

# Psychological Treatments for Social Phobia

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**Objective:** To review the empirical status of psychological treatments for social phobia (SP), commenting both on cognitive-behavioural interventions and on more recent iterations of those approaches. We also review the effective components of cognitive-behavioural therapy (CBT).

**Method:** We qualitatively reviewed the empirical literature on the psychological treatment of SP. We include empirical studies, metaanalyses, and recent conference presentations in this review.

**Results:** Cognitive and behavioural interventions for SP appear to be more effective than wait-list controls and supportive therapy. Comparisons of CBT and pharmacologic treatment have produced inconsistent results. Several new treatments for SP demonstrate promising results.

**Conclusion:** Evidence suggests that various psychosocial treatments for SP are better than wait-list controls and credible placebo interventions. Ongoing projects investigate the relative efficacy of combining medication and psychosocial treatments over monotherapies; this line of research is important to continue. Further research should also focus on which components of CBT are most effective.

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## Clinical Implications

- Cognitive and behavioural interventions are empirically supported treatments for social phobia.
- Treatments such as task concentration and mindfulness meditation, although still early in their development and validation, demonstrate promise as alternative treatments.

## Limitation

- We reviewed the studies qualitatively.

**Key Words:** *social phobia, social anxiety disorder, anxiety, treatment, therapy, cognitive-behavioural therapy*

Social phobia (SP) is a prevalent and impairing disorder. In recent years, there have been several advances in the psychological treatment of SP. Much attention has been paid to cognitive-behavioural treatments, and research efforts have focused on evaluating this treatment and on the most effective components of cognitive-behavioural therapy (CBT). More recently, researchers have begun to look at combination treatments for this disorder as well as new and innovative treatment strategies. We review the empirical status of psychological treatments for SP, commenting both on cognitive-behavioural interventions and on more recent iterations of these approaches.

SP is characterized by an intense fear of embarrassment, humiliation, or scrutiny by others in social or performance situations (1). Some situations that persons with SP often fear include attending parties, meeting strangers, speaking at meetings, or interacting with authority figures. The number of situations feared by people with SP varies among individuals. Some people report concerns about a few situations or even just one particular situation (for example, public speaking), whereas others indicate fear across a broad range of social and performance situations. Epidemiologic studies suggest that the lifetime prevalence of SP ranges from just under 3% (2) to just over 13% (3), with some investigators arguing that 7% is a reasonable estimate (4). SP has been demonstrated to have

significant effects on quality of life (5) and costs to health care systems (6).

Recently several psychological models of SP have emerged that provide a conceptual framework for understanding the development and maintenance of the disorder. These models also inform psychological or psychosocial treatments of SP. We briefly review 4 of these models, including 2 cognitive models, a self-presentational model of SP, and a recent review of a developmental profile of SP. We also describe and review evidence for psychological treatments of the disorder, whose strategies were devised partly from the models reviewed.

### Models of SP

Cognitive models of SP are based partly on a significant body of research suggesting that individuals with social anxiety process information differently than do people who are not socially anxious. Clark and Wells' model suggests that persons with SP place much importance on making a favourable impression on others, and yet, they believe that they will act incompetently in social situations (7). As a result of these concerns, people with SP use various processes intended to protect themselves in feared situations, which, unfortunately, often fail to help. Indeed, these processes seem to exacerbate and maintain anxiety. Processes include intensified, self-focused attention, including paying attention to one's internal state; viewing oneself from an observer's perspective; overuse of safety behaviours; and biased anticipatory and postevent processing. When in social situations, people who are anxious about their presentation to others are thought to pay more attention to themselves, ignoring useful and necessary social cues from others. This inward focus is encouraged by the presence of physiological sensations of anxiety (for example, a racing heart or blushing). As a consequence of this inward attention shift, people with SP construct invariably negative images of themselves, based on how they feel and how they think others see them. Further biases are seen in people's anticipation of ("I'm going to blow it") and reflection on ("I really messed that up") social events. Safety behaviours are various strategies that people use to protect themselves and to avoid "catastrophes" in social situations (for example, overrehearsing what one is going to say and using makeup to hide blushing). Once again, behaviours intended to help symptoms of anxiety actually create further problems by limiting social interaction, exacerbating anxiety symptoms, and preventing the disconfirmation of negative beliefs.

Rapee and Heimberg also emphasize distorted information processing in their cognitive-behavioural model of SP; they suggest that people with SP demonstrate attentional biases for social threat stimuli (8). In their model, they highlight the importance of a real or perceived audience for eliciting symptoms of social anxiety. Once a person believes he or she is

being evaluated and that the expectations of the audience are high (regardless of whether this is objectively true), attention is allocated to monitoring the environment for social-evaluative feedback (for example, others' reactions) and the appearance of the person in a given social situation. Owing to biases in information processing and the inherently ambiguous nature of many social situations, persons with SP focus on social threat and often misperceive threat in social situations. These perceptions only serve to exaggerate and enhance anxiety levels.

The self-presentation theory of social anxiety also posits that social anxiety will exist if people are motivated to make a particular impression on others but doubt their ability to do so (9,10). However, it differs from the above models in its idea that individuals may hope to impart a positive social impression, a negative impression, or something in between. In other words, this model suggests that people do not necessarily hope to make a good impression or to avoid rejection (though this may be the most common desire). If the impression is not made in its entirety, the person will experience anxiety. For example, a person who wants to make a good impression on others and who wants to be included in a social group may feel anxious, even if he or she feels liked by others but not liked enough to become a member of the group. Motivation for achieving a particular impression is idiosyncratic (for example, some people are motivated to avoid rejection, whereas others are motivated to impress others), and not achieving the desired impression has unfavourable implications for anxiety levels.

In a recent review, Neal and Edelmann provide a developmental profile of people with SP, based on research on key developmental and interpersonal constructs thought to be important in the disorder (11). They suggest that some children are born with a vulnerability to overreact to various environmental stimuli in social domains and that it is these children who may be at higher risk for developing SP. However, the authors argue that some variability in the stability of behavioural inhibition suggests that family and peer interactions also influence levels of social anxiety. Studies suggest that parents of inhibited and shy children may be more overprotective, insensitive, and shaming, with fathers of SP children retrospectively perceived by their adult children (especially by daughters) as being rejecting and possibly even abusive (12). Further, this research suggests that, as children begin to interact with peers, initial shyness or passivity is tolerated until adolescence but then results in rejection. Thus it is suggested that the behavioural inhibition that a child is born with strongly interacts with family and peer influences to create a vulnerability to the development of SP (12).

## Psychological Treatments of SP

There are several empirically supported treatments for SP, including both pharmacologic and psychological approaches. For a review of pharmacologic treatment approaches for social anxiety, see Davidson (13) or Antony and Swinson (14). Evidence-based psychological treatments for SP include exposure therapies, cognitive treatments, applied relaxation, and social skills training (SST). In addition, more recent research has focused on the use of interpersonal psychotherapy (IPT), attention training, and mindfulness treatment strategies. Psychological treatments have also been combined with pharmacotherapies. We review each of these treatment strategies and the evidence for their efficacy.

## Cognitive-Behavioural Therapy

CBT is the most widely used psychological treatment for SP. It usually combines exposure principles with cognitive restructuring tools, although some forms of CBT rely more heavily on cognitive techniques and behavioural experiments than on exposure (15). The use of *in vivo* exposure is based on models of fear development that implicate the learned nature of particular fears (16) and the instrumental role that avoidance plays in maintaining anxiety. In exposure treatment of social anxiety, clients develop an exposure hierarchy, or list of feared situations, that ranges from moderately to extremely anxiety provoking. Using this hierarchy as a guide, clients are encouraged to repeatedly and systematically expose themselves to their feared situations, staying in the situation until their anxiety has subsided. Exposure-based treatments also include role-playing with the therapist or a confederate. Role play can be useful as a precursor to *in vivo* exposures, wherein skills are practised before they are implemented, and in situations where it is difficult to create a particular exposure scenario.

With the widespread impact of recent cognitive models of social anxiety, there is increasing interest in using cognitive techniques to treat social anxiety. Cognitive therapy encourages clients to identify and monitor examples of biased information processing (for example, negative interpretations of an ambiguous or neutral situation) and then challenge this distorted thinking. For example, a client may be asked to consider alternative ways of interpreting a situation, to gather evidence for and against fearful thoughts, or to test fearful predictions.

Research supports the efficacy of CBT for SP. Several metaanalyses demonstrate that various forms of CBT are more effective than wait-list controls (17) and that effect sizes for the components of CBT are significantly different from zero (18). For example, mean pretreatment to posttreatment effect sizes for the variants of CBT have ranged between 0.80 and 1.08 on SP measures (17–20). Studies of the long-term

outcome of exposure treatment suggest favourable remission rates for people who are able to complete treatment (21). Even short-term individual CBT (that is, 4 to 8 treatment sessions; 22) and short-term group CBT (6 sessions; 23) appear to be useful for improving symptoms of SP. Although the variants of CBT appear to be more effective than placebo or wait-list controls, it is less clear what components of CBT are the most effective and whether CBT is more effective than alternative treatments. We briefly review this literature.

## CBT vs Supportive Therapy

CBT appears to be superior to supportive therapy. Heimberg and colleagues compared group CBT with a supportive group psychotherapy that emphasized education and discussion (24). Although both groups showed improvement at posttreatment and follow-up, the participants who completed group CBT were more improved than were those in the supportive group, and they maintained improvements at 5-year follow-up (25). More recently, Cottraux and colleagues compared CBT (which included cognitive therapy, social skills training, and exposure instruction) with supportive therapy (26). Although treatment conditions were not equivalent on time spent with therapists (participants in the CBT arm received more therapist time), the CBT group demonstrated superior outcomes to the supportive therapy group. Moreover, when participants who initially received supportive therapy were switched to CBT, they experienced significant improvements in addition to the initial improvement from supportive therapy.

## Cognitive Therapy vs Exposure

The relative efficacy of cognitive therapy (CT) and exposure is less straightforward, with studies revealing some conflicting results. A metaanalysis by Fedoroff and Taylor suggested no differences among any psychological treatments for social anxiety, including exposure and cognitive techniques; however, this metaanalysis excluded any studies that dismantled CT and exposure (18). In direct comparisons of exposure and CT, exposure seems to be equivalent to (19,27–29) or even more effective than (30,31) the combination of both exposure techniques and cognitive strategies. A metaanalysis suggested that an exposure component, whether alone or combined with cognitive techniques, produced larger effect sizes for treatment than did cognitive restructuring alone (20). Conversely, other results have found that combination treatments (that is, exposure plus cognitive techniques) are the most effective treatment for social anxiety (17,32–34).

## CT vs Associative Therapy

Some authors have suggested that some benefits of cognitive techniques may be the result of exposure that is inherent in CT. For example, Taylor and colleagues claim that CT

involves a form of imaginal exposure, when patients recount anxious situations, and in vivo exposure, when the client reveals distressing thoughts and feelings in front of the therapist (35). To examine whether the benefits of CT are simply due to exposure effects, these researchers compared pure CT (that is, involving no in vivo exposure instruction) with a control intervention called associative therapy. This control intervention involved having the client free-associate to thoughts and memories of previous social encounters, which equalized the amount of time spent talking about social events and revealing private thoughts. Results suggested that CT was more effective than associative therapy on several outcome variables, confirming that CT techniques have value in addition to any exposure effects inherent in these techniques.

### CT vs Medication

Research comparing CBT with medications is also equivocal. Few studies have directly compared CBT with medications, and some studies have used comparison medications that were no more effective than placebo in treating SP, which rendered results inconclusive. For example, one study compared exposure-based treatment (in vivo and imaginal exposure) with the beta blocker atenolol. Turner and colleagues randomly assigned persons with SP to receive 3 months of individual exposure therapy, atenolol, or placebo (36). Results suggested clear superiority of exposure therapy, compared with placebo, and indicated its superiority over atenolol on certain outcome measures. However, atenolol was not significantly different from placebo on most outcome measures, making it difficult to make conclusions about the relative effectiveness of exposure, compared with this medication. Similarly, Oosterbaan and colleagues found that CT was superior to moclobemide, a medication that demonstrated superiority to placebo in some previous studies but that was not superior to placebo in the current study (37). Thus the only conclusion that can be made from these studies is that exposure and CT appear to be better than placebo.

In Federoff and Taylor's metaanalysis, results suggested that benzodiazepines were the most effective treatment for social phobia, at least over the short term (18). However, different results emerged in a study by Heimberg and colleagues, wherein both CBT and phenelzine (a monoamine oxidase inhibitor) were effective in treating SP over a 12-week period (38) and CBT appeared to have an advantage in long-term gains (39). Similarly, studies have not found differences in outcome between group CBT and clonazepam plus self-exposure (40) or between group CBT and phenelzine or alprazolam plus self-exposure (41). Gould and colleagues' metaanalysis also suggested similar effect sizes for CBT, compared with pharmacologic treatments (20).

More recent results of medications vs CBT continue to be equivocal. Initial results from Foa and colleagues' randomized, placebo-controlled trial of CBT, fluoxetine, and their combination suggest that all monotherapies and the combination appear to be similarly effective for SP (42). Conversely, results from Clark's group favoured CBT over medication. Using a specific form of CT derived from his model (7), Clark and colleagues recently demonstrated the superiority of CT to both fluoxetine and placebo. Patients in this study were randomly assigned to 16 weekly sessions of CT, fluoxetine plus self-exposure, or placebo plus self-exposure (15). Using a composite score of symptom outcome, the authors noted improvements across all 3 treatment groups, with larger effect sizes for CT, compared with the other conditions. Gains made in CT were maintained across a 1-year follow-up. One could argue that this study demonstrates the superiority of CT vs both medication and exposure. However, it is unclear to what degree exposure-like exercises were used by participants during behavioural experiments in the CT protocol. It is safest to conclude that CT based on Clark and Wells' model (7) (whether pure CT or a form of CBT) demonstrated stronger results than an effective medication for SP. Further research on these questions is currently underway in large US trials by Foa, Davidson, and colleagues, as well as by Heimberg, Liebowitz, and colleagues. Results from these trials will be important in helping us further understand the relative efficacy of CBT, CT, and medication.

### Social Skills Training

Social Skills Training (SST) is predicated on the notion that social anxiety is the result of impoverished or underused social skills. Clients receive direct instruction in both verbal and nonverbal skills (for example, eye contact, tone and volume of speech, conversational skills, and assertiveness training). Skills are also acquired through modelling by the therapist, role-playing in therapy, obtaining direct feedback from therapists, and implementing skills in the client's life.

Research generally suggests that SST is helpful for social anxiety, although it is unclear whether SST is more helpful than placebo conditions and whether benefits are maintained over long-term follow-up. In one study, results were equivalent for SST and rational emotive therapy (a type of CT) at posttreatment (43) and at follow-up (44), even when patients were preferentially allocated to types of therapy according to classification as a cognitive or behavioural reactor. Similarly, SST appears to be as effective as exposure (45) or cognitive restructuring (17), although it may not be more effective than credible placebo comparison treatments (17). Even though individuals receiving CBT often maintain their improvements or even continue to improve over long-term follow-up, evidence is mixed for the long-term effectiveness of SST (46).

A recent study compared the effectiveness of group CBT plus SST with standard group CBT (Herbert, January 2004, personal communication). Results from this trial found a significant advantage for the combination treatment over standard group CBT. Thus SST may be less helpful alone than as part of a combination protocol.

Although SST may show some evidence for effectiveness in SP, this does not confirm that people with the disorder have significant social skills deficits. In fact, research suggests that persons with social anxiety assume they make a worse impression than they actually do (14) and that they rate their performance in public speaking tasks significantly worse than do objective observers (47,48). SST may work by encouraging the use of underused social skills or by facilitating exposure to social situations through role-plays and real-life practices. One study that found an advantage for SST over CBT eliminated exposure instructions from the CBT group, leaving open the possibility that part of SST's superior effect arose from its exposure component (49). Consistent with a deviation from a deficit model, Stravynski and colleagues found preliminary support for a type of SST that focused on improving social conduct rather than "fixing" social skills deficits (50). Their case series of 5 SP patients yielded meaningful improvements in symptoms for 4 of 5 patients that were maintained at 2-year follow-up.

### **Applied Relaxation**

Applied relaxation aims to combat the physiological effects of social anxiety. Patients are provided instruction on progressive muscle relaxation, cue-controlled relaxation, and skill generalization in social situations (that is, relaxation training is combined with exposure therapy). Results suggested that applied relaxation is better than a wait-list control condition for treating SP (51) and provides similar (52) or better (53) improvement, compared with SST. However, results are equivocal on whether applied relaxation shows superior effects to alternative treatments when patients are matched to treatment by response style (that is, physiological vs cognitive reactors). Some studies suggest that matched treatment produces superior end-state functioning (52), whereas others suggest that CT is superior to applied relaxation, even when participants are matched to treatment (51).

### **Attentional Focus Training**

Drawing from theory and evidence that heightened self-focused attention is characteristic of SP and may help maintain symptoms (7,54), some authors have investigated the efficacy of attentional focus training, also called task concentration training (TCT), for treating SP. In this treatment, individuals are taught to preferentially allocate attention away from themselves and toward external objects, starting with

neutral stimuli and progressing to anxiety-provoking stimuli. Mulkens and colleagues described this procedure as having 3 phases: 1) becoming aware of self-focused attention, 2) focusing attention outward in nonthreatening situations, and 3) focusing attention outward in threatening situations (55). For example, individuals may be encouraged to focus on sounds in the room or the sound of the therapist's voice instead of on his or her own physiological status; patients start treatment in the therapist's office before using these skills in social situations.

Currently case studies support the use of TCT or attention training for treating the anxiety levels and belief ratings of people with SP (56) and for people with SP whose feared consequence is blushing. For example, Bögels and colleagues present case studies of individuals whose fear of blushing in front of others was significantly reduced by TCT (57,58). However, it is unclear whether favourable results can be fully attributed to TCT and not to exposure therapy. In one case study, the client was instructed in both TCT and exposure and used each technique independently during corresponding phases of treatment (55). Results suggested that, first, exposure seemed to be more effective than TCT in reducing fears of blushing, and second, the client used TCT during weeks when she was supposed to use pure exposure methods. Thus it is unclear whether it was the combination of exposure and TCT or either component in isolation that was most helpful for this client. To address this question, Mulkens and colleagues conducted a randomized trial that compared in vivo exposure with TCT in patients with fears of blushing (58). Although TCT appeared to have some small advantages at post-treatment and at 6-week follow-up, 1-year follow-up revealed no significant differences between groups in effectiveness. Thus TCT appears to be as credible as, and to have an effect similar to, exposure for people who fear blushing.

### **Combination Strategies**

In clinical practice, it is common for clients to receive both medication and psychological treatments. It is therefore important to investigate any benefits of combining these treatments for SP. As noted earlier, scant research has compared the combination of medication with monotherapies. As Heimberg posits, the combination of medication and psychotherapy could produce several outcomes (59). First, combined therapies could be more powerful than monotherapies, owing to a synergistic effect. Further, it is possible that providing sequential treatment that begins with medication may be particularly useful for patients who cannot initially manage the tasks of a psychological therapy such as CBT because of overwhelming anxiety symptoms. However, combined therapies may provide no benefit to either therapy alone if both CBT and medications contain a similar mechanism of action or if

they are sufficiently powerful on their own to invoke significant change (59). Preliminary results from Foa and Davidson's study support the latter idea; they found no advantage for combination therapy over monotherapies in their large-scale trial (42). Conversely, Blomhoff and colleagues' data suggested that combined sertraline and exposure showed a tendency to be superior to exposure alone, although the effects of exposure continued to improve through follow-up (60), whereas sertraline and combination therapies showed some deterioration at follow-up (61). Further, Heimberg and Liebowitz's initial data suggest an advantage for the combination of phenelzine and group CBT over either treatment alone (with the combination consistently outperforming CBT and outperforming phenelzine on some measures) (62). It will be interesting to return to this question once both ongoing trials are complete.

### Innovative Strategies

In addition to the treatments described above, there has been a recent upsurge in the use of novel treatments or innovative deliveries of standard treatments for SP. In this section, we review some of the treatments and strategies that have been studied, with the hope of expanding the repertoire of effective treatments for the disorder.

One trend in recent years involves the application to SP of effective treatments for other psychological difficulties. For example, IPT—an effective short-term treatment for depression—has been applied to SP in an uncontrolled treatment trial. IPT focuses on improving various relational factors in a person's life. IPT sessions involve examining 1 of 4 main interpersonal domains: unresolved grief, role disputes, role transition, or social isolation. The application of IPT to SP is not surprising, given that SP's core feature is fear of negative evaluation from others and that the main concerns addressed in treatment often involve interpersonal issues. The sole trial of IPT for SP demonstrated positive results, with most patients showing significant improvement on symptoms (63). However, one could argue that the benefits of IPT revolve around therapy goals of increased interaction and assertiveness training—goals that contain elements of SST and exposure. Further, it is unclear whether all persons with SP would be able to identify specific therapy goals that correspond to the foci of IPT sessions listed above. Research comparing IPT with such proven treatments as exposure or CBT is necessary.

Researchers are also beginning to investigate the use of mindfulness meditation as a treatment strategy for social anxiety, often in combination with other treatment strategies. Building from research that suggests that mindfulness-based therapies are effective for other disorders (for example, preventing relapse in depression; 64), researchers have suggested that mindfulness strategies may be useful in SP. In a preliminary

study, Bögels and colleagues reported a large effect size when patients were treated with a combination of mindfulness strategies and TCT (65). Other researchers suggest using mindfulness principles within the context of acceptance and commitment therapy for social anxiety (66). In this context, individuals use mindfulness strategies to become more accepting of anxious thoughts and feelings while pursuing valued goals, instead of using avoidance or suppression strategies. Further research on these techniques will be illuminating.

Another significant innovation in SP treatment involves the use of technology to enhance the delivery of CBT. Preliminary studies have used virtual reality techniques to treat fear of public speaking (67–69), of being scrutinized by others, of interacting with friends in an intimate environment, and of navigating through situations requiring assertiveness (70). In these studies, participants engage in repeated exposure to virtual environments (for example, computer-simulated audiences who can be manipulated to appear bored or interested) for prolonged periods of time. Initial studies provide encouraging results for the use of this medium. First, studies suggest that exposure to a virtual environment or audience provokes symptoms of anxiety similar to those provoked by exposure to an actual audience (71), which supports the validity of these techniques. Studies have also found that repeated exposure to virtual situations leads to reductions in fear and avoidance of public speaking (67,68), and results are similar to those obtained with group CBT (70). As Heimberg and Coles pointed out in their commentary on innovations in CBT for anxiety disorders, virtual reality components in treatment are exciting because they can provide ready access to rare or difficult-to-control situations. Further, their realistic nature allows for clients' complete immersion into the feared situation (72).

Another use of technology in the treatment of SP is a telepsychology program designed to provide a self-applied program of CBT over the Internet that emphasizes exposure. Participants undergo assessment and then receive treatment instructions through this program, including feedback about their rate and sequence of progress (73). Initial data from 12 participants is encouraging, with participants reporting reductions on several SP symptoms maintained through 1-year follow-up.

Further innovation involves the use of novel exposure stimuli in CBT for SP. Masia and colleagues describe the use of exposure to social threat words in addition to a standard CBT protocol (74). They note that language has the power to elicit emotion and that people with SP may have numerous emotional associations with such social words as “embarrassment” and “inferiority.” Thus exposure to these words may prove a useful type of imaginal exposure in treatment. Pilot studies have provided initial support for the anxiety-reducing

effects of reading social threat words, with participants showing a reduction in the Stroop interference effect, in anxiety ratings, and in social anxiety symptoms after treatment; as well, participants demonstrated significantly more improvement than a control group who read neutral words.

## Conclusion

SP is a prevalent condition that causes significant functional impairment for sufferers. In the 2 decades since SP was included in the DSM-III (75), new theoretical models explaining the development and maintenance of SP were developed; a large body of research on how to treat this disorder has now grown. Here, we show evidence for various psychosocial treatments, that are better than wait-list controls and credible placebo interventions. In more recent years, studies have focused on comparing active treatments. Ongoing projects are investigating the relative efficacy of combining medication and psychosocial treatments, compared with monotherapies, and it is important that this line of research continues. Although we should feel confident in what has been achieved in our understanding of effective SP treatments, much work remains to be done. For example, there are still many inconsistencies in the literature about identifying the effective and necessary components of treatment packages (that is, exposure vs SST vs CT vs CBT). The recent study by Clark and colleagues suggested significantly higher effect sizes for this version of CT than have been seen in previous studies of group CBT or components of CBT (15). It is possible that CT based on Clark and Wells' model (7) may be superior to other psychosocial and pharmacologic treatments, and we await research to replicate these findings. However, the advantage of this treatment may rest with its mode of delivery: it may be that treatment offered individually is superior to group treatment, despite speculation and widespread belief in the benefit of group treatments for SP. Research that tackles these and other questions will enhance our knowledge of treatments and refine our understanding of the disorder itself.

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**Résumé : Les traitements psychologiques de la phobie sociale**

**Objectif :** Examiner l'état empirique des traitements psychologiques de la phobie sociale, en commentant à la fois les interventions cognitivo-comportementales et les itérations plus récentes de ces approches. Nous examinons également les composantes efficaces de la thérapie cognitivo-comportementale.

**Méthode :** Nous avons examiné qualitativement la documentation empirique sur le traitement psychologique de la phobie sociale. Nous avons inclus les études empiriques, les méta-analyses et les présentations récentes à des congrès dans cet examen.

**Résultats :** Les interventions cognitives et comportementales dans la phobie sociale semblent être plus efficaces que les contrôles de listes d'attente et que la thérapie de soutien. Les comparaisons entre la thérapie cognitivo-comportementale et le traitement pharmacologique ont produit des résultats inégaux. Plusieurs nouveaux traitements de la phobie sociale affichent des résultats prometteurs.

**Conclusion :** Les données probantes indiquent que nous avons divers traitements psychologiques de la phobie sociale qui sont meilleurs que les contrôles de listes d'attente et les interventions avec placebo crédibles. Les projets en cours recherchent l'efficacité relative de la combinaison des médicaments avec les traitements psychosociaux par rapport aux monothérapies, et il est important que se poursuive cet aspect de la recherche. Les études ultérieures doivent aussi déterminer quelles composantes de la thérapie cognitivo-comportementale sont les plus efficaces.

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