NEAR EAST UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
APPLIED (CLINICAL) PSYCHOLOGY PROGRAM

MASTER PROJECT

SOCIAL PHOBIA AND COGNITIVE BEHAVIOURAL THERAPIES

AYŞE GENÇ
20060975

SUPERVISOR
Assoc. Prof. Dr. EBRU ÇAKICI

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Examining Commitee in Charge

Prof. Dr. Mehmet ÇAKICI	**Chairperson of the commitee** **Department of Psychology** **Near East University**
Assoc. Prof. Dr. Ebru ÇAKICI **(Supervisor)**	**Department of Psycholog** **Near East University**
Asist. Prof. Dr. Zihniye OKRAY	**Department of Psychology** **European University of Lefke**

Approval of the Graduate School of Social Sciences

Prof. Dr. Çelik Aruoba - Dr. Muhittin Özsağlam

ÖZET

SOSYAL FOBİ VE BİLİŞSEL DAVRANIŞÇI TERAPİLER

Ayşe Genç

Eylül, 2015

Sosyal fobi erken ergenlik yıllarında başlayan, sık görülen, kronik ve kişinin yaşam kalitesini olumsuz etkileyen bir anksiyete bozukluğudur. Sosyal fobi kısaca, performans veya sosyal etkileşim ortamlarında kendini küçük düşürücü bir şekilde hareket etmekten ve olumsuz eleştiri ve yargılanmaktan belirgin ve sürekli şekilde korkma olarak tanımlanabilir. Sosyal fobinin yaşam boyu yaygınlığı %3 ile %13 arasında değişmekte ve kadınlarda daha yaygın görülmektedir. Sosyal fobiyi etkileyen ana faktörler; ailesel ve genetik faktörler, çocukluk çağı yaşantıları ve davranışsal ketlenmedir. Sosyal fobinin tedavisinde bilişsel davranışsal terapi etkili bir tedavi yöntemidir. Bilişsel davranışsal terapinin amacı hastaya, olumsuz ve tehlike-ilişkili düşüncelerini ve ilişkili davranışlarını nasıl belirleyeceğini, değerlendireğini, kontrol edeceğini ve değiştireceğini öğreterek anksiyetesini azaltmaktır. Sosyal fobinin tedavisinde birçok farklı bilişsel davranışçı teknikler kullanılmaktadır. Yapılan araştırmaların sonuçları incelendiğinde, bu tekniklerin sosyal fobi semptomları üzerindeki olumlu etkileri görülmektedir. Bu çalışmada sosyal fobi tedavisinde kullanılan çeşitli bilişsel davranışçı tedavi tekniklerine yer verilmiş ve sosyal fobi hastalarıyla çalışan klinisyenler için yararlı bir kaynak olmayı hedeflemektedir.

ABSTRACT

SOCIAL PHOBIA AND COGNITIVE BEHAVIOURAL THERAPIES

Ayşe Genç
September, 2015

Social phobia is an anxiety disorder which generally starts early in teenage years, commonly occuring, chronic and negatively affecting individual's quality of life. Social phobia can be briefly described as a persistent and evident fear of acting in a humiliating way and being criticized and judged negatively in performance or social interactive situations. The lifetime prevalence of social phobia is ranging from 3% to 13% and it is more common in women. The main factors affecting social phobia are; parental and genetic factors, childhood experiences, and behavioral inhibition. In social phobia's treatment, cognitive behavioural therapy is an effective method. The aim of the cognitive behaviour therapy is to reduce patient's anxiety by teaching them how to identify, evaluate, control and modify their negative danger-related thoughts and related behaviours. Many different cognitive behavioral techniques are used in the treatment of social phobia. When the results of researches investigated, positive effects of these techniques on social phobia symptoms are seen. This study has been included various cognitive bahvioural techniques used in the treatment of social phobia and intends to become a useful resource for clinicians working with social phobia patients.

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Ayşe Genç

Nicosia; September, 2015

CONTENTS

ABBREVIATIONS

CBM : Cognitive Bias Modification

CBT : Cognitive Behavioural Therapy

SET-C : Social Effectiveness Therapy for Children

TBTR : Trial-Based Thought Record

1. INTRODUCTION

The main characteristic of social anxiety disorder or social phobia is a persistent and evident fear of being humiliated and being criticized and judged negatively in performance or social interactive situations (APA,2013). The lifetime prevalence of social phobia is 9.5% in females and 4.9% in males (Wittchen *et. al.*, 1999). The age of onset of social phobia is generally in early teenage years. And the frequency of social phobia in adolescents is seen as 14.4% (Bayramkaya *et. al.*, 2005).

Social Phobia is a disease that affects people's quality of life. It causes impairments in work, school or household management (Wittchen *et. al.*, 1999) and also affects person's relations with others and subjective well-being (Öztürk and Mutlu, 2010).

Social phobia is a disorder which has a treatment. In social phobia's treatment cognitive behavioral treatment is very effective (Gil *et. al.*, 2001). It is effective in increase of social skills, reduction of social anxiety, and improving social anxiety disorder symptoms (Purehsan and Saed, 2010). The aim of the cognitive behaviour therapy is to reduce patient's anxiety by teaching them how to identify, evaluate, control and modify their negative danger-related thoughts and related behaviours (Hawton *et.al.*, 1989, 63).

The aim of this study is to make a review about social phobia and different cognitive behavioral therapy techniques used in social phobia's treatment. It is expected to become useful resource for clinicians working with social phobia patients.

2. SOCIAL PHOBIA

Social phobia or social anxiety disorder is a commonly occurring, chronic and seriously impairing disorder (Kessler *et. al.*, 1999).

The DSM-V criterias for social phobia (APA, 2013, 202-203) :

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).

Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.

B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing: will lead to rejection or offend others).

C. The social situations almost always provoke fear or anxiety.

Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.

D. The social situations are avoided or endured with intense fear or anxiety.

E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmoφhic disorder, or autism spectrum disorder.

J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from bums or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

Specify if:

Performance only: If the fear is restricted to speaking or performing in public.

2.1. Prevalence and Sociodemographic Characteristics

The 12 month prevalence of social phobia is 7% (APA, 2013, 204). According to researches about community prevalence of social phobia, the lifetime prevalence of social phobia is diverse accross the nations within a range of 0.4–13.7%, and also twelve months prevalence within range of 1.3-7.9%. When we look at the life prevalence according to countries, in United Arab Emirates it is 0.4%, in Germany 1.6%, in Italy 3.27%, in Norvey 13.7%, in France 4.7%, in Iran 0.82%, in Brazil 11.7%, in US 12.01%, in Canada 7.2% and 10.2% in Chile. It is seen that social phobia is more common in developed countries than developing countries. When analyzed by age, it is observed that the prevalence rate is 1.6% under the age 18 and vary between 0.4% and 17% in individuals at age 18 and over. And also the prevalence rates were higher in women than men (Memik *et.al.*, 2011).

Wittchen and co-workers' study showed that the lifetime prevalence of social phobia is 9.5% in females and 4.9% in males. And the generalized subtype of social phobia is more persistent, impairing and co-morbid than non-generalized social phobia

(Wittchen *et.al.,* 1999). And the frequency of social phobia in adolescents is 14.4% (Bayramkaya *et. al.*, 2005).

In the Ontario Health Survey, one-year and lifetime prevalence rates of social phobia are 6.7% and 13.0%, and also lifetime social phobia is associated with being female and being young. When we look at the subtypes of social phobia, the lifetime prevalence of speaking fears is 7.0%, generalized or complex fears is 5.9%. And 54.0% of the individuals with social phobia have the speaking fear subtype of social phobia (Stein and Kean, 2000).

2.2. Age of Onset

The age at onset of social phobia is generally in early teenage years (Bayramkaya *et. al.*, 2005). It mostly starts between the ages 8 and 15 (APA, 2013, 205). And the generalized subtype of social phobia has an earlier age of onset than non-generalized social phobia (Wittchen *et. al.*, 1999).

2.3. Comorbidity

Social phobia is often associated with other psychiatric disorders. Social phobia significantly affects the development of depression (Bayramkaya *et. al.*, 2005). Lifetime social phobia is associated with substantially greater probability of experiencing lifetime major depression. About one-third (33.8%) of the persons with lifetime social phobia has a lifetime diagnosis of major depression with 15.7% comorbidity on a 12-month basis (Stein and Kean, 2000).

In a study with children, most of the children with avoidant disorder met criteria for social phobia and showed that the avoidant disorder is part of the social phobia spectrum in a clinical sample (Denardin *et.al.*, 2004).

Social anxiety disorder during adolescence or young adulthood is an important predictor of following depressive disorder. Individuals with social anxiety disorder are more likely to experience a depressive disorder during the follow-up period than individuals with no mental disorder. Persons with early form of social anxiety disorder and depressive disorder comorbidity, experience more damaging course of depressive illness. And this is manifested in more suicidal ideation and suicide attempts, and more depressive symptoms during episodes and also more frequent or prolonged depressive episodes (Stein *et. al.*, 2001).

Comorbidity of anxiety and mood disorders is common. There is associations between lifetime social phobia and mojor depressive disorder, dysthymia and bipolar disorders. The age of onset is earlier for social phobia than mood disorders in the most of comorbid cases. Social phobia predicts subsequent onset of mood disorders, with population risk ratio of 10-15%, and also associated with severity and persistence of co-morbid mood disorders (Kessler *et. al.*, 1999).

2.4. Parental, Genetic and Childhood Factors

The relatives has a great importance on person's behaviors and development. The behavior patterns and attitudes learned from family, and taking the parents as a model can play a role on social phobia's transfer.

In a study on the attitudes of parents, the results show that children with lower social anxiety have parents with higher education and more democratic attitudes. However, children with high levels of social anxiety have parents with inconsistent and careless attitudes and authoritarian attitude (Kaya *et. al.*, 2012).

Parental psychopathology and perceived parenting style especially parental overprotection are associated with the development of social phobia in youth. And also there is association between parental social phobia and social phobia among offspring (Lieb *et. al.*, 2000).

Social phobia is heritable and first-degree relatives are more likely to have this disorder (APA, 2013, 205). In researches especially the generalized type of social phobia seems to transfered from families. In a family study, social phobia was found about ten times higher at the first-degree relatives of probands with generalized social phobia probands than the first-degree relatives of probands without social phobia. Also they found that avoidant personality disorder was limited to the relatives of probands with generalized social phobia and it occured only when generalized social phobia was also exist (Stein *et. al.*, 1998).

In another family study with mothers, mothers of children with a diagnosis of social phobia and mothers of children with a diagnosis of attention deficit and hyperactivity disorder was observed. Social phobia scores were higher in the social phobic children's mothers than control group. And at the somatization, depression and hostility subscales of the symptom checklist, social phobic children's mothers have scored significantly higher. Also a markedly avoidance behavior was observed at these mothers (Öztürk *et. al.*, 2005).

The factors of early childhood is considered to be important in the development of this disorder. Childhood family violence could be a risk factor for social anxiety. Binelli and co-workers study showed that the family violence is associated with social anxiety (Binelli *et. al.*, 2012).

At the National Comorbidity Surveys in US, studies showed that childhood adversities is associated with the onset, persistence and functional impairment of psychiatric disorders, with a especially strong effect on anxiety disorders (Green *et. al.*, 2010, Mc Laughlin *et.al.*, 2010). In another study on adult patients with social phobia, seen that 50% of patients reported a history of trauma before the age of 16,

and 75% of patients had a history of anxiety disorders in childhood (Manfro *et.al.*, 2003).

2.5. Behavioral Inhibition

Behavioral inhibition predicts onset of social anxiety. The ratio of lifetime social anxiety in inhibited children is more than noninhibited children. Also behavioral inhibition considerably predicts the new onset of social anxiety within children unaffected at baseline in inhibited children against noninhibited children. And leads to subsequent social anxiety in middle childhood (Hirshfeld-Becker *et.al.*, 2007).

Behavioral inhibition in children is a risk for avoidant disorder, social phobia and disruptive behavior disorder. Social anxiety disorder found more in the children with behavioral inhibition than in children without behavioral inhibition. Behavioral inhibition is related with social anxiety among children whose parents had panic disorder. So we can say that children with parental panic disorder and child behavioral inhibition is under a high risk for having social anxiety (Biederman *et. al.* 2001). And chronic high levels of behavioral inhibition are related with a lifetime history of soacial anxiety disorder by adolescence (Essex *et.al.*, 2010).

2.6. Influences of Social Phobia in Person's Life

Social phobia effects person's quality of life. Individuals with social phobia have less satisfaction with their quality of life (Barrera and Norton, 2009). And social anxiety disorder is a risk factor for the subsequent onset of cannabis and alcohol dependence (Buckner *et.al.*, 2008).

Social phobia causes impairments in work, school or household management. These impairments are more frequent in pure and co-morbid generalized social phobics than non-generalized social phobics. And also co-morbid conditions cause increase in social-role impairments (Wittchen *et. al.*,1999).

Social phobia also affects person's relations with others and subjective well-being. In addition, it is related with attachment style. Fearful, preoccupied and dismissing attachment affecting romantic relationship structure and communication between couples negatively (Öztürk and Mutlu, 2010).

In a study showed that social phobia significantly decreased current quality of life, especially causes reduction in vitality, general health, mental health, role limitations due to emotional health, and social functioning. And also affects most areas of life, however, especially education, career, and romantic relationship (Wittchen *et.al.*, 1999).

3. COGNITIVE BEHAVIORAL THERAPIES IN SOCIAL PHOBIA'S TREATMENT

3.1. Cognitive Behavioural Therapy (CBT)

The aim of the cognitive behaviour therapy is to reduce patient's anxiety by teaching them how to identify, evaluate, control and modify their negative danger-related thoughts and related behaviours (Hawton *et.al.*, 1989, 63).

The main techniques of cognitive behavioural treatment are (Hawton *et.al,* 1989, 66-90) :

- Identifying negative thoughts : While some patients can easyly identify their negative thoughts some others may have difficulties to identify their negative thoughts. The reasons of this are; first, nagative automatic thoughts are habitual and acceptable, so that people would not be aware of. Secondly, visual images are short-lived and for this reason its difficult to become aware of or remember. And thirdly, thoughts about danger can cause anxiety so patients try to engage in different forms of covert and overt avoidance.

  The techniques to help patients identify negative automatic thoughts are: discussing a recent emotional experience, using imagery or role-play to relive an emotional experience, shifts in mood during a session and determining the meaning of an event.

- Modifying negative thoughts and associated behaviours: The procedures used to help patients evaluate, control, and modify their negative thoughts and associated behaviours are; rationale, giving information about anxiety, distraction, activity schedules, verbal challenging of automatic thoughts, behavioral experiments, dealing with avoidance behaviour, learning new behaviours and skills, assumption techniques, relaxation techniques, and preventing relapse.

In social phobia's treatment cognitive behavioral treatment is very effective (Gil *et. al.*, 2001). It is effective in increase of social skills and reduction of social anxiety (Purehsan and Saed, 2010). In a open trial study of interpersonal psychotherapy for the treatment of social phobia, after 14 weeks of treatment completed 78% of patients rated improve on overall social phobia symptoms. Patients showed qualitative life improvements, such as obtaining a new job, returning to school, and initiating dating. And nearly all clinician ratings and self-ratings of social phobia symptoms significantly improved (Lipsitz *et. al.* 1999). However when the cognitive therapy and interpersonal psychotherapy's efficacy compared; they both led to significant improvements but the cognitive therapy was more effective than interpersonal psychotherapy in reducing social phobia symptoms (Stangier *et. al.* 2011).

3.2. Some Cognitive Behavioral Techniques Used In Social Phobia's Treatment

3.2.1. Behavioral Experiments

Behavioral experiments are assessment teqnique which helps direct testing of patient's thoughts and assumptions and used alone or in combination with Socratic questioning (Beck, 1995, 222).

In a study about behavioral treatment of childhood social phobia, children treated with Social Effectiveness Therapy for Children (SET-C), which includes educational session, social skills training, peer generalization experiences, and exposure. Assessments were applied at pretreatment, postreatment, and 6-month follow-up, included self-report inventories, parent ratings, independent evaluator ratings, daily diary ratings, and ratings of skill and anxiety in behavioral tasks (role-play scenes and reading aloud before a group). The treatment, SET-C, was provided twice weekly ,one group session and one individual session, for 12 weeks. The results

showed that the SET-C produced improvement across multiple dimensions of functioning, including increased social skill, reduced social fear and anxiety, reduced related psychopathology, and increased social interaction (Beidel *et. al.* , 2000).

Exposure is one of the affective behavioral technique in CBT for social phobia. In Wells and co-workers study, patients received two exposure conditions, which were decrease condition; session of exposure plus decrease in safety behaviors, and neutral condition; session of exposure with no change in safety behaviors. And the patients anxiety and belief ratings was analyzed during before and after conditions. As a result, it was observed that the decrease condition is more effective than neutral condition. But both types of exposure produced reductions in anxiety and belief for most patients. However, the reduction was more in the decrease condition and also all patients showed improvements in anxiety after the decrease condition. This study showed that in case formulations it is important to include in-situation safety behaviors, and modify them in the course of treatment (Wells *et.al.,* 1995). However, when the effectiveness of exposure plus applied relaxation and cognitive therapy compared it is seen that cognitive therapy led to greater improvement in the treatment of social phobia (Clark *et.al.*, 2006).

3.2.2. Trial-Based Thought Record (TBTR)

The trial-based thought record (TBTR) is a 7-column thought record developed by Irismar Reis de Oliveira in 2007. It is a new cognitive behavioral approach used in trial-based cognitive therapy and designed to identify and modify negative core bliefs in cognitive behavioral therapy. TBTR helps to make patients aware of their core beliefs especially about themselves and engaging them in a constructive trial to develop more positive and functional core beliefs (De-Oliveira, 2008).

At TBTR, firstly, the patient is asked to describe the uncomfortable situation . In Column 1, the therapist asks what goes through the patient's mind when he/she notices a strong affect. This phase of the technique is designed to elicit the automatic

thoughts linked to the current emotional state, and is recorded in column 1. Columns 2 and 3 have been designed to help the patient to collect information that supports and information that does not support the negative core belief. Column 2 deals with the core belief in column 1 and its like playing a prosecutor role. The patient is stimulated to identify all the evidence that supports the negative core belief, taken as self-accusation. In column 3, the patient is stimulated to actively identify all the evidence that does not support the negative core belief. Column 4 is devoted to the thoughts such as ''yes, but...'' that the patient uses to disqualify, discount or minimize the evidence or rational thoughts formed in column 3, making them less credible. Column 5 and 6 are the central aspects of this technique. In column 5, the patient is stimulated to invert the propositions in columns 3 and 4, and once again connecting them with the conjunction ''but''. The patient copies down each sentence from column 4 and connects it to the corresponding evidence in column 3 with using the conjunction. The idea is; to cause the patient to disqualify the negative, rather than the positive. The result is the change of perspective to a more positive and realistic one. At this time, the patient is stimulated to read each one of the inverted sentences in column 5 and record in column 6 the new positive meaning reproduced from them. And finally, the column 7contains the analytical part of the TBTR and performed in a jury's deliberation format. The patient answers a series of questions involving the performance of the prosecutor and defense attorney (De-Oliveira, 2008).

TBTR is at least as effective as conventional cognitive therapy in decreasing symptoms of social anxiety disorder, and more effective than conventional cognitive therapy in decreasing fear of negative evaluation (De-Oliveira *et.al.*, 2011).

In a study comparing the measures of quality of life in social phobia between TBTR and conventional cognitive behavioral therapy; after 12 treatment sessions and 12 month follow-up process, the results displays significant treatment effects in the bodily pain, social functioning, role-emotional, and mental health domains, with higher scores in the TBTR group. TBTR led to significantly better post-treatment and follow-up results than the conventional cognitive behavioral therapy techniques. And

also it has a significant treatment effect on the role-emotional domain at follow-up, relative to conventional cognitive behavioral therapy. Consequently TBTR is significantly more effective than traditional cognitive therapy, especially in improving some domains of quality of life (Powell *et. al.* 2013).

3.2.3. Memory and Imagery Rescripting

Most of the patients experience their automatic thoughts also as a mental pictures or images, but few of them has cite these to their therapists. Even if asking repeatedly, just asking could not be sufficient to expose these images. These images are usually instant and disturbing, because of that most patients throw away them from their minds immediately. After determined the patient's frequently recurring and disturbing images, there are some techniques that patients can learn to cope with these suddenly occurring images. These techniques are; taking the image until the end, skip to a later time, becoming capable of dealing with image, changing the image, making the reality testing of image, and repetition of image. These six techniques include the reducing patient's worry by looking the situation from different ways. The last technique is stopping images, and replace anothers or to lead himself away from the image, provides a temporary relaxation by giving the attention to another things (Beck, 1995, 257-277).

Imaginal exposure is difficult for the patients to do alone so generally therapist has to direct. At the standard procedure therapist ask the patient to imagine an item from the phobic hierarchy while he/she is as relaxed as possible. The patient starts by imagining the item vividly enought to alert anxiety, and goes on thinking about it in detail as possible until anxiety calms down (Hawton *et. al.* 1989, 114).

Rescripting early memories linked to recurrent negative imagery in patients with social phobia. In Wild and co-workers study (2007) one session of memory rescripting significantly reduced the distress and vividness of patients' traumatic social memories as well as their meaning within session and 1 week later and also

produced notable within session decrease in the distress and vividness of patients' negative images. One week later, patients rate their images as less distressing, but not less vivid. In the end, on a measure of social cognitions, patients reported fewer negative social concerns in the previous week and reported believing them much less strongly. They also showed significant improvement on a scale (SPWSS), which measures the severity of components of social phobia such as, anxious affect, avoidance, self-focused attention, and anticipatory and postevent processing (Wild *et. al.*, 2007). Also in their another study at 2008, they investigate the therapeutic impact of rescripting social phobia related traumatic memories. When patients imagined participating in their two most feared social situations, one session of memory rescripting produced significant within-session change in the meaning of the traumatic memory, the distress associated with the memory, and the amount of anxiety experienced. Also, 1 week after the memory rescripting session, patients reported that their spontaneously occurring images were less vivid and distressing. One of the other main effect of memory rescripting was that it reduced anxiety about fear of negative evaluation (Wild *et. al.*, 2008).

3.2.4. Cognitive Bias Modification (CBM)

Cognitive Bias Modification (CBM) procedures focusing on attention biases or interpretation biases (Sportel *et. al.*, 2013). CBM interventions modify attention and interpretation biases with a computerized modification programs. CBM affects these cognitive biases via repeated practice on tasks that require rapid processing (Beard *et. al.*, 2011).

CBM for interpretation biases method is a text-based computerised task aimed at systematically training individuals to interpret emotionally ambiguous information in a particular direction (Mobini *et. al.*, 2014). And in the attention modification task, participants respond to a visual probe that consistently replaces stimuli of neutral valence, thereby directing attention away from threat (Amir *et. al.*, 2011).

Social anxiety can be caused by negative interpretation of various social situations. Mobini and co-workers (2014) showed the effectiveness of cognitive bias modification training on the social anxiety over 76 volunteers (Mobini *et. al.* , 2014). Attention and interpretation biases are important targets for the treatment of anxiety disorders. However, the usefulness of the combined use of these two methods can not be shown. Results showed that CBM for interpretation was more helpful than CBM for attention (Beard *et. al.* , 2011).

Beard and Amir (2008) showed that a computer-based interpretation modification program given twice weekly for four weeks can be used to enable benign interpretations of people with high level of social anxiety. Their study's results showed that the interpretation modification program decreased threat interpretations, increased benign interpretations, and decreased social anxiety symptoms (Beard and Amir, 2008).

At Sportel and co-workers study (2013) an internet-based cognitive bias modification (n: 86) was compared to a school-based cognitive behavioral group training (n: 84) and a control group (n:70) in reducing symptoms of social and test anxiety in high socially and/or test anxious adolescents aged 13–15 years. At 6-month follow-up cognitive behavioral group showed lower social anxiety scores than the control group. But this effect was only significant trend. And at 12 month follow-up this primary effect was not no longer present. In both short and long term, the test anxiety reduced more in the cognitive behavioral condition than the control condition. But in the long term, participants in the internet-based cognitive bias modification condition showed further improvement regarding automatic threat-related associations than both other conditions. The results showed that all interventions caused a faster reduction in social anxiety symptoms. And the CBM yielded increased positive results at automatic threat-related associations (Sportel *et. al.* , 2013).

4. CONCLUSION

Despite social phobia is a prevalent (APA, 2013, 204) and early onset (Bayramkaya *et. al.*, 2005) mental health problem which impairs life qulity, usually it is underdiagnosed. Effective measures should be taken for prevention and treatment of this prevalent health issue.

CBT is a short-term, cost-effective treatment method which alleviates the severity of the symptoms and improves the quality of life of the people suffering from social phobia. CBT is very effective (Gil *et. al.*, 2001), especially in increase of social skills and reduction of social anxiety (Purehsan, Saed, 2010).

Many different cognitive behavioral techniques are used in the treatment of social phobia. Some of these are; Behavioral Experiments, Trial-Based Thought Record (TBTR), Memory/ Imagery Rescripting and Cognitive Bias Modification (CBM). When the results of researches about these techniques investigated, positive effects of these techniques on social phobia symptoms are seen. More researches on such different techniques will be useful resources for clinicians to benefit. In social phobias treatment, a better CBT implement will be occur by the appropriate combination of these techniques according to the patient's needs.

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