Painfully Shy, Socially Phobic: An Inquiry Into the World of Social Anxiety

A Review of

Shy Children, Phobic Adults: Nature and Treatment of Social Anxiety Disorder (2nd ed.)
by Deborah C. Beidel and Samuel M. Turner
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Reviewed by
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The first edition of Beidel and Turner's book, *Shy Children, Phobic Adults: Nature and Treatment of Social Anxiety Disorder*, published in 1998, was a small but comprehensive coverage of the emerging field of social anxiety disorder (SAD) research. I used the first edition often and frequently recommended it to my students. This might be the reason why I am no longer able to locate it in my office. I vaguely remember that I gave it to one of my students, but I don't remember who and when it was. (If the student is reading this, shame on you—give it back!) This seems to be the fate of good academic books—they tend to vanish. I promised myself that I would be more careful with the second edition.

Since the first edition of this book, a number of changes have occurred in the field of social anxiety research. Those of us who specialize in that area know much more now about the psychopathology of SAD than we knew then, thanks to many studies ranging from tightly controlled experimental psychopathology research to functional imaging experiments. New and more specialized measures of aspects related to social anxiety have been developed, and large, randomized, placebo-controlled trials have been published. These trials compared cognitive behavioral treatments (CBT) and other exposure-based psychotherapy with state-of-the-art pharmacological therapy, such as the monoamine oxidase inhibitors (Heimberg et al., 1998) and selective serotonin inhibitors (Davidson et al., 2004). Moreover, the Food and Drug Administration approved paroxetine as a treatment for SAD in 1999 based on positive outcomes from well-controlled trials (e.g., Stein et al., 1998). This has led to a further increase in research interest and has enhanced the visibility of SAD.

Beidel and Turner were some of the first psychologists who studied the disorder. The team has made remarkable contributions to the field, ranging from psychopathology experiments to developing assessment instruments and treatment protocols. Their names are associated with the Social Phobia and Anxiety Inventory for adults (Turner, Beidel, Dancu, & Stanley, 1989) and children (Beidel, Turner, & Morris, 1995), social effectiveness therapy (Turner, Beidel, Cooley, Woody, & Messer, 1994), and rigorous experimental studies on the diagnostic subtypes, among many other things. Without any doubt, the programmatic research by the Turner–Beidel team contributed in large part to the advancement of the field. Therefore, the team is highly qualified to write such a text.

Beidel and Turner's book is an authored, not an edited, text. It is therefore able to synthesize a large number of studies from different perspectives and sources. The result is an authoritative and comprehensive text that combines a scholarly review and hands-on clinical guidelines, illustrated with case examples and treatment-relevant materials. The book further strikes a nice balance between the adult and child clinical literature, as well as between psychological approaches and psychiatric treatments. In general, this is a first-rate text written by two of the foremost experts in the field of SAD. My critique primarily focuses on theoretical details that reflect some of the current controversies in the field.
From Shyness and Social Anxiety to SAD

Social anxiety is not only normal but also a necessary part of what makes us human. Social contact and affiliation are fundamental needs of essentially all species. Humans, in particular, have evolved high-level motivations to compete for the approval and support of others. We need to be liked, valued, and approved of in order to elicit parental investment, develop supportive peer relationships, attract desirable mates, and engage successfully in many types of social relationships. Evolutionary psychologists conceptualize social anxiety as a form of competitive anxiety, triggered in social situations in which individuals would like to increase or defend their social standing in the eyes of others. Every healthy person knows what it feels like to be socially anxious or embarrassed. In fact, it is the absence of any social anxiety that is reason for concern. The typical child undergoes periods of stranger anxiety and separation anxiety. Perhaps this is one reason why the clinical expression of social anxiety was neglected for so many years.

In order to describe the abnormal range of social anxiety, Beidel and Turner remain firmly rooted in the Diagnostic and Statistical Manual of Mental Disorders (DSM; e.g., American Psychiatric Association, 1994). SAD is conceptualized as a mental disorder next to other Axis I and II diagnoses. The boundaries to the nonclinical form of social anxiety are more or less clearly demarcated by diagnostic criteria. The authors carefully discuss issues of comorbidity and differential diagnoses of SAD in adults and children.

Without any doubt, the DSM has been enormously influential for identifying and studying individuals with SAD. However, DSM criteria are man-made, not empirically derived. They are decided by committees, not nature. They facilitate communication between researchers and clinicians, but they do not carve nature at its joints. In fact, I think the diagnostic criteria for SAD are a prime example of the problems associated with a medical model and categorical nosological system. Individuals who are diagnosed with SAD are remarkably heterogeneous in the expression of their social anxiety. The diagnostic subtype (i.e., classified by who does or does not fear most or all social situations) is a crude and atheoretical method of making sense of this heterogeneity. Beidel and Turner remain within the confines of an imperfect nosological system. As a result, considerable space is devoted to comorbid Axis I and II disorders. Alternatively, a dimensional framework for SAD may be a better fit with reality. A more in-depth discussion of alternative classification schemes for SAD is beyond the boundaries of this review, but it certainly would have been within the boundaries of an authoritative text of SAD, such as the one by Beidel and Turner. It takes courage to step outside the confines of the DSM, but if researchers dare, a whole new world could open up.

Where Does It All Come From?

During the quest for the origins of SAD, researchers are typically confronted with the old nature–nurture dilemma. Not surprisingly, there is evidence to support both perspectives. Some of the findings by Kagan and his colleagues (e.g., Schwartz, Snidman, & Kagan, 1999) are relevant for this discussion and were, to some extent, acknowledged by Beidel and Turner.

One could argue that the empirical evidence from prospective temperament research is considerably stronger than that from retrospective studies examining the role of conditioning and other environmental influences in the development of social anxiety. There is clear empirical evidence to suggest that high-reactive infants and inhibited children are more likely to develop SAD in adolescence and adulthood. Beidel and Turner question the specificity of behavioral inhibition as a precursor for SAD. Furthermore, not every high-reactive infant becomes a behaviorally inhibited child, and not every inhibited child later develops SAD. Similarly, not every adult with SAD was highly reactive during infancy and behaviorally inhibited during childhood. Beidel and Turner argue that other factors, such as early relationships and conditioning events, might have contributed to the development of the disorder in many cases. As support for this contention, the authors cite some retrospective studies that appear to support the conditioning theory of SAD. It is not surprising to find phobic individuals who remember an extremely unpleasant encounter with the phobic stimulus in the past. This, however, does not mean that the disorder is caused by a traumatic event. At the minimum, one would need to demonstrate temporal precedence of the events in relation to the onset of the disorder. To my knowledge, this has
not been demonstrated. In fact, the few studies that examined the relative onset of the phobic event in relation to the traumatic experience found that the trauma occurred many years after the onset of SAD. Unfortunately, these studies are not included in the discussion of this topic. Similarly problematic are other studies that examine etiological models of SAD with retrospective data (observation learning and information transfer). The heterogeneity of SAD further complicates the situation because it is possible that SAD is more heritable in some individuals than in others.

## How Can It Be Changed?

Beidel and Turner are behaviorists and are critical toward the cognitive model (Clark & Wells, 1995), which has become very influential in the field of SAD. The following paragraph illustrates their position:

Initially, cognitive-behavioral therapy (CBT) was based on the notion that negative cognitions presenting as part of a clinical syndrome were (a) etiological factors for the development of the disorder and (b) in need for specific intervention for there to be a positive treatment outcome. Although there were those who always challenged this view... it is gratifying that proponents of CBT now recognize that cognitions are not unique, etiologically responsible for the onset of a disorder, or necessarily in need of direct intervention, at least for treatment of social anxiety disorder. Specifically, CBT is now viewed as a generic label for myriad interventions held together by the acknowledgment that exposure... is the key ingredient of most CBT treatments. (p. 206)

Beidel and Turner correctly note that so far, little data exist to support the notion that change in cognitions mediate CBT of SAD. However, this is not unique to CBT of SAD; the mechanism of psychological intervention is generally not well understood. Our field has only recently begun to mature beyond the simple question of treatment efficacy. CBT-oriented therapists no longer need to demonstrate that the treatment is generally effective for most people with the disorder. This has clearly been shown in a number of well-controlled trials, many of which were reported by Beidel and Turner. Researchers have now begun to focus their attention on why and how these treatments work. The next generation of treatment researchers is dealing with a different set of questions. They include the following: What are the variables that determine treatment response? What are the treatment ingredients that produce treatment change in some individuals but not in others? Why does treatment not work in some individuals, and what needs to be changed to make it work? And what exactly is the difference between the different treatment modalities, such as CBT and exposure therapy? Similar questions apply to the pharmacotherapy of SAD.

These questions force psychologists to rethink many basic assumptions. Beidel and Turner have argued that CBT strategies always also include exposure procedures. This is almost certainly correct. At the same time, however, it could be argued that any exposure procedure also always leads to changes in cognitions (e.g., Hofmann, Moscovitch, Kim, & Taylor, 2004). Answering these questions is important because they give us a better understanding of the psychopathology of SAD and point to novel intervention methods (Hofmann et al., 2006). Beidel and Turner's book lays the foundations for work on many of these fundamental questions for the next generation of studies on SAD.

## Epilogue

It is satisfying to see how far research in SAD has come. At the same time, it is humbling to review the enormous body of research that was conducted by Sam Turner during his distinguished career. He passed away too soon—too soon for our field, too soon for his colleagues who admire his work, and too soon for those who suffer from SAD.

## References


Social Phobia and Anxiety Inventory for Children. *Psychological Assessment, 7*, 73–79.


