Development of a Treatment Program for Social Anxiety Disorder

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F-11: Can design and produce a significant artifact or document that gives evidence of advanced competence.

F-12: Can design a counseling program based on independently conducted research that analyzes current psychological treatment methods for social anxiety disorder.

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I. Introduction

Social anxiety disorder can be quite debilitating for those afflicted and can cause the sufferer to miss out on important opportunities in both their social and working lives. With social anxiety disorder being the most common of the anxiety disorders (Lampe, 2009), and the third most common psychological disorder (Rosenberg & Kosslyn, 2011), it is important that the most effective methods are utilized in the treatment of this condition.

There has been a lot of research testing the efficacy of various treatment methods for social anxiety disorder and a general consensus has been formed among researchers about which methods prove to be the most effective. However, what is true in a controlled research setting does not always transfer over to real world practice and thus the recognition of a need to survey practitioners was realized. Surveying those who have had experience using the various treatment methods in a real world setting allows for the comparison of empirically demonstrated methods, with their real world application in treatment settings. The resulting data allows for the development of a treatment program for social anxiety based on what has been most effective in both research setting, and in the experience of mental health practitioners. The treatment program I have created was developed by comparing and using the data from both empirical studies and from data collected from mental health practitioners and thus fulfills the need for a program utilizing the most effective methods.

The competence statement for my F-12 project states that I: *Can design a counseling program based on independently conducted research that analyzes current psychological treatment methods for Social Anxiety Disorder.* My goal for carrying out

this research is to get a consensus of the most effective treatments for social anxiety disorder from the perspective of those who have actually treated people with social anxiety disorder. The goal is simple in principle but the opinions of those working in mental health are of the highest value for the purpose of this study.

II. Research Methodologies

To collect data from individuals who have had experience treating people with social anxiety disorder I developed a nine question survey based on a 5-point Likert scale (see exhibit A). The anchors used for the Likert scale were as follows: 1 Not Effective; 2; 3 Moderately Effective; 4; 5 Very Effective. Each of the nine items on the survey was a form of psychological treatment used for treating social anxiety disorder; the nine treatments listed were: *cognitive therapy, cognitive-behavioral therapy, cognitive-behavioral group therapy, exposure therapy, exposure group therapy, rational emotive therapy, behavioral activation therapy, relaxation techniques, and social skills training.* The participants were given the instructions at the top of the survey to first give their job title and years experience in that position. Then, the participants were instructed to indicate the level of efficacy, in their experience, of each treatment method listed. If they had not had any experience with a certain treatment method, they were instructed to leave that item blank. The survey itself was an online survey hosted for free on Survey Gizmo, and remained active for 13 consecutive days.

When conceptualizing this research project my intent was to first conduct an interview with a social worker contact who works for the Indiana Department of Corrections doing substance abuse counseling. This social worker contact uses cognitive-behavioral treatment, as well as other behavioral treatment methods for individuals with

substance abuse issues, and my intent was to discuss these treatment methods with her. I was then going to use what I had gained from the interview as a foundation of knowledge about behavioral treatment methods. Afterwards, I was going to have my survey distributed among her professional contacts. However, my social worker contact surprisingly opted not to participate. My social worker contact didn't have any experience with treating social anxiety disorder, so the fact that she decided that she no longer wanted to participate turned out not to be significant. I explored other options for getting my survey to people who have had experience treating those with social anxiety disorder and I was able to use two contacts that I have made within the psychology department at DePaul University; one a doctoral student in the clinical psychology program, and the other a community psychologist. These two contacts turned out to be quite an asset. Using these two contacts I was able to get my survey distributed among clinical professionals who have had experience working with clients with social anxiety disorder.

III. Findings

A. Literature Review

OVERVIEW

The areas to be explored in this review of the literature are: *anxiety; social anxiety; prevalence of social anxiety disorder; etiology of social anxiety disorder; and treatment methods.* All of these topics are important to consider while developing a treatment program for social anxiety disorder.

Looking at how and why anxiety happens can help one impede the onset of anxious reactions. When focusing in on social anxiety disorder's prevalence, one can see

that there are many people who suffer from the disorder and conclude that developing a treatment method would be a worthwhile endeavor that could potentially help many people. Investigating the etiology of social anxiety disorder from the main paradigms of psychopathology gives one an idea of what the likely causal factors are in the onset and maintenance of social anxiety disorder and can thus design a treatment program that addresses these factors. Reviewing past and present methods for treating social anxiety disorder gives one an understanding of how effective these methods have or have not been. When developing a treatment program for social anxiety disorder it is very important to know what has been empirically demonstrated as being effective.

ANXIETY

Anxiety is something everyone experiences and is a normal part of life. Individuals experience anxiety for a variety of reasons such as anxiety related to work, health, or interpersonal relationships. Anxiety can actually be helpful in many cases in that it serves as a sort of biologically wired warning system that alerts us to potential danger (Noyes & Hoehn- Saric, 1998). Anxiety can be defined as psychological distress commonly accompanied by uncomfortable bodily sensations, and is future oriented in that it is a reaction to a current of future threat as opposed to depression which is a reaction to loss and associated with the past (Noyes & Hoehn-Saric, 1998). Under normal circumstances, anxiety is a reaction to a real threat, and is proportional in severity to that threat (Beck, Emery, & Greenberg, 1985). The body responds to a perceived threat by activating the sympathetic nervous system in preparation for the utilization or a large amount of energy; this is called the fight or flight response (Rosenberg & Kosslyn, 2011). Sometimes, individuals perceive a threat even when there is no such threat present.

However, even if the threat is not actually real, the flight or flight response is still triggered.

SOCIAL ANXIETY DISORDER

Social anxiety disorder, or social phobia as it is sometimes alternately called, can be defined as: *A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others* (American Psychiatric Association, 2000). The fear of social situations must cause marked distress and impaired functioning to be considered an actual psychological disorder. In addition, the anxiety experienced must not be due to any substance abuse related issues and should be present for at least six months to meet diagnostic criteria for social anxiety disorder (American Psychiatric Association, 2000).

Some of the common fears of those with social anxiety are: public speaking, informally meeting people, eating/drinking in public, initiating and/or maintain conversations, attending parties, and even using public restrooms (Beidel & Turner, 1998). Engaging in these, or other feared social situations can cause the individual to experience many different somatic symptoms such as: heart palpitations, increased rate of breathing, sweating, increased muscle tension, difficulties speaking, abdominal cramping, and even the urge to urinate (Stravynski, 2007). These symptoms are highly unpleasant and thus cause many of those afflicted with social anxiety disorder to avoid most social interactions. This in turn causes the individuals to feel lonely and isolated and miss both social and career opportunities.

Prevalence:

The lifetime prevalence of social phobia is 12.1% of the population; breaking the numbers down into age ranges we see a lifetime prevalence of 13.6% for 18-29 year olds; 14.3% for 30-44 year olds; 12.4% for 45-59 year olds; and 6.6% for those aged 60 and above (Kessler et al., 2005). Because one of the main features of social anxiety is a fear of being evaluated by others, it makes sense that there may be a valid relationship between cultural norms and expectations, and social anxiety disorder. Hofmann, Asnaani, and Hinton (2010) state that the 12 month prevalence rate of social anxiety disorder (SAD) among adults in the United States is 7.1-7.9%; in Chile is 6.4%; and in Brazil is 9.1% of the respective populations. In other areas of the world, the prevalence rates were significantly lower. For example, in many of the East Asian countries with 0.8% in Japan, 0..2% in China, and from 0.2-0.6% in South Korea (Hofmann, Anaani & Hinton, 2010).

Other parts of the world have similarly low prevalence rates as well such as: Mexico with 1.7%, Nigeria with 0.3%, and Europe as a whole with 0.8% (Hofmann, Anaani & Hinton, 2010).There are also a couple of interesting outliers in regard the prevalence rates of SAD. There is a remote rural region of Russia called Udmurtia in which 49.4% of the population meets criteria for SAD, with 50.7% of the women and 35.6% of the men meeting criteria (Hofmann, Anaani & Hinton, 2010). Also, there was a study done with university students in Oman which indicates that up to 54% of the sample met criteria for SAD (Hofmann, Anaani & Hinton, 2010).

Older epidemiological data shows that among the adult population in the U.S., three females for every two males will seek treatment for social anxiety (Beidel & Turner, 1998). The age of onset of social anxiety disorder is usually between the ages of

13-15 (Chartier, Walker, & Stein, 2003) and many individuals with social anxiety disorder report being shy as children (Rosenberg & Kosslyn, 2011).

Regardless of the geographical location or prevalence rates in any one region, the fact remains that there are a lot of people suffering from social anxiety disorder. Because there are so many whose lives are affected directly or even indirectly (spouse, relative, etc.) by social anxiety disorder, one can easily come to the conclusion that the development of an effective treatment program for SAD is a worthwhile endeavor.

ETIOLOGY OF SOCIAL ANXIETY

There are five main paradigms in psychopathology: *the neurobiological paradigm; the genetic paradigm; the psychoanalytic paradigm; the diathesis-stress paradigm; and the cognitive-behavioral paradigm.* The five main paradigms attempt to explain causal factors of mental health condition from their respective perspective. Looking at the etiological information from these different paradigms gives valuable information about causal factors, and more importantly for this project, factors that sustain and reinforce social anxiety; this information is vital when creating a treatment method for SAD.

Neurobiological Paradigm:

Studies looking for neurobiological abnormalities have found that individuals with social anxiety disorder have a lower density of peripheral benzodiazepine receptors on platelets than individuals without social phobia. However, it is at this time, uncertain what the implications of the density of peripheral benzodiazepine receptors are in regard to social anxiety (Stravynski, 2007). There have also been many studies looking at specific neurotransmitter systems via pharmacological challenge. The pharmacological

challenge method uses pharmacological agents that act as agonists of specific receptors. Thus far, studies looking at the 5-HT1A, D2, and the Andrenergic Alpha 2 receptors (a serotonin, dopamine, and adrenalin receptor respectively) haven't provided any concrete information about significant differences between these receptors when activated by chemical agents in those with social anxiety disorder and those individuals without the condition (Stravynski, 2007).

However, studies looking at brain regions that control automatic responses that also rely on dopamine for activation show that there may be a connection between diminished dopamine activity in individuals with social anxiety disorder (Rosenberg & Kosslyn, 2011). Furthermore, studies looking at the Hypothalamic-Pituitary Adrenal Axis with regard to cortisol secretion haven't observed a significant difference between those with social phobia and those without (Stravynski, 2007).

The volume of the brains putamen has been shown to diminish more rapidly with age in individuals with social phobia than in controls (Stravynski, 2007). Also, individuals with social phobia show significantly higher levels of activity in the hippocampus, parahippocampalcorticies, and amygdala than controls when exposed to socially challenging situations (Stravynski, 2007). Activation of the amygdala is well documented as being strongly associated with fear (Rosenberg & Kosslyn, 2011).

Genetic Paradigm:

While there have been studies that show those with relatives with social phobia may be at a greater risk for social phobia, there is no concrete evidence that social phobia as a whole is inherited via the genes (Stravynski, 2007). Similar to other anxiety disorders, social anxiety disorder likely comes from a combination of genetic and

environmental variables that predispose one to develop the disorder (Rosenberg & Kosslyn, 2011).

Psychoanalytic Paradigm:

There is no specific psychoanalytic theory of social anxiety disorder. Anxiety as a whole tends to be viewed as a piece of larger psychological problems dealing with repression of urges (Noyes & Hoehn- Saric, 1998).

Diathesis-Stress Paradigm:

Lampe (2009) points out that there may be a link between children with anxious attachment styles and the development of social anxiety. In addition, having controlling parents, or having an introverted disposition may also increase the likelihood of developing social anxiety disorder (Lampe, 2009).

Cognitive-Behavioral Paradigm:

A popular theory among psychologists is that faulty or distorted thoughts may result in psychological distress and improper behavior, which brings about more distress (Stravynski, 2007). The idea with this theory is that those afflicted with social phobia start to become anxious when they are anticipating and/or participating in social interactions or activities. According to the Cognitive paradigm, individuals with social phobia have anxiety while anticipating and participating because of distorted assumptions and expectations about social interactions (Stravynski, 2007). These distorted thoughts trigger somatic symptoms in the phobic individual, and the idea that social situations are dangerous becomes reinforced. Furthermore, the individual may become mentally hung up on their distorted thoughts which, in turn, results in hindered social performance;

further reinforcing the idea that social situations are dangerous (Stravynski, 2007). There was a study conducted that showed individuals with social anxiety tend to view negative social events as being more threatening than negative non-social events, while individuals without social anxiety tend to view the negative non-social events as being more threatening (Rheingold, Herbert, & Franklin, 2003). Another study monitoring eye movements showed that individuals with social anxiety tend to focus their gaze longer on socially threatening images than those without social anxiety. Interestingly, the same study showed that the socially anxious and non-socially anxious individuals both focused on non-socially threatening images for the same length of time (Buckner, Maner & Schmidt, 2008). These studies really emphasize the cognitive bias toward negative social cues present among those with social anxiety disorder.

Behavioral conditioning is also believed to play a significant role in both the formation and perpetuation of social anxiety. Having a negative social experience may increase the likelihood of avoiding future social situations. The avoidance will in turn reduce the anxiety associated with that social situation and becomes a learned behavior (Kring, Johnson, Davison, & Neale, 2010). The cognitive-behavioral paradigm is essentially the coupling of the distorted thoughts (cognitive aspect) with the avoidance as reinforcement (behavioral aspect) to form a coherent model of the phenomenon.

Etiological Conclusion:

The review of the literature suggests that there may be many variables at play in the development of social anxiety disorder. Neurobiological studies show that social anxiety disorder tends to be associated with dopamine activity, as well as activity in certain brain regions. Genetic studies suggest that there may be a genetic predisposition

for social anxiety disorder, though there is no specific gene responsible. In a similar fashion, environmental stressors have also been shown to predispose an individual to social anxiety disorder. However, the cognitive-behavioral model, according to the review of the literature, is believed to have the biggest influence on the formation and perpetuation of social anxiety disorder. I expect that the survey data will show cognitive-behavioral therapy to be among the most effective treatment for social anxiety disorder and will thus be included in the treatment method I develop. In fact, cognitive-behavioral therapy will be the foundation of the treatment program.

ASSESSMENT

A detailed description of how an individual is assessed and diagnosed as having social anxiety disorder is beyond the scope of this project, but the methods for assessment typically involve an interview administered by a clinician, and a self-report measure. The clinical interview serves to break the ice, but also serves to learn about the client's history and course of the condition. In addition, the interview allows the therapist to find the main situations that the client tries to avoid. The interview is also a good time to probe the client for the beliefs they hold about social situations (Antony, 1997).

There are many self-report questionnaires that a client can fill out including: Social Phobia and Anxiety Inventory, Social Interaction Anxiety Scale, Social Avoidance and Distress Scale, and the Liebowitz Social Anxiety Scale. The self-repot scales are useful for assessing the severity of anxiety the client feels in specific situations (Beidel & Turner, 1998).

NON-PHARMACALOGICAL TREATMENTS:

As someone who is not an M.D., I will leave pharmacology to the professionals.

However, there may be many people who do not wish to use medication and want to treat their social anxiety and the following methods are some of the most popular behavioral treatment methods being used today. Each method will be examined for its likelihood of being effective in the treatment of social anxiety disorder with the most effective methods being compared to the survey data and then used in the treatment method.

Social Skills Training:

It has been noted that while some individuals with social phobia have appropriate social skills (anxiety gets in the way of social functioning), many of those with social phobia lack appropriate social skills and become anxious due to their social awkwardness (Beidel & Turner, 1998). Thus, social skills training has become a popular method for treating those with social phobia. With this method, the therapist will introduce certain behaviors and skills such as casual conversation and holding eye contact. The therapist demonstrates the appropriate way to engage in these social activities and then rehearses them with the client. The therapist gives feedback and keeps working on the target behaviors and skills until the client has made improvement in the target behaviors (Beidel & Turner, 1998).

Relaxation Training:

The main idea behind using relaxation techniques is to reduce the severity of the somatic symptoms experienced by those individuals with social phobia. Relaxation techniques on their own tend to show minimal improvement in those with social phobia, but have been shown to be effective when combined with other treatments (Heimberg & Juster, 1995).

Cognitive-Behavioral Therapy (CBT):

Researchers have concluded that cognitive factors are more paramount in both the development and perpetuation of social anxiety, than to other anxiety disorders (Heimberg & Juster, 1995). The distorted thoughts and fears about negative evaluation tend to be at the root of social phobia, and thus an intervention to restructure these distorted thoughts has proved to be an effective treatment (Heimberg & Juster, 1995). Addressing and correcting the distorted thoughts is the cognitive aspect of CBT while addressing the behavioral conditioning is the behavioral aspect of CBT (Rosenberg & Kosslyn, 2011); some therapists may only address the cognitive aspect. Other therapists may use cognitive-behavioral group therapy. Cognitive-behavioral group therapy allows for the use of cognitive-behavioral therapy in a social setting which allows for the teaching of cognitive concepts while simultaneously allowing for some integration of exposure via the group setting (Beidel & Turner, 1998).

A study by Herbert et al. (2004) showed that 12 weekly CBT treatment sessions for social anxiety disorder was more effective and had lower rates of attrition than an extended treatment program with 12 sessions taking place over 18 weeks. The study suggests that there is no benefit to an extended treatment program for SAD, and that an extended program may actually be less effective and have higher dropout rates. A study by Hope et al. (1995) shows that 12 sessions based on cognitive-behavioral therapy were effective and participants had maintained improvements at a six month follow-up. In addition, a study by Scholing and Emmelkamp (1993) showed 8 sessions to be effective. Heimberg and Becker (2002) suggest utilizing a 12 session approach as well.

Exposure Therapy:

Sigmund Freud himself noted that when treating individuals who suffer from

phobias those individuals tend to not make progress until they are exposed to the feared situation (Beidel & Turner, 1998). With exposure therapy, the client will create a list of fears from most to least feared situations. Then, under the supervision and guidance of the therapist, will expose themselves to the least feared situation until they become comfortable with that situation. It is important for the therapist to have the client remain in the feared situation until their anxiety wanes until they reach a level of comfort in the situation. This way, the negative reinforcement that had previously been maintaining the fear is eradicated (Beidel & Turner, 1998). When combined with cognitive restructuring (i.e. cognitive-behavioral therapy, cognitive therapy), clients report significantly less avoidance of the target phobia than those who receive exposure alone (Beidel & Turner, 1998). Because of the reported level of efficacy in both the academic literature as reported by the sample in the survey, exposure therapy will be utilized in the F-11 treatment program. Exposure therapy can also be utilized in a group setting.

Rational Emotive Therapy:

Rational Emotive Therapy was developed by Albert Ellis and first introduced in the 1950s (Haaga & Davison, 1993). The idea behind Rational Emotive Therapy is that it is not actual events that cause an individual to feel negative emotions such as anxiety, depression, or rage. Instead, it is the individuals' beliefs about those events that are responsible for the negative emotions and behaviors associated with those events (Haaga & Davison, 1993). Rational Emotive Therapy is based on what Ellis calls the ABC model. A: An event happens. B: You have a belief about that event. C: You feel an emotional reaction to the belief about the event (Ross, 2006). RET also states that any beliefs that upset people all stem from variations of three beliefs which Ellis calls the

"Three Basic Musts." The Three Basic Musts are:

1. I must do well and win the approval of others for my performance or I am no good.
2. Other people must treat me considerately, fairly, and kindly, and in exactly the way I want them to treat me. If they don't, then they are no good and they deserve to be condemned and punished.
3. I must get what I want, when I want it, and I must not get what I don't want. It's terrible if I don't get what I want, and I can't stand it.

The first belief in The Three Musts is the belief that is associated with social anxiety. The therapist will then work with the client to dispute these irrational beliefs (Ross, 2006).

Behavioral Activation Therapy:

Behavioral Activation Therapy (BAT) is based on operant conditioning and encourages behavior conducive to the patient's goals while discouraging behavior that is not conducive to their goals. Where cognitive and cognitive-behavioral therapies are concerned with changing beliefs, BAT focuses on the consequences of those beliefs (Spett, 2004). BAT is typically used for mood disorders like depression, but because there tends to be a high level of co-morbidity with anxiety disorders and mood disorders, BAT is a possible treatment for individuals with an anxiety disorder (Hopko, 2006).

Conclusions from the Literature Review:

My goal in conducting a review of the literature was to explore the available non-pharmacological treatments for social anxiety disorder and determine which methods are the most effective. All of the methods explored above are supported by empirical evidence as being at least somewhat effective, but after a review of the literature I found

that cognitive-behavioral therapy and exposure therapy are the methods with the highest levels of efficacy in the treatment of social anxiety disorder. Both cognitive-behavioral therapy and exposure therapy are the most frequently discussed methods of treatment in scholarly books and textbooks. In fact, cognitive-behavioral therapy has been shown to be as effective as the SSRI medication Citalopram at altering key areas of the brain (Rosenberg & Kosslyn, 2011).

B. Findings from Research Methodologies

Survey:

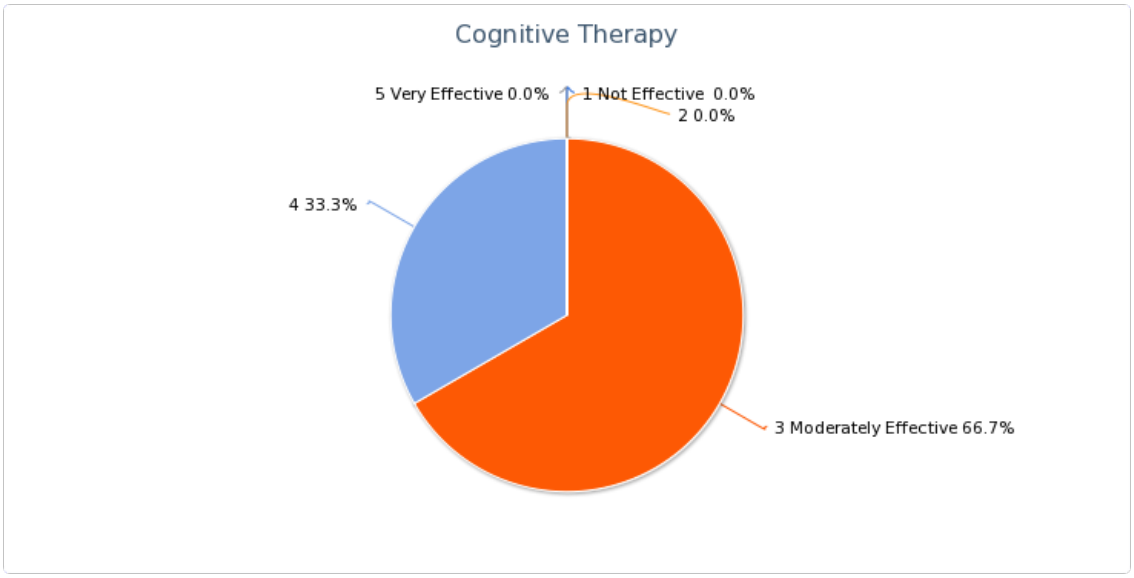
Sample

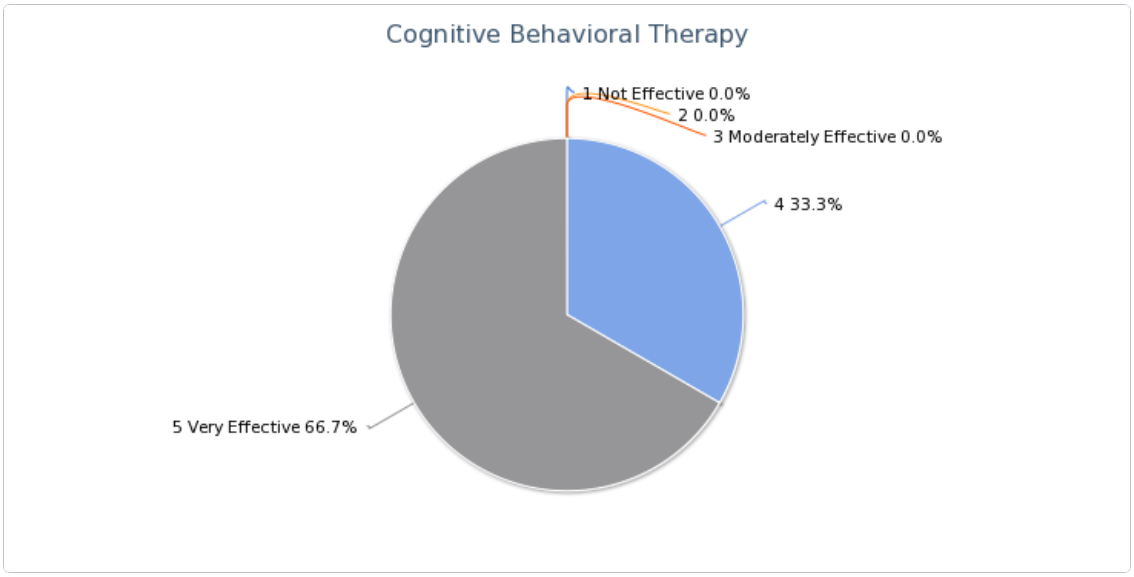
The participants (n = 10) were reported as: a professor of psychology and practicing clinician; a graduate student; a therapist; a clinical psychologist; a psychologist; a clinician; a school social worker; two school psychologists; and one who declined to answer. The average number of years experience of the nine participants who answered the question was 8.44 years. However, it should be noted that one of the participants reported 40 years experience, while the next highest was 8 years experience. So, if the participant with 40 years experience is removed, the average experience comes to 4.5 years.

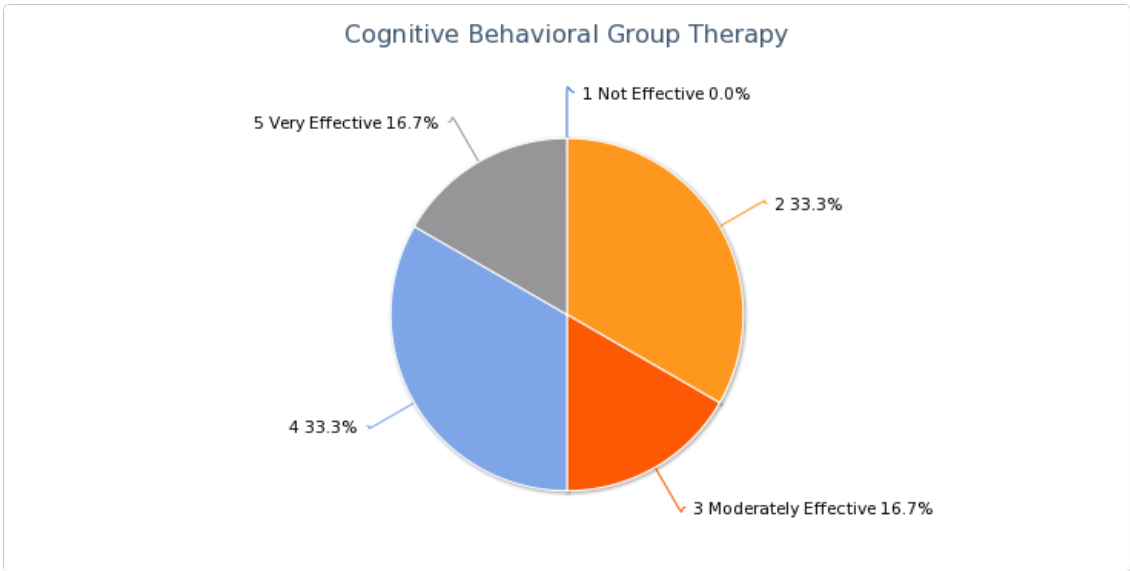
Results

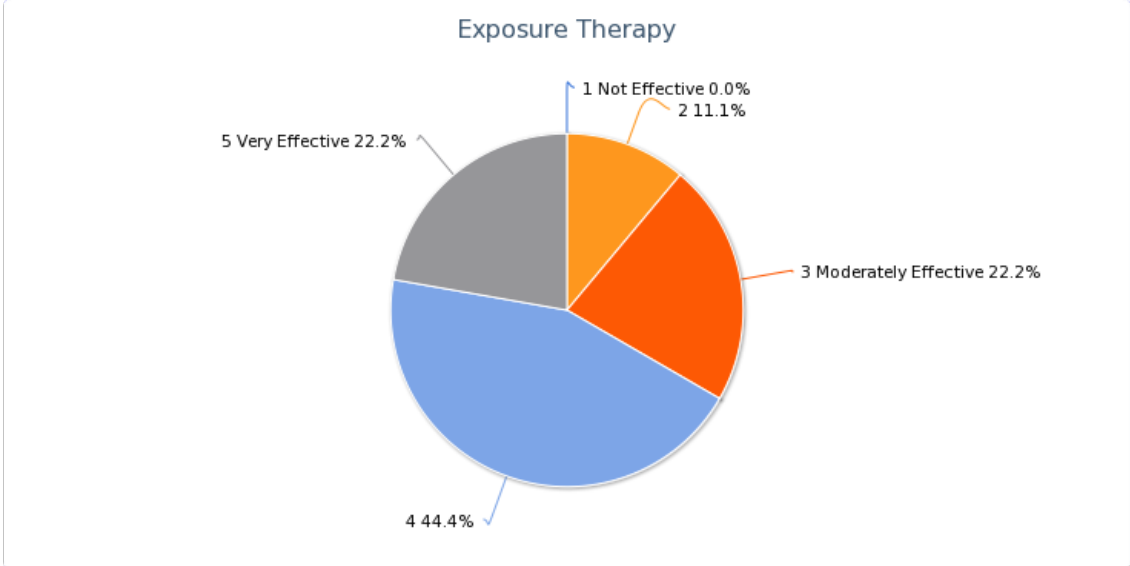
The 5-point Likert scale used for this survey has a score of 1 being not effective, a score of 3 being moderately effective, and a score of 5 being very effective. Thus, a score of 3 for an item on this survey is average; anything below a score of 3 is below average, while any item with a score above 3 is considered above average. The collected data returned the following scores: cognitive therapy (M = 3.3, *SD* = 0.47) with 9 responses;

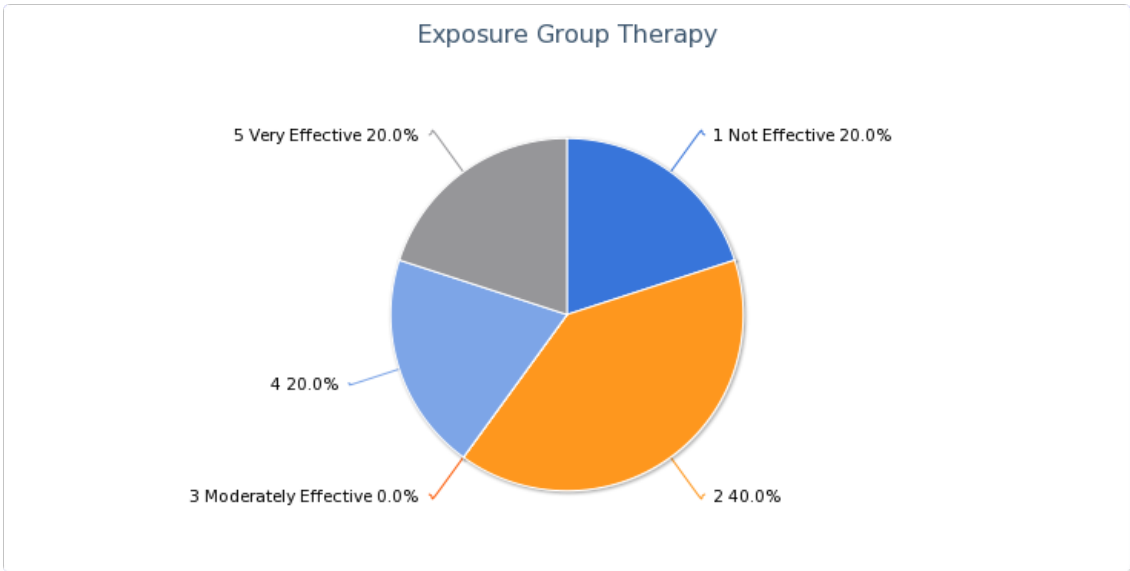
cognitive-behavioral therapy (M = 4.7, *SD* = 0.47) with 9 responses; cognitive-behavioral group therapy (M = 3.3, *SD* = 1.11) with 6 responses; exposure therapy (M = 3.8, *SD* = 0.92) 9 responses; exposure group therapy (M = 2.8, *SD* = 1.47) with 5 responses; rational emotive therapy (M = 1.8, *SD* = 0.75) with 5 responses; behavioral activation therapy (M = 2.5, *SD* = 0.71) with 8 responses; relaxation techniques (M = 2.9, *SD* = 0.30) with10 responses; and social skills training (M = 2.6, *SD* = 0.83) with 9 responses.

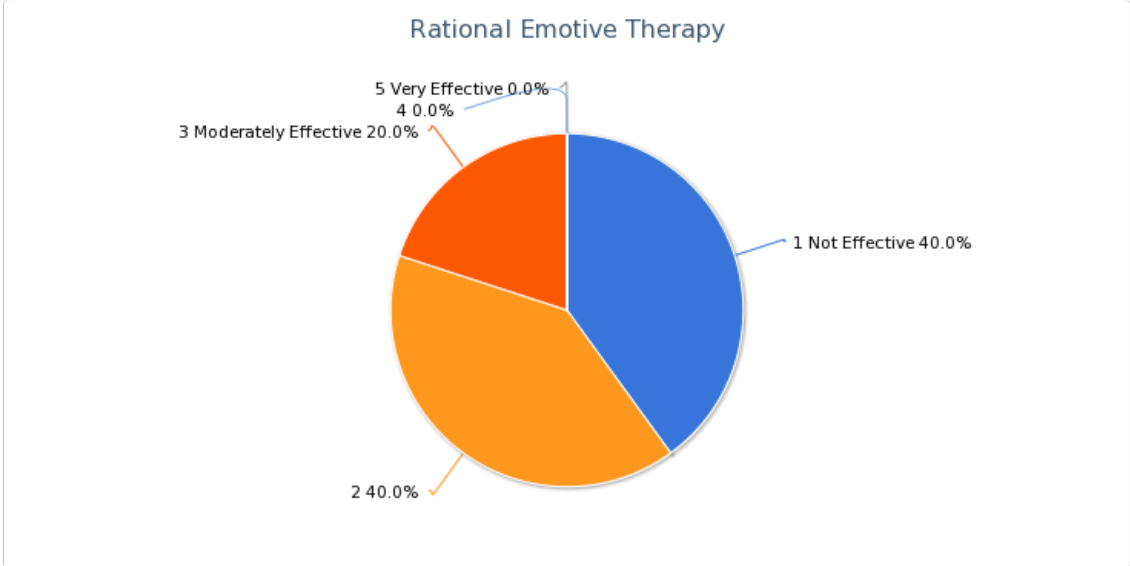


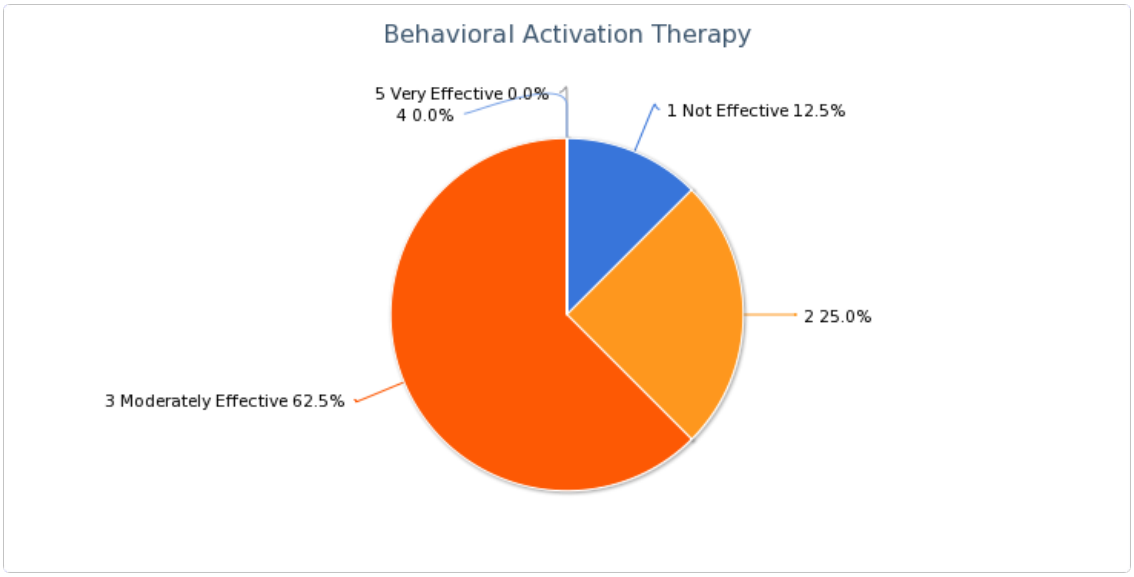



Cognitive Behavioral Group Therapy
1 Not Effective 0.0%
2 33.3%
3 Moderately Effective 16.7%
4 33.3%
5 Very Effective 16.7%


Exposure Therapy
1 Not Effective 0.0%
2 11.1%
3 Moderately Effective 22.2%
4 44.4%
5 Very Effective 22.2%


Exposure Group Therapy
5 Very Effective 20.0%
1 Not Effective 20.0%
4 20.0%
3 Moderately Effective 0.0%
2 40.0%


Rational Emotive Therapy
5 Very Effective 0.0%
4 0.0%
3 Moderately Effective 20.0%
1 Not Effective 40.0%
2 40.0%


Behavioral Activation Therapy
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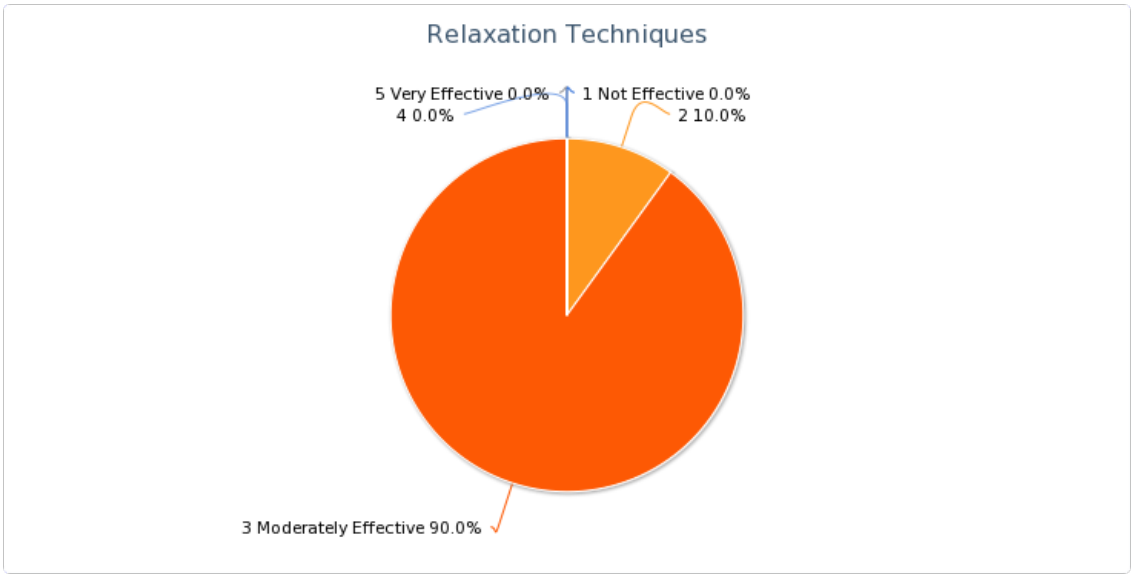
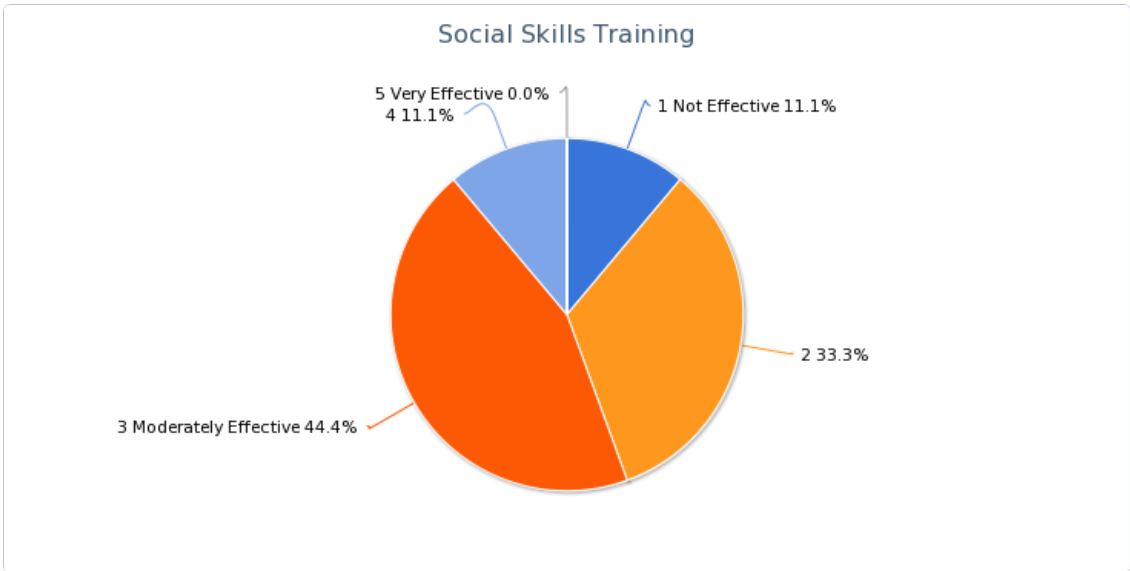
2 25.0%
3 Moderately Effective 62.5%


Relaxation Techniques
5 Very Effective 0.0%
4 0.0%
1 Not Effective 0.0%
2 10.0%
3 Moderately Effective 90.0%



DISCUSSION

These results show that, of the seven treatment methods surveyed, four of them scored above average. What this in turn means is that in the experience of the mental health practitioners who completed the survey, cognitive-behavioral therapy; exposure therapy; cognitive therapy; and cognitive-behavioral group therapy have been shown to be effective treatments for social anxiety disorder. These results were similar to what the literature review found in terms of what methods are the most effective in the treatment of social anxiety disorder. After a comparison of the survey data with the literature review, a decision was made to implement both cognitive-behavioral therapy and exposure therapy in the treatment program being developed.

Cognitive therapy was left out in favor of cognitive-behavioral therapy due to cognitive-behavioral therapy being ranked as more effective and because cognitive-behavioral therapy address both the cognitive AND behavioral issues with social anxiety disorder. Cognitive behavioral group therapy was left out simply because the treatment program is designed to treat one individual at a time.

IV. Analysis

The actual F-11 product I created was a full, written treatment program for individuals with social anxiety disorder; the program is presented as a guidebook. The guidebook begins by giving the reader a quick introduction about how the method was developed; the length of the program; and the methods on which the treatment method is built (cognitive-behavioral and exposure therapies). Next, the guidebook lists several words and concepts that may be new to the therapist with which they should become familiar. These include: Negative Social Thoughts, the Vertical Arrow Technique, Cognitive Distortions, the Argue With It Technique, Positive Rational Responses, and Subjective Units of Distress. The guidebook then gives an overview of what is to take place in each session; this is just an overview to give the therapist a way to quickly view the entire program. After the initial overview, the guidebook gives detailed step by step instructions for each session.

Sessions 1 & 2 are the longest and most detailed sections of the guidebook because the first two sessions are the foundation for the whole program. These sessions introduce the client to the cognitive-behavioral model of social anxiety disorder, and give them the instructions on how to use cognitive-behavioral therapy throughout the rest of this program. Session 3 introduces the client to the concept of exposure therapy and how exposure therapy and how they will use exposure therapy along with cognitive-behavioral therapy in this program. Sessions 4-9 are presented together because they will be structured in the same manner. Sessions 4-9 consist of exposure session that gradually increase in intensity over each session. Sessions 10-11 are the final two exposure sessions and expose the client directly to their target feared situation. Finally, the program

concludes with session 12 where the client and therapist review accomplishments and discuss future goals.

The research methods that I used most definitely gave me sufficient knowledge to create my treatment program. Through conducting a thorough literature review I accomplished several goals. The first goal being, as stated in the Advanced Project contract, that I wanted to discover the main causes of social anxiety. I learned that while there are some components of the neurobiology, heredity, and environmental stressors playing a role in social anxiety disorder, the distorted cognitions and behavioral conditioning are considered to have the most influence on the development and maintenance of social anxiety. In addition to learning about the main causes of social anxiety, I also learned about the different prevalence rates by age, gender, and even geographic location. The widely varying rates of prevalence throughout different geographic locations adds support to environmental stressors and/or distorted cognitions due to cultural norms having an influence on the development of social anxiety.

My second goal was to learn which treatments for social anxiety were the most effective. Again, a thorough review of the literature gave me the information I sought. I discovered that among the nine most well known therapies: *cognitive therapy, cognitive- behavioral therapy, cognitive-behavioral group therapy, exposure therapy, exposure group therapy, rational emotive therapy, behavioral activation therapy, relaxation techniques, and social skills training,* they all had at least some empirical support for their efficacy. However, the highest levels of efficacy belonged to cognitive-behavioral therapy and exposure therapy. The information I gained from my survey was extremely helpful in determining which methods to use in my program. The survey yielded above average

results for: cognitive therapy, cognitive- behavioral therapy, cognitive-behavioral group therapy, and exposure therapy; these results correspond with the information gained from the academic literature.

My final goal was to use the knowledge gained from the review of the literature, survey, and interview to develop a treatment program for social anxiety disorder. The most useful and most practical methodology used was the survey. A fairly simple, but well designed survey can yield very important information. The survey was a quick and unobtrusive way to get the opinions about treatment methods from those who have experience using the methods for social anxiety disorder

Had time permitted, I would have liked to have used the survey I developed to assess which treatment methods have been the most effective from the client/patient perspective. In future studies I would like to see those who have undergone several treatment methods for SAD polled for their opinions about which methods were the most effective. While it may be difficult for clients to differentiate which treatment methods worked best for them when methods were combined, their input would still likely prove to be valuable.

V. Generalizations

In short, the skills I learned while completing my Advanced Project will be a huge asset to me in the next phase of my education, and in my career. The actual process of conducting research is a huge part of higher education and a process that anyone considering post-graduate education should be very comfortable with doing. As someone who will be immersed in the rigorous curriculum of law school very soon, the skills learned in Advanced Project become quite apparent.

The ability to conduct a review of relevant literature is the most obvious practical skill I will use in the future. But, there are other not so obvious skills that I learned in completing this project. This was the first time I have ever done a project of this magnitude mostly on my own. I have completed Research Methods I and II and Statistics for the Behavioral Sciences as Focus Area classes. I have been involved in a research project with a community psychologist for the past year and have even presented the project at a couple of conferences. So, I have had a pretty good amount of research experience in a relatively short period of time. However, in all of my other experiences with research, the subject matter was either chosen by someone else, or the project was very brief. With the Advanced Project I was given a lot more liberty than I had ever had before with a research project. I learned a lot about discipline and staying focused on the task at hand. I also had to do most of the inquiry on my own, as this was the first solo project I have ever worked on.

VI. Conclusions

The F-11 competence statement for my Advanced Project is as follows: *Can design and produce a significant artifact or document that gives evidence of advanced competence.* This competence was demonstrated by the treatment program for social anxiety that I developed based on the data from my literature review, interview, and independent research. I also used what I learned about cognitive-behavioral therapy to create the *Argue With It* sheet (see exhibit B) for disputing (NSTs) Negative Social Thoughts. The F-12 competence statement for my Advanced Project is as follows: *Can design a counseling program based on independently conducted research that analyzes current psychological treatment methods for Social Anxiety Disorder*. This competence

was demonstrated by my design of a survey to collect data from mental health professionals, and the subsequent interpretation of that data. I was able to design and implement an assessment tool for collecting data to be used in the design of my F-11 product.

This project fits into my Focus Area of psychology in more than one way. The first and most obvious way this project fits in with my focus are is due to its subject matter being a psychological disorder. The first thing I had to do when beginning work on this project was to conduct an in-depth review of the literature on social anxiety disorder. This process alone greatly increased my knowledge of social anxiety disorder. I learned about the main theories pertaining to the causal factors associated with SAD. I also learned about the prevalence rates and how they can differ greatly depending on culture and/or geographic location. The most important information I took from the review of the literature, for the scope of this project, was the information on treatment methods. I learned which methods are commonly implemented, and which methods are favored for treating SAD.

The other way this project fits into my Focus Area is through undergoing the actual research process. In the field of psychology, research is arguably the most important aspect of the discipline. After conducting the literature review I began developing a survey for use as a data collection tool. I researched some research methodologies for collecting the opinions of others and came up with a design based on a Likert scale, a commonly used scale in psychological research. I then put the survey up on an online survey site to make completing the survey more convenient for the participants; also a common practice for psychological researchers using surveys.

After data collection I was able to run a descriptive statistical analysis giving me the mean and standard deviation of scores for each item. The statistics gleaned from analysis were what allowed me to determine which methods the mental health professionals have been the most effective. In completing this project I was able to really experience the act of conducting research, and learned just how important the process of conducting research actually is.

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Exhibit A

SOCIAL ANXIETY TREATMENT METHODS

Instructions: Please indicate the level of efficacy for the treatment of social anxiety/social phobia for each treatment method listed below (in your experience). If you have no experience with a particular treatment method, please leave blank.

Job Title:

Years Experience:

1. Cognitive Therapy

1	2	3	4	5
Not Effective		**Moderately Effective**		**Very Effective**

2. Cognitive Behavioral Therapy

1	2	3	4	5
Not Effective		**Moderately Effective**		**Very Effective**

3. Cognitive Behavioral Group Therapy

1	2	3	4	5
Not Effective		**Moderately Effective**		**Very Effective**

4. Exposure Therapy

1	2	3	4	5
Not Effective		**Moderately Effective**		**Very Effective**

5. Exposure Group Therapy

1	2	3	4	5
Not Effective		**Moderately Effective**		**Very Effective**

6. Rational Emotive Therapy

1	2	3	4	5
Not Effective		**Moderately Effective**		**Very Effective**

7. Behavioral Activation Therapy

1	2	3	4	5
Not Effective		**Moderately Effective**		**Very Effective**

8. Relaxation Techniques

1	2	3	4	5
Not Effective		**Moderately Effective**		**Very Effective**

9. Social Skills Training

1	2	3	4	5
Not Effective		**Moderately Effective**		**Very Effective**

Exhibit B

ARGUE WITH IT!

The Argue With It technique is used to assess an NST and root fear to determine whether that NST and root fear are valid. Below is a series of questions that are designed to challenge the automatic assumptions about a specific social situation. The questions on the Argue With It sheet can of course be altered by the therapist or the client to fit specific situations, and the sheet is by no means a complete list.

1. In reality, is there actually anything wrong with _____ ?

2. Does _____ always mean _____ ? Are there ever times when _____ does not mean _____?

3. What are the implications of _____being true?

4. Is there an alternative interpretation to _____ being true?

5. If _____is true, what is the absolute worst possible outcome? How likely is that outcome?

6. If a friend or family member told you they thought _____ what would you say to them?

7. Suppose the worst case scenario happened; how do you feel about it in a week, month, year, 5 years?