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## The behavioral and cognitive therapy for social phobia

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## Conclusions and discussion

In this chapter the results of the studies described in the preceding chapters will be discussed in a broader perspective. Also, some critical remarks will be made about the clinical and diagnostic state of the art in social phobia. Finally, suggestions for future research will be made.

### Discussion of the results

In general, it can be concluded that three treatments have shown to be effective: social skills training, cognitive therapy and exposure *in vivo*, while the effectiveness of applied relaxation is, at this stage, questionable and awaits further study (see chapter 1). Although these treatments are effective, it is generally felt that, in comparison to other anxiety disorders (e.g., agoraphobia, panic disorder and simple phobia) their effectiveness is less. Follow-up studies show that too many patients need additional treatment and of the patients that did not need additional treatment a considerable percentage shows a relapse (see chapter 8 and 9). The most important hypothesis for this state of affairs is that in social phobia individual differences are large (e.g., Marzillier & Winter, 1983; Scholing & Emmelkamp, 1990). Therefore, from the first studies on social phobia on (e.g., Kanter, & Goldfried, 1979: high vs. low social anxious; Trower, Yardley, Bryant, & Shaw, 1978: unskilled vs. social phobic patients), the influence of subtype of social phobia and treatment effectiveness has been an important topic in research. A somewhat different approach in this context is the classification of patients on the basis of disturbances in one of three response systems, the psychophysiological, the cognitive and the behavioral system (Lang, 1971; Rachman and Hodgson, 1974). Öst, Jerremalm, & Johansson (1981) found some support that a treatment matched to the specific response system deficiency was more effective than a treatment that was not. A study by Jerremalm, Jansson, & Öst (1986) was not able to replicate these findings.

The Mersch, Emmelkamp, Bögels, and Van der Sleen (1989) study (chapter 4) applied more rigid criteria, in order to create more extreme patient groups. However, this study also failed to confirm the hypothesis that treatments matching patient characteristics are more effective than treatments that do not. One of the fundamental issues in these three studies is the choice of assessment instruments to divide patients in the respective reactor group. Often, these instruments are not psychometrically studied and developed for the study at hand. Whether or not these instruments are valid with respect to their purpose is questionable. For the Mersch et al. (1989) study both the cognitive criteria variable (the Rational Behavior Inventory; Sanderman, Mersch, Van der Sleen, Emmelkamp, & Ormel, 1987) as well as the behavioral variable (the Simulated Social Interaction Test; Mersch, Breukers, & Emmelkamp, 1992; see chapter 3) were analyzed. The behavioral test (SSIT; Curran, 1982) was translated in Dutch and adapted for use on both male and female subjects. This did not affect the reliability of the test. The SSIT appeared to have high reliability coefficients, which were comparable with figures from studies in the USA. The Mersch et al. (1992) study confirmed the hypothesis that social behavior is largely situation specific (Bellack, 1983; Nelson, Hayes, Felton, & Jarret, 1985; Wessberg, Curran, Monti, Corriveau, Coyne, & Dziadosz, 1981). The consequences of this result will

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be discussed later on. Other findings were that female subjects judged themselves as less skillful than male subjects, while judges rated their level of skill about equally good. Also, the test appeared to be sensitive for educational level.

As discussed in chapter 1, another approach to improve treatment effectiveness was to include different treatment techniques in one integrated treatment package, in order to do justice to the individual characteristics of the patient. Results of studies to investigate the surplus value of these treatments were not encouraging. In the Mersch (1993) study the inclusion of social skills training in a cognitive-exposure treatment package did not enlarge treatment effectiveness in comparison to exposure *in vivo* alone.

The presence of predominant somatic symptoms like sweating, blushing, and trembling in social phobic patients may be another clinically relevant distinction. The treatment of patients in whom somatic symptoms are predominant has, in contrast to panic disorder, received little attention in social phobia. Reduction of visible somatic symptoms has never been included in the assessment of social phobia, whereas the fear that these symptoms will be visible to other people is at the core of the fear of a substantial number of social phobic patients. The fear that others will notice their symptoms and by association, their uncertainty, triggers a vicious anticipatory cycle that almost inevitably leads to the appearance of the feared symptom. In the Mersch, Hildebrand, Van Hout, Lavy, & Wessel (1992) study (chapter 7) the effectiveness of an experimental treatment on 3 social phobic patients with, respectively, a fear of blushing, trembling, or sweating is described. It is argued that in social phobics for whom somatic symptoms are the principal complaint, a paradoxical approach like prescribing the symptom may be called for. Because the feared stimulus is symptom rather than situation, exposure *in vivo*, for instance, is less effective when the symptom is absent. The important finding of this study was that the treatment was not only able to reduce the fear and avoidance of social situations and the fear of the symptoms, but also to actually reduce the occurrence of these symptoms. Also, patients attributed their improvement to rational emotive therapy instead of to exposure *in vivo*, providing them with a powerful coping mechanism for the future.

One subgroup of social phobia has recently received growing attention, namely patients with an additional personality disorder. An important question is whether the presence of a personality disorder has influence on the effectiveness of treatments for social phobia. Several authors have emphasized that social phobics may be hard to treat with cognitive-behavioral or pharmacological treatments (Heimberg, Dodge, & Becker, 1987; Greenberg & Stravynski, 1983). According to Heimberg et al. (1987) a patient with APD '...has little desire to confront the phobic event and has adopted avoidance as a comfortable if unfulfilling life-style....' and '...the avoidant personality would appear to be a poor risk for treatments such as our multicomponent group program' (p.302). The one study performed so far seems to confirm this notion. Turner (1987) compared the effectiveness of a cognitive-behavioral group treatment for social phobic patients without personality disorder (n=6) and for social phobic patients with personality disorder (n=7). At the posttest two patients were diagnosed as avoidant, three as schizotypal, one as borderline, while one patient had two Axis II diagnoses, avoidant and borderline. On most anxiety and avoidance measures, the patient group without personality disorder improved significantly more than the group with personality disorder.

Results of the Mersch, Jansen, and Arntz (1993) study are much more encouraging. Although patients with a personality disorder had more severe complaints at the pretest, this did not influence treatment outcome

(chapter 6). Both groups appeared to benefit equally from the treatments on all variables. Nevertheless, the functioning of personality disorder patients at the first follow-up was on most variables significantly worse than that of patients without personality disorder. This means that although patients with personality disorder benefit from a relatively short structured behavioral treatment, this is not enough to reach an acceptable end-state functioning. On most variables the end-state functioning of personality disorder patients is about equal as the pretreatment functioning of patients without personality disorder. It may be hypothesized that for patients with a personality disorder the treatment, although effective, must be considerably longer.

Little is known about the long-term effectiveness of cognitive-behavioral treatments for social phobia. In a review of the literature (chapter 8) the reasons for this state of affairs are discussed. In the first place, the follow-up periods are relatively short. Only six studies, of which two were case-studies, published so far (Alström, Nordlund, Persson, Harding, & Ljungqvist, 1984; Biran, Augusto, & Wilson, 1981; Stravynski, 1983; Wlazlo, Schroeder-Hartwig, Hand, Kaiser, & Münchau, 1990; Scholing & Emmelkamp, 1993b,c) reported follow-up periods of more than six months. These generally short follow-up periods prevent conclusions about relapse. More serious, however, are the methodological flaws in the designs. Especially the lack of information on additional treatments and medication, the inclusion of booster sessions or homework between posttest and follow-up and the undocumented omission of variables are violations of a sound methodology of this phase of the studies and tend to exaggerate maintenance of treatment effect. Therefore, a more creative use of the possibilities of follow-up research was proposed.

The results of the follow-up study (Mersch, Emmelkamp, & Lips, 1991) of the patients of the Mersch et al. (1989) study, show the merits of a more elaborate approach (chapter 9). In general there was a clear maintenance of treatment effect. If the different groups of patients are analyzed separately, however, the results were less favorable. Of the 57 patients who participated in the follow-up assessment no less than 25 (44%) had received additional treatment between follow-up I and follow-up II. Furthermore, of the 32 patients that did not receive additional treatment, 9 showed a significant relapse. Overlooking the consequences of these findings, it appears that of the 74 patients starting the treatment, for only 23 patients (31%) the treatment was successful. The main reason for this finding may be that the treatments were too short (cf. Scholing, 1993). Another important finding of this study is that a short follow-up period (in our study the first follow-up was after 6 weeks) does not seem to give additional information. Finally, it appeared that level of social skill may be an important outcome predictor. From a methodological point of view this study shows how a more thorough data analysis may give important additional information.

#### **Critical remarks and suggestions for future research.**

##### *Clinical considerations*

In the treatment of social phobia, there seems to be a group of patients that is hard to treat, no matter what treatment is given. This group seems to be delineated by more serious initial psychopathology and may benefit from prolonged treatment. Another indication for the importance of treatment duration is the number of additional treatments. Comparison of the results of four long-term follow-up studies (Mersch et al., 1991;

Mersch, 1993; Scholing & Emmelkamp, 1993) shows that the number of additional treatments and number of additional treatments (Mersch et al., 1991; Scholing & Emmelkamp, 1993) study, it seems that duration of treatment (Mersch et al., 1991; Scholing, 1993), maybe even more so than the number of additional treatments (Mersch et al., 1991; Scholing, 1993), whether more treatment time is needed to d

##### *Subgroups in social phobia*

As mentioned, social phobic patients are considered to be a heterogeneous group. This point of view was expressed by the DSM-IV (1994) type) of social phobics. The question is whether

Most research has focused on the distinction between social phobia and personality disorder. Results from several studies (Mersch et al., 1993; Turner & Hope, 1992; Mersch et al., 1993; Turner & Hope, 1992) show that the differences that are found between subgroups in social phobia. It is possible that the differences between subgroups in social phobia. It is likely that when patients with any Axis I disorder who are severely disturbed the outcome will be poor. In other words, it is likely that a study comparing the effectiveness of treatment in supermarkets with agoraphobic patients who avoid supermarkets, rooms and restaurants, would find more severe outcomes for social phobic patients diagnosed with the specific subtype for less severe pathology than the 'generalized' subtype. Non-generalized social phobics reported a relapse rate of 10% in subgroups (with or without APD) reported a relapse rate of 10% (Heimberg et al., 1990) did not report duration of treatment.

A problem with the division of social phobia into subtypes is the place. The diagnosis of specific or discrete subtypes or two social situations (e.g., speaking in public) is given to patients who fear most social interactional anxiety, like going to parties or public places (Gibbon, Fyer, & Liebowitz, 1991). Also, patients with the specific subtype (Scholing & Emmelkamp, 1993) distinction is considerable. Although, acknowledgment of the distinction (Liebowitz, 1992; Widiger, 1992) the inclusion of specific and generalized social phobia (Holt et al., 1992) by Holt et al., 1992), does not seem to be a problem and leads Widiger (1992) to state that

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Mersch, 1993; Scholing & Emmelkamp, 1993b,c) suggests a negative relationship between duration of treatment and number of additional treatments. Considering these studies and the Scholing and Emmelkamp (1989) study, it seems that duration of treatment is an important variable in the treatment of social phobia (cf. Scholing, 1993), maybe even more so than treatment technique. Future research should study the question whether more treatment time is needed to do full justice to an integration treatment.

#### *Subgroups in social phobia*

As mentioned, social phobic patients are considered a heterogeneous group, consisting of different subtypes. This point of view was expressed by the DSM-III-R that distinguishes two subgroups (specific and generalized type) of social phobics. The question is whether there is evidence for the existence of these subgroups.

Most research has focused on the distinction between specific and generalized social phobia and avoidant personality disorder. Results from several studies (Heimberg, Hope, Dodge, & Becker, 1990; Holt, Heimberg, & Hope, 1992; Mersch et al., 1993; Turner, Beidel, Dancu, & Keys, 1986; Turner, Beidel, & Townsley, 1992) show that the differences that are found are in the level of severity. These results show the problem with subgroups in social phobia. It is possible that these studies are merely comparing severity of psychopathology. It is likely that when patients with any Axis I diagnosis who are lightly disturbed are compared with patients who are severely disturbed the outcome will be that the latter group has more severe symptoms. In other words, it is likely that a study comparing agoraphobic patients who only become anxious in and avoid supermarkets with agoraphobic patients who become anxious and avoid streets, public transportation, waiting rooms and restaurants, would find more severe symptomatology in the latter group. There is a possibility that social phobic patients diagnosed with the subtype 'specific' have a shorter duration of complaint to account for less severe pathology than the 'generalized' subtype. In one study this indeed is the case (Holt et al. 1992), non-generalized social phobics reported a mean duration of complaint of 15.3 years, while the generalized subgroups (with or without APD) reported a mean of 24.2 years. The two other studies (Turner et al., 1992; Heimberg et al., 1990) did not report duration of complaint.

A problem with the division of social phobia in subgroups are the criteria to which the distinction takes place. The diagnosis of specific or discrete social phobia is given to a person with social anxiety in only one or two social situations (e.g., speaking in public or using public restrooms). The diagnosis of generalized subtype is given to patients who fear *most* social situations. These latter patients are characterized by more social interactional anxiety, like going to parties and talking to co-workers. Sometimes, patients are diagnosed with a specific social phobia if they do not fulfill the criteria of generalized social phobia (Schneier, Spitzer, Gibbon, Fyer, & Liebowitz, 1991). Also, patients with predominant somatic symptoms have been diagnosed with the specific subtype (Scholing & Emmelkamp, 1993). It can be said that the confusion concerning the distinction is considerable. Although, acknowledged by several researchers (e.g., Holt, Heimberg, Hope, & Liebowitz, 1992; Widiger, 1992) the inclusion of a non-generalized subgroup to fill the gap between a specific and generalized social phobia (Holt et al., 1992; Heimberg, Holt, Schneier, Spitzer, & Liebowitz, 1991, cited by Holt et al., 1992), does not seem to be a practical solution. This merely creates two grey areas instead of one and leads Widiger (1992) to state that 'One is still left with the ambiguity of what is meant by many,

some, and most social situations, the definitions of which are likely to vary across studies.'(p. 341).

Another question is whether the distinction of subgroups has clinical relevance. Although, according to Scholing (1993), this is indeed the case, it remains to be seen whether there is a differential treatment effectiveness between the different subgroups of patients. Comparisons in treatment effectiveness between subgroups awaits investigation. Scholing and Emmelkamp (1993) were the first to study the treatment effectiveness of cognitive-behavioral therapies on generalized social phobics, but since no comparison group of specific social phobics was used nothing can be said about differential effects.

The conclusion from the above is that the subgroups of social phobia may only differ with respect to the severity of the complaint. Whether this distinction has consequences for treatment outcome is thus far unknown. A problem with these subgroups is that the diagnosis is left to clinical judgement, which will undoubtedly differ across researchers. This means that in future research agreement should be reached about the boundaries of the subgroups. The inclusion of another subtype by Heimberg et al., 1991, cited by Holt et al. 1992, the non-generalized subtype does merely seem to add to the boundary conflict. Also, the considered inclusion in DSM-IV (APA, 1991) of a third subtype (performance type) next to a limited situational type and a generalized type seems premature.

In addition to a sub-group approach, the study of individual differences and treatment-outcome in social phobia will undoubtedly profit from a retrospective approach as well. Therefore, the neglected area of the study of long-term effectiveness should be considered less as a time consuming obligation and should be approached with more enthusiasm and creativity. The analysis of follow-up data offers an opportunity for a more individual approach and, if possible, should include an analysis of 'failures' and 'successes'.

#### *Personality disorders*

Personality disorders seem to be more prominently present in social phobia in comparison to other anxiety disorders (Klass, Dinardo, & Barlow, 1989; Alnaes & Torgersen, 1988). Percentages vary from 20% to 100% personality disorder (Mersch et al., 1993). In all studies on this subject, avoidant personality disorder (APD) is the predominant personality disorder in social phobia (Van Velzen & Emmelkamp, 1993).

Although APD is not a subgroup of social phobia but often an additional DSM-III-R, Axis-II disorder, the relationship between social phobia and APD resembles the state of affairs with respect to the subgroups of social phobia. The introduction of Personality Disorder (PD) as a distinct diagnostic category separate from the symptom disorders in the DSM-III (APA, 1980), has stimulated the study of the relationship between Axis I and Axis II disorders. Two developments have influenced the study of personality disorders in social phobia. First, the above discussed distinction in DSM-III-R (APA, 1987) between specific social phobia and generalized social phobia led to studies with the purpose to delineate subtypes of social phobia. The second development was the consequence of an influential article by Marks (1985). In line with results of a study in which social phobics showed less adequate social skills than patients with APD (Greenberg & Stravynski, 1983), Marks (1985) differentiated between two types of social anxiety: pure social phobics (SP) and patients with social skills deficits (SSD), the latter group being identical to avoidant personality disorder. Marks (1985) characterized both groups as follows: 'In brief, SPs

have fears more limited to particular social situations which is more like a trait of shyness in extreme cases and avoidant personality disorder resembles the latter. The guided research of the last 5 years concerning social phobia therefore focused on the comparison between

It may be, however, that an artefactual distinction between criteria of APD and of (generalized) social phobia is that of a severe form of social phobia, an hypochondriacal social phobia and APD (cf. Widiger, 1991). The predominant personality disorder in mania is not APD. APD is a side-effect of social dysfunctioning. Jansen and Torgersen (1988) APD was the most prominent disorder found in the study of Jansen et al. (1991) who often diagnosed PD. Furthermore, in the study of Holt et al. in their number of dependent personality disorders. Another hypothesis is that APD patients have better social skills (Marks, 1985). Marks may have been wrong, indeed had shown this difference. Since Marks' exploratory study by Turner et al. (1986) comparing social phobics with APD, the latter group, however, failed to find significant differences. Bellack, 1992; Turner et al., 1992; Holt et al. At this stage, a skills deficit explanation for the difference is rejected. If APD patients are indeed less socially competent, the hypothesis is interesting. In this respect, it is interesting to note that social phobia (i.e., public speaking phobia) is not a generalized social phobia.

In the study of personality disorders, the role of the duration of the symptoms. Especially the criteria have a large overlap with or social phobia or panic disorder, obsessive-compulsive disorder, anxiety disorder), should be looked upon as a symptom of complaint rather than stable, enduring personality disorders is called for. Question is whether the age of onset of personality disorder or Axis I disorder are more vulnerable to treatment. The point of view from a preventive and clinical point of

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have fears more limited to particular social situations and more discrete in onset than the anxiety of SSD, which is more like a trait of shyness in extreme form' (p. 615). What Marks described as social skills deficit and avoidant personality disorder resembles the definition of generalized subtype of social phobia and has guided research of the last 5 years concerning social phobia and personality disorder. The study of APD, has therefore focused on the comparison between the generalized form of social phobia and APD.

It may be, however, that an artefact is being studied. In the first place, in view of the overlap in the criteria of APD and of (generalized) social phobia, it may be that a diagnosis of APD is merely a reflection of a severe form of social phobia, an hypothesis that is confirmed in several studies comparing (generalized) social phobia and APD (cf. Widiger, 1992; Mersch et al. 1993). In the second place, APD may be the predominant personality disorder in many Axis I disorders, especially the anxiety disorders. It may be that APD is a side-effect of social dysfunction as a result of many severe Axis I diagnosis. In a study of Alnaes and Torgersen (1988) APD was the most predominant PD in 8 out of 13 Axis I disorders. The same result was found in the study of Jansen et al. (1993). In social phobia as well as in panic disorder APD was the most often diagnosed PD. Furthermore, in the latter study, social phobics differed most from panic disorder patients in their number of dependent personality disorders.

Another hypothesis is that APD patients differ from social phobics without an APD in their level of social skills (Marks, 1985). Marks may have been inspired by a study of Greenberg and Stravynski (1983), which indeed had shown this difference. Since then, this matter is hardly investigated and results are mixed. An exploratory study by Turner et al. (1986) found significant differences between social phobics without an APD and social phobics with APD, the latter group showing less effective social skills. Three recent studies, however, failed to find significant differences in level of social skill between both groups (Herbert, Hope, & Bellack, 1992; Turner et al., 1992; Holt et al., 1992). It is hard to draw conclusions from these studies. At this stage, a skills deficit explanation for social phobia or avoidant personality disorder can be accepted nor rejected. If APD patients are indeed less socially skillful, this could well be accounted for by the severity hypothesis. In this respect, it is interesting that in a study by Heimberg et al. (1990), patients with a specific social phobia (i.e., public speaking phobics) had significantly better social skills than patients with a generalized social phobia.

In the study of personality disorders, the development of reliable and valid assessment instruments is of importance. The role of the assessor should be minimized and more attention should be devoted to the duration of the symptoms. Especially the personality disorders that may be a function of general pathology (e.g., avoidant personality disorder and dependent personality disorder) and/or personality disorders of which the criteria have a large overlap with one or more Axis I disorders (e.g., avoidant personality disorder and social phobia or panic disorder, obsessive-compulsive personality disorder and the obsessive-compulsive anxiety disorder), should be looked upon with scepticism. There is evidence that they may represent severity of complaint rather than stable, enduring traits. Longitudinal and epidemiological research with respect to personality disorders is called for. Questions involving the prevalence of the different personality disorders, the age of onset of personality disorders, and whether 'normals' with a personality disorder but without an Axis I disorder are more vulnerable to develop psychopathology are important, from a theoretical as well as from a preventive and clinical point of view.

*Assessment of social skills*

A major difficulty in the social skills debate in social phobia is the assessment of social skills. Not two of the abovementioned studies that employed behavioral tests used the same test situation. Also, the rating levels (molecular, intermediate or molar) differed, as well as the measures (qualitative or quantitative). One study used subjective measures only (Holt et al. 1992), which are not comparable to more objective measures by independent raters. Another study (Heimberg et al., 1990) used different individualized situations, making comparisons between groups impossible. All these differences are the more problematic, since the reliability and validity of these tests are unknown. All behavioral tests used in research in social phobia are used only once in the involved studies, and are hardly ever evaluated psychometrically. These methodological flaws which would invalidate all assessment instruments are even more troublesome in the assessment of social behavior, which is to a great extent related to specific situations (Bellack, 1983; Mersch et al., 1992; Nelson et al., 1985; Wessberg et al., 1981). In other words, someones performance on a test is to a large extent dependent on the situation represented by the test. Furthermore, social behavior rated by higher class judges in behavioral tests may be sensitive to educational level (Mersch et al., 1992). In view of these considerations interpretation of the results of the different studies is an hazardous affair.

Therefore, in order to pursue this issue further, the development of reliable and valid assessment instruments to measure a complex phenomenon like social skills is a basic requirement. Preferably, the study of social skills should take place in a more embracing context in which the simultaneous measurement of physiological arousal, subjective anxiety and cognitive aspects is included. The importance of the inclusion of these variables is shown by the preliminary results of a recent study (Mersch, van der Wijngaart, Hofman, & van Hout, 1993) which are in contrast to the Beidel, Turner, and Dancu (1985) study. In a multidimensional study, Beidel et al. (1985) studied physiological reactivity, cognitive variables and social skills of 26 social phobic patients and 26 non-social phobics in different social situations. The conclusion from their study was that both groups differed from each other on all three systems. Social phobics showed higher physiological arousal, more negative self-statements and less skillfull behavior than non-social phobics. Since Beidel et al., (1985) used subjects that rated above a cut-off score on a questionnaire and not social phobic patients, this study was replicated by Mersch et al. (1993) comparing social phobic patients with 'normals'. Conclusions from this study are that both groups did not differ on physiological arousal during a behavioral task (a conversation with two confederates). As expected, the social phobics showed highly increased heartrate and blood pressure, indicating that the situation was indeed anxiety arousing. The 'normals', however, showed an identical increase in arousal on both variables. The social phobics showed both before, as well as immediately after the behavioral test significantly more negative self-statements. Although both groups showed the same physiological arousal, the patients were judged as significantly more anxious and less skillful by the confederates than the 'normals'. Subjectively, the social phobics did not judge themselves as significantly less skillful than the 'normals' judged themselves. An interesting finding in this study is the high negative correlation between negative self-statements and the subjectively experienced skillfulness for the social phobics ( $r = -.78$ ) in contrast to the 'normals' ( $r = -.04$ ). This result may be an indication that lack of social skills may be a consequence of the believe by the patient that he or she does not behave as competent as other people.

In other words, this lack of social skills (Bandura, 1977). The differences in outcomes on all levels of measurement and the importance of this area is called for.

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ia is the assessment of social skills. Not two of the used the same test situation. Also, the rating levels e measures (qualitative or quantitative). One study are not comparable to more objective measures by D) used different individualized situations, making nces are the more problematic, since the reliability sts used in research in social phobia are used only ted psychometrically. These methodological flaws en more troublesome in the assessment of social ations (Bellack, 1983; Mersch et al., 1992; Nelson meones performance on a test is to a large extent ore, social behavior rated by higher class judges ersch et al., 1992). In view of these considerations azardous affair.

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In other words, this lack of social skills may be a consequence of low efficacy and outcome expectations (Bandura, 1977). The differences in outcome between the two studies shows the complexity of behavior on all levels of measurement and the important role that situational context may play on behavior. More research in this area is called for.

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