Shorter communication

In the absence of rose-colored glasses: Ratings of self-attributes and their differential certainty and importance across multiple dimensions in social phobia

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ABSTRACT

Sixty-seven individuals with social phobia (social anxiety disorder) and 60 healthy controls rated their perceived standing relative to others on 13 self-attribute dimensions, their level of certainty concerning those standings, and the importance of each dimension. As expected, individuals with social phobia provided self-ratings that were significantly more negative than controls across all dimensions. In addition, positive self-views were equated with higher levels of certainty and importance for controls, but not for individuals with social phobia. Thus, whereas reports of control participants reflected a healthy, positive framing of self-views, the ratings of clinical participants demonstrated an orientation toward self-framing that was neither positive nor negative. Together, these novel findings shed light on the nature of self-appraisals in social anxiety. Implications of these results are discussed in terms of contemporary cognitive-behavioral models of social phobia.

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Social phobia (social anxiety disorder) is a highly prevalent, life-impairing disorder characterized by extreme fear and avoidance of social and public performance situations. Contemporary theories suggest that social anxiety arises from one’s perceived inability to convey a desired impression of oneself to others (e.g., Leary, 2001; Leary & Kowalski, 1995). Cognitive models of social phobia emphasize the central role of negative self-perception in the development and maintenance of anxiety symptoms (Clark & Wells, 1995; Hofmann, 2007; Rapee & Heimberg, 1997). Studies have shown that socially anxious individuals perceive that their self-attributes and social abilities fall short of expected standards (e.g., Alden, Bieling, & Wallace, 1994; Moscovitch & Hofmann, 2007; Strauman, 1989, 1992; Strauman & Higgins, 1987; Wallace & Alden, 1991; Weigle & Hope, 1999) and view others as holding unreasonably high expectations for their performance, particularly when standards are ambiguous (Moscovitch & Hofmann, 2007). Under threat, highly socially anxious and phobic individuals shift their focus of attention inward and experience negative mental representations of self, including excessively negative self-images (Hackmann, Clark, & McManus, 2000; Hackmann, Surawy, & Clark, 1998; Hirsch, Mathews, Clark, Williams, & Morrison, 2006) viewed through the imagined eyes of evaluative others (Wells, Clark, & Ahmad, 1998). Following social situations, they focus retrospectively on perceived shortcomings and blunders, with post-event self-evaluations greatly minimizing any positive aspects of their performance (Alden & Wallace, 1995; Ashbaugh, Antony, McCabe, Schmidt, & Swinson, 2005; Norton & Hope, 2001; Rapee & Lim, 1992; Stopa & Clark, 1993).

Most research on self-appraisals in social phobia has focused on anxious individuals’ perceived social skills, visible signs of anxiety, and behavioral performance. But do concerns about self amongst individuals with social phobia extend beyond those domains traditionally assessed? For example, in a recent study by Antony, Rowa, Liss, Swallow, and Swinson (2005), individuals with social phobia were found to engage in frequent upward social comparisons, to make more multidimensional comparisons than control participants, and to be selective about the types of dimensions on which they compare themselves to others (with social skills and personality most prominent, followed by signs of anxiety). Despite the greater prevalence of comparisons on these selective dimensions, the results on the multidimensionality of comparisons suggest that there may be other self-attributes about which individuals with social phobia feel inferior.

Mounting evidence suggests that core concerns in social phobia often encompass a much wider range of self-attributes than social behaviors and anxiety symptoms alone. According to Moscovitch (in press), people with social phobia are uniquely and primarily concerned about characteristics of self that they...
perceive as being deficient or contrary to perceived societal expectations or norms. Clinical observation and converging empirical evidence suggest that despite this common, fundamental fear that unites all individuals under the diagnostic category of social phobia, there is substantial heterogeneity in clinical presentation amongst patients with this diagnosis (e.g., Hofmann, Heinrichs, & Moscovitch, 2004). Much of the variance in symptom presentation might be due to variance in the nature of self-attribute concerns, which can differ widely from patient to patient (Moscovitch, in press). Thus, it is important to investigate the potential range of self-attributes about which individuals with social phobia might be concerned. The first objective of the present study, therefore, was to compare socially phobic and healthy individuals’ self-views across a broad range of self-relevant domains, many of which have not previously been investigated.

Although understanding the nature of self-perception in social phobia requires a careful examination of self-views across various domains, it is crucial to acknowledge that perceived self-worth is more than the sum total of a person’s positive versus negative self-views. In their seminal paper, Pelham and Swann (1989) argued that, “self-esteem is shaped by the manner in which people frame their specific self-views” (p. 673), demonstrating that the impact of a particular positive or negative self-attribute on individuals’ self-perception depends critically on how important that attribute is to them and on the extent to which they are certain that they possess that attribute. In their study, Pelham and Swann (1989) collected information on participants’ self-views and then calculated differential importance and differential certainty indices for each participant. These indices reflected the amount of importance/certainty that people ascribed to particular attributes relative to their other attributes. In so doing, Pelham and Swann (1989) demonstrated that the way participants framed their self-views (i.e., their differential importance and certainty indices) accounted uniquely for variance in self-esteem over and above the valence of self-views alone.

Thus, our second objective in the present study was to investigate how views of self in social phobia are framed by judgments of differential certainty and importance. In a recent study, Wilson and Rapee (2006) found that individuals with social phobia rated themselves more negatively and less positively than healthy controls across a number of personality attributes and reported significantly less confidence in their ratings for both positive and negative attributes. However, these researchers assessed group differences in perceived self-attributes within only one self-relevant domain (i.e., personality) and they did not examine ratings of differential importance or group differences in differential certainty.

In line with these aforementioned objectives and based on the research reviewed thus far, we hypothesized, first, that individuals with social phobia would appraise themselves negatively in comparison to healthy controls across a broad range of self-relevant domains. Second, given past findings on the various negative biases that characterize the manner in which individuals with social phobia process and frame social information (Hirsch & Clark, 2004), we predicted that participants with social phobia would attach more certainty and importance to self-attributes they rated most negatively, while controls would not demonstrate this negative orientation toward self-framing.

Method

Participants

Sixty-seven individuals with a principal DSM-IV (American Psychiatric Association, 1994) diagnosis of social phobia and 60 healthy individuals with no current DSM-IV diagnoses participated in this study. Clinical participants were either referred to a specialty anxiety disorders clinic for treatment or were recruited from the community via advertisements seeking research participants. All diagnoses were determined based on the administration by experienced clinicians of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; First, Spitzer, Gibbons, & Williams, 1996). As the present study was based on the same sample as in Antony et al. (2005), readers are referred there for a detailed description of the methods of training clinician interviewers and establishing diagnostic reliability. Potential clinical participants were excluded if they had current diagnoses of substance abuse/dependence, psychotic disorder, or active bipolar disorder (i.e., evidence of at least one manic episode within the previous six months). Forty-six participants (71.9%) with a principal diagnosis of social phobia had at least one additional diagnosis, with 25 (37.3%) of these participants receiving at least two comorbid diagnoses. The most common comorbid diagnoses were specific phobia (n = 25), dysthymic disorder (n = 11), generalized anxiety disorder (n = 7), major depressive disorder (n = 7), and major depressive disorder in partial remission (n = 8). Other comorbid diagnoses included panic disorder with agoraphobia (n = 5), alcohol/substance abuse or dependence (n = 5), obsessive-compulsive disorder (n = 5), and a somatoform disorder (n = 4).

Control participants were healthy volunteers who responded to advertisements posted in the community seeking individuals without a history of mental health problems. As in previous studies (e.g., Antony, Bieling, Cox, Enns, & Swinson, 1998; Antony, Purdon, Huta, & Swinson, 1998; Moscovitch, McCabe, Antony, Rocca, & Swinson, 2008; Summerfeldt, Hood, Antony, Richter, & Swinson, 2004), these participants were included in the study after trained clinicians determined that diagnostic criteria were not met for any current mental disorder based on their answers during a phone interview, which consisted of screening questions from the SCID-I, and extensive follow-up queries about each diagnostic category for which an initial screening question was endorsed. Anyone who answered positively to the screening prompts was excluded, as were any individuals who had a history of treatment for mental health problems. Demographic characteristics of each group are listed in Table 1.

### Table 1

<table>
<thead>
<tr>
<th>Demographic variable</th>
<th>Social phobia (N = 67)</th>
<th>Controls (N = 60)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (% female)</td>
<td>62.1%</td>
<td>84.7%</td>
</tr>
<tr>
<td>Age (M (SD))</td>
<td>34.21 (9.63)</td>
<td>33.54 (11.65)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>89.4%</td>
<td>86.1%</td>
</tr>
<tr>
<td>Others</td>
<td>10.6%</td>
<td>13.9%</td>
</tr>
<tr>
<td>Relationship status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>54.5%</td>
<td>46.2%</td>
</tr>
<tr>
<td>Married/cohabitating</td>
<td>28.8%</td>
<td>35.9%</td>
</tr>
<tr>
<td>Separated, divorced, widowed</td>
<td>27.3%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>College/university degree</td>
<td>42.4%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Did not complete college/university</td>
<td>57.6%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$10,999</td>
<td>30.9%</td>
<td>28.6%</td>
</tr>
<tr>
<td>$20,000–39,999</td>
<td>38.2%</td>
<td>14.3%</td>
</tr>
<tr>
<td>&gt;$40,000</td>
<td>30.9%</td>
<td>57.1%</td>
</tr>
<tr>
<td>Taking psychotropic medications</td>
<td>56.9%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Note: Values were calculated based on total number of valid responses for each category (Total N – Missing N).
Trait measures

Social Interaction Anxiety Scale and Social Phobia Scale (SIAS and SPS; Heimberg, Mueller, Holt, Hope, & Liebowitz, 1992; Mattick & Clarke, 1998)

The SIAS measures anxiety associated with social interaction, while the SPS assesses performance-based anxiety associated with being observed by others. Developed as companion measures to be administered simultaneously, these instruments consist of 19 (SIAS) and 20 (SPS) items, respectively, rated from 0 to 4 (0 = not at all characteristic of me; 4 = extremely characteristic of me). Both measures have been shown to be psychometrically strong (see Antony, Orsillo, & Roemer, 2001) and both are widely used in the assessment of social phobia. In this study, internal consistency was excellent for both the SIAS (α = .93) and SPS (α = .97).

Beck Depression Inventory, 2nd edition (BDI-II; Beck, Steer, & Brown, 1996)

This widely used 21-item measure of depressive symptomatology has strong psychometric properties. It has shown good internal consistency (α = .89) and test–retest reliability (ICC = .91), as well as adequate convergent and discriminant validity in patients with social phobia (Coles, Gibb, & Heimberg, 2001). In the present study, internal consistency was excellent (α = .95).

Self-Attributes Questionnaire (SAQ)

Following the scaling and instructions used by Pelham and Swann (1989), participants rated their perception of relevant self-attributes, including level of intelligence, social skills, physical appearance, tendency to show signs of anxiety, quality of life, quality of relationships, artistic abilities, athletic abilities, current happiness, personality characteristics, possessions/wealth, achievements, and sense of humor. We included the five original items from the short version of the SAQ (intelligence, social skills, artistic abilities, athletic abilities, and physical attractiveness; Pelham & Swann, 1989), and added an additional eight relevant items, for a total of 13 dimensions that corresponded identically to those examined by Antony et al. (2005) in their investigation of social comparison processes in social phobia. For each attribute, participants rated themselves relative to other people their own age on scales ranging from 0 (bottom 5%) to 9 (top 5%), with higher numbers corresponding with more positive self-ratings. Because we modified this measure from its original form, we analyzed participants’ standings on each of the 13 SAQ attributes separately rather than summing across dimensions to create a composite score. To control for Type I error, we employed a Bonferroni-adjusted alpha level of p < .004 (.05/13) as the statistical significance threshold for each analysis.

Indices of differential certainty and importance

For each of the 13 SAQ domains, participants also rated their level of certainty in their standing on each self-attribute and the extent to which each attribute was personally important to them on scales ranging from 0 (not at all certain/important) to 8 (extremely certain/important). Following the methodology of Pelham and Swann (1989), a differential certainty and differential importance index was computed for each participant by correlating a) each participant’s thirteen self-attribute ratings with his/her corresponding thirteen certainty ratings and b) each participant’s thirteen self-attribute ratings with his/her corresponding thirteen importance ratings. Thus, indices were within-subjects correlation coefficients that represented the association between each participant’s self-attribute ratings (higher scores = more positive ratings) and his/her corresponding certainty and importance ratings (higher scores = more certainty and importance ascribed to each self-rating). Because the indices were correlations, the values ranged from –1 to +1. Higher scores on the differential certainty and importance indices (closer to +1) meant that participants were more certain of, and attached more importance to their positive self-attributes; lower scores (closer to –1) meant that participants were more certain of, and attached more importance to their negative self-attributes. Scores closer to zero meant that there was no association between the positivity of participants’ self-attributes and the level of certainty and importance they ascribed to each rating.

Results

Preliminary analyses

Demographic characteristics of the study sample are listed in Table 1. Clinical and control participants did not differ in age, t(122) = .35, p = .72, income levels, χ²(5, N = 90) = 10.33, p = .07, ethnic group membership, χ²(1, N = 102) = .86, p = .37, or relationship status, χ²(5, N = 105) = 8.42, p = .14. There was a significantly higher proportion of female participants in the control group (84.7%) than in the clinical group (62.1%), χ²(1, N = 125) = 8.05, p < .01, as well as a significantly higher proportion of individuals who completed university/college in the control group (75%) than the clinical group (42.4%), χ²(1, N = 106) = 10.67, p = .001.

Trait measures

As expected, independent-sample t-tests comparing group scores on the SPS, SIAS, and BDI-II demonstrated significant differences for each of the three symptom measures. Individuals with social phobia reported higher ratings than controls on the SPS (Mclinical = 41.73; Mcontrols = 4.82, t(122) = 17.49, p < .001, d = 3.2), the SIAS (Mclinical = 48.58; Mcontrols = 14.93, t(120) = 23.55, p < .001, d = 4.3), and the BDI-II (Mclinical = 19.73; Mcontrols = 3.97, t(122) = 9.36, p < .001, d = 1.7).

SAQ attributes

Separate independent-sample t-tests were performed comparing the two groups across the 13 self-attribute dimensions of the SAQ. Detailed results are displayed in Table 2. Participants with social phobia provided ratings that were significantly more negative than those of controls across all dimensions of the SAQ, all ts > 3.70, all ps < .001, all ds > .56.1

Differential importance and differential certainty

Data were missing for two participants from each group for the differential certainty index (Nclinical = 65; Ncontrols = 58), and two participants with social phobia for the differential importance index (Nclinical = 65; Ncontrols = 60). As depicted in Fig. 1, controls scored higher than clinical participants on both the differential certainty index (Mclinical = 1.01; Mcontrols = 3.80) and the differential importance index (Mclinical = .07; Mcontrols = .39). The positive coefficient values for control participants on both indices indicated that they ascribed higher levels of certainty and importance to 1 It is of interest to determine whether these group differences are driven by symptoms of social anxiety per se, or by comorbid symptoms of depression. While our study design did not allow us to answer this question conclusively (Miller & Chapman, 2001), we tentatively explored whether differences in symptoms of depression may have accounted for any of the significant group effects by reanalyzing our group comparisons with BDI-II scores entered as covariates. With BDI-II scores covared, group differences at the p < .004 level were no longer observed for physical appearance, artistic abilities, athletic abilities, and possessions/wealth. All other group contrasts remained significant.
positive self-views relative to negative self-views. Conversely, both index coefficient values for individuals with social phobia were essentially zero, suggesting that they did not differentially ascribe certainty or importance to either their positive or negative self-views. Because the sampling distribution of Pearson’s r is not normally distributed, differential importance and certainty index scores were subjected to Fisher’s z transformation, and group means of these transformed scores were then compared using independent-sample t-tests. Results revealed significantly higher z'-transformed scores for controls versus clinical participants on both the differential certainty index, $M_{\text{clinical}} = .04$; $M_{\text{controls}} = .49$, $t(121) = 4.53$, $p < .001$, $d = .82$, and the differential importance index $M_{\text{clinical}} = .08$; $M_{\text{controls}} = .49$, $t(123) = 5.32$, $p < .001$, $d = .96$.

### Discussion

What is the nature of self-perception in social phobia? As predicted, our results suggest that individuals with social phobia rate themselves more negatively than healthy controls across a broad range of self-relevant domains, including level of intelligence, social skills, physical appearance, signs of anxiety, quality of life, quality of relationships, artistic abilities, athletic abilities, current happiness, personality characteristics, possessions/wealth, achievements, and sense of humor. The effect sizes of most of these group differences were very large, with the largest effects demonstrated for participant ratings of personality and social skills – the same two self-attribute dimensions that were previously found to be associated with the greatest frequency of social comparisons in individuals with social phobia relative to healthy controls (Antony et al., 2005). However, there were also several group differences in self-ratings across self-attribute dimensions in the present study that were not reported in Antony et al. (2005) as being associated with group differences in social comparisons, suggesting that negative self-perception in social phobia extends beyond those selective dimensions about which socially anxious individuals make social comparisons.

Furthermore, we hypothesized that clinical participants would attach more certainty and importance to their negative self-attributes, while controls would not demonstrate this negative orientation toward self-framing. Contrary to this prediction, our results suggest that controls frame their views of self in a positively oriented manner, while individuals with social phobia do not frame their self-views in either a positive or negative manner. We did not collect comparative ratings of participants’ attributes by objective observers and are, therefore, unable to draw conclusions about whether the less positive reports from the clinical participants reflect a cognitive bias or a true representation of self, which is a limitation of our study. Previous studies on this matter have generally shown that socially anxious and phobic individuals underestimate their social abilities and performances when self-ratings are compared to those of objective raters (for reviews of these findings, see Moscovitch & Hofmann, 2007; Norton & Hope, 2001).

Regardless of whether participants’ self-perceptions in the present study were accurate or biased, it is important that healthy participants tended to associate those self-attributes they viewed most positively with the highest levels of certainty and importance, while clinical participants demonstrated no positive orientation in their framing of self-attributes. Thus, relative to individuals with social phobia, healthy people appear to be more certain of their positive self-views and to attach more importance to them. Framing self-views in this optimistic manner is likely self-protective, as it may provide a continuous, self-correcting, healthy boost to self-esteem while bolstering concomitant positive affect (e.g., Pelham & Swann, 1989) and psychological well-being (e.g., see Taylor & Brown, 1988). On the other hand, the non-positive orientation toward self-framing displayed by socially phobic individuals might play an important role in maintaining the “vicious” cognitive cycle that underlies the persistence of social anxiety symptoms over the course of time (e.g., Clark & Wells, 1995; Hofmann, 2007). These findings indirectly evoke previous work on impaired positive inferential bias (e.g., Hirsch & Matthews, 2000) and fear of positive evaluation (e.g., Weeks, Heimberg, Rodebaugh, & Norton, 2008) in social anxiety.

### Table 2

<table>
<thead>
<tr>
<th>SAQ dimension</th>
<th>Social phobia M (SD)</th>
<th>Controls M (SD)</th>
<th>t (df)</th>
<th>Cohen’s d*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intelligence</td>
<td>5.32 (1.41)</td>
<td>6.67 (1.00)</td>
<td>6.15 (124)*</td>
<td>1.11</td>
</tr>
<tr>
<td>Social skills</td>
<td>3.44 (1.84)</td>
<td>6.54 (1.09)</td>
<td>11.30 (123)*</td>
<td>2.04</td>
</tr>
<tr>
<td>Physical appearance</td>
<td>4.33 (1.69)</td>
<td>5.92 (1.11)</td>
<td>6.14 (124)*</td>
<td>1.10</td>
</tr>
<tr>
<td>Quality of life</td>
<td>4.17 (1.64)</td>
<td>6.58 (1.21)</td>
<td>9.33 (124)*</td>
<td>1.68</td>
</tr>
<tr>
<td>Quality of relationships</td>
<td>4.21 (1.86)</td>
<td>7.07 (1.51)</td>
<td>9.41 (124)*</td>
<td>1.69</td>
</tr>
<tr>
<td>Artistic abilities</td>
<td>3.95 (2.58)</td>
<td>5.38 (1.95)</td>
<td>3.48 (124)*</td>
<td>0.63</td>
</tr>
<tr>
<td>Athletic abilities</td>
<td>4.03 (1.97)</td>
<td>5.02 (1.57)</td>
<td>3.09 (124)*</td>
<td>0.56</td>
</tr>
<tr>
<td>Current happiness</td>
<td>3.65 (1.76)</td>
<td>6.65 (1.70)</td>
<td>9.72 (124)*</td>
<td>1.75</td>
</tr>
<tr>
<td>Personality</td>
<td>3.34 (1.71)</td>
<td>6.83 (1.33)</td>
<td>12.72 (124)*</td>
<td>2.28</td>
</tr>
<tr>
<td>Possessions/wealth</td>
<td>3.58 (1.89)</td>
<td>5.28 (1.57)</td>
<td>5.48 (124)*</td>
<td>0.98</td>
</tr>
<tr>
<td>Signs of anxietyb</td>
<td>6.05 (2.28)</td>
<td>2.40 (2.14)</td>
<td>9.22 (124)*</td>
<td>1.66</td>
</tr>
<tr>
<td>Achievements</td>
<td>4.33 (1.88)</td>
<td>6.65 (1.02)</td>
<td>8.49 (124)*</td>
<td>1.53</td>
</tr>
<tr>
<td>Sense of humor</td>
<td>5.15 (1.65)</td>
<td>6.97 (1.23)</td>
<td>6.94 (124)*</td>
<td>1.25</td>
</tr>
</tbody>
</table>

* Cohen’s $d = (t(n_1 + n_2)/[(\sqrt{df}))/\sqrt{(n_1n_2)}]$.  
* Higher ratings represent tendency to show more signs of anxiety.
As noted earlier, our study design did not allow us to conclusively disentangle the unique effects of symptoms of anxiety and depression on self-attribute ratings (e.g., Miller & Chapman, 2001). Our confidence in our findings would have been maximized if our study contained a clinical control group of individuals who had a principal diagnosis of depression without a comorbid anxiety disorder, and/or if the participants with social phobia had no comorbid symptoms of depression. However, symptoms of social anxiety and depression tend to co-occur in nature (e.g., Moscovitch, Hofmann, Suvak, & In-Albon, 2005), so although studying diagnostically homogenous groups would have increased the internal validity of our findings, it would have also greatly limited their generalizability to “real world” psychopathology.

Efficacious cognitive-behavioral therapy (CBT) for social phobia is thought to be mediated by extinction learning processes (see Moscovitch, Antony, & Swinson, 2009), which lead to therapeutic changes in the salience and retrievability of positive versus negative mental representations of self (e.g., Brewin, 2006). The results of this study suggest the need to incorporate interventions into CBT protocols for social phobia that not only help patients challenge their negative automatic thoughts (e.g., Heimberg & Becker, 2002), but also interventions that facilitate the development and accessibility of – as well as greater confidence in – more positive beliefs about self. Future research is needed to replicate our results and test these intriguing clinical implications.

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