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Clinical features and treatment response in social phobia: axis II comorbidity and social phobia subtypes

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The aim of the present study was twofold. First, we studied the differential demographic and clinical features regarding social phobia subtype and axis II comorbidity. Second, we studied the role of social phobia subtype and axis II comorbidity in treatment effectiveness. The sample included 28 patients diagnosed of social phobia (DSM-IV, APA, 1994). We divided the sample attending to social phobia subtype and axis II comorbidity. When we compared the groups, we did not find significant differences in demographic variables. However, we found differences regarding clinical variables: Patients with generalized social phobia were more impaired than patients with circumscribed social phobia; patients with axis II comorbidity were also more impaired than patients without axis II comorbidity. All patients were treated with a group cognitive-behavioral program, adapted from Heimberg, Juster, Hope & Mattia (1995). There were no differences in effectiveness regarding the different sub-samples. However, some of the clinical differences found at the pre-treatment regarding some clinical variables disappeared after the termination of the treatment.

Características clínicas y respuesta al tratamiento en fobia social: Comorbilidad en el eje II y subtipos de fobia social. El presente estudio tiene un objetivo doble. En primer lugar, estudiamos las diferencias demográficas y clínicas en función del subtipo de fobia social y de la comorbilidad que presentaban una muestra de pacientes diagnosticados de fobia social. En segundo lugar, analizamos el efecto que el subtipo de fobia social y la comorbilidad en eje II tenían en la mejoría terapéutica. La muestra se compuso de 28 pacientes diagnosticados de fobia social (DSM-IV, APA, 1994). Dividimos la muestra en función del subtipo de fobia social y la comorbilidad en eje II. Al comparar los grupos, no encontramos diferencias significativas en características demográficas. Sin embargo, sí encontramos diferencias en características clínicas: Los pacientes con fobia social generalizada presentaban un mayor deterioro que los pacientes con fobia social circunscrita; asimismo, los pacientes con comorbilidad en eje II también presentaban un mayor grado de deterioro. Todos los pacientes recibieron un tratamiento cognitivo-comportamental en grupo adaptado de Heimberg, Juster, Hope & Mattia (1995). No encontramos diferencias en la eficacia del tratamiento en función del subtipo de fobia social y la comorbilidad en eje II. Sin embargo, algunas de las diferencias en características clínicas que se encontraron en el pretratamiento, no aparecieron en la evaluación realizada tras la finalización del tratamiento.

The essential feature of Social Phobia is a persistent and intense fear of one or more social situations in which the individual is exposed to the observation of others. The individual fears that he/she will behave in a way that will be humiliating. Exposure to those stimuli provokes an immediate anxiety response that can lead to the avoidance of those situations or to the endurance of them with intense anxiety (DSM-IV, APA, 1994). The clinical features of this diagnostic category include a wide number of situations, from specific fears such as eating, writing or speaking in public, to more generalized fears which appear in all or almost all social situations (Heimberg, Holt, Scheneier, Spitzer & Liebowitz, 1993).

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This variability has opened up a discussion on the necessity of distinguishing among different social phobia subtypes. As a background, we can take the Öst, Jerremalm & Johansson (1981) study. This authors, using the performance in a role-play, distinguished between «behavioral reactors» (behavioral disruption without cardiac acceleration) and «physiological reactors» (cardiac acceleration without behavioral disruption). Later, they considered another subtype, «cognitive reactors» (predominance of irrational thoughts) (Jerrelmalm, Jansson & Öst, 1986). DSM-III-R (APA, 1987) specifies the generalized social phobia subtype when the individual fears «most» social situations. This subtype is maintained by DSM-IV (APA, 1994). Heimberg distinguished three social phobia subtypes: generalized social phobia, which includes fear across almost all domains of social situations; non-generalized social phobia, which includes individuals who fear multiple social situations, but who report no problems in at least one social domain; and finally, discrete social phobia, which includes individuals with fear in only one or two circumscribed social si-

tuations (public speaking, eating in public (Heimberg, et al., 1993).

In the last years, several studies have been carried out to determine the differences in clinical and demographic features and the differential responses to treatment of different social phobia subtypes.

In the area of psychopathological and demographic differences, Turner, Beidel, Dancu & Keys (1986) found higher sensitivity to interpersonal relationship, depression, and worse performance in a social skills test in generalized social phobics. Heimberg, Hope, Dodge & Becker (1990) noticed that generalized social phobics were younger, less educated, and less likely to be employed than those with non-generalized social phobia. Also, generalized social phobics were more impaired, and depression, anxiety and fear of negative evaluation scores were higher. Turner, Beidel & Townsley (1992) found higher scores of distress and social anxiety in generalized social phobia. Tran & Chambless (1995) compared generalized social phobia with and without Avoidant Personality Disorder (APD) and circumscribed social phobia. They did not find differences in age, socio-economic status, age at onset, and the duration of the disorder. However, generalized social phobics with APD were more likely to be single or taking medication than circumscribed social phobics. Besides, generalized social phobics with APD presented a higher level of depression than the other two groups. Finally, in self-report measures, generalized social phobics (with or without APD) scored higher in the FNE (Fear of Negative Evaluation Scale, Watson & Friend, 1969) and the SADS (Social Avoidance and Distress Scale, Watson & Friend, 1969), and in measures of social impairment. Among the studies which used the Heimberg subtypes, we would like to mention the work by Herbert, Hope & Bellack (1992), where differences in age were not found, but generalized social phobics were more likely to be male. These patients received a greater number of secondary axis II diagnosis, and clinicians judged them as being more impaired overall, they showed worse social skills, and their performance in a social interaction behavioral test was worse. In a similar study, Holt, Heimberg & Hope (1992) noticed that generalized social phobics were more impaired overall, and presented extreme scores on self-report measures of social anxiety and depression. Also, generalized social phobia had an earlier age of onset of the disorder than non-generalized social phobia.

From these studies we can conclude that generalized social phobics, when they are compared with circumscribed or non-generalized social phobics, present more severity, more impairment overall and higher levels of associated psychopathology, such as anxiety, depression and social skills.

With regard to the differential response to psychological treatment, several studies have been carried out. Using the Öst subtypes, contradictory results have been found. Öst et al., (1981) found that «behavioral reactors» obtained better outcomes in social skills training, and «physiological reactors» had a better response in applied relaxation training. However, other studies (Jerrelman et al., 1986; Mersch, Emmelkamp, Bögels & van der Sleen, 1989) did not find differential response to treatment when comparing these social phobia subtypes.

The studies which compare the DSM-III-R and DSM-IV subtypes did not show conclusive results. On one hand, Heimberg (1986) found that social phobia subtype was the main predictor of outcome in group cognitive-behavioral treatment. However, Holt, Heimberg & Holt (1990), did not find that social phobia subtype was an outcome predictor. In this same sense, Turner, Beidel, Wolff, Spaulding & Jacob (1996) observed that there were no differences between generalized social phobics and circumscribed social phobics in the response to an exposure treatment, although generalized social phobia showed more impairment than circumscribed social phobics at pre-test, and these differences in overall impairment also appeared at post-test. Finally, using the Heimberg subtypes, Hope, Herbert & White (1995) and Brown, Heimberg & Juster (1995), found that patients with generalized social phobia did not differ in their response to a group cognitive-behavioral treatment. However, the same as occurred with Turner et al. (1996), they noticed that generalized social phobics were more impaired overall than non-generalized social phobics at pre-test, post-test and follow-up assessments.

In summary, it seems that there are no relevant differences in the response of different social phobia subtypes to psychological treatment, although patients with generalized social phobia present more impairment overall than patients with non-generalized or circumscribed social phobia at pre-test assessments, and these differences in impairment are maintained after completion of treatment.

Another important issue in social phobia literature is the study of axis II comorbidity in social phobia. Along this research line, we should mention the difficulty in distinguishing generalized social phobia and APD (Alden & Capreol, 1993). On the other hand, regarding response to treatment, the findings are not conclusive (Heimberg, 1996). Many studies on this issue obtained no differences in response to treatment between social phobics with APD and social phobics without APD (i.e., Brown et al., 1995; Van Velzen, Emmelkamp & Scholing, 1997). However, these studies also show a higher level of impairment in patients with APD at pre-test which is maintained after treatment completion (Brown et al., 1995; Hoffman, Newman, Becker, Taylor & Roth, 1995; Hope et al., 1995; Turner et al., 1996). However, other studies (Turner, 1987; Lucas & Telch, 1993; Chambless, Tran & Glass, 1997; Scholing & Emmelkamp, 1999) found that APD was associated with poorer outcome on several measures.

In this work, it is our intention to study, on one hand, the differences in demographic and psychopathological features, and, on the other hand, the differential response to a cognitive-behavioral treatment in a sample of patients who meet social phobia criteria (DSM-IV, APA, 1994). Both objectives were studied comparing social phobia subtypes (generalized vs. circumscribed) and social phobia with and without axis II comorbidity.

Method

Subjects

The sample was made up of 28 patients who attended the University Jaume I Anxiety Disorders Clinic in response to an advertisement that appeared in the local newspapers and on the radio. The patients were assessed using an admission interview that screens the presence of anxiety disorders. Then the patients who seem to suffer from social phobia were interviewed using the Anxiety Disorders Interview ADIS-R (Di Nardo & Barlow, 1988) to confirm the diagnosis. This instrument follows DSM-III-R (APA, 1987) criteria. We also evaluated each subject who took part in the study, following the DSM-IV (APA, 1994) criteria, and we found that diagnosis and severity showed no changes in any of the cases. Diagnoses were made by experienced clinicians. The patients were also interviewed to determine axis II comorbidity. We

use an instrument designed for this aim, following the Spitzer & Williams SCID-II (1987) structure, but introducing the DSM-IV criteria. We also established certain exclusionary criteria: severe organic disease, mood disorders, psychosis, and substance abuse related disorders.

46.4% of the participants met the criteria for circumscribed social phobia (persistent and intense fear in one or two social situations) and 53.6% met criteria for generalized social phobia (persistent and intense fear in most social situations). 32.1% presented axis II comorbidity (most patients met criteria for APD, just one patient met criteria for paranoid personality disorder). A binomial test was carried out and results showed that in our sample, there were no differences in the proportion of participants with generalized social phobia and circumscribed social phobia (p= 0.70), and there were no differences either between the proportion of participants with axis II comorbidity and without axis II comorbidity (p= 0.24).

The participants age ranged in age from 18 to 63, with a mean of 28 years (SD= 11.51). 39.3% of the participants were males and 60.7% females. 78.6% were single and 21.4% were married. Regarding the level of education, 67.9% of the patients have a degree or were studying at the university, 25% had finished high school and 7.1% had finished primary school. The mean duration of the disorder was around 12 years. During the interviews, many patients reported to have suffered this problem «for ever». To clarify the onset of the disorder we use as a criterium, the time when their social fears began to cause significant impairment in their lives.

We divided the sample according the different aims of our study:

1) Circumscribed Social Phobia (N= 13) vs Generalized Social Phobia (N= 15). The mean age of the first group was 26 years (SD= 12.78) and of the second group 29 (SD= 10.53). With regard to the mean duration of the disorder in the first group, this was 12.76 years (SD= 14.11) and in the second, 12.46 (SD= 9.77).

2) Axis II comorbidity (N= 9) vs. No Axis II comorbidity (N= 19). The mean age in the first group was 28 years (SD= 7.35) and in the second 28 (SD= 13.21). The mean duration of the disorder in the first group was 12.11 years (SD= 7.32) and in the second this was 12.84 (SD= 3.53).

The data were analyzed in two assessment periods: pre-treatment and post-treatment.

Measures

Diagnostic Interviews

Admission Interview (unpublished manuscript): Through this interview, information on demographic and clinical variables was obtained: The reason for coming to the clinic, the duration of the problem, severity of the problem as perceived by the patient, former treatments, alcohol and substance use, and presence of organic diseases. During the interview, the patient was also asked certain questions to determine the presence of different anxiety disorders.

Anxiety Disorders Interview Schedule (ADIS-R) (Di Nardo & Barlow, 1988): This instrument is an interview designed to assess and diagnose Anxiety Disorders with the DSM-III-R criteria. Besides the clinical diagnosis, this interview assesses the situational and cognitive factors that have influenced in anxiety.

Inventories and scales:

a) Weekly measures

AFS (Avoidance and Fear Scale) (Adapted from Marks & Mathews, 1979): The patient and the therapist established 4 behaviors or situations that the patient avoided because of social phobia and he/she rated the level of avoidance on a 0-10 scale where 0 was *I never avoid it* and 10 was *I always avoid it*; the level of fear was rated on another 0-10 scale, where 0 was *No fear* and 10 was *Extreme fear*.

Therapist and patient improvement measures (Adapted from Guy, 1976):

TGI (Therapist Global Impression): The therapist answered the question: *From your clinical experience, how would you evaluate the overall severity of this patient?* and evaluated from a clinical point of view the global impression on the severity of the patient on a 1-6 subjective scale, where 1 was *Normal*, 2 was *Slightly perturbed*, 3 was *Moderately perturbed*, 4 was *Quite perturbed*, 5 was *Severely perturbed*, and 6 was *Very severely perturbed*.

CIT (Clinical Improvement: Therapist): The therapist evaluated patient improvement from the beginning of the treatment on a 0-7 scale where 1 was *Much better*, 2 *Quite better*, 3 *A little better*, 4 *No changes*, 5 *A little worse*, 6 *Quite worse*, and 7 *Much worse*.

CIP (Clinical Improvement: Patient): The patient evaluated the level of improvement from the beginning of the treatment on a 1-7 subjective scale, the same as *CIT2*.

b) Pre/Post measures

State-Trait Anxiety Inventory (STAI) (Spielberger, Gorsuch & Lushene, 1970), Spanish version (TEA, 1988).

Beck Depression Inventory (BDI). (Beck, Ward, Mendelsohn, Mock & Erbaugh, 1961), Spanish version (Conde & Franch, 1984).

The Social Avoidance and Distress Scale (SADS) (Watson & Friend, 1969). This is a 28-item true-false scale that assesses anxiety and avoidance of several social situations.

Fear of Negative Evaluation Scale (FNE) (Watson & Friend, 1969). This is a 30-item true-false scale that assesses concern about being evaluated negatively by others.

The Social Phobia and Anxiety Inventory (SPAI) (Turner, Beidel, Dancu & Stanley, 1989). This instrument includes 2 scales: Social Phobia Scale (32 items), and Agoraphobia Scale (13 items). It assesses cognitive, behavioral, and physiological responses across several situations.

Self-esteem Scale (Rosenberg, 1965). This instrument assesses the degree of self-satisfaction. It is a 10-item instrument that is responded to on a 4-point scale ranging from 0 (*I completely agree*) to 3 (*I completely disagree*).

Impairment Questionnaire. (in Borda & Echeburúa, 1991): This questionnaire evaluated the impairment that the disorder had caused in several areas of the patient's life: couple, family, leisure, social area, work, and global impairment. Each area was rated on a 5-point scale with scores ranging from 0 (Not at all) to 5 (Completely).

Results

Demographic and psychopathological features at pre-treatment

These features were analyzed in regards to the social phobia subtype and axis II comorbidity. We carried out Chi-Square and MANOVAs (Wilks lambda). Dependent variables were grouped in 4 categories: variables directly related to social phobia (FNE, SADS, SPAI-S and Self-esteem Scale); Anxiety and depression variables (BDI and STAI-R); clinical status: impairment and improvement measures (TGI, CIT, CIP and Impairment Scale); and, finally the Avoidance and Fear Scale. Previously we checked that the measures in each category were highly correlated

Circumscribed vs. Generalized Social Phobia

Chi-Square tests did not reveal any significant differences in sex, level of education or marital status.

Regarding measures directly related to social phobia, MANOVAs revealed significant differences between the groups ($F(4,20)= 10.77$, $p< 0.001$). Univariate tests showed the Group effect in all measures. We also found statistical differences in the anxiety and depression measures, $F(2,21)= 3.81$, $p<0.05$). Regarding the clinical status measures, there were also significant differences between the groups, $F(4,21)= 3.307$, $p<0.05$). Univariate tests showed, however, differences in only one of the measures, TGI. Finally, we found no significant differences in fear and avoidance. In all cases where differences were encountered, the generalized social phobia group scored higher (and lower in the Self-esteem Scale) than the Circumscribed social phobia group. Table 1 shows the mean, standard deviations, F values and level of significance for these groups in the measures analyzed.

Axis II Comorbdity vs No Axis II Comorbidity

Chi square tests did not reveal significant differences in demographic variables: sex, level of education and marital status.

Regarding measures directly related to social phobia, the MANOVA did not reveal any differences between the groups. There were no differences regarding either anxiety or depression measures. As for clinical status variables, multivariate analysis showed no differences. However, univariate tests did reveal significant differences between the groups in TGI (Therapist Global Impression). Patients with axis II comorbidity were evaluated by therapists as more severe than patients without axis II comorbidity. Finally, there were no differences between the groups in avoidance and fear. Even though we did not find any significant differences, we would like to point out that the group with axis II comorbidity scored higher than the group without axis II comorbidity in several measures, of which we would emphasize SADS, FNE, BDI, and Global Impairment (See table 2).

Treatment Response

To analyze differential treatment response, repeated measures MANOVAs (Wilks lambda) were carried out.

Circumscribed vs. Generalized social Phobia

Repeated measures MANOVAs showed the following results:

Measures directly related to social phobia: We obtained a significant Group effect, $F(4,16)= 3.7$, $p<0.05$. Univariate analysis revealed a Group effect in Self-esteem, $F(1,19)= 7.45$, $p<0.05$, SADS, $F(1,19)= 12.77$, $p<0.005$, and SPAI-S, $F(1,19)= 5.30$, $p<0.05$. In all these measures, generalized social phobics showed a higher impairment. We also found a significant Time Effect, $F(4,16)= 6.63$, $p<0.005$), which was evident in all the measures on univariate tests: FNE, $F(1,19)= 11.49$, $p<0.005$, Self-esteem, $F(1,19)= 23.25$, $p<0.001$, SADS, $F(1,19)= 10.25$, $p<0.005$, and SPAI-S, $F(1,19)= 21.65$, $p<0.001$. No Group x Time effect was found.

Anxiety and Depression measures: MANOVAs revealed a Group effect, $F(2,21)= 5.01$, $p<0.05$. In univariate tests, we found this effect in both measures, BDI $F(1,22)= 6.44$, $p<0.05$, and STAI-R, $F(1,22)= 10.00$, $p<0.005$; generalized social phobics scored higher in these measures than circumscribed social phobics.

Table 1
Means, Standard Deviations, F values and level of significance of the scores in the measures at pre-treatment and post-treatment in generalized social phobia and circumscribed social phobia groups

Measures	Group	Pre-treatment			Post-treatment		
		M	SD	F	M	SD	F
SPAI-S	1	89.04	20.75	8.63**	68.67	21.11	10.23*
	2	117.48	23.64		72.64	21.83	
FNE	1	20.87	3.87	23.31***	19.12	4.73	NS
	2	26.84	2.03		18.53	7.35	
SADS	1	12.62	5.58	24.22***	11.12	4.39	20.21**
	2	23.31	5.29		15.15	6.68	
Self-Esteem Scale	1	29.62	4.50	13.29***	31.62	4.56	11.39*
	2	23.23	3.85		29.00	3.76	
BDI	1	7.81	5.34	6.69*	4.63	3.17	6.78*
	2	16.77	8.85		9.23	9.03	
STAI-Trait	1	28.18	10.95	5.38*	19.09	7.34	7.20*
	2	39.46	9.64		29.69	11.78	
TGI (Therapist Global	1	3.83	0.39	12.18**	1.83	0.57	NS
Impression)	2	4.00	0.00		1.80	0.86	
CIT (Clinical	1	3.25	0.96	NS	1.75	0.63	NS
Improvement: therapist)	2	3.40	0.82		1.66	0.82	
CIP (Clinical	1	3.25	0.86	NS	2.25	0.45	NS
Improvement: Patient)	2	4.47	0.84		2.33	0.97	
Global Impairment	1	2.75	0.97	NS	1.45	0.93	NS
	2	3.47	1.13		2.00	1.33	
Avoidance	1	2.83	1.94	NS	1.83	1.40	NS
	2	3.33	1.75		1.13	1.18	
Fear	1	3.50	1.68	NS	2.66	1.07	NS
	2	3.66	1.40		2.07	1.28	

Group 1: Circumscribed Social Phobia Group 2: Generalized Social Phobia
Level of statistical significance: * p < .05; ** p < .005; *** p < .001; NS: Non statistically significant
Note: Degree of freedom (pre-treatment) for SPAI-S, FNE, SADS and Self-Esteem scale: 1, 23; for STAI-T and BDI: 1, 25 and for TGI: 1, 24.
Note: Degree of freedom (post-treatment) for SPAI-S, SADS and Self-Esteem scale: 1, 20; for STAI-T and BDI: 1, 22

We also found a Time effect, $F(2,21)= 11.50$, $p<0.001$ that appeared in both measures in univariate tests, BDI, $F(1,22)= 17.26$, $p<0.001$, and STAI-R, $F(1,22)= 16.84$, $p<0.001$. Finally, analysis revealed no Time x Group interaction effect.

Clinical status measures: Analysis revealed no Group effect, but a Time effect, $F(4,22)= 45.65$, $p<0.001$. Univariate tests showed this effect in all measures: (TGI) Therapist Global Impression, $F(1,25)= 63.59$, $p<0.001$, Global Impairment, $F(1,25)= 21.83$, $p<0.001$, (CIP) Clinical Improvement: Patient, $F(1,25)= 67.19$, $p<0.001$, and (CIT) Clinical Improvement: Therapist, $F(1,25)= 179.27$, $p<0.001$. There was no Group x Time effect.

Avoidance and Fear Scale (AFS): We only found a time effect, $F(2,24)= 9.95$, $p<0.001$. Univariate tests showed this effect in both measures, Avoidance, $F(1,25)= 20.71$, $p<0.001$, and Fear, $F(1,25)= 12.45$, $p<0.005$.

In summary, we found a Group effect in variables directly related to social phobia and in anxiety and depression measures. In these variables, generalized social phobics were more impaired throughout the entire process. We found a Time effect in all analyzed measures, which revealed that our treatment was effective in both groups. Finally, it seemed that the treatment was equally effective in both groups, given the fact that we found no interaction effects. However, if we look at the means (see table 1), we notice that in the measures directly related to social phobia, the differences found between the groups before treatment tended to decrease after treatment completion.

Table 2
Means, Standard Deviations, F values and level of significance of the scores in the measures at pre-treatment and post-treatment in axis II comorbidity and non axis II comorbidity groups

Measures	Group	Pre-treatment			Post-treatment		
		M	SD	F	M	SD	F
SPAI-Social	1	119.21	22.43	NS	70.98	22.43	NS
	2	98.90	28.39		71.21	21.19	
FNE	1	27.75	1.38	NS	16.62	8.74	NS
	2	22.61	3.94		20.08	4.21	
SADS	1	23.62	4.13	NS	14.75	8.25	NS
	2	16.53	7.91		12.92	4.62	
Self-esteem Scale	1	23.00	4.72	NS	29.50	4.72	NS
	2	27.30	4.78		30.31	3.98	
BDI	1	18.12	10.29	NS	9.25	11.13	NS
	2	9.93	6.35		6.06	4.34	
STAI-Trait	1	41.12	10.03	NS	32.50	13.06	5.46*
	2	30.87	10.98		21.00	11.18	
TGI (Therapist global Impression)	1	4.66	0.86	7.48*	2.66	1.00	NS
	2	3.55	0.92		2.11	0.58	
CIT (Clinical Improvement: Therapist)	1	4.00	0.00	NS	1.88	0.93	NS
	2	3.89	0.32		1.77	0.64	
CIP (Clinical Improvement: Patient)	1	3.22	0.83	NS	1.66	0.86	NS
	2	3.40	0.91		1.72	0.67	
Global Impairment	1	3.00	1.51	NS	1.88	1.61	NS
	2	2.61	1.03		1.77	1.06	
Avoidance	1	3.22	1.78	NS	1.11	1.27	NS
	2	3.05	1.89		1.61	1.33	
Fear	1	3.22	1.48	NS	1.88	1.05	NS
	2	3.77	1.51		2.55	1.24	

Group 1: Axis II Comorbidity. Group 2: Non Axis II Comorbidity.
Level of statistical significance: * $p < .05$; NS: Non statistically significant
Note: Degree of freedom (pre-treatment) for TGI: 1, 24 and for STAI-T (post-treatment): 1, 25

Axis II Comorbidity vs. No Axis II Comorbidity

Variables directly related to social phobia: We did not find a group effect, but there was a significant Time effect, $F(4,16)= 12.44$, $p<0.001$. Univariate tests showed this effect in all analyzed variables: FNE, $F(1,19)= 25.98$, $p<0.001$, Self-esteem Questionnaire, $F(1,19)= 33.43$, $p<0.001$, SADS, $F(1,19)= 15.65$, $p<0.001$, and SPAI-S, $F(1,19)= 28.02$, $p<0.000$. There were also a Time x Group interaction effect, $(4,16)= 4.82$, $p<0.010$). Univariate tests showed this effect in the following measures: FNE, $F(1,19)= 10.26$, $p<0.005$, and Self-esteem Questionnaire, $F(1,19)= 4.54$, $p<0.05$, that is to say, the treatment achieved a higher decrement in fear to negative evaluation and a higher increment in self-esteem in patients with axis II comorbidity.

Anxiety and Depression measures: There was a Group effect, $F(2,21)= 4.01$, $p<0.05$. Univariate analysis showed that this effect appears only in STAI-R, $F(1,22)= 8.40$, $p<0.01$; patients with axis II comorbidity presented higher scores in this variable. We found a significant Time effect, $F(2,21)= 12.34$, $p<0.000$, which appeared in both measures, BDI, $F(1,22)= 22.37$, $p<0.001$, and STAI-R, $F(1,22)= 14.53$, $p<0.001$. No Time x Group effect was found.

Clinical status measures: We did not find a Group effect, but we did find a Time effect, $F(4,22)= 40.55$, $p<0.000$, which appeared in all measures, TGI, $F(1,25)= 54.85$, $p<0.001$, Global impairment, $F(1,25)= 26.10$, $p<0.001$, CIP, $F(1,25)= 59.39$, $p<0.001$, and CIT, $F(1,25)= 160.44$, $p<0.001$. No interaction effect was found.

Avoidance and Fear Scale (AFS). Only a significant Time effect was found, $F(2,24)= 10.32$, $p<0.001$. Univariate tests showed this effect in both measures, Avoidance, $F(1,25)= 21.23$, $p<0.001$, and Fear, $F(1,25)= 11.79$, $p<0.005$.

In summary, in measures related to social phobia and anxiety and depression variables, a group effect was evident. In these measures, patients with axis II comorbidity scored higher. On the other hand, treatment was effective, as can be concluded from the Time effect found in all measures. Finally, we found only differential treatment effectiveness (interaction effect) in two measures, the fear to negative evaluation (FNE), and self-esteem. In these measures, patients with axis II comorbidity improved more than patients without axis II comorbidity.

Psychopathological Features at post-treatment

Circumscribed Social Phobia vs. Generalized Social Phobia

As we have just seen, the differences found at pre-test tended to decrease after treatment completion. Upon observing this tendency, we planned to analyze whether or not the differences in clinical measures were maintained at post-test. Results are shown in table 1. Regarding measures related to social phobia, again we found significant differences, $F(4,20)= 12.17$, $p<0.001$). Univariate tests revealed differences in SPAI-S, SADS, and Self-esteem Questionnaire. In anxiety and depression measures, we also found

significant differences, $F(2,21)= 3.610$, $p<0.05$. Univariate analysis revealed differences in both measures. In the other measures, there were no statistical differences between Circumscribed and Generalized Social Phobia. If we compare these differences with those obtained at pre-test, we see that some differences were maintained once treatment was completed. However, in some variables where we found differences at pre-test, we did not find any differences at post-test, FNE, Global Therapist Impression. That is to say, although at pre-test generalized social phobics presented a higher fear to negative evaluation and the therapist evaluated them as more impaired than circumscribed social phobics, after treatment completion both groups presented similar scores in these measures (see table 1).

Axis II Comorbidity vs. No Axis II Comorbidity

Finally, we also analyzed clinical differences at post-test regarding Axis II comorbidity. Multivariate analysis showed no significant differences at post-test. We only found differences at post-test in STAI-T. The group with axis II comorbidity scored higher than the group without axis II comorbidity. If we compare these differences with those obtained at pre-test, it can be seen that the differences in Therapist Global Impression disappeared at post-test (see table 2).

Discussion

Over the past 10 years, numerous studies have been carried out to demonstrate the effectiveness of cognitive-behavioral programs for the treatment of Social Phobia (Feske & Chambless, 1995; Moreno, Méndez & Sánchez, 2000; Taylor, 1996; Turner, Cooley-Quille & Beidel, 1996). However, the success indices are smaller than those obtained in other disorders, such as Panic Disorder (Gould, Otto & Pollack, 1995). Because of this, researchers have recently been paying attention to the analysis of differential features and response to treatment regarding social phobia subtype and axis II comorbidity (i.e., Heimberg et al., 1990; Herbert et al., 1992; Hoffman et al., 1995; Holt et al., 1992; Mersch et al., 1989; Öst et al., 1981; Turner et al., 1992; Turner et al., 1996). The present work was designed to study these issues in a Spanish population.

Regarding the first aim, that is, the study of demographic and clinical differences regarding social phobia subtype and axis II comorbidity, our results showed that there were significant differences between social phobia subtypes in general measures as trait anxiety (STAI-R), and depression (BDI), and in more specific social phobia measures as FNE, SADS, SPAI-S, self-esteem, and also the therapist's clinical global impression. In all these measures, patients with generalized social phobia were more impaired. This data confirmed that generalized social phobics were more impaired than circumscribed social phobics, Generalized social phobics had a higher fear to negative evaluation, higher social anxiety, lower self-esteem, and, finally, the patients evaluated themselves as being more impaired. These results are similar to those of other studies (Heimberg et al., 1990 and Turner et al., 1996).

As for Axis II Comorbidity, results only showed differences in the therapist's global impression. The therapist evaluated patients with axis II comorbidity as being more impaired. These results are similar to those of Hoffman et al. (1995), Tran & Chambless (1996) and Turner et al. (1996).

The second aim was the analysis of the differential treatment response regarding social phobia subtype and axis II comorbidity. As for social phobia subtype, in most measures there were no differences in treatment effectiveness between generalized social phobics and circumscribed social phobics. With regard to axis II comorbidity. This data is along the same line of Brown et al. (1995), Hope et al., (1995) and Turner et al., (1996). These last authors found that although the treatment showed similar effectiveness in generalized and circumscribed social phobics, generalized social phobics were more impaired than circumscribed social phobics after termination of treatment. Our findings indicate that at pre-test generalized social phobics showed differences in some clinical variables –they were more impaired– and at post-test they continued to show higher impairment in some of these measures. In two variables, however, fear to negative evaluation and therapist global impression, the treatment managed to make those differences disappear.

Regarding axis II comorbidity, there were no differences in treatment response in most measures. However, the differences between the groups at pre-test disappeared at post-test. Besides this, we also found interaction effects in FNE and Self-esteem Scale which revealed that patients with a personality disorder had a higher improvement in these variables than patients without personality disorder. This would appear to suggest that our treatment has been very effective regarding fear to negative evaluation and self-esteem in social phobics with axis II comorbidity. However we should be cautious in regards to this finding. We will have to wait for a follow-up assessment to see if this result is maintained. In conclusion, our results about axis II comorbidity are similar to those of Brown et al. (1995), and Hope et al. (1995), who, despite having found a differential tendency in social phobics with personality disorder, the treatment response did not differ from social phobics without personality disorder. We agree with Heimberg (1996) in that it would seem reasonable to think that suffering from a personality disorder associated to social phobia should make the treatment more difficult. However, our data and that from other studies (see Heimberg, 1996) would support the idea that treatment responses are not different when there is a personality disorder. These results brought us to a controversy over whether or not APD is qualitatively distinct from social phobia. Heimberg (1996), taking into account the results from certain studies (i.e., Brown et al., 1995; Holt et al., 1992; Hope et al., 1995), states that the differences between these disorders are dimensional, that is to say, a question of degree, in regards to the severity of the disorder (Heckelman & Schneider, 1995; Heimberg, 1996). Other researchers, although their results did not support the idea that these disorders are qualitatively different, suggest we should look for the qualitative differences in measures as self-esteem (Tran & Chambless, 1995) or, even, to improving the methodology of the studies (Hoffman et al., 1995). Finally, Turner et al. (1992) are also of the opinion that these disorders are qualitatively different, and state that the fact that no differences were found is due to the similarity of diagnostic criteria which tends to make these two disorders overlap. Our findings support the idea that these disorders are only different from a quantitative point of view, given the fact that we did not find different treatment responses.

Results from this study therefore support the idea that our treatment is equally effective for all the patients in the sample, independent of the social phobia subtype or axis II comorbidity. On the other hand, we find encouraging the fact that, in the measure of

fear to negative evaluation (FNE) and the Therapist Global Impression, those patients who showed a more severe impairment (axis II comorbidity) achieved the same level of impairment as patients who were less impaired. Follow-up studies, however, are needed to be able to confirm this finding.

This study agrees with writings on the high effectiveness of cognitive-behavioral programs in social phobia, which have become the first lines of therapeutic action for this disorder. We feel, however, that research must design treatment alternatives that can help patients with higher levels of severity.

In summary, our findings support the idea that social phobia subtype and axis II comorbidity can help to explain the heterogeneity that clinicians find in their daily practice with social phobia. These results will hopefully encourage researchers to continue in delimiting the differential features and achieve treatments that are equally effective for all sufferers of social phobia, including or deleting therapeutic differential components that can provide an answer for these differences.

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