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Cognitive Behavior Therapy for Social Anxiety Disorder

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Abstract: The emotional state of feeling uneasy, strange, uneasy, apprehensive, or even afraid while dealing with people is known as social anxiety. Developed by A.T.B. in the 1960s, cognitive behavior therapy is a systematic, brief, cognitively focused psychological treatment approach that focuses on psychological disorders including anxiety and depression as well as psychological issues brought on by illogical thought. This study provides a quick overview of related knowledge about social anxiety disorder and cognitive behavioral treatment through the analysis of two research. The results of this study indicate that social fear may be effectively treated using cognitive behavioral therapy; nevertheless, several limitations remain in the current research. People will benefit from the study by having a better understanding of cognitive behavioral therapy and being able to select the appropriate course of treatment going forward.

Keywords: social anxiety disorder, cognitive behavior therapy, anxiety, treatment

1. Introduction

Psychology could not be separated from real life. Since there are so many people with social phobia in real life, we can't ignore their condition. Haili Yan pointed out that the WTO had investigated 26,000 outpatients in 14 countries and found that 10.45 percent of them had depressive symptoms [1]. According to the Global Burden of Disease Survey, ischemic heart disease will be the leading cause of functional impairment by 2020, with serious depression coming in second. Numerous community and medical studies have revealed a high prevalence of both depression and anxiety disorders, and almost all of them have shown that. Researchers reviewed the literature of others and discovered that cognitive behavioral therapy is a kind of most social psychological treatment, including psychological education, exposure to CBT, and other technology [2]. As for the treatment of social disorders, the study reviewed the literature and found that cognitive behavioral therapy is the most popular and effective treatment. It is precisely because social anxiety disorder is a common symptom and cognitive behavioral therapy is now a more effective treatment. Based on the above information, it is of great interest to study topics related to the treatment of anxiety disorders with cognitive behavioral therapy. The study reviewed the literature in recent years and selected articles that the study thought covered two different aspects of cognitive behavioral therapy. The two articles in this study were both published within the last five years. Although the researchers studied relatively young people, their specific methods, treatment duration, and social environment differed.

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2. Literature review

2.1. Social Anxiety Disorder

Social skills are essential skills in people's daily lives because individuals have to meet and communicate with different people. But, it can not ignored that some people are not good at socializing, and even some people are afraid of talking to strangers. Throughout a lifetime, anxiety disorders impact around 34% of individuals in the United States and are linked to severe discomfort and disability.2,001 young people between the ages of 18 and 35 participated in a poll by the Social Research Center of China Youth Daily, and 64.2% of them said they had behavioral or psychological "social stagnation," with 26.7% of them saying they had trouble interacting with others in person [3]. 17.0% of the respondents felt that they had barriers to social interaction online, and 20.5% felt that they had problems both online and offline. Just 30% of the youngsters thought they had no friendly troubles. "People whose interactive abilities have not been completely evolved resemble voyagers who have quite recently gone to an unfamiliar land. They don't figure out the nearby language and can't incorporate it into neighborhood life." Philip Zimbardo, a therapist, portrays Social nervousness as this [4].

According to the relevant Manual, the characteristic of a Friendly Tension Problem (Social Fear) is that when an individual is presented with a conceivable examination by others, he will feel dread or uneasiness about this circumstance, for instance, when he needs to have a few social communications, be noticed or act before others [5,6]. Individuals with social tension issues experience nervousness, in actuality, circumstances, yet in addition strengthen social uneasiness by continually examining and "replaying" restless circumstances to them after leaving what is happening that made them restless. Individuals with social tension frequently experience actual side effects while collaborating with others, like perspiring, becoming flushed, and fits of anxiety. To stay away from circumstances that lead to social nervousness, individuals normally decrease their social exercises and pick a single way of life. Social tension issues happen generally in early puberty. In China, social tension problem is a typical mental issue, with 2-5 percent of individuals having no less than one episode in the course of their life, with a somewhat higher frequency in ladies than in men, and with 95% of patients having a beginning around the time of 20 [7].

When a person is infected with social anxiety, there are three stages called the "bad three cycles" of embarrassment, and the first stage is "fear". People with social anxiety tremble with fear when they are ready to interact with others. These concerns result in a negative prediction of the outcome of a communication, an automatic prediction, which is amplified according to the customer's concerns. There is a struggle between being proactive and avoiding, but generally at this stage, you are ready to approach others. The second stage is shame and self-flagellation. When negative expectations and spontaneity increase, people with social anxiety will reflect more on their actions, and feel ashamed and remorse. Shame makes us feel that others are stingy, despised, or malevolent, and as a result, we become angry or resentful of others. At this stage, you stop trying or trying to approach a person, but a typical feature of this behavior is avoidance/atrophy. The third stage is anger and resentment. Shame is an emotional experience and can be relieved by blaming someone above you. When anger or resentment arises, they change the object of attack or blame from the inside out and start complaining that they are selfish and uncaring. Typical actions at this stage are aggressive or passive.

2.2. Cognitive Behavioral Therapy

CBT, as a brief cognitive-based psychiatric treatment in the 1960s, is primarily intended to treat mental illnesses like anxiety and depression as well as mental issues brought on by illogical thought. By altering the patient's thought patterns and perspective toward things, others, and himself,

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psychological disorders are primarily addressed in response to the patient's unreasonable cognitive issues.

One of the most popular psychotherapy treatments is cognitive behavioral therapy , which focuses on the erroneous inner beliefs that people hold and the flawed thought patterns that people have. Wang Ling researched cognitive behavioral therapy's therapeutic benefits [8]. Thirty individuals with anxiety disorders were chosen between March 2013 and February 2015, and they received 12 weeks of cognitive therapy treatment. The Hamilton Anxiety Scale (HAMA) was used to examine the patients' response to treatment, and the life scale, general quality of life assessment questionnaire, functional global assessment scale, quality of life, and social functioning were used to measure the patients' life satisfaction. Outcomes The results of the global assessment, complete quality of life assessment questionnaire, life satisfaction scale, and Hamilton Anxiety Scale.

CBT combines psycho-dynamic therapy and behavioral therapy, which can alleviate explicit symptoms and change behavior by changing people's thinking modes and emotional responses. The Cognitive Model holds that anxiety is caused by negative thoughts. The word “cognition” means “thought”. Whenever we feel anxious or afraid, we are worrying ourselves. For example, if you are afraid of flying, you may experience extreme panic when the plane encounters turbulence because your subconscious will think that the plane is about to crash. Then you see the plane exploding and passengers screaming. Your fear is not an objective “airflow”, but a subjective conjecture. According to the cognitive model, to beat anxiety, we must change the way we think. Cognitive models are based on the following three simple ideas: 1. The way you think affects how you feel. 2. When you feel anxious, you're scaring yourself. Anxiety is caused by some twisted, illogical thoughts, a kind of mental “deception”. 3. When you change the way you think, your feelings will change.

There are four main approaches to CBT. The first is to provide information. The main objective is to help patients understand disease occurrence and progression patterns and the meaning of intervention so they can actively cooperate and participate in joint treatment. The information delivery also focused on the circulatory pathway between dysfunctional thinking and anxiety and avoidance and was able to obtain a basic understanding of the characteristics and hierarchy of anxiety. The second is cognitive remodeling. The information is generally followed by a transition to a cognitive reconstruction intervention. “In doing so, the patient learns to recognize and examine his or her own negative and dysfunctional thoughts and general cognitive distortions, such as emotions being the result (because I feel bad, I will behave badly), and the pursuit of absolute perfection (a near-perfect behavior is a failure).” In the process of cognitive reconstruction, Socratic dialogue is a common discussion model to help patients self-monitor the cognitive characteristics of the process of anxiety, and “behavioral experiments” are used to test the authenticity of beliefs. Cognitive reconstruction can help patients reduce negative expectations and self-defeating cognitive styles. The third is exposure therapy. Exposure therapy is a common method after cognitive intervention. The purpose of exposure therapy is to help patients enter social situations and stay in social situations through appropriate behavior, and eventually eliminate fear. Exposure therapy helps patients develop different cognitive coping techniques in real social situations, provides realistic situations to correct dysfunctional thinking, and allows patients to practice using their reconstructed cognition in real life and to try to remove safety behaviors. As patient confidence increased at the time of exposure, the frequency of negative expectations and the level of anxiety decreased continuously. The fourth area is social skills training. Social skills training is also commonly used to coach patients with social anxiety. Leaders can instruct patients to perform corrective feedback exercises in the form of coaching and modeling to improve their social skills and reduce social anxiety.

Without the need for medication, it is particularly helpful in treating depression and other anxiety disorders, including phobias, panic attacks, public speaking anxiety, chronic anxiety, shyness, and

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test anxiety. This type of therapy aims to achieve both full healing and localized improvement. Everyone should have a desire for a new life and not feel afraid when they wake up in the morning.

3. Predictors of Treatment Outcome in a Quasi-Naturalistic Setting

They analyzed the results of individual cognitive behavioral therapy with a sample of 93 adults seeking treatment for SAD at a university outpatient clinic [9].

The researchers found that there is a large body of literature supporting CBT as an effective non-pharmacological treatment for SAD, but very few people have done this experiment on CBT for SAD in a naturalistic setting because it was thought that CBT protocols may not be followed, monitored or supervised as closely in a clinical setting. So they thought more research should be done in this area. In addition, they considered issues related to co-morbidities of social anxiety disorders, but this does not fit well with the main issue discussed in this paper - cognitive behavioral therapy for social anxiety disorders - and will not be described here.

They made three hypotheses about the study, that social anxiety was reduced and quality of life improved after treatment. Cognitive distortions and avoidance would moderate the treatment effect so that patients with higher initial levels would experience a greater degree of improvement throughout treatment. The presence of clinician-rated SAD severity and co-morbid diagnoses attenuated the treatment effect, so patients with a more severe SAD and co-morbid generalized anxiety disorder (GAD) or depression benefited less.

Before a face-to-face semi-structured diagnostic interview, participants first completed a telephone screen to determine inclusion criteria. Forty-eight patients evaluated from 2011-2014 and met DSM-5 diagnostic criteria for extensive SAD based on ADIS IV-L were included. To meet the criteria for generalized SAD, individuals must support greater than moderate fear in five or more different social situations. Since 2014, a total of 45 patients have met the DSM-5 diagnostic criteria for SAD based on ADIS-5-L. Measurements were collected again after approximately 20 sessions, or at the end of treatment if the measurements were earlier than 20 sessions. In this study, assessments performed after approximately 20 treatments (M = 20.59, SD = 2.69, range 11 - 28) were considered "post-treatment". However, some patients continued to receive treatment at the clinic after assessment based on individual needs.

Managing social anxiety was chosen as their CBT approach for this study. In this treatment program, patients completed readings and worksheets that corresponded to each treatment topic. They used these measures. Treatment outcomes: Liebowitz Social Anxiety Scale (LSAS) [10], Social Anxiety Scale (SIAS-S) [11], and Social Phobia Scale (SPS) [12]. Regarding hypothesized treatment predictors, they used the Subtle Avoidance Frequency Examination (SAFE) and the Cognitive Distortions Questionnaire (CD-Quest).

Outcomes relevant to the topic of this article include a reduction in social anxiety and an improvement in quality of life after approximately 20 weeks of treatment. Mean values of several scales decreased significantly before and after treatment, and QOLI values tended to increase. This may indicate that patients with more severe pre-treatment SAD or co-morbid depression exhibit higher levels of social anxiety before and after treatment. In addition, the mean LSAS scores also showed an increasing trend after the treatment, so it can be demonstrated that CBT is effective in a quasi-natural setting. These support the researcher's expectations and hypotheses [13].

4. Long-term viability of mental conduct treatment for youth with tension issues

The inquiry association viewed that, until now, there had been no examinations analyzing the drawn-out results of CBT for tension in local area psychological well-being centers, so they began this study [14].

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The review estimates, first, that CBT results are supposed to be kept up with or further developed in local area settings, however less so than in investigations of similar treatment impacts. Second, the impacts of the two treatment models were supposed to continue as before during follow-up and to be tantamount at long haul follow-up. At long last, more youthful patients determined essentially to have social tension were displayed to have lower results than those determined principally to have fearing abandonment or potentially unavoidable uneasiness problems.

Subjects who met the standards were chosen from a companion of 179 teenagers who partook in a randomized controlled preliminary (RCT). The review occurred somewhere in the range of 2008 and 2012. The age range at the hour of enlistment was 8 ~ 15 years. Mostly determined to have Miserable, SOP as well as Stray. Prohibitions incorporate inescapable formative problems, insane issues, serious behavioral conditions, or potential mental impediments. At the member's pre-treatment, post-treatment, and one-year follow-up appraisals. A sum of 139 teenagers partook in the review. Young people were surveyed at a mean of 3.9 years (SD = 0.8, territory 2-6 years) after treatment. The long-haul follow-up members were 11 to 21 years old (M = 15.5, SD = 2.5), and 54.7% were ladies. Associated with the long haul follow-up investigation of 139 young people with the first RCT (N = 40) of the members, including the treatment before the social segment qualities (for example age, orientation, race, guardians' occupation state) and treatment before clinical factors (for example clinical seriousness score (CSR) fundamental tension analysis, uneasiness and discouragement side effects, comorbidities, Finding of significant nervousness after treatment). There were no huge contrasts in any of these factors between the youth who took part and the people who didn't take part in the long-haul follow-up study.

Specialists picked Companions for Life as the treatment. The technique they utilized for this study incorporates the Nervousness Issues Interview Timetable Youngster and Parent version(ADIS-C/P), the Uneasiness Issues Interview Timetable for DSM-IV (ADIS-IV-L), The Spence Kid Tension Scale Kid and Parent rendition (SCAS-C/P), and the Short Temperaments and Sentiments Survey kid and parent version(SMFQ-C/P).

The consequences of the information in this paper showed no huge contrasts in the viability of ICBT and GCBT. Members at first determined to have SOP were more averse to recuperating than those at first determined to have Miserable or Stray. Results for youth with nervousness issues treated with CBT in local area psychological wellness centers worked on almost four years after treatment, with recuperation rates at long haul follow-up like those in the preliminary. It was presumed that the side effects of tension additionally improved fundamentally, however side effects of discouragement in youths didn't; there were no distinctions in finding or side effect results among ICBT and gbt; contrasted with Stray, youthful grown-ups with an underlying determination of SOP at passage had a fundamentally lower likelihood of losing visits Discoveries.

5. Discussion

The initial study's minimal sample variety is one of its limitations. In comparison to community outpatient clinics, their sample size was smaller. As a result of the majority of White patients in their sample, the percentage reached 77.4%. Furthermore, rather than community clinics, their study was conducted in a university setting with a large number of college students as patients. Additionally, The second research had certain drawbacks as well. Initially, ADIS-C/P could only be used with the SAD, SOP, and GAD modules. As a result, they were unable to monitor the occurrence of concomitant illnesses during the experiment and the subsequent time. Secondly, there was no control group in this study. A third limitation is that the study was conducted in Norway, which may affect the generalizability of the results. The results of this study would have been more representative if it had been conducted in a wider region, or if it had been conducted globally.

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6. Conclusion

After consulting relevant materials and reading these two articles, the study could help people have a deeper understanding of both separation anxiety disorder and cognitive behavioral therapy. Many people think that socially anxious people simply lack expressive and communication skills, which is a misconception. While the vast majority of people with social anxiety have adequate social skills, the problem is that anxiety prevents them from performing well in social situations. What appears to be a lack of social skills, such as avoiding eye contact with others, is a safety behavior -- behavior used to cover up possible embarrassment and anxiety. CBT can help people with social anxiety to realize the negative effects of safe behaviors and eventually abandon safe behaviors through scientific practice. And, CBT is by far the most widely studied psychotherapy for "depressive disorder" and is recommended by most clinical treatment guidelines.

References

[1] *Yan Haiping (2006) Progress in the treatment of depression Chinese Journal of Clinical Medical Research, 000 (006), 59-60.*

[2] *Pelissolo, Antoine; Abou Kassm, Sandra; Delhay, Lauriane (2019). Therapeutic strategies for social anxiety disorder: where are we now? Expert Review of Neurotherapeutics,14737175.2019.1666713–.doi:10.1080/14737175.2019.1666713.*

[3] *Wang Pinzhi (2023) China Youth Daily Youth. cn. https://t.m.youth.cn/transfer/index/url/news.youth.cn/gn/202305/t20230505_14496941.htm.*

[4] *Szuhany KL, Simon NM. Anxiety Disorders: A Review. JAMA. 2022 Dec 27;328(24):2431-2445. doi: 10.1001/jama.2022.22744. PMID: 36573969.*

[5] *American Psychiatric Association. (1994). Diagnostic and statistical manual of mental Disorders, 4th edition (DSM-IV). Washington, D.C.: American Psychiatric Publishing. https://doi.org/10.1007/springerreference_179660.*

[6] *American Psychiatric Association, American Psychiatric Association, DSM-5 Task Force. Diagnostic and statistical manual of mental disorders: DSM-5. 2013.*

[7] *A recent poll found that 64.2 percent of young people surveyed felt they had "social stagnation." Retrieved May 5, 2023, from https://baijiahao.baidu.com/s?id=1765004710647655613&wfr=spider&for=pc.*

[8] *Mattick, R.P., & Clarke, J.C. (1998). Development and validation of measures of social phobia scrutiny fear and social interaction anxiety. Behavior Research and Therapy, 36, 455-470. https://doi.org/10.1016/s0005-7967(97)10031-6.*

[9] *Butler, Rachel M.; O'Day, Emily B.; Swee, Michaela B.; Horenstein, Arielle; Heimberg, Richard G. (2020). Cognitive Behavioral Therapy for Social Anxiety Disorder: Predictors of Treatment Outcome in a Quasi-Naturalistic Setting. Behavior Therapy, S000578942030085X–. doi:10.1016/j.beth.2020.06.002.*

[10] *Heimberg, R. G., Horner, K. J., Juster, H. R., Safren, S. A., Brown, E. J., Schneier, F. R., & Liebowitz, M. R. (1999). Psychometric properties of the Liebowitz Social Anxiety Scale. Psychological Medicine, 29, 199-212. https://doi.org/10.1017/s0033291798007879.*

[11] *Rodebaugh, T.L., Woods, C.M., & Heimberg, R.G (2007). The reverse of social anxiety is not always the opposite: The reverse-scored items of the Social Interaction Anxiety Scale do not belong. Behavior Therapy, 38, 192-206. https://doi.org/10.1016/j.beth.2006.08.001.*

[12] *Wang L. (2016). Clinical analysis of cognitive behavioral therapy for anxiety disorders. Chinese Medical Guide, 14(12), 1.*

[13] *Frisch, M. B. (1994). Quality of Life Inventory (QOLI). Minneapolis, MN: National Computer Systems.*

[14] *Kodal, Arne; Fjermestad, Krister; Bjelland, Ingvar; Gjestad, Rolf; Öst, Lars-Göran; Bjaastad, Jon F.; Haugland, Bente S.M.; Havik, Odd E.; Heiervang, Einar; Wergeland, Gro Janne (2018). Long-term effectiveness of cognitive behavioral therapy for youth with anxiety disorders. Journal of Anxiety Disorders, 53, 58–67. doi:10.1016/j.janxdis.2017.11.003.*