esteem and dysfunctional automatic associations in social anxiety disorder

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ABSTRACT

Background and Objectives: Negative automatic associations towards the self and social cues are assumed to play an important role in social anxiety disorder. We tested whether social anxiety disorder patients ($n = 45$) showed stronger dysfunctional automatic associations than non-clinical controls ($n = 45$) and panic disorder patients ($n = 24$) and whether there existed gender differences in this respect.

Methods: We used a single-target Implicit Association Test and an Implicit Association Test to measure dysfunctional automatic associations with social cues and implicit self-esteem, respectively.

Results: Results showed that automatic associations with social cues were more dysfunctional in socially anxious patients than in both control groups, suggesting this might be a specific characteristic of social anxiety disorder. Socially anxious patients showed relatively low implicit self-esteem compared to non-clinical controls, whereas panic disorder patients scored in between both groups. Unexpectedly, we found that lower implicit self-esteem was related to higher severity of social anxiety symptoms in men, whereas no such relationship was found in women.

Conclusions: These findings support the view that automatic negative associations with social cues and lowered implicit self-esteem may both help to enhance our understanding of the cognitive processes that underlie social anxiety disorder.

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1. Introduction

Individuals who suffer from social anxiety disorder (SAD) typically experience an intense and persistent fear of social situations in which they are exposed to unfamiliar people or to the possible scrutiny by others (APA, 2000). According to the cognitive model of social anxiety of Wells and Clark (1997), socially anxious individuals interpret social situations as threatening, because of negative beliefs about their selves and dysfunctional assumptions about their social performance; together with excessively high standards for social performance. Negative self-beliefs typically are unconditional negative statements about the self (e.g., “I’m stupid” or “I’m a failure”). Dysfunctional assumptions concerning social performance take the form of conditional beliefs about possible negative

consequences of social behaviours (e.g., “if they see my anxiety, then they will think I’m a failure”). In support of the role of these dysfunctional cognitions in SAD, research showed that high socially anxious individuals indeed display more negative self-statements (e.g., Beidel, Turner, & Dancu, 1985; Cacioppo, Glass, & Merluzzi, 1979; Dodge, Hope, Heimberg, & Becker, 1988) and lower levels of self-esteem in social situations (e.g., Bouvard et al., 1999; Tanner, Stopa, & De Houwer, 2006) than low socially anxious individuals.

According to the multi-process model of anxiety, not only dysfunctional assumptions and negative self-beliefs (belonging to so-called ‘rule-based processes’) constitute the cognitive vulnerability to anxiety disorders, but also dysfunctional associative processes play an important role in the development and maintenance of anxiety disorders (Ouimet, Gawronski, & Dozois, 2009). In response to anxiety-relevant stimuli, threat-related associations are thought to be directly activated via the spreading of activation from one concept to associated concepts in memory. Subsequently, the input from the associative system is assumed to be used for more deliberate, rule-based mental processing (Strack & Deutsch, 2004) which involves the more rational analysis of factual relationships between concepts. Associative and rule-based information processing systems are

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thought to jointly influence other cognitive processes (e.g., negative interpretive bias) and behaviours (e.g., attention bias or avoidance behaviours) that work together in a way to aggravate and/or maintain the anxiety disorder. Based on the model of Wells and Clark (1997) two types of automatic associations seem to be most important for SAD: first of all, negative automatic associations towards the self (i.e. implicit self-esteem) and secondly, associations between social cues and negative outcomes of social performance such as failure or rejection.

In line with the presumed role of automatic associations in anxiety, automatic associations were found to predict experimentally-provoked anxiety behaviours in unselected student samples in the laboratory (e.g., Asendorpf, Banse, & Mücke, 2002; Egloff & Schmukle, 2002; Spalding & Hardin, 1999). In addition, three studies showed that automatic self-anxious associations were related to having an anxiety disorder diagnosis as well as to the maintenance and onset of anxiety disorders over time (Glashouwer & de Jong, 2010; Glashouwer, de Jong, & Penninx, 2011, 2012). Furthermore, one study showed that socially anxious students were characterized by stronger automatic self-anxious associations than non-anxious students and that these associations seemed to reduce following treatment (Gamer, Schmukle, Luka-Krausgrill, & Egloff, 2008).

Up to now, only a few studies looked specifically at implicit self-esteem and associations with social cues in SAD and, in addition, these studies mainly relied on analogue samples. Two studies showed that high socially anxious female students indeed were characterized by relatively low implicit self-esteem (de Jong, 2002; Tanner et al., 2006). In addition, recently it was shown that for adolescent girls, but not boys, lower implicit self-esteem was related to more social anxiety symptoms (de Jong, Sportel, de Hullu, & Nauta, 2012). Furthermore, there is some evidence supporting the view that also threat-related automatic associations with social cues may be involved in SAD. High socially anxious female students displayed stronger negative automatic associations with social cues than low-anxious participants (de Jong, Pasman, Kindt, & van den Hout, 2001). Similar results were found in an adolescent sample, showing that social cues automatically elicited relatively strong threat-related associations in high compared to low socially anxious adolescents (de Hullu, de Jong, Sportel, & Nauta, 2011).

Although the available evidence suggests that both dysfunctional automatic associations with respect to the self and social cues seem to be involved in SAD, some important questions still remain unanswered. Prior studies in this field typically compared analogue groups of high socially anxious individuals with low socially anxious individuals. Since there may be quantitative as well as qualitative differences between analogue and clinical samples (Emmelkamp, 1982), it seems important to replicate these findings in a clinical sample. In addition, prior studies did not include clinical-control groups, leaving open the question whether differences regarding automatic associations can indeed be attributed to SAD or have to be seen as more general characteristics shared among several anxiety disorders. Furthermore, most studies until now relied on female samples. However, there might be gender differences in the relationship between dysfunctional automatic associations and social anxiety symptoms. Earlier work showed that women are more likely than men to base their judgements on intuitions and gut impressions (e.g., Pacini & Epstein, 1999). Perhaps this could mean that, compared to men, women tend to rely more on their automatic associations as a guideline for their behaviour and self-judgements (cf. Pelham et al., 2005). Consequently, automatic associations could have stronger predictive validity in women than in men and one study indeed showed findings in this direction in a group of adolescents (de Jong et al., 2012). Finally, prior studies usually focused on one kind of

automatic associations, making it impossible to examine independent contributions of different types of automatic associations for social anxiety symptoms.

The main goal of the present study is to test whether SAD patients show stronger dysfunctional automatic associations (regarding self and social cues) than both clinical and non-clinical controls and whether there exist differences for females and males in this respect. Therefore, we included a clinical sample of treatment-seeking SAD patients, a non-anxious control group and a clinical sample of treatment-seeking panic disorder patients as a clinical control group. We hypothesize that automatic associations with social cues are more dysfunctional in the SAD group than in both control groups. In addition, we expect the SAD group to have a lower implicit self-esteem than controls. For the panic disorder group we have no clear expectations with respect to implicit self-esteem. Furthermore, we expect automatic associations to have stronger predictive validity for social anxiety symptoms in women than in men. Finally, an additional strength of the present study is that it is the first to examine two types of automatic associations in one socially anxious sample, allowing to test whether both types of associations are independently related to social anxiety symptom severity.

2. Method

2.1. Participants

Patients with generalized social anxiety disorder (SAD) as primary diagnosis ($n = 45$; 17 women) and patients with panic disorder (PD) as primary diagnosis and no SAD as comorbid disorder ($n = 24$; 13 women) were recruited among individuals seeking treatment in various ambulant community health care centers in The Netherlands (GGZ Nijmegen: $n = 33$; Hendriks & Roosenboom: $n = 19$; GGZ Friesland: $n = 15$; University Medical Centre Groningen: $n = 2$). The mean age in the SAD group was 31.47 ($SD = 10.57$) and in the PD group 37.46 ($SD = 14.03$). Mean (and median) educational level was intermediate vocational education for both the SAD group and the PD group. All patients met DSM-IV criteria for SAD or PD respectively as assessed with Minnesota International Neuropsychiatric Interview Plus (M.I.N.I.-Plus; van Vliet, Leroy, & van Megen, 2000). In the SAD group 33 patients (73%) suffered one or more comorbid disorders, among which were depression and/or dysthymia (40%), generalized anxiety disorder (31%) and panic disorder (20%). In the PD group 11 patients (46%) suffered from one or more comorbid disorders, among which were depression or dysthymia (38%) and generalized anxiety disorder (17%).

Healthy control participants ($n = 45$) were recruited through local advertisements and through indirect acquaintances of the staff members and students of the Department of Clinical Psychology of the University of Groningen and Radboud University Nijmegen. They were asked to serve as control participants in a study about anxiety. The non-clinical controls (NCC) matched with the SAD patients on gender, age and level of education and were included after screening on the absence of any DSM-IV axis-I disorder as measured by the M.I.N.I.-Plus, although one of the controls was diagnosed with alcohol dependence. Mean age was 31.16 years ($SD = 11.60$) and mean (and median) educational level was intermediate vocational education.

All participants included in the study had an estimated IQ of 90 or higher, good comprehension of the Dutch language, showed no signs of current psychosis and did not suffer from dyslexia. The number of participants in the groups differed, because the present report was part of a larger study with a longitudinal design in which we followed the SAD and NCC groups (but not the PD group) over

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