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Clinical Experiences in Conducting Cognitive-Behavioral Therapy for Social Phobia

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Several authors have identified a disconnect between psychotherapy research, including research on cognitive behavioral therapy (CBT), and real-world psychotherapy practice. This disconnect has several negative consequences, potentially including less-than-optimal practice standards as well as a lack of input from practicing psychotherapists on how research can be improved and made more relevant in their day-to-day clinical work. As part of an ongoing effort to engage practicing psychotherapists in a feedback loop with psychotherapy researchers, this study reports the results of a survey of CBT therapists who have used CBT in the treatment of social phobia (SP). The survey was designed primarily to document how often certain potential problems, identified by expert researchers and CBT manuals, actually act as barriers to successful treatment when CBT is employed in nonresearch environments. The participants were 276 psychotherapists responding to email, online, and print advertisements completing the online survey. Participants varied considerably in psychotherapy experience, work environment, experience in using CBT for SP, and in some ways varied in their usual CBT techniques when treating SP. Among the most prominent barriers identified by many of the participants were patient motivation, comorbidity, logistical problems (especially with exposures), patient resistance, and severity and chronicity of SP symptoms. These findings may be useful for psychotherapy researchers as areas for potential study. The results may also suggest topics requiring clinical guidelines, innovations within CBT, and dissemination of successful techniques to address the barriers identified here.

Keywords: empirically supported treatment; social phobia (social anxiety disorder); CBT (cognitive-behavioral therapy); psychotherapy resistance; psychotherapy expectations

SOCIAL PHOBIA (SP; ALSO CALLED SOCIAL ANXIETY DISORDER) is the most commonly diagnosed anxiety disorder in the United States, with a lifetime prevalence rate higher than 12% in the National Comorbidity Survey Replication (Kessler et al., 2005). The primary features of SP in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) include negative self-view, fear of embarrassment or criticism, and fear and/or avoidance of social situations. Several forms of treatment have been shown to be effective in randomized controlled trials, including both pharmacological and psychological therapies, especially cognitive-behavioral therapies (CBT; Gould, Buckminster, Pollack, Otto, & Yap, 1997). Despite the established effectiveness of CBT for SP, it is not a guaranteed cure, and several pitfalls in its treatment are possible. The goal of this study was to investigate what interferes with the successful implementation of this empirically supported treatment. Before reporting on such potential difficulties, however, we present some of the defining and characteristic features of SP and its cognitive-behavioral treatments.

Nature of Social Phobia

There are a number of characteristics that may affect the psychological treatment of SP and make it a

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unique clinical challenge, including both diagnostic and nondiagnostic features. One important aspect of SP as a diagnostic entity is its dimensional severity. Ruscio (2010), for instance, has shown through taxometric analyses that the distinction between diagnosable SP and subclinical traits is a continuous dimension rather than discrete categorization, and that a dimensional severity rating outperformed categorical DSM-IV diagnosis in predicting outcomes and life events. This is important because if there is a dimension of social anxiety rather than discrete groups, we must infer that individuals diagnosed with SP comprise a widely variable group of individuals in terms of their symptomatic severity. Treatments for SP must therefore be applicable to patients at all levels of this severity continuum. In the case of SP, the severity continuum is also particularly broad, ranging from individuals who are somewhat too shy to perform at their desired level to individuals who rarely engage in any social activities and suffer severe functional impairments in occupation, education, or interpersonal life. In the DSM-IV-TR, the diagnosis of SP was also provided an additional indicator meant to capture some of the heterogeneity of presentations. Diagnosticians can assign the label "generalized" to describe those individuals whose negative self-evaluations and functional impairment occur across a broad range of environments and situations, which distinguishes them from persons whose fears are primarily or exclusively problematic in one domain (e.g., public speaking).

Several other clinical features are sometimes associated with SP and may influence treatment. One example is socially cued panic attacks. These panic attacks and similar somatic symptoms of anxiety are not uncommon, especially when self-reported (Hofmann, Ehlers, & Roth, 1995). Often, individuals whose social anxiety includes such strong somatic symptoms of anxiety (e.g., sweating, respiratory difficulty, racing heart) also develop fears regarding these symptoms themselves (Bögels & Reith, 1999). In some cases this may relate to more severe physiological symptoms of anxiety (and/or panic disorder), but in others these may more simply relate to increased anxiety about others' perception of these signs of anxiety rather than stronger symptoms per se (Gerlach, Wilhelm, Gruber, & Roth, 2001).

In cases of long-standing social anxiety, personality disorders are frequently comorbid. This is particularly true for avoidant personality disorder (APD), which shares phenomenology and behavioral patterns with generalized SP (e.g., avoidance of social situations, negative self-beliefs). Indeed, there have been some calls for the abolishment of one or both disorders from diagnostic systems because they so frequently overlap that they may describe the same phenomenon (e.g., Herbert, Hope, & Bellack, 1992). In some cases, comorbid APD may indicate a more entrenched, pervasive, severe, or chronic instance of SP (Hofmann, Newman, Becker, Taylor, & Roth, 1995; Hofmann, Newman, Ehlers, & Roth, 1995).

SP also has a pattern of comorbidity with other Axis I disorders that can have an impact on clinical presentation and treatment. As mentioned above, it is frequently comorbid with panic disorder and other anxiety disorders such as generalized anxiety disorder (Newman, Przeworski, Fisher, & Borkovec, 2010). In addition, it has a very high rate of comorbidity with major depressive disorders (Ruscio et al., 2007). This is understandable because both depression and SP share negative self-evaluations and some behavioral inhibition as diagnostic or clinical features as defined in the DSM. There is a relatively high rate of substance and alcohol abuse in people diagnosed with SP. Often this is due to a sense that alcohol or other drugs are relaxing, disinhibiting, or otherwise useful in social situations, which can lead to maladaptive reliance on these substances to enable social connection (Davidson, 2006).

Several nondiagnostic but potentially important risk factors and underlying processes of SP have been identified. One of the most predominant early theories of the cause of SP was deficient social skills. Indeed, persons with SP tend to report lower overall social competency than individuals without SP (Teachman, Goldfried, & Clerkin, in press). However, this reported deficiency seems to be much greater than the discrepancy actually observed or rated by others. That is, though people with SP believe themselves to be socially awkward and unlikeable, objective others as well as peers rate their level of social ability only slightly below healthy controls and sometimes as not below average at all (see, e.g., Davidson, 2006; Herbert et al., 1992). In addition, research on attentional biases has shown that individuals with SP show specific information processing tendencies to attend to negative cues in social situations at the expense of attending to the positive cues (Teachman et al., in press).

CBT for SP

There have been several decades of research to support the use of cognitive and behavioral techniques with SP. Some early treatments in the behavioral tradition focused on social skills deficits by providing additional social skills training (Linehan, Goldfried, & Goldfried, 1979) as well as other purely behavioral treatments (Newman, Hofmann, Trabert, Roth, & Taylor, 1994). As noted above, however, it is not clear that a defining feature of SP is lack of social skills. Though such direct social skills training

methods have been shown to be effective in many cases (e.g., Herbert et al., 2005), some authors have suggested that the mechanisms of action are largely cognitive (e.g., improved self-efficacy), or simple behavioral principles such as exposure (Emmelkamp, 2013). As such, social skills training is sometimes included as a behavioral treatment, though other forms of behavioral therapy may be directly or more specifically exposure-based. Exposure to feared social situations in SP, similar to exposure to other feared stimuli in other treatments, has been shown to be effective in reducing symptoms of social phobia (Emmelkamp; Feske & Chambless, 1995; Newman et al., 1994). Generally, exposures involve simulating particular interactions, such as meeting a new person, attending a party, or giving a speech. These simulations often require confederates—individuals unknown to the patient who can act as an audience or conversation partner. Other situations may require additional materials to be optimally simulated, such as a podium for public speaking fear.

Cognitive and cognitive-behavioral techniques have also been developed for use with SP (Hollon & Beck, 2013). Many of these techniques are directed at identifying and altering maladaptive thought processes during exposures or other behavioral techniques (as in the work of Clark et al., 2006, such as asking patients to view themselves in videos with and without safety behaviors), as well as independently of exposures. The focus of such treatment is often on the belief experienced by the persons with SP that they are fundamentally inadequate and will be seen as such by others in social situations (Turk, Heimberg, & Magee, 2008). These cognitive techniques, as in the treatment of such related disorders as depression and anxiety, often focus on evaluating personal evidence to change cognitions, producing testable hypotheses, and identifying cognitive errors.

There is good research evidence to support the use of behavioral and cognitive interventions in the treatment of SP. Meta-analyses have found treatment efficacy to be quite strong and often equivalent to the effect size of pharmacotherapies, especially after drug tapering has occurred (Acarturk, Cuijpers, van Straten, & de Graaf, 2009; Federoff & Taylor, 2001; Gould et al., 1997). Exposure in particular (whether alone or in conjunction with cognitive techniques) has received considerable empirical support, though the combination of various behavioral and cognitive techniques in treatment is overall optimal (Heimberg, 1989; Mattick & Peters, 1988; Mattick, Peters & Clarke, 1989).

Many modifications and extensions of CBT for SP have been developed. One important extension (if it can be considered this) is the use of group CBT, which has been demonstrated to be effective and transportable from research settings to clinical practice (McEvoy, Nathan, Rapee, & Campbell, 2012). Other additions and alternatives to standard CBT have included incorporation of mindfulness meditation and mindfulness-inspired techniques (e.g., Hofmann & Asmundson, 2008; Kocovski, Fleming, & Rector, 2009; Ossman, Wilson, Storaasli, & McNeill, 2006) as well as motivational interviewing and motivational enhancement techniques, especially in the early stages of treatment (e.g., Buckner, 2009; Westra & Dozois, 2006).

Despite the clearly established efficacy of CBT treatments for SP, it is not uniformly effective for all patients. Some patients improve without making a full recovery, others do not improve, and still others even deteriorate during treatment (though deterioration is rare, it does happen: Lincoln et al. (2003) reported deterioration rates ranging from 0–6.8% in a field trial, depending on the outcome measure used). Several specific difficulties in the application of CBT for SP have been noted informally in clinical trials and effectiveness studies, and treatment manuals (e.g., Hope, Heimberg, & Turk, 2010) often include some warnings to clinicians to be aware of these dangers when using CBT for SP. Among such problems is the failure to initiate treatment or to terminate prematurely. Exposure techniques have been linked to some increased risk of dropout, and group CBT treatments can be difficult to initiate, both for logistical reasons (such as scheduling large groups of people) and because people with SP may be hesitant to agree to a group setting for treatment, despite assurances of its efficacy. In addition, patients in treatment for SP may have difficulty with avoidance of therapy and therapy tasks, such as by missing sessions or not completing homework. Alternatively, patients' negative self-attributions may lead them to blame themselves for perceived treatment failures, making progress difficult and/or slower than necessary (Turk et al., 2008). These potential problems may represent threats to the utility of CBT for SP if they cannot be resolved in the context of applied practice.

The Present Study

As part of an effort to involve practicing clinicians in uncovering variables that may undermine the clinical effectiveness of CBT for SP, the present study was designed to survey psychotherapists who have used CBT to treat SP, seeking their experience of the types of interventions they use as well as the particular problems that they encounter when applying CBT in practice. This effort, described in Goldfried et al. (2014–this issue), serves as a "two-way bridge" between research and practice: by collecting and disseminating practitioners' difficulties with CBT for

SP, researchers may then be able to study and improve this treatment for use in the community.

Method

INSTRUMENTS

The general survey methods are described in Goldfried et al. (2014). To develop the current survey, the initial survey described by Wolf and Goldfried (2014) was revised to address SP rather than panic disorder, retaining the overall structure of that survey including the section headings and prompt stems. Emphasis was placed on identifying features unique to SP that might impact treatment adversely. Where additions were made, these were based on treatment manuals of CBT for social phobia (Hope et al., 2010; Kelly, 1982), research literature on SP. An initial draft of the survey was provided to a panel of experts on SP and its treatment (Martin Antony, David Fresco, Joann Galst, Richard Heimberg, Stephen Holland, Jeffrey Magnavita, Douglas Mennin, Michelle Newman, Linda Sobell, and Bethany Teachman). This panel, some of whom had been aware of the panic disorder survey already, provided feedback on survey design and additional variables that might be important to include related to SP. One significant departure from the panic disorder survey was the inclusion of demographic variables at the beginning of the survey rather than the end.

The final survey consisted of basic demographic items, one section of questions related to the techniques typically used in CBT to treat SP, and eight sections specifically focused on barriers to treatment efficacy: (1) patient's symptoms related to SP; (2) other patient problems or characteristics; (3) patient expectations; (4) patient beliefs about SP; (5) patient motivation; (6) social system (home, work, other); (7) problems/limitations associated with the CBT intervention method; and (8) therapy relationship issues. Each of these sections was introduced with the following instructions: "Indicate those variables you have observed in your clinical work using CBT to treat Social Phobia that limit successful symptom reduction," and each option was presented as a check-box, so that participants indicated whether they had experienced the particular barrier as limiting successful treatment or not. The survey required roughly 10 minutes to complete.

PARTICIPANTS

The request for participants was posted on the following U.S. listservs and websites: Association for Behavioral and Cognitive Therapies; Society for Psychotherapy Research; Society for the Exploration of Psychotherapy Integration; and American Psychological Association Divisions 12 (Clinical Psychology), 17 (Counseling Psychology), 29 (Psychotherapy), and 42 (Psychologists in Private Practice). In addition, requests were made on several English-speaking listservs throughout the world (e.g., Canada, UK, Australia). Because the total number of potential participants contacted is unknown, no survey response/nonresponse statistics are available. At the end of data collection, there were 303 respondents to this survey, 276 (91.1%) of whom completed the survey to the end. Tests of significant differences (chi-square or *t*-tests) were conducted to determine whether completers differed from noncompleters on demographic and experience variable.

Of the completers, 60.9% (168) were female, and their ages ranged from 23 to 75 years (mean = 42 years). The majority of completers (59.1%, 163) had a Ph.D. in clinical psychology, 38 (13.8%) were current graduate students, 21 (7.6%) had an M.S. in Clinical Psychology, 13 (4.7%) had a Psy.D., with other levels of training accounting for less than 5% of the total sample each. Participants were allowed to endorse more than one typical clinical setting. Of the options, 172 respondents reported treating SP patients in outpatient clinics, 147 reported being in private practice, 25 reported counseling center, and 17 reported working in an inpatient unit. The respondents ranged from 0 to 50 years since receiving their highest degree, with a mean of 12 years and a median of 8 years. There were no significant overall differences between completers and noncompleters in highest degree achieved. However, study noncompleters were significantly more likely to be female (16 of 19) than the completers, χ^2 (1) = 3.92, p = .048. Age was not significantly different between completers and noncompleters (t = -0.19, p = .85), nor was race/ethnicity, χ^2 (5) = 2.01, p = .85, nor highest degree completed, χ^2 (16) = 18.41, p = .30. Additional information regarding the sample's experience is presented in Table 1.

Question-wise completion rates (defined as the percent of individuals endorsing at least one item on each question) ranged from 46.2% for the question regarding therapeutic alliance to 99.0% for the question regarding therapeutic experience. However, it should be noted that the therapeutic alliance question seemed to elicit an unusually low completion rate (perhaps reflecting a low number of respondents who see these as particularly problematic issues), as all other questions had response rates above 75%, and most were above 85%.

The survey respondents were largely cognitive and behavioral in their overall treatment orientation. On average, behavioral orientation was endorsed by respondents as 46.4% of their practice, and cognitive orientation was reported at 41.0%. Though other orientations (psychodynamic, experiential/humanistic, family/systems, and other) were endorsed, these were

Table 1
Therapist Experience Levels

	Completers	Non-Completers			
	% (*n*)	% (*n*)	χ^2	*df*	*p*
Highest degree completed			16.44	12	.17
Ph.D. in clinical psychology	59.1 (163)	40.7 (11)			
Ph.D. in counseling psychology	1.8 (5)	3.7 (1)			
Ph.D. in educational psychology	1.1 (3)	0 (0)			
Ph.D. in social work	0.4 (1)	3.7 (1)			
Psy.D.	4.7 (13)	11.1 (3)			
M.D.	1.4 (4)	0 (0)			
Ed.D.	0.7 (2)	0 (0)			
M.S.W.	1.8 (5)	0 (0)			
MSc	4.7 (13)	3.7 (1)			
MA/MS in counseling psychology	1.8 (5)	7.4 (2)			
MS in Clinical Psychology	7.2 (20)	3.7 (1)			
Current graduate student	10.1 (28)	22.2 (6)			
Other	5.1 (14)	3.7 (1)			
Training in CBT for SP					
Graduate school	72.1 (199)	51.9 (14)	4.83	1	.03
Books, journals, videos	60.9 (168)	33.3 (9)	7.68	1	.01
Workshops	44.2 (122)	37.0 (10)	.51	1	.47
Postdoctoral experience	39.9 (110)	14.8 (4)	6.57	1	.01
Internship	42.0 (116)	29.6 (8)	1.56	1	.21
Peer supervision	33.7 (97)	14.8 (4)	.43	1	.05
Number of Social Phobia patients treated			4.76	6	.58
Less than 10	20.1 (55)	33.3 (8)			
10 to 20	24.5 (67)	20.8 (5)			
21 to 30	12.0 (33)	16.7 (4)			
31 to 40	8.8 (24)	4.2 (1)			
41 to 50	7.3 (20)	0 (0)			
51 to 100	12.0 (33)	12.5 (3)			
Over 100	15.3 (42)	12.5 (3)			
Years of experience conducting psychotherapy			4.60	6	.60
Less than 5	19.9 (55)	21.7 (5)			
5 to 10	27.2 (75)	30.4 (7)			
11 to 15	19.9 (55)	8.7 (2)			
16 to 20	12.7 (23)	13.0 (3)			
21 to 30	12.8 (35)	8.7 (2)			
31 to 40	8.3 (23)	17.4 (4)			
Over 40	1.8 (5)	0 (0)			

much smaller influences on the respondents (7.3–10.6%). The medians and modes of these distributions were more heavily skewed towards behavioral and cognitive orientations than were the means.

Results

Respondents' endorsements of the different techniques they used in the treatment of SP are displayed in Table 2. It is notable that there were a set of techniques that may be considered "core" techniques as they were endorsed by over 80% of respondents. Among these were psychoeducation, cognitive restructuring, and assigning behavioral homework. The vast majority also reported typically using individual therapy. Many therapists reported using behavioral interventions, including developing a fear/avoidance hierarchy, in-session exposures, focusing on behavior in social situations, and specifically focusing on behavioral avoidance. Specifically, cognitive homework (interventions focused on exploring or altering attributions or cognitions) was also endorsed by more than 80% of the sample, though it was less common than behavioral homework. Among the least frequently endorsed techniques were group therapy, motivational enhancement, mindfulness or acceptance-based strategies, communication training, relaxation training, and self-help readings. All of these were endorsed by less than half the respondents. However, none of these interventions were entirely uncommon, suggesting that they are still

Table 2
Techniques Typically Used in Conducting CBT for Social Phobia

	%	n
Psychoeducation regarding social anxiety	99.6%	275
Assigning out-of-session behavioral exposure homework	94.6%	261
Cognitive restructuring of negative beliefs regarding social situations and other people	93.8%	259
Focus on behavioral avoidance	92.0%	254
Individual therapy	92.0%	254
Developing a fear/avoidance hierarchy	90.9%	251
Cognitive restructuring of negative beliefs about self	90.6%	250
Focus on behavior in social situations	88.8%	245
Cognitive restructuring of negative evaluations after social interaction	88.4%	244
In-session exposure to social situations (e.g., role-play rehearsals)	88.4%	244
Assigning out-of-session cognitive homework	83.7%	231
Focus on relevant in-session behavior (e.g., eye contact, quiet voice, other social skill deficits)	73.2%	202
Focus on attentional bias toward external threat cues in social interactions (e.g., other person's expression)	64.5%	178
Focus on emotions in social situations	63.4%	175
Instructions to develop external, rather than self-focused attention during social interactions	60.1%	166
Social skills training	58.3%	161
Helping patient understand developmental roots of social anxiety	56.2%	155
Using feedback from others about client's social behavior	55.8%	154
Assertiveness training	55.8%	154
Self-help readings	46.0%	127
Relaxation training	44.9%	124
Mindfulness or acceptance-based strategies	43.5%	120
Communication training	39.9%	110
Group therapy	38.8%	107
Motivational enhancement	36.2%	100

important parts of many therapists' implementation of CBT for SP.

The frequencies of responses reporting perceived barriers to progress due to patient symptoms related to SP are reported in Table 3. A majority of respondents indicated that there were three features of SP that made change more difficult: severity, chronicity, and poor social skills. The least reported barrier to treatment was public speaking fear. Most other features were not endorsed by many participants, suggesting that few CBT therapists find these characteristics of SP to be barriers to successful treatment.

The findings regarding other patient characteristics that created barriers to successful treatment are reported in Table 4. Overall, none of these characteristics were identified by a large majority of the sample, but the most common characteristics that caused problems included resistance to the directiveness of the treatment, inability to work independently between

Table 3
Perceived Barriers to Treatment Progress Due to Symptoms Related to Social Phobia

	%	n
Severity	63.8%	176
Chronicity	62.3%	172
Poor social skills	56.5%	156
Functional impairment	34.8%	96
Generalized to many social situations	31.5%	87
Fear of rejection	21.9%	58
Attentional or information-processing bias toward negative information in social situations	19.6%	54
Panic attacks	17.8%	49
Fear of scrutiny by others (e.g., while eating, signing name)	16.7%	46
Believe that they will appear anxious in social situations	14.1%	39
Public speaking fear	5.4%	15

Table 4
Perceived Barriers to Treatment Progress Due to Other Patient Characteristics

	%	n
Resistance to directiveness of treatment (e.g., noncompliance with behavioral homework)	56.5%	156
Inability to work independently between sessions	55.4%	153
Avoidant personality disorder	50.7%	140
Premorbid functioning is limited	49.6%	137
Poor interpersonal skills	48.2%	133
Depressed mood/mood disorder	47.8%	132
Chaotic lifestyle	42.0%	116
Other personality disorder	42.0%	116
Substance abuse	41.7%	115
Inflexible cognitive style	40.2%	111
Perfectionistic/obsessive style	36.2%	100
Low self-esteem/self-efficacy	31.5%	87
Dependency/unassertiveness	29.3%	81
Intellectual/cognitive/introspective ability is limited	28.3%	78
Fear of exposure and associated emotional reactions	27.5%	76
Inability to identify automatic thoughts	20.3%	56
Problems with medications (e.g., insufficient dosage, frequently changes dose during treatment)	17.0%	47
Inability to identify emotions	12.7%	35
Low socioeconomic status	10.9%	30
Physical problems	8.3%	23
Diversity issues associated with ethnicity/race/sexual orientation	2.5%	7

sessions, the diagnosis of APD, limited premorbid functioning, poor interpersonal skills, and depressed mood. Interestingly, several of the commonly endorsed items related to comorbid conditions. The least frequently endorsed problems were patient diversity in ethnicity, race, or sexual orientation; physical problems; low socioeconomic status, and inability to identify emotions.

The findings of perceived barriers to progress due to patient expectations are reported in Table 5. The most common response in this category, which was endorsed by roughly one half of the participants, was patients' expectations that the therapist will do all the work to make things better. Pessimism regarding therapy was also very frequently identified as a barrier to treatment success. The least common endorsement was the patient believing that symptom reduction is not enough; that is, most therapists said that patients wanting more from therapy than symptom reduction did not pose a problem to treatment efficacy.

The reported responses to perceived barriers to progress associated with patients' specific beliefs about SP are reported in Table 5. The two most commonly cited problematic beliefs were that the fears are realistic (rather than exaggerated, say), and that the social anxiety is part of their personality. These two responses share much in common with a sense of pessimism for treatment and entrenchment of symptoms, which were noted as well. Few participants noted any other problematic patient

Table 5
Perceived Barriers to Treatment Progress Due to Patient Expectations, Patient Beliefs About Social Phobia, Patient Motivation, Patient's Social System, and Therapy Relationship Issues

	%	n
Perceived barriers to treatment progress due to patient expectations		
Therapist will do all the work to make things better	51.4%	142
Pessimism about therapy (due, for example, to disappointment with past therapy)	47.5%	131
Successful socializing means not having any anxiety	38.0%	105
They will be free of all social anxiety and/or will become very social	37.7%	104
They need medication to reduce anxiety	31.2%	86
Treatment will be brief and easy	22.8%	63
Symptom reduction is not enough	12.7%	35
Perceived barriers to treatment progress due to patient beliefs about Social Phobia.		
Belief that their fears are realistic (e.g., people really are usually judging them negatively)	51.8%	143
Being socially anxious is part of their personality and inherently unchangeable	45.7%	126
Their problems are due to external factors (e.g., situation, other people)	25.7%	71
Being anxious is abnormal/dangerous	22.8%	63
Social phobia is biologically based	16.7%	46
Belief that loss of vigilance/anxiety will have negative impact on relationships(s)	15.6%	43
Perceived barriers to treatment progress due to patient motivation		
Minimal motivation at outset	60.5%	167
Premature termination	57.2%	158
Motivation decreased as patient attributes gains to medications	26.1%	72
Motivation decreased as some improvement occurs	16.3%	45
Motivation decreased as understanding of social phobia develops	9.1%	25
Perceived barriers to treatment progress due to the patient's social system		
Social isolation of patient	61.6%	170
Symptoms/dependency is reinforced/supported	51.4%	142
Trapped in a dysfunctional home, work, or social situation	46.4%	128
Family is controlling and critical	38.8%	107
Stress very high at home or school/work	38.0%	105
Lack of time due to other commitments	34.8%	96
Family does not support treatment	33.3%	92
Family members are very anxious	33.0%	91
Loss of family member, partner, employment	10.1%	28
Perceived barriers to treatment progress due to therapy relationship issues		
Therapy alliance not strong enough	30.4%	84
Patient doesn't feel his/her distress is sufficiently understood/validated	21.7%	60
Therapist's frustration with progress	17.4%	48
Therapist's negative feelings toward patient	12.0%	33

beliefs about SP, suggesting that therapists feel that they are able to be helpful to patients who enter treatment with those beliefs or that these beliefs are not common enough to be major factors.

The frequencies of responses to perceived barriers to progress due to patient motivation are reported in Table 5. The two major problems identified were minimal motivation at outset and premature termination, both identified by over half of participants. The other options in this section indicated that motivation decreased over the course of therapy due to various reasons, and these responses were selected by a minority of participants. Of these, the most commonly identified barrier was when motivation decreases due to attribution of gains to medication.

The results regarding how the patient's social system (home, work, other) influenced symptom reduction are reported in Table 5. Problematic social systems can be characterized in several ways, and the responses suggest that several different social dynamics may be difficult for CBT in the context of SP. The most common response was that the patient is socially isolated, and the next most common endorsement was that the patient's social network reinforced or supported their symptoms/dependency. Many of the remaining responses, all of which are somewhat distinct, were endorsed at similar frequencies to one another, suggesting that there are many ways that a patient's social system can complicate or impede CBT for SP. The only response endorsed by fewer than 30% of the sample was the loss of a family member, partner, or employment.

The frequencies of responses to perceived barriers to progress due to therapy relationship issues are reported in Table 5. Close to a third of the participants reported that a weak alliance was a barrier to treatment success. Also, nearly a quarter reported that their patients' feeling that they didn't sufficiently understand/validate his/her distress interfered with the treatment. Athough they were endorsed at relatively low levels, two items related to therapists' negative feelings toward patients and frustration with progress were each endorsed as being problematic by several participants.

The survey results associated with how the CBT intervention itself may limit successful treatment are reported in Table 6. Overall, these were some of the least-endorsed options on the entire survey. There were three options that had notable response rates (over 30%), while many of the options did not generate many endorsements among participants. The three most commonly reported limitations were that in vivo exposures have logistical problems, simulating anxiety-provoking situations in session is difficult, and that the treatment does not deal with comorbid problems/symptoms. The other options were endorsed at low rates, though each item was endorsed by at least a few participants.

Table 6
Perceived Barriers to Treatment Progress Due to Problems/Limitations Associated With the CBT Intervention Method

	%	n
Exposure in vivo has logistical problems	38.4%	106
Simulating anxiety-provoking situations in session is difficult	34.8%	96
Doesn't deal with comorbid problems/symptoms	33.3%	92
Strict adherence to CBT protocol	19.6%	54
Absence of guidelines for dealing with resistance/noncompliance	19.2%	53
Doesn't provide sufficient "dose" of behavioral exposure	18.5%	51
Relaxation doesn't work or causes anxiety	18.1%	50
Not enough time for patient to respond to treatment within the time frame of a CBT manual (if using a manual in regular practice)	17.8%	49
Doesn't deal with linking social anxiety to other clinical problems	17.0%	47
Doesn't deal with patient's anger	13.4%	37
Treatment is too directive	11.2%	31
Too much time spent lecturing/psychoeducation	9.8%	27
Assigned too much homework	9.4%	26
Patient not sufficiently socialized to treatment model	9.1%	25
Doesn't deal with fear of interpersonal loss	8.0%	22
Triggers for social anxiety are not linked to past	7.2%	20
Current coping skills are not linked to past	6.9%	19
Doesn't deal with comprehensive or lasting change	6.5%	18
Felt uncomfortable with patient's extreme anxiety, possibly sought to decrease the anxiety	3.3%	9

On average, the survey respondents reported 77.6% (*SD* = 14.2) success in reduction of symptoms with CBT for SP. In addition, the respondents reported that, on average, 47.0% (*SD* = 27.7) of patients seen were also taking prescription pharmacological treatments.

Discussion

The main objective of this study was to document CBT for SP as it is practiced in the field, and to use therapists' experience of applying CBT in their practice to identify potential barriers to successful treatment. It should be noted that the success rate reported by respondents (77.6%) is quite high in treating SP. This in and of itself suggests that most survey participants find CBT for SP to be largely efficacious—a promising result for the dissemination of CBT for SP. However, because it is a simple self-report and retrospective assessment, this figure may be an overestimate of actual treatment success in

the community, and no objective assessment is possible in this data. Even if it is not perfectly accurate, however, the other results of the survey should be interpreted within the context of this reported success rate, since it suggests that the respondents to this survey are either quite good at CBT for SP (and are reporting their success accurately) or are likely to feel more positively about this treatment than other therapists (and therefore may have unintentionally reported an inflated success rate).

Nevertheless, the survey results suggest some potential barriers to successful treatment. Possible challenges to the effectiveness of this empirically supported treatment involve issues related to patient characteristics (including symptoms, expectations and beliefs, motivation for treatment, and social system factors), as well as problems related to techniques and relationship issues in CBT. Based on these potential barriers, a number of clinical implications and future research directions are suggested.

It is important to consider some more descriptive information about this sample before deriving any tentative conclusions from the data. Overall, this sample self-identified as primarily cognitive and behavioral, suggesting that their responses represent professionals who are most likely to practice CBT for SP, and may have specific graduate experience in CBT as well. In addition, this sample was fairly skewed towards individuals who had completed or may be in the process of completing a Ph.D. in Clinical Psychology, among the most research-oriented psychological degrees available in the American educational system. This suggests that this is not nearly a representative sample of practicing psychotherapists in the United States, but rather, an especially CBT-oriented group of practicing psychotherapists. The sample was not well representative of other practicing therapists, such as M.S.W. holders, which is a limitation. Based on these sample characteristics, the results of the survey should be interpreted to be the feedback of people who may be more supportive of CBT than therapists who view their work through the lenses of other approaches.

Although participants were relatively homogeneous in terms of their personal theoretical orientation, and to a lesser extent, in degree level, they were relatively heterogeneous in terms of their experience conducting psychotherapy and in the number of SP patients treated. While a fifth of the sample had treated fewer than 10 patients with SP, more than half of the participants had treated more than 20, and a substantial minority (15.2%) had treated over 100. Similarly, a fifth of the sample had less than 5 years of psychotherapy experience, but over half had more than 10 years and nearly a quarter reported having greater than 20 years of experience. This distribution of clinical experience in general may suggest that the participants reflect a good cross-section of practicing CBT clinicians in terms of experience. If not representative of the total population of psychotherapists, they at least have some representation across levels of experience.

Respondents' report of the techniques they used in CBT for SP revealed that some interventions and strategies are much more common than others. Almost every participant endorsed employing psychoeducation as a part of treatment, making this the most ubiquitous technique. In addition, several of the most frequently researched and empirically supported techniques in treating SP were very common (over 80% reported using them): cognitive restructuring and various behavioral techniques such as in-session exposure and behavioral homework. This strongly suggests that these core elements of CBT for SP are, at least in some ways, being successfully disseminated to practice settings. Though there are going to continue to be obstacles to dissemination, it is clear that CBT for SP is not exclusively available in research contexts.

However, some techniques were much less common, including motivational enhancement and group therapy, which were the least-endorsed techniques, and each of which was endorsed by fewer than 40% of respondents. In the case of these techniques, this may represent a true failure of dissemination, as a substantial body of research has examined motivation enhancement techniques and group CBT interventions specifically in the SP and anxiety disorders, often finding that these techniques or strategies are beneficial and/or cost-effective additions to standard individual CBT for SP (e.g., Gould et al., 1997; Westra & Dozois, 2006). The variability in responses to the technique items suggests that not all therapists conduct CBT for SP in the same way. Indeed, it may suggest that there is significant heterogeneity in practice, even among this highly CBT and research-oriented sample.

One potentially meaningful difference was that 63.4% of participants reported focusing on emotions in social situations. Given that anxiety is itself an emotion, this may seem to be a counterintuitively low number of responders. However, it can be inferred from this that, while any CBT will focus on anxiety in social situations, some therapists may go beyond this to examine other emotions or the feelings of anxiety in greater depth than others. Though CBT therapists in general tend to focus less on emotion than psychodynamic therapists (Blagys & Hilsenroth, 2002, 2006), at least some evidence suggests that when they do, it is associated with better outcomes in treatment of other disorders (e.g., Castonguay,

Goldfried, Wiser, Raue, & Hayes, 1996; Coombs, Coleman, & Jones, 2002). Future research could examine the context of emotion focus in CBT for SP, describing this differential focus on anxiety and its relationship with outcome.

In addition, some of the techniques investigated here have been found to be empirically associated with better outcomes in RCTs, while others have not found as much support, leading to further questions. In a review, Ponniah and Hollon (2008) found that although CBT had consistent and specific efficacy in the treatment of SP (including when CBT encompassed techniques related to social skills training combined with cognitive restructuring), RCTs that examined social skills training as a stand-alone therapy (i.e., without cognitive restructuring) found that it had little support. While participants reported using social skills training, this survey does not allow us to know whether they were using these techniques as a stand-alone protocol or as an adjunct to a broader CBT treatment. In addition, in CBT, as in any form of psychotherapy, the therapist must tailor treatment to a certain degree to the idiographic needs and case formulation of the particular client. Thus, in certain ways it should be expected that some techniques supported with research would be less common in practice simply because therapists determine that they are not necessary. This would not be viewed as a challenge of dissemination if it were the case. Future research is thus needed to better understand how CBT interventions are implemented in naturalistic settings.

Considering the defining characteristics of SP described earlier in this article, some of the potential challenges identified are not surprising. Among them is the fact that the vast majority of this sample of participants identified SP symptom severity and chronicity as barriers to successful treatment. This finding is in line with the previous research indicating that more severe cases, especially among depressed and anxious populations, may require more intense, longer, or more specific treatments (e.g., Driessen, Cuijpers, Hollon, & Dekker, 2010; Fournier et al., 2010; Hofmann, Newman, Becker, Taylor, & Roth, 1995; Newman, Crits-Christoph, Gibbons, & Erickson, 2006). As noted earlier, there exists considerable variability of symptom severity associated with SP under current diagnostic systems. For instance, while SP can account for specific public speaking fears without other difficulties, it can also describe individuals who go without meaningful social contact of any kind due to anxiety. A related finding from this study was that only 5.4% of respondents indicated that public speaking fear was associated with difficulty in treatment, suggesting that the vast majority of therapists find this particular problem to be relatively easier to treat. Perhaps CBT (and other treatments for SP) could benefit from more explicit flexibility in treatment approach based on severity level and symptom types—for instance, by lengthening some modules of CBT for especially severe and generalized SP. Likewise, chronicity of symptoms may play an important role in SP, given the variability in symptom duration afforded by the DSM-IV-TR diagnosis (for adults there is no minimum duration of symptom presence in the DSM-IV-TR), as does SP's close relationship with personality constructs of introversion and shyness, as well as with APD. SP also tends to be more chronic than some anxiety disorders, with only 31% of patients experiencing remission of symptoms during one 8-year study (Yonkers, Bruce, Dyck, & Keller, 2003). One potential way to resolve these issues would be to incorporate assessment of severity and chronicity of SP explicitly in RCTs of CBT, similar to the way that severity and recurrence of major depressive episodes is frequently used in diagnosis and research.

More than half of the sample identified patient resistance to directiveness of CBT, and perhaps relatedly, patients' inability to work independently between sessions as barriers to treatment success. This suggests that many therapists feel that CBT treatment protocols with which they are familiar do not contain sufficient recommendations for clinical problem solving when the patient is resistant to treatment directiveness. Though some of this may overlap with patient motivation (discussed below), resistance to directiveness has also been identified as an important patient characteristic. Beutler, Harwood, Michelson, Song, and Holman (2011) conducted a meta-analysis across disorders in which they found that therapist directiveness predicted worse outcome when patient resistance/reactance (measured before treatment) was high. These authors suggested that tailoring treatment directiveness based on this patient characteristic would be potentially helpful. This does not necessarily mean the CBT cannot be used successfully when patients are generally resistant, but rather that therapists may need to make some accommodation in their therapeutic style, such as giving more control to the patient about the type and/or pace of interventions during sessions (see Castonguay, 2000; Goldfried & Castonguay, 1993). Perhaps CBT manuals and training programs could identify better ways for CBT therapists to make such accommodations when confronted with individual differences in patients.

Patient expectations were also viewed by practicing clinicians as important potential barriers. In particular, the belief that the therapist will do all of the work to make the patient better was viewed as

problematic. However, expectancy/credibility in CBT has been shown to partially mediate the effect of baseline GAD symptom severity (Newman & Fisher, 2010), perhaps showing that the patient can play an active role in therapeutic process and outcome. Though research and practice on role-induction seems to have waned in recent years, such preparatory sessions for therapy designed to assist patients with better understanding the tasks and goals of psychotherapy have been shown to better orient patients to their responsibilities for treatment, and to have robust effects on treatment outcome (Orlinsky, Rønnestad, & Willutzki, 2004). Perhaps returning to such a preparatory perspective early in CBT would be beneficial. Diminished outcome expectation (pessimism about therapy) was also identified by a large part of this sample as an important barrier to treatment success. This has been identified as a common factor across psychotherapies and disorders, and a recent meta-analysis found a significant effect (Constantino, Arnkoff, Glass, Ametrano, & Smith, 2011). Since promising results have been obtained in the treatment of other disorders (e.g., Constantino, Klein, Smith-Hansen, & Greenberg, 2009; Newman & Fisher, 2010), research needs to be conducted to directly determine if expectation-enhancing techniques can be beneficial in CBT for SP.

One common problematic patient belief identified in this sample was that their fears are realistic. In such cases, a patient may actually believe that the amount of anxiety they experience is appropriate, that others are truly and frequently negatively evaluating them, that other people's opinions of them can have catastrophic consequences. It is possible that in such cases the initial psychoeducation segments of CBT may not be sufficient to convince patients of the validity of the CBT model, which would make virtually all subsequent work difficult. When faced with this issue, the best suggestion may well be for the therapist to adopt Linehan's (1993) dictum of finding a balance between validation and acceptance of their patient's fears with encouragement to change. If these patients do not seriously question the veracity of their beliefs, they are less likely to desire to engage in behavioral experiments. But while such refusal to engage in a core task of CBT can engender disputes or arguments between patients and therapists, so can a therapist's inflexible attempt to convince a patient of the validity of his/her therapeutic rationale (see Castonguay et al., 1996). Research informs us that even when such negative processes are short-lived in therapy, they can have negative impacts on therapy outcome (Ablon & Jones, 1999; Binder & Strupp, 1997; Henry, Strupp, Butler, Schacht, & Binder, 1993). Fortunately, research also suggests that the use of experiential and interpersonal techniques (see Safran & Muran, 2000) can help address such relationship problems in CBT (Castonguay et al., 2004; Constantino et al., 2008; Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008; Newman et al., 2011).

In this sample, approximately 60% of therapists identified that when patient motivation at treatment outset was low, CBT could be less successful. This is consistent with the body of literature suggesting that patient readiness for change at pretreatment is a predictor of treatment outcome (Norcross, Krebs, & Prochaska, 2011). These results suggest that clinicians might find it helpful to supplement their technical repertoire of CBT for SP with additional tools to help in this circumstance. Motivational interviewing (MI; Miller & Rollnick, 2002) is a group of techniques that have been developed with the primary aim of enhancing patients' intrinsic motivation for change. Though not a panacea, when applied to specific treatments, MI sessions (sometimes called motivational enhancement) have been found to have some benefit to treatment outcomes in anxiety disorders (Westra & Dozois, 2008). While some treatment protocols have already recommended that these methods be incorporated into treatment (e.g., Hope et al., 2010), this has been a relatively recent development. Perhaps training programs and treatment manuals in CBT for SP—and the clinical trials that use them—would be enhanced with even further focus on strategies and techniques for improving motivation for change when clients do not present with strong motivation.

The patient's social system was identified as potentially challenging in several different ways, including social isolation, overdependence, and others. Isolation may be problematic in CBT for SP because initiating new social connections is more difficult than examining ongoing relationships in therapy, and creates more barriers to generalization of skills than when the patient has some ongoing social contact. On the other hand, an overly dependent social role suggests an enmeshment of social ties, reducing opportunities for the patient to ever be exposed to essential social anxiety long enough. The diversity of responses in this section suggests that the patient's social system can be problematic in several ways when conducting CBT for SP. Perhaps one technique that may be universally applicable, therefore, is to complete a thorough functional analysis of patients' social systems at the start of treatment. Doing so may well reveal potential problems in advance, even if it would not provide a guideline for therapists on what will be helpful.

Perhaps this would be an excellent opportunity for clinical case information from treatment failures, as called for by Dimidjian and Hollon (2011), because lessons from similar cases may be helpful to clinicians working with particular patients.

The primary barriers associated with CBT itself that were identified in this sample were that in vivo exposures have logistical problems, simulating anxiety-provoking situations in session is difficult, and that the treatment does not deal with comorbid problems/symptoms. The first two options are quite similar, reflecting difficulty of implementing CBT techniques in real-world practice. This may be especially the case when therapists are not specialists in anxiety disorders but rather conduct general practices, so their offices may not be set up in such a way to easily facilitate necessary exposures (such as mock public speaking events or parties). The fact that participants also identified the lack of specific treatment accommodations for comorbidity within CBT for SP is important for two reasons: first, because the symptoms of SP are often comorbid with other Axis I and Axis II disorders, and second, because participants also identified various comorbid conditions that were barriers to treatment in other sections of the survey. Essentially, participants reported that comorbidity is an important barrier to success in CBT for SP, and that the CBT intervention method did not adequately address it. While counter evidence exists (i.e., treatment for primary concerns using CBT seems to simultaneously improve comorbid conditions, in some cases even more than focusing on comorbid conditions; Craske et al., 2007; Newman et al., 2010), perception of clinicians practicing CBT seems to suggest that comorbidity remains a serious barrier to treatment success. Additional work to understand this pattern is likely required.

Therapy relationship issues, it should be noted, were not identified as much as other variables in limiting the successful use of CBT in treating SP. This suggests that, in general, CBT therapists find it relatively easy to establish alliance with SP patients, and rarely do relationship problems create barriers to treatment outcome. Still, the alliance in particular was indicated as a potential barrier by close to one third of participants. It is important to remember that the alliance has been found to be related to positive in-session processes in CBT for SP (Hayes, Hope, VanDyke, & Heimberg, 2007), so though alliance difficulties may not be frequent, they still remain clinically important. Negative reactions to patients on the part of the therapist, either due to frustration with the pace of progress or other reasons, though not overwhelmingly common, were reported by several therapists in this study. As noted by Dimidjian and Hollon (2011), one likely difficulty in studying treatment failure may be the reluctance on the part of therapists to discuss failures due to embarrassment, fear, or discouragement. It is possible that the minority of therapists in this sample who endorsed these experiences is actually an underestimate, as some other participants may have been reluctant to discuss this issue. Indeed, there is an increasing amount of scholarship on this subject, suggesting that negative reaction on the part of therapists toward their patients is often underreported (e.g., Wolf, Goldfried, & Muran, 2013).

As mentioned above, although CBT has empirically been found to be effective in treating SP (e.g., Acarturk et al., 2009), the present study can help to identify some possible ways that treatment failures can occur. Dimidjian and Hollon (2010, 2011) have identified treatment failures in ESTs as an important area requiring further study; the authors recommended collecting clinical feedback from actual practice as an important way of improving clinical effectiveness. In this study, the barriers to successful treatment may constitute just such important feedback. As such, this study demonstrates an ongoing and potentially fruitful feedback system from practicing psychotherapists to researchers in the field. The results suggest several potentially valuable areas for researchers to target in the future in order to improve CBT for SP as it is practiced in the field. In particular, studies involving the most severe and chronic cases of SP, application and dissemination of motivational interviewing or other techniques to improve patient motivation and reduce resistance to directiveness, explorations of different social system dynamics in patients' lives, and ways to reduce logistical difficulties of CBT treatment may be valuable. In addition, other efforts to further survey clinical practitioners and more objectively monitor and assess services provided may be useful to gain more confidence in the responses found in this study.

Conflict of Interest Statement

The authors declare that there are no conflicts of interest.

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