Social anxiety disorder in adults: Psychotherapy

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INTRODUCTION

Social anxiety disorder (SAD), or social phobia, is a mental disorder characterized by an intense fear of negative evaluation from others in social and/or performance situations. In severe cases, the disorder can follow a chronic, unremitting course, leading to substantial impairments in the affected individual [1,2].

SAD is a prevalent condition, estimated to affect between 4 and 10 percent of the adult United States population. SAD typically begins in childhood or adolescence and, untreated, can be associated with the subsequent development of major depression, substance use disorder and other mental health problems. The disorder can be associated with extensive functional impairment and reduced quality of life [3].

This topic addresses treatment of SAD with psychotherapy. The epidemiology, pathogenesis, clinical manifestations, diagnosis, and pharmacotherapy for SAD are discussed separately. (See "Social anxiety disorder in adults: Epidemiology, clinical features, assessment, and diagnosis" and "Pharmacotherapy for social anxiety disorder in adults".)

APPROACH TO TREATMENT

Our approach to selecting among treatments for social anxiety disorder, including pharmacotherapy and psychotherapy, is discussed separately. (See "Approach to treating social anxiety disorder in adults".)

GENERAL PRINCIPLES

- Psychotherapy for social anxiety disorder (SAD), as for any disorder, can only be effective if the therapeutic context and the therapeutic relationship between clinician and patient are adequate (ie, if the therapist shows the necessary empathy, warmth, and support).

- Psychotherapy for SAD is negatively affected if patients lack motivation and are deficient in setting appropriate treatment goals. Motivational enhancement strategies can augment cognitive-behavioral therapy techniques [4].

- Studies suggest that different cultures (eg, certain racial/ethnic minority groups in the United States) may express SAD differently, potentially requiring modification to methods for assessment and psychotherapy [5].

- In our clinical experience, the psychotherapies discussed in this topic are comparably effective for SAD (formerly known as “generalized SAD”)and SAD, performance-only subtype. Rigorous randomized trials have only included patients with generalized SAD; no trials have specifically studied performance-only SAD, or compared psychotherapy’s efficacy between the two SAD types. (See "Social anxiety disorder in adults: Epidemiology, clinical features, assessment, and diagnosis".)

COGNITIVE-BEHAVIORAL THERAPY

Cognitive-behavioral therapy (CBT) is the best studied and most efficacious psychotherapy tested in randomized, placebo-controlled trials in patients with social anxiety disorder (SAD) [6]. In CBT for SAD, works with the patient to identify and challenge maladaptive cognitions associated with social situations. More recent CBT protocols, which target specific maintenance factors, have been shown to be more efficacious for SAD, compared with standard CBT approaches to the disorder [7,8].

Theoretical foundation — A variety of cognitive models have been proposed to explain pathologic thought processes in SAD. One widely regarded cognitive-behavioral model assumes that individuals with SAD believe they are in danger of behaving in an inept and unacceptable fashion, and such behavior would have disastrous consequences in terms of loss of status, loss of worth, and interpersonal rejection [9]. When exposed to situations that might put them in such danger, they become increasingly vigilant for cues that would signal the realization of their fears. They closely attend to sources of potential negative scrutiny and environmental cues. As an example, a person with SAD who is asked to give a speech in front of people might scan the

audience members for negative reactions to their speech. They maintain a negative view of how they appear to others and pay close attention to cognitive, behavioral, and affective cues related to the severity of their anxiety in the moment.

Another model proposes several psychopathological processes that prevent individuals with SAD from disproving their maladaptive beliefs [10]:

- Shifting their attention, when entering a social situation, to detailed monitoring and observation of themselves. This attentional shift produces an enhanced awareness of feared anxiety responses (eg, increase in heart rate and hot flushes) and interferes with processing their perceptions of other people's behavior. Together with the perception of the physiological anxiety response, this information is then used to construct a negative self-impression.

- Engaging in behaviors to reduce the risk of rejection and provide a sense of safety (eg, wearing dark clothes or a turtle neck to hide facial blushing). Such safety behaviors are subtle avoidance strategies that give the patient a sense of safety in fearful social situations. These behaviors might lead to a short-term decrease in anxiety. However, they contribute to the long-term maintenance of the problem because they prevent individuals with SAD from critically evaluating the outcomes they fear (eg, shaking uncontrollably) and other catastrophic beliefs.

- Showing an anxiety-induced deficit in performance and overestimating how negatively other people evaluate their performance.

- Thinking before and after a social event, about the situation in detail and primarily focus on past failures, negative images of themselves in the situation, and predictions of poor performance and rejection. These anxious feelings and negative self-perceptions are strongly encoded in memory because they are processed in such detail.

A third model posits that individuals with SAD are apprehensive in social situations in part because they perceive a high standard or expectations for social performance [11]. They desire to make a particular impression on others but doubt that they will be able to do so, partly because they are unable to define goals or select specific, achievable behavioral strategies to reach those goals. These thoughts lead to a further increase in social apprehension and increased self-focused attention, which triggers a number of additional cognitive processes, including:

- Exaggerating the probability of a negative outcome of a social situation and overestimate the potential social costs.

- Perceiving little control over their physiologic response to anxiety in social situations.
- Holding a negative view of themselves as social objects.
- Viewing their social skills as very poor or inadequate to master the social task.

As a result, the individual with SAD anticipates social mishaps and engages in avoidance and/or safety behaviors followed by rumination after the event. This cycle feeds on itself, ultimately leading to the maintenance and exacerbation of the problem. In general, the three cognitive models of SAD show a considerable overlap. They primarily differ in their emphasis of certain components. Preliminary studies support the notion that changes in cognitions mediate changes in social anxiety [12-14]. However, the precise mechanism through which CBT acts on symptom change is not known.

Components — In the standard CBT approach, the therapist acts as a coach, setting up the opportunities for learning and guiding accurate interpretations of current performance. As treatment progresses, longer-term maintenance is promoted by helping patients become their own therapists by understanding and applying treatment strategies on their own. Such independent application of therapy skills is initiated by the therapist providing a model of the disorder.

SAD is a heterogeneous diagnostic category, and individuals differ considerably in the factors that maintain the problem. Clinicians are encouraged to carefully explore the core problems of each patient. More recent CBT protocols [7,8] targeting specific maintenance factors for SAD patients have been found to be more effective than earlier noncustomized approaches. (See 'Theoretical foundation' above and 'Efficacy' below.)

Following problem identification, goal setting, and treatment planning, which should be conducted within the general guidelines of CBT [15], components of the therapy process specific to SAD include:

Psychoeducation — Patients are taught a maintenance model of SAD. Social apprehension is associated with unrealistic social standards and a deficiency in selecting attainable social goals. When confronted with challenging social situations, individuals with SAD shift their attention toward their anxiety, view themselves negatively as a social object, overestimate the negative consequences of a social encounter, believe that they have little control over their emotional response, and view their social skills as inadequate to effectively cope with the social situation. In order to avoid social mishaps, individuals with SAD revert to maladaptive coping strategies, including avoidance and safety behaviors, followed by post-event rumination, which leads to further social apprehension in the future.

Cognitive restructuring — Cognitive goals of CBT are to help the patient understand the maladaptive nature of their concerns about social situations. Specific negative cognitions associated with social situations are identified and challenged using cognitive restructuring techniques. This includes identifying maladaptive beliefs and automatic thoughts, observing the association between anxious mood and automatic thoughts, examining maladaptive ways of thinking, and formulating rational alternatives to these beliefs and thoughts.

People with SAD often ruminate over perceived or actual social mishaps. This postevent rumination can be effectively targeted by helping patients process negative social events more adaptively through guided questions (eg, "How will your life change as a result of a particular social mishap?").

Exposure — Exposure tasks challenge the maladaptive thoughts and beliefs. The goal of social mishap exposures is to purposely violate the patient's perceived social norms and standards in order to break the self-reinforcing cycle of fearful anticipation and subsequent use of avoidance strategies. Patients are asked to intentionally create the feared negative consequences of a feared social situation. As a result, patients are forced to reevaluate the perceived threat of a social situation after experiencing that social mishaps do not lead to the feared long-lasting, irreversible, and negative consequences.

As an example, a patient who was concerned about inconveniencing others, being the center of attention, and being thought of as unintelligent was asked to perform several tasks: interrupt a group of people in a restaurant to practice a toast for a maid of honor speech (targeting inconveniencing others and being the center of attention); asking strangers in a bookstore to read the back cover of a book because she did not know how to read (targeting being thought of as unintelligent); and asking people on the street if they were "Carl Smith" because his car was being towed, while wearing band aids on her face (targeting inconveniencing others, being the center of attention, and being thought of as "weird").

Safety behaviors are identified during exposure exercises and discouraged. Safety behaviors are avoidance behaviors that signal a sense of safety, but also prevent patients from critically evaluating their feared outcomes and other catastrophic beliefs, leading to the maintenance and further exacerbation of the social anxiety. An example is a patient who puts his or her hands in the pocket so that people cannot detect hand shaking. Despite providing a short-term reduction in anxiety, this avoidance strategy does not address underlying cognitions or effective and physiologic responses to the precipitating social situations.

Video feedback can be used to help correct distorted self-perception. As part of in-session exposure, patients are asked to predict in detail what they will see in the video and form an

image of themselves in the social situation. They then watch the video from an observer's point of view following completion of an exposure task.

Efficacy — A meta-analysis of five randomized trials totaling 318 patients found traditional CBT to be efficacious for SAD compared with placebo control (odds ratio 4.21, 95% CI 2.07-8.98). Medium to large positive effects (Hedges' g = 0.84, 95% CI 0.72-0.97) on social anxiety symptoms have been seen for group CBT compared with waitlist [6,16], with considerable variation in effect sizes across studies [6]. CBT has been shown, in general, to be superior to no treatment, pill placebo, and psychological placebos [17]. As examples:

- A randomized trial of 133 patients with SAD compared traditional group CBT, phenelzine (a monoamine oxidase inhibitor used to treat SAD), a pill placebo, and an educational-supportive group therapy (serving as a psychological control intervention) [18]. After 12 weeks, a higher proportion of patients were assessed as responding to treatment in the groups receiving phenelzine (65 percent) and group CBT (58 percent) than pill placebo (33 percent) or the psychological control (27 percent).

Few head-to-head comparisons of tailored versus traditional CBT for SAD have been conducted [19]; however, greater effect sizes have been achieved in placebo-controlled trials of tailored CBT compared with placebo-controlled trials of traditional CBT. Trials of tailored CBT include:

- A randomized trial of 169 patients with SAD compared tailored group CBT in combination with pill placebo or a cognitive enhancer (d-cycloserine). After 12 weeks, both CBT-placebo and CBT-medication patients showed high response rates, but results did not differ between groups (73.3 versus 79.3 percent) [20].

- A randomized trial of 60 patients randomly assigned to tailored CBT, fluoxetine and self-exposure, or placebo and self-exposure supported the efficacy of tailored CBT approach for SAD [7]. After 16 weeks of treatment, the group receiving CBT experienced a greater reduction of social anxiety than the groups receiving fluoxetine/self-exposure or placebo/self-exposure. No responder rates were reported. A large posttreatment effect size was found for CBT compared with placebo (Cohen's d = 1.31) and small (d = 0.21) for the fluoxetine/self-exposure group.

Traditional CBT strategies can be successfully augmented with strategies targeting relational processes to enhance the patient's relationship satisfaction. As an example, a waitlist-controlled trial randomly assigned 100 SAD patients to 14 weekly sessions of either CBT with a relationship focus (CBT-R), a relaxation-focused treatment, or a waitlist control condition. The trial found that CBT-R was more efficacious than the relaxation and waitlist control condition in reducing social anxiety and enhancing relationship satisfaction [21].

Administration — CBT can be provided as an individual or group therapy. It has traditionally been provided for SAD to groups, by two therapists for a group of four to six patients in 12 weekly two and a half hour sessions. More recent modifications of this format include individual treatment sessions lasting 60 minutes scheduled weekly for up to 15 weeks. A methodologically limited clinical trial found individual CBT to be superior to group CBT in patients with SAD [22]. A treatment manual provides detailed information about the delivery of targeted CBT approaches for SAD [8].

Advantages of group CBT include the social support of the group and its utility in conducting exercises involving exposure to social situations. Individual CBT affords more therapeutic time and attention to the individual patient and allows for the targeting of specific cognitive factors that cannot be easily addressed in a group.

Although CBT is usually delivered as a face-to-face treatment, it can also be delivered via the internet (iCBT). A meta-analytic review examining the efficacy of iCBT showed that the intervention produces small but sustained treatment effects compared with an active control condition [23]. Additionally, a small pilot study of intensive, seven-day iCBT showed improvements in patient important outcomes as measured by patient rating scales (ie, social phobia scale, social interaction anxiety scale) [24].

Toastmasters — Individuals with only public-speaking anxiety (ie, meet American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [DSM-5] criteria for the performance-only specifier for SAD) can benefit from post-CBT social skills training in peer-led programs providing opportunities for members to repeatedly practice public speeches (eg, Toastmasters and others). Most peer-led public speaking classes encourage participants to improve their public speaking skills. This focus on performance could enhance the patient's cognitive biases about his/her deficiencies in social skills and perceptions that social situations involve unattainable and unclear social standards, goals, and norms (see 'Exposure' above). Accordingly, whereas these classes do provide in vivo exposure, in our clinical experience, they are most likely to be beneficial after completion of a course of CBT.

Strategies for nonresponse — Reasons for nonresponse to CBT include cognitive errors that enhance social anxiety in response to actual or imagined social threat, and avoidance strategies (such as safety behaviors, described above) that lead to the maintenance of social anxiety. Examples of such maladaptive strategies include obvious avoidance and safety behaviors but might also include distraction techniques if they serve the purpose to lessen the anxiety experience.

If a patient does not respond to these approaches, the clinician should explore other factors that might contribute to the maintenance of the problem. These may include problems that directly impact social functioning, such as autism spectrum disorder and schizoid and schizotypal personality traits. These problems may be targeted through social skills trainings. Other strategies to treat the associated clinical problems may include interpersonal therapy to target complicated grief, cognitive processing therapy, or prolonged exposure to treat interpersonal trauma, and motivational interviewing to address substance use problems related to social anxiety disorder. Depression is often comorbid with SAD and can interfere with treatment motivation. Those patients may benefit from adjunctive psychotherapy (such as motivational enhancement therapy for substance use disorder or targeted cognitive therapy and behavioral activation for mood disorders) and/or pharmacotherapy for depression and other problems. A functional analysis can clarify which of these problems should we targeted first. (See "Unipolar major depression in adults: Choosing initial treatment" and "Interpersonal Psychotherapy (IPT) for depressed adults: Indications, theoretical foundation, general concepts, and efficacy" and "Substance use disorders: Motivational interviewing" and "Autism spectrum disorder in children and adolescents: Evaluation and diagnosis".)

ATTENTION RETRAINING

Clinical trials have found mixed results for attention retraining (also known as attention bias modification training [ABMT]) in patients with social anxiety disorder [19,25-32].

Theoretical foundation — Attentional biases have been proposed to contribute significantly to the etiology and maintenance of anxiety disorders, including SAD. Consistent with the cognitive model, researchers have postulated that anxiety disorders are uniquely associated with a bias in the initial stimulus registration phase of cognitive processing [33]. In anxiety disorders, attention to threatening information is rapidly and automatically deployed. Although this shift toward threatening information is evolutionarily adaptive, it becomes problematic when it leads to hypervigilance to social and environmental queues, as is proposed to occur in social anxiety.

Components — Attention retraining is an intervention that modifies the attentional bias by training patients to attend to nonthreatening rather than threatening stimuli. A commonly used paradigm is the dot-probe task [34]. The task involves simultaneously presenting two stimuli that vary in emotional content (eg, a threatening word and a neutral word) side-by-side on a computer screen, removing the stimuli, and then replacing one of the stimuli with a probe (ie, a neutral symbol, such as a dot or a line). The viewer is instructed to identify the presence of the probe as quickly as possible. It is assumed that participants will be faster at detecting a probe that replaces the stimulus to which the participant was attending before the probe appeared.

As an example, a socially anxious viewer is typically faster at detecting a probe (eg, a dot) that replaces a threatening stimulus (eg, the word "speech") than a nonthreatening stimulus (eg, the word "flower") because the viewer's initial attention is captured by the threatening stimulus. More recently, investigators have used a novel eye-tracking-based attention bias modification method involving gaze-contingent music reward [29].

In traditional attention retraining paradigms, the connection between probes and nonthreatening stimuli is strengthened, whereas the connection between probes and threatening stimuli is weakened. As an example, if probes are more likely to appear after the nonthreatening than after the threatening stimuli, the viewer is encouraged to pay closer attention to the nonthreatening than to the threatening stimuli without the viewer's conscious awareness.

In the case of the gaze-contingent music reward paradigm, attention allocation to threat is assessed with an eye-tracking task. Subjects are presented with a 4x4 matrix of 16 faces, half with disgusted and half with neutral facial expressions. Each face appears randomly at any position on the matrix. Patients in the gaze-contingent music reward therapy group hear a preferred music piece when fixating on one of the neutral faces. When fixating on one of the disgusting faces, the music stops.

Efficacy

Clinical trials — Clinical trials have found mixed results for attention retraining or ABMT in patients with social anxiety disorder [19,25-32]. As examples:

- A clinical trial randomly assigned 44 patients with generalized SAD to receive attention retraining or an attention control condition [25]. The treatment consisted of eight 20-minute attention training sessions delivered over a four-week period. Following treatment, patients assigned to active intervention experienced greater disengagement from threat and reduced SAD symptoms compared with patients assigned to the control condition. A smaller proportion of patients receiving the active intervention subsequently met Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) diagnostic criteria for SAD compared with control patients (50 versus 14 percent). Symptom reduction among patients receiving attention retraining was maintained on assessment four months after treatment.

- A clinical trial randomly assigned 40 patients with social anxiety disorder to receive eight sessions of either gaze-contingent music reward therapy, designed to divert patients' gaze toward neutral stimuli rather than threat stimuli, or a control condition [29]. Gaze-contingent music reward therapy yielded greater reductions of SAD symptoms compared

with the control condition on both clinician-rated and self-report measures. Therapeutic effects were maintained at three-month follow-up. Gaze-contingent music reward therapy, but not the control condition, also reduced dwell time on threat, which partially mediated the reduction of social anxiety.

- A 2019 trial randomly assigned 58 adolescents with SAD (mean age: 14) to either ABMT, a placebo control condition, or attention control training [31]. Changes in attention bias were not observed, and no differences were seen between the ABMT and the control conditions.

Experimental studies — Experimental studies in nonclinical samples support the theoretical model underlying attention retraining. As an example is an experiment that manipulated attention by training participants to attend to threatening words using a dot-probe task [35]. One group of participants was trained to attend to threatening words (ie, the probes always replaced the threatening words) while the other group was trained to attend to neutral words (ie, the probe always replaced the neutral words). Posttraining, the participants in the threat group exhibited faster reaction times to probes replacing new threatening words. The participants in the threat group additionally reported higher levels of negative mood and anxiety during a stressful task than participants in the neutral group, supporting the hypothesis of a causal relationship between attentional biases toward threat and a vulnerability to anxiety.

INTERPERSONAL PSYCHOTHERAPY

Interpersonal psychotherapy (IPT) is a time-limited psychodynamically based form of psychotherapy. Originally developed to treat grief and depression, IPT has been adapted to treat other mental disorders including social anxiety disorder (SAD) [36,37]. (See "Interpersonal Psychotherapy (IPT) for depressed adults: Indications, theoretical foundation, general concepts, and efficacy".)

A principal difference between IPT and cognitive-behavioral therapy (CBT) is that instead of CBT's conceptualization of maladaptive cognitions as the primary target of treatment, IPT specifically targets interpersonal problems. IPT focuses more on interpersonal role disputes, interpersonal deficits, and role transitions.

The therapist addresses past interpersonal difficulties in the service of enhancing the patient's understanding of current problems. As an example, if passivity in the patient's past relationship with his/her parents appears to have contributed to current interpersonal problems, the therapist may work with the patient on being more assertive in an upcoming parental visit.

A frequently used strategy is to encourage the patient to find ways of enlisting their partner's support in their attempt to overcome social anxiety and to turn them into an ally [38-40].

Theoretical foundation — IPT, based on psychodynamic theories, assumes that early adverse experiences and later peer experiences influence feelings and patterns within adult relationships. IPT further postulates that SAD is primarily maintained by problems related to role dispute (a prominent conflict within an important relationship) and role transition (a major life change such as marriage, divorce, the birth of a child, graduation, or retirement) [38,41-43].

As a consequence of such insecurity, interpersonal models propose that people with SAD develop a number of self-protective strategies that keep others unaware of the person's wishes and feelings (eg, individuals with SAD may avoid eye contact or avoid asking open-ended questions to limit the degree of social interaction).

Self-protective strategies may make the person with SAD appear uninterested in others, leading others to feel rejected and subsequently to withdraw. This is called a self-perpetuating, interactional cycle, in which individuals unwittingly produce the very response they fear. Observation of their fear, avoidance, and failure to perform socially enhances patients' role insecurity and sense of defectiveness, leading to maintenance of the problem.

Efficacy — Findings from clinical trials of SAD comparing IPT with a control condition have been mixed:

- A trial randomly assigned 70 patients with SAD to receive 14 weekly, individual sessions of either IPT or supportive therapy (administered as a psychological control intervention) [43]. Patients in both groups experienced a reduction in symptoms, with no difference in improvement between IPT and the supportive therapy group.
- One hundred and seventeen patients with SAD were randomly assigned to receive 16 individual sessions of either CBT or IPT, or to a waitlist control group [44]. After 20 weeks of treatment, the proportions of patients who responded to CBT and to IPT were greater than the proportion that responded to the waitlist control (65.8 and 42.1 versus 7.3 percent). A greater proportion of patients responded to CBT compared with IPT.

PSYCHODYNAMIC THERAPY

Theoretical foundation — Attachment theory suggests that early childhood experiences shape the person's expectations about the responsiveness and trustworthiness of attachment figures

[45]. A predominantly anxious attachment style predisposes the person to anxiety disorders [46] and to social anxiety disorder if the person expects devaluation in social interaction [47].

Techniques — Consistent with psychodynamic techniques for other disorders, the therapeutic strategies include discussions and interpretations about early and present relationships, including the therapeutic relationship. Also included are instructions for exposure practices, which are an important component of cognitive-behavioral therapy (CBT).

Efficacy — The two most recent and most rigorously designed trials both found psychodynamic therapy to achieve superior results in patients with social anxiety disorder compared with waitlist controls. Response rates for psychodynamic therapy were less than but similar to responses rates from cognitive behavioral therapy; however, the trials were not powered to detect differences in clinical outcomes between the two psychotherapies. A 2014 network meta-analysis of earlier clinical trials of psychodynamic psychotherapy for social anxiety disorder identified three clinical trials with findings supporting the efficacy of psychodynamic psychotherapy compared with a waitlist control [17].

- A clinical trial randomly assigned 495 outpatients with social anxiety disorder to receive up to 25 weekly individual therapy sessions of manual-guided CBT or manual-guided psychodynamic therapy, or were assigned to a waitlist condition [48]. At the end of treatment, patients assigned to receive CBT and psychodynamic psychotherapy were more likely to respond to treatment (60 and 52 versus 15 percent) and to experience remission of SAD (36 and 26 versus 9 percent) compared with the waitlist group. No difference was seen between the two therapies in patients' response or remission rates.

- A clinical trial randomly assigned 107 adolescents (ages 14 to 20 years) with social anxiety disorder to receive CBT or psychodynamic therapy, or as a waitlist control [49]. At the end of treatment, response rates for CBT and psychodynamic therapies were both superior to the waitlist control but did not differ between the two therapies in rates of response (66 and 54 versus 20 percent) or remission (47 and 34 versus 6 percent). Treatment gains were maintained at 6- and 12-month follow-up. Limitations of the trial included an unusually lengthy CBT intervention and the inclusion of exposure instructions as part of psychodynamic therapy.

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Anxiety and anxiety

disorders in adults".)

INFORMATION FOR PATIENTS

UpToDate offers two types of patient education materials, "The Basics" and "Beyond the Basics." The Basics patient education pieces are written in plain language, at the 5th to 6th grade reading level, and they answer the four or five key questions a patient might have about a given condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written at the 10th to 12th grade reading level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or e-mail these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on "patient info" and the keyword(s) of interest.)

- Basics topic (see "Patient education: Social anxiety disorder (The Basics)")

SUMMARY AND RECOMMENDATIONS

- Our approach to selecting among treatments for social anxiety disorder (SAD), including pharmacotherapy and psychotherapy, is discussed separately. (See "Approach to treating social anxiety disorder in adults".)

- In cognitive-behavioral models of SAD, maladaptive beliefs are important maintaining factors that are closely associated with anxious feelings, physiologic responses, and avoidance behaviors. (See 'Theoretical foundation' above.)

- Cognitive-behavioral therapy (CBT) is the best studied and most efficacious psychotherapy tested in clinical trials for SAD. Components vary by treatment protocol but typically include psychoeducation, cognitive restructuring, and exposure practices. CBT is usually provided in group or individual therapy over approximately 12 weekly sessions. (See 'Cognitive-behavioral therapy' above.)

- Cognitive restructuring involves identifying and challenging negative maladaptive beliefs and automatic thoughts, observing the association between anxious mood and automatic thoughts, examining errors of logic, and formulating rational alternatives to these beliefs

and thoughts. In exposure, patients are confronted with feared situations and asked to examine specific expectations that arise. (See 'Components' above.)

- Reasons for nonresponse to CBT include cognitive errors that enhance social anxiety in response to actual or imagined social threat, and avoidance strategies (such as safety behaviors, described above) that lead to the maintenance of social anxiety. Other factors that might contribute to the maintenance of the problem include the presence of: autism spectrum disorder; schizoid and schizotypal personality traits; or associated problems such as depression, complicated grief; interpersonal trauma, or substance use disorder. (See 'Strategies for nonresponse' above.)

- Attention retraining is an intervention that modifies attentional bias by training patients to attend to certain types of stimuli by using dot-probe detection tasks. It is based on a conceptual model that postulates that anxiety disorders are uniquely associated with a bias in the initial stimulus registration phase of cognitive processing. Attention to threatening information is thought to be excessively, automatically deployed in anxiety disorders. Clinical trials suggest that attention retraining is efficacious in SAD, but larger, more robust trials are needed before its use can be recommended. (See 'Attention retraining' above.)

- Interpersonal psychotherapy (IPT) is a time-limited psychodynamically based form of psychotherapy that postulates that SAD is primarily maintained by problems related to role dispute and role transition rather than maladaptive cognitions. The therapy thus targets interpersonal problems. Clinical trials have found mixed evidence of efficacy for IPT in SAD. (See 'Interpersonal psychotherapy' above.)

- A manual-based psychodynamic psychotherapy has been found to be efficacious compared with a control condition but less efficacious compared with CBT. (See 'Information for patients' above.)

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