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**The relationship between attachment and social anxiety, focusing on self-esteem and locus of control as possible mediators.**

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**CRITICALLY DISCUSS PSYCHIATRIC  
DIAGNOSTIC SYSTEMS FOR ADULT MENTAL  
HEALTH PROBLEMS. SHOULD CLINICAL  
PSYCHOLOGISTS USE SUCH CLASSIFICATION  
SYSTEMS?**

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## **CRITICALLY DISCUSS PSYCHIATRIC DIAGNOSTIC SYSTEMS FOR ADULT MENTAL HEALTH PROBLEMS. SHOULD CLINICAL PSYCHOLOGISTS USE SUCH CLASSIFICATION SYSTEMS?**

Psychiatric diagnostic systems are widely used. While they can be useful in clinical practice and research they also have limitations. The following paper will explore these systems, particularly the Diagnostic and Statistical Manual of Mental Disorders (DSM) and to a lesser extent the International Statistical Classification of Disease, Injury, and Causes of Death (ICD), briefly presenting their development. It will also discuss the pros and cons of implementing these systems and ultimately debate the use of psychiatric diagnostic systems by clinical psychologists.

The purpose of classification is to order or group concepts according to their similarities and differences for the purpose of communication and prediction (Goodwin & Guze, 1989). According to Blashfield (1998) there are four main models of classification categorical, dimensional, disease, and prototype. The categorical model organises individuals for the purpose of psychiatric diagnosis into categories based on a number of predetermined conditions into which 'patients' either fit or don't fit. Categories should ideally be distinct and should identify a homogeneous group. Cluster analytic methods are generally used in order to identify the conditions which inform a particular category. This entails using descriptive data related to patients and analysing it in an attempt to identify a category which represents a homogeneous group. The dimensional model utilises sets of descriptive variables, for instance symptoms, behaviours, self-reports, and diagnostic criteria, which are correlated into dimensions by factor analysis. These dimensions may be independent of one another or may also be correlated. According to the disease model diagnostic categories are medical diseases. In this sense a cluster of symptoms would be identified according to a set of predetermined rules which would inform the course of the disease and

responses to treatment. This model assumes an essentialist perspective whereby diseases are considered real entities as opposed to abstract concepts. Finally the prototype model relies on representative examples to define categories, acknowledging that some examples are more representative than others. The number of symptoms a patient has is related to their inclusion or exclusion into a category though there is no set of rules specifying exactly how many or which particular symptoms a patient must have in order to be considered under a specific category. In contrast to the disease model, this model assumes a nominalist perspective with regards to categories. This means categories are concepts used to organise information but are not considered real entities in themselves, simply names for the purpose of classifying.

The most widely employed psychiatric diagnostic systems are the Diagnostic and Statistical Manual of Mental Disorders (DSM) which is published by the American Psychiatric Association and the International Statistical Classification of Disease, Injury, and Causes of Death (ICD), published by the World Health Organisation. Initially the role of the ICD was to report national and international statistics of morbidity and mortality. This changed with the sixth edition of the ICD in 1948, when classifications of mental disorders were included in response to the first edition of the DSM.

It is necessary to present a brief history of the developments of the DSM at this stage in order to put criticisms and developments of psychiatric diagnostic systems into context. The first DSM was published in 1952 after the Second World War with the explicit aim of improving communication between professionals and providing standard categories to aid discussion of clinical cases. This was particularly important due to the fact that during this period there were four competing classification systems in use. These included the standard system used by the American Psychiatric association (APA), the US Army classification, the US Navy classification, and the Veterans Administration system (Raines, 1952, cited in Blashfield, 1998). The construction of the DSM was influenced by Emil Kraepelin's sixth edition textbook entitled *Clinical psychiatry: A text-book*

*for students and physicians* (Kraepelin, 1902/1896 cited in Blashfield, 1998), which classified mental disorders by making a distinction between organic disorders, functional psychoses, and neurotic or character disorders. The first edition of the DSM included 108 different categories based on a consensus of popular diagnoses used primarily by members of the APA in the 1940s and 50s. As mentioned earlier the ICD responded to the publication of the DSM by including mental disorders into its sixth addition, though these diagnostic categories were not accepted or implemented by the international community. To rectify this the World Health Organisation published the ICD-8 (i.e. eighth edition) in 1966, including a mental disorders section comprising a classification system which met with international consensus, and represented a useful set of terms to refer to groups of people that professionals were seeing in their clinical practice. As one change led to another the American Psychiatric Association adapted the DSM to correspond with the ICD-8, hence publishing the DSM-II in 1968. A subtle and yet notable change in this latest edition of the DSM was the omission of the term 'reaction' (APA 2000). The DSM-I used this term which reflected the influence of a psychobiological approach to mental disorders whereby mental disorders were considered to be reactions of the personality to psychological, social, and biological elements. This second edition of the DSM included 185 categories. These early diagnostic tools were based on categorical models established primarily through professional consensus. As the psychodynamic view was prominent during this period consensus was informed in part by this theoretical approach.

During the 1970's the DSM-II began to face criticism particularly for having low reliability. It was argued that professionals using the DSM were not able to consistently identify individuals as having a particular disorder and agreement between professionals was low. The diagnostic categories used in the DSM could have social implications for those who were given these 'labels'. It was theorised that by giving an individual a psychiatric label like schizophrenia they would be compelled to act in a way which would validate this diagnosis (Szasz, 1972; Breggin, 1993). In other words it was like a self-fulfilling prophecy which would

also have an impact on how they were viewed by society (Breggin, 1993; Rogers & Pilgrim, 1997). Another criticism made was that although the DSM was based on a categorical model of classification it fundamentally accepted a medical model approach to mental disorders. According to the medical model, classification is diagnosis (Goodwin & Guze, 1989) and the medical model perspective views mental health problems as diseases in the same sense as physical disorders where causation can be traced to a biological mechanism (Blashfield, 1984).

In response to these criticisms the Neo-Kraepelin (Klerman, 1978 cited in Blashfield, 1998) movement emerged. The movement emphasised a return to focusing on the biological aspects of mental disorders, strengthening the traditional relationship of psychiatry to medicine and using empirical methods to inform diagnosis instead of consensus (Blashfield, 1984). This in turn promoted a greater interest in research and the necessity for psychiatric illnesses to be validated statistically. For psychiatric diseases to be subsumed under the same heading as physical diseases the movement needed a definition of disease which would satisfy a medical model approach. Ultimately a member of the Neo-Kraepelin movement produced a definition which differentiated between the terms *disease* and *mental disorder*. The term *disease* was used to describe disorders which had physiological psychopathology that could be observed, for example organic brain disorders. The term *mental disorder* was used to describe psychological conditions that were beyond an individual's control which had psychological causes, influenced behaviour and social functioning, and produced distress. The fact that two definitions were needed to distinguish between organic and psychological mental illnesses, disease and disorder, seems to indicate that there is some degree of fundamental difficulty fitting mental disorders into a medical model and this may not be addressed by creating two definitions. This definition did have an impact as it was used in 1973 to provide evidence that homosexuality was not a mental disorder.

The DSM-III published in 1980 was influenced by the Research Diagnostic Criteria (Spitzer et al, 1975 cited in Blashfield, 1998) which aimed to establish diagnostic criteria based on research findings. The DSM-III claimed to be both an atheoretical and empirical tool (Guimon, 1989). In an attempt to be less reductionist it took the form of a multiaxial system. Each axis described a separate area of potential psychopathology that an individual may be suffering from. Axis I included categories found under the heading of clinical disorders or the individual's psychopathology, Axis II included categories which identified personality styles and disorders, Axis III subsumed general medical conditions, Axis IV included social and environmental problems, and Axis V represented role disturbances and contained criteria related to getting on in society or social functioning. Although Axes were not explicitly arranged in hierarchical order the majority of the written text within the manual was dedicated to Axis I, with less dedicated to Axis II, even less to Axis III, etc... In total there were 265 mental disorders contained in this version of the DSM.

While the third edition of the DSM had an impact on increasing the amount of mental health research being conducted it was criticised for not being empirical. Examining the axes contained within the text, it becomes evident that difficulties with social functioning may require a value judgement based on social norms. Social norms are influenced by class norms and cultural norms, and therefore judgement becomes further diluted. Another concern is that behaviour is more complex than merely what can be empirically observed (e.g. motivation, purpose, and the meaning of an act), therefore clinicians are either making inferences not based on scientific evidence or are not treating behaviours which are not observable. A practical criticism levelled at this edition was that the multiaxial approach was more time consuming and descriptions were not exclusive to specific categories. A revision of the DSM-III was published in 1987 entitled the DSM-III-R. Changes to this version were meant to correspond with current research findings. In addition there was a general revision with six categories being dropped and some being renamed. Notably homosexuality was dropped and this version of the DSM contained 297 categories. The DSM-IV was

published in 1994 and contained 354 categories. This version was also multiaxial and alleged to be updated to reflect developments in research. To accompany this edition a source book was published in four volumes (The DSM-IV Sourcebook) containing clinical and research references which provide support for the decisions made with regards to changes in this edition.

The ICD was intended to be revised every ten years. The ninth version of the ICD (ICD-9) corresponded closely to its eighth version. The tenth version of the ICD aimed to be a reliable tool that could be used uniformly by various clinicians, providing acceptable categories of mental disorders (Blashfield, 1998). This edition also included two separate forms, one which included descriptions of mental disorders intended for clinical use (blue form) and the other intended for research purposes containing diagnostic criteria which need to be specifically met (green form).

Thus far this paper has briefly presented the development of commonly used psychiatric diagnostic systems, with this in mind a discussion of the pros and cons of implementing these systems within clinical practice and research can proceed.

One of the benefits of having a widely accepted psychiatric classification system is that it provides a common language by which professionals can communicate. This can assist case discussion, prognosis, treatment strategies and availability and planning of services. While this may be advantageous for an individual with a psychiatric diagnosis in the sense of receiving some help, it is dependent on the efficacy of the diagnosis. The diagnosis needs to meaningfully identify a phenomenon which reflects the relationship among behaviours and experiences (Boyle, 1996). Simply put, the diagnosis should accurately describe the difficulties an individual is having, and the mechanism by which these have developed and are maintained. Having a standardised language by which professionals can communicate is also beneficial in the area of research. Diagnostic systems often provide the criteria by which participants are selected for studies and make it possible for comparisons to be made between studies.

Graham Davey (2003) reported that 60% of articles published in the *Journal of Clinical Psychology and Behaviour Research and Therapy* used DSM criteria demonstrating the widespread use of this tool.

There is much debate as to whether current diagnostic systems actually provide meaningful descriptions. It has been argued that the current systems lack an explanation of processes or mechanisms (Boyle 1996) and causes (Guimon, 1989) and don't take into account the context of the difficulties and the impact this may have on symptoms. One of the cons levelled at psychiatric diagnostic systems is that they have low reliability in the sense that individuals are not consistently diagnosed with the same disorder. Although this has improved with the later publications of the DSM, it is thought this is partly due to the increased use of the tool (Pilgrim, 2000). This is particularly the case if professionals working in the area of mental health are encouraged to have knowledge of this tool to aid communication between professionals. In order to be a meaningful classification system it is necessary for a diagnosis to identify a discrete category which reflects an individual's pathology. The DSM has not been able to satisfy this as comorbidity within DSM defined diagnosis is considered 'the rule and not the exception' (Kessler et al, 1994) and specifically comorbidity of Axis I and II disorders is described as 'extensive' (Roth & Fonagy, 1996).

Another problem with using psychiatric diagnostic systems is that they have low validity. A useful diagnostic system would need to be able to identify a homogenous or distinct group of people who meet the same criteria and share characteristics or symptoms. Using DSM criteria it is possible to have individuals with the same diagnosis who do not share any of the same symptoms (e.g. schizophrenia) and others where symptoms overlap into a number of categories (e.g. personality disorders). This demonstrates poor construct validity reflected in correlation studies which have been unsuccessful at consistently identifying schizophrenic symptoms which define this diagnosis (Bental et al, 1988). Predictive validity aims to provide information regarding what outcomes may be anticipated in the course of a particular disorder and what treatment is the most

effective. In practical terms this is particularly relevant to the planning and providing of mental health services. As it stands certain DSM diagnoses provide poor information regarding the course of an illness or what treatment will be effective. This is particularly the case with the diagnosis 'schizophrenia' (Bental et al, 1988).

There seems to be a tautological problem which develops from initially using a diagnostic system with poor construct validity. In doing so outcome studies are based on participants selected by using DSM criteria where diagnoses don't provide information about the underlying mechanisms of a disorder and may not even reflect an individual's behaviours and experiences. Consequently any treatment strategy which is identified as beneficial may be so only in relation to the accuracy and usefulness of the diagnosis. An example of this problem is the DSM diagnostic label 'schizophrenia'. A number of individuals with this diagnosis may not share any of the same symptoms and as the diagnosis stands at the moment there is a lack of conclusive evidence as to the cause of this disorder (Bental et al, 1988; Boyle, 1996). Yet 0.5-1.5% of the population in the developed world will be diagnosed with schizophrenia (APA 2000) and they will be offered treatment options based in part on research findings using a set of diagnostic criteria which may not accurately portray their difficulties.

Neuroleptics are considered the treatment of choice and as yet studies show that only a proportion of individuals benefit from this treatment (Bental et al, 1988; Roth & Fonagy, 1996).

It is also noteworthy that each subsequent edition of both the DSM and ICD include more diagnostic categories. Why has this occurred? Are people getting 'sicker'? It may be that the widening research efforts that these systems have advocated, have enabled researchers and clinicians to identify more disorders. On the other hand this may explain why construct validity is poor and a number of diagnostic categories describe features of the same illness.

As stated earlier current psychiatric diagnostic systems use a medical or biological approach to psychiatric disorders. Proponents of the biological model of illness would argue that this position is a strength of psychiatric diagnostic systems because biological models identify causes in comparison to other models like psychosocial ones which allegedly only deal with meanings (Guimon, 1989). It is true that biological models are often able to identify the causes of physical illnesses though they are less capable of uncovering the causes of mental disorders. The structural pathology employed to describe physical illnesses is unable to shed the same light on psychopathology. Physical tests like brain scans or blood tests cannot measure hallucinations or delusions (Bental et al, 1988). With regards to individuals who are receiving a psychiatric diagnosis, studies have shown that it may be less stigmatising to view mental illnesses as biological illnesses rather than psychological ones (Crocker, 1999). The proposed rationale follows that if an illness is reduced to physical biology than it is less likely to be seen as an individual's own fault. This argument could be seen as a 'pro' for the use of psychiatric diagnostic tools if the cause is seen as biological, though it also highlights the social implications inherent in diagnoses. With the development of multi-axial editions of the DSM came an axis devoted to social functioning (Axis V in DSM-IV). This can be viewed as a positive improvement, taking into consideration both biological and social factors. However, social factors contain an implicit value judgement and therefore are not empirical. Social functioning describes an individual's ability to engage in social support, respond to social cues, make stable attachments, follow the rules within a community, be successful in terms of what society values (e.g. money, position, etc...), and meet the standards of their social class (Tyrrer & Casey, 1993). It is clear from this description that not only are these not empirical characteristics but it would be conceivable for an individual to have a mental illness and still be functioning according to social standards or also have poor social functioning in the absence of a DSM/ICD identified disorder.

As suggested above diagnostic labels can have a stigmatising effect. Whether viewed as an individual's fault or not, implicit in the use of diagnostic categories

is the assumption that a normal process exists and this process is defective in the diagnosed individual. This also implies that disorders have different processes in comparison with what normally occurs, though to date there is a paucity of evidence to back this up and research actually tells us very little about processes (Davey, 2000).

A fundamental criticism of psychiatric diagnostic systems, which has been echoed in criticisms about reliability, validity, and measuring social functioning, is that diagnostic categories are not empirical but are ultimately reliant on value judgements. For instance, some of the diagnostic criteria for 'Narcissistic Personality Disorder' include: 'show arrogant, haughty behaviours or attitudes....' (APA, 2000). Even the judgement that a behaviour is disturbing is a value judgement related to certain norms. Diagnostic categories are also culturally and socially bound as demonstrated in prevalence studies which have identified that ethnic minorities in England, especially black Caribbeans, are more likely to be diagnosed with mental illness than other groups particularly white ones (DOH, 2002). This then raises the question of whether diagnostic categories are simply descriptions of characteristics which in some way deviate from accepted norms and is that in itself illness? Jones and Cochrane (1981) confirmed that stereotypes of mental illness do exist and female stereotypes in general, correlate more closely to mentally ill female stereotypes than male ones. So in some sense our social norms expect women to be more mentally fragile than men.

Thus far this paper has briefly examined the development of psychiatric diagnostic systems and the pros and cons of using these systems. With this in mind a discussion as to whether clinical psychologists should use these classification systems can be addressed.

There are a number of reasons why clinical psychologists should have a knowledge of these systems if not directly use them. If there is widespread use of these systems then is it necessary for clinical psychologists to have knowledge of them in order to communicate with colleagues from other disciplines. Many

mental health settings use multidisciplinary teams (e.g. community mental health teams, hospitals, forensic settings, etc...) including psychiatrists, clinical and counselling psychologists, community psychiatric nurses, occupational therapists, and social workers. A common language is not only an advantage but also a necessity to ensure each profession is talking about the same thing.

Clinical psychologists are trained to disseminate and conduct research. As stated earlier if a large percentage of research is using DSM criteria within its studies then clinical psychologists must be able to 'speak the language' in order to understand this research and consider it in terms of clinical practice. There is a certain amount of pressure to use DSM criteria when conducting research for publication purposes and to enable comparison across studies. While these are important factors in support of clinical psychologists using psychiatric diagnostic systems, Davey (2003) proposes that concentrating on these systems has restricted research and prevented studies from discovering more about psychological mechanisms in mental illness. It does seem apparent that what is lacking in the bulk of research into mental illness is information about 'how'. As clinical psychologists are practitioners as well as scientists this is a particularly important question in terms of treatment strategies which will be most effective. Knowing 'what' works in randomised control trials is useful information but to gain a genuine understanding of mental health problems it is important to gain information about 'how' treatments are effective, 'how' problems develop, 'how' they are maintained, etc... Another responsibility of this scientist practitioner role is the obligation to use evidence-based practice. As outcome studies tend to be based on DSM criteria, it is necessary to explore how a client's difficulties meet DSM criteria to ensure they are being offered the correct treatment approach.

There are also very practical reasons why clinical psychologists should use classification systems. Sometimes the legal or social/economic implications of diagnoses are necessary to insure clients are provided access to particular services, financial benefits, etc... For example the British Psychological Society's (BPS) Professional Affairs Board advocates the classification and diagnosis of learning disability to ensure that an individual's civil and legal rights are protected. This

being the case the board further recommends caution with regards to the conceptual limitations of classification (BPS, 2000). These limitations are echoed in another BPS Professional Affairs Board document (BPS, 1999) where the legal rights of those diagnosed may be impinged upon in relation to how individuals with specific diagnoses are treated. The document presents concerns regarding the diagnosis of 'personality disorder', which some psychologists believe is seriously flawed and should not be used on the basis of poor reliability, amongst other concerns.

There are some compelling reasons why clinical psychologists should use psychiatric diagnostic systems but there are also a number of reasons why they should not. Clinical psychologists provide formulations of clients' problems, which are based on psychological models and theories, and not just a description of symptoms. Formulations consider the context of a problem, how it developed, how it is maintained, the impact it has on an individual, etc... It provides an idiosyncratic perspective of a client's problem including details of what an individual finds distressing or is functional, instead of the sort of generalised approach which classification systems use. In essence clinical psychologists assess the whole person and not just an illness.

Psychology approaches mental health problems differently than psychiatry. Psychiatric diagnoses use all or nothing criteria, either a client has a particular illness or not. Psychology tends to take a more dimensional approach where difficulties are perceived on a continuum, extremes positioned on each pole and an average tending to cluster around the middle. An example of the distinction between these approaches is, using a psychiatric system there is only a description of extreme anxiety which leads to dysfunction, there is no conceptualisation of a healthy or functional amount of anxiety and in a sense anxiety is considered bad.

A very simplistic argument could state that clinical psychologists are not psychiatrists and therefore should not be using psychiatric tools. As stated earlier they provide formulations therefore why would they need to use diagnostic

classifications? The BPS Professionals Affairs Board endorses the use of diagnostic classification in clinical reports to facilitate cross-referencing with reports from other disciplines (e.g. psychiatrists). So there may be a need to use a diagnosis in conjunction with a psychological formulation in order to aid communication between professionals. While this is an important point it is also true that clinical psychologists do not use a medical model approach to mental illness which psychiatric diagnoses support. David Pilgrim (2000) warns that by supporting psychiatric diagnosis professionals increase and expand its use. This ultimately increases the support for the medical model view of mental health disorders and its acceptance in mental health services, leading to support for medical treatments for disorders (e.g. medication and electro-convulsive therapy) instead of psychological ones. If psychiatrists are trained in diagnostic classification systems then it seems reasonable to expect that they have the ability to read a clinical psychology assessment report and ascertain how this fulfils diagnostic criteria. Therefore communication between professionals may be achieved without the necessity of using psychiatric classifications.

One of the purposes of diagnosis is to inform professionals about the best treatment approach to implement. However treatment is more than just a response to diagnosis, there is also a necessity to consider social and economic resources, motivation, social stress, suitability, acceptability to the individual, etc... Therefore relying just on a diagnosis will not provide enough information to facilitate a comprehensive treatment plan. The UK government Department of Health (DOH) guidelines on care co-ordination in mental health services (DOH, 1999) recommends that decisions regarding the implementation of care/services be based on 'need, risk, and vulnerability' and not on diagnosis. So according to these guidelines psychiatric diagnosis will not be an adequate indication of what treatment an individual should be offered and additional information needs to be obtained. As practitioners clinical psychologists are concerned with providing evidenced based treatments. Outcome studies tend to be conducted for specific disorders therefore if a client has a comorbid diagnosis, which quite often is the case, then the most efficacious treatment may not be identified in the research

findings. In this case having more information particularly more than a diagnosis, regarding how the comorbid illnesses interact, maintain each other, etc... would be beneficial when considering how to plan a treatment intervention.

Clinical psychologists and psychiatrists have very different treatment approaches. Inherent in this difference is the relationship the professional has with the client and the type of interpersonal skills needed to administer each type of treatment. A clinical psychologist is in the unique position of having a responsibility to the client to foster a therapeutic alliance. The formulations clinical psychologists use are produced in collaboration with the client using a non-judgemental approach. As discussed earlier diagnoses may be considered value judgements and are culturally influenced therefore they may lack the ability to advocate clients' needs and may jeopardise the therapeutic alliance. On the other hand some clients may be relieved to have a 'name' for what they have been suffering with, though the need to gain an understanding of what is happening to them could also be served using a formulation.

Ultimately a clinical psychologist needs to fulfil the professional guidelines set out by their professional body. The BPS guidelines on professional responsibility (DCP, 1991, p 19) states that 'case notes should include: presenting problem clearly stated; a description of the formulation of psychologist's view of client's problems and relevant factors...'. While this is clearly not advocating that clinical psychologists do not use psychiatric diagnostic systems and as noted earlier in this paper, the use of a diagnosis to ease communication between professionals is recommended by the BPS, it is instructing clinical psychologists to provide more information than a diagnosis. The BPS states that the reason for assessment is to develop an appropriate psychological formulation to help an individual understand their problem and determine what is likely to help (DCP, 2000). With this in mind a clinical psychologist needs to take an idiosyncratic approach to identify each individual's unique situation, experiences, and characteristics, in addition to the presenting problem and how it interacts with these factors.

In summary it is my opinion that clinical psychologists need to have a working knowledge of psychiatric diagnostic systems in order to understand colleagues from other disciplines, to ensure they are part of the debate about how useful these diagnoses are, and to work effectively in multidisciplinary settings. Having this information is paramount to help clients understand a specific diagnosis they have been given and to encourage a dialogue about what this means to them. In certain circumstances it may be necessary for a psychologist to question a diagnosis that a client has been given and act as their advocate. In the area of research having knowledge of diagnostic systems is beneficial both for understanding published studies and to conduct research. It is also necessary to have an understanding of these systems in order to challenge their validity and reliability, and to offer alternatives.

Clinical psychologists should not use these classification systems. They are trained specifically to provide formulations for clients and for the purpose of conducting therapy this is a superior diagnostic tool. Constructing formulations and conducting therapy are generally collaborative endeavours and diagnosis may undermine these processes.

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## **ESSAY**

**‘As clinical psychologists we cannot claim to have objective knowledge of the world, meanings or problems of our clients; instead, we can and must take responsibility for our descriptions of their world, and for the ways in which we influence the bringing forth of their descriptions of their worlds.’ Please discuss this statement critically.**

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**‘As clinical psychologists we cannot claim to have objective knowledge of the world, meanings or problems of our clients; instead, we can and must take responsibility for our descriptions of their world, and for the ways in which we influence the bringing forth of their descriptions of their worlds.’ Please discuss this statement critically.**

This statement addresses a number of topics relevant to both clinical psychologists and their clients. In order to discuss every aspect of the statement I will therefore examine it by looking at one section at a time. The statement will be divided into three subsections and each of these will be addressed in turn.

The first section: ‘as clinical psychologists we cannot claim to have objective knowledge of the world, meanings or problems of our clients...’ will be discussed in terms of the existence of objective knowledge and how accurate it would be for us to claim having it. Specifically, it will examine where and how our knowledge evolves predominately from a social constructionist perspective.

The second section: ‘...instead, we can and must take responsibility for our descriptions of their world...’ will be addressed by contemplating an awareness of the enormity of our responsibility and an understanding of what may have an impact on the ways in which we describe our clients’ worlds. In order to help us manage this responsibility we need to make appropriate use of our supervision and professional issues. We also need to practice in a way, which continually questions if our descriptions are authentic for our clients, and revise our formulations when it is appropriate and be open to seeing things differently. In addition we can employ methods to help us ensure that our clients have an active role in presenting their realities. We need to consider the factors that may have an impact on the ways in which we describe their worlds, our biases including cognitive biases related to memory and perception, or cultural biases and stereotypes. Past experiences both personal and professional may have an impact on how we describe our clients’ experiences and the type of attributions we make. Issues like counter-transference, current social or political issues may also influence our descriptions. We will never

be able to remove ‘ourselves’ from the therapeutic encounter, though for many therapeutic approaches this is not the goal, instead developing an understanding of who we are as individuals and exploring our own selves can lead to more awareness of our role in these descriptions.

The third section: ‘...for the ways in which we influence the bringing forth of their descriptions of their worlds,’ is likely to be informed by the psychological approach we are employing. If using Cognitive Behavioural Therapy (CBT) then we may concentrate on behaviours and cognition, if using a psychodynamic approach it is likely our focus will be on unconscious defenses, etc. Ultimately the salient or relevant issues which we choose to focus on, will be underpinned by the psychological theories we are using. In some cases we may be influenced by service provision and this could restrict our descriptions to issues concerning the here and now. Adopting a client-centred approach one would expect to be influenced in the way we bring forth the clients’ descriptions by their needs and wishes. From this perspective we would need to consider carefully issues of consent and identify what is important to clients, in addition to considering how any information we do bring forth will serve or harm them.

**I. ‘As clinical psychologists we cannot claim to have objective knowledge of the world, meanings or problems of our clients...’**

A social constructionist theory would propose that objective knowledge does not exist and therefore the tenet of this statement is true. There are a number of key assumptions within social constructionism which would lead to this position (Burr, 2003). First with regards to knowledge, it is necessary to begin from the point of critical scepticism or suspicion regarding ones own assumptions. This position is in contrast to that of empiricism which proposes that observation leads to unbiased knowledge about the world. Second, knowledge about the world is influenced by historical and cultural context. Therefore when and where an individual lives will effect how they define and understand the world. For instance physical punishment

for children both in school and at home was an acceptable practice in England for many years. In the last decades however this practice has gradually come to be considered unacceptable and may even have legal implications for those who engage in this behaviour. What was once considered a duty in order to discipline a child is now perceived as abuse. Third, knowledge evolves through social interactions between people. This can be demonstrated through clinical practice with different client groups. Through the interaction of working with clients who have learning disabilities, understanding of their difficulties develops which leads to the adaptation of techniques (e.g. CBT diary sheets using a pictorial form) in order to incorporate this knowledge and meet the clients' needs. Finally there is a relationship between knowledge and social action, therefore a description or construction of the world will have an impact on the behaviour which is permitted and that which is not. For example when knowledge dictated that individuals who were unable to control their alcohol consumption were considered deviants and their behaviour was viewed as self-indulgent, they tended to be imprisoned. Currently these individuals may be considered alcoholics and their behaviour would be viewed as symptomatic of their illness, leading ideally to being offered care and treatment.

Knowledge about the world from an essentialist perspective would propose the world is comprised of materials and objects which have their own particular essence or nature. In this way our clients would be perceived as having unique characteristics like personalities, which inform how they feel and behave. As personalities are viewed as essential qualities of an individual they remain relatively fixed. Taking an essentialist point of view one could argue that it is possible to have objective knowledge of the world, meanings or problems of our clients, though it would be necessary to first have knowledge regarding the essence of the client. At this point objective knowledge becomes problematic as emotions generally belong to the private internal world of an individual and they are related to a person's essence. Having access to the internal world of another cannot be achieved directly but relies on self-reports and therefore the knowledge obtained is subjective (Nagel, 1997). To get around this problem one could invoke categorical factors like personality types or predicted human behaviour/responses. The difficulty here is that humans rarely fit

into discrete categories. For instance the Diagnostic and Statistical Manual of Mental Disorders (DSM) attempts to categorise people's problems using objective criteria yet this tool is unreliable in the sense that individuals are not consistently diagnosed with the same disorder (Pilgrim, 2000) and the problems they present do not often fit into one category (Kessler et al, 1994; Roth & Fonagy, 1996).

In contrast a social constructionist perspective would argue that knowledge is not the result of direct observation or reality but instead is socially constructed and therefore there is no essential nature to the world or people. As this knowledge is influenced by culture and history, it is likely to change with time and from culture to culture. This is not to say that each individual creates their own way to see the world but that individuals inhabit worlds where language exists as a means to describe the world and events, and as one acquires language so they acquire meanings. Therefore language provides a frame for structuring experiences and ourselves, our worlds, meanings or problems. This supposition is not the same as that of constructivism where each individual perceives the world differently and creates their own meaning from events. One such constructivist approach is Kelly's Personal Construct Psychology (1955) whereby individuals develop their own meanings or constructs about the world like a scientist that has existing theories and conducts experiments to test hypotheses derived from these theories (Fransella & Dalton, 2000). The possible constructs that can develop are influenced by the social context in which one lives. Although this seems very similar to social constructionism the difference between the two lies in the extent to which the individual is perceived as a dynamic agent in constructing and the degree to which social influences are seen as the product of constructions (Burr, 2003).

Language is therefore an essential factor in obtaining knowledge about the world and paramount to developing an understanding of our clients' meanings and problems. The diversity of language provides a number of possibilities for understanding our clients, our world, and ourselves. Language cannot be constructed in isolation but occurs between people as part of a social phenomenon (Saussure, 1974). Language can then provide us with a means to understand our clients' worlds through a verbal

exchange, though the social diversity of language may obscure this process. This process may be further complicated through the discourse constructed around obtaining information from clients. Discourse refers to "...a domain of language-use that is unified by common assumptions." (Abercrombie, Hill & Turner, 1994). A particular discourse can inform what is acceptable to say and do, and what is not. In addition discourse can provide a framework for people to conceptualise their role. If a client arrives for an assessment and the emergent discourse portrays the psychologist as the expert, they may limit the information they provide to that which directly addresses the psychologist's questions and refrain from sharing their own beliefs about their problems. The French philosopher Foucault proposed that the knowledge that is predominant in a culture is related to power (in Burr, 2003). Consequently if an individual's behaviour is considered symptomatic of a mental illness and is further judged to be dangerous, then the prevailing discourse would allow for a compulsory treatment order. To this end both clinicians and clients participate in discourses which describe their roles and what is considered acceptable within the consulting room. In addition they subscribe to many other discourses which they use to make sense of themselves and their everyday lives, which are related to age, gender, sexuality, employment status, etc. Ultimately we cannot claim that the knowledge we obtain about our clients is objective as it will be embedded in the social phenomena of language and discourse, which have an impact on both how information is presented by clients and how we interpret it.

## **II. '...instead, we can and must take responsibility for our descriptions of their world....'**

Clinical psychologists are in a trusted position in the sense that clients often disclose information not previously shared with others. The responsibility for how we receive this information and the way in which we feedback both to clients and referrers is great and may require consideration. How we feedback needs to incorporate a sensitivity for how clients' problems will be framed from the perspective of the clients, services/referrers, and ourselves. Through the use of supervision, both our

responsibility and the potential subjectivity of our descriptions can be explored with a senior colleague. Supervision can provide the opportunity to see clients' problems from a different perspective and also challenge the way in which we have construed it. In addition we must take responsibility for how we address professional issues such as confidentiality, our obligation to clients, and personal conduct. As an established profession there are professional practice guidelines which begin to inform how we practice and our responsibilities (Division of Clinical Psychology, 1996).

The current movement from a 'scientist-practitioner' model to a 'reflective scientist-practitioner' one in clinical psychology highlights the importance of considering both our descriptions of our clients' worlds and the impact these have. Lavender (2003) proposed four processes involved in reflective practice: reflection in action, reflection on action, reflection about impact on others, and reflection about self (awareness and development). Reflection in action is described as reflecting cognitively and emotionally while actively in a session with a client. Lavender suggests this is necessary particularly when the use of theory with regards to understanding what is being presented is exhausted, and therefore one must reflect on how to proceed. Reflection on action requires thinking about what has already been done, the theories that have been utilised, and what the next step will be. This is traditionally done in supervision but could be done alone by reviewing session notes or tapes of sessions. Reflection about the impact on others regards thinking about what we do as professionals and how it affects our clients, colleagues, team members, etc. Often this is achieved through obtaining feedback. Finally, reflection on self is in many ways self-explanatory. It is particularly important to clinical psychology, as no one is immune to psychological difficulties and the impact of their past. It is therefore important to develop an awareness of our vulnerabilities and the situations which activate feelings associated with these. This in turn can also lead to a position where clients are not viewed so differently from ourselves, thereby facilitating understanding and empathy. The author argues that this task is so important that it should not be optional in clinical training. Through reflective practice we are better positioned to discover when our descriptions of our clients'

worlds need to be revised in order to facilitate better understanding. In addition it promotes an active reflection of our responsibility.

If we assume an expert role with regards to our clients' problems then our descriptions may reflect our theoretical understanding but may lack authenticity for our clients. Anderson and Goolishian (1992) propose an approach based on a hermeneutic and interpretive understanding of therapy. From this perspective the therapist is a "participant observer and facilitator" and the client is the expert. The role of the therapist is to provide space and to facilitate the therapeutic conversation. In contrast to other approaches the therapist proceeds from a stance of 'not-knowing' as opposed to testing hypotheses informed by prescribed methods. The authors take the view that through socially constructed narratives people live and understand their experiences. They describe the problems clients bring to therapy as those which are ascribed meaning through the individual's narrative, but which the client struggles with, in terms of how to act or have a sense of control over. Any change that may take place is brought about through the creation of new narratives and therefore includes a change in meaning. The authors particularly emphasise the continuous changing story of 'self', which is not perceived as fixed in contrast to other theories. This is the basis for the 'not-knowing' stance and therefore what we learn in sessions as therapists does not come exclusively from our experience or knowledge of theories but from our curiosity. Our understanding of clients' difficulties will be based on our interpretation and not an objective truth.

The client's role as expert is evident in the fact that they hold the knowledge and narrative about themselves and the therapist relies on the client to understand the problem. This is not to say that the therapist does not utilise their training. On the contrary the therapist enters the session with some preconceived ideas about the problem being presented based on past experience, knowledge of models and theories, and the referral information. This then necessitates that the therapist listens carefully to clients in order to hear their narrative and create new meanings, which is particularly important in order to take responsibility for our descriptions of their worlds and not limit our understanding. The premise of this approach is that the

client and therapist effect each other's formation of meaning through exploring and discussing the problem together, talking *with* each other to create new meanings and narratives. This approach is very different from more traditional psychological approaches where the questions asked in a session would reflect the therapist's expertise and knowledge about theories, past experience with clients, and understanding of behaviour. The authors suggest that using the more traditional approaches introduces the therapist's narrative instead of the client's. In this way assuming a 'not-knowing' perspective to asking questions of clients and gathering information, helps to insure that therapists take responsibility for their descriptions and also that they resemble more closely clients' narratives.

Through adopting other therapeutic techniques like using a collaborative style, directly addressing and minimising the power differentials between ourselves and our clients, and by using Socratic questions, we can help to ensure that our clients have an active role in constructing our descriptions of them. By establishing a collaborative style in sessions and explicitly presenting this to clients, it is likely that we may change the meaning of therapy for them and empower them as active agents in the endeavour. Socratic questions are used to understand clients' views and not explicitly to change them. Questions represent instruments to guide discovery both for therapists and clients. Padesky (1993) outlines four principles which define Socratic questioning: "the client has the knowledge to answer; draw the client's attention to information that is relevant to the issue being discussed but which may be outside the client's current focus; generally move from the concrete to the more abstract; encourage the client to apply the new information to either re-evaluate a previous conclusion or construct a new idea". Our goal is to help empower our clients so they are more able to assert their descriptions on how we interpret their worlds.

Integral to the responsibility we can and must take for our descriptions of our clients' worlds, is an exploration into what factors may influence our descriptions. An awareness of any cognitive biases operating is a basic first step. This may include memory or even perceptual tendencies which will have an impact on how we retain

the information from our clients. It is possible that we will more closely attend to information which is more salient to us, and fail to recall that which isn't. Recording sessions is one way to address this issue.

Another important factor which may affect our descriptions is cultural biases or ignorance. Halsey and Patel (2003) recently argued that cultural awareness is a particularly relevant topic for clinical psychology trainees. The authors argue that it is necessary to examine the theories which we are using with our clients as these may obstruct trainees from developing culturally aware practice. The theories developed in psychology have not occurred in neutral environments, void of historical and cultural context. In the same way as our descriptions of clients cannot be based on objective knowledge, nor can the theories we subscribe to. The authors highlight the fact that psychological theories have developed predominately with white, western, heterosexual, middle class individuals in mind. This in itself would suggest that they contain an element of racism or at least Western/eurocentric partiality. There also appears to be a propensity that when white psychologists see white clients, there is an underlying assumption that because they are both white, they are the same and exploring cultural issues is redundant. Taking an approach that ignores clients' ethnic or cultural differences in a sense denies the existence of the whole person and a large part of the story of who they are. The authors refer to this as a "colour blind" position which may be adopted due to the misguided believe that it in some way guarantees that the therapist won't undermine or be insensitive to different cultural or ethnic perspectives than their own. By ignoring these issues the therapist may miss the opportunity to enquire about cultural or ethnic issues that are vital to clients and their conceptualisation of problems. In addition psychological theories generally contain an individualist approach which will have an impact on how problems are defined and where they are seen to be located, while many non-western cultures have a more collectivist position. A serious consideration of our own ethnicity and cultural identity and how this defines who we are as individuals, will help us to appreciate our clients' diversities and consider how these may influence our descriptions of their worlds.

Our own narratives may have an effect on how we describe our clients' worlds. Our past experiences both personal and professional will be incorporated into the ways in which we see other people and ourselves. Part of the discourse operating will include stereotypes regarding people, how their behaviour is viewed, and what is considered an acceptable response. It is possible that we will not be aware of some of the stereotypes that we subscribe to, as they are not always explicit even to ourselves (Banaji & Greenwald, 1994). Our attribution style will also have an impact on how we perceive our clients. This may particularly be the case with regards to agency if we attribute clients' difficulties to their disposition as opposed to the situation (Aronson *et al*, 2004). In addition how we react to a client on a personal level will have an impact on the way we describe them. A particular client may trigger our own personal issues and thereby activate a particular response from us. This is often apparent when considering counter-transference which may interfere with how we experience clients, thereby influencing our attitude and behaviour towards them (Racker, 1968).

Finally social or political issues may have an impact on how we describe our clients' worlds. Both issues in the media and government initiatives or policies can contribute to our descriptions, in many cases they may inform our descriptions by providing information. For instance issues regarding the plight of refugees and the conditions in their countries of origin may influence our descriptions. We also may be more likely to highlight certain difficulties clients are having or potential risks when these are the focus of government targets. Ultimately we cannot escape the fact that we are social beings, and we construct our meanings within our social context the same as our clients. In the end the best we can do is endeavour to have an awareness of the impact that the issues discussed will have on how we construct our descriptions of our clients and accept responsibility for our role in these descriptions and their imperfections.

### **III. '...for the ways in which we influence the bringing forth of their descriptions of their worlds.'**

The ways in which we influence the bringing forth of our clients' descriptions of their worlds will be induced by a number of factors. As psychologists the theories that we subscribe to or the models which we are applying will directly affect how we describe our clients. This is the case both in terms of the language we use and the issues we focus on. A criticism of psychotherapy is that it focuses predominately on the individual and ignores social implications (McNamee & Gergen, 1992).

Problems tend to be located within the individual instead of the larger system.

Willoughby (2003) goes as far as to say that therapists are unwilling to admit and acknowledge the reality of social injustice and inequality which exists. He proposes that dysfunctional situations within society directly impact on mental health and in some sense make it difficult to respond to the world in a way that would be considered functional. In this sense if we fail to consider the social conditions which affect our clients this will be absent in our descriptions and we will have conceptualised their problems in a skewed way. In addition it is likely that our influence in how their stories are told, could position them as designers of their own distress. It is therefore necessary for psychologists to consider the limitations of theories and practice in relation to clients' lives which may include poverty, prejudice, lack of freedom, powerlessness, and to consider these as authentic struggles and not attempt to psychologise them. To minimise our subjectivity in the way we influence how our clients' descriptions are brought forth, we must first attend to the accounts that are provided by clients and only after this consider our own theoretical stance (Roy-Chowdhury, 2003).

The services that psychologists work in may also influence how they communicate clients' descriptions. For instance if one is working within a team where there is a long waiting list and senior management dictates that there is an aggressive drive to reduce this, then there may be a certain amount of pressure to move clients through the service quickly. In this sense clients' descriptions of their worlds may be presented in ways which minimise their difficulties and emphasise the strategies they have available to them. A service may also be limited to offering clients a fixed number of sessions as part of the agreement between service purchasers and

providers. This may effect the way in which clients' difficulties are conceptualised, through how the assessments are conducted and how the focus of treatments are determined. The focus may therefore be on the here and now as opposed to historical perspectives. As clinical psychologists currently work in a climate where there is an abundance of referrals but a dearth of services to offer, it is possible that they may not even be aware of the way this pressure is contributing to how they describe clients' worlds. Consequently it is necessary for psychologists to reflect on the impact this may have on their practice and also to seek support with regards to the stress of managing this tension.

In order to take responsibility for our influence in the ways, in which our clients' descriptions of their worlds are presented, we need to ensure that these descriptions are informed by clients. Working in a client-centred manner will help us to attend more closely to our clients' needs and may even make it easier to prioritise them despite the pressures of the system. Structuring services to meet clients' needs and giving them a voice in how these are provided will help to empower them in our descriptions and guarantee they are represented. This approach would also lend credence to working collaboratively with our clients. It is contradictory to ask clients to work collaboratively with us in sessions, while the sessions are part of a larger system which advocates a more authoritarian approach. The National Service Framework stipulates that service users should be involved in the planning and delivery of services. Dunn *et al* (2003) asked service users if they were involved in the planning of local mental health services and if they would like to be. Of those participants who said they were not involved, the reasons given for this tended to focus on the failure of services to initiate their involvement, in addition to feeling they lacked the skills and were not empowered enough to accept this role. When asked if they would like to have more involvement those who said no cited feeling helpless and it being pointless as their reasons. This seems to highlight that *our* descriptions of clients' worlds do not always reflect the impact the system has on them and how it may disable them. Elphick and Rankin (2003) looked at patients' responses to receiving clinical reports in a pain management programme and found that when this occurred patients reported feeling better understood and valued the

open communication. This finding seems quite predictable and yet from personal experience within the different services that I have worked in as an assistant psychologist and a trainee, this practice appears to be the exception and not the rule, suggesting we may keep our descriptions of clients' worlds safeguarded/concealed to a certain extent.

Finally the issue of consent is relevant to ensuring that the way in which we bring forth our clients' descriptions is informed by them. This means that clients are both aware of how we are presenting their worlds and that they have not been coerced into this. Lucas (2003) warns that it is necessary to consider the power imbalance insidious within mental health services and that the existence of the Mental Health Act (1985) means that coercion is implicit in the system. A reflection on the language we use as a profession to describe clients, who are not adhering to treatment (e.g. lacks motivation; not ready to engage; unable to think psychologically) highlights this power relation and our propensity to hold clients responsible. In order to be responsible for our descriptions of clients' worlds and how we influence their presentation, we need to consider how these descriptions will affect our clients. For instance when we conduct psychometric tests with our clients do we have their welfare in mind? Consideration and discussion with our clients of how the information we gather may help or harm them before we subject them to these tests should be an integral part of consent.

## **Conclusion**

'As clinical psychologists we cannot claim to have objective knowledge of the world, meanings or problems of our clients; instead, we can and must take responsibility for our descriptions of their world, and for the ways in which we influence the bringing forth of their descriptions of their worlds.' From a social constructionist approach we cannot claim to have objective knowledge and the implication of this on our practice necessitates that we change our stance with regards to how we listen to our clients and interpret the information they share with us, recognising their expertise. Our training as clinical psychologists will be utilised through employing our

knowledge of psychological theories and models to begin to think about our clients. in addition to listening to clients and prioritising their information. In order to take responsibility for our descriptions of their worlds and how we bring these forth, we need to acknowledge and take responsibility for our position in the systems we are a part of. This includes reflecting on our role in a position of power and using our therapeutic skills to help distribute power more evenly. It is possible that we may be able to achieve this by changing the emphasis in our practice from focusing on clients' problems (scientist-practitioner), to focusing on the interaction between clients and ourselves, and the meanings we both convey in relation to the problem (reflective scientist-practitioner).

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# **Small Scale Service Related Project**

**Service evaluation of an anger management group for clients with learning disabilities in a medium secure setting.**

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**Service evaluation of an anger management group for clients with learning disabilities in a medium secure setting.**

**ABSTRACT**

This study evaluates the impact of a cognitive behavioural anger management group including cognitive restructuring, arousal reduction and behavioural skills training, for five clients who were identified as having difficulties dealing with their anger in an appropriate manner. The 10-session anger management group was conducted with male clients, with mild to borderline learning disabilities in a medium secure forensic unit. The results indicate three out of the five men reported clinically significant and reliable change on the majority of the NAS-PI (Novaco, 2003) subscales and totals, in the direction of improvement, suggesting that the group was effective for these individuals. Clients' behavioural descriptions of how they would respond to provoking situations obtained by administering the Novaco Provocation Inventory (Novaco, 1988) revealed a general pattern of decreases in aggressive reactions and an increase in coping strategies, suggesting the group was successful in helping clients to manage their anger more appropriately. The results are discussed in the context of previous findings of anger management interventions, for individuals with learning disabilities. Suggestions are also made for improvements to future anger management groups.

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## 1. INTRODUCTION

A specialist service is required to respond to the complex needs of people with learning disabilities (LD) and a forensic history. The Reed report (Reed, 1992) states that medium secure facilities providing services to people with LD must consider the individual's needs and this recommendation has been reiterated in the government's white paper on valuing people with LD (DoH, 2001a). In addition services for offenders with LD need to develop links with local LD teams and should together consider long-term needs including social, clinical, educational and resource issues (Reed, 1992). The Department of Health guidelines specify evidence-based practice for psychological treatment, stating particularly who is likely to benefit from specific treatment approaches and which treatments are most appropriate for particular patients (DoH, 2001b). Unfortunately these guidelines are not currently available for people with LD and consequently there is a limited research base in relation to the most effective treatment for specific problems in this population. Emerson et al (1998) suggests that treatments for offenders with LD should be comprised of three components: lifestyle changes (particularly to combat feelings of helplessness), direct treatment of the problem, and prevention and management of further offending. More generally cognitive behavioural approaches have been demonstrated to be effective with people with LD (Stenfert Kroese, Dagnan & Loumidis, 1997; Lindsay, 1998).

A number of studies report the prevalence of high levels of aggression and poor anger control in people with LD including physically and verbally abusive behaviour, and these rates appear to be the highest when individuals are living in institutional settings (Harris, 1993; Sigafos et al, 1994; Smith et al, 1996, Willner et al, 2002). Difficulty appropriately managing anger can have far reaching consequences for individuals with LD and those around them. Aggression has been cited as the main reason for individual's with LD to be admitted to an institutional

setting (Lakin et al, 1983) and is largely represented under the heading 'challenging behaviour' (Wanless & Jahoda, 2002). Staff working with LD clients report a high incidence of physical assaults against them by clients, and this ultimately leads to high rates of staff turnover (Attwood & Joachim, 1994; Kiely & Pankhurst, 1998). While anger control and aggression have been identified as areas of difficulty for some individuals with LD, there is little research which examines the most effective assessment and treatment approaches. In Taylor's (2002) review of the current literature/studies he proposes that this dearth of information may be related to a more general lack of knowledge regarding the emotional lives of those with LD. He sites three reasons why this may be: emotional difficulties in people with LD are exclusively attributed to their disability, there is a lack of tools to assess and understand emotional issues in people with LD, and there is a scarcity of funding for research into psychological difficulties and interventions for people with LD.

### **1.1 Assessment for anger control and aggression**

In the past there has been debate as to whether people with LD can reliably report their own emotions particularly relevant to assessment, however recent evidence suggests that they can, and the body of research demonstrating this is gradually growing (Stenfert Kroese et al, 1997; Lindsay et al, 1998; King et al, 1999). A number of studies have demonstrated the employment of Novaco's self-report instruments including the Novaco Provocation Inventory (PI; Novaco, 1988) and the Novaco Anger Scale (NAS; Novaco, 1994) with LD populations (Walker & Cheseldine, 1997; Lindsay et al, 1998; Taylor et al, 2002). Novaco and Taylor (2004) demonstrated high degrees of internal reliability, concurrent validity and predictive validity for physically aggressive behaviour, for the PI and NAS measures, in a study involving 129 inpatients with learning disabilities and a forensic history. The NAS-PI questionnaire (Novaco, 2003; most recent version of the two measures combined) has been standardised using forensic inpatient populations and both clinical and non-clinical populations, and has been shown to have high internal reliability across these groups. In addition the NAS-PI questionnaire reports moderate to high construct validity with a forensic, developmentally disabled male population in an inpatient setting (Novaco & Taylor, 2002).

## **1.2 Treatment for anger control and aggression**

A number of studies have demonstrated the use of cognitive behavioural treatments for managing anger problems and aggression in people with LD particularly the model developed by Novaco (1976, 1979) (Lindsay et al, 1998; King et al, 1999; Rose, et al, 2000; Willner et al, 2002). This model considers the cognitive factors which mediate anger, the level of physiological arousal and behavioural reactions and therefore components of the intervention should include cognitive restructuring, arousal reduction and behavioural skills training to address these factors. In a study where twenty detained patients with LD and a history of offending were offered a treatment package of eighteen individual cognitive behavioural therapy (CBT) sessions compared to waiting-list controls, the authors found that those who received CBT reported lower anger intensity to provocation and staff reported more use of coping behaviours than those in the control group (Taylor, Novaco, Gillmer & Thorne, 2002). Rose et al (2000) evaluated a sixteen session CBT group intervention aimed at reducing physical and verbal aggression in people with mild to moderate LD compared to a waiting-list control group. They demonstrated a significant reduction in reported levels of physical and verbal aggression in the treatment group compared to the control group; this was maintained at both the six and twelve months follow-up. Similar findings were also reported by Willner and his colleagues (2002) in a randomised control trial involving sixteen LD clients. They reported that clients in the treatment group reported less anger intensity to anger-provoking situations and this was also reflected in carers' reports.

## **1.3 Setting**

The following study took place in a medium secure forensic unit for males with borderline to moderate degrees of learning disabilities. Clients within this setting are detained under the provisions of the Mental Health Act 1983 and are considered to possess behaviour which poses a danger to themselves or others. Detention generally lasts between one to three years and the facility's aim is to treat clients and resettle them into a safe and supportive environment. Intrinsic to clients' behaviour posing a risk to themselves or others is the inability to deal with anger in an appropriate

manner. One aspect of the facility's duty of care requires a treatment programme which will address this issue and therefore the anger management group is offered to meet this need. While the unit provides the anger management group, evaluation of this group is necessary to ensure evidence-based practice is being conducted and the approach is effective.

#### **1.4 Aim of Study**

This study aims to evaluate the impact of an anger management group including cognitive restructuring, arousal reduction and behavioural skills training, for patient's who were identified as having difficulties dealing with their anger in an appropriate manner. The study specifically explores if the 10 session anger management group is effective in reducing participant's score on the Novaco Anger Scale and Provocation Inventory (NAS-PI) (Novaco, 2003) and Novaco Provocation Inventory (Novaco, 1988), a behavioural measure of anger reactions.

## **2. METHODOLOGY**

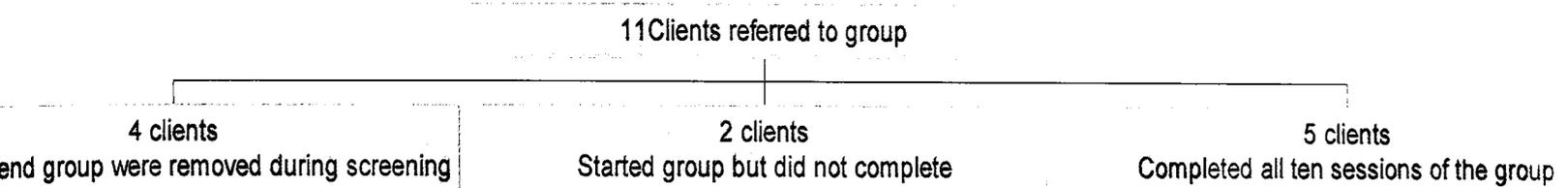
### **2.1 Design**

This is a non-experimental evaluation study (clinical trial), using a one-group pretest-posttest design to identify the impact of a routine anger management group offered to clients with borderline to mild learning disability, in a medium secure unit, as part of their treatment package.

### **2.2 Sample**

Initially eleven clients were referred to the anger management group and assessed to determine suitability. Of these eleven, four clients were not invited to participate in this group due to receiving an ongoing individual intervention or the group was unable to meet their current needs as determined during the assessment. Of the seven clients remaining five attended almost all ten sessions of the group. Two clients were removed from the group due to safety issues, further data was not collected on these clients and therefore the final analysis was conducted on five clients who completed the group intervention.

## Participant flow chart



### 2.3 Assessment

Initially the staff identified clients that they appraised as needing to learn anger management skills and improve their ability to respond appropriately when they became angry. These clients were identified based on previous aggressive incidents both in the community and within the unit. Clinical team meetings were used to discuss these clients and eleven men were referred as potential participants for the group. Assessments were then carried out by a Trainee Clinical Psychologist and an Assistant Psychologist, based on Black, Cullen & Novaco's (1997) criteria to determine each individual's suitability for the group. The assessment included a clinical interview; providing details of the group so the client could express their motivation to join the group, in addition to asking the client if they subjectively considered themselves to have difficulty dealing with anger, and generally determining the degree of insight into their own anger and behaviour. The NAS-PI questionnaire and the Provocation Inventory were also administered. Joint supervision with the Consultant Clinical Psychologist was utilised to discuss each assessment and make the final selection for inclusion. The clients who were selected to join the group demonstrated that they had insight into their anger management difficulties and were willing to work on these in a group setting. Potential group dynamics were also considered when identifying individuals in order to create a group setting which was both supportive and conducive to learning.

### 2.4 Intervention

The intervention consisted of ten weekly group sessions lasting an hour and a half conducted by three members of staff (Trainee Clinical Psychologist, Assistant Psychologist and Staff Nurse). Due to annual leave occasionally only two members were available. The group focused on developing skills to manage angry feelings in an appropriate way, incorporating alternatives to aggression. Session plans were influenced by cognitive behavioural approaches found in O'Neill (1999) and Taylor, et al. (2002) and homework assignments were an integral component. The following topics were covered:

- Identifying emotions
- Positive and negative impact of anger and the difference between anger and aggression.
- Exploring what situations/incidents trigger one's anger.
- Identifying the physiological changes associated with anger and a number of relaxation techniques.
- Problem solving skills (e.g. identify problem, generate possible solutions or ways to cope with the problem & the consequences which would follow), highlighting compromise.
- Role of cognition in anger and the use of calming statements to manage anger.
- Responsibility for inappropriate and appropriate responses to feeling angry (empowerment).

Interactive techniques were used including the frequent use of role-play to demonstrate and practice new skills. Each group member was given the opportunity to participate in role-plays and there was a general emphasis on participation. The facilitators adopted a client-centred approach encouraging ownership of the group to members and providing opportunities to discuss environmental factors in the institution which contributed to feelings of anger and frustration. This fostered the therapeutic alliance with facilitators and group cohesion, in addition to addressing the importance of contextual perspectives (Novaco, 1993). Clients were encouraged to use timeout accompanied by one of the facilitators, if they became angry during a

session. To increase clients' ability to generalise skills to real life situations and make the sessions more salient, clients' shared their own experiences and this was utilised for both discussion and role-play. Overall the intervention focused on arousal reduction and behavioural skills training, though the role of cognition was introduced and clients began to identify them (e.g. angry and calming statements). Cognitive restructuring was limited, as this is a particularly difficult skill for this client group to acquire (Rose et al, 2000; Willner et al, 2002) and it was felt this would be too ambitious for a ten session model.

A typed summary of every session was provided to clients to enable them to review what was covered and retain for future reference. This summary was also given to each group member's named nurse to assist homework completion and encourage the use of coping strategies in real life settings.

## **2.5 Measures**

The NAS-PI questionnaire (Novaco, 2003) and the Provocation Inventory (Novaco, 1988) were administered pre- and post-treatment. The NAS section is comprised of sixty items that examine psychological aspects related to the experience of anger. Anger reactivity is measured using cognitive, arousal and behavioural subscales and these comprise the NAS total score. High scores on these components indicate that an individual will be more likely to respond to an aversive situation with anger. The PI section is comprised of 25 items to provide an index of anger intensity in response to a range of provocations. In addition the measure includes an anger regulation subscale which reflects anger coping responses, and a high score on this scale indicates that an individual reports effective coping strategies in response to provocation. This score does not contribute to the NAS or PI totals.

The Novaco Provocation Inventory was administered to examine behavioural responses to fourteen separate situations. This measure was modified for use with individuals with LD (Black & Novaco, 1993) and an open-ended verbal response is sought in relation to how one would respond to provoking situations which can then be categorised (e.g. verbal aggression, damage to property, coping strategy, etc.).

The measure was specifically utilised in this manner, as the aim of the group is to help participants to manage their anger more appropriately and therefore any changes in strategies could be relevant.

### **3. RESULTS**

Five men attended the group and attendance was high for all ten sessions. Two members each missed one session due to conflicting scheduling of their case reviews. The ages of group members ranged from 30 to 50. Recent Wechsler Adult Intelligence (WAIS-III) scores were not available for every client though the range of ability from previous assessments reflected the level of ability between mild to borderline degrees of learning disabilities.

#### **3.1 Novaco Anger Scale-Provocation Inventory (NAS-PI)**

The evaluation of the intervention was achieved through self-report measures administered before the anger group and approximately two weeks after completion. Figure 1 below illustrates the group means for each component of the NAS-PI measure pre and post treatment. The graph indicates that clients' scores were reduced for anger reactivity (NAS total) and the cognitive, arousal and behaviour subscales, in addition to a reduction in anger intensity (Total Provocation Index). The graph also depicts an increase in anger regulation associated with the ability to control anger.

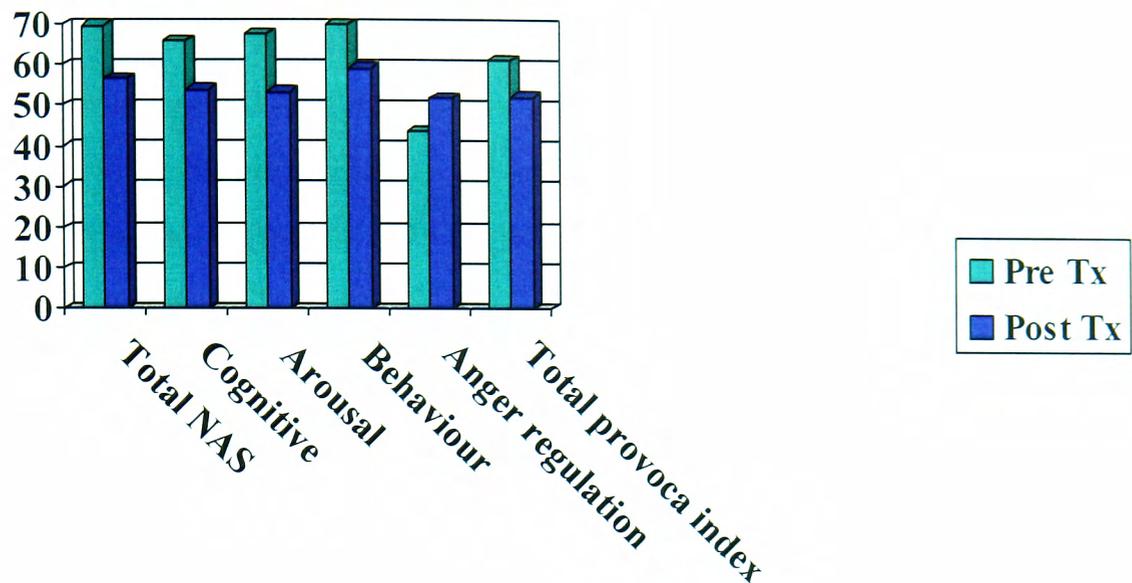


Figure 1: Group means for the NAS-PI pre and post treatment

The actual group means which correspond to the graph are shown in Table 1 below.

Table 1: Means, standard deviations for subscales of NAS-PI

	Total NAS		Cognitive		Arousal		Anger Regulation		Behaviour		Total Provocation Index	
	Pre Tx	Post Tx	Pre Tx	Post Tx	Pre Tx	Post Tx	Pre Tx	Post Tx	Pre Tx	Post Tx	Pre Tx	Post Tx
Mean	69.6	56.6	65.8	54	67.6	53.2	43.8	51.8	69.8	59.2	61.2	52.2
Standard Deviation	7.27	13.46	7.69	13.02	9.66	11.1	9.09	13.7	4.92	12.2	8.23	13.7

Scores are standardised with a mean of 50 and standard deviation of 10. Interpretation of scores: very low ( $\leq 29$ ); low (30-39); low average (40-44); average (45-55); high average (56-59); high (60-69); very high ( $\geq 70$ ).

In order to consider the effectiveness of the anger group this study applied two procedures proposed by Jacobson & Truax (1991). Firstly that clinically significant change can be conceptualised in terms of an individual's scores moving from those found in a dysfunctional population distribution to a functional one by utilising a cut-off point distinguishing these two populations. Secondly through calculating the reliable change index (RCI) it is possible to calculate whether this change is reliable at the five- percent level. Table 2 below presents the percentages of reliable and clinically significant change calculated for the group.

Table 2: Percentage of reliable and clinically significant change

	Total NAS	Cognitive	Arousal	Behaviour	Anger Regulation	Total Provocation Index
Percentage of improved reliable change	60%	40%	60%	60%	20%	60%
Percentage movement to functional population	60%	60%	60%	60%	60%	60%

Figures 2, 3 and 4 below depict each of the five clients' pre and post scores for the Total NAS, Total PI, and the behaviour subscale. The black line indicates a conservative cut-off and scores below this line would represent average to very low anger intensity and reactivity, considered sub-clinical.

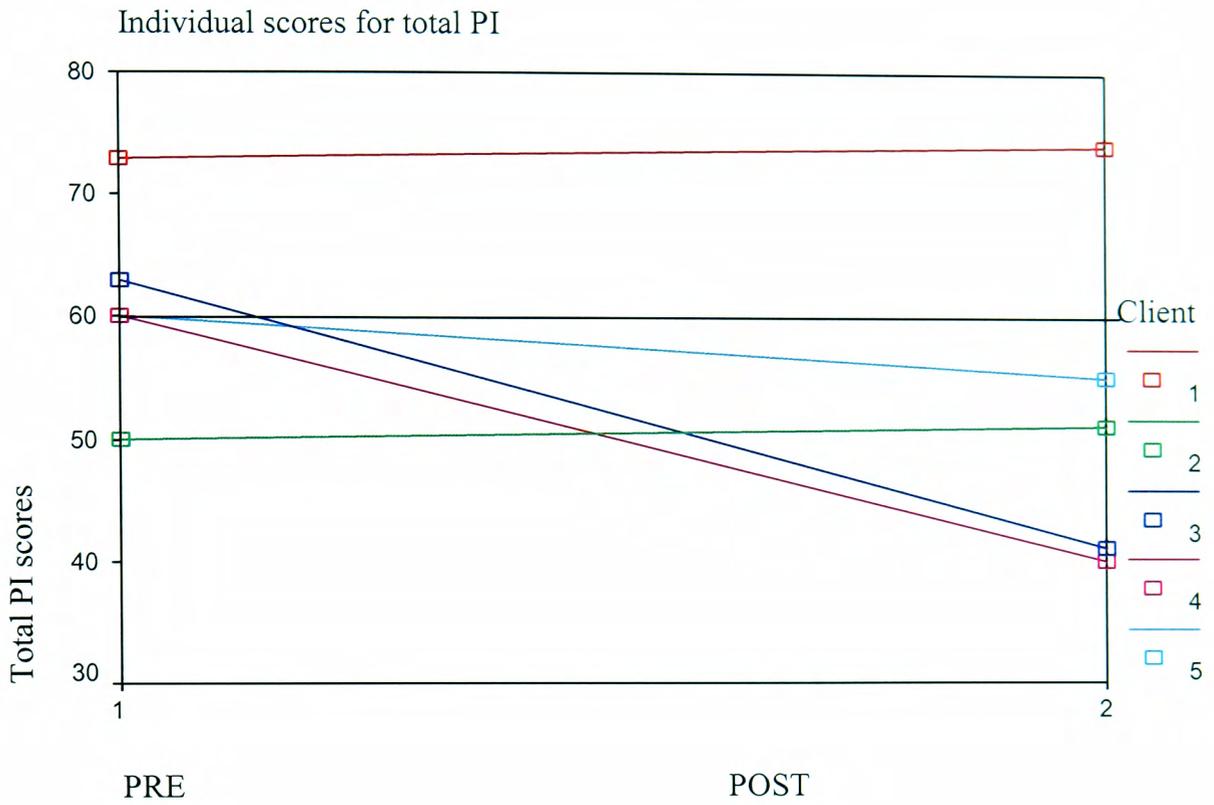


Figure 2: NAS total scores pre and post treatment

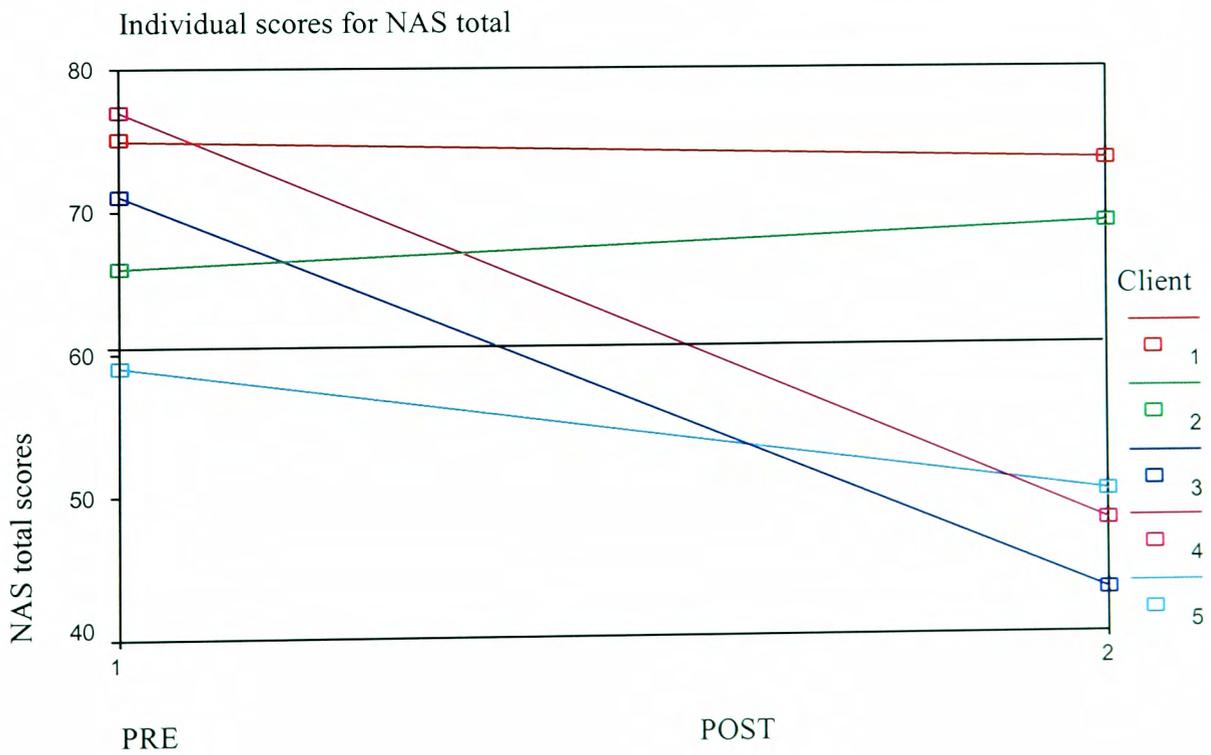


Figure 3: Total PI scores pre and post treatment

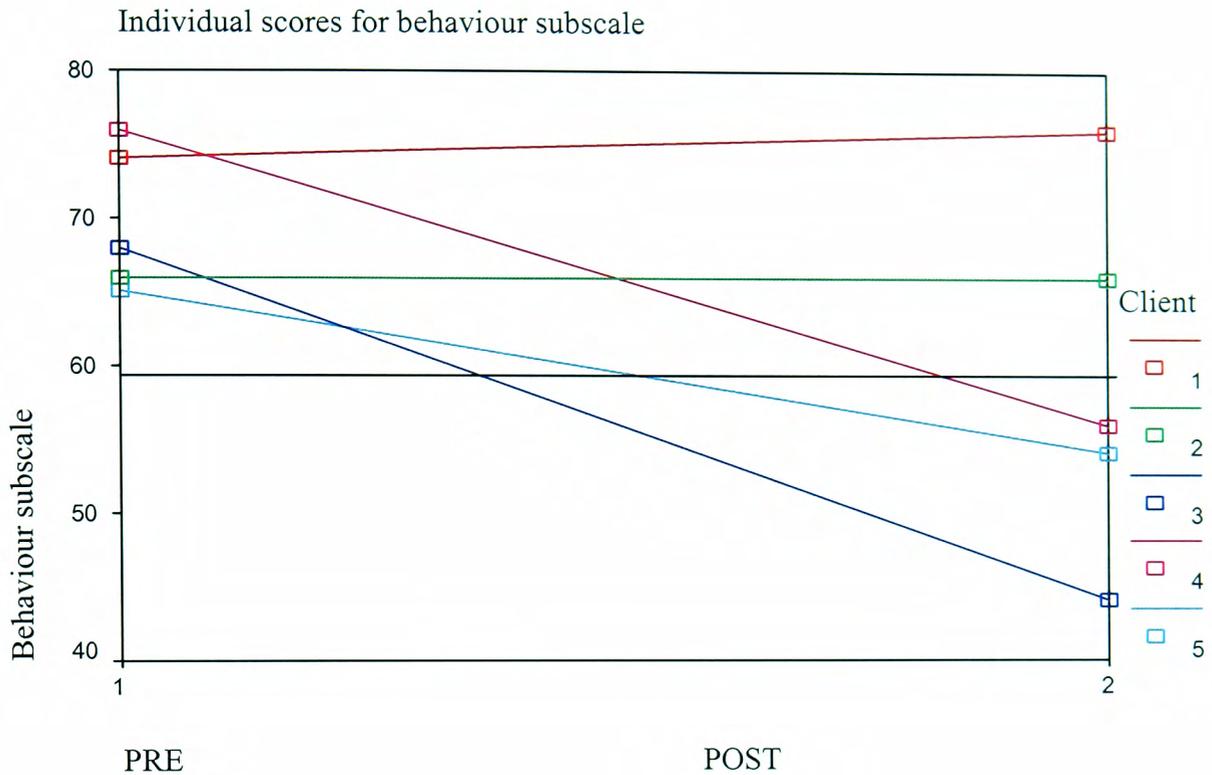


Figure 4: Behaviour subscale scores pre and post treatment

Three out of the five clients' scores revealed both clinically significant and reliable change in the direction of improvement on most of the NAS-PI subscales, and on the total NAS score, total provocation index, and behaviour subscale after attending the group. Two of the clients' scores revealed little change after attending the group and on the some of the measures actually increased.

### 3.2 Provocation Inventory

Clients' behavioural descriptions of how they would respond to provoking situations revealed a general pattern of decreases in aggressive reactions and an increase in coping strategies. Table 3 below summarises the types of responses clients reported to potentially provoking situations before attending the group and after.

Table 3: Responses to the Provocation Inventory

<b>Clients</b>	<b>Pre-group strategy</b>	<b>Post-group strategy</b>	<b>Summary of strategy change</b>
Client 1	Verbal aggression 2 Physical aggression 1 Coping strategy 10 Other 1	Verbal aggression 1 Physical aggression 1 Coping strategy 11 Withdrawal 1	1 decrease verbal aggr 1 increase coping strategy
Client 2	Verbal aggression 2 Physical aggression 1 Coping strategy 8 Withdrawal <sup>1</sup> 1 Other 2	Verbal aggression 1 Physical aggression 1 Coping strategy 11 Other 1	1 decrease verbal aggr 3 increase coping strategy
Client 3	Verbal aggression 1 Physical aggression 1 Coping strategy 11 Other 1	Coping strategy 14	1 decrease verbal aggr 1 decrease physical aggr 3 increase coping strategy
Client 4	Verbal aggression 7 Physical aggression 1 Coping strategy 6	Coping strategy 14	7 decrease verbal aggr 1 decrease physical aggr 8 increase coping strategy
Client 5	Coping strategy 12 Withdrawal 2	Coping strategy 14	2 increase coping strategy

<sup>1</sup> Withdrawal on its own is not seen as an effective coping strategy as it is likely that an individual may go away and ruminate about the situation and the problem situation will be left unchanged.

## 4. DISCUSSION

### 4.1 Summary of results

Three of the five clients who attended the anger management group reported clinically significant and reliable change on the majority of the NAS-PI subscales and totals, in the direction of improvement, suggesting that the group was effective for these individuals. With regards to the cognitive subscale which asks about thoughts that may mediate anger; categorised as justification, suspiciousness, rumination and hostile attitude, only two of the clients' scores indicated reliable change. The 10-session group only briefly focused on cognitive restructuring and therefore it is not surprising that the majority of the clients did not make improvements in this area. This finding is similar to that reported by Willner et al (2002) where clients found behavioural coping strategies easier to acquire than cognitive restructuring of anger-provoking situations and improvements in this area were not identified. The anger regulation subscale asks about adaptive aspects of anger and only one client's responses indicated reliable change on this measure. This may be due to cognition being a large component in anger regulation, for instance the use of calming thoughts and as stated earlier this area was not substantially covered in the group. With regards to the Provocation Inventory all the clients described the use of more coping strategies in relation to provoking situations and for three of the clients this included describing coping strategies in response to all fourteen situations. In this sense the group was successful in helping clients to manage their anger more appropriately though this needs to be considered cautiously as the way individuals describe how they would behave hypothetically and their actual behaviour in real life situations may not correspond exactly. The number of role-plays conducted in the group and the fact that they were often based on scenarios which the group members brought themselves and therefore were authentic for them, may have helped individuals to gain more appropriate strategies for coping with anger and generalise these when responding to the situations presented in the Provocation Inventory at post-treatment. In this sense they were encouraged to be

involved in their own treatment and Rose et al (2000) have demonstrated that this is helpful for motivation. While the results demonstrate that some of the group members improved, two did not and on some of the measures their scores increased in the direction of deterioration. This may be due to the relatively short intervention and further sessions may address this, though more information regarding these clients' individual experiences and their views on the limitations of the group needs to be explored.

#### **4.2 Methodological issues and limitations of the intervention**

There are a number of limitations associated with this study particularly the small sample size and lack of control group, though as the aim of the study was to examine the effectiveness of a particular treatment within the unit the design was restricted. Using self-report measures for anger may introduce some difficulties. For instance clients may have difficulty self-monitoring their own feelings and behaviours. In addition inappropriately responding to anger has social costs and therefore clients may want to present themselves in a socially desirable way. This may be particularly relevant for individuals who are incarcerated as it is likely that they have already had experience of their behaviour being judged as socially unacceptable. It would therefore be helpful to use additional observational measures completed by staff in the unit, as part of clients' daily reports. In addition the inclusion of multiple baseline measures and follow-up measures (e.g. 3, 6 & 12 months) would improve the design of this study.

The five clients that attended the group did not represent a homogenous sample in terms of mental health issues. One of the clients is diagnosed with Borderline Personality Disorder and it is likely that he did not accurately reflect the progress he had made in the group in his responses when the post-treatment measure was taken, as he found the ending of the group particularly difficult and seemed to react negatively to this. In addition some of the clients are on anti-psychotic medication which occasionally made concentration difficult, though to address this the sessions were planned to be active and contain a variety of teaching modes. The clients in the group are however representative of those in the unit and therefore the delivery of an

effective treatment needs to accommodate these difficulties. Although the Trainee Clinical Psychologist planned all the sessions not every session was conducted by the same combination of people due to annual leave. This could have impacted on how the sessions were delivered and may have affected the acquisition of skills.

Another issue to consider particularly in this setting are expectancy effects. It is likely that individuals may have expectations regarding their improvement which could impact on self-reports and in addition they may perceive pressure from staff for them to improve. There is also a further degree of external pressure, as client's participation in treatment and improvement is contingent with their release. This being the case, it was particularly important for ownership of the group to be located within the clients and for them to have direct input into aspects of the sessions. Additionally it was necessary to provide clients with a space to discuss issues about the unit which made them angry and problem-solve ways to cope with this.

## **5. Service implications and further research**

The medium secure unit has a duty of care to its clients and also must meet purchasers' expectations which necessitates that it is able to provide effective interventions. One of the important outcomes of this study is that by scrutinising the intervention and the findings, it may begin to consider how the group can be improved. As discussed earlier cognitive components in anger management interventions for people with LD can be difficult both to administer and to acquire (Whitaker, 2001; Willner et al, 2002). One way to address this issue could be by offering more sessions of longer duration (e.g. 18 sessions) and increasing the frequency (e.g. two times per week). Taylor et al (2002) found this intensity in treatment reinforced motivation and aided assimilation and recall. With this in mind a recommendation was made after the anger management group had finished to conduct a 'level II group' after a period of consolidation. The focus of the next group would be on extending the skills already acquired and placing a greater emphasis on cognitive restructuring. Discussion with the clients who had attended the group about a further level II group in the future was met with enthusiasm.

Alternatively additional sessions concentrating on cognition could be offered individually as is recommended by Taylor (2002), though the limited resources in the unit may not facilitate this approach.

A further improvement to the group could include the use of video, to facilitate feedback of role-plays and group discussion. This method was successfully incorporated into a group intervention by Rose et al (2000) and aided the acquisition of problem-solving strategies. More intensive co-operation and participation from staff in the unit particularly named-nurses, could help to support homework which may also improve outcomes; insuring lessons learned in the group are practised and applied to real life situations (Willner, et al, 2002). This would also help clients to generalise the skills they learn in the group which is often difficult for individuals with LD (Stenfert Kroese et al, 1997). Finally greater participation by staff could help to raise awareness regarding their own impact on triggers for anger and those of the institutional environment for clients (Black et al, 1997; Rose et al, 2000; Wanless & Jahoda, 2002).

There is a need for further research examining the effectiveness of CBT interventions for anger, for people with LD as there is limited research to date. This is particularly the case for people with LD, with a forensic background (Whitaker, 2001). Studies conducted within forensic settings possessing high ecological validity may be particularly valuable as clinical practice will have to be adapted to these environments and developments in practice will need to consider the unique characteristics of these environments. The development of effective interventions also needs to address the lack of resources available in LD services and how best to meet clients' needs.

In summary this study evaluated the effectiveness of an anger management group for clients' with mild to borderline LD in a medium secure unit, identified as having difficulties dealing with their anger in an appropriate manner. A progress report for each client was submitted to the team at the end of the intervention and suggestions

for further improvements to the group were discussed with the Consultant Clinical Psychologist, responsible for disseminating these.

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# **Literature Review**

**The relationship between attachment and social anxiety:  
Theoretical and clinical implications**

**Student No: 02055476**

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# The relationship between attachment and social anxiety: Theoretical and clinical implications

## Introduction

Bowlby (1973) identified that the significance of primary caregivers went beyond merely providing for the physical needs of the infant. Separation from primary caregivers activates the attachment system which is evolutionary and biologically driven to ensure proximity to the caregiver for security and survival (Bowlby 1970; 1982). The quality of the attachment between the caregiver and the infant is based on the physical availability and responsiveness of the caregiver, and the quality of caregiver/infant communication. Through naturalistic observations and the strange situation studies, Ainsworth and her colleagues (Ainsworth, Blehar, Waters & Wall, 1978) found that there is an interaction between the attachment system and the exploration system. The strange situation studies also identified individual differences in behavioural strategies used when the attachment system was activated. This led to the infant/child attachment classifications: *secure*, *insecure-avoidant*, *insecure-ambivalent* (resistant), and later *disorganised* (Main & Solomon, 1986). More contemporary research into attachment tends to concentrate on Bowlby's concept of internal working models of attachment. These models are thought to provide an understanding of how early relationships have an impact on adult relationships (Bowlby, 1982; Main, Kaplan & Cassidy 1985; Collins & Read, 1990). This perspective can be useful when considering psychopathology, particularly as relationship issues are important for understanding the development and maintenance of disorders (Sroufe, Duggal, Weinfield & Carlson, 2000). Social anxiety is predominantly concerned with one's appraisal of competence in social situations. It is likely that these appraisals are related to early social interactions. Attachment theory may be able to provide a comprehensive explanation of the development and maintenance of social anxiety which could incorporate aspects of other theories, particularly cognitive theories. The clinical implications of this could be the development of treatment approaches which include attachment relevant aspects to existing cognitive behavioural interventions.

## Internal Working Models of Attachment

Bowlby (1973; 1980) proposed that through attachment experiences a child develops an internal working model of attachment. Expectations about the availability and responsiveness of caregivers are learned through interactions and these expectations are the basis for working models of the self and others (Bowlby, 1982; Heard & Lake, 1986). The models emphasise motivational tendencies, behavioural strategies, and an emotional component. Specifically, information about who the attachment figures are, where they can be found, and an expectation of how they will respond is learned through experiences of when they are sought for support. Main, et al (1985) argued that internal working models have an impact on feelings, behaviour, attention, memory, and cognition. The model of self develops in relation to how the attachment figures respond to the child when they seek support. Individuals who develop secure attachments are thought to have had responsive caregivers, who provide warm, positive interactions. They therefore internalise a model of others as trustworthy and attentive to their needs and a model of self as lovable and worthy (Collins & Read, 1990). Insecure- ambivalent (Preoccupied) individuals are likely to have had inconsistent caregivers (Bartholomew, 1990). They may internalise a model of others as conditionally accepting and tend to seek others out for validation. Their model of self is tenuous and based on others' approval, as they have an underlying doubt of their self-worth (Mikulincer, 1998). Insecure-avoidant (Dismissing) individuals tend to have had caregivers who were unresponsive and unreliable and often punitive (Levy, Blatt & Shaver, 1998). They are likely to have models of others as unreliable and untrustworthy and tend to maintain emotional distance. Their model of self is relatively positive and they tend to value independence and self-reliance (Bowlby, 1982; Shaver & Hazan, 1988). Individuals who develop a Disorganised (Fearful) attachment are likely to have had caregivers who they perceived as punitive and rejecting, frightened or frightening (Main & Solomon, 1986). They tend to develop models of others as uncaring and rejecting, and models of self as unlovable and unworthy (Bartholomew, 1990).

Bowlby also hypothesised that these working models will influence the behavioural strategies associated with attachment related thoughts and feelings. In this sense if a child has a model of others as loving and available, and a model of self as lovable and valued, they will tend to develop secure strategies for gaining access to caregivers when they are distressed or in need (e.g. seek out for comfort, receive comfort quickly, and move away again for exploration) (Ainsworth et al, 1978). Bowlby (1973; 1980) proposed that when children develop models of others as rejecting or unavailable and/or models of self as rejected they will tend to develop alternative insecure strategies to cope with distress, and are consequently at risk of developing psychopathology (Lyons-Ruth, Easterbrooks & Cibelli, 1997; Cicchetti, Cummings, Greenberg & Marvin, 1990). Despite this, insecure attachment is not *unadaptive* in an absolute sense. For instance children with abusive caregivers who react punitively when the child is actively distressed learn to be quiet or avoidant, reducing the risk of abuse (Crittenden, 1985). In this context this behaviour would be protective; it is then the inability to adapt this behaviour in environments where responsive figures are present that leads to psychopathology (Cicchetti & Lynch, 1995). Bowlby (1970) also stressed the role of temperament, describing incidents where infants demonstrated either diminished reactivity (e.g. respond weakly, cry very little) or high reactivity (cry readily, show sudden unpredictable shifts in responses) and its impact on caregivers' responses. This has also been shown in studies which look at emotional reactivity and attachment in infants with delayed cognitive development (Ganiban, Barnett & Cicchetti, 2000; Lyons-Ruth, 1996). It is hypothesised that these infants may be more difficult to interact with and the interactions may be experienced as unrewarding which will have an impact on attachment.

Models of self and others are both complementary, as reciprocal parts of a relationship, and independent (Bowlby, 1973; Bartholomew & Horowitz, 1991). This is evident in the variations between models of self and models of others related to different attachment styles. It is expected that securely attached individuals will have positive self and others models, preoccupied individuals will have a negative

model of self and a positive model of others, those with fearful attachment will possess a negative model of self and a negative model of others, and dismissive attachments will have a positive model of self and a negative model of others (Luke, Maio, & Carnelley, 2004; Park, Crocker & Mickleson 2004). Bartholomew (1990) systematically represented Bowlby's conception of internal working models of self and others into two dimensions, positive or negative, leading to four prototypical attachment patterns (see Figure 1 below). The self model represents the degree of anxiety and dependency on others for approval. The other model represents avoidance and the ability to seek others for support. Bowlby's models are conceptualised as developmental and therefore require revision as the child grows to accommodate changes in physical, social, and cognitive development. As these models are complementary adaptation is required in both the child's and the caregivers' models. When revisions are not made Bowlby hypothesised that there would be an increased risk of psychopathology (Greenberg, Speltz & DeKlyen, 1993; Rutter, 1997). It has also been argued that while insecure attachment may put individuals at risk of developing psychopathology, it is unlikely that attachment difficulties alone lead to this (Cicchetti & Rogosh, 1997; Sroufe, 1990). Despite this, relationship issues are important for understanding the aetiology and maintenance of disorders (Sroufe, Duggal, Weinfield & Carlson, 2000). Two aspects of the caretaker role which have consistently been identified as risk factors for developing psychopathology are harsh treatment, including rejection and hostility, and lack of supervision and discipline, often considered neglect (Farrington, et al, 1990). These aspects directly relate to attachment goals (e.g. availability and responsiveness).

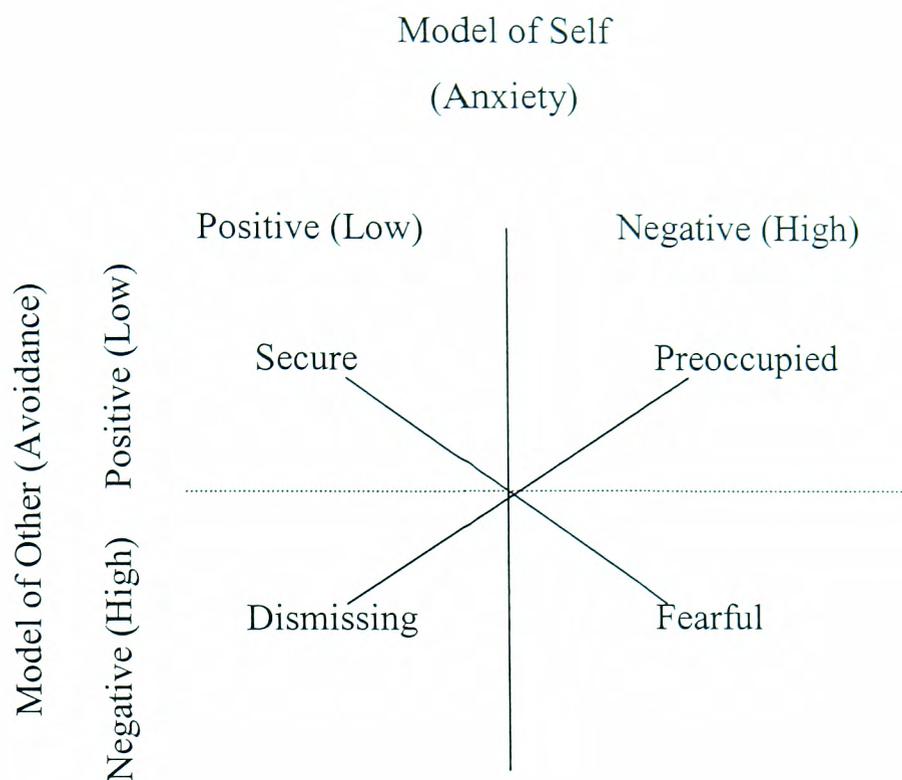


Figure 1: Bartholomew (1990) Four-category model of adult attachment

Although some supporters of attachment theory translate the model in a deterministic manner Bowlby envisioned the model in more dynamic terms (Bowlby, 1970 p.348) and although early relationships form the foundations of working models of attachment these models are subject to changes and revision. This has been demonstrated in studies which examine adolescent attachment and the changes in attachment-related behaviour which take place at this developmental stage (Ammaniti, van Ijzendoorn, Speranza & Tambelli, 2000; Waters & Cummings, 2000). Hazan and Shaver (1994) found that adolescence is a period during which attachment relationships evolve to include peer and romantic relationships. In addition there is a transformation from receiving care from an attachment figure to both receiving and offering care and support. Black and McCartney (1997) found that attachment and security classifications to parents and peers were unrelated. Ainsworth (1989) identified four characteristics which are specific to attachment

relationships: proximity seeking/maintenance (who one wants to spend time with and be near), secure base behaviour (who one knows can always rely on, will do anything for you), safe-haven behaviour (turn to when feeling upset), and separation distress/protest (hate to be away from, miss most during separations). Hazan and Zeifman (1994) examined these four components in children aged 6-17, asking who the most preferred person would be for each of the four areas. They found that the majority of children preferred to turn to peers for proximity seeking, and between the ages of 8 and 14 children began to prefer peers for safe-haven seeking. Parents remained the preferred source for secure base and separation protest until the ages of between 15 and 17, when some adolescents identified peers as preferred for all four components. These studies demonstrate that attachment relationships and behaviour is not fixed. The clinical implications for this would suggest that revisions in the model of self or others are possible, in those who are at risk of developing psychopathology or who are already experiencing mental health problems, and may be considered an important focus of interventions. There do seem to be parts of attachment which remain relatively constant through development. Collins and Read (1990) demonstrated that adult attachment contains core elements which are also central to infant attachment; specifically, beliefs about the responsiveness and availability of caregivers/romantic partners. Although an attempt to change these beliefs may be considered impractical it may be possible to reframe them in a future-oriented way and thereby change some of the cognitions related to these beliefs.

### Social Anxiety

Social anxiety is considered the most common type of anxiety disorder in the United States, with a reported lifetime prevalence of 13.3% according to the National Comorbidity Survey (Kessler et al, 1994). It is defined as “a persistent fear of one or more social situations in which the person fears that he or she may do something or act in a way that may be embarrassing or humiliating”(Roth & Fonagy, 1996). Specific situations may include speaking in public, eating in public or situations where one perceives that their performance may in some way be scrutinised by

others. An individual is able to recognise that their fear is excessive though the anxiety that social situations provoke leads them to avoid these situations. This then leads to a disruption in social and occupational functioning. There is not a clear distinction between the terms social anxiety disorder and social phobia, and they are often used interchangeably (e.g. in the Diagnostic and Statistical Manual of Mental Disorders-IV (APA, 1994)). For the purpose of this paper I will tend to use the term social anxiety in order to conceptualise anxiety on a continuum ranging from sub-clinical levels of anxiety which the majority of people would experience, to clinically significant levels which impair functioning.

### Cognitive Theories

Cognitive theories of social anxiety propose that negative beliefs about social situations are what maintain the disorder (Hoffman, 2004), particularly beliefs about the likelihood of behaving in a way that is unacceptable or inept, and that this behaviour will have grave consequences to status, worth, or acceptance. Clark and Wells' (1995) cognitive model of social anxiety emphasises the position that individuals are unable to enter a feared situation and process any information which is contrary to their negative beliefs. They propose that this is due to the individual's attentional bias away from external social cues. This has been demonstrated in studies which examined the attendance to facial expressions and found that individuals with social anxiety demonstrated a bias for attending away from faces (Chen, Ehlers, Clark, & Mansell, 2002; Mansell, Clark & Ehlers, 2003). In this sense individuals would not process alternative or competing information and would therefore miss opportunities to disprove their negative beliefs. Related to this, there also seems to be a bias toward very self-focused attention or self-consciousness which maintains anxiety (Clark & Wells, 1995; Hoffman, 2000). The role of perceived control is also relevant when considering social anxiety. Individuals with social anxiety tend to attribute control over anxiety-provoking situations to 'powerful others', reflecting an external locus of control (Cloitre, Heimberg, Liebowitz & Gitow, 1992). In addition it is thought that in an attempt to increase their control over anxiety-provoking situations they have a tendency to over-control anxiety-related emotions. Mäntynen, Happonen, and Toskala (2000) examined this tendency

in a qualitative study by examining the narratives of social phobics in relation to experiences of anxiety-provoking situations. The authors revealed that social phobics did attempt to control anxiety-related emotions and more specifically this control extended both to private and public self-consciousness. They identified a strategy they termed “fogginess” which represents an attentional disturbance that serves to insure one will lose a sense of contact with the environment and also obscure public and private self-consciousness.

Clark and Wells (1995) also highlight the importance of loss in terms of one’s perception of self in addition to social status. The appraisal that a situation is dangerous (in terms of loss of status and self-worth) activates an anxiety cycle which in cognitive behavioural terms includes physiological, cognitive, affective, and behavioural components. As these components are activated (fight/flight response) anxiety increases and the problem is maintained. Individuals will then tend to avoid situations they have judged as dangerous. When avoidance is not possible individuals may experience anticipatory anxiety and ruminate about an upcoming situation. This may lead to rehearsing how they will act or what they will say in a particular situation. These are considered safety behaviours as they have been constructed to enable one to enter a ‘dangerous’ situation and ideally minimise the amount of anxiety. In fact safety behaviours tend to contaminate the social situation as the individual is portrayed as unnatural or unfriendly (e.g. avoiding eye contact, using rehearsed dialogue, holding hands to face, not actually attending to the other person, etc...). It is also likely that any success in a social situation which is perceived, will be attributed to the use of safety behaviours and not the possibility that the appraisal of danger was erroneous. In addition individuals with social anxiety tend to rerun social situations in their minds, scrutinising their performance. This scrutiny will tend to reinforce negative beliefs as they will have ignored any external cues due to their self-focused attention and their attentional bias.

### Alternative Theories of Social Anxiety

The prominent focus of this review is on cognitive theories of social anxiety although there are other existing theories. Genetic theories posit that there is a

degree of genetic contribution to the development of social anxiety evidenced by the finding that there is an elevated risk of developing social anxiety in relatives of people with this disorder. Twin studies have reported a 57% contribution attributed to genetic and environmental factors (21% genetic & 36% environmental) specific to social phobia (Kendler, Neale, Kessler, Heath & Eaves, 1992). This study was conducted with 2,163 female twins. A later study including 2,396 male twins (Kendler, Myers, Prescott & Neale, 2001) revealed a 13% genetic contribution and a 35% environmental one specific to social phobia. This suggests that there is some genetic component though the environmental influence is greater. The environmental influence could take the form of relationships with caretakers.

Evolutionary theories conceptualise social anxiety as an adaptive emotional response which is utilised in order to maintain links between individuals and groups which are necessary for access to resources and survival (Trower & Gilbert, 1989). This is considered particularly adaptive when one perceives themselves as lower in the social hierarchy or when they sense there is a threat of being socially excluded. Gilbert (2001) suggests that by being socially anxious and displaying defensive submissive behaviours, one is not considered threatening, reduces the chances of being rejected, and is still able to access resources. It is thought that the usefulness of these behaviours also maintains the social anxiety. Submissive behaviours are very similar to cognitive theory's construction of safety behaviours. For instance not holding eye gaze, positioning one's head downwards to avoid looking at someone's face, maintaining a proximal distance, could all be construed as submissive behaviours and safety behaviours.

### Interpersonal Theories

Under the umbrella of interpersonal theories there are contributors who advocate a social-skills deficit theory (Beidel, Turner & Dancu, 1985). While social skills are essential to social interactions there is little evidence that a lack of these skills can exclusively account for the entire experience of social anxiety (Vertue, 2003). In Heimberg and Juster's (1995) review of treatment interventions for social phobia they found that treatments which concentrated on social skills but did not address

cognitive or affective components were not as effective, suggesting poor social skills are not the only factor contributing to social anxiety. Another interpersonal theory is Leary's (2001) self-presentational/relational devaluation theory. According to this theory there are three conditions necessary for social anxiety: a desire to make a certain impression on others, a belief that attempts to make an impression will fail, and a belief that the outcome of failure will be devaluation, which will impact on one's own interpersonal goals (e.g. inclusion in social groups, occupational opportunities, finding a partner, etc...). Devaluation is described as others not seeing the individual as valuable or important and therefore the individual will not have desired close relationships. Although there is a lack of direct support for this theory, the Epidemiologic Catchment Area Study (Schneier, Johnson, Hornig & Liebowitz, 1992) revealed that the socio-demographic composite indicative of individuals with social phobia are: female, young, single, poor education and low socio-economic status. It's proposed that these characteristics would be likely to describe a group which is interpersonally devalued and hold a belief that their ability to make a positive impression will fail. While this may be the case it is also likely that these socio-demographics would be identified in populations with other mental health disorders and physical health disorders.

### Development of Social Anxiety

Although there are a number of theories which conceptualise social anxiety they are not very elaborated with respects to the aetiology. Clark and Wells' (1995) model suggests that individuals with social anxiety not only have a distorted perception of themselves in social situations and an exaggerated prediction of the likelihood that they will humiliate themselves, but also a distorted perception of others. It may be that models of 'social self' are influenced by early traumatic social experiences where an individual was humiliated or criticised and that this model is reactivated in social situations and not revised (Clark, 1999). This model would then include a self component as humiliated and of low self-worth and an other model as humiliating and criticising. Wells (1997) hypothesises that dysfunctional assumptions may have been learned early in life through interactions with family and peers. Chorpita and

Barlow (1998) suggest that anxiety may develop from a history of lack of control. Significant early experiences where events are perceived as uncontrollable may lead to the tendency to process events as out of ones control. Foa and Kozak (1986) posit that fear is represented in memory structures which act as blueprints for activating fear behaviour. These memories also contain meaning constructions which correspond to perceiving the content of the memory as dangerous or fearful. This position relates social anxiety to information about an experience which is stored. They further suggest that changes to the memory must modify both the affective and the cognitive information to be effective.

### Insecure Attachment and Social Anxiety

Based on the previous discussions of attachment theory and social anxiety it is evident that social relationships are salient to both of these. Insecure attachments develop in relation to early relationships with caregivers who are inconsistent, unavailable and unresponsive. Expectations about these relationships lead to models of others and self which are at least partly negative. It is likely that a central feature in social anxiety is relationship problems (Sroufe et al, 2000). Dysfunctional assumptions and models of 'social self' may have developed along the same mechanism as working models of attachment. Bowlby (1973) proposed that anxiety disorders could be explained by the anxiety produced in response to the availability of attachment figures. He hypothesised that the types of environments which would contribute to developing anxiety disorders would be ones where the child worried about abandonment or rejection, worried about the caregivers survival in the child's absence (e.g. domestic violence, suicide attempts, etc...), the child acting as companion or caregiver to the parent, and/or where the caregiver is unable to foster independence because of fear the child will be harmed. Internal working models of attachment may be able to inform the causal mechanism through which social anxiety develops (Vertue, 2003) and it has the capacity to describe the impact environment has on individuals and their impact on the environment (complimentary model).

There does appear to be a relationship between attachment and anxiety. Warren, Huston, Egeland & Sroufe (1997) found a significant association between resistant (preoccupied) attachment in infancy and a diagnosis of anxiety disorder in adolescence, even when temperament was controlled for. Chambless, Gills, Tran and Steketee (1996) revealed that most people with anxiety disorders described their parents as unloving and controlling. While there are studies which examine the relationship between attachment and anxiety disorders, very few studies look specifically at attachment and social anxiety. This seems surprising as theoretically one could propose that the internal working model of attachment (self and others models) would be directly related to fears about social situations. Mickleson, Kessler, and Shaver (1997) conducted a study using the National Comorbidity Survey epidemiological sample (NCS; Kessler, et al., 1994) and identified that both avoidant and anxious attachment styles (measured using Hazan and Shaver's (1987) attachment style measure), were positively associated with social anxiety. The strength in association for both avoidant and anxious attachment styles was the same ( $b = 0.52$ ). This may be due to the attachment measure used, as Hazan and Shaver's (1987) tool is comprised of three descriptions corresponding to secure, avoidant and anxious/ambivalent, which respondents are asked to select according to which best describes their feelings. It is thought that this measure does not include two important aspects of attachment: beliefs about the responsiveness and availability of others and reactions to separation from caregiver/partner (Collins & Read, 1990). Therefore the findings in this study may be limited by the brief attachment measure used and further studies would benefit from using a more extensive, detailed measure. Another study which examined the relationship between attachment style and social anxiety was conducted by Eng, Heimberg, Hart, Schneider and Liebowitz (2001). They specifically examined the hypothesis that social anxiety mediates the relationship between adult attachment style and depressive symptoms. They used a clinical sample of 118 patients who sought treatment for interpersonal or performance anxiety, a replication clinical sample of 56 patients who sought treatment for interpersonal or performance anxiety from a different institution, and a non-clinical control group of 36 participants. Adult attachment was measured using the Romantic Adult Attachment Scale (RAAS; Collins, 1996), which is a self report

questionnaire developed to assess Hazan and Shaver's (1987) three attachment styles. The authors found that patients with social anxiety reported both anxious-preoccupied and secure attachment styles, though the anxious-preoccupied group demonstrated significantly more social fear and avoidance, were more impaired by their anxiety and were more depressed, than the secure group. This finding may suggest that difficulties in attachment may not be the only mechanism in the development of social anxiety. Using mediational analysis the authors found support for their hypothesis, reporting that a significant relationship between attachment style and depression was mediated by the severity of social anxiety. By examining social anxiety in relation to factors which would be likely to develop from difficulties with attachment, more information may be provided about the mechanism involved. In addition a broader assessment of attachment generated from interview instead of self-report questionnaire, may provide more detailed information and may also reduce self-presentation effects (present self in positive way).

### Self-esteem and Locus of Control

Self-esteem and locus of control are related to how one sees oneself and their belief about their ability to impact upon their environment. It is likely that these variables are also related to internal working models of self and others. Mickleson, Kessler, and Shaver (1997) reported that secure attachment was related to higher self-esteem and internal locus of control, while anxious and avoidant attachment was associated with low self-esteem and external locus of control. Collins and Read (1990) examined the model of self by measuring self-esteem and belief in the ability to control the outcomes of one's life. The authors revealed that secure attachment style was related to high self-esteem, while anxious and avoidant styles were not. Those with secure attachment also felt more able to control the outcomes in their lives, while insecure attachments did not. Additionally the study found that differences in attachment related to beliefs about self and others consistent with attachment theory. Park et al (2004) looked at contingencies of self-worth as sources of self-esteem, and attachment styles. They divided contingencies of self-worth into interpersonal

sources of self-esteem (e.g. others' approval, appearance, family support, & God's love) and non-interpersonal sources of self-esteem (e.g. academic competence, competition, & virtue). The authors demonstrated that people with secure attachment report high self-esteem derived from family support and virtue. People with pre-occupied attachment report low self-esteem derived from others' approval and appearance. People with fearful attachment report low self-esteem derived from others' approval, appearance and academic competence. Finally those with dismissing attachment reported high self-esteem, though as predicted they did not derive this from others' approval, family support, God's love, or academic competence. The authors suggest that the information gleaned regarding where dismissing individuals *do not* derive self-esteem is important, as it supports the position that although high self-esteem is reported by this group it is likely to be 'defensive self-esteem'. Hexel (2003) reported that participants with secure attachment style also had internal locus of control and those indicating insecure attachments had external locus of control.

Self-esteem and locus of control are also likely to be important factors related to social anxiety. Luke et al (2004) proposed that global evaluations of others would be associated with positive attachment models of others. They hypothesised that global evaluations of others should reflect specific beliefs, feelings and past behaviours that are associated with others. This hypothesis could have an impact on what would activate perceived social assumptions and danger for individuals with social anxiety. The findings demonstrate that the attachment self model predicts global evaluations of self (e.g. self-esteem) and the attachment other model predicts global evaluations of others (e.g. humanity-esteem). Related to this Griffin and Bartholomew (1994) found that attachment-self models uniquely predicted a positive self concept and attachment-other models predicted positive interpersonal functioning. In reviewing findings associated with the development of anxiety Chorpita and Barlow (1998) posit that early experiences of uncontrollable events may lead to anxiety in the sense that one is more likely to develop a belief that events are not in their control. In the case of social anxiety it may be that early experiences of being ineffectual in attachment related strategies foster beliefs that one is not able to influence social

interactions. Cloitre, Heimberg, Liebowitz, and Gitow (1992) reported that social phobics tend to have external locus of control, particularly believing that powerful others have control over anxiety-provoking situations.

## Conclusion

Attachment theory has been extensively elaborated and presents a sound research base. Conceptually the hypothesis that insecure attachment is related to social anxiety seems evident though very few studies have directly examined this relationship. A large body of research related to interventions for treating social anxiety have been published, though the aetiology of the disorder is still relatively vague. The implication of this is that treatments which are developed may potentially lack the ability to address issues related to the cause and possibly maintenance of the disorder. Attachment theory may be able to provide a model explaining the mechanism underlying the development of social anxiety. Internal working models of self and others influence how individuals conceptualise themselves and people they interact with. This conceptualisation is particularly related to perceptions of value, self-worth, ability to influence, availability, and responsiveness. As low self-esteem and external locus of control are related to both attachment and social anxiety these factors may mediate the relationship between them. The clinical implications of this finding would necessitate that interventions would need to be developed that considered one's early attachment experiences and helped the individual to make sense of how this had an impact on their lives. In addition strategies to directly address self-esteem and perceptions of locus of control would need to be incorporated.

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## Appendix 1

### Method/Search Strategy

#### 1. Consulted Databases

Studies in this review were identified via computerised literature searches using PsychINFO, AMED, Cinahl, HMIC, SIGLE, the Cochrane and Medline databases.

#### 2. Terms searched

The terms searched included: “attachment”; “attachment measures”; “working models of attachment”; “social anxiety”; “social phobia”; “cognitive models of social anxiety/phobia”; “attachment” AND “social anxiety”; “attachment” AND “social phobia”; “attachment” AND “self-esteem”; “attachment” AND “locus of control”.

#### 3. Inclusion and Exclusion Criteria

A number of criteria were utilised in order to refine the search and limit the scope of the search to those papers which were more directly relevant. The following are the criteria which were used:

- Due to the small number of studies generated in this search (attachment and social anxiety; attachment and social phobia), the inclusion criteria consisted of studies which examined the association between attachment and social anxiety/phobia, directly or indirectly.
- Attachment papers that specifically examined working models of attachment both in terms of theoretical discussions or research studies were included.
- Papers which did not examine the attachment relationship in terms of interpersonal relationships (e.g. attachment as medical term) were excluded.
- Papers which examined specific populations (e.g. alcohol/substance abuse, offenders, etc) other than social anxiety/phobia, were excluded.
- Studies which examined different developmental stages in relation to attachment and the development of working modes of attachment were included (e.g. general adult, adolescent, or infant).
- Studies which examined cognitive models of social anxiety/phobia were included.

- Studies which directly examined the association between attachment and self-esteem or attachment and locus of control were included.

#### 4. General Procedure

As there were a very limited number of papers retrieved for attachment and social anxiety/phobia, all papers were hand-searched for relevance. In addition some papers were identified from the contents of the studies found in the original search. Priority was given to the most recent papers (2000 onwards). With regards to attachment theory, original text sources were consulted initially (e.g. authored by John Bowlby, Mary Ainsworth, etc...) to build knowledge of theory base before secondary sources were utilised. The grey literature search did not reveal any results with regards to attachment and social anxiety/phobia and PsychINFO produced the most numerous and relevant search results.

The relationship between attachment and social anxiety, focusing on self-esteem and locus of control as possible mediators.

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A Thesis submitted in partial fulfilment of the requirements of the University of Hertfordshire for the degree of Degree of Doctor of Clinical Psychology

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## **The relationship between attachment and social anxiety, focusing on self-esteem and locus of control as possible mediators.**

### **Abstract**

Social anxiety is an excessive fear of social situations characterised by negative beliefs about one's performance in social situations and an exaggerated perception of the potential for catastrophic outcomes, e.g. negative judgements by others, humiliation, and loss of self-worth (Clark & Wells, 1995). People with social anxiety report experiencing their parents as emotionally cold, controlling or intrusive, and as using criticism or shame when disciplining them (Harvey, Ehlers & Clark, 2005; Leung, Heimberg, Holt & Bruch, 1994; Rapee & Melville, 1997). Social anxiety may be conceptualised from an attachment perspective particularly as interpersonal relationships are fundamental to both, and the experiences of being parented reported by people with social anxiety, may predispose individuals to developing an insecure attachment style. Self-esteem and locus of control are related to both social anxiety and attachment, and therefore may be important to both of these. The following study was conducted to examine the relationship between adult attachment and social anxiety, using an interview measure of attachment (ASI; Bifulco, Lillie, Ball & Moran, 1998). Thirty adults, recruited from a university and social anxiety support groups were screened for a high threshold of symptoms, of social anxiety. Participants completed self-report questionnaires for anxiety, self-esteem and locus of control, and were interviewed. The study found that this socially anxious group had a predominately insecure attachment style, and more specifically fearful and anxious classifications. Individuals with an insecure attachment style were not found to be significantly more socially anxious, though those with a fearful style and an anxious attachment classification were significantly more socially anxious. Social anxiety was significantly related to low self-esteem but not to locus of control. Finally individuals with an insecure attachment style did not report significantly lower self-esteem or external locus of control. The results are discussed in the context of attachment theory and cognitive models of social anxiety. Suggestions are made with regards to the development of existing treatment approaches for social anxiety, incorporating attachment components.

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# 1 Introduction

## 1.0 Social Anxiety

Social anxiety encompasses a fear of social situations whereby the individual is fearful of negative evaluation in response to perceived failed performance on their own part, which would lead to embarrassment and/or humiliation. This excessive fear then leads to the avoidance of situations where the potential for humiliation is perceived, leading to social and occupational dysfunction (Clark & Wells, 1995; Roth & Fonagy, 1996).

There are a number of theories of social anxiety: Cognitive, Genetic, Evolutionary, and Interpersonal. These models have been discussed in some detail in the literature review (see McCarty, 2004) and therefore will not be repeated here. For the purpose of this study social anxiety will be conceptualised within a cognitive framework. From this position negative beliefs about one's potential for failure in social situations and the impact this would have to their self-worth maintain the disorder, particularly as individuals with social anxiety fail to process information contrary to their negative beliefs (Clark & Wells, 1995; Hoffman, 2004).

The development of social anxiety conceptualised from a developmental perspective, particularly considering the influence of parenting styles is less elaborated, though individuals with social anxiety tend to rate their parents as less likely to encourage engagement in social events and as more emotionally cold (Harvey, Ehlers & Clark, 2005). In addition they describe their parents as having been more controlling or over intrusive (Rapee & Melville, 1997) and as employing criticism or shame when disciplining (Leung, Heimberg, Holt, & Bruch, 1994). Early traumatic social experiences where an individual felt humiliated or criticised may also have an impact on models of 'social self'. This experience is then processed in a ruminative manner and the opportunity for revision is limited (Clark, 1999; Harvey et al., 2005). It has also been hypothesised that early experiences with parents and peers may contribute to dysfunctional assumptions (Wells, 1997). In addition the role of control is

important to the development of anxiety and the experience of perceiving situations as uncontrollable increases anxiety (Chorpita & Barlow, 1998).

### 1.1 Social Anxiety and Insecure Attachment

Central to both social anxiety and attachment security is relationships. It is possible that the types of experiences which contribute to insecure attachment styles (e.g. inconsistent, unavailable and unresponsive caregiving) also have an impact on the development of social anxiety (e.g. critical, controlling, and emotionally cold caregivers). Internal working models of attachment may inform models of the ‘social self’ and the distorted perceptions of others, and contribute to the mechanism through which social anxiety develops (Vertue, 2003). Conceptualising social anxiety in terms of the development of attachment strategies would address motivational tendencies, behavioural strategies, and affective processing. It would also explain the interaction between the environment and the individual.

There is a limited amount of research that has demonstrated a relationship between insecure attachment and social anxiety (Eng, Heimberg, Hart, Schneider & Liebowitz, 2001; Mickleson, Kessler & Shaver, 1997). Both of these studies employed self-report measures of adult attachment and therefore are subject to the limitations of self-report measures, which will be discussed in more detail in proceeding sections.

Self-esteem and locus of control are two factors which have been associated with both insecure attachment and social anxiety. Studies have demonstrated that individuals with insecure attachment styles generally have lower self-esteem, possibly reflecting a negative self model, and also external locus of control, possibly reflecting a negative other model (Collins & Read, 1990; Griffin & Bartholomew, 1994; Hexel, 2003; Luke, Maio & Carnelley, 2004; Mickleson et al, 1997; Park, Crocker & Mickleson, 2004). Furthermore studies have demonstrated that low self-esteem and external locus of control are associated with social anxiety (Chorpita & Barlow, 1998; Cloitre, Heimberg, Liebowitz & Gitow, 1992; de Jong, 2002:

Kocovski & Endler, 2000; Rapee, 1997). These two factors may mediate the relationship between insecure attachment and social anxiety particularly as they both contribute to the way in which individuals perceive themselves and others in relational terms, and in the beliefs they hold regarding their ability to be effective in social situations and more generally. If individuals with social anxiety did not have low self-esteem and/or external locus of control this may reduce the association between insecure attachment and social anxiety, as these may be particular characteristics related to insecure attachment that impact on social anxiety.

Self-esteem and locus of control potentially represent areas which could be targeted for the treatment of social anxiety. By conceptualising the development of self-esteem and locus of control using attachment theory, the strategies (emotional regulation, cognition, and behaviour) that have developed can be identified, understood and validated. Interventions can then focus on uncovering and testing the beliefs, which maintain these strategies. Ultimately this could lead to developing alternative beliefs and testing out new ways of coping.

In order to consider social anxiety in the context of insecure attachment, it is necessary to elaborate on the concept of working models of attachment. The next section will give a brief overview of this. A fuller discussion of working models of attachment can be found in the literature review (see McCarty, 2004), though the main points have been summarised in the following section.

## 1.2 Internal Working Models of Attachment

Attachment theory proposes that through experiences with caregivers children develop internal working models of attachment (Bowlby, 1973; 1980). The basis for working models of attachment are specifically developed through expectations about the availability and responsiveness of caregivers (Bowlby, 1982; Heard & Lake, 1986). These interactions inform models of the self and others, and impact upon feelings, behaviour, attention, memory and cognition (Main, Kaplan & Cassidy, 1985).

While studying attachment, researchers identified different strategies emerging in relation to the attachment system being activated (Ainsworth, Blehar, Waters & Wall, 1978; Bowlby, 1973; Main & Solomon, 1986). It was hypothesised that these patterns represented the expression of the internal model of self and others. Four classifications of attachment were identified: Secure, Insecure-ambivalent (Preoccupied), Insecure-avoidant (Dismissing) and Disorganised (Fearful). The secure classification represents a positive model of the self seen as loveable and worthy, and a model of others as positive, emotionally available and responsive. The insecure-ambivalent classification reflects a tenuous model of the self, dependent on others for validation and a model of others as positive, though inconsistent and conditionally accepting. The insecure-avoidant classification is characterised by a relatively positive model of self, emphasising self-reliance and independence, and a negative others model, where others are seen as unreliable, unresponsive and untrustworthy. Finally the disorganised classification corresponds to a negative model of self, unlovable and unworthy and also a negative model of others, rejecting and uncaring.

Studies have demonstrated that there is an association between insecure attachment patterns and psychopathology. This association has been found for a number of disorders including depression (Bifulco, Moran, Ball & Lillie, 2002), eating disorders (Fonagy et al., 1996), schizophrenia (Tyrrel & Dozier, 1997) and borderline personality disorder (Patrick, Hobson, Castle, Howard & Maughan, 1994). The different cognitive and behavioural strategies that insecurely attached individuals develop in response to unresponsive or rejecting caregivers are associated with vulnerability to developing psychopathology (Bowlby, 1973; 1980; Cicchetti, Cummings, Greenberg & Marvin, 1990; Lyons-Ruth, Easterbrooks & Cibelli, 1997). The type of caregiving which is particularly a risk factor for developing psychopathology includes harsh treatment, specifically rejection and hostility, and neglect in the form of a lack of supervision and discipline (Farrington et al., 1990).

### 1.3 Life Span View of Attachment

Bowlby did not propose a critical period for the development of attachment in infancy but hypothesised that individuals have a tendency to seek continuity in parent-child relationships which will have an impact on the range of attachment strategies which develop. These strategies are then proposed to influence personality characteristics and future relationships, however through cognitive development, new attachment relationships, reflection and reinterpretation of past relationships, attachment patterns may change. Studies which have examined adolescent attachment have demonstrated that this is a developmental period during which attachment relationships evolve to encompass both peer and romantic relationships (Ammaniti, van Ijzendoorn, Speranza & Tambelli, 2000; Hazan & Shaver, 1994; Waters & Cummings, 2000). Bowlby (1970/1982) and Ainsworth (1989) both hypothesised that early attachment relationships are similar to later romantic relationships, and attachment-based behaviour is a function of adult relationships. Adult attachment behaviour is similar to child attachment behaviour as both include proximity-seeking when stressed, comfort in the presence of the attachment figure, and the activation of anxiety when the attachment figure is not accessible (Ainsworth, 1989; Shaver, Hazan & Bradshaw, 1988; Weiss, 1991). Adult attachment relationships are different to adult-child attachment relationships as they contain the element of reciprocity, both care giver and care receiver roles. Researchers generally attribute the development of adult attachment to three sources: caregiver-child attachment relationships, peer and romantic experiences, and current adult attachment relationships (Crowell, Fraley, & Shaver, 1999).

### 1.4 Measuring Attachment and Prevalence Rates

There are a number of attachment measures which have been developed for use with infants and children, older children, adolescents, and adults. The methods employed with these measures include observations, interviews or self-report questionnaires. Adult attachment theories have developed from two different research traditions, social psychology and developmental psychology (Simpson & Rholes, 1998). Both

approaches assume that early internal working models influence adult attachment, though they differ in how they propose that these models operate, and therefore use different methods to assess these.

Social psychology conceptualises adult attachment as a generalisation of children's attachment patterns (Hazan & Shaver, 1987; 1994). From this perspective it is proposed that adult attachment can be assessed through self-reports of behaviours and expectations in relation to adult attachment relationships. The types of measures that have developed from this perspective tend to focus on two dimensions: avoidance to closeness and anxiety over abandonment. In contrast researchers from a developmental perspective have developed measures based on the assumption that adult attachment and internal working models can be accessed in the way individuals mentally organise their childhood attachment experiences when describing them. More specifically patterns of attachment are inferred from the amount of coherence and the defences utilised in the adult's mental organisation of their childhood attachment experiences, in addition to the degree to which individuals perceive and process cognitive and affective aspects of the early attachment narrative. For instance those classified as secure would process both cognitive and affective aspects and provide a coherent account of childhood experiences, acknowledging their importance.

The prevalence rates of adult attachment styles in general and at-risk populations are available due to the considerable amount of research done in this area. The distribution of adult attachment styles using Hazan and Shaver's (1987) attachment style measure with a large nationally representative sample of American adults are 59% secure, 25% avoidant and 11% anxious (Mickleson et al., 1997). A review including a number of adult attachment measures reports the distribution of adult attachment styles in a non-clinical sample as 55% secure, 25% avoidant, and 20% anxious (Shaver & Clark, 1994). The distribution of adult attachment classifications for the Adult Attachment Interview (AAI) with non-clinical samples of men, women and adolescents was 58% secure (autonomous), 24% dismissing (avoidant), and 18% preoccupied (anxious). With a clinical at-risk population the distribution of

classifications was 8% secure, 26% dismissing, 25% preoccupied, and 40% unresolved (Bakermans-Kranenburg & van IJzendoorn, 1993).

### 1.5 The First Adult Attachment Measures

The first adult measure, the Adult Attachment Interview (AAI) was devised by George, Kaplan and Main (1984). Following the developmental tradition, the interview examines adults' views about their relationships with each caregiver in relation to experiences where it is assumed that the attachment system would be activated (e.g. separation, illness, injury, etc...). It also examines the meanings attributed to the caregivers' behaviour, in addition to the development of the adult's personality and their behaviour as a parent if applicable. Two scales thought to characterise the adult's childhood experiences are then utilised to code the interview: parental behaviour and state of mind. The coder would also rate the coherence of the account and the coherence of mind. Finally the patterns that are identified, are used to assign an individual to one of the three major classifications: secure (autonomous), insecure (dismissing or preoccupied), and the additional classification of insecure-unresolved, reflecting disorganisation or confusion which has often been found to be related to traumatic loss or abuse. At a later date a fifth category emerged: 'cannot classify'. These categories do not signify an adult's attachment in relation to another individual but instead are thought to represent the state of mind with regards to attachment (Hesse, 1999).

The limitation of this measure is that it relies on the coder's opinion and it does not assess secure-base behaviours in adults or the adult-adult attachment. It only measures attachment in relation to past childhood caregivers and does not examine current adult romantic relationships. Training for the AAI takes two weeks and during the period of 1989 to 1997 the only qualified trainers were Mary Main and Erik Hesse, consequently limiting access to the use of this measure. Although it is a well validated measure it is expensive and difficult to learn to score. The AAI has particularly been used to predict and examine caregiving (van IJzendoorn, 1995). As this measure lacks any investigation into current interpersonal strategies it is less

suitable to studying attachment patterns in individuals with social anxiety, particularly as it will not yield information about current attachment relationships or specific strategies that prevent individuals from pursuing relationships.

Hazan and Shaver (1987) were the first researchers to directly address the issue of romantic (adult) attachment and devise a tool that measures attachment patterns in romantic relationships. They hypothesised that the secure-base and safe-haven strategies observed in romantic relationships are similar to those found in infant-caregiver relationships. Following a social psychology tradition they devised a questionnaire which provides three descriptions of how adults think, feel and behave in romantic relationships based on Ainsworth et al's, (1978) classifications: secure, insecure-ambivalent, and insecure-avoidant. Respondents are asked to consider their own history of romantic relationships and select the description that best represents their experience, which corresponds to an attachment type.

The measure has been criticised for its forced-choice method which disregards any variation between categories. It also lacks any means of identifying the extent to which a specific category actually reflects an individual's attachment strategies (e.g. severity). The measure uses a single-item response to make classifications and therefore relies on very narrow parameters for inclusion. It has been proposed that Hazan and Shaver's (1987) questionnaire omits two important aspects of attachment: beliefs about the responsiveness and availability of others and reactions to separation (Collins & Read, 1990). In addition the measure has been found to have weak test-retest reliability (Baldwin & Fehr, 1995).

### 1.6 The Development of New Attachment Measures

New self-report measures were developed to address these limitations (Brennan, Clark & Shaver, 1998) and have been utilised by many researchers due to the ease with which they can be employed (Collins, 1996; Collins & Read, 1990; Hexel, 2003; Luke et al., 2004; Van Buren & Cooley, 2002). Self-report measures are often

considered advantageous research tools as they do not require extensive training, take less time to administer, and tend to have high face validity. As new adult attachment, self-report measures developed, factor analytic research identified two major underlying dimensions: anxiety and avoidance (Brennan et al., 1998). These dimensions were identified within all the available self-report measures at that time and were demonstrated to correspond to Ainsworth et al.'s (1978) infant classifications (Brennan et al., 1998). Bartholomew (1990) interpreted these two dimensions in terms of Bowlby's conception of internal working models of self and others (attachment figures), thereby producing four prototypical attachment patterns (see McCarty 2004, pp 60-61). Although measures of adult attachment have continued developing there is still debate as to the best way to conceptualise attachment: types (styles) or dimensions.

A dimensional approach implies that individuals can be quantitatively ordered and that there is no qualitative difference on the dimensions which would represent a different category. It also implies that each dimension is independent and there is no interaction between the various dimensions. There are a number of advantages associated with using a dimensional approach. For instance information is retained that could be lost through dividing people into groups. In addition multi-item dimensional scales are often highly reliable and using a two-dimensional model of attachment provides simplicity as attachment patterns are summarised by two scores (Griffin & Bartholomew, 1994). In contrast there are a number of disadvantages associated with using a dimensional approach. Properties or characteristics which could occur due to the combination of dimensions would be lost. In addition person-centred characteristics which distinguish individuals as 'types' will be overlooked as the focus is on how variables relate across individuals not characteristics. It has also been suggested that expert judges are actually able to rate individuals more accurately on ideal types than on dimensions (Bem, 1983).

The categorical approach to measuring attachment is the first approach that was utilised in attachment research, and developed out of Ainsworth et al.'s (1978) strange situation categories and later Hazan and Shaver's (1987) adult equivalents.

This approach involves assigning individuals to the most appropriate category. It is underpinned by the theoretical assumption that individuals represent discrete types and therefore those within a type will be relatively homogenous with respect to that factor. The advantages to this approach is that it fosters ease of communication between researchers (e.g. a limited number of types) and the statistical analyses required involves simply comparing group means. Ultimately, each 'type' theoretically has the potential to encompass the 'true' nature of the phenomenon (Griffin & Bartholomew, 1994). The disadvantage to this approach is the potential to lose information regarding within group differences, as the focus is only on between group differences. In addition there is also a risk that while assigning individuals to groups or categories, a process of stereotyping individuals develops. It is thought that this tends to lead to the minimising of any individual differences within the group and exaggerating the similarities (Griffin & Bartholomew, 1994). This form of identifying individuals as types can also effect the sorts of services or treatments that are provided.

Fraley and Waller (1998) have hypothesised that attachment is not represented accurately by typology and precision of the measure is forfeited when a continuous measure is not applied. If attachment is conceptualised as a dimensional phenomenon then categorical measures will not adequately assess this and self-report measures of adult attachment have been shown to best represent a dimensional model, therefore requiring continuous measures as opposed to typology (Fraley & Waller, 1998). In addition the authors argue that typological approaches foster a belief that adult attachment develops solely from experience of early caregivers and therefore represents a single etiological pathway, though to date researchers are uncertain of the exact pathway and the possibility of the contribution of multiple factors remains. While this position may be the view of some supporters of the typology model the literature suggests this is not unanimously the case, as Bowlby (1970) himself sights the impact of changes in physical, social, and cognitive development in addition to loss and trauma as having an impact on attachment strategies.

In response to this debate Griffin and Bartholomew (1994) proposed that attachment could best be measured using a prototypical approach, suggesting that this approach allows for within group differences and still provides a method to define complex person-centred patterns that define a particular type. A prototypical approach provides an example of an ideal member of a category, while explicitly acknowledging membership to individual types, which vary within the category. Bartholomew's (1990) four-category model (mentioned earlier) uses a prototype approach.

Another continuing debate in measuring adult attachment is whether self-report or interview is the best methodology. Both methodologies are uncorrelated with verbal intelligence (Crowell et al., 1996; Treboux, 1997) and social desirability (Crowell et al., 1996; Fraley, Davis & Shaver, 1998). It has been argued that interview methods are better able to access unconscious processes while self-reports are limited to an individual's conscious reports. This may be particularly important as people's conscious reports do not always accurately reflect their attachments; they may lack insight or their responses could be restricted by defences. Interviews are thought to be more powerful and revealing than self-report measures, as they are not subject to the same sorts of response bias. A questionnaire format would not allow the opportunity to probe defences or gain insight into the motives of particular behaviours, potentially making it less likely to detect 'earned security'<sup>1</sup>. In addition questionnaires may have greater face validity and therefore are more vulnerable to the effects of self-presentation. In contrast it can also be argued that adults have adequate emotional and relational experience to reflect upon this and accurately report on it. It can equally be argued that revealing information to an interviewer about personal experiences may activate self-presentation to the same degree as self-report measures, though in an interview situation the interviewer can be sensitive to this and take steps to address this (e.g. building rapport, probing for further information in a non-threatening manner, asking for examples, etc).

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<sup>1</sup> The ability to understand and make sense of earlier unfavourable attachment experiences which would generally be related to insecure attachment (e.g. experiences of neglect or abuse).

## 1.7 The Attachment Style Interview

The Attachment Style Interview (ASI; Bifulco, Lillie, Ball & Moran, 1998) is an adult attachment interview which measures an individual's ability to access and utilise social support and evolves from the social psychology tradition. The measure facilitates the interviewer/coder to categorise an attachment style in addition to assessing specific support contexts and the quality of close relationships. The attachment profile identifies the style of attachment which best represents the individual's attachment pattern (secure, enmeshed, fearful, angry-dismissive, or withdrawn), as well as the extent to which the insecure styles are dysfunctional (e.g. mildly, moderately or markedly). This is particularly advantageous as mildly insecure patterns are associated with less risk of psychopathology (Bifulco, Moran, Ball & Bernazzani, 2002). The attachment styles identified by the measure include anxious styles (enmeshed and fearful) and avoidant styles (angry-dismissive and withdrawn), consistent with the major underlying dimensions identified by Ainsworth et al's (1978) infant classifications and Brennan et al's (1998) factor analytic research on self-report measures. (See Appendix I for a description of each attachment style) The subdivision of the avoidant styles, angry-dismissive and withdrawn is unique to the ASI and discriminates the two, in terms of levels of mistrust and anger. The measure is also able to identify within group differences as it examines the degree to which an attachment pattern is present.

To date the ASI has mainly been applied in research contexts, specifically as an assessment of vulnerability (Bifulco, Moran, Ball & Bernazzani, 2002; Bifulco, Moran, Ball & Lillie, 2002; Bifulco, et al, 2004). It has been used with different age groups, men and women, cross-culturally, with high risk groups and antenatal populations, demonstrating consistent results with regards to increased vulnerability of highly insecure styles to depression. More recently the measure is being adopted for use in examining how attachment style is related to post-placement support needs and the stability of placements in the area of adoption and fostering.

The ASI has high inter-rater reliability ranging from 1.00-.60 weighted Kappa, as well as cross-cultural reliability (Asten, Marks, Oates, 2004). Similar to the AAI it employs an investigator-based approach as opposed to self-report, and researchers are trained in the administration and coding of the interview. The ASI differs from the AAI in three relevant ways:

- The ASI examines attitudes and behaviours in current adult relationships, while the AAI concentrates on relationships in childhood.
- The ASI focuses on attachment in relation to mental health outcomes in comparison to the AAI which has concentrated more on parental issues.
- Scoring for the ASI is derived from reported instances of behaviour (e.g. confiding, emotional support, etc..) and global attitudes to closeness (e.g. mistrust, fear of rejection, etc..). The AAI uses discourse analysis to identify reporting style, coherence of the account, coherence of mind, etc...

This study employs the ASI to measure adult attachment. The rationale for using this measure is based on a number of considerations:

- To gain the benefits of an interview measure as discussed above.
- The tool measures adult attachment within current relationships which is relevant to this study as it focuses on vulnerabilities to social anxiety and its effect on current interpersonal interactions.
- The training for the interview and coding procedures is practical and accessible.
- The measure has been validated with different age ranges and with both community and at risk populations.
- The measure uses a categorical approach thought to be important for identifying those at risk of developing psychopathology (Bifulco, Mahon, Kwon, Moran & Jacobs, 2003) though these incorporate the two dimensions: anxiety and avoidance, and allow for variation within types.

## 1.8 Aims of Study

The following study was undertaken to examine the relationship between adult attachment and social anxiety incorporating an interview measure of attachment (e.g. the ASI). There are very few studies which have addressed this to date and of these, none have assessed attachment using interview methodology but have relied on self-report questionnaires. This seems particularly important as there is continuing debate as to the method which is best suited to assessing attachment. In addition these studies were unable to identify a particular attachment style which was associated with social anxiety. Mickleson et al (1997) identified both avoidant and anxious attachment styles associated with social anxiety and Eng et al (2001) found anxious-preoccupied and secure attachment styles were related to social anxiety. The anxious preoccupied pattern is thought to reflect a negative model of self and a positive model of others (Luke et al., 2004; Park et al., 2004). It is predicted that the socially anxious sample used in this study will have predominately insecure (non-standard) attachment styles, specifically fearful attachment. The fearful attachment style is predicted and not the preoccupied style because it incorporates anxious strategies and reflects a negative model of self and a negative model of others (see McCarty, 2004 for a fuller review). It is thought that the presence of negative models for both the self and others is particularly relevant to individuals with social anxiety as they tend to have a distorted perception of themselves in social situations and also a distorted perception of others (Clark & Wells, 1995).

When attachment styles are considered along the two dimensions of avoidant and anxious styles, this socially anxious group are predicted to have predominately anxious patterns. Bowlby (1973) proposed that anxiety disorders could be explained by the anxiety produced in response to the availability of attachment figures, therefore in the case of individuals with social anxiety it is likely that they will have developed anxious strategies particularly in terms of interpersonal relationships.

It is hypothesised that individuals with an insecure attachment style will be more socially anxious, as insecure attachment styles have been found to be related to social anxiety (Mickleson et al., 1997; Eng et al., 2001) and fearful insecure attachment reflects a negative model of self and a negative model of others (Luke et al., 2004; Park et al., 2004), consistent with Clark & Wells' (1995) model of social anxiety which includes a distorted perception of one's self and others.

Finally it is hypothesised that social anxiety will be related to low self-esteem and external locus of control, and individuals with an insecure attachment style will report lower self-esteem and external locus of control as found in previous studies (Chorpita & Barlow, 1998; Cloitre et al., 1992; Collins & Read, 1990; de Jong, 2002; Griffin & Bartholomew, 1994; Hexel, 2003; Kocovski & Endler, 2000; Luke et al., 2004; Mickleson et al., 1997; Park et al., 2004; Rapee, 1997). These factors are important as they may represent potential areas where interventions for social anxiety could focus, in addition to those specific to fearful attachment.

In summary the study hypotheses are:

1. The socially anxious study group will be comprised of individuals with a predominantly insecure attachment style.
2. The attachment style that best represents this socially anxious group is fearful.
3. When attachment patterns are considered along the two dimensions of avoidant and anxious styles, this socially anxious group will demonstrate a predominately anxious style.
4. (i) Individuals with an insecure attachment style will be more socially anxious than those with a secure attachment style, (ii) those with a fearful style will be more socially anxious than those with a non-fearful style, and (iii) those with an anxious attachment classification will be more socially anxious than those with an avoidant or secure classification.

5. (i) Social anxiety will be related to low self-esteem and external locus of control, and (ii) individuals with an insecure attachment style will report lower self-esteem and external locus of control.

## **2 Method**

### 2.0 Design

This study employed a non-experimental, case controlled observational research design, utilising a sample group with a restricted range on social anxiety, incorporating an elevated threshold. The study is conducted using self-report questionnaires and a semi-structured interview to examine the hypothesis that insecure attachment styles, particularly fearful, is associated with social anxiety. In addition the study examines the relationships between external locus of control and low self-esteem, and social anxiety and insecure attachment styles.

### 2.1 Recruitment Procedures

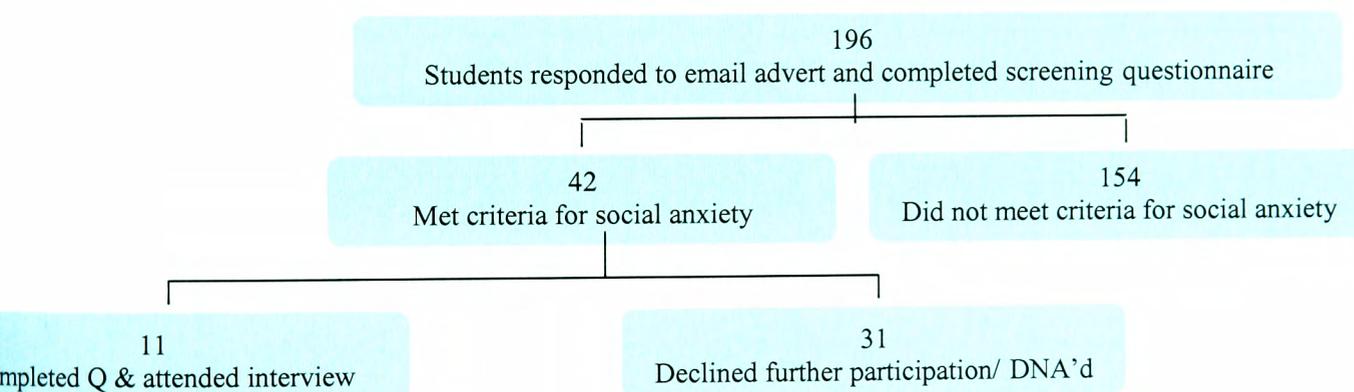
Recruitment for the study was conducted in three ways:

1. Through an email invitation which provided information about the study and a link to a website where potential participants were asked to complete the screening questionnaire. (See Appendix II for study information sheet)
2. Through attending a presentation about the study given by the researcher at the social anxiety support group meeting and receiving a study information sheet. For members that had not attended that weeks meeting, the group organiser gave out study information sheets to interested members. Members were then asked to contact the researcher via email or mobile telephone, if they were interested in participating or required more information. (See Appendix III for study information sheet)
3. Through a description of the study posted on the social anxiety support group website inviting interested parties to email the researcher.

## 2.2 Participants

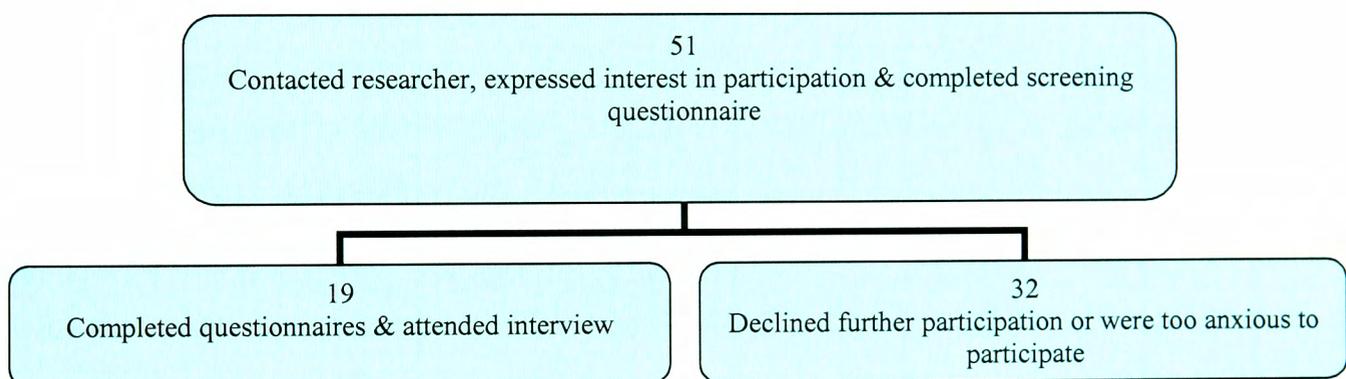
The sample for this study was obtained from two sources, though the inclusion criteria for each included elevated levels of symptoms of social anxiety, aged eighteen or over, the ability to read and speak English fluently and depression scores below moderate levels of depression. The first was a purposive sample of university students who responded to an email advertisement requesting participants for the study and directing them to a website (<http://www.psy.herts.ac.uk/anxiety/>). The website included further information about the study and a screening questionnaire for those interested in participating to complete. Participants from this source were only contacted for interview if they fulfilled the DSM-IV criteria for social anxiety. One hundred and ninety six students completed the screening questionnaire. Forty-two of these respondents reported elevated levels of symptoms of social anxiety and of these eleven attended an interview.

Participant flow chart for university sample



The rest of the sample was a purposive sample, obtained via contact with social anxiety support groups in London and England, both in person and through the use of the internet. Approximately 35 people attend the London based anxiety support group, though the number fluctuates and weekly attendance tends to include approximately fifteen to twenty members. The support group website reported 101,429 hits during the period that the study was advertised, though this number is constantly changing. Individual's who responded to requests to be part of the study and reported an elevated level of symptoms via the screening questionnaire, were invited to be interviewed either in person or via the telephone. Fifty-one people expressed an interest in the study and a willingness to participate. Fifteen of these people actually completed questionnaires and took part in the interview.

Participant flow chart for anxiety support group sample



### 2.3 Measures

In total thirty individuals completed questionnaires and took part in the attachment interview. The age of participants ranged from 18 to 62, with a mean age of 30.3 (10.8). Sixty percent of the sample were female (n=18) and forty percent male (n=12). The marital status of participants was 70% (n=21) single/never married, while 23% (n=7) were married or cohabiting and 7% (n= 2) were separated. The

majority of the sample (63%) were working in some capacity, e.g. full-time, part-time, or self-employed, while 17% were unemployed and 20% were students (students who were also working were not included in this percentage). The educational attainment for the whole sample was GCSE level or above, with 17% reporting a higher education degree qualification. Sixty-three percent of the participants were either currently receiving treatment for a mental health problem or had done so in the past.

## 2.3 Measures

### **Screening Questionnaire**

The screening questionnaire required in this study needed to be placed on the inter/intranet and therefore prompted concerns regarding copyright violations. To address this issue a screening questionnaire was developed by the researcher. It contains sixteen items based on the Diagnostic and Statistical Manual of mental disorders' (DSM-IV; American Psychiatric Association, 1994) criteria for diagnosing social anxiety, specifically including criterion set out in the manual. Respondents were asked to rate the degree to which they agreed or disagreed with each statement using a five point Likert scale. Scores ranged from 16 to 80, where a higher score indicated the respondent reported fewer symptoms of anxiety. Inclusion for the study required respondents to indicate the presence of all the core symptoms required to diagnosis social anxiety according to the DSM-IV. With this in mind the cut-off was set at 40. (See Appendix IV for screening questionnaire)

### **Study Questionnaires**

The State Trait Anxiety Inventory (STAI; Spielberger, Gorsuch & Lushene, Vagg & Jacobs, 1983) measure was employed to examine both the state anxiety which could be transitory and evoked by the individual's mood during the testing or due to the testing experience itself and also a more enduring dispositional anxiety referred to as trait anxiety. Spielberger et al., (1983) proposed that individuals found to be high on trait anxiety would be more likely to respond with high state anxiety in situations involving interpersonal relationships and perceived threat to self-esteem. The self-

report measure consists of the S-Anxiety scale evaluating how respondents feel 'right now' and the T-Anxiety scale assessing how respondents 'generally feel'. Both scales contain twenty items examining subjective experience and anxiety proneness as a personality trait. The measure has been used extensively in research with adults, older adults, adolescents and also cross-culturally (Kirisci, Clark & Moss, 1996; Metzger, 1977; Novy, Nelson, Goodwin & Rowzee, 1994; Rodrigo & Lusiardo, 1988; Stanley, Beck & Zebb, 1996).

There is a distinction between subjective anxiety and behaviour, therefore feeling anxious may not amount to behaving in an observably anxious manner. For this reason it was important to include measures of social anxiety which assess both behaviours and affective experiences to insure that participants are socially anxious to the extent that it would meet criteria for diagnosis and have a dysfunctional impact on the individual's life. Two separate self-report measures were used in the study to insure the presence of social anxiety as the sample was not recruited through a clinical service.

The Fear of Negative Evaluation (FNE; Watson & Friend, 1969) Scale was one measure employed in this study to assess social anxiety. It is a thirty item scale which focuses on subjective feelings of social anxiety and has been widely used with clinical samples and nationally representative samples. Specifically it assesses the degree to which individuals worry about how they are evaluated and perceived by others, considered to be cognitive aspects of social anxiety. It has been found to be highly correlated with both patients' and clinicians' ratings of social anxiety disorder (Heimberg et al, 1999) and has been found to discriminate individuals with social anxiety disorder from nonpatient controls and those with other anxiety disorders (Stopa & Clark, 1993). The measure has high internal consistency (KR-20= .92 and .94 for the original and subsequent sample of 205 and 128 university students) and test-retest reliability over the interval of one month is .78. In addition it has been shown to have high construct and criterion validity. The mean of the original sample was 15.5 (SD= 8.6).

The second measure of social anxiety employed in this study was the Social Avoidance and Distress Scale (SAD; Watson & Friend, 1969). The SAD examines both affective and behavioural components of social anxiety, specifically the tendency to avoid social interactions and to feel anxious while in social situations. The measure has been used in over 100 outcome studies examining the effectiveness of different talking interventions for social anxiety (Leary, 1983). The measure is comprised of twenty-eight items, fourteen of which assess social avoidance and fourteen assess social anxiety. The measure has high internal consistency (KR-20 = .94) and test-retest reliability over a month interval was found to be .68. The mean for university students is 9.1 (SD= 8.0) (Watson & Friend, 1969).

The Rosenberg Self-esteem scale (SES; Rosenberg, 1965) was employed in this study to assess self-esteem. It is a ten item self-report measure containing five positively and five negatively worded statements reflecting evaluations of one's self, which respondents are asked to rate on a four point Likert scale (strongly agree to strongly disagree). The SES has high internal consistency (.90) and high test-retest reliability (.85) over a two week interval, as well as robust convergent and discriminant validity (Blascovich & Tomaka, 1991). The measure has been used extensively with both clinical and non-clinical populations, with adolescents, adults, and older adults. The maximum possible score is thirty and the minimum is zero, where a higher score reflects high self-esteem.

Rotter's Locus of Control Scale (RLOC; Rotter, 1966) was utilised in this study to assess whether respondents reported internal or external locus of control. The measure is comprised of twenty-nine pairs of statements, one reflecting internal control, the other external. Specifically the measure examines the extent to which an individual perceives that events are contingent on their own behaviour or characteristics. Respondents are asked to choose the statement that best describes how they feel. Scores range from zero to twenty-three. Low scores of ten or less indicate internal control and high scores of thirteen or more represents external locus of control. The questionnaire reports high reliability and validity, and dominates the literature on locus of control (Parker, 2003).

Beck's Depression Inventory-II (BDI-II; Beck, Steer & Brown, 1996) was used to measure any current depression of respondents due to the high rate of co-morbidity between social anxiety and depression (Roth & Fonagy, 1996). The BDI-II is a widely used twenty-one item self-report measure, which assess cognitive, affective, behavioural and somatic symptoms of depression. Items are scored on a four point scale and high scores indicate the presence of more symptoms of depression. Authors report high reliability (an alpha of .93 for 120 college students) and test-retest reliability for a one-week interval of .93 with a sample of 26 outpatients (Beck et al, 1996).

The Attachment Style Interview (ASI; Bifulco et al., 1998) was administered to participants to obtain their attachment style. Training for the ASI takes four days, with the fourth day focusing on the reliability of individual's coding skills. The attachment interview takes approximately one hour to administer though the length of the interview can vary depending on the respondent's reporting style. The ASI includes both an assessment of support obtained through specific examination of domains in relationships with partners and 'very close others'. In addition the interview assesses attachment attitudes which reflect anxiety and avoidance (e.g. fear of rejection, constraints on closeness, etc.). Overall attachment is then determined based on the ability to make intimate relationships and the pervasiveness of anxious or avoidant attitudes. Inter-rater reliability for the attachment ratings in this study was conducted on twenty randomly selected interviews (ten from the face to face interviews and ten from the telephone interviews). The second rater was a researcher involved in the training for the ASI and the inter-rater reliability for this study was .71 Kappa, for the overall attachment style rating. A lengthier discussion of the measure including reliability and validity can be found in the introduction and therefore will not be repeated here.

## 2.4 Procedures

Each potential participant was asked to complete the screening questionnaire via the website or email, if they were interested in participating. Those participants who reported an elevated level of symptoms for social anxiety were then contacted either by phone or email and invited to take part in the study. Respondents who wished to participate were contacted to arrange a time convenient to them, to meet with the researcher in order to complete the self-report questionnaires and to be interviewed.

Half of the sample (n=15) was interviewed face to face. This included all the participants who were recruited via the university email invitation (n=11) and some from the social anxiety support group (n=4). The rest of the sample was interviewed over the telephone. This second procedure was adopted due to the difficulty participants with social anxiety expressed in meeting with a stranger face to face. For this group of participants, the self-report questionnaires were posted to them with a self-addressed envelope. Once they were completed and returned to the researcher an appointment was arranged at their convenience for the researcher to phone them and conduct the interview.

Each interview was recorded to assist coding. Coding consists of listening to the interview and transcribing responses that relate directly to each aspect of attachment strategies in relationships and attitudes. A fifty page rating schedule is completed for each participant and is then used to determine and justify the overall attachment style.

## 2.5 Ethical Issue

Ethical approval was granted by the Ethics Committee of the Psychology Department under delegated authority from the Ethics Committee of the University of Hertfordshire. Ethical approval was not sought through the NHS Central Office for Research Ethics Committees as the study was not conducted within NHS

premises nor were the participants recruited through NHS services. The usual ethical issues of providing information about the study, obtaining informed consent and debriefing participants after the interview were exercised in this study. Consent was informally obtained when individuals contacted the researcher expressing an interest in participating in the study and a study information sheet was provided. Formal written consent was obtained prior to individuals completing study questionnaires or being interviewed (See Appendix V for consent form). In addition participants were reminded of their right to terminate participation at anytime without providing an explanation. Debriefing of the study included a verbal discussion about the aims of the study and an opportunity to ask questions following the interview. Participants were also offered the option of emailing the researcher following the interview, if they had later questions with regards to material in the attachment interview or questionnaires.

To insure anonymity respondents' date of birth was not collected. Questionnaires and interview tapes were assigned a corresponding number to insure that a participant could not be identified by name. The necessity for taping interviews was explained to participants and participants were made aware when recording commenced. In addition if participants became upset during the interview the tape was stopped, they were given time to compose themselves, and asked if they would like to proceed. This practice was only necessary for one participant.

As the study sample is comprised of individuals who report a high degree of social anxiety symptoms, the prospect of meeting a stranger in person was too distressing for some participants. For those who expressed a desire to take part in the study but felt unable to attend an interview, telephone interviews were offered. For some of these individuals it was necessary to protect confidentiality by sending the questionnaires in envelopes marked 'private and confidential' to prevent family or housemates from opening their mail. It was also necessary to arrange a specific time to phone participants when they felt their privacy would not be compromised, and in some instances this meant ringing participants' mobile phones.

The participants in this study were not recruited through NHS services or clinics, and therefore the researcher was not in a position to assume clinical responsibility or have a supervisor working in the service who would take on this responsibility, as is usually the case. As stated earlier 63.3% of the participants were currently receiving mental health treatment or had done so in the past, though in order to address any emerging clinical issues an information pack was prepared for participants. This included information about social anxiety, references for further information and reading, and support and self-help group contact details. If participants were interested in seeking treatment, information about how to contact NHS direct were provided as well as suggestions for making an appointment to see their GP to discuss their needs. To request details of a registered Clinical Psychologist or Cognitive Behavioural Therapist for private treatment, information was provided for the British Psychological Society and the British Association for Behavioural and Cognitive Psychotherapies. Finally participants were advised that if they were in need of immediate help or if they were feeling unsafe and worried they might harm themselves, to attend their nearest hospital's Accident and Emergency Department. Fortunately none of the participants in this study expressed suicidal ideation or needed to be referred to Accident and Emergency.

## 3 Results

### 3.0 Descriptives

Of the 30 participants in this study, 15 were interviewed face-to-face and 15 were interviewed over the telephone. No significant differences were found between the two halves of the sample for gender, age, marital status, educational attainment, employment, past mental health problems and type of treatment, and the number of stressors in the past year (see Appendix VI). When ethnicity was dichotomised (British & non-British) there was a significant difference between the two groups, with the face-to-face interview group containing more non-British participants (see Appendix VI). In addition there were no significant differences found between those interviewed face to face and those interviewed over the telephone for the social anxiety measures, self-esteem, locus of control, depression, and attachment patterns (see Appendix VI for statistical comparisons).

The sample group was screened for a high threshold of symptoms for social anxiety, which was confirmed by the elevated means on the two social anxiety measures, Fear of Negative Evaluation Scale (FNES; Watson & Friend, 1969) and Social Avoidance and Distress Scale (SADS; Watson & Friend, 1969) (see Table 1). In addition the State Trait Anxiety Inventory (STAI; Spielberger, Gorsuch & Lushene, Vagg & Jacobs, 1983) was administered as it is thought that high trait anxiety predicts high state anxiety in situations involving interpersonal relationships and perceived threat to self-esteem, which would be salient to individuals with social anxiety (Spielberger, 1983).

There are no available clinical cut-off points for the anxiety measures used in this study, although other studies have reported means for non-socially anxious and low socially anxious groups (see Table 1). Data from two other studies were used for comparative purposes in this study. The first data set was taken from Turner, Beidel, Dancu and Stanley (1989). This study screened students from introductory psychology classes for social anxiety, and included 52 non-socially anxious college

students and 34 socially anxious students. The second data set was taken from a study conducted by Mansell, Clark and Ehlers (2003). The study included 64 university students who scored in the top 25% and bottom 25% on a social anxiety screening measure, comprising the study sample of 32 participants with low social anxiety and 32 participants with high social anxiety. These were considered appropriate comparison groups for this study as they were not clinical sample groups and participants were recruited from a university population, as were some of the participants in this study. Table 1 illustrates the means and standard deviations for the study group and the comparative data taken from two published studies (Mansell et al., 2003; Turner et al., 1989).

The study also looked at self-esteem and locus of control as potentially important factors in social anxiety and insecure attachment. The Rosenberg Self-esteem Scale (SES; Rosenberg, 1965) and Rotter's Locus of Control Scale (RLOC; Rotter, 1966) were administered to examine this.

The range of scores on the measure examining self-esteem (SES) is 0 to 30 where a low score represents low self-esteem. The group mean for self-esteem in this study was 11.7 and the standard deviation was 5.4, with a median score of 10. This demonstrates a low group mean, suggesting the sample group have low self-esteem.

Scores range from 0 to 23 on the locus of control scale, with low scores of ten or less indicating internal control and high scores of thirteen or more representing external locus of control. The group mean for locus of control was 13.53 and the standard deviation was 4.4, with a median score of 13. Fifty-four percent of the study sample reported external locus of control and 23% reported internal locus of control. The remaining 23% reported scores in the middle range which represents a balance between internal and external locus of control.

The Beck's Depression Inventory-II (BDI-II; Beck, Steer & Brown, 1996) was also administered to participants in order to control for high levels of symptoms of depression, to insure the study group was comprised of solely socially anxious

individuals as much as possible. The mean level of depression in the sample group was 16.43 (9.73) falling within the mild range of depression on the BDI-II.

The questionnaire data was examined for any distributional anomalies (See Appendix VII for box plots depicting the distribution of the scores in the study group). One outlier was identified on the Rosenberg self-esteem scale and two were identified on the Fear of Negative Evaluation scale, though all other distributions were normal. As the sample size was relatively small, non-parametric statistics were performed.

Table 1. Means and standard deviations (SD) for anxiety measures in the current study and comparative data.

Questionnaire	Study Group Mean (SD)	Comparative data			
		Non/low SA group Mean (SD)	SA group Mean (SD)	Non/low SA group Mean(SD)	SA group Mean (SD)
		Turner, et al study (1989)		Mansell, et al study (2003)	
	n=30	n=52	n=34	n=32	n=32
Fear of Negative Evaluation Scale	26.7(4.5)	7.0(3.8)	22.4(5.0)	4.9(3.2)	24.8(4.7)
Social Anxiety and Distress Scale	21.8(5.9)	3.2(2.4)	14.1(6.6)	3.5(5.5)	12.5(7.1)
State Trait Anxiety Inventory- Trait	57.9(9.8)	32.0(5.7)	45.5(9.8)	33.4(7.6)	48.9(9.0)

### 3.1 Group comparisons for anxiety

T-tests were hand calculated to statistically examine the differences between the means for the anxiety measures in this study compared to those reported in the other two studies. Table 2 shows the t-values, 95% confidence intervals, and the effect sizes (Cohen's d).

Table 2. T-tests comparing the study sample with comparative data on measures of anxiety.

Measure	Turner et al (1989) study			Mansell et al (2003) study		
	Non SA group (n=52)			Low SA group (n=32)		
	t	95% CI	effect size	t	95% CI	effect size
Fear of Negative Evaluation Scale	22.1	17.9 to 21.4	d = 4.8	23.4	19.9 to 23.6	d = 5.6
Social Anxiety and Distress Scale	20.9	16.8 to 20.3	d = 4.6	13.2	15.5 to 21.0	d = 3.2
State Trait Anxiety Inventory- Trait	15.8	22.6 to 29.1	d = 3.5	11.6	20.3 to 28.6	d = 2.8
	SA group (n=34)			SA group (n=32)		
Fear of Negative Evaluation Scale	3.7	1.9 to 6.5	d = 0.9	1.7	-0.33 to 4.1	ns
Social Anxiety and Distress Scale	5.1	4.6 to 10.7	d = 1.2	5.9	6.1 to 12.4	d = 1.1

State Trait Anxiety Inventory- Trait      5.6    7.7 to 17.1     $d = 1.3$       3.9    4.5 to 13.5       $d = .9$

The means for the anxiety measures in this study are significantly more elevated than those found in the non/low socially anxious (SA) comparison groups of the other two studies with a large effect size. In addition the sample used in this study scored significantly higher on most of the anxiety measures than the SA groups in the other two studies, confirming that participants were adequately screened and do represent a sample with a high threshold of symptoms, of social anxiety.

### 3.2 Attachment patterns

The Attachment Style Interview (ASI; Bifulco et al., 1998) was used to identify the attachment style which best represents participants' attachment pattern (secure, enmeshed, fearful, angry-dismissive, or withdrawn). For reasons outlined earlier it was hypothesised that this socially anxious sample would be predominately insecure. In order to determine if the distribution of attachment patterns in the socially anxious sample group was significantly different to that found in a normal population the attachment patterns identified in this study were compared to those in another published study. Information concerning the comparison group was collected from three separate papers, which all utilise this comparison group (Bifulco, Moran, Ball & Bernazzani, 2002; Bifulco, Moran, Ball & Lillie, 2002; Bifulco et al, 2004). The sample represents a community comparison group of 80 women aged 20 to 45, who were registered with GPs in North London and were questionnaire respondents as part of another study. This group was used for this study because attachment was measured using the ASI as opposed to another attachment measure, and because respondents were screened for social anxiety and depression.

Initially, the attachment patterns in the study group were dichotomised into standard (clearly secure or mild) or non-standard (marked or moderate insecure) ratings, in

order to determine the total prevalence of insecure attachment in the sample and to address the first study hypothesis: 1. *The socially anxious study group will be comprised of individuals with a predominantly insecure attachment style.*

Seventy percent (n=21) of the study sample were rated as non-standard or insecure while only 30% (n=9) were rated standard or secure. The dichotomised patterns of standard (secure) and non-standard (insecure) attachment were then compared to those in the community comparison group. Table 3 depicts the percentage of observed secure and insecure attachment patterns in the study group and the percentage of expected secure and insecure attachment patterns in the community comparison group.

Table 3. Percentages of the observed and expected secure and insecure attachment patterns in the study group and the community comparison group.

	<b>Non-standard insecure</b>	<b>Standard secure</b>
	% (n)	% (n)
Observed percentage (n=30)	70% (21)	30% (9)
Bifulco et al (2004) (n=80)	19% (15)	81% (65)

For the standard secure and non-standard insecure attachment ratings there was a 51% difference between the observed percentage of the study group and the expected percentage of the community comparison group. A Chi-square test was conducted using the distribution of attachment styles from the community comparison group as the expected values. This revealed significant differences between the secure and

insecure classification for the socially anxious group and the community comparison group:  $\chi^2 = 26.15$ ,  $df = 1$ ,  $p \leq 0.001$  with an effect size of  $\phi = .49$ , indicating that the socially anxious group contained significantly more insecurely attached participants.

Next the attachment style was examined using the full five-style classification to address the second study hypothesis: 2. *The attachment style that best represents this socially anxious group is fearful.* Individuals with an enmeshed attachment style were not present in the study sample. Sixty-four percent ( $n=19$ ) of the sample were identified as having a fearful attachment style, 3% ( $n=1$ ) were angry-dismissive, 3% ( $n=1$ ) were withdrawn, and 30% of the sample were rated secure ( $n=9$ ). As hypothesised, this suggests that this socially anxious sample have a predominately fearful attachment style. Table 4 illustrates the percentages of observed five-style attachment classification in the study group and the equivalent control figures.

Table 4. Percentages of the observed and expected five-style attachment classification in the study group and the community comparison group.

	<b>Enmeshed</b> % (n)	<b>Fearful</b> % (n)	<b>Angry-dismissive</b> % (n)	<b>Withdrawn</b> % (n)	<b>Secure</b> % (n)
Observed frequency (n = 30)	0%(0)	64% (19)	3% (1)	3% (1)	30% (9)
Bifulco et al (2004) (n=80)	9% (7)	6% (5)	24% (19)	13% (10)	48% (39)
Percentage difference	-9%	58%	-21%	-10%	-18%

For the fearful attachment rating there was a 58% difference between the observed percentage of the socially anxious group and the expected percentage of the community comparison group. A Chi-square test could not be conducted on the five separate attachment styles as the assumptions of the test were violated, due to the absence of any individuals in the enmeshed classification, and only one individual in both the angry-dismissive and withdrawn categories for the study group. To address this the cells were collapsed into fearful or non-fearful attachment (see Table 5). Individuals who were rated markedly or moderately fearful were included in the fearful group, though individuals who were rated as mildly fearful, which would not be considered non-standard (insecure) were included in the non-fearful group.

Table 5. Percentages of the observed and expected fearful and non-fearful attachment classification in the study group and the community comparison group.

	<b>Fearful</b>	<b>Non-fearful</b>
	% (n)	% (n)
Observed percentage (n=30)	64% (19)	36% (11)
Bifulco et al (2004) (n=80)	6% (5)	94% (75)

For the fearful and non-fearful attachment ratings there was a 58% difference between the observed percentage of the study group and the expected percentage of the community comparison group. A Chi-square test revealed significant differences between the fearful and non-fearful classification for the socially anxious group and the community comparison group:  $\chi^2 = 41.7$ ,  $df = 1$ ,  $p \leq 0.0001$  with an effect size of  $\phi = .62$ , indicating that the study group contained significantly more fearful participants than the community comparison group.

Consistent with other attachment measures, attachment patterns were then grouped into the two major underlying dimensions (anxious and avoidant) to yield three classifications (anxious, avoidant and secure) and to address the third study hypothesis: 3. *When attachment patterns are considered along the two dimensions of avoidant and anxious styles, this socially anxious group will demonstrate a predominately anxious style.*

Table 6 below illustrates the percentages of observed anxious, avoidant and secure attachment classification in the study group and the percentage of expected anxious, avoidant and secure attachment classification in the community comparison group.

Table 6. Percentages of the observed and expected anxious, avoidant and secure attachment classification in the study group and the community comparison group.

	<b>Anxious</b>	<b>Avoidant</b>	<b>Secure</b>
	% (n)	% (n)	% (n)
Observed frequency (n=30)	64% (19)*	6% (2)	30% (9)
Bifulco et al (2004) (n=80)	33% (26)*	19% (15)	48% (39)
Percentage difference	31%	-13%	-18%

\* adjusted residual: 2.9

For the anxious classification there was a 31% difference between the observed percentage in the socially anxious group and the expected percentage in the community comparison group. A Chi-square test was conducted using the distribution of attachment styles from the community comparison group as the expected values. This revealed significant differences between the anxious, avoidant, and secure classifications for the socially anxious group and the community comparison group:  $\chi^2 = 8.88$ ,  $df = 2$ ,  $p \leq 0.01$ , with an effect size of  $\phi = 0.27$ . The adjusted residual for the anxious classification is larger than two, indicating a significant difference between the anxious classifications of the study group and the community comparison group.

### 3.2 Attachment and anxiety comparisons

To address the fourth hypothesis, tests were carried out in order to determine if there was a difference between the means of the social anxiety measures for the secure and insecure attachment style. Hypothesis: 4. *(i) Individuals with an insecure attachment style will be more socially anxious than those with a secure attachment style, (ii) those with a fearful style will be more socially anxious than those with a non-fearful style, and (iii) those with an anxious attachment classification will be more socially anxious than those with an avoidant or secure classification.*

In order to examine this, first the dichotomised patterns of standard (secure) and non-standard (insecure) attachment were compared to the two social anxiety measures (Fear of Negative Evaluation Scale & Social Anxiety and Distress Scale) and trait anxiety. Due to the small n in each group, non-parametric tests (Mann-Whitney U) were performed. Table 7 depicts the means and standard deviations of the anxiety measures for the secure and insecure attachment, in addition to the Mann Whitney U value and the p value.

Table 7. Means, standard deviations (SD) and Mann Whitney U for the anxiety measures, with the secure and insecure attachment style.

Anxiety measure	Insecure	Secure	df	U	p
	(n=21)	(n=9)			
	Mean (SD)	Mean (SD)			
Fear of Negative Evaluation Scale	27 (4.1)	25.9 (5.5)	28	86.5	.71
Social Anxiety And Distress Scale	22.9 (5.2)	19 (7.1)	28	61.0	.13
State Trait Anxiety-Trait Inventory- Trait	58.8 (9.4)	55.8 (10.9)	28	84.0	.63

No significant differences were identified between the groups although anxiety levels were marginally higher for the insecure group on all three measures.

In order to examine the attachment classification in terms of fearful attachment style, attachment was dichotomised into fearful or non-fearful attachment style. Though due to the lack of variation in the questionnaire scores, those who were rated as mildly fearful were included in the fearful group. Non-parametric tests were then conducted in order to determine if there was a difference between the means of the social anxiety measures (Fear of Negative Evaluation Scale & Social Anxiety and Distress Scale) and trait anxiety, for fearful and non-fearful attachment. The relevant descriptive and inferential statistics are presented in Table 8.

Table 8. Means, standard deviations (SD) and Mann Whitney U of the anxiety measures, for fearful and non-fearful attachment styles.

Anxiety measure	Fearful <sup>2</sup>	Non-fearful	df	U	p
	(n=23)	(n=7)			
	Mean (SD)	Mean (SD)			
Fear of Negative Evaluation Scale	27.8 (3.6)	23 (5.4)	28	34.0	.02*
Social Anxiety And Distress Scale	23.6 (4.8)	15.9 (5.9)	28	26.0	.01**
State Trait Anxiety-Trait Inventory- Trait	59.8 (9.3)	51.6 (9.3)	28	39.0	.06

\*  $p \leq .05$  \*\* $p \leq .01$

The predicted significant differences were evident for the Fear of Negative Evaluation Scale with an effect size of 1.2 and the Social Anxiety and Distress Scale, with an effect size of 1.5, while a trend was found for trait anxiety.

Finally the three attachment classifications (anxious, avoidant and secure) were examined in relation to the two social anxiety measures (Fear of Negative Evaluation Scale & Social Anxiety and Distress Scale) and trait anxiety. Table 9 depicts the means and standard deviations of the anxiety measures for the anxious, avoidant and secure attachment classifications.

<sup>2</sup> The fearful classification in this table represents participants who were rated markedly, moderately fearful and also includes mildly fearful participants.

Table 9. Means and standard deviations (SD) for the anxiety measures, with the three attachment classifications.

Anxiety measure	<b>Anxious</b> (n=19)	<b>Avoidant</b> (n=2)	<b>Secure</b> (n=9)
	Mean (SD)	Mean (SD)	Mean (SD)
Fear of Negative Evaluation Scale	27.2 (4.2)	25.5 (3.5)	25.9 (5.5)
Social Anxiety And Distress Scale	24.2 (3.7)	11.5 (.71)	19.0 (7.1)
State Trait Anxiety-Trait Inventory- Trait	58.4 (9.7)	62.0 (7.1)	55.8 (10.9)

As there were only two participants who were rated as avoidant it was not possible to compare the three groups in order to identify any differences between the social anxiety measures (Fear of Negative Evaluation Scale & Social Anxiety and Distress Scale) and trait anxiety for the anxious, avoidant and secure attachment. Therefore the avoidant classification was omitted and a non-parametric t-test was conducted to compare the anxious and secure classifications. Significant differences were not found for the Fear of Negative Evaluation Scale, ( $U = 75, p > .05$ ) nor for trait anxiety ( $U = 78, p > .05$ ), with effect sizes of  $d = .28$  and  $d = .26$  respectively. Significant differences were identified for the Social Anxiety and Distress Scale ( $U = 45.5, p \leq .05$ ), with an effect size of  $d = 1.04$ .

### 3.3 Self-esteem and locus of control comparisons

The final analyses examined the self-esteem and locus of control variables in the study group. Correlations and non-parametric tests were carried out to address the sixth hypothesis: 5. (i) *Social anxiety will be related to low self-esteem and external locus of control, and (ii) individuals with an insecure attachment style will report lower self-esteem and external locus of control.*

To examine the relationship between social anxiety and self-esteem and locus of control, Spearman's correlations were conducted. The correlations can be found in Table 10.

Table 10. Correlations for anxiety measures and self-esteem and locus of control

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	Self-esteem	Locus of control
Fear of Negative Evaluation Scale	-0.56*	0.18
Social Anxiety And Distress Scale	-0.24	0.04
State Trait Anxiety-Trait	-0.70**	0.29

\*  $p \leq 0.001$  \*\*  $p \leq 0.0001$

A significant negative correlation was identified for self-esteem and the Fear of Negative Evaluation Scale, and also for trait anxiety and self-esteem, suggesting that low self-esteem is related to social anxiety and trait anxiety. A significant relationship was not identified for the Social Anxiety and Distress Scale and self-

esteem. Locus of control was not significantly related to social anxiety or trait anxiety in this study group.

It was also hypothesised that individuals with an insecure attachment style would report lower self-esteem and external locus of control. Non-parametric t-tests (Mann Whitney U) were conducted in order to determine if there was a difference between the means of the self-esteem measure (The Rosenberg Self-esteem Scale) and locus of control (Rotter’s Locus of Control Scale), for secure and insecure attachment.

In order to examine this, the dichotomised patterns of standard (secure) and non-standard (insecure) attachment were compared to self-esteem and locus of control. Table 11 illustrates the means and standard deviations of the self-esteem and locus of control measures for the secure and insecure attachment, in addition to the Mann Whitney U value and the p value.

Table 11. Means, standard deviations (SD) and Mann Whitney U for the self-esteem and locus of control measures, with the secure and insecure attachment styles.

Test Variable	<b>Insecure</b>	<b>Secure</b>	df	U	p
	(n=21)	(n=9)			
	Mean (SD)	Mean (SD)			
Self-esteem	11.5 (5.9)	12.2 (4.1)	28	80.5	.52
Locus of control	13.5 (4.8)	13.5 (3.6)	28	94	.98

Significant differences were not identified between the insecure/secure attachment style and the reported level of self-esteem or locus of control, with an effect size of  $d = -.13$ . In addition there were no significant differences between the secure and insecure groups for locus of control (including an effect size of zero), with the means indicating that both groups have reported external locus of control.

In order to examine the attachment classification in terms of fearful attachment style, the attachment was dichotomised into fearful attachment style or non-fearful attachment style. Non-parametric t-tests were then conducted in order to determine if there was a difference between the means of the self-esteem measure (The Rosenberg Self-esteem Scale) and locus of control (Rotter's Locus of Control Scale), for fearful and non-fearful attachment. Table 12 illustrates the means and standard deviations of the self-esteem and locus of control measures for the fearful and non-fearful attachment, in addition to the Mann Whitney U value and the p value.

Table 12. Means, standard deviations (SD) and Mann Whitney U for the self-esteem and locus of control measures, with the fearful and non-fearful attachment style.

Test Variable	<b>Fearful<sup>3</sup></b>	<b>Non-fearful</b>			
	(n=23)	(n=7)			
	Mean (SD)	Mean (Sd)	df	U	p
Self-esteem	10.9 (5.4)	14.3 (4.7)	28	51.5	.15
Locus of control	14 (4.6)	11.8 (3.7)	28	62	.36

<sup>3</sup> The fearful classification in this table represents participants who were rated markedly, moderately fearful and also includes mildly fearful participants.

The mean for the fearful group on the self-esteem measure is lower than the mean for the non-fearful group indicating lower self-esteem, though significant differences were not identified between the two groups, with an effect size of  $d = -.65$ . In addition there were no significant differences between the fearful and non-fearful groups for locus of control, with an effect size of  $d = .49$ . However the mean for the non-fearful group is below the cut-off for external locus of control ( $\geq 13$ ) suggesting that they are more balanced between internal and external locus of control.

Finally the three attachment classifications (anxious, avoidant and secure) were examined in relation to self-esteem and locus of control. Table 13 depicts the means and standard deviations of the self-esteem and locus of control measures for the anxious, avoidant and secure attachment classifications.

Table 13. Means and standard deviations (SD) for self-esteem and locus of control measures, with the three attachment classifications.

Test Variable	<b>Anxious</b>	<b>Avoidant</b>	<b>Secure</b>
	(n=19)	(n=2)	(n=9)
	Mean (SD)	Mean (SD)	Mean (SD)
Self-esteem	11.4 (6)	12 (7.1)	12.2 (4.1)
Locus of control	13.7 (4.4)	12 (9.9)	13.5 (3.6)

As there were only two participants who were rated as avoidant it was not possible to compare the three groups in order to identify any differences between the self-esteem and locus of control measures for the anxious, avoidant and secure attachment.

Therefore the avoidant classification was omitted and a non-parametric t-test (Mann Whitney U) was conducted to compare the anxious and secure classifications.

Significant differences were not identified for self-esteem ( $U = 73, p > .05$ ) with an effect size of  $d = -.15$ , nor for locus of control, ( $U = 84.5, p > .05$ ) with an effect size of  $d = .05$ .

## 4 Discussion

### 4.0 Findings discussed in relation to research hypotheses

The participants in this study were screened for a high threshold of symptoms, of social anxiety. This was done to insure that the study group represented individuals who suffered with social anxiety to the extent that it had an impact on their functioning and would meet the criteria for a diagnosis of social anxiety, particularly as they were not recruited from clinical settings. The study was interested in examining the attachment patterns in individuals with social anxiety and the impact that this may have on individual's functioning in relation to social anxiety, in addition to contemplating the potential impact attachment may have on formulating treatment approaches. It was therefore important to insure that the study group had a high threshold of symptoms so that the findings would potentially be clinically relevant.

The socially anxious group in this study was compared to both the non/low socially anxious comparison groups and socially anxious groups in two other studies (Mansell, Clark & Ehlers, 2003; Turner, Beidel, Dancu & Stanley, 1989) in order to provide comparative data. The socially anxious group used in this study reported significantly more symptoms of social anxiety than both of the non/low anxious comparison groups did, with a large effect size. In addition the socially anxious group used in this study reported significantly more symptoms of social anxiety than the socially anxious group in the other two studies, on two out of the three anxiety measures. This suggests that the screening protocol used in this study was effective.

The socially anxious group used in this study reported low self-esteem and just over half of the sample reported external locus of control. If locus of control is conceptualised as the way in which individuals see others and the world (e.g. model of others), it might have been expected that a larger proportion of the socially anxious participants would report external locus of control. It may be that the

measure did not tap into individual's model of others as well as expected. though as over half of the sample reported this style, it does suggest that a proportion of the socially anxious group do not feel that events are contingent on their own behaviour or characteristics, and others are often more powerful. Chorpita & Barlow (1998) report that the perception of control is particularly important to the development of anxiety and anxiety is increased when situations are perceived as uncontrollable.

Low self-esteem and external locus of control have both been found to be related to insecure attachment style and social anxiety (Collins & Read, 1990; Griffin & Bartholomew, 1994; Kocovski & Endler, 2000; de Jong, 2002). From an attachment perspective low self-esteem may reflect a negative model of self, while external locus of control may represent a negative model of others (Hexel, 2003; Luke et al, 2004). It is possible that these two factors mediate the relationship between insecure attachment and social anxiety. Particularly as self-esteem would influence models of the self and also perceptions of one's self in social interactions, while locus of control could impact on models of others and perceptions of others in social situations. If this were the case then self-esteem and locus of control would represent important areas of intervention when treating social anxiety.

In order to consider the attachment styles the socially anxious group used in this study was compared to a community comparison group of eighty women used in other attachment studies (Bifulco, Moran, Ball & Bernazzani, 2002; Bifulco, Moran, Ball & Lillie, 2002; Bifulco, et al, 2004). Attachment style in these other studies was measured using the same measure as this study (the ASI) and the women were also screened for social anxiety and depression to insure that these were not present.

The first study hypothesis stated that the socially anxious study population would be comprised of individuals with a predominantly insecure attachment style. As predicted the socially anxious group used in this study did reflect a predominantly insecure (non-standard) attachment style. In addition when the study sample was compared to a community comparison group, there were significantly more participants classified as insecurely attached in the study sample, with a large effect

size. This finding is consistent with the theoretical perspectives of attachment. From an attachment theory approach, the types of caregiving experiences that would influence insecure attachments have also been reported by individuals with social anxiety (e.g. critical, controlling, and emotionally cold caregivers; Harvey et al., 2005; Leung, et al, 1994; Rapee & Melville, 1997). The tenet of attachment security and social anxiety is interpersonal relationships, therefore it is likely that if one's difficulties are specifically relating to others, as is the case in social anxiety, then attachment difficulties will also be present as the findings demonstrate.

The second study hypothesis stated that the attachment style that would best represent the socially anxious group in this study was fearful. When attachment was considered using the full five attachment styles (e.g. secure, enmeshed, fearful, angry-dismissive and withdrawn), the majority of the participants in this study were classified as having a fearful attachment style. Furthermore when the attachment classifications were collapsed into fearful or non-fearful, the socially anxious study group contained significantly more fearful participants than the community comparison group, with a large effect size. This suggests that individuals in this socially anxious group are most likely to report aspects of supportive relationships and attachment attitudes, which represent fearful attachment.

Attachment styles are hypothesised to represent the expression of the internal models of self and others (Bowlby, 1973; Ainsworth et al, 1978; Main & Solomon, 1986). Fearful attachment represents a negative model of self and a negative model of others (Luke et al., 2004; Park et al., 2004). Bartholomew (1990) hypothesised that the self model represents the degree of anxiety and dependency on others for approval, while the other model represents avoidance and the ability to seek others for support. As individuals with social anxiety tend to have a distorted perception of themselves in social situations and also a distorted perception of others (Clark & Wells, 1995), it is likely that they would have a negative self model and a negative others model. In addition it is likely that they would have a high degree of anxiety and worry about the judgements of others (negative self model) and have difficulties using others for support and find it hard to trust others (negative others model). This

would therefore be represented by a fearful attachment style as the findings demonstrate.

Consistent with other attachment studies, the attachment styles in this study were considered along the two major underlying dimensions of anxiety and avoidance. These two dimensions have been identified in the majority of the available self-report attachment measures and correspond to Ainsworth et al's (1978) infant classifications (Brennan et al, 1998).

The third hypothesis stated that the socially anxious group used in this study would demonstrate a predominately anxious attachment style. As predicted the participants in this study tended to be classified as anxious, as opposed to avoidant or secure. When compared to the community comparison group, the study group were found to be significantly more likely to be classified as anxious, with a medium effect size. When attachment is considered along the two dimensions of anxiety and avoidance, an anxious style represents a lack of attachment security, a desire for closeness conflicted with anxiety regarding relationships and fear of rejection (Mikulincer, Shaver & Pereg, 2003). This anxious style is potentially evident in individuals with social anxiety in relation to their distorted beliefs and fears about being judged negatively or humiliated in social situations.

The fourth hypothesis proposed that individuals with an insecure attachment style would be more socially anxious. The study did not find that individuals with an insecure or secure attachment style were more socially anxious, though when the insecure attachment pattern examined was the fearful/non-fearful classification, then those classified as fearful were significantly more socially anxious on both social anxiety measures, with a large effect size. This would be expected particularly as the fearful attachment style incorporates a negative model of self and a negative model of others, which would be likely to activate anxiety in social situations. In addition when the anxious or secure classifications were examined it was found that individuals with an anxious classification reported significantly more symptoms of anxiety on one of the social anxiety measures, than the secure classifications.

However these findings may suggest that the significant finding with regards to more participants in the study group being classified as insecure, may be an artefact of the large proportion of fearful and anxious classifications in the insecure group. This can be inferred from the fact that the insecure/secure classification was not significant for any of the social anxiety measures. This may suggest that it's not insecure attachment as such, but specifically fearful and anxious attachment patterns which are salient to social anxiety.

With regards to individuals with an anxious classification reporting significantly more symptoms of anxiety on only one of the social anxiety measures, this was identified as the Social Anxiety and Distress Scale (Watson & Friend, 1969). This measure was employed as it measures both the affective and behavioural components of social anxiety. It may be that the behavioural component on the measure was more sensitive to anxious strategies, which delineate anxious from avoidant and secure classifications.

The final study hypothesis proposed that social anxiety would be related to low self-esteem and external locus of control, and individuals with an insecure attachment style will report lower self-esteem and external locus of control. The relationship between social anxiety and self-esteem and locus of control was hypothesised to be important as potential areas in which to target interventions for social anxiety. As predicted low self-esteem was found to be significantly related to one of the measures of social anxiety (Fear of Negative Evaluation Scale; FNES) and to trait anxiety. The FNES particularly measures cognitive aspects of social anxiety. This measure may be more sensitive to the negative thoughts about one's self related to low self-esteem. Social anxiety was not found to be significantly related to external locus of control in this study.

Low self-esteem was conceptualised as a negative model of self and external locus of control, as a negative model of others. It was therefore proposed that individuals with an insecure attachment style would report lower self-esteem and external locus

of control. The study was unable to identify any significant differences between those classified as secure or insecure for self-esteem or locus of control. Even when examining the insecure attachment classifications as fearful or non-fearful, or as anxious or secure, no significant differences were revealed for self-esteem or locus of control. The failure to identify any significant differences between those classified as secure or insecure for self-esteem may be due to the lack of variance for self-esteem in the study group as a whole, in addition to a floor effect for self-esteem. Individuals who were classified as secure still reported low self-esteem. In addition there was little variation between the locus of control ratings in the study group, though when differences between the locus of control ratings were examined in the fearful/non-fearful classification, the non-fearful group would not meet the cut-off to be classified as having external locus of control.

#### 4.1 Findings in relation to other studies

The distribution of adult attachment styles in the general population, using Hazan and Shaver's (1987) attachment style measure are reported as 59% secure, 25% avoidant, and 11% anxious (Mickleson et al., 1997). Similarly Shaver and Clark (1994) reported the distribution of adult attachment styles in non-clinical samples, using a number of adult attachment measures as 55% secure, 25% avoidant, and 20% anxious. In this study with a socially anxious group, the distribution of adult attachment styles was 30% secure, 6% avoidant, and 64% anxious, using the ASI (Bifulco et al., 1998) demonstrating that the secure classification is lower and the anxious classification represents over half of the distribution. When considering this finding in relation to cognitive models of social anxiety, individuals with social anxiety would expect social situations to be threatening to them with regards to their sense of self-worth and potential for humiliation (Clark & Wells, 1995; Rapee, 1997). They would therefore use strategies like self-monitoring and hypervigilance for potential dangers in the environment, while also failing to process any competing information which was not congruent with their beliefs. When these sorts of strategies are considered in attachment terms, they represent anxious attachment-

related strategies particularly where a desire for closeness is in conflict with a fear of rejection and harsh judgements of others.

Shaver and Mikulincer (2002) proposed a model which integrates the activation of the attachment system with the type of strategy applied. The authors make a distinction between hyperactivating strategies and deactivating strategies.

Individuals with social anxiety are more likely to have an anxious attachment and therefore would tend to utilise hyperactivating strategies. Hyperactivating strategies involve hypervigilance in relation to monitoring for potential threats to the self and the unavailability of the attachment figure, similar to the monitoring behaviours found in social anxiety (Clark & Wells, 1995; Kocovski & Endler, 2000; Rapee, 1997). In addition the use of hyperactivating strategies has been found to predispose one to detect threats in the physical and social environment and also to exaggerate the potential for aversive outcomes (Shaver & Mikulincer, 2002). This is similar to Rapee's (1997) finding that fear of social situations was predicted by the perceived consequences of threat. Perg (2001) found that individuals who used hyperactivating strategies focused more on negative emotions and tend to ruminate on negative thoughts. Negative cognition then exacerbates negative affect, fears of rejection and negative views of relationship partners, maintaining the activation of the attachment system. This negative processing bias is similar to that found in individuals with social anxiety as described by Clark and Wells (1995), particularly the belief that negative evaluations of one's behaviour by others will lead to rejection and humiliation. Furthermore catastrophic beliefs about the outcome of social situations seem to maintain social anxiety in the same way as negative cognition maintains the activation of the attachment system and hyperactivating strategies.

Secure attachment has been found to be related to higher self-esteem and internal locus of control, while insecure attachment has been found to be related to low self-esteem and external locus of control (Collins & Read, 1990; Mickleson et al, 1997). In addition Cloitre et al., (1992) found that people with social anxiety tended to have external locus of control and held the belief that powerful others have control over anxiety-provoking situations, and de Jong (2002) reported that socially anxious

participants had lower levels of self-esteem. While the socially anxious group used in this study reported low self-esteem and over half of the participants rated themselves as having external locus of control, the study was unable to identify significant differences between self-esteem and locus of control for those classified as secure or insecure (or for the fearful/non-fearful or anxious, avoidant or secure classifications). This may be due to the lack of a non-socially anxious comparison group in this study for self-esteem and locus of control. Consequently regardless of whether individuals were classified as having an insecure or secure attachment style, they still reported a high threshold of symptoms for social anxiety and low self-esteem and external locus of control.

Individuals in this study who were classified as having a fearful attachment style reported significantly more symptoms of social anxiety. This finding is consistent with those found in Mickleson et al's (1997) study in the sense that insecure attachment styles were positively associated with social anxiety and a fearful style is an insecure classification. In Mickleson et al's (1997) study they found a positive association between both avoidant and anxious insecure attachment and social anxiety. The current study was able to differentiate between insecure styles and identify that particularly those with an anxious style, as opposed to an avoidant or secure style, were more socially anxious. This finding may be due to using an interview measure of attachment as opposed to a self-report measure, which represents a more detailed and extensive measure, compared with the questionnaire measure used in the Mickleson et al (1997) study. In the study conducted by Eng et al (2001) they found that patients with social anxiety reported both anxious-preoccupied insecure attachment and secure attachment styles, though having an anxious-preoccupied style was associated with significantly more reported social fear and avoidance. In the current study individuals with a fearful style reported more symptoms of social anxiety. While both the pre-occupied and the fearful attachment styles would be classified as anxious according to Brennan et al.'s (1998) two major underlying dimensions, the preoccupied classification may be more similar to the enmeshed style on the ASI in the sense that they both incorporate a negative model of self but a positive model of others. The Eng et al (2001) study

used the Revised Adult Attachment Scale questionnaire (Collins, 1996) and the Mickleson et al (1997) study used Hazan and Shaver's (1987) attachment style measure, while this study used the ASI, and therefore the comparability of the results are somewhat restricted.

The study sample used in Eng et al's (2001) study was comprised of two clinical groups who sought treatment for anxiety disorders from two separate clinics and met the diagnosis for social anxiety, and a nonclinical control group recruited through media advertisements. The study sample in the Mickleson et al (1997) study included data collected from 8,080 participants who were initially part of a nationwide household survey in the U.S. This study did not look specifically at social anxiety and therefore participants could meet the diagnostic criteria for a number of psychiatric disorders including social anxiety. The sample used in this study was recruited through a university and social anxiety support groups, though participants were screened for a high threshold of symptoms of social anxiety and low levels of depression which were also found in Eng et al's (2001) clinical groups. While the group used in this study is clearly different to those used in the other two studies in terms of recruitment and screening, it may be comparable to the other studies. For instance screening for social anxiety was stringent and potentially comparable to a clinical diagnosis of social anxiety like Eng et al's (2001) sample. Furthermore participants were recruited through a university and social anxiety groups using an internet-based approach, reaching a geographically diverse group similar to the sample used in the Mickleson et al (1997) study, though on a much smaller scale.

#### 4.2 Limitations of study

The results need to be considered in relation to the limitations of this study. The sample group was small which reduces the extent to which the findings can be generalised to other socially anxious populations. Although the study did not collect comparison data, the findings were examined in relation to the comparison groups

found in other published studies. The two comparison groups obtained from the Mansell et al., (2003) and Turner et al., (1989) studies to examine the levels of social anxiety in the study were both recruited from university populations, as were 11 out of the 30 participants in this study, and screened for social anxiety. Both groups included males and females, though the actual distributions of gender in the study groups are not provided. Most importantly these were considered valid comparison groups because the studies incorporated the same anxiety measures as those used in this study.

The comparison group used from the Bifulco et al., (2004) study to investigate the attachment classifications was recruited from GP surgeries and only included women, unlike this study which included 60% females and 40% males. Despite this the comparison group was considered valid for this study because it measured attachment using the ASI and participants were screened for social anxiety and depression. The utilisation of the same attachment measure was particularly important as it meant that the attachment classifications identified were conceptually the same and the results between the groups could be directly compared.

This study was unable to find another study with suitable comparison data for self-esteem and locus of control. While the measures used in this study for self-esteem and locus of control are widely used, there are a number of scoring methods associated with them. Therefore unless the scoring procedure is specified in a study, it is difficult to insure that the scoring procedure on the measures between studies would be equivalent. Ultimately this limited the findings in this study related to self-esteem and locus of control, in relation to secure or insecure attachment styles.

The screening procedure which was employed allowed only those with a high level of symptoms of social anxiety to be included in the study. This procedure was deliberately adopted to increase the likelihood of the study group having clinically significant levels of social anxiety. It was thought that any findings would therefore be more relevant to clinical practice, particularly in relation to the types of interventions which would be offered and to the focus of treatment (e.g. issues of

self-esteem, cognition related to how others are perceived, etc...). It is possible that the types of individuals with social anxiety who would be willing to participate in a research study may be a unique group. Particularly where they expect to be interviewed, in the sense that this participation could trigger their symptoms as the interview is a type of interpersonal interaction. They may also represent people with social anxiety that are more motivated or have more insight into their difficulties. This group may have more tolerance for their anxiety than those who would feel unable to participate or may have developed specific strategies to cope with their anxiety. Alternatively 63% of participants were either currently receiving treatment for a mental health problem or had done so in the past and this may suggest that this sample was comprised of individuals with particularly treatment-resistant difficulties. Additionally a large group of individuals who completed the screening process did not go on to take part in the study. It is possible that these individuals have never sought treatment for their social anxiety and may find it more difficult to be interviewed and think about their difficulties with a stranger. These individuals may also be less functional than the study group, to the extent that their social anxiety interferes with their lives, as 63% of the study group were working in some capacity. It is possible that individuals who are more functionally impaired by their social anxiety find it more difficult to approach services for help or participate in research (e.g. unable to meet strangers in person, unable to use the telephone, etc...).

Attempts were made to control for depression though a mild level of depression exists in the group and therefore it is not a 'pure' socially anxious group. However, as social anxiety and depression are highly comorbid it is unlikely that this 'pure' group exists or that the findings with a group of this type would be ecologically valid.

The procedure for conducting the interview consisted of half of the sample being interviewed face to face and half via the telephone. This was a beneficial method for individuals with social anxiety as it allowed individuals who were unable to contemplate meeting with a stranger to participate in the study and interviews were not restricted by distance. The information collected from the telephone interviews

appeared to be qualitatively similar to that collected in person, with respect to the length of responses and the amount of detail provided. The second rater of the attachment transcripts for the inter-rater reliability was unable to distinguish the telephone interviews from those conducted in person. It is however possible that using two different methodologies may have introduced a confounding variable. Comparison of the two groups on demographic variables, questionnaire measures, and attachment classifications, demonstrated no significant differences. This does not however rule out the possibility that the two groups did differ in some way. Although the group interviewed via the telephone did not differ in their level of social anxiety, it may be that their particular manifestation of social anxiety made some aspect of a face to face interview more difficult for them. It is also possible that the two groups differed in some facet not measured.

Theoretically attachment patterns develop initially in childhood and then the potential for revisions occur as a developmental process throughout one's life. This study does not use a longitudinal approach to examine if early insecure attachment occurred before the development of social anxiety, and therefore cannot demonstrate this developmental pathway. The attachment measure used in the study examines current adult attachment attitudes and relationships, yet this is based on the theoretical notion that early working models of attachment would have developed in childhood. While the results suggest that insecure attachment, particularly fearful, may have some role in social anxiety, they do not have the potential to identify a causal role.

#### 4.3 Clinical implications

There is a great deal of research which examines insecure attachment styles and attachment disorders, however there is very little research regarding strategies for interventions which address these issues. There are a number of clinical implications for the treatment of social anxiety which emerge from this study. Conceptualising social anxiety in terms of attachment highlights particular areas which may not be

addressed in interventions currently being offered. This raises the issue of developing new treatments or augmenting existing ones.

The attachment interview identifies the areas of mistrust and constraints to closeness as being particularly salient to social anxiety. As social anxiety often develops in late childhood or adolescence it is possible that early experiences where an individual was criticised or humiliated is incorporated into beliefs about the self in social interactions and about the potential for others to be judgmental (Clark, 1999). This model is then thought to be reactivated in social situations and information that is incongruent with this model is not assimilated. Mistrust and constraints to closeness could represent strategies to reduce the potential for perceived catastrophic outcomes in social situations by suspiciously scrutinising and limiting interactions with others. It would therefore be important to explore these areas in more detail with clients.

People with social anxiety tend to rate their parents as emotionally cold (Harvey et al., 2005), controlling or over intrusive (Rapee & Melville, 1997), or as employing criticism or shame when disciplining (Leung et al., 1994). This suggests that people with social anxiety may have experienced caregivers as unavailable or rejecting. Models of self and others develop in relation to how the attachment figures respond to the child when they seek support. When children experience caregivers as rejecting or unavailable they are likely to develop models of the self as unlovable and unworthy and models of others as uncaring and rejecting (Bartholomew, 1990). In order to cope with distress or anxiety they would develop insecure strategies (Bowlby (1973; 1980). For people with social anxiety these strategies may include monitoring the social environment for potential threats in addition to self-focused attention and processing oneself from an observer perspective in social situations (Clark & Wells, 1995). Though beliefs and images of the self from this observer perspective tend to be negatively distorted, as they would be influenced by the negative model of self.

In order to address mistrust and negative model of others it would be necessary to facilitate the development of the therapeutic relationship and the therapeutic alliance. In treating attachment disorders in children and young people, Hughes (2004) advocates affect attunement as central to the therapeutic experience and the need to stay emotionally engaged with the client.

Low self-esteem and external locus of control are prevalent in individuals with social anxiety (Collins & Read, 1990; Griffin & Bartholomew, 1994; Kocovski & Endler, 2000; de Jong, 2002) and therefore would need to be the focus of treatment. These factors seem to be related to models of the self and others, consequently they would need to be elaborated to gain an understanding of how individuals see themselves and the world. Van Buren & Cooley (2002) found that participants who had attachment styles with a negative view of self, reported more social anxiety and therefore interventions which address negative self-awareness and focus on developing therapeutic alliance are particularly salient to individuals with fearful attachment styles. Although the social-skills deficit theory (Beidel, Turner & Dancu, 1985) of social anxiety tends to concentrate exclusively on social skills as being linked to the development and maintenance of difficulties, it is likely that the improvement of social skills could have an impact on how one perceives themselves in social situations and the extent to which they feel in control. This would therefore seem to be an important strategy to incorporate into an intervention for treating social anxiety

O'Connor and Zeanah (2003) suggest social-cognitive approaches to treatment should be explored for attachment disorders. With regards to social anxiety this may indicate that changes to existing treatments, as opposed to the development of entirely new ones would be adequate to meet clients' needs. Incorporating an attachment component into an existing cognitive model of social anxiety could expand the way it is conceptualised. Internal representations of early attachment experiences are thought to reflect an individual's first attempt to understand and predict other people's behaviour, as well as the impact of their own behaviour. The models that develop from this will then influence how one judges people (Luke et al.

2004). These judgements would then need to be explored in therapy to determine how they impact on social interactions. Wells (1997) model of social anxiety can be altered to address the attachment components which are activated when an individual enters a social situation. In addition dual processing seems to occur whereby individuals process themselves as social objects and also others (possibly as untrustworthy or judging- see figure 1 below). In the same way that individuals use safety behaviours to enable them to tolerate social situations perceived as dangerous and to reduce their anxiety, they may also use attachment-related strategies. These may be the hyperactivating strategies proposed by Shaver and Mikulincer (2002), which involve hypervigilance in relation to monitoring for potential threats to the self and the unavailability of the attachment figure.

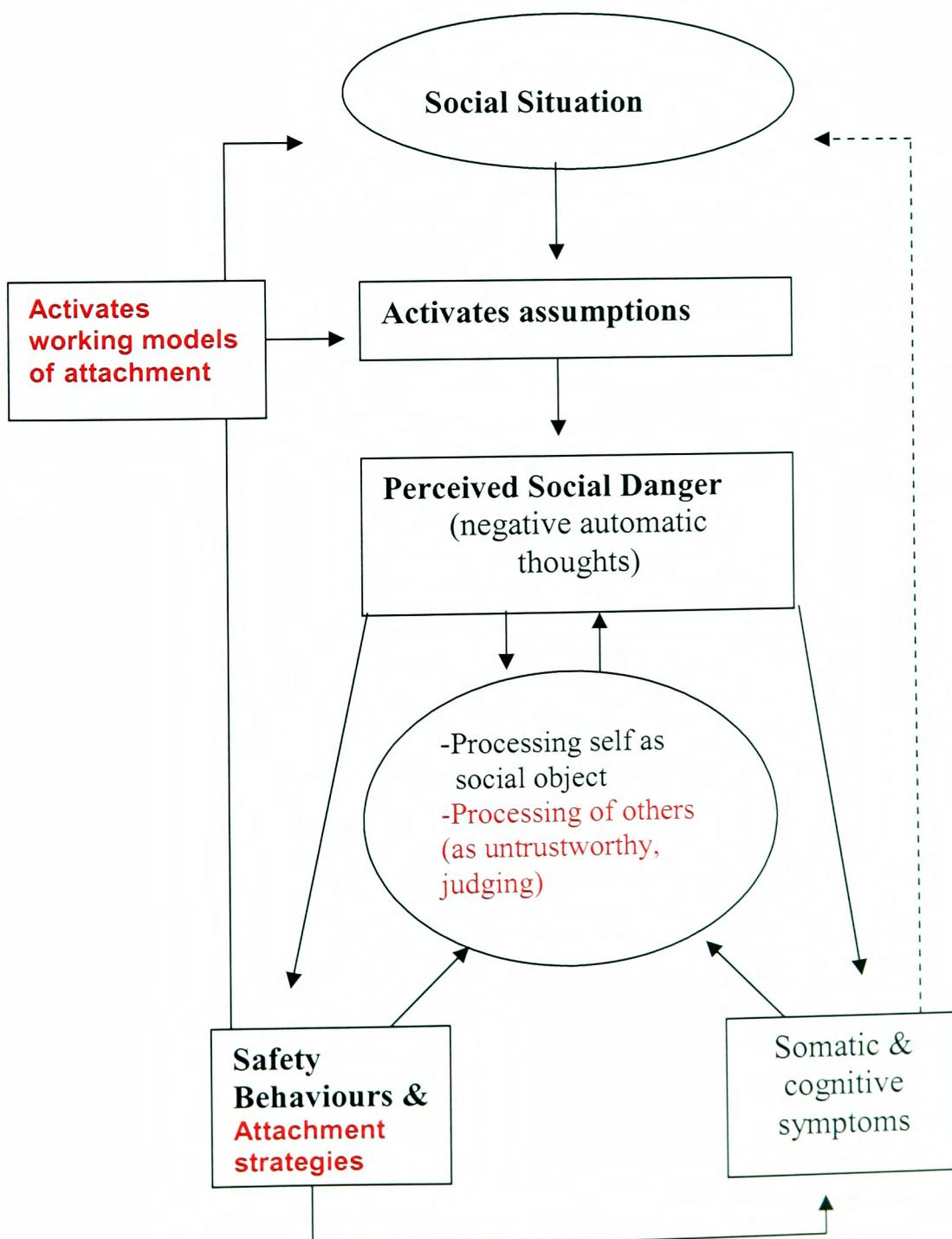


Figure 1. Wells' (1997) cognitive model of social anxiety conceptualised to include attachment issues.

From the perspective of altering existing cognitive-behavioural treatment, it is also necessary to maximise the match between the content of exposure situations and the fear structure. This will lead to more evocation, which increases the amount of emotional processing which will occur, and ultimately leads to better therapy outcomes (Foa, Steketee, Turner & Fischer, 1980). To fully understand the fear structure it may be necessary to understand the deeper emotional processing which occurs at the level of the attachment system when it is activated. This would be a particular consideration when constructing exposure work.

It may be that if this deeper emotional processing level is involved that interventions need to work at the schema level, for instance using schema therapy. Using this cognitive approach it would be necessary to identify in more detail the origins of models of the self and others, and to validate these experiences. It would be essential to explore the attachment strategies or 'safety behaviours', which maintain a client's difficulties, and then through imagery and behavioural experiments begin to challenge these. Finally as trust and self-esteem develop new strategies could be explored.

#### 4.4 Future research

A future study looking at social anxiety and attachment patterns with a clinical sample recruited through NHS services which included a range of severity for social anxiety, would be beneficial to ascertain if a fearful attachment style was present. This would help to inform how services are provided in the sense that it may be that attachment-based treatments are only necessary for those who are more severely socially anxious.

This study was unable to conduct mediational analysis though future research looking at the potential mediating role of self-esteem and locus of control, in the relationship between attachment and social anxiety may provide more information

about how social anxiety develops. This may be particularly the case if self-esteem is conceptualised as the model of self. From this perspective information regarding how attachment-related experiences impact on the development of the model of self, and the potential for this to predispose an individual to developing social anxiety could inform the mechanisms involved in social anxiety. As the study was unable to demonstrate any significant effects for locus of control, this measure may not access models of others and alternative measures may need to be sought. If a measure were found which could adequately represent models of others, this may be important as a mediating factor as well.

An important area for future research is the conception and development of treatment approaches for social anxiety which incorporate the issues related to fearful attachment styles. Possibly by considering current models of treatment for social anxiety and the findings in the attachment literature related to models of self, others, affect regulation, attachment strategies, etc... a treatment protocol could be developed. A synthesis of the research and theoretical understanding, regarding social anxiety and attachment related issues, could lead to a treatment protocol which addressed social anxiety in the here and now (e.g. CBT), but also dealt with deeper underlying issues, which maintain the disorder and often make it treatment resistant or vulnerable to relapse. It may be possible to manualise the treatment, setting out various sub-goals of therapy and how they can be achieved in therapy and through set tasks. This manualisation of the treatment approach would facilitate the piloting of the intervention and evaluation of the outcome.

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## Appendices

Appendix I: Attachment Style Interview (ASI Bifulco, Lillie, Ball & Moran, 1998) classifications sited from training manual.

**Enmeshed - Anxious:** This is a dependent attachment style exhibited by a high need for company and low self-reliance. There is high ambivalence and 'push-pull' in relationships.

**Fearful – Anxious:** This attachment style is also avoidant but characterised by social anxiety and fear of being rejected or let down. This may relate to actual experiences of having been let down which has generalised to fear of future interactions. There may be a high desire to get close to others, together with fear of doing so.

**Angry-dismissive – Avoidant:** Is characterised by avoidance, with high mistrust, high self-reliance and low desire for company. Its key characteristic is high anger. Tend to be isolated and contemptuous of others.

**Withdrawn – Avoidant:** This is an avoidant style characterised by high self-reliance and high constraints to closeness. There is neither fear of intimacy nor high anger present. Appears as practical, rational and non-emotional style.

## Study Information Sheet

### 1. Study Title

The relationship between attachment and social anxiety focusing on self-esteem and locus of control as possible mediators.

### 2. What is the purpose of the study?

The purpose of this study is to increase our understanding of how social anxiety develops and how early relationships may have an impact on this. It will also look at the role of self-esteem and people's perception of control and their influence. This will help us to provide treatment which considers these factors.

### 3. Why have I been chosen?

You have been chosen to participate in this study because you responded to the study invitation email, completed the anxiety questionnaire, and agreed to be interviewed.

### 4. Who is organising the study?

The study is being organised by myself with the support of the University of Hertfordshire. The study will take place over the next five months.

### 5. What will happen to me if I take part?

If you agree to take part in this study you will be contacted by me to arrange an interview. The interview will take place at the University of Hertfordshire and will last approximately two hours. During this time you will be asked to complete three self-report questionnaires and give some general information about yourself (e.g. age, ethnicity, etc...). You will also be asked some questions about anxiety and a number of questions about your early relationships. The interview will be audio taped to make sure that your answers are recorded accurately and your name will not be associated with the tape. The tape will be destroyed after your answers have been written out.

### 6. What are the risks in taking part?

There are no foreseeable risks involved in taking part in this study. There are no *right* answers to the questions that you will be asked and you will be the expert on yourself. You are free to stop the interview at anytime and to withdraw from the study without giving a reason. If you feel that you need more help with your anxiety or any other mental health problems you will be given a pack at the end of the interview with information about various services you could contact.

### 7. What are the possible benefits of taking part?

The interview will give you the chance to talk about your early relationships and to think about how this may have had an impact on feeling anxious. The information I get from this study may help to increase our understanding of social anxiety and improve the services provided.

**8. Is anyone being paid for including me in the study?**

No one will be receiving payment for participation in any part of this study.

**9. Confidentiality – Who will know I am taking part in the study?**

All the information which is collected from the questionnaires and the interview will be kept strictly confidential and all information will be anonymised so that you cannot be recognised from it.

**10. Local Research Ethics Committee Approval**

The University of Hertfordshire's research ethics committee has given ethical approval for this study.

**11. What will happen to the results of the study?**

The results of the study will be written up and submitted as part of a thesis. In addition a summary of the findings will be written and those wishing to receive a copy can request one during the interview and a copy will be sent to you. ALTERNATIVELY findings will be posted on the study website.

**12. Contact for further information**

If you have any questions or would like some more information about the study you can contact me on 07966 534142 or by email: karenmccarty67@yahoo.co.uk

**Thank you!**

**Karen McCarty**

Trainee Clinical Psychologist

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The study is being organised by myself with the support of the University of Hertfordshire. The study will take place over the next five months.

**5. What will happen to me if I take part?**

If you agree to take part in this study you will be contacted by me to arrange an interview. The interview will take place at the University of Hertfordshire and will last approximately two hours. During this time you will be asked to complete three self-report questionnaires and give some general information about yourself (e.g. age, ethnicity, etc...). You will also be asked some questions about your anxiety symptoms and a number of questions about your early relationships. The interview will be audio taped to make sure that your answers are recorded accurately and your name will not be associated with the tape. The tape will be destroyed after your answers have been written out.

**6. What are the risks in taking part?**

There are no foreseeable risks involved in taking part in this study. There are no *right* answers to the questions that you will be asked and you will be the expert on yourself. You are free to stop the interview at anytime and to withdraw from the study without giving a reason. If you feel that you need more help with your social anxiety or any other mental health problems you will be given a pack at the end of the interview with information about various services you could contact.

- 7. What are the possible benefits of taking part?**  
The interview will give you the chance to talk about your early relationships and to think about how this may have had an impact on feeling socially anxious. The information I get from this study may help to increase our understanding of social anxiety and improve the services provided.
- 8. Is anyone being paid for including me in the study?**  
No one will be receiving payment for participation in any part of this study.
- 9. Confidentiality – Who will know I am taking part in the study?**  
All the information which is collected from the questionnaires and the interview will be kept strictly confidential and all information will be anonymised so that you cannot be recognised from it.
- 10. Local Research Ethics Committee Approval**  
The University of Hertfordshire's research ethics committee has given ethical approval for this study.
- 11. What will happen to the results of the study?**  
The results of the study will be written up and submitted as part of a thesis. In addition a summary of the findings will be written and those wishing to receive a copy can request one during the interview and a copy will be sent to you. ALTERNATIVELY findings will be posted on the support group website bulletin board.
- 12. Contact for further information**  
If you have any questions or would like some more information about the study you can contact me on 07966 534142 or by email:  
karenmccarty67@yahoo.co.uk

**Thank you!**

**Karen McCarty**  
Trainee Clinical Psychologist

## Appendix IV: Social anxiety screening questionnaire

Please fill in the following questionnaire:

Each item on the questionnaire is a statement.

- Please read each statement and indicate to what degree you agree or disagree with this statement.
- You can select your chosen statement by clicking in the adjacent box.
- Please select only one statement from each group and please make sure that you complete all the items.

### Question A)

I find social situations very uncomfortable.

- 1.strongly agree.
- 2.agree.
- 3.uncertain.
- 4.disagree.
- 5.strongly disagree.

### Question B)

I worry other people are judging me and will not approve of me.

- 1.strongly agree.
- 2.Agree.
- 3.uncertain.
- 4.disagree.
- 5.strongly disagree.

### Question C)

I become very anxious if I have to speak in front of a group of people.

- 1.strongly agree.
- 2.agree.
- 3.uncertain.
- 4.disagree.
- 5.strongly disagree.

### Question D)

I worry that I will embarrass or humiliate myself when I am in a social situation.

- 1.strongly agree.
- 2.agree.

- 3.uncertain.
- 4.disagree.
- 5.strongly disagree

Question E)

I feel very anxious when I have to do things in front of other people.

- 1.strongly agree.
- 2.agree.
- 3.uncertain.
- 4.disagree.
- 5.strongly disagree

Question F)

I feel very anxious when I meet new people.

- 1.strongly agree.
- 2.agree.
- 3.uncertain.
- 4.disagree.
- 5.strongly disagree

Question G)

I feel very anxious when I have to attend social situations.

- 1.strongly agree.
- 2.agree.
- 3.uncertain.
- 4.disagree.
- 5.strongly disagree

Question H)

Although I recognise that my fear about social situations is excessive I can't seem to do anything about it.

- 1.strongly agree.
- 2.agree.
- 3.uncertain.
- 4.disagree.
- 5.strongly disagree

Question I)

I feel nervous when I am around people I don't know.

- 1.strongly agree.
- 2.agree.
- 3.uncertain.
- 4.disagree.
- 5.strongly disagree

Question J)

I try to avoid social situations as much as possible.

- 1.strongly agree.
- 2.agree.
- 3.uncertain.
- 4.disagree.
- 5.strongly disagree

Question K)

I try to avoid having to speak in front of a group of people as much as possible.

- 1.strongly agree.
- 2.agree.
- 3.uncertain.
- 4.disagree.
- 5.strongly disagree

Question L)

If I can't avoid a social situation I would be very anxious and distressed about having to endure it.

- 1.strongly agree.
- 2.agree.
- 3.uncertain.
- 4.disagree.
- 5.strongly disagree

Question M)

When I am in social situations I experience my heart racing, sweating, feeling shaky, feeling nauseous, blushing or muscle tension (not necessarily all of these).

- 1.strongly agree.
- 2.agree.
- 3.uncertain.
- 4.disagree.
- 5.strongly disagree

Question N)

I find feeling anxious and worrying about social situations has a negative impact on my life.

- 1.strongly agree.
- 2.agree.
- 3.uncertain.
- 4.disagree.
- 5.strongly disagree

Question O)

I find feeling anxious and worrying about having to perform (give a talk, do a presentation, etc...) negatively interferes with my life.

- 1.strongly agree.
- 2.agree.
- 3.uncertain.
- 4.disagree.
- 5.strongly disagree

Question P)

Sometimes I feel very distressed about my anxiety or fears.

- 1.strongly agree.
- 2.agree.
- 3.uncertain.
- 4.disagree.
- 5.strongly disagree

Thank you very much for filling in the Anxiety questionnaire.

Appendix V: Consent form

**Participant Consent Form**

Title of Project: The relationship between attachment and social anxiety, focusing on self-esteem and locus of control as possible mediators.

Name of researcher: Karen McCarty

1.	I confirm that I have read and understand the information sheet dated December 2004.	
2.	I understand that my participation will include being interviewed by Karen McCarty, a Trainee Clinical Psychologist. I understand that all responses I give will be confidential and that I am free to refuse to answer any questions or to stop the interview at any time without providing a reason.	
3.	I understand that the interview will be audio taped for the purpose of collecting my responses. The tape will be destroyed once this information has been transcribed.	
4.	I confirm that I agree to take part in the above study.	

\_\_\_\_\_  
Name of Participant  
(block capitals)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

I have explained the nature, demands and foreseeable risks of the above research to the participant.

\_\_\_\_\_  
Name of researcher  
(block capitals)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

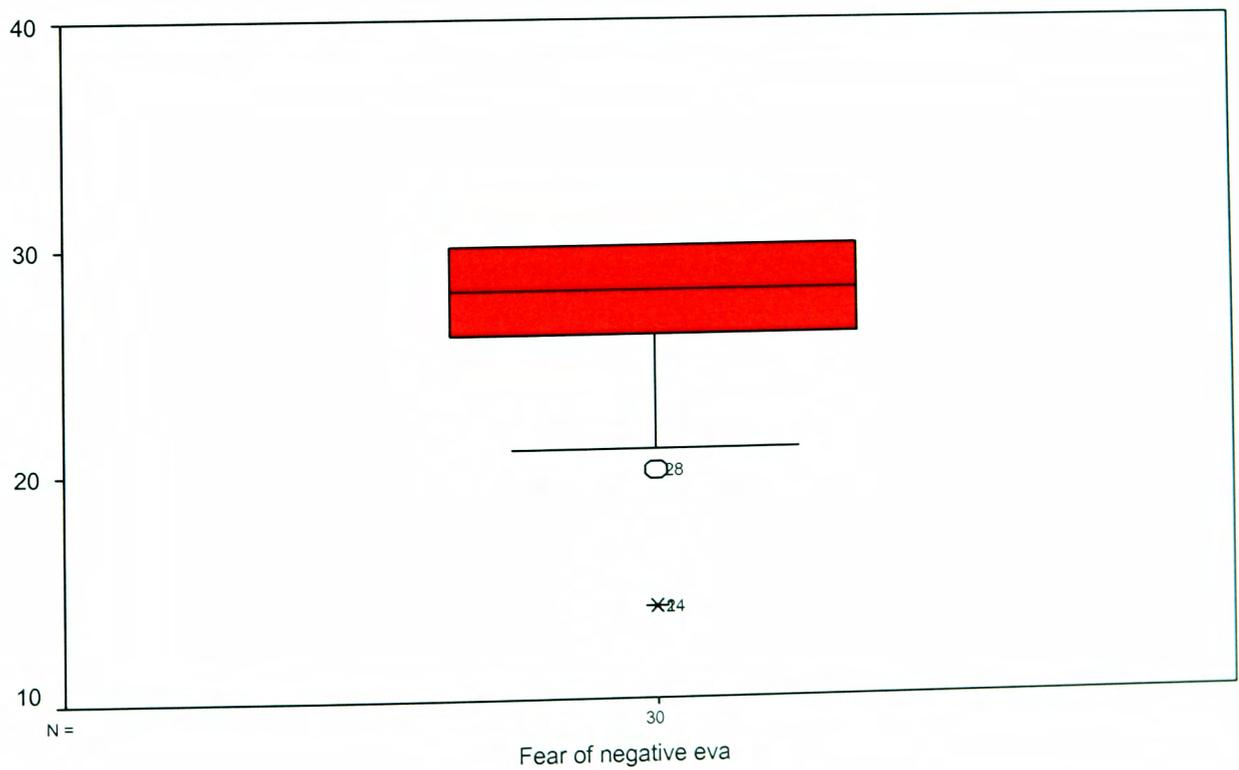
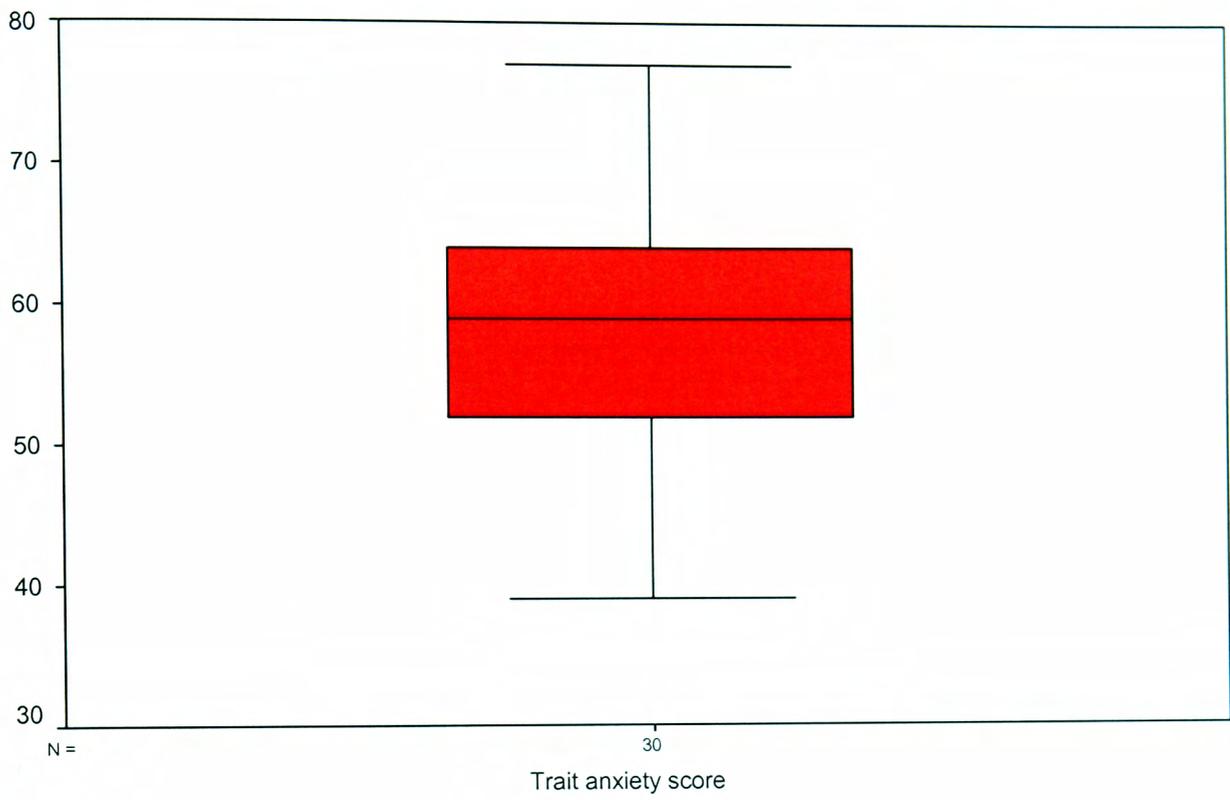
Appendix VI: Comparisons between face to face interviews and telephone interviews.

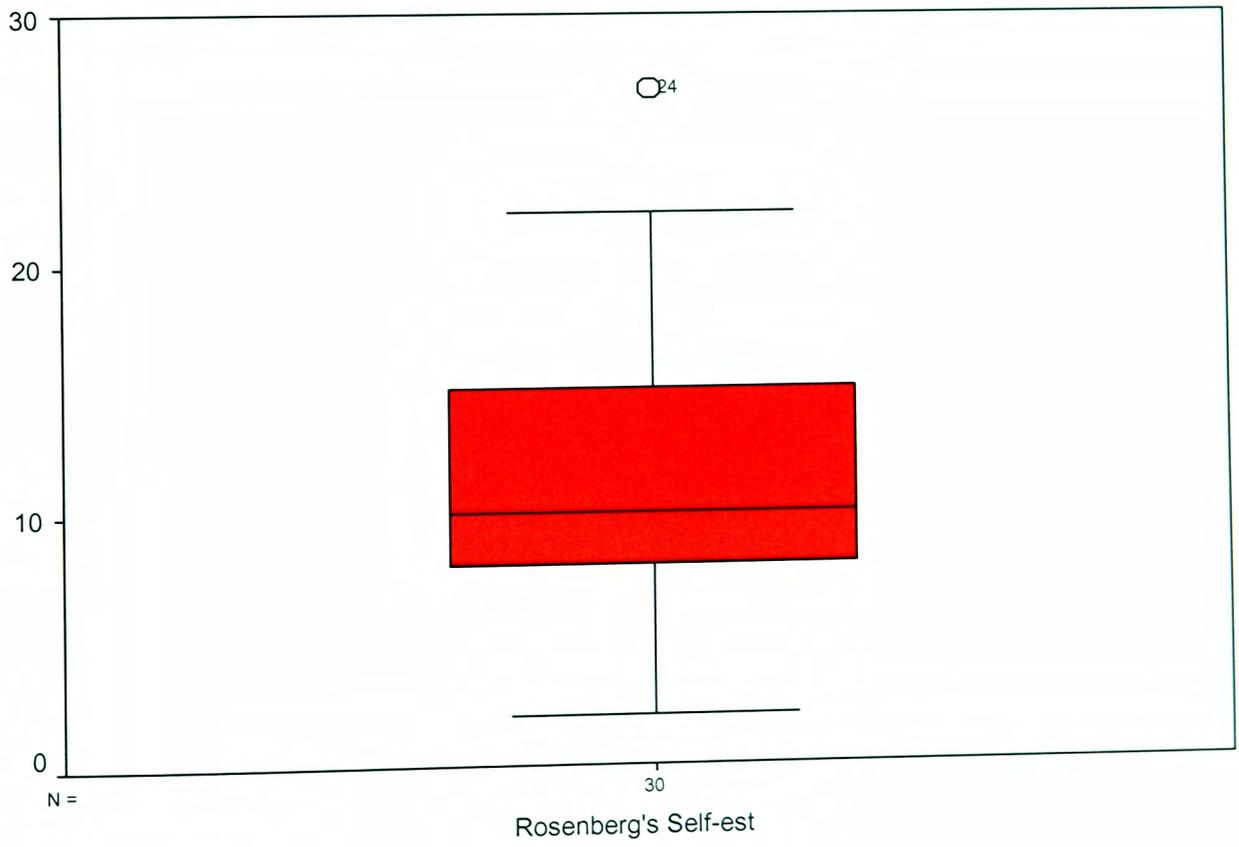
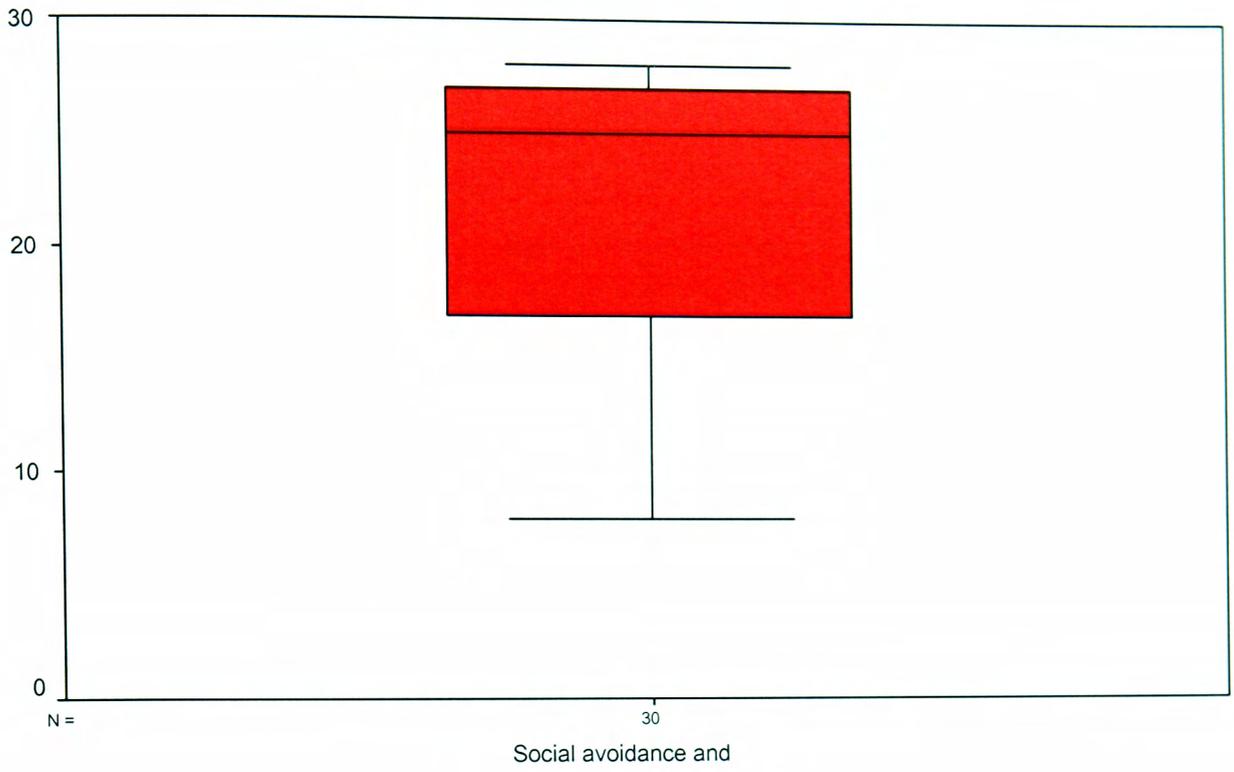
<b>Descriptive information</b>	<b>Face to face Interview Means</b>	<b>Telephone Interview Means</b>	<b>Significance</b>
Gender	33.3% M; 66.7% F	46.7% M; 53.3% F	$\chi^2 = 0.56$ , $df=1$ , $p=0.46$
Age	28.3 (10.5)	32.3 (11.1)	$U = 94$ , $p = 0.44$
Ethnicity	46.7% not British	13.3% not British	$\chi^2 = 3.97$ , $df=1$ , $p = 0.05$
Marital status	80% single	73.3% single	$\chi^2 = 0.19$ , $df=1$ , $p = 0.67$
Educational attainment	53.3% above GCSE level	53.3% above GCSE level	$U = 105.5$ , $p = 0.77$
Employment	46.7% employed	80% employed	$\chi^2 = 3.59$ , $df=1$ , $p = 0.07$
Treatment for Mental Health problem	60% have received treatment for MH problem	66.7% have received treatment for MH problem	$\chi^2 = 0.14$ , $df=1$ , $p = 0.71$
Type of mental health problem treated	66.7% treatment for social anxiety	60% treatment for social anxiety	$\chi^2 = 0.09$ , $df=1$ , $p = 0.76$
Number of stressors in last year	3.5 (1.9)	3 (1.3)	$U = 92$ , $p = 0.39$

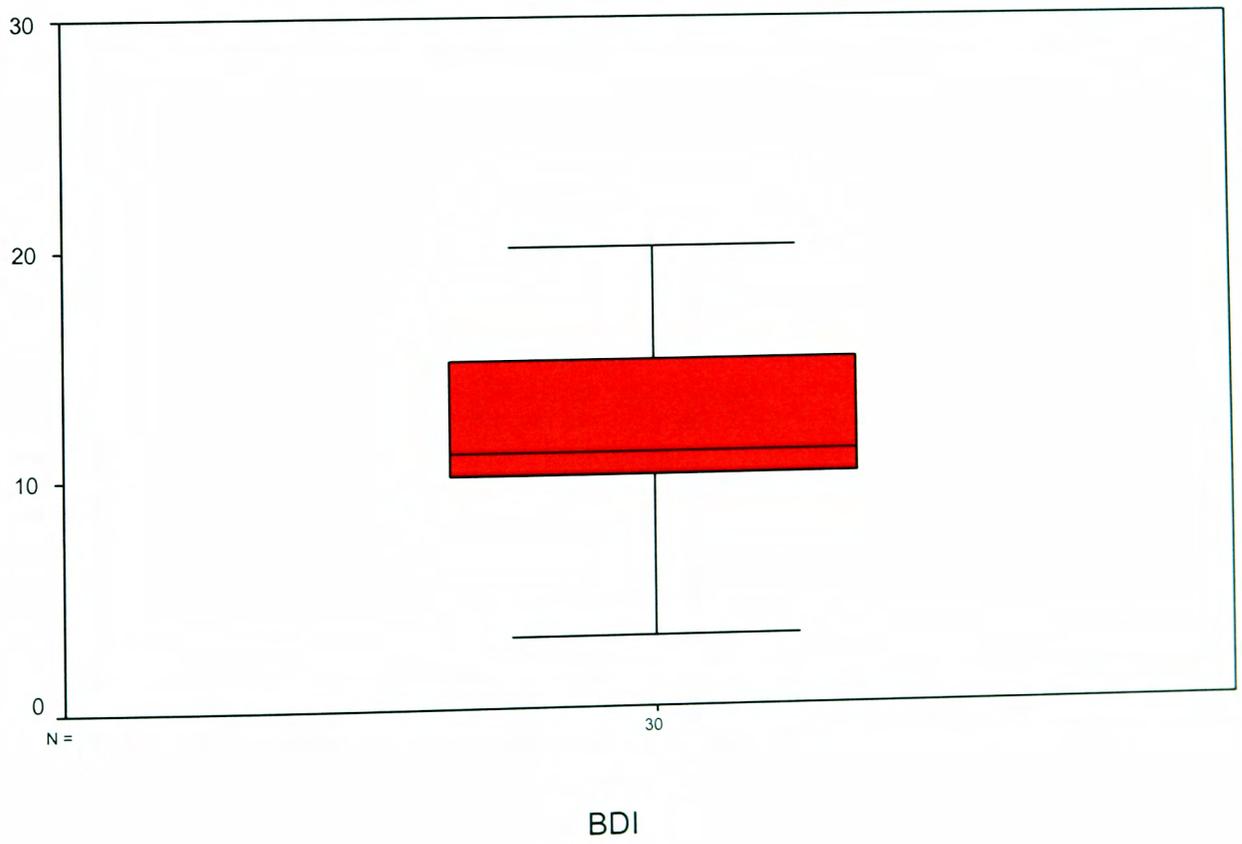
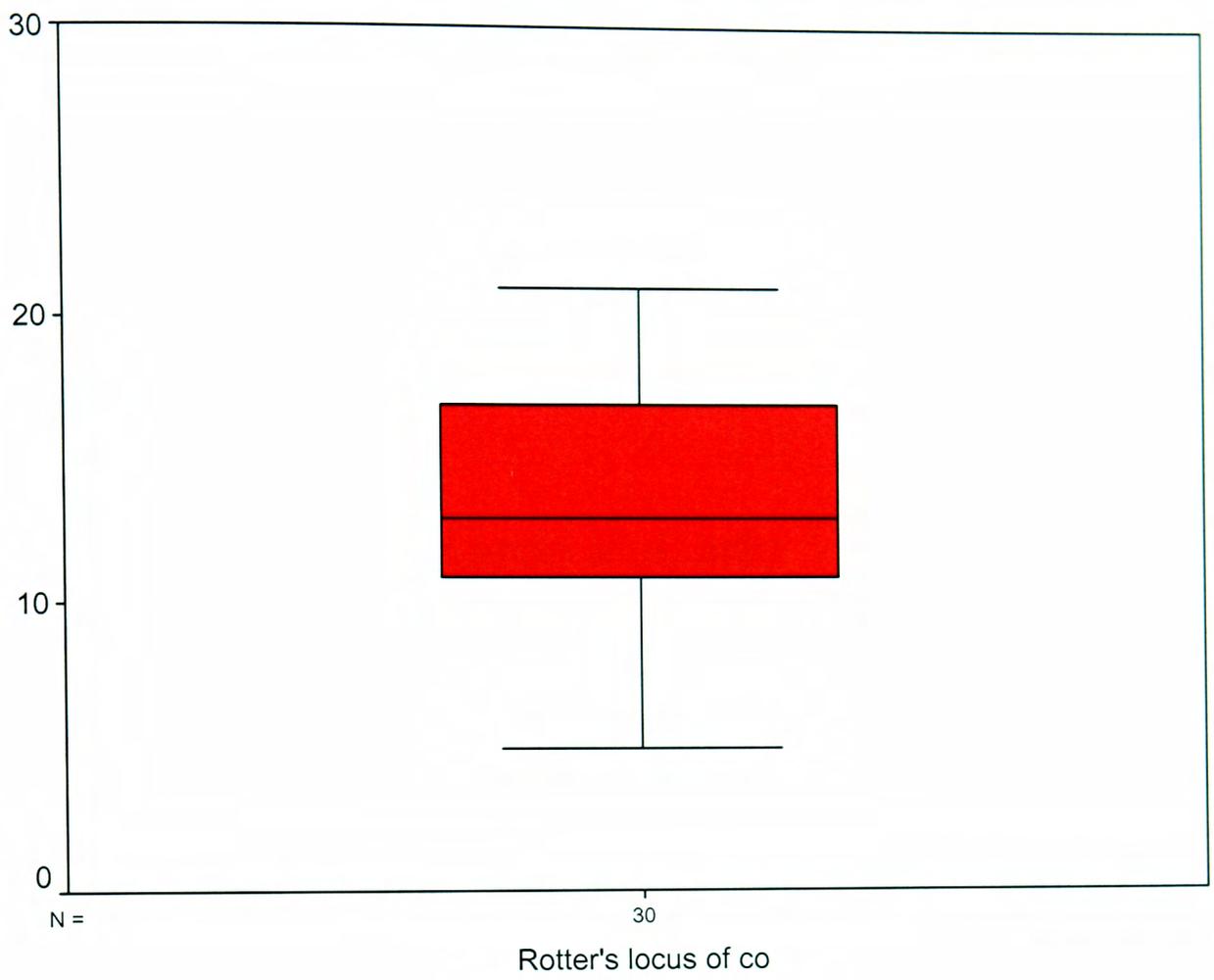
<b>Questionnaire Measure</b>	<b>Face to face Interview Means</b>	<b>Telephone Interview Means</b>	<b>Significance</b>
State Anxiety	49.1 (7.8)	45.5 (12.8)	$t = 0.91$ , $df = 28$ , $p= 0.97$
Trait Anxiety	57.6 (8.8)	58.1 (11)	$t = -0.15$ , $df = 28$ , $p= 0.88$
Fear of Negative Evaluation	26.5 (4.3)	26.9 (4.8)	$t = -0.24$ , $df = 28$ , $p= 0.81$
Social Avoidance and Distress Scale	20 (6.8)	23.5 (4.6)	$U = 84.5$ , $p= 0.24$
Rosenberg's Self-esteem Scale	12.3 (5.1)	11.1 (5.8)	$t = 0.64$ , $df = 28$ , $p= 0.53$
Rotter's Locus of Control Scale	13.9 (4.5)	13.2 (4.4)	$t = 0.41$ , $df = 28$ , $p= 0.69$
Beck's Depression Inventory	12.7 (4.6)	11.2 (4.4)	$U = 94.0$ , $p= 0.44$

Attachment	Face to face Interview	Telephone Interview	Significance
Dichotomised attachment styles	66.7% insecure	73.3% insecure	$\chi^2 = 0.16$ , $df=1$ , $p = 0.69$
Five-style classification	60% fearful	66.7% fearful	$\chi^2 = 2.16$ , $df=3$ , $p = 0.54$
Two dimension attachment patterns	60% anxious patterns	66.7% anxious patterns	$\chi^2 = 0.16$ , $df=2$ , $p = 0.92$

Appendix VII: Box plots depicting the distribution of the questionnaire scores in the study group.







**Critical Review**

**Karen McCarty**

**November 2005**

**Year 3**

**Word count:**  
**3204**  
(excluding references)

## Critical Review

The experience of conducting this study was valuable to me as a clinician and as a researcher. The study raised a number of issues which required consideration and reflection both in terms of the procedures and my role as a scientist-practitioner. The specific issues concerned were: how interviews were conducted, the experience of support groups and self-help website/internet services, expressing anger, conceptualising the interview as a clinical tool, and the balance within my role as a scientist-practitioner. Finally the study will be considered from a constructivist perspective. These issues will be discussed in more detail in turn.

### 1.0 Interview methods

A number of potential participants expressed their difficulties in meeting to be interviewed in person. In some cases this concern was not expressed directly, but although individuals expressed a desire to be part of the study, they felt unable to arrange a time for the interview. As the sample consisted of socially anxious individuals it is likely that the act of meeting a stranger triggered a degree of anticipatory anxiety. To address this problem and maximise participation, but also to be sensitive to the potential for increasing individual's anxiety, telephone interviews were offered. This seemed to be a more ethical approach for those individuals who found the prospect of meeting in person anxiety provoking.

As a clinician I felt more confident in my ability to help someone feel comfortable in a face to face situation. Consequently I felt a degree of anxiety myself as to how well I could conduct the interview over the phone, where I would not be receiving and providing non-verbal feedback. My subjective experience of the telephone interviews is that they were not qualitatively different from the interviews I conducted in person. This method also afforded me the experience of interviewing people who would otherwise be inaccessible.

I am aware that other research is conducted in this manner particularly longitudinal research which requires follow-up interviews over time. Currently the Institute of Psychiatry is conducting a large-scale twin study which successfully uses telephone interviews.

The strategies for insuring confidentiality were somewhat different while conducting telephone interviews. For instance the environment of the person on the other end of the phone was beyond my control. To address this, very specific times were arranged when I would phone people to help insure that they would have privacy. This included phoning early on weekend mornings, at times when children or spouses were out, and phoning mobile phones so housemates wouldn't over hear.

In one case an individual expressed a desire to participate in the study and completed the questionnaires and returned them to me. While arranging a time to conduct the interview through email contact, they shared their anxiety about speaking on the phone but also their desire to confront this. We proceeded to arrange a time for me to phone (a mobile phone) though at the specified time the phone rang and was not answered. I proceeded to send the individual an email offering to arrange another interview, acknowledging the courage it had to taken to arrange the first one, and thanking them for taking the time to complete the questionnaires and send them back to me. I assured this individual that I would not contact them again, though if they decided they would like to participate in the interview or just discuss it further, I would be happy to hear from them.

Unfortunately I did not hear from this individual again. As a clinician I wanted to follow this person up, to see how I could support them in possibly doing a smaller more accomplishable task. I felt concerned that they may go away feeling they had failed by not taking part in the interview. As a researcher I needed to respect that this individual may just have decided not to take part in the study and it is not necessary for them to provide any explanation. I felt sending the email was the best compromise between these two positions.

Ultimately I think the use of telephone interviews was beneficial to my study and allowed me to access individuals that I would otherwise not have had the opportunity to. It also provided me with the experience of using this methodology which increased my confidence and heightened my awareness of issues of social anxiety.

### 1.1 Support groups and website/internet services

Through conducting this study I have become aware of the number of alternative services that are available to individuals with social anxiety. The reception that my study received from the organisers of support groups and the website was very supportive and enthusiastic. I also learned that a number of people suffering from social anxiety who have received specifically cognitive behavioural therapy, find it's effects are short term and are interested in treatments that look at deeper issues. I was surprised at the number of people who do not seek professional help but rely on these support groups and websites. It seems that in some cases this is due to the difficulties individuals have discussing their problems with their GP and their inability to be assertive when they feel their needs are not being met.

For some people who suffer from social anxiety the prospect of receiving treatment face to face is too daunting and anxiety provoking. There are however other modes of delivering interventions. For instance there are computer-based interventions like 'Beating the Blues' for anxiety and depression. This program uses a cognitive behavioural approach to treatment, though sessions are conducted at the computer as opposed to with an actual therapist. There are also some therapeutic services which are available over the internet known as 'E-therapy'. Therapy is conducted with a qualified therapist via email or in private chat rooms. Responsible sites do not claim to be equivalent to psychotherapy and state that having therapy in person is preferable, though for people who are unable or unwilling to seek help in person, this may offer a first step toward engaging in a process to understand their difficulty and receive help. There are also group therapy sites available on the internet where group members can use a headset and microphone to talk to the group counsellor and other members of the group during the session.

This is a relatively new mode of therapy and there are a number of ethical implications which should be addressed, for instance the safety of clients and how the risk of suicide is handled, issues of projection, how endings are dealt with, etc.. (King & Moreggi, 1998). Ultimately these internet services already exist and people are using them though professional and consumer controls do not seem to be in place. It is concerning that while people with social anxiety may be able to benefit from some of the services offered on the internet, they may also be vulnerable to the risks or lack of checks involved in this practice. This seems notably the case as they are a client group which would particularly struggle with meeting a therapist in person and yet taking this step and building up interpersonal trust seems to be a necessary step toward their recovery.

## 1.2 Issue of anger

One of themes that repeatedly came up while conducting the interviews was people's inability to express anger and an avoidance of any confrontation. In fact twenty-seven out of thirty people expressed that they rarely got into arguments with people and would deliberately avoid any confrontation. Below are some of the participants' responses.

"I would do anything to avoid an argument, I wouldn't confront anyone."

"I avoid arguments like the plague and I do that with all my relationships. Even if I was angry I would avoid people or say nothing."

"I usually just bite my tongue, I don't say anything."

"I hate confrontations, I run a mile from it. I just don't argue with people."

"It's rare that I'd get into an argument, I just wouldn't say anything."

"I rarely have arguments with people, I find it hard to express anger."

In many of the interviews people expressed a view that they often felt taken for granted or taken advantage of. Thirteen out of thirty people directly stated that they felt taken for granted. Below are some of the participants' responses.

“I often feel taken for granted”

“People take me for granted, I do whatever people want me to.”

“I feel taken for granted and it upsets me.”

“I feel taken for granted but I would never show it or say anything about it.”

“I feel taken for granted by my friends but I wouldn’t say anything.”

The sense of being taken for granted seems to contribute to their feelings of mistrust in social interactions and in interpersonal relationships. Many individuals reported that they often lacked the ability to assert themselves for fear of rejection or worries about other people’s responses. Social anxiety has been demonstrated to be related to a self-perception of less assertive behaviour (Weber, Wiedig, Freyer & Gralher, 2004) and people with a fearful attachment style have been found to lack assertiveness skills (Bartholomew & Horowitz, 1991). In addition difficulties with assertiveness have been found to be related to low self-esteem, which was a feature of the study group (Sharp, 1996; Gosse, Sullivan, Ross, & Simmonds et al, 1992; Katzman, Weiss & Wolchik, 1986). This lack of assertion and experiencing others as insensitive to their needs may well become a cycle which maintains feelings of mistrust. For instance an individual does not express their needs, others do not respond to them, and this feeds back into the perception that people take advantage of them. In fact Collins, Powell and Oliver (2000) demonstrated that individuals who are low in assertiveness take longer to process and state their needs, which contributes to the difficulties they may perceive of getting their needs met.

The lack of assertiveness skills would be hypothesised as a contributor to developing social anxiety from a social-skills deficit theory (Beidel, Turner & Dancu, 1985). This may well be an area that needs to be explored and targeted in therapy, though Heimberg and Juster’s (1995) found that treatments which exclusively concentrated on social skills training, were not as effective as those which also addressed affect and cognition. Possibly by incorporating the use of role-plays into CBT sessions, individuals could begin to practice assertiveness skills. This could then lead to

behavioural tests where an individual practices the assertiveness skills and monitors how other people respond to them.

### 1.3 The interview as a clinical tool

Using an attachment interview in this study was an important aspect to me. A part from the methodological advantages, I was keen to develop the skills and training required to conduct an attachment interview. This training has increased my awareness of the distinct factors that contribute to attachment patterns, for instance with regards to aspects of seeking help and using available support. In addition it has heightened my awareness of how pervasive attachment is to so many areas of people's lives. For example, seeking help can be as basic as going to one's GP when they are not well. It is possible that people who have difficulty trusting others, would also have difficulty trusting a doctor and following the advice that is given. In cases where early diagnosis is paramount it is possible that individuals with particular attachment patterns may delay seeking professional help, deleteriously affecting their prognosis.

Using the attachment interview with a socially anxious sample allowed me to probe areas that I would not have considered if I were assessing someone in a clinical situation. It increased my awareness of the idiosyncratic way that this sample views themselves in interpersonal interactions and relationships, and how they view others. Having used CBT for social anxiety with clients, I am now aware that these are areas which I did not directly address, particularly how others are viewed. Now I would assess individuals with regards to their perceptions of others and also explore how these perceptions were learned. If it was appropriate and an individual did have negative beliefs about others, I would approach this using a schema therapy model. I would also have more awareness of the necessity of the therapeutic relationship to foster the development of trust, in addition to being aware that impasses in therapy may be due to the compliance of clients and avoidance of confrontation. Suggesting

that genuine trust and engagement had not been developed and the treatment approach was not authentic for the client.

Since being trained in the attachment interview I have used aspects of the interview in assessment and clinical sessions with clients. I am currently working in an adolescent in-patient unit where attachment difficulties are often at the core of the young people's difficulties. From an assessment perspective this has given me the opportunity to consider attachment related attitudes, for instance mistrust or constraints to closeness. This has enabled me to think about the type of attachments my clients have and to consider how this may impact on the interventions. For instance providing a secure base within the therapeutic relationship, staying emotionally attuned to the client and consistent. In addition encouraging and helping the client to express anger and testing out their fear that if they assert themselves they will be rejected. Reflecting on attachment patterns and strategies has also contributed to my formulations of client's difficulties and essentially provided me with an extra dimension to consider. In addition I have been more aware of the types of attachment strategies that clients have learned and how these impact on their interpersonal relationships, including the therapeutic relationship. Once strategies have been identified and hypotheses shared with the client, the client is in a better position to make sense of these in the present. Ultimately I have found that being trained in the attachment interview has provided me with another research skill and has also enhanced my clinical skills.

#### 1.4 Scientist-practitioner role

While conducting this study I had email communication with a number of people who saw the advert for the study on the social anxiety website. Generally people were requesting more information about the study. My role in this capacity was as a researcher. I did however receive an email from a man who was requesting to be part of the study as a means to receiving a diagnosis. He described suffering from anxiety symptoms which he believed matched those described on the internet by other sufferers of social anxiety, though he stated that these symptoms are not

constant. He believes if his symptoms are indeed the symptoms of social anxiety, than he has struggled with them for thirty years. This man went on to further describe how these symptoms have led him to become depressed. The man stated that he had gone to his GP for help, but found this experience very frustrating as the doctor just trivialised his problems and did not offer any help or treatment.

After reading this email I was initially worried about what I could do for this man and what my role was. Obviously he was not suitable for the study and as a researcher I was not in a position to provide a clinical diagnosis. I therefore composed a response to his email, initially thanking him for his email and acknowledging his struggle over the past years and crediting him with the resources to keep going and looking for help. I stated what the purpose of the study was and felt that the interview would not be helpful to him at the moment and that getting help seemed to be the priority. I explained that ethically it would be inappropriate for me to see him in any clinical capacity though I provided information which I thought could help him understand more about his difficulties as well as helplines and website addresses (e.g. Mind, Sane, the Samaritans etc..) that he could contact which would offer support. I enquired about the possibility of him seeing another GP at his surgery, sympathising with how difficult it is to be assertive when you are feeling low but reminding him that he is entitled to help. In addition I provided him with some information about his right to treatment under the National Service Framework. I provided information on how he could get help privately by contacting the British Association for Behavioural and Cognitive Psychotherapies or the British Psychological Society in order to get the name of a registered therapist. Finally I suggested that if he was feeling particularly unwell or if he was worried about his own safety to attend his nearest hospital's Accident and Emergency, where he would be assessed by a Psychiatrist on duty.

This man responded to my email by stating that he found the information I provided very useful and that he intended to follow it up. He also said that he felt at last someone had recognised and understood his struggle. From my initial position of trepidation regarding how well I could respond to and/or help this man, I felt that I

was useful and that I had managed to use the information that I possessed and the therapeutic skills of empathy and validation, to provide a responsible and ethical response.

### 1.5 Constructivist perspective

From a constructivist perspective using labels like insecure attachment and social anxiety disorder can influence the way in which an individual sees themselves. In this way the labels may constrict an individual and impose meanings onto a person, instead of fostering their own meanings or constructs about themselves and the world. The diagnosis of social anxiety can be considered to be a social construction which encompasses expectations or demands pertaining to what society deems are normal social interactions. From this perspective social anxiety would be based on behaviours which deviate from these norms. Different cultures are likely to have different norms. For instance what is considered shy behaviour in one culture, may be considered appropriate respectful behaviour in another. These societal norms became particularly apparent to me while conducting the attachment interviews. A number of men that I interviewed discussed the difficulties they had conforming to gender stereotypes related to the way men are suppose to interact, particularly with each other. For instance one man spoke about his dissatisfaction with socialising with men by meeting up in pubs and talking about football. He described how difficult he found this interaction, as he wasn't particularly interested in football, as well as the alienation he felt in relation to his desire to talk about what he termed, more real topics. This same sentiment was reported by other men that I interviewed and contributed to them having difficulties engaging with males. Reflecting on the social dilemma this presented for these men made me consider how society's norms impact on what is considered acceptable social behaviours and how deviating from these presents problems for individuals. From this perspective one may contemplate whether the individual has difficulties with social interactions or whether this difficulty is driven/produced by society.

In conclusion, conducting this study had far reaching benefits for me as a clinician and a researcher. As an aspect of my development and training as a clinical psychologist, it represents an authentic experience of the scientist-practitioner role and the challenges that this role presents.

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