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The aim of this work was to test the contribution of cognitive therapy to exposure *in vivo* in the group treatment of generalized social phobia. Seventy-one severely disabled social phobics, selected according to *DSM-III-R* criteria, were assigned at random to: (a) self-exposure *in vivo*, (b) self-exposure *in vivo* with cognitive therapy, or (c) a waiting-list control group. A multigroup experimental design with repeated measures of assessment (pretreatment, posttreatment, and 1-, 3-, 6-, and 12-month follow-ups) was used. Additionally, half of the patients in both therapeutic groups were given self-help manuals for managing anxiety. Most patients that were treated (64%) showed significant improvement at the 12-month follow-up, but there were no differences between the two therapeutic modes. No improvement was shown by the control-group participants at the 6-month follow-up. The results of the present trial do not support the beneficial effects of adding cognitive therapy or a self-help manual to exposure alone. Finally, several topics that may contribute to future research in this field are discussed.

Long-Term Outcome of Cognitive Therapy's Contribution to Self-Exposure *in Vivo* to the Treatment of Generalized Social Phobia

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According to the *DSM-IV* (American Psychiatric Association [APA], 1994), social phobia is an intense and lasting fear of one or more social situations in which a person is exposed to observation by others and experiences the fear of doing something or behaving in such a way as to cause humiliation or embarrassment. Alhough social anxiety may be present in all anxiety-related problems, social phobia is distinguished from other disorders by the fear and avoidance of a great number of interpersonal situations—which constitute the central

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components of this syndrome—and by the preeminent interference of social fears in the daily lives of patients (Beidel, Turner, & Dancu, 1985; Rapee, Sanderson, & Barlow, 1988).

The psychophysiological symptoms most commonly experienced are sweating, trembling, increased heart rate, and blushing. From a cognitive point of view, social phobics have an exaggerated fear of being criticized. Specifically, their attention is focused on themselves, with the belief that others are aware of their every social behavior; they pay selective attention to the negative messages that they get from others about themselves; they selectively remember their negative social experiences; and finally, they underestimate their abilities in interpersonal situations (Echeburúa, 1993; Lucock & Salkovskis, 1988).

Social phobias, according to the *DSM-IV* (APA, 1994), can be in response to very specific stimuli (eating or drinking in the presence of others, speaking in public, etc.), or they may be present in a generalized manner in response to a variety of social situations. It is this latter type of social phobia that is the object of this study due to its greater clinical relevance and to the degree to which it incapacitates those who suffer from it (Mannuzza et al., 1995; Tran & Chambless, 1995).

Social phobia is the second most common phobic disorder seen in clinical practice—it accounts for 25% of all phobias—surpassed only by agoraphobia. It affects up to 3% of the population, both men and women alike, and is especially present in single people. The problem usually starts at some point between the ages of 15 and 20. The phobia may begin progressively with previous shyness in childhood or isolation in adolescence, or it can begin suddenly after a traumatic experience, later stabilizing in the middle phase of life. It usually follows a chronic course because help is not sought—the patient may attribute the problem to shyness, which is considered to be unalterable—or therapy is sought in advanced phases (from 5 to 10 years after the onset of the problem) (Echeburúa, 1993, 1995).

The initial treatment of this disorder focused on training in social skills (Mersch, Emmelkamp, Bögels, & Van Der Sleen, 1989; Öst, Jerremalm, & Johansson, 1981; Wlazlo, Schroeder-Hartwig, Hand, Kaiser, & Münchan, 1990). Nevertheless, at present, social phobia is

approached therapeutically with techniques of self-exposure *in vivo* and of cognitive therapy. The technique of exposure to the feared stimuli is always necessary, but it can be insufficient due to the greater technical difficulties that the use of this treatment in the case of social phobia implies (the improvisational nature of most social interactions together with the brevity of most encounters) (Butler, 1985) and due to the role that cognitive factors play in the disorder (Heimberg, Salzman, Holt, & Blendell, 1993).

For these reasons, the current tendency is to incorporate cognitive therapy into techniques of exposure, the goal of which is to confront the cognitive alterations that are present and to eventually facilitate exposure to the feared stimuli (Echeburúa & Salaberría, 1991, 1994). Nevertheless, the results obtained with this behavioral-cognitive approach (cognitive rehearsals, behavior rehearsals, or exposure and cognitive evaluation) turn out to be contradictory. In some studies (Butler, Cullington, Munby, Amies, & Gelder, 1984; Heimberg et al., 1993; Mattick, Peters, & Clarke, 1989), the addition of cognitive techniques improved the results obtained by exposure alone. In other studies, however, cognitive techniques did not improve the efficacy of exposure in any significant way (Biran, Augusto, & Wilson, 1981; Hope, Heimberg, & Bruch, 1995; Mersch, 1995; Scholing & Emmelkamp, 1993a, 1993b; Stravynski & Greenberg, 1989). In a recent meta-analytic comparison of studies testing cognitive behavior therapy and exposure treatment, the treatment modalities are equally effective (Feske & Chambless, 1995).

These contradictory results lend a provisional character to the conclusions reached by these studies, and it is for this reason that the aim of our research is to determine the added value of cognitive therapy to the treatment of exposure in a homogeneous—and clinically significant—sample of patients: generalized social phobics with long-term follow-up. To this end, a 6-month waiting-list control group has been used to determine the incidence of spontaneous evolution in untreated patients. Finally, the therapeutic import of a self-help manual as an added value to the proposed treatment has been tested.

As is habitual in the majority of current clinical investigations, the evaluation of therapeutic change has been carried out by means of self-reports. Specifically, the tools of evaluation of social anxiety and

of other psychopathological variables (anxiety and depression) that have been used here are the same as those most often used in other studies.

METHOD

PARTICIPANTS

The sample of participants was made up of patients referred by mental health centers and of individuals who responded to a call for volunteers to participate in this study, made through the local media in the Basque Country. The mental health centers are public services of mental health supported by the Basque government for outpatients with mental and personality disorders, to which patients are referred by family doctors, and treatments are free of charge. The mental health centers mentioned in this study cover an area of 750,000 inhabitants. The periods of selection, treatment, and follow-up of the patients took place from April 1992 to December 1993.

The criteria for admission to the study were the following: (a) to meet the diagnostic criteria for generalized social phobia set forth in the *DSM-III-R* (APA, 1987) according to the *Anxiety Disorders Interview Schedule-Revised* (*ADIS-R*) structured interview (Di Nardo & Barlow, 1988); (b) to score 15 or more points on the Social Avoidance and Distress Scale (SAD) (Watson & Friend, 1969) or to score 21 or more points on the Fear of Negative Evaluation Scale (FNE) (Watson & Friend, 1969); (c) to have been suffering from this disorder for at least 1 year; and (d) not to be suffering from any other incapacitating illness or additional behavioral disorder of a serious nature. These two latter criteria reflect the goal of this study to include pure social phobics and not individuals suffering from a merely passing disorder.

Once the introductory study was carried out in 105 patients who sought help in the therapeutic program during the period of time designated, the sample of patients selected according to the proposed criteria was reduced to 80 participants. The reasons for excluding the other 25 patients were the following: (a) They scored lower than 15 on the SAD and lower than 21 on the FNE ($N = 4$); (b) their social

phobia was of the specific type ($N = 6$); (c) they suffered from anxiety disorders other than social phobia ($N = 6$); (d) they were afflicted with a severe behavioral disorder (depression, psychosis, bipolar disorder, substance abuse, or mental deficiency) ($N = 8$); and (e) one patient had a debilitating stutter ($N = 1$).

Of the 80 participants selected, 9 were lost before treatment began, 7 of whom did not attend the pretreatment evaluation and 2 of whom failed to initiate treatment. The final sample, therefore, was made up of 71 patients.

Regarding the most significant demographic characteristics of the sample selected, the mean age was 31 years ($SD = 8.3$; range 18-54), the ratio of men to women was nearly the same (52% and 48%, respectively), there was a marked majority of single people (63% of the sample), and 62% of the sample were actively employed. These results are similar to those obtained in other studies (cf. Turner & Beidel, 1989).

EXPERIMENTAL DESIGN

This study used a multigroup design with repeated measures. There were two experimental groups and a 6-month waiting-list control group, with independent measures in the treatment factor and with multiple and repeated measures in the evaluation factor, distributed throughout pretreatment, posttreatment, and in the 1-, 3-, 6-, and 12-month follow-ups.

Patients were randomly assigned to the three groups, after they had been preliminarily stratified according to age and gender. The resulting modalities were the following: (a) self-exposure *in vivo* ($N = 24$); (b) self-exposure *in vivo* with cognitive therapy ($N = 24$); and (c) waiting-list control group ($N = 23$).

At the same time, and given that another of the aims of this study was to assess the additional efficacy of a self-help manual for management of anxiety, a factorial 2×2 design was used, with independent measures in the factors of manual and type of treatment and with repeated measures in the evaluation factor.

The distribution of the manual was carried out randomly among the participants of the two therapeutic modalities.

ASSESSMENT MEASURES

Interviews

A structured individual interview was held with the help of the *ADIS-R* (Di Nardo & Barlow, 1988), used to achieve the diagnostic differential of generalized social phobia according to the diagnostic criteria of the *DSM-III-R* (APA, 1987).

In this interview, which lasts an average of 60 minutes, the patients describe the intensity of their fears and their avoidance of different types of social situations as well as the stimuli associated with these situations and the degree of interference of the phobia in their daily lives. Additionally, the participants detail the evolution of their fears from the time of their inception up to the present.

The data on interobserver reliability obtained with this scale in this study are satisfactory (coefficient kappa = .91).

Evaluation of Social Phobia

The assessment measures used were SAD and FNE (Watson & Friend, 1969), which are complementary and have proven to be sensitive to therapeutic change after treatment for social phobia (cf. Echeburúa, 1993).

SAD consists of 28 items, each with two possible answers (true or false) referring to the behavioral components of the disorder; that is, to the subjective malaise in social situations (14 items) and to the active avoidance or the wish to avoid such situations (14 items). The points obtained on the scale range from 0 to 28. The cutoff point proposed for this study is 15. In the Spanish version, the test-retest reliability after an interval of 1 month is .70 and the alpha coefficient of internal consistency is .92.

FNE is made up of 30 items, each with two possible answers (true or false) related to the cognitive components of the disorder; that is, to the fear of receiving criticism or negative assessments from others. The points obtained on the scale range from 0 to 30. The cutoff point proposed for this study is 21. In the Spanish version, the test-retest reliability after an interval of 1 month is .76 and the alpha coefficient of internal consistency is .90.

Evaluation of Other Associated Psychopathological Symptoms

The State-Trait Anxiety Inventory (STAI) (Spielberger, Gorsuch, & Lushene, 1970) consists of 20 items related to anxiety traits and another 20 related to anxiety states. The range of scores is from 0 to 60 on each subscale. In the Spanish version, the test-retest reliability coefficient is high (r = .79) on the anxiety-trait and, as is to be expected, quite a bit lower on the anxiety-state scale (.40). The alpha coefficient of internal consistency is .89. In this study, only the subscale of the anxiety state has been taken into account—that is to say, the one that is useful as the variable dependent on therapeutic change.

The Beck Depression Inventory (BDI) (Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961) consists of 21 items and measures the intensity of symptoms of depression. The range of scores is from 0 to 63. The cutoff point most often used to discriminate between the healthy population and the population afflicted with symptoms of depression is 18 (Steer & Beck, 1988). In the Spanish version, the reliability coefficient by the split-half method is .91. The convergent validity with clinical evaluation of depression range is .64.

The Scale of Adaptation (Echeburúa & Corral, 1987) measures the degree to which the disorder affects different areas of daily life: work and/or studies, social life, free time, relationship with one's partner, and relationship with one's family. This tool, with six items that range from 1 to 6 on a Likert-type scale, also includes a global subscale that reflects the degree of global adaptation to daily life. The range of the total scale is from 6 to 36 (the higher the score, the poorer the adapation).

Evaluation of Several Dimensions of Personality

The Self-Esteem Scale (Rosenberg, 1965) aims to evaluate feelings of satisfaction with oneself. This tool consists of 10 items structured on a Likert-type scale, 5 of which are presented in a positive way and 5 in a negative way, the objective being to measure acquiescence. The range of points obtained is from 10 to 40 (the higher the score, the greater the self-esteem). In the Spanish version, the test-retest reliabil-

ity after an interval of 2 weeks is .83 and the alpha coefficient of internal consistency is .90.

The Rathus Assertiveness Scale (Rathus, 1973) aims to evaluate the participant's assertive social behavior. It is made up of 30 items, the points for which can be assigned between +3 (*very characteristic of me*) to –3 (*not at all characteristic of me*). The range of total scores is from +90 to –90, with a cutoff point of 0; the higher the positive score, the greater the degree of assertiveness. In the Spanish version, the alpha coefficient of internal consistency is .78.

THERAPEUTIC MODALITIES

Self-exposure in vivo. With this procedure (simulated exposure), the participants confront, little by little and in a consistent fashion, those significant social situations that they avoid in daily life and that cause them great discomfort. The goal is to break the chain of avoidance as well as to confront the autonomic and cognitive components of social anxiety. The treatment is carried out in a group format, which allows for the practice of various behavior rehearsals related to the different types of social behavior usually avoided. Every patient had to carry out at least two exercises of simulated exposure each session. Homework (self-exposure) is assigned on the target behaviors, and record-keeping sheets are distributed so that the patients may take notes at home on said exercises.

Self-exposure in vivo with cognitive therapy. With this combined treatment, the patients are taught, according to the method proposed by Beck, Emery, & Greenberg (1985), to identify and question their automatic thoughts and to suggest alternative responses to their irrational fear of negative evaluation as well as to face little by little and in a consistent manner the significant social situations that they tend to avoid in daily life. The treatment is carried out in a group format that permits, on one hand, the practice of various types of behavior rehearsals implicated in the social behaviors that the patients tend to avoid, and on the other hand, the practice of cognitive restructuring exercises that are integrated into the behavior rehearsals. Homework

is given on cognitive and behavioral tasks related to the target behaviors and should be written up on the record-keeping sheets provided.

PROCEDURE

The program of evaluation and treatment was designed jointly by the therapist (the first author of this work, a clinical psychologist with 3 years of experience in the cognitive-behavioral treatment of anxiety disorders) and by the director of the study (the second author).

The patients excluded from the study were referred to mental health centers or, in the least serious cases, were given coping strategies with which to confront the problem. At the same time, the control-group participants received therapeutic aid after the 6-month evaluation but were not included in the experimental modalities. To keep them any longer on the waiting list for the sole purpose of facilitating the experiment would have posed a situation hardly compatible with ethical requirements.

Evaluation

In pretreatment, the assessment measures were carried out with the patients selected for the study, and the content of the therapy was thoroughly explained.

Subsequent evaluations took place once therapy was finished, in posttreatment and in the 1-, 3-, 6-, and 12-month follow-ups. In addition to these global evaluations, in the intratreatment—during the 4th week of therapy—global perceptions of change were evaluated, as was the evolution in target behaviors and on the Scale of Adaptation.

On the other hand, the control-group participants were evaluated after their selection and at the end of the 6-month observation period.

Treatment

The general characteristics of the therapeutic procedure in each of the clinical modalities are shown in Table 1.

Additionally, in the second session, half of the participants in the experimental groups—14 from the self-exposure group and 13 from

TABLE 1
Characteristics of Therapeutic Modalities

Type of Treatment	*Exposure*	*Exposure With Cognitive Restructuring*
Modality	Group (4-8 patients)	Group (4-8 patients)
Therapists	2 (1 man and 1 woman)	2 (1 man and 1 woman)
Number of sessions	8	8
Periodicity	Weekly	Weekly
Duration of each session	2.5 hours	2.5 hours
Total duration of program	2 months	2 months

the self-exposure with cognitive therapy group—were given a self-help manual for the management of anxiety (Spanish version, Butler, 1990). The aim was to evaluate whether the self-help manual provided an added value to the therapeutic program offered.

Finally, all of the follow-ups were carried out in the form of interviews, used to bring the groups back together to talk about their progress and the problems posed as well as to recall concepts about the treatment.

RESULTS

The participants of the sample ($N = 71$) obtained a mean score of 23.98 ($SD = 3.36$) in pretreatment on the SAD and of 25.56 ($SD = 3.56$) on the FNE, both of which are well above the cutoff points proposed in this and other studies (Heimberg, Hope, Rapee, & Bruch, 1988; Oei, Kenna, & Evans, 1991). In fact, 91.55% of the sample surpassed the cutoff point in both measures. The group, then, was made up of patients afflicted with critical social anxiety, an anxiety that they have carried with them for practically all of their lives and that manifests itself, fundamentally, in the forms of blushing, trembling, and overall freezing-up in social situations.

The distribution of the sample follows a normal curve according to the Kolmogorov-Smirnoff analysis, except in the area of fear of negative evaluation ($DN = 0.18$, $p < .05$). Before initiating treatment, the three groups were homogeneous in demographic variables

and in the measures of social phobia, psychopathological variables, and dimensions of personality, the only exception being in the area of assertiveness, $F(2, 68) = 3.97$, $p < .05$, in which the control-group participants obtained lower scores than those of the participants in the combined-treatment group.

REFUSALS AND DROPOUTS

Although there were no individuals who actively refused treatment, there were 2 patients who failed to attend and who can be categorized as passive refusals. The number of dropouts in all phases was 15 (3 of them control-group participants). Thus, the total number of refusals, dropouts, and loss of patients in all groups comes to 17, representing 23% of the total.

There are no significant differences among the different modalities. From a temporal perspective, the dropouts tended to occur before the fourth session of treatment and in the 6- and 12-month follow-ups.

An analysis of variance in the quantitative variables and a chi-square analysis in the qualitative variables were done for all participants in pretreatment, both those who completed all the phases of the study and those who dropped out. There were no differences between the two groups in any of the demographic, psychopathological, or personality variables analyzed in this study.

RATES OF IMPROVEMENT AND FAILURE

In this study, therapeutic success is defined as the disappearance of social phobia according to the diagnostic criteria for the *DSM-III-R* and the achievement of two of the following requirements: (a) scoring less than 15 on the SAD; (b) scoring less than 21 on the FNE; and (c) scoring 3 or lower on the Subscale of Global Adaptation of the Scale of Adaptation.

From a categorical perspective, the results obtained with the two therapeutic modalities are satisfactory: an improvement rate of 64% of all of the cases in the 12-month follow-up, when behavior is fairly well stabilized. However, there were no significant differences between the groups in any of the evaluation periods (Table 2).

TABLE 2
Therapeutic Improvement Percentage and X^2 Results ($N = 36$)

Assessment	*Exposure* N = *18* n (%)	*Exposure With Cognitive Restructuring* N = *18* n (%)	X^2	*Total (%)*
Posttreatment	8 (44, 4)	8 (44, 4)	—	44, 4
1 month	8 (44, 4)	7 (38, 8)	0, 11 *ns*	41, 6
3 months	9 (50)	8 (44, 4)	0, 11 *ns*	47, 2
6 months	13 (72)	10 (55, 5)	1, 08 *ns*	63, 8
12 months	12 (66, 6)	11 (61, 1)	0, 12 *ns*	63, 8

As far as the control group was concerned ($N = 20$), there were no significant differences in any of the variables used as criteria for improvement when the pretreatment and 6-month evaluations are compared.

RESULTS OF THE MEASURES OF SOCIAL PHOBIA, PSYCHOPATHOLOGICAL VARIABLES, AND DIMENSIONS OF PERSONALITY

From a dimensional perspective, the goal of treatment is to lower the scores for psychopathological variables and social phobia and to raise the scores in the personality dimensions considered (self-esteem and assertiveness).

Between-Group Analysis

The means and standard deviations of the social-phobia variables, psychopathological measures, and dimensions of personality studied at the various points of evaluation are set forth in Table 3, along with the values for F and for t, whichever the case may be, in the independent measures.

Regarding the social-phobia variables, in the independent ANOVA measures there are only significant differences in the 6-month evaluation. The post-hoc LSD test reveals, on one hand, the superiority of the therapeutic groups with respect to the control group, and on the other hand, shows that differences between the experimental groups

TABLE 3
Means (and standard deviations) and *F* and *t* Values in Social Phobia, Psychopathological Symptoms, and Personality Aspects

	Exposure	*Exposure With Cognitive Restructuring*	*Control*		
	M (SD)	M (SD)	M (SD)	F	t
SAD (0-28)					
Pretreatment	24.7 (3.38)	23.2 (2.92)	23.9 (3.71)	1.27	
Posttreatment	15.8 (5.85)	16.9 (5.81)			0.62
6 months	12.8 (7.66)	13.5 (7.37)	23 (4)	14.8***	
12 months	11.8 (8.35)	12.7 (8.37)			0.31
FNE (0-30)					
Pretreatment	25.7 (4.06)	25.4 (3.31)	25.5 (3.39)	0.03	
Posttreatment	20.6 (7.45)	19.5 (5.82)			0.54
6 months	16.2 (9.10)	16.8 (7.49)	24.4 (5.36)	7.58**	
12 months	17.8 (9.32)	14.4 (7.45)			1.20
STAI (0-60)					
Pretreatment	32.2 (13.8)	34 (9.2)	35.5 (11.1)	0.45	
Posttreatment	24.9 (13.8)	25.1 (10.7)			0.06
6 months	20.3 (14.8)	26.2 (11.9)	34 (13.9)	4.93**	
12 months	16.2 (10.9)	24.9 (11.7)			2.30*
BDI (0-63)					
Pretreatment	14.5 (9.61)	12.9 (6.97)	15.6 (7.39)	0.65	
Posttreatment	9.61 (8.24)	9.5 (5.73)			0.02
6 months	5.63 (7.88)	8.7 (7.35)	14.8 (7.44)	7.57**	
12 months	5 (7.97)	8.2 (6.69)		1.33	
Inadaptation (6-36)					
Pretreatment	4.75 (1.36)	4.5 (0.83)	4.78 (0.73)	0.71	
Posttreatment	3.57 (0.97)	3.82 (0.98)			0.85
6 months	2.63 (1.16)	2.95 (1.28)	4.65 (0.93)	17.9***	
12 months	2.66 (0.97)	3.05 (1.34)			0.99
Self-esteem (10-40)					
Pretreatment	24.5 (5.13)	25.8 (3.72)	25 (4.86)	0.51	
Postreatment	28.1 (5.50)	27.1 (3.89)			0.70
6 months	30.3 (5.52)	27.8 (4.6)	25 (4.67)	5.77**	
12 months	29.9 (5.77)	29.3 (4.6)			0.31
Assertiveness (–90/+90)					
Pretreatment	–29.2 (18.7)	–21.1 (16.3)	–35.1 (16.2)	3.91*[a]	
Posttreatment	–18.1 (21.6)	–11.7 (15.9)			1.1
6 months	–12 (19.2)	–5.5 (17.7)	–34.9 (16.1)	15.3***	
12 months	–7.6 (22.8)	–4.4 (22.1)			0.43

NOTE: SAD = Social Avoidance and Distress Scale; FNE = Fear of Negative Evaluation Scale; STAI = State-Trait Anxiety Inventory; and BDI = Beck Depression Inventory.
a. The differences are between control group and combined-treatment group.
*$p < .05$. **$p < .01$. ***$p < .001$.

are nonexistent. In the 12-month evaluation when the control group is absent, no differences exist between the two therapeutic modalities.

As far as the psychopathological measures are concerned, in the ANOVA of the 6-month evaluation, significant differences between the experimental groups and the control group can be seen in depression and in global inadaptation. The control group is surpassed by the therapeutic groups, yet there are no differences between them. Nevertheless, in anxiety, there are no differences between the control group and the combined-treatment group. In the 12-month evaluation, there are no differences between the therapeutic modalities in the variables measured, except for in the level of anxiety ($t = 2.30$, $p < .05$), which tends to be lower in the self-exposure group.

Regarding the dimensions of personality, there are significant differences in the 6-month follow-up in assertiveness between the experimental groups and the control group, favoring the former, yet with no differences between the two therapeutic groups. On the other hand, there are no differences between the combined-treatment group and the control group in self-esteem. In the 12-month follow-up, there are no differences between the experimental groups in either self-esteem or assertiveness.

Within-Group Analysis

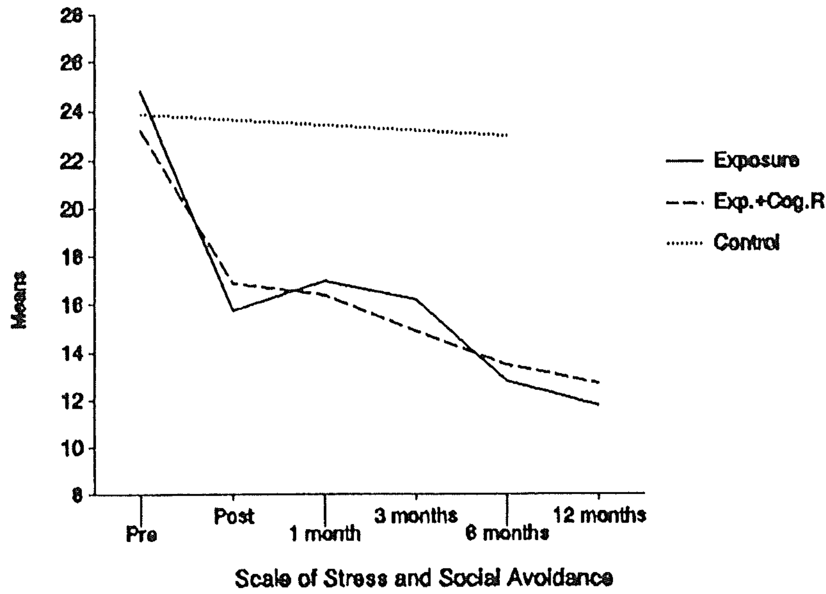
Table 4 shows the values for F and t in the repeated measures at the fundamental periods of evaluation, in social-phobia variables, in psychopathological measures, and in dimensions of personality. The evolution of these measures throughout the entire period of treatment is represented by Figures 1 and 2.

A marked improvement can be seen in the social-phobia variables between pre- and posttreatment along with a slow improvement between posttreatment and the 6-month follow-up, in both therapeutic modalities. On the scale of stress and avoidance, the results tend to level off between the 6- and 12-month evaluations; nevertheless, on the scale of fear of negative evaluation, there is a different evolution: a slight improvement in the combined-treatment group and a slight worsening in the self-exposure group. Finally, the control group showed no improvement in any of the variables.

TABLE 4
Within-Group Comparisons (*F* and *t* values) in Social Phobia, Psychopathological Symptoms, and Personality Aspects

	Exposure	*Exposure With Cognitive Restructuring*	*Control*
	t	t	t
SAD	*F* = 26.85***	*F* = 19.59***	
Pre- and posttreatment	6.76***	5.08***	—
Pre-6 months	6.28***	6.14***	1.66
Post-6 months	2.33*	2.57*	—
6 months to 12 months	1.02	0.19	—
FNE	*F* = 15.02***	*F* = 22.71***	
Pre- and posttreatment	4.12***	5.63***	—
Pre-6 months	5.02***	5.56***	1.19
Post-6 months	3.33**	2.36*	—
6 months to 12 months	5.29***	2.11*	—
STAI	*F* = 7.48***	*F* = 5.28***	
Pre- and posttreatment	4.40***	4.04**	—
Pre-6 months	3.78***	2.85*	0.92
Post-6 months	0.77	0.28	—
6 months to 12 months	0.99	0.2	—
BDI	*F* = 14.24***	*F* = 9.86***	
Pre- and posttreatment	3.29**	2.79*	—
Pre-6 months	4.41***	3.86**	0.27
Post-6 months	2.62*	0.65	—
6 months to 12 months	1.43	0.88	—
Inadaptation	*F* = 23.98***	*F* = 11.90***	
Pre- and posttreatment	3.85***	3.10**	—
Pre-6 months	5.77***	5.24***	0.90
Post-6 months	3.03**	4.16***	—
6 months to 12 months	0.23	0.36	—
Self-Esteem	*F* = 14.43***	*F* = 7.63***	
Pre- and posttreatment	3.84**	2.04	—
Pre-6 months	4.02**	2.40*	0.24
Post-6 months	1.94	0.92	—
6 months to 12 months	1.34	1.44	—
Assertiveness	*F* = 15.92***	*F* = 8.27***	
Pre- and posttreatment	3.59**	2.77*	—
Pre-6 months	5.15***	3.96**	0.55
Post-6 months	2.68*	2.21*	—
6 months to 12 months	1.44	0.19	—

NOTE: SAD = Social Avoidance and Distress Scale; FNE = Fear of Negative Evaluation Scale; STAI = State-Trait Anxiety Inventory; and BDI = Beck Depression Inventory.
$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$.



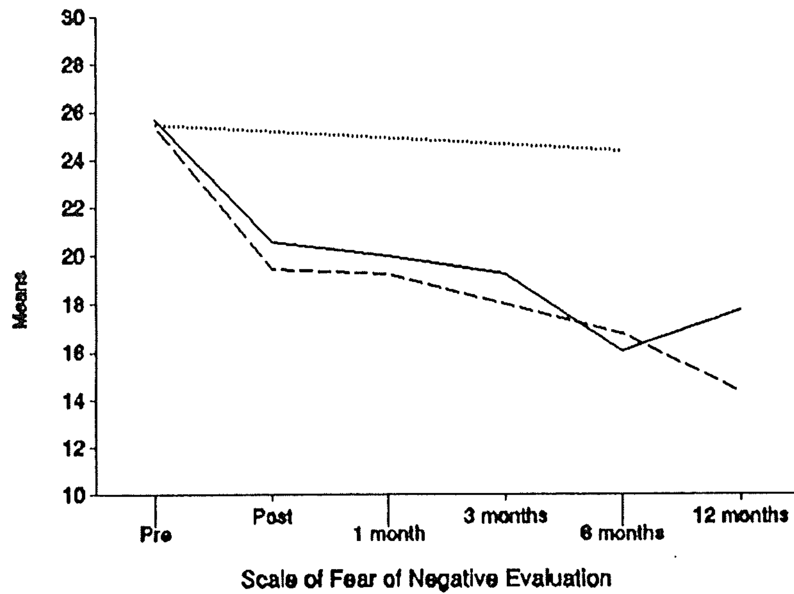
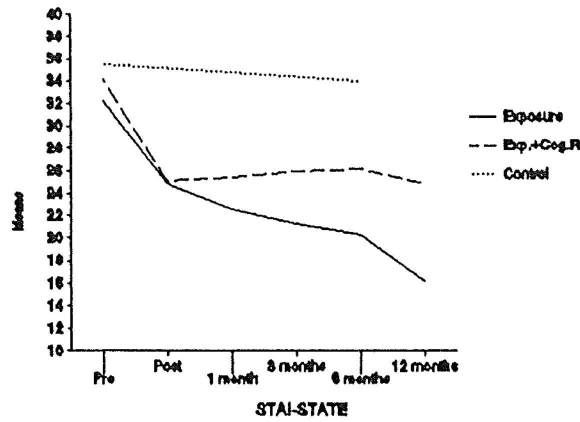
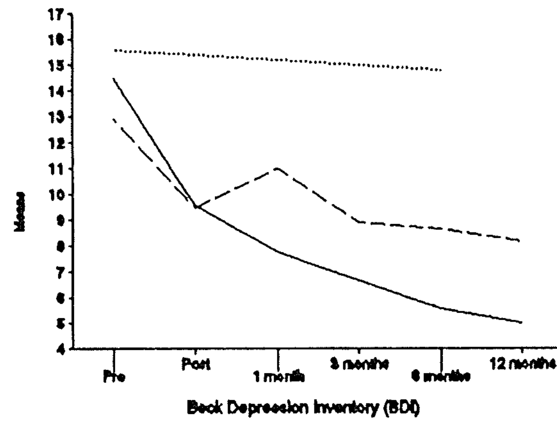


Figure 1. **Mean scores on the dependent social-phobia measures (Social Avoidance and Distress Scale and Fear of Negative Evaluation Scale) for the waiting-list control group and both treatment conditions at the different assessment occasions.**





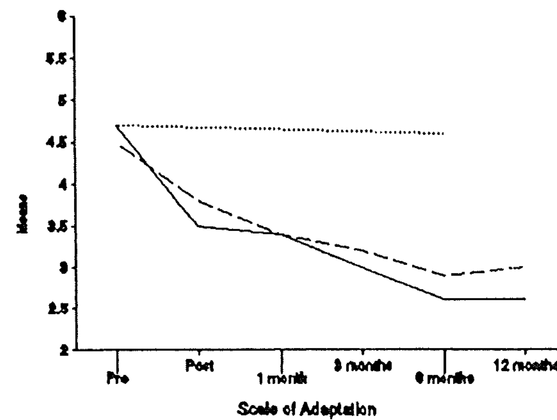


Figure 2. Mean scores on the dependent psychopathological measures (State-Trait Anxiety Inventory, Beck Depression Inventory, and Scale of Adaptation) for the waiting-list control group and both treatment conditions at the different assessment occasions.

As far as the psychopathological measures (anxiety, depression, and inadaptation) are concerned, the evolution is slightly different. In both therapeutic modalities, there is a significant improvement between pre- and posttreatment. Nevertheless, in the group of exposure, a slow increase in said improvement can be seen up until the 6-month follow-up (e.g., in depression $t = 2.62$, $p < .05$), after which the results tend to level off; on the contrary, in the combined group, the results do not improve after the posttreatment assessment (e.g., in depression $t = 0.88$, *ns*). Finally, the control group showed no improvement in any of the variables.

In dimensions of personality, the evolution is notably different. Improvement took place gradually between the pre- and posttreatment and continued until the 6-month follow-up. There were no differences between the two therapeutic modalities. Finally, the control group showed no improvement in any of the variables.

EFFECTIVENESS OF THE SELF-HELP MANUAL

A factorial analysis of variance was carried out in the variables of social phobia, in the psychopathological measures, and in the dimensions of personality at each of the evaluation periods to test the effectiveness of the self-help manual.

In the posttreatment evaluation, a significant interaction ($F = 4.46$, $p < .05$) can only be seen in the SAD. The principal effects due to the use of the manual and to the type of treatment employed are not statistically significant. The exposure group without the manual ($X = 13.4$, $SD = 1.8$) is the one with the best results compared to the other ones (exposure with manual, $X = 17.6$, $SD = 1.6$; exposure and cognitive therapy with manual, $X = 15.5$, $SD = 1.6$; and exposure and cognitive therapy without manual, $X = 18.5$, $SD = 1.7$).

There are no significant differences in the 1- and 3-month follow-ups. In the 6-month evaluation, there is a significant interaction ($F = 4.30$; $p < .05$) in the Self-Esteem Scale and in the 12-month evaluation, interaction is significant in the Scale of Adaptation ($F = 7.47$; $p < .01$). Here as well, the exposure group without the manual is the one with the best results.

It is safe to conclude, then, that the distribution of a self-help manual is not a factor of any significant weight in the treatment's end result.

CONCLUSIONS

The validity of this study is derived from the equivalence of the groups in pretreatment and from the consistency of the results obtained in the different variables measured as well as from the homogeneity of the sample, the size of the sample ($N = 71$), and the length of the follow-up period (12 months).

Generalized social phobia is shown to be a disorder that can be successfully treated. In fact, there is a clear improvement in the participants treated compared to the control-group participants in all of the variables measured. This conclusion is concordant with the results of previous studies (Butler et al., 1984; Hope, Herbert, & White, 1995; Kanter & Goldfried, 1979; Mersch, 1995; Scholing & Emmelkamp, 1993b).

The percentage of participants who improved with one of the two modalities of treatment totals 64% of the cases by the 12-month follow-up. The improvement in social behavior is synchronous with the modification of cognitive responses. This percentage is reasonably satisfactory, although somewhat lower than that described by Öst (1989) for specific social phobias (75%-85%) or for agoraphobia (65%-75%). Social phobia is more difficult to treat than other phobias, probably because of the roots this disorder has in certain dimensions of personality (especially neuroticism and introversion) and because of the lack of social skills that usually goes along with the disorder (Edelman & Chambless, 1995; Hope et al., 1995; Heimberg, & Bruch; Tran & Chambless, 1995).

Regarding the differential efficacy of the therapeutic modalities, consistent differences between the two experimental conditions do not exist in the variables measured in any of the evaluation periods. Consequently, the addition of cognitive therapy to the treatment of self-exposure does not constitute an increased therapeutic effect. These results are congruent with the studies done by Biran et al. (1981), Hope, Herbert, and White (1995), Mersch (1995), Stravynski,

Marks, & Yule (1982), and Scholing & Emmelkamp (1993b) but are discordant with the results of other studies (Butler et al., 1984; Mattick et al., 1989).

The self-help manual, tested for the first time by this study, does not carry an added weight in the final result of the treatment. From a cost-benefit point of view, its usefulness is dubious. Perhaps future studies should assess other variables, such as the education levels of the participants, how reading assignments can be checked, and whether the participants who do the reading know how to benefit from it.

As far as the therapeutic evolution is concerned, the rate of improvement was 44% in posttreatment and 64% in the 12-month follow-up. That is, there is a rapid improvement between the pre- and posttreatment and a more gradual improvement between posttreatment and the 6-month follow-up, after which point the results tend to level off. For this reason, determinations of therapeutic results should not be made until at least 6 months after treatment.

The rate of dropouts in the largest sense of the word (refusals, dropouts, loss of patients in the follow-up) is 23%, the same as in other studies (Scholing & Emmelkamp, 1993b). The most critical moments for loss of patients are before the fourth treatment session and after the 3-month follow-up. The criterion for dropout used in this study is very strict. Dropouts during treatment are clearly therapeutic failures. However, the loss of patients in the follow-up period could, at least in some cases, be due to the degree of improvement noted by the patients, reducing motivation to return to the therapy center.

Several questions remain to be answered in future studies. The therapeutic results obtained in this study are satisfactory, yet 36% of the patients ($N = 13$) did not benefit from it. It would be useful to study the characteristics of these types of patients and to fine tune treatments dedicated to helping them. It may be necessary to design a comprehensive treatment (education, social-skills training, and exposure) to address the multifaceted syndromal features characteristic of social phobia (Turner, Beidel, & Cooley-Quille, 1995).

Cognitive therapy, integrated into the self-exposure, has not been proven to be efficacious in this study. Systematic application of cognitive therapy in the treatment of social phobia seems unjustified. Perhaps it should be applied in other studies under different conditions

(i.e., individual format, greater duration of treatment, etc.) and with a selection of patients (i.e., higher educational level, lesser degree of affliction, etc.) who can benefit specifically from this technique.

Finally, the growing use of self-help manuals should be accompanied by studies regarding their efficacy. The results obtained in this first study are not satisfactory. It would be a good idea, however, to replicate these results in other studies, using, for instance, a more specific manual, a greater number of participants, and a precise selection of patients.

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