**Targeting Fear of Positive Evaluation in Patients with Social Anxiety Disorder via a Brief Cognitive-Behavioral Therapy Protocol: A Proof-of-Principle Study**

Justin W. Weeks1

M. Taylor Wilmer2, a

Carrie M. Potter2, b

Elizabeth M. Waldron2, c

Mark Versella2, d

Simona C. Kaplan2

Dane Jensen2, e

­Richard G. Heimberg2

1 Nebraska Medicine, Department of Psychology; University of Nebraska Medical Center, Department of Psychiatry; Omaha, NE, USA 68198-4185

2 Adult Anxiety Clinic of Temple, Temple University, Philadelphia, PA, USA

a M. Taylor Wilmer is now at McLean Anxiety Mastery Program, McLean Hospital, Cambridge, MA 02138

b Carrie M. Potter is now at Cambridge Health Alliance/Harvard Medical School, Cambridge, MA 02139

c Elizabeth M. Waldron is now at Northwestern University Feinberg School of Medicine,

Department of Psychiatry and Behavioral Sciences, Chicago, IL 60611

d Mark Versella is now at Rutgers University, Piscataway NJ 08901

e Dane Jensen is now at Haverford College Counseling and Psychological Services,

Haverford, PA 19041

Corresponding author: Justin W. Weeks

Telephone: (402) 559-5031; Fax: (402) 559-9592; E-mail: juweeks@nebraskamed.com

**Abstract**

**Background:** Our aim was to develop a brief cognitive-behavioral therapy (CBT) protocolto augment treatment for social anxiety disorder (SAD)*.* This protocol focused specifically upon *fear of positive evaluation* (FPE). To our knowledge, this is the first protocol that has been designed to systematically target FPE.

**Aims:** To test the feasibility of a brief (two-session) CBT protocolfor FPE and report proof-of-principle data in the form of effect sizes.

**Method:** Seven patients with a principal diagnosis of SAD were recruited to participate. Following a pre-treatment assessment, patients were randomized to either (a) an *immediate* CBT condition (*n* = 3), or (b) a comparable wait-list (WL) period (two weeks; *n* = 4). Two WL patients also completed the CBT protocol following the WL period (*delayed* CBT condition). Patients completed follow-up assessments one week after completing the protocol.

**Results:** A total offive patients completed the brief, FPE-specific CBT protocol (two of the seven patients were wait-listed only and did not complete *delayed* CBT). All five patients completed the protocol and provided one-week follow-up data. CBT patients demonstrated large reductions in FPE-related concerns as well as overall social anxiety symptoms, whereas WL patients demonstrated a marked increase in FPE-related concerns.

**Conclusions:** Our brief FPE-specific CBT protocol is feasible to use and was associated with large FPE-specific and social anxiety symptom reductions. To our knowledge this is the first treatment report that has focused on systematic treatment of FPE in patients with SAD. Our protocol warrants further controlled evaluation.

*Keywords:* Social anxiety disorder; Social phobia; Fear of evaluation; Fear of Positive Evaluation; Cognitive-behavioral therapy

**Targeting Fear of Positive Evaluation in Patients with Social Anxiety Disorder via a Brief Cognitive-Behavioral Therapy Protocol: A Proof-of-Principle Study**

Social anxiety disorder (SAD) is characterized by excessive fear of social situations, and is the fourth most common psychological disorder, with a lifetime prevalence rate of 12.1% (Kessler et al., 2005). The majority of individuals seeking treatment for SAD report moderate-to-severe impairment across various life domains such as education, employment, family relationships, marriage/romantic relationships, and friendships(e.g., see Aderka et al., 2012; Rodebaugh, 2009; Stein, McQuaid, Laffaye, & McCahill, 1999). Moreover, SAD is highly comorbid with other disorders such as depression and alcohol use disorders (Kessler, Stang, Wittchen, Stein, & Walters, 1999; Ruscio et al., 2008), and individuals with SAD endorse a low quality of life (Safren, Heimberg, Brown, & Holle, 1997; Dryman, Gardner, Weeks, & Heimberg, 2016).

**Efficacy of Cognitive-Behavioral Therapy for SAD**

Cognitive-behavioral therapy (CBT) is an effective first-line treatment for SAD (e.g., see Canton, Scott, & Glue, 2012; Gordon, Wong, & Heimberg, 2014; Kaplan, Swee, & Heimberg, 2018). CBT facilitates maintenance of treatment gains and prevents relapse relative to patients receiving pharmacotherapy; nevertheless, the percentage of patients with SAD who show clinically significant change in response to CBT remains suboptimal, and relapse rates suggest that maintenance of psychotherapeutic gains can be improved (Gordon et al., 2014). Thus, efforts to increase the effectiveness of CBT for SAD are an important endeavor.

Empirically-supported treatments for SAD have focused systematically on fear of negative evaluation (FNE), a well-established cognitive feature of social anxiety (e.g., see Clark & Wells, 1995; Rapee & Heimberg, 1997; Watson & Friend, 1969). Indeed, FNE was recently added to the diagnostic criteria for SAD (*Diagnostic and Statistical Manual of Mental Disorders, 5th edition* [DSM-5]; American Psychiatric Association [APA], 2013).

Fear of positive evaluation (FPE) has more recently been introduced, and available data suggest that it is also an important cognitive feature of SAD (see Reichenberger & Blechert, 2018, for a review). FPE is defined as the sense of dread associated with being evaluated favorably and publicly, which begets direct social comparison of the self to others and therefore causes the recipient to feel highly conspicuous (Weeks, Heimberg, & Rodebaugh, 2008). However, published CBT protocols for the treatment of SAD have not systematically targeted FPE. FPE has been shown to improve in response to both exposure therapy (Fergus et al., 2009) and CBT (Weeks et al., 2012) for SAD with large effect sizes; nevertheless, effect sizes for FPE were smaller than those for FNE in the above studies, suggesting that there is room for improvement in the effects of CBT on FPE, and possibly, SAD more broadly.

**Developing a brief CBT protocol to systematically target FPE**

We developed a manualized CBT protocol targeting FPE to be delivered across two sessions in an individual format. The theoretical foundations of this protocol were directly informed by research conducted on FPE over the past 10 years (Reichenberger & Blechert, 2018). To illustrate, cognitive restructuring targeted FPE-specific, negative automatic thoughts such as *disqualification of positive social outcomes* (Weeks, 2010). Exposures (both in vivo and in-session) focused on either: (a) engaging in *self-promotion* (Weeks & Zoccola, 2015, 2016); or (b) *accepting/receiving compliments* without disqualifying positive social outcomes (Weeks, 2010). The practical elements of this brief, FPE-specific protocol were derived from a previously well-validated CBT protocol for SAD (Hope, Heimberg, & Turk, 2010).

**The current study**

In the current study, we administered our brief, FPE-specific CBT protocol to individuals seeking treatment for SAD. All patients ultimately received ongoing individual weekly CBT based on the Hope et al. (2010) protocol after completing the present study, but their later outcomes are not considered here. Our primary aim was to assess the feasibility and potential clinical benefits of a brief, FPE-specific CBT protocol with regard to both FPE-specific concerns as well as overall SAD symptoms. The present study is a proof-of-principle trial.

**Method**

*Participants*

Participants were recruited at the Adult Anxiety Clinic of Temple University (AACT), a specialty outpatient anxiety clinic in Philadelphia, PA. Inclusion criteria required that patients were actively seeking CBT for SAD, received a principal diagnosis of SAD according to DSM-5 criteria, were aged 18 years or older, and were fluent in English. Patients who met criteria for additional psychological disorders were eligible, excepting a current diagnosis of bipolar disorder, a current or past diagnosis of any psychotic disorder, and/or a diagnosis of a current substance use disorder. All eligible patients were invited to engage in our FPE-specific CBT protocol prior to initiating a full course of CBT for SAD (Hope et al., 2010). Participation in the present trial was entirely voluntary and did not affect eligibility for treatment at the AACT.

A total of seven patients enrolled in the present study. Three of the seven patients were randomly assigned to and completed *immediate CBT* with the FPE-specific protocol; the remaining four patients were randomly assigned to and completed a two-week waitlist period (WL). Additionally, two of the four WL patients completed the CBT protocol following the waiting period (*delayed* CBT; *n* = 2). The two-session FPE-specific therapy was provided at no cost, and patients did not receive compensation for completion of pre- or post-treatment assessments.

One patient reported at post-CBT follow-up that they had initiated an alternative psychotherapy while also completing the FPE-specific CBT protocol, and one patient reported that they had initiated pharmacotherapy while completing the protocol; results were substantively identical when either of these patients were excluded from effect size calculations, and so they were retained in order to maximize the external validity of the reported effects. Ethical approval for the present study was obtained from the Institutional Review Board at Temple University, and all patients provided informed consent prior to participation.

*Design*

Patients were in the study for two to four weeks (i.e., two weeks for the *immediate* CBT or WL only conditions; four weeks for the *delayed* CBT condition following the initial WL period). All patients completed baseline questionnaires prior to initiating the FPE-specific CBT protocol. All patients completed the same questionnaires one-week post-CBT or one week post-WL, depending on condition. The two patients in the delayed CBT condition also completed the questionnaires at one week post-WL and one week post-CBT.

*Measures*

*Diagnostic.*

**Anxiety and Related Disorders Interview Schedule for DSM-5 Lifetime Version (ADIS-5L; Brown & Barlow, 2014)**. The ADIS-5L provides probes and questions that assist in assigning DSM-5 diagnoses for a subset of psychiatric disorders. All patients in the present study completed the full ADIS-5L to confirm a primary diagnosis of SAD. Interviewers were clinical psychology doctoral students who were trained according to the criteria outlined by Brown and Barlow (2014). Although specific reliability data for the ADIS-5L have yet to be published, previous versions of the interview have exhibited strong inter-rater reliability for the diagnosis of SAD (Brown et al., 2001).

*Self-report.*

**Primary outcome measure.**

***Brief FPE Outcome Scale (BFOS).***Given the brief timeframe during which our FPE-specific CBT protocol was administered, we developed a brief (three-item), face-valid outcome scale that focused directly on FPE-specific symptoms relevant to the exposures that patients were asked to complete (i.e., “How anxious would you be to show off your positive qualities to others right now?”, “How distressing would it be for you to talk about yourself in front of others and in a positive way right now?”, and “How anxious would it make you to receive a compliment in front of others right now?”). All BFOS items were rated on a 10-point Likert-type scale, ranging from 0 (*not at all true*) to 9 (*very true*). The BFOS demonstrated adequate internal consistency within the present sample (*α* = .75).

**Additional state measures.**

***Social Interaction Phobia Scale-state version (SIPS-s).***The original 14-item Social Interaction Phobia Scale (SIPS; Carleton et al., 2009; see below for additional details on the trait version of the SIPS) uses a 5-point Likert-type rating scale ranging from 0 (*not at all characteristic of me*) to 4 (*entirely characteristic of me*) and yields a total *social anxiety* score as well as subscale scores for *social interaction anxiety*, *fear of overt evaluation,* and *fear of attracting attention* (Carleton et al., 2009; see also Menatti et al., 2015). SIPS items (e.g., “When mixing socially I am uncomfortable”) were modified for the purposes of the present study to assess *state* social anxiety (hereafter, the SIPS-s). Specifically, all 14 of the original SIPS items were modified for state administration by adding the phrase “right now” (e.g., “I’d be uncomfortable mixing socially with others right now”) in order to examine *changes* in social anxiety in response to our FPE-specific CBT protocol. The SIPS-s demonstrated excellent internal consistency in the present study (*α* = .89).

***State social anxiety ratings.*** Patients reported their state anxiety on a 100-point Subjective Units of Discomfort Scale throughout the in-session exposures. State anxiety ratings were recorded: immediately before, at one-minute intervals throughout, and immediately upon completion of, each exposure.

**Trait measures.**

***Fear of Positive Evaluation Scale (FPES).*** The 10-item FPES (Weeks, Heimberg, & Rodebaugh, 2008; e.g., “I am uncomfortable exhibiting my talents to others, even if I think my talents will impress them”) uses a 10-point Likert-type rating scale, ranging from 0 (*not at all true*) to 9 (*very true*). Two reverse-scored items are included (for the purpose of potentially detecting response biases) but are not utilized in the calculation of the FPES total score. The FPES has demonstrated strong internal consistency (all αs > .80), convergent and discriminant validity (Weeks, Heimberg, & Rodebaugh, 2008; Weeks, Heimberg, Rodebaugh, Goldin, & Gross, 2012), and factorial validity (Weeks, Heimberg, & Rodebaugh, 2008; Weeks et al., 2012) in both undergraduate and clinical samples. The FPES demonstrated good internal consistency in the present sample (*α* = .80).

***Social Interaction Phobia Scale (SIPS).***As noted above, the original, trait-based, 14-item SIPS (Carleton et al., 2009; see above for details on the state version of the SIPS used for this study) uses a 5-point Likert-type rating scale ranging from 0 (*not at all characteristic of me*) to 4 (*entirely characteristic of me*) and yields a total social anxiety score as well as subscale scores for *social interaction anxiety*, *fear of overt evaluation,* and *fear of attracting attention* (Carleton et al., 2009; see also Menatti et al., 2015). The SIPS was administered at pre-treatment to confirm that our social anxiety *state* outcome measure (i.e., SIPS-s) demonstrated convergent validity with the psychometrically-validated *trait* SIPS measure (see *Preliminary Analyses* sectionbelowfor details). The trait SIPS demonstrated excellent internal consistency in the present study (*α* = .89).

*The intervention.*

Our brief, FPE-specific CBT protocol was designed to target situations in which individuals with social anxiety tend to fear positive evaluation (Weeks, 2010; Weeks & Zoccola, 2015, 2016). Treatment was provided by clinical psychology doctoral students, under the supervision of the first and eighth authors. The protocol was delivered in an individual format over two sessions, scheduled one week apart, with no contact between sessions. The first session was designed to last 120 minutes; the second session was designed to last 60 minutes.

We explained to patients that the goal of the protocol was to reduce FPE given that it has been shown to be an important cognitive component of social anxiety, regardless of whether patients presented for treatment of FPE.

Session 1 of the protocol focused on: (i) psychoeducation pertaining to FPE; (ii) cognitive restructuring of FPE-specific, negative automatic thoughts; (iii) conducting an in-session exposure focusing on either [a] engaging in *self-promotion* or [b] *accepting/receiving compliments*; and (iv) designing of a first in vivo exposure focusing on either [a] engaging in *self-promotion* or [b] *accepting/receiving compliments* (to be completed within one week of Session 1). Session 2 focused on: (i) additional cognitive restructuring of FPE-specific, negative automatic thoughts; (ii) conducting an in-session exposure focusing on either [a] engaging in *self-promotion* or [b] *accepting/receiving compliments*; (iii) structuring of a second in vivo exposure focusing on either [a] engaging in *self-promotion* or [b] *accepting/receiving compliments* (to be completed within one week of Session 2); and (iv) recommendations for maintenance of gains. Sessions were scheduled a week apart.

*Analysis*

At this stage of protocol evaluation, the focus was on feasibility and effect sizes from pre- to post-treatment. Hedges’ *g*s were calculated to assess change in the outcome measures. Pre-treatment scores were compared to (a) post-CBT and/or (b) post-waiting list scores. Our analyses do not focus on *p* values, consistent with recommendations by Lancaster, Dodd, and Williamson (2004).

**Results**

*Preliminary Analyses*

As noted previously, all patients were assigned a principal diagnosis of SAD according to DSM-5 criteria. The majority of patients in the overall study sample were men (5/7; 71.4%), with a mean age of 27.3 years (*SD* = 6.29). Of note, FPE does not tend to vary across sex (e.g., see Weeks, Jakatdar, & Heimberg, 2010). The majority of patients in the overall study sample identified as Caucasian (6/7; 85.7%); one out of seven (14.3%) identified as Hispanic (non-Caucasian). Of note, levels of FPE has been shown to be factorially-invariant across Caucasian and Hispanic/Latino(a) individuals (see Norton & Weeks, 2009).

All patients in the present study obtained scores on a pre-treatment trait administration of the Fear of Positive Evaluation Scale (Weeks, Heimberg, & Rodebaugh, 2008) that exceeded a cutoff score of 22(*M* = 41.43, *SD* = 14.51), which has been found to reflect clinically-severe levels of FPE (Weeks, Heimberg, Rodebaugh, Goldin, & Gross, 2012). Moreover, all patients in the present study obtained scores on a pre-treatment *trait* administration of the SIPS (Carleton et al., 2009) that exceeded a cutoff score of 20 for classifying patients with SAD (Menatti et al., 2015); *M* = 32.29, *SD* = 8.88. Importantly, scores obtained on a pre-treatment administration of our state version of the SIPS (SIPS-s) that we used as one of our outcome measures correlated strongly and positively with a pre-treatment administration of the original trait version of the SIPS (Carleton et al., 2009), *r* = .76, *p* = .046, providing strong evidence for the convergent validity of our SIPS-s.

*Feasibility of the brief FPE-specific CBT protocol*

As noted above, all five patients who initiated the FPE-specific treatment protocol completed both sessions (*n* = 3 for *immediate* CBT, *n* = 2 for *delayed* CBT), and all patients completed the protocol within a two-week period (as expected). Average peak state anxiety ratings across the two in-session exposures were in the expected range (i.e., first in-session exposure: average peak state anxiety rating = 52.5; second in-session exposure: average peak state anxiety rating = 48.75). Four of the five patients who received either immediate or delayed treatment reported that they had successfully completed both assigned in-vivo homework exposures within one week of each session. One treatment completer reported having completed the first, but not the second, in-vivo homework exposure.

*Clinical outcomes*

Figures 1 and 2 display changes in FPE-specific symptoms (i.e., the Brief FPE Outcome Scale) and overall social anxiety symptoms (i.e., SIPS-s), respectively. As shown in Figure 1, FPE-specific symptoms (i.e., BFOS scores) were roughly equivalent across the CBT (*M* = 19.20, *SD* = 3.56) and WL (*M* = 22.00, *SD* = 0.71) conditions at baseline. However, upon completing the brief, FPE-specific CBT protocol (either *immediate* or *delayed* CBT), CBT patients’ FPE-related concerns reduced markedly (*M* = 13.60, *SD* = 4.16), Hedges’ within-group *g* = 1.29. In contrast, FPE-related concerns for those patients in the WL condition (either WL only, or prior to undergoing CBT) *increased* (*M* = 23.50, *SD* = 1.91), Hedges’ within-group *g* = -0.80 (see Figure 1).

Similarly, overall social anxiety symptoms (i.e., SIPS-s scores) were roughly equivalent across the CBT (*M* = 31.4, *SD* = 6.99) and WL (*M* = 33.5, *SD* = 12.77) conditions at baseline; moreover, as would be expected, the SIPS scores of both groups exceeded the cutoff score (>20) proposed by Carleton et al. (2009) for classifying clinically-severe SAD symptoms. Upon completing the brief, FPE-specific CBT protocol (either *immediate* or *delayed* CBT), CBT patients’ overall social anxiety symptoms (i.e., SIPS-s scores) reduced considerably (*M* = 25.2, *SD* = 8.35), Hedges’ within-group *g* = 0.72; in contrast, overall social anxiety symptoms for those patients in the WL condition (either WL only, or prior to undergoing CBT) did not change appreciably (*M* = 34.5, *SD* = 8.96), Hedges’ within-group *g* = -0.08 (see Figure 2).

**Discussion**

Treatment-seeking patients with a primary diagnosis of SAD took part in this first evaluation of a brief CBT protocol targeting FPE. The treatment was well-received, in that all patients who initiated the CBT protocol completed it successfully; all five CBT patients completed both in-session FPE-related exposures; and the majority of patients (4/5; 80%) completed both in vivo FPE-related homework exposures. These findings suggest that patients were willing to engage in and able to tolerate FPE-related exposures in a relatively brief period of time.

Improvements on outcome measures assessing FPE-specific symptoms and social anxiety symptoms were in the large effect size range for the CBT group and exceeded those of the WL group. The reduction in overall social anxiety symptoms is notable given that the protocol targeted FPE rather than social anxiety in general. These results lend additional support to the idea that FPE is an important cognitive feature of SAD and has value as a direct target of treatment. Moreover, these effects are particularly striking given that we did not recruit patients who endorsed high FPE per se, but rather, we examined the effects of our FPE-specific CBT protocol in an open, treatment-seeking sample of patients with a principal diagnosis of SAD.

To our knowledge, this study was the first evaluation of a FPE-specific CBT protocol. However, this proof-of-principle study has limitations. The sample was small, and the present findings must be replicated in larger samples of treatment-seeking individuals with SAD. The outcome measures were self-report only, and the present findings must be extended in future studies to include blinded clinician-administered outcome measures. The protocol itself was also brief, and thus, future studies should examine longer, more extensive FPE-specific protocols or incorporate FPE-specific psychoeducation and exposures into existing CBT protocols for SAD. Lastly, long-term follow-up effects (beyond one week of condition completion) were not assessed.

Nevertheless, our brief, FPE-specific CBT protocol, informed by a growing body of empirical evidence (Reichenberger & Blechert, 2018; Weeks & Howell, 2014), demonstrated considerable promise. The current study’s feasibility and preliminary efficacy results are encouraging. Our protocol warrants further controlled evaluation.

In summary, we believe that psychotherapy for SAD should target fear of evaluation *in general,* including fears of both positive and negative evaluation. Our preliminary results suggest that such an approach has utility, and our FPE-specific protocol could potentially augment CBT for SAD.

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**Brief FPE Outcome Scale Scores** (range: 0-30)

(range: 0-30)

**Figure 1.** Changes in state levels of FPE-specific symptoms from pre- to post-intervention, plotted separately for those patients who completed the FPE-specific CBT protocol (*n* = 5) versus wait-list patients (*n* = 4). CBT = cognitive-behavioral therapy group (*immediate* and *delayed* CBT combined); WL = wait list group (either WL only or prior to undergoing CBT). FPE = fear of positive evaluation.

**Social Interaction Phobia Scale–state (SIPS-s) Scores**

(range: 0-56)



**Figure 2.** Changes in overall social anxiety symptoms from pre- to post-intervention, plotted separately for those patients who completed the FPE-specific CBT protocol (*n* = 5) versus wait-list patients (*n* = 4). CBT = cognitive-behavioral therapy group (*immediate* and *delayed* CBT combined); WL = wait list group (either WL only or prior to undergoing CBT). FPE = fear of positive evaluation.