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Videotaped experiments to drop safety behaviors and self-focused attention for patients with social anxiety disorder: Do they change subjective and objective evaluations of anxiety and performance?

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ABSTRACT

Safety behavior (SB) and self-focused attention (SFA) have been posited as important maintenance factors in the cognitive model of social anxiety disorder (SAD). The present study reports the results of experiments to drop SB and SFA among clinically diagnosed patients with SAD employing their own idiosyncratic anxiety-provoking situations. The ratings for observable anxiety, belief in feared outcome and overall performance were better for role plays without SB and SFA than for role plays with them. The degree of drop in SFA predicted drop in observable anxiety and belief in feared outcome. Dropping SB and SFA, however, was unable to completely correct the cognitive distortion because the subjective ratings were still significantly worse than the objective ratings.

1. Introduction

Although cognitive-behavior therapy (CBT) has been shown to be more effective for social anxiety disorder (SAD) than control treatments, some patients do not benefit from it and many remain

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symptomatic (Rodebaugh, Holaway, & Heimberg, 2004; Zaider & Heimberg, 2003). The past decade has however seen significant progress in the theories and treatments that specifically target the maintaining factors in SAD (Clark, 2001). One of these newly introduced procedures is the so-called experiment to drop safety behavior (SB) and self-focused attention (SFA) (Clark et al., 2003).

Safety behaviors refer to systematic behavioral and cognitive strategies that are intended to prevent the feared outcomes, such as showing symptoms of anxiety, performing poorly in the public and being negatively evaluated by others in the case of SAD patients, from becoming true (Salkovskis, 1991). Typical examples of SB in SAD include sitting in the corner of a room during recess time to avoid drawing attention to oneself, lowering one's head to prevent an anxious expression from being seen by others, gripping glasses and cups tightly with both hands to prevent shaking, or mentally rehearsing sentences to reduce the chance of stumbling over one's words. As Clark and Wells (Clark & Wells, 1995; Wells et al., 1995) have pointed out, SBs are problematic in three respects. First, SBs increase self-monitoring and SFA and are by themselves likely to increase social anxiety. Second, performing SBs prevents the patient from learning that most of their feared outcomes do not happen in reality. Third, SBs often paradoxically increase the likelihood of the feared outcomes. For example, gripping tightly onto the glass is likely to increase the chance of hand trembling; wearing thick clothes to prevent sweating to be noticed by others would increase sweating; or speaking only a little and/or in a soft voice in social situations for fear of saying something stupid or offensive may actually give a wrong impression of being disinterested in conversation and likely invite less friendly and less positive responses from others.

The cognitive model of SAD proposes that SB and SFA play an integral part in the maintenance of the disorder. However, there have been only a few studies which examined how SB and SFA affect the patients' subjective and objective evaluations of anxiety and performance in social situations. Wells et al (1995) in their preliminary pioneering work demonstrated that an exposure session with instructions to decrease SB produced greater within-subject reduction in anxiety and belief in the feared catastrophe than an exposure session without such instructions among 8 patients with SAD, when anxiety and belief were measured by behavioral tests before and after the sessions. Morgan and Raffle (1999) conducted a randomized clinical trial comparing the standard treatment according to Andrews et al. (2002) and the standard treatment with an additional instruction to drop SBs during exposure tasks among 30 patients with SAD. The added instruction produced significantly greater reduction in social anxiety at the end of the trial. Although very illuminating, neither of these studies explored the processes involved in the exposure tasks themselves through which the instructions to drop SB may have worked.

Two studies have appeared recently that tried to scrutinize these mechanisms. Kim (2005) compared exposure alone, exposure with reduced SB based on an extinction rationale ("exposure is like dipping yourself in cold water; you feel anxious first but then find out that you do not feel as anxious as before") and exposure with reduced SB based on a cognitive rationale ("exposure is to find out that the feared outcome does not happen") among socially phobic undergraduate students making 5-min presentations ($n = 45$). The last condition produced significantly greater reductions in anxiety and belief ratings for feared outcomes than the first two conditions. The authors concluded that a cognitive process of disconfirmation of negative thoughts is the critical element in determining effectiveness of decreasing SB. McManus and colleagues (McManus, Sacadura, & Clark, 2007) ran an experiment to manipulate the use of SB and SFA among socially anxious non-patient volunteers ($n = 20$) and demonstrated that the use of SB and SFA was unhelpful in a number of ways. When participants had 5-min conversations with a stranger, they felt more anxious, believed they appeared more anxious, believed their negative predictions to have occurred more, and perceived their overall performance to be poorer when they carried out SB and SFA than when they did not do so. Also the conversation partner perceived the participants to appear more anxious and rated their overall performance as poorer when participants were engaging in SB and SFA. The results also supported the role of SB and SFA in the cognitive process of SAD, because the overestimation of how anxious they appeared was greater under the condition with SB and SFA than otherwise.

However, feared situations and employed SB vary greatly from one patient with SAD to another, and it is sometimes difficult to determine whether a specific behavior is a SB or a coping behavior (Rachman, Radomsky, & Shafran, 2008; Thwaites & Freeston, 2005). None of the foregoing studies dealt