Comprehensive Cognitive Behavior Therapy

for

Social Phobia:

A Treatment Manual

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Summary of Modifications to the Ledley, Foa, & Huppert Comprehensive CT for SAD Manual

James D. Herbert, Evan M. Forman, & Erica Yuen
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Introduction

1. In "notes," clarified that manual is designed for comorbid SAD and depression, if applicable.
2. Changed program from 16 to 12 weeks, and from 1.5 hours to 1 hour sessions, with the exception that the first two sessions remain at 90 min.
3. Condensed sessions 2 & 3 into a single session (Session 2)
4. Exposure exercises begin in session 3 instead of 4.
5. Note that all sessions beginning at session 3 include at least one exposure (rather than "most" sessions…)
6. Relapse prevention (sessions 15 and 16) is condensed to session 12.
7. Rather than allowing for 2 additional sessions (as needed) to focus on depression, instead the total treatment duration remains at 12 sessions, but therapists are permitted to delay implementation of the social phobia specific intervention in order to allow for an initial focus on behavioral activation, if necessary.
8. Deleted study-specific instructions (e.g., videotaping, specific measures, etc.).

Throughout the Manual

1. Modified the language to be more gender neutral (e.g., "his" → "his or her").
2. Corrected typos, grammatical errors, and formatting inconsistencies.

Session 1

1. Changed the specific time frames, given the shorter duration of each session.
2. Noted that the specific references to depression should only be used as relevant, i.e., for patients with significant depressive symptoms.
3. A few principles that highlight the cognitive aspect of treatment were underlined, in order to draw specific attention to this focus.
4. In the original manual, the session concluded with noting that there would be 3 HW tasks, but yet only two were described. This was therefore changed to read two HW assignments.

Session 2

1. Condensed original sessions 2 and 3 into session 2.
2. Deleted development of fear hierarchy, as this will already have been done.
3. De-emphasized the amount of time devoted to reviewing the model at the beginning of the session.

4. Underlined key procedures in the safety behavior and video feedback exercise.
5. Noted that each exercise (e.g., conversation) should last approximately 5 minutes.
6. Deleted the rating of anticipated self-consciousness, as this is likely to be interpreted similarly as the rating of anxiety. This was also deleted in order to save time and streamline the procedure.
7. The timing of the confederate making ratings of the patient's anxiety and performance during the safety behavior experiment was modified. Rather than the confederate providing ratings to the therapist following the end of session 2, the confederate provides the ratings directly to the therapist immediately following each exercise. The therapist will then decide if and how to utilize these ratings.
8. Homework assignments for the original sessions 2 and 3 are combined into the revised session 2.

Sessions 3-12

1. It was noted that the *in vivo* exposures can be both simulated and unsimulated.
2. Language about these sessions being unstructured was modified to note that they are more flexible than the first two sessions, but still structured. In particular, it was noted that except in the most unusual circumstances (e.g. crisis, sudden significant worsening of depressive symptoms), exposure exercises should be conducted in each session, and in fact are the focal point of each session in this phase.
3. It was emphasized that confederates, rather than the therapist, are typically employed in exposure exercises, increasingly over the course of treatment.
4. (p. 41) Formal cognitive restructuring, derived from the Heimberg model, was introduced in the discussion of *in vivo* exposure exercises.
5. Re. the optional modules, it was noted that such modules should *not* replace *in vivo* exposures, but rather should be integrated with them as indicated.
6. In the discussion of the general structure of sessions, caveats about keeping this discussion brief and focused was added, as well as the importance of the therapist being aware of patients' tendencies to extend this discussion as a subtle form of avoidance of anxiety provoking exposure exercises.
7. Homework assignments were modified to include two new forms: the Attention and Safety Behaviors Monitoring Form and the Cognitive Self-Monitoring Form.

***In vivo* exposure module**

1. Formal cognitive restructuring (from the Heimberg model) was integrated into the description of exposure exercises throughout this module.

Social skills and Assertiveness modules were unchanged (other than correcting typos, etc.)

Termination module

1. The treatment length was changed from 16 to 12 sessions.

Table of Contents

List of Forms to Accompany Manual

Notes on Use of the Manual

This manual outlines a treatment program designed for patients with social phobia. The program includes 12 weekly sessions of individual treatment, each lasting approximately 1 hour.

Overview of CCBT

The treatment described in this manual places primary focus on social phobia; it is appropriate for treating patients with social phobia and secondary comorbidities. The treatment program is flexible, allowing therapists to tailor treatment according to the idiosyncratic presentation of social phobia symptoms for each patient.

In **Session One,** the treatment program begins with the therapist and patient deriving a model for the patient's social phobia, using Form 2. By illuminating the importance of focus of attention and safety behaviors in maintaining social phobia, the model serves as a guide for treatment. At the end of the first session, activity monitoring is introduced (Form 4) and is assigned as homework.

Session Two consists of the safety behaviors experiment and video feedback. The purpose of this experiment is to demonstrate to the patient, in an experiential way, the detrimental impact of self-focused attention and the use of safety behaviors, and that the patient's belief/experience about the way that he/she comes across to others is significantly different from reality (based on video feedback and confederate feedback).

For **Session Three** and beyond, treatment consists of exposures, as well as other treatment techniques (video feedback, surveys, imaginal exposure, social skills training, and assertiveness training) that are used on an as needed basis. All sessions beginning with session 3 include at least one *in vivo* exposure exercise (e.g., conversation with one or more

confederates or going into public places to ask questions, etc.), and *in vivo* exposures are also assigned each week for homework. Accordingly, the patient has repeated opportunities to practice shifting focus of attention and dropping safety behaviors, thereby gathering evidence regarding exaggerated probability and cost judgments in the feared social situations. The manual includes guidelines for when to make use of the optional modules (imaginal exposure, social skills training, and assertiveness training) as a complement to ongoing *in vivo* exposure work.

In **Session 12**, treatment concludes with a discussion of relapse prevention and with the therapist helping their patients to set specific goals for the year following treatment. This is meant to help the patient to be his/her own therapist once formal treatment ends.

In some cases, secondary symptoms (e.g., depression) are so severe that it will be difficult to move on with social anxiety treatment in Session 3. For such patients, one can split the focus of sessions between social phobia and secondary symptoms. The main goal of such work is to get patients to the point that they are able to carry through with the treatment program. Examples would include behavioral activation to decrease depression and cognitive restructuring aimed at increasing patients' motivation for the treatment and confidence in their ability to make positive changes in their lives. Such modification is only conducted when absolutely necessary, and would occur prior to the safety behavior and video feedback exercise scheduled in session 2. While shifting focus back to social phobia treatment might seem difficult with these patients, moving on to the safety behaviors experiment can be helpful with both their mood and social anxiety. Doing something in service of the social anxiety can be experienced quite positively by patients and in most cases, they come away from the safety behaviors experiment with a sense of hope and with a

framework for understanding the maintenance of social phobia and what they need to do to get better.

One final note on the style of the manual: Rather than prescribing exactly what to say to patients and what to do during particular sessions, the manual presents therapists with concepts and techniques that are used in the treatment program. Therapists should be familiar with all concepts and techniques and apply them in a clinically astute way based on the patient's idiosyncratic presentation. Samples of how to present particular concepts to clients are presented in gray text boxes.

Session One

Note that session 1 and 2 are 90 min; all subsequent sessions are 60 min.

Before the Session:

The therapist should review the patient's pre-treatment questionnaires and his/her fear hierarchy.

Session Goals:

(1) Derive an idiosyncratic model of social anxiety; illuminate roles of safety behaviors and attentional focus in maintaining social phobia

(2) Using the model, give an overview of the treatment program (goals will be to change behaviors and beliefs; discuss evolutionary function of emotions and embarrassment)

(3) Assign homework (complete blank model of social anxiety, and form about how social anxiety has impacted life)

(4) Summarize session

Notes on general tone of the first session

The first 10 to 15 minutes of the session should be taken to establish rapport with the patient. This can be done by introducing oneself, describing experience in working with social anxiety, and answering any questions the patient has. The therapist should get to know the patient. Keep in mind that some patients with social phobia have a difficult time with open-ended questions such as, "Tell me about yourself." Rather, the therapist needs to ask specific questions such as where the patient is from, age, current employment/educational status, current living arrangements, history and impact social anxiety has had on their lives, etc. The therapist should also ask the patient what has motivated them to seek treatment for their social anxiety. Given how difficult it can be for patients with social phobia to meet new

people and to share personal information, the therapist should strongly reinforce patients for their decision to come for treatment, their willingness to reveal personal information, etc.

Throughout the session, as the model is derived and discussed, therapists should make use of a whiteboard. Not only does the whiteboard serve as a good medium for explaining the key aspects of treatment, but it also shifts focus away from the patients, making it easier for them to share their thoughts and feelings.

The other essential point to keep in mind during the first session is to set the tone of collaborative empiricism. The purpose of the first session is for the client, who is "an expert in his own difficulties," to help the therapist understand his or her current experiences. Socially anxious patients often have a difficult time correcting others. Therefore, therapists should "check in" with the client frequently, making sure that they are deriving a model that accurately represents the patient's thoughts, feelings, and behaviors, and that the patient does not feel that the therapist is forcing the patient into a predetermined framework. Similarly, it is important not to make it seem as if there is an answer that the therapist is expecting to put on the board (like a teacher may do in school), as this can cause significant anxiety for the patient. At the same time, the basics of the treatment should be described: 60 minute sessions, once weekly, with homework between sessions. Phone call check-ins are encouraged as needed.

Overview

I am really glad that you've come for treatment for your social anxiety. It can be really difficult, particularly for socially anxious people, to come and talk about their problems with someone that they don't know. But, doing so is a really important step to getting over your social anxiety and I am really glad that you've taken this step.

Let me tell you a bit about our treatment program. This program is unique in that it is designed for patients like you who have social phobia. [If the patient has significant depressive symptoms, add: We have strong reasons to believe that addressing your social anxiety with CBT will also provide significant relief to your depressive symptoms. Thus, while we do not deny the importance of your depression, we believe that given that given the fact that your social anxiety preceded your depression, it is likely to improve your mood if we can help you to be less socially anxious and more engaged in more social situations.]

In the first session, we will spend time learning about your social anxiety symptoms. This will allow us plan an effective treatment program for you.

1. Deriving the Model

-Therapists should use the white-board to derive the model.

-Therapists should use Form 2, Blank model of social phobia and Form 3, the annotated model, to guide them through the process of deriving the model.

I want to take the rest of our session today by seeing if we can put together a model to understand more about your social anxiety. It is important before we start to treat social anxiety that we understand how all of the different aspects of the problem may fit together. Then, over the next few weeks we will test out this model to see what works and what doesn't within it.

When people expect to experience social anxiety in a particular situation, they can do two things – they can either avoid the situation completely or they can put themselves in the situation, but do things to make being in the situation somewhat easier.

Are there any situations that you completely avoid? What are the things that you just won't do because of your social anxiety?

When these situations come up, what kinds of thoughts do you have about them?

(*These questions allow you to derive the top left of the model, about avoidance behaviors and thoughts. Fill in the specific patient-specific information for each category).*

Now we are going to talk about those situations that you do enter, but that cause you a great deal of anxiety. *(Allow patient to list off a few).* We are going to gather a detailed list during our next session of these situations. For working through your model today, let's come up with one situation – maybe one you were in recently. Can you think of a situation in which you experienced social anxiety, but were able to stay in the situation? (*It is important to find a situation that caused moderate social anxiety, but that the patient was able to stay in, in order to get accurate information about the thoughts, safety behaviors, etc. experienced).*

What were you thinking about in the situation? What was going through your mind? What else? And what would that lead to? *(spiral down as needed).* In your mind, was the worst thing that could happen in that situation? What would be so bad about that?

(physical symptoms): How did your body feel in the situation? Did you experience any physical symptoms of anxiety? Did you notice anything like sweating, blushing, trembling? How about your heart?

(safety behaviors): Did you do anything in the situation to try to prevent your feared consequences (*use specific feared consequences from patient's information)* from occurring? *Other questions to elicit safety behaviors:* Did you do anything to try to prevent people from noticing _____? Is there anything you do to try to ensure that you will come across well?

Do you do anything to try to control your symptoms? Do you do anything to try to avoid drawing attention to yourself?

(self-focus) When you were afraid that ___ would happen in this situation, what happened to your attention? Did you become more self-conscious? As you focused attention on yourself, what did you notice?

(self-image) As you focused attention on yourself, did you have an image in your mind of how you were coming across to others? What did it look like? If I closed my eyes and tried to picture the image you have, what would I see? How does having this image affect you? When you completely avoid situations, is your decision affected by an image like this?

After getting a few answers (3-4 is sufficient usually) from each category, ask the patient to describe how they understand the relationships between the different categories that you have put on the board. Guide them through socratically, without challenging them if you think that they are wrong (e.g., if they think safety behaviors decrease negative thoughts and anxiety symptoms). Instead, just state that it is an interesting observation that we will test out more fully in the coming weeks.

Avoidance-Thoughts relationship

(*Explain dotted line on mode Socratically: What happens to these thoughts if you avoid completely? Does your decision to avoid these situations affect the way that you think about yourself? How do you feel the next time the opportunity arises to do the same thing? Are your thoughts stronger, weaker, or the same? How do these kinds of thoughts affect your likelihood of going into the situation? How about the next time that same situation comes up?* **The goal:** *Complete avoidance interferes with the ability to change or learn anything*

new. If situations are completely avoided, nothing else really happens except that patients tend to have thoughts about those situations that tend to maintain their social anxiety, beliefs, and avoidance over time. When patients do enter situations, other factors come into play (in addition to negative thoughts) that maintain social anxiety), necessitating a continuation of the model beyond thoughts.

S**afety Behaviors (SB) and Self-Focus** What happens to your focus of attention when you do these things (*SBs)* that are meant to prevent your feared consequences from occurring? Again, how does this affect you? What are you focused on- yourself or the conversation?

Physical symptoms and self-focus. As you noticed yourself sweating, blushing, heart racing (i.e., becoming more anxious, what effect did that have on your attention?

Self focus and thoughts. When you are aware of *(contents of self-focus)* does it make it seem more or less likely that these feared outcomes will occur?

Ask if there are other relationships between categories that the patient hypotheses or has observed in him/herself.

Okay, so let's see if we have this right. (*Review model with the patient).* Have I understood correctly? Is there anything missing or anything that doesn't make sense?

What do you make of this model?

Some patients will "get" the model right away and will be able to discuss the following ideas with the therapist:

1. There are two general ways that patients handle social anxiety and try to protect themselves from negative outcomes in social situations. First, there are social

situations and circumstances that they avoid altogether. While avoidance is reinforcing in the short-term by reducing anxiety, over the long-term, it prevents patients from learning how likely it is that the negative outcomes that they fear will actually occur.

2. Second, many times it is impossible to avoid social circumstances altogether and patients try to minimize the likelihood that their feared outcomes will occur by focusing attention on themselves and checking how they are coming across to other people.
3. Self-focused attention precludes patients with social phobia from picking up on evidence in the environment that would disconfirm their negative beliefs.
4. Patients also try to minimize the likelihood of feared outcomes in social situations by engaging in certain behaviors that are called safety behaviors. But as we have seen in the model, safety behaviors often backfire and actually increase the likelihood of the negative outcome that patients are trying to prevent.

Other patients might not immediately "get" the model – in other words, they might not immediately see that safety behaviors and self-focused attention can be detrimental. Therapist should not insist on the patient's accepting this view. Rather, they should let patients know that together with the patients they will be exploring aspects of the model in future sessions and examining how the ways that patients behave in social situations might play a role in maintaining difficulties with social anxiety over time. In keeping with a scientific or collaborative approach to treatment, introduce the ideas about the factors that maintain social anxiety as possibilities to be tested– not as laws. The safety behaviors and focus of attention experiment can then be used to experientially to demonstrate these

principles to patients. For patients who do "get" the model right from the start, the safety behaviors and focus of attention experiment will serve to further demonstrate, in an experiential way, the premise underlying the treatment.

2. Using the model, give an overview of the treatment program

So, now that we have some ideas of how the various aspects of social anxiety might fit together, how can we help you overcome anxiety? Any thoughts on what we might be able to do?

The treatment is about examining this model more fully, in ways to determine how these different behaviors, thoughts, and feelings interact. The goal is to determine which relationships are maintaining or increasing your anxiety.

As you've probably already noticed, simply *being* in social situations won't break the cycle of social anxiety. Right now, you do put yourself in some social situations, but still feel anxious when you are in them. In treatment, we want to help you change the way that you experience social situations, which will likely also change the way that you think about social situations.

Let's first talk about the way that you experience social situations. There are things that you can do to make social situations easier to handle and that might actually make social situations more enjoyable for you. Is there anything that you saw in the model that might be making social situations more difficult for you? (*It is good, but not necessary if the patient sees the potential difficulties with focus of attention and safety behaviors).* In the treatment, we will work on changing where you focus attention and see how these changes affect your experiences in social situations. We will also see more about how these behaviors impact your anxiety. (*Therapist should note that some patients will be skeptical at this point about*

the benefits of shifting focus of attention and dropping safety behaviors. This is completely fine, and therapists should not "argue" with patients or try to convince them of the benefits of making these changes. Rather, therapists should suggest that the patient takes the stance of a scientist, treating these changes as experiments that may or may not turn out to be beneficial to them).

This idea of changing thoughts is also important since people with social phobia sometimes think in a way that actually maintains their social avoidance and distress over time. Specifically, socially anxious people tend to overestimate the likelihood of experiencing negative outcomes in the social world, and furthermore, tend to see negative outcomes as having a much greater cost than do people without social anxiety. *(Therapist gives an example relevant to patient).* We will discuss some of these beliefs directly, but the best way to test out their validity is through experience. As you begin to put yourself in social situations, you will likely see a shift in your beliefs about how likely your feared outcomes are and also in your ability to handle them were they to occur.

Patients will be asked to devise another model, based on another situation for homework (give patients a blank model, form 2). This will serve as a check on their understanding of the key concepts and allow them to consider safety behaviors/thoughts/focus of attention in another situation. Likely, they will see more similarities than differences between situations.

It can be helpful to describe some of the functions that social anxiety is supposed to have and how its "overworking" can backfire and cause more social isolation. One such model is describing that social anxiety is a "fear of embarrassment or criticism." The concept can be taught trough a mix of Socratic questioning and didactics.

Our emotions are most likely not simply accidents. We believe that we have been given the ability to experience emotions as ways to help communicate to ourselves and others efficiently, and potentially nonverbally. For example, what do you think is the evolutionary function of anxiety? In other words, why do people in general feel anxious? *Lead the patient to see that anxiety serves a protective function of communicating to the self and others that danger may be present and that they should seek safety.* And why do you think people feel embarrassed? *Try to elicit to keep one from violating social mores or norms. To help:* What do you think someone would be like if he/she had no concerns whatsoever about being embarrassed? Would you like to be around such a person? How might it backfire? *Note that some patients who are socially anxious are so weighed down by their fears that it seems a relief to them to not have the burden of embarrassment. Part of the goal of this discussion is to begin a reframe of this perspective.* In fact, psychologists have done extensive research examining how people respond when someone makes a minor social infraction and then does vs. does not exhibit embarrassment or blush. People are liked MORE when they appear embarrassed after such an event. Why would that be? *See if the patient is getting the idea.* Exactly. If one never was embarrassed, they would seem as if they did not care about violating the social rules that society has created in order to keep people together. One way of seeing social anxiety is that you want so much to be part of a group (*for very anxious, generalized SPs, this is humanity)*, that you are afraid that you might do something that will indicate that you violated a social rule. Unfortunately, this actually keeps you from becoming part of the groups that you value the most. Our goal is to help you be able to be part of the groups you value without an appropriate/adaptive amount of concern about violating their mores.

4. Assign Homework

Patients will be assigned two tasks for homework:

(1) Complete a model of social anxiety, based on another situation (provide patients with a blank model, Form 2, to fill in and a copy of the model that was completed in session that they can refer back to;

(2) Complete the form about how social anxiety has affected their lives (Form 4) and what they hope will change for them once social anxiety is no longer as impairing for them.

It is useful to set the stage for homework in the first session in order to provide the patient with appropriate model and expectations of the role of homework in the treatment program. One metaphor that can be useful for the patient is that of learning a foreign language.

This should be done Socratically through asking a patient if they have learned a second language, what it takes to become fluent in another language, and what indicators suggest fluency in another language. Doing this treatment is like learning a new language. We help in treatment through providing most of the vocabulary and grammar (i.e., skills and techniques to cope with social anxiety). Homework is one way of helping transfer these ideas into the real world. The more you create opportunities to use your new language, the more accessible it will be. However, learning a language takes time: As you continue to practice, it will become second nature. But the skills and techniques will not be immediately available, especially in the most difficult situations. In fact, the goal is to practice enough that you will be able to do two things that indicate being truly fluent: you will be able to argue under stress and to dream in this new language.

Have patients write down their homework assignment so that they don't forget any of it.

5. Summary

Do you have any questions about today's session?

What did you learn from today's session?

Starting at Session One, the therapist and patient can begin a running list of "things I learned." At the end of each session, the patient should be asked to summarize what the most important "take home messages" were for them from the session. Each week, these lessons can be added to a running list that patients can refer back to when they are having difficulties. Such lessons might include, "Focusing on myself makes it harder for me to pay attention to what is happening in social situations;" "Safety behaviors feel like they are going to help, but they actually make it more likely that bad things will happen;" "The more I avoid, the harder things will be;" "Even if I don't feel motivated to do something, I should do it – I will likely not regret it later."

** Remind patients to come a few minutes early to the next session to fill out their forms **

** Write a Progress Note and complete the Technique Record, (Form 5) **

Session Two

The Safety Behaviors Experiment and Video Feedback

Session 2 is 90 min; beginning next week, sessions will be only 60 min.

Before the Session:

Ask the patient to complete weekly measures.

Session Goals

(1) Review measures

(2) Review model that patient completed for HW

(3) Briefly discuss treatment expectancies and review questions about social anxiety using handout

(4) Conduct safety behaviors experiment [select situation, obtain prediction ratings, identify associated safety behaviors, give instructions for first social interaction, carry out first social interaction (with safety behaviors), obtain post-interaction ratings, give instructions for second social interaction, obtain prediction ratings, carry out second social interaction (without safety behaviors), process the exercise]

(5) Conduct video feedback and possible confederate feedback [give instructions to watch videos as if observing someone else, obtain prediction ratings, watch first video, obtain "actual" ratings, watch second video, obtain "actual" ratings, process ratings, discuss confederate ratings]

(6) Assign homework

(7) Summarize session

Therapist Notes

Session 2 is dedicated to the Safety Behavior Experiment and video feedback. As in any other session, it is essential to leave enough time to review homework at the beginning of each session, assign new homework at the end of each session, and summarize each session and record what the patient learned from it. Therapists should use Form 6 to guide them through the safety behaviors experiment and video feedback.

1. Review measures and briefly discuss the past week

At the beginning of each session, the therapist and patient review the measures that the patient completed at the beginning of the session. In general, the therapist should use these measures as a means of discussing the week, rather than showing patients how their scores have changed numerically. For example, the therapist may notice that the patient's avoidance of social situations went up in the prior week and could then say, "I notice that you've been avoiding social situations a bit more this week than you had the past few weeks. What came up this week that you decided to avoid?" Therapists should also discuss with patients the relationship between the social anxiety measures and the BDI (e.g., "It looks like your avoidance of social situations was quite extreme this week and you also seem to have been feeling a bit depressed. Do you see a link between these two things?").

In Session Two, there might not be a great deal to discuss regarding the measures since a pattern has not been established and no specific interventions have been introduced. The therapist should look, however, for any significant changes since the previous week. For example, some patients might have an increase in depressed mood and social anxiety simply because they became more aware of these problems in the past week as a result of being in treatment. Others might actually show a slight improvement in their mood because they feel

hopeful about starting to work on their difficulties. These sorts of issues can be briefly discussed at the beginning of the session.

2. Review model that patient completed for homework

A brief note about homework compliance:

When reviewing homework, be mindful of how social anxiety might interfere in homework completion – some patients might complete their homework, but feel embarrassed to show it to the therapist for fear of being judged negatively; some might be so anxious about negative evaluation that they simply avoid doing the homework at all. Depression can also make completion of homework difficult, due to lack of motivation or avoidance.

During this session, therapists should discuss these possible obstacles in order to facilitate homework compliance. Therapists can tell the patient that many patients get nervous about reviewing homework – to such an extent that some actually will tell the therapist that they did homework that they didn't do or that they had a much easier time with homework than they actually had. Therapists should patients know that they recognize that patients with social phobia are not vindictive! Rather, their social anxiety carries over into the therapeutic relationship with some patients becoming concerned that the therapist is just one more person who will judge them negatively. It is helpful to inform patients that they will get the most out of treatment if they are open and honest with the therapist, letting them know when homework was too difficult or when something got in the way of completing it. Basically, the goal of this conversation is to set a non-judgmental tone for the therapy so that patients truly feel that this is one arena in which they do not have to worry about negative evaluation.

Obviously, homework is an essential part of CBT, but early in the treatment program, therapists should ensure that they do not take a punishing stance with their patients. Rather, they should explore with them why completing the homework was difficult and try to come up with a solution for the week ahead. It can also be useful to review with patients why homework is such an integral part of the treatment (so important, in fact, that the first 10 minutes of the session are dedicated to reviewing homework and the last few minutes of the session are dedicated to assigning it). For patients who did complete homework, therapists should reinforce their behavior. When giving feedback on homework, therapists should take a positive attitude, framed as helping patients to make homework optimally beneficial for them.

At the start of Session Two, the first homework assignment to review is the blank model of social phobia that the patient should have completed. Therapists should be mindful that the model is quite complex and that patients are introduced to it for the first time during Session One when their anxiety is likely to get in the way somewhat of their ability to process information. So, therapists should not be surprised if patients come back with a less-than-perfect model, and should avoid spending too much time discussing details of the model. The primary goal is simply to ensure that patients have a general understanding of the concepts of safety behaviors, self-focused attention, the likelihood that feared consequences will come to pass, and the possible relationships that exist among them.

For Session 3, a review of the results of the attentional exercise, and examples of how they applied the concepts that they learned from session in their daily lives should be elicited.

3 . Discuss Treatment Expectancy and Review Questions about Social Anxiety Using Handout

Another potential complication when treating patients with social anxiety who are also depressed is that they might have a more pessimistic view of treatment and of their ability to change than patients with social anxiety who are not depressed. At this point, the patient will have had one week to give some thought to the idea of *being* in treatment. Session One provided them a brief introduction to the treatment and a way to conceptualize their social anxiety. During Session Two, therapists should ask patients if they have any questions about the model for understanding social anxiety or about the treatment program. Patients should also be asked how they feel about being in treatment and should be encouraged to be up front with their beliefs and not to worry about the therapist's feelings!

At Session Two, very few patients will feel overwhelmingly positive about being in treatment. Most will have doubts about the effectiveness of the treatment, and whether it will work for them. Therapists should not try to convince the patient that the treatment *will* work for them. It is fine to point out that the treatment has been very helpful to other patients, but it is important that patients adopt an investigative approach where their own future is concerned and we want them to be willing to try what we know to be effective techniques for treating social anxiety and depression, but we invite them to withhold judgment on the potential benefits until they try and see for themselves.

When patients express beliefs like "Nothing will help me," or "I've been isolated for so long that there is no use changing now," therapists should spend some time examining these beliefs and trying to increase hopefulness. Therapists should reinforce patients for sharing these beliefs and then use Socratic questioning to help them arrive at other ways of viewing their current situation. This approach is in stark contrast to trying to "convince" patients that they are incorrect (e.g., "Of course the treatment will work!"). For example,

with the thought, "Nothing will help me," therapists can ask, "Has anything ever helped before?" "Have you ever tried cognitive behavioral therapy?" or "Was there a time in your life when you were doing better than you are now?" Therapists should help patients recognize that they are trying something new, the outcome of which they cannot know.

Some patients may still be in the stage of wondering whether they should change at all since it is easier to stay in the "status quo" than to make changes that are anxiety-provoking and effortful. In such cases, the therapist can help the patient to draw up a list of the pros and cons of making changes. In doing so, therapists can draw on the handout **Questions About Your Social Anxiety (Form 4**) that patients completed for homework about their social anxiety (*the handout includes the following three questions: (1) What sorts of things are you not doing or not enjoying that you would do if you didn't have social anxiety? (2) What opportunities have you missed out on because of social anxiety? (3) How will your life be different if you no longer have social anxiety? Be specific about what you would do or change.)*. In most cases, patients will recognize that they will not able to accomplish any of their goals if they don't put in the effort (and endure initial increase in anxiety) that is necessary for making changes. We cannot emphasize enough how important it is not to reprimand patients or tell them "point blank" that they will get nowhere unless they try. The therapist should stay completely neutral regarding whether or not the patient should make changes. Rather, it is his/her role to ask the appropriate questions to help patients arrive at their own decision.

Therapists can also provide information about the data supporting the treatment program: that this is the most effective method of treating social anxiety we know of, with

more than 75% of patients feeling like they are able to engage in social situations without their social anxiety limiting them by the end of treatment.

If patients feel quite hopeful about treatment and about their ability to change, therapists should explore their expectations. However, the "Questions about Your Social Anxiety" handout should still be reviewed. This handout allows patients to share, in a non-threatening way, their feelings about social anxiety – what they have missed out on, and what they would like to do differently in the future. This understanding will likely enhance the therapeutic relationship and facilitate treatment planning based on what is important to the patient.

4. Conduct Safety Behaviors Experiment (adapted from Clark's manual)

In the safety behaviors and focus of attention experiment, patients engage in a social interaction that is moderately difficult for them under two conditions: In the first interaction, patients make a point of engaging in their typical safety behaviors and are instructed to pay special attention to how they are coming across to others, trying to come across well. In the second interaction, the goal is to drop safety behaviors and to focus outward on the social situation ("immerse themselves / get lost in the conversation"), and not trying to come across well, instead of focusing inward on how the patient believes that he/she is coming across to others.

The goal of the safety behaviors and focus of attention experiment is to establish one main point: *Patients typically feel more anxious and self-conscious when performing their safety behaviors and focusing attention inward, as compared to when they drop their safety behaviors and focus their attention outward on the situation at hand.* Because patients have relied on these strategies for so long, believing that they reduce anxiety and prevent bad

outcomes from occurring, finding out that these strategies are not particularly useful can be quite surprising and increase patients' willingness to try dropping safety behaviors and shifting focus of attention when in social situations.

Instructions for the safety behaviors and focus of attention experiment:

(a) Selecting a situation and setting up the experiment

In the experiment, patients should engage in a social interaction that is moderately difficult for them. By moderately difficult, we mean that the interaction should cause some anxiety, but not so much anxiety that the patient would want to leave the situation. The interaction should be one that is relatively easy to set up in the session (e.g., because it is being decided on at the beginning of the session, doing a speech in front a large audience would be logistically impossible). The social interaction can be between the patient and the therapist, if appropriate, but is typically a casual one-on-one conversation with a "confederate" who is brought in for the experiment. Having *both* confederate and patient on tape can be very helpful later on in the exercise. For example, if a patient says that his hands were shaking, it can be helpful to have him (or an objective observer) compare the degree to which the patient's **and** the confederate's hands were shaking. Often, when patients become focused on a particular sign/symptom like shaking or saying "um", they in fact do not engage in the behavior to a noticeably greater degree than the other individual.

Once the situation is selected, patients should be asked what their most feared outcome of the situation is. This should be clearly articulated. The experiment must be set up in such a way as to evaluate the predictions later. For example, if a patient fears blushing, have her point out something in the office that is as red as she expects to be (have some red books on hand, or pieces of paper of various shades of red). Make sure that the

red object is in the frame near the patient's face (e.g., hang the piece of paper behind them on the wall) so that during video feedback, the patient can compare her face to the color of the paper.

Prior to telling them about engaging in safety behaviors or focus of attention, patients are asked to make predictions about the experiment. They will be asked to rate:

- how anxious they expect to feel
- how anxious they expect to appear
- their expectations for their performance overall
- the extent of any other negative consequence that they are afraid will occur (i.e., the outcome they are trying to avoid by using their safety behavior).

After patients have clearly articulated their feared consequences, they should be asked what kind of behaviors they would typically engage in while in that situation in order to decrease the likelihood that these feared outcomes would occur (a blank model can be used to guide this process). Developing an exhaustive list will be counterproductive – rather, therapists should identify a few (i.e., one or two) key safety behaviors that the patient would rely on in such a situation. In order to narrow a potentially long list of safety behaviors down to one or two key ones, patients can be asked which safety behavior they *most* rely on or feel is *most* important in terms of managing the situation. This safety behavior will be focused on during the experiment. Alternatively, the therapist can select one that he/she feels would be most useful in demonstrating the point of the experiment (e.g, one that can be exaggerated). One can also select a behavior or two from the SBQ. The goal is not to have the patient engage in many safety behaviors, but a few while they

are trying to come across well in the conversation by doing whatever possible to not let other see any flaws and to say and do things just right.

b. Instructions for the first social interaction

It is important not to delineate the purpose of the experiment before beginning. It is also important not to give patients a "sneak preview" of what will be happening throughout the whole exercise (i.e., **do not mention that there will be two role-plays**). Just take it one step at a time.

Example of instructions for the first social interaction (information in italics will vary from patient to patient):

> Now, we are going to go ahead and *have a conversation with a stranger*. The goal is just to get to know each other, as you might if you were introduced to each other at a party. When you are having the conversation, I want you to really pay attention to how you are coming across, and to try to come across as well as possible. I want you to pay careful attention to what you are saying and to how you look and to what the other person might be thinking of you in order to make sure you are coming across well. I want you to also focus on using safety behaviors, especially *holding your arms really still so that the person you are chatting with can't see your hands shaking. So, hold your arms really tightly at your sides and really focus on making sure that your hands aren't shaking.*

Before bringing the confederate in, the patient may practice by having a very brief conversation with the therapist while being self-focused and really playing up the one safety behavior that they will focus on during the experiment. Therapists should make sure that patients are really following the instructions before bringing in the confederate. Therapists may need to model how to fully engage in the safety behavior and can also provide patients

with the kind of thoughts they might engage in when they are trying to be as self-focused as possible (e.g., "How am I coming across right now?", "What should I say next?").

c. Carry out the first social interaction and do ratings

The therapist should not overly cue the confederate who is having the conversation with the patient. The goal should be stated as just having the two get to know each other. The confederate is then brought in, and the therapist remains in the room observing the conversation without participating. The exercise should last approximately 5 minutes.

After the social interaction, the confederate is asked to leave the room and the patient is asked how self-focused he/she was during the interaction from 0 (completely outwardly focused) to 10 (completely self-focused). This serves as a kind of "manipulation check" – patients should report feeling more self-focused in this experiment than in the "without safety behaviors experiment" that they will engage in next.

- The patient then rates the experiment on the same dimensions for which predicted ratings were obtained (see above). The two sets of ratings are normally written down by the therapist side-by-side on a single sheet of paper (or on the computer in an Excel spreadsheet) so that they can subsequently be inspected and discussed by therapist and patient. Patient and therapist should not have an in depth discussion at this time about the interaction – rather, ratings should be obtained and the session should immediately move along to the "without safety behaviors experiment."
- Following this and the following conversation, the therapist should ask the confederate to rate the patient's anxiety and performance, using the same scales that the patient used to rate themselves. The confederate should be asked to provide these ratings directly to the therapist, who will then decide if and how to use them , as described further below.

d. Instructions for the second social interaction

Now, we are going to have another conversation with the same person (*or do another of the same task, whatever it was)*. This time, however, I want you to try to do things a little differently than the first time. I want you to really focus your attention on what is going on in the interaction – get lost in the conversation. Forget about monitoring yourself – forgot about what you are saying, how you look, how you are coming across to others. Sometimes when people really focus on others, they start searching for cues of how they are coming across. Make sure not to do this – instead, just really focus on what the other person is saying and forget all about the impression that you are making. You basically want to let the conversation volley just like ping pong or tennis- whatever [name of role player] says to you, just hit right back/respond to that without monitoring or censoring your response. Just let your arms relax and focus your attention outward rather than on whether or not your hands are shaking. Try not to hide your true self, just participate in the conversation.

Therapists should ask the patients again for their predictions about this interaction, using the exact same dimensions as assessed in the "with safety behaviors experiment." Then, before the confederate is brought back in, the therapist and patient should briefly practice the interaction without safety behaviors to ensure that there will be a clear difference between the first and second role play.

e. Carry out second social interaction and do ratings

As above, carry out the second social interaction and then do ratings. Remember to ask patients how self-focused they were during the second experiment. Once again, the exercise should last approximately 5 minutes.

f. Possible repeat of second social interaction

By asking patients to rate how self-focused they were after each of the role-plays (with and without safety behaviors), therapists will know whether the patient was successful in carrying out the instructions. If patients report being completely *unable to* shift their focus of attention and drop the safety behaviors in the second role-play, it is unlikely that they will get much out of the experiment. In such situations, it can be helpful to repeat the second experiment before discussing the contrast between the two conditions. However, if the patient was more self-focused in the second interaction, the therapist should determine whether the desired message can still be conveyed, with the expectation that the first conversation would then have gone better.

g. Processing the Exercise

At the end of the experiment, patients should be asked for their "open-ended" impressions of both interactions. Then, their predicted and actual ratings can be reviewed. These numbers can be displayed on paper, on a white-board, or using an Excel spreadsheet on the computer. It is VERY overwhelming for the patients to complete and make sense of all these numbers at once. Rather, ratings should be shown bit by bit so that patients can process the information and arrive at conclusions.

The best place to start is to show the predicted and actual ratings for the "with safety behaviors" experiment. Ask the patient, "What do you make of these numbers?" **Patients will often notice that they predicted that the experiments would go much worse than they actually did**. This is a great take-home message for patients – that their anticipatory anxiety is often much worse than their actual anxiety.

Next, therapists show patients the actual ratings of the two interactions and ask them to focus on the contrast between the ratings. **Very often, patients will have rated the "without safety behaviors" experiment more favorably than the "with safety behaviors" experiment.** This can come as a big surprise to patients who have used safety behaviors and focused their attention inward for years in order to make social situations easier for themselves. Realizing that they don't have to expend so much effort can be very liberating!In addition, the therapist can ask: "when you were not trying to hide yourself (i.e., in the second conversation), was that acceptable? This can help the patients learn that they are acceptable/not likely to be rejected even if they don't hide who they really are.

At times, there is very little difference between actual ratings in the two experiments. There is a way for therapists to "save" this situation. Patients can be asked, "Did you think the safety behaviors and self-focused attention would be MORE helpful than they were? What do you make of the fact that you did equally well when using safety behaviors and focusing inward as when you dropped safety behaviors and focused outward?" The idea in this scenario is to help patients see that safety behaviors and self-focused attention might not be worth all the effort. This point is even easier to sell if patients predict that they will do much better with safety behaviors and self-focused attention, but then don't. Also, the idea that the patients are equally acceptable even when they are not hiding themselves can be quite useful.

In processing this experiment, patients should be given time to digest their ratings and reach their own conclusions. At the same time, the therapist must be adept at seeing which contrasts help "sell" the message of the treatment and then use Socratic questioning to help patients "see" that self-focus and safety behaviors had some negative impact on their

perceived performance. Therapists should not feel that they need to discuss every possible contrast with the patient – rather, they should highlight the ones that they believe will really communicate an important message. By the end of the session, the patient will hopefully recognize that safety behaviors and self-focused attention do not help reduce anxiety and prevent feared outcomes. Rather, often they increase anxiety and the likelihood of feared outcomes.

h. when the patient discredits the information

At times, a patient will suggest that the second conversation was easier than the first because they knew what to expect, they had practiced, and they were less anxious going in to the second conversation. There are two main options to deal with this: 1) have them do the experiment again with safety behaviors and self-focus, where they will not have the rationale they provided, or 2) ask the patient what they predict would happen were they to do the experiment again as they did the first time. One can also suggest that experience has shown that many patients will be more anxious the second time because they feel they have run out of things to say. One can also describe that most people have these thoughts, but that when they test the procedure again as they did the first time, people continue to believe the outward focus is better. At the same time, the therapist should not be defensive. Critical thinking should be encouraged, and the therapist can suggest that there are many other things to do to gather data, and that he/she looks forward to designing different ways in collaboration with the patient.

5. Conduct Video Feedback

The purpose of video feedback (see Clark's manual for additional video feedback techniques) is to allow patients to see themselves as they are seen by others, rather than

assuming that they came across in a certain way based on how they *felt* during the interaction (e.g., "I felt anxious, so I must have come across terribly").

In this session, patients view the video of the two role-plays from the previous exercise and compare how they *actually* appeared to how they thought they would appear. Such video feedback can be very powerful but needs to be set up carefully to obtain the best results. The first (and most important) step is to instruct patients that when they watch the video they are to watch as if they were observing someone else (like watching a movie), rather than watching themselves. The goal is for them to focus on how they came across in the situation, not on how they felt in the situation. If they watch from a subjective point of view, patients will be prone to feeling as they did during the interaction, clouding their ability to focus on how they looked. It can be helpful to remind the patient that the purpose of watching the video is not for a critique, but just to see what happened from another viewpoint.

Next, therapists ask the patients to close their eyes and visualize what they expect to see in the video (from this observer perspective). As patients describe what they expect to see, they should be very specific. For example, if they say, "I'll look stupid," they must operationalize what stupid looks like. Similarly, if they say, "My face will be bright red," they should point out something in the room that is as bright red as they expect their face to be. Appropriate rating scales are developed (e.g., rate how red the face will look, or how certain the patient is that a certain outcome occurred) and predictions are then first made for the "with safety behaviors" role-play. The therapist and patient then watch the video; the therapist should pause the video once or twice and ensure that patients are adhering to the instructions to watch as if they are objective observers. Following the "with safety

behaviors" experiment, actual ratings will be completed based on what the patient observed. They are then asked to make predictions for the "without safety behaviors" experiment, the video is shown, and actual ratings are again assigned.

At this point, the therapist must help the patient process the video feedback ratings. As with the safety behaviors experiment, it is very confusing to show all of the patient's ratings at once. Rather, the therapists begins with predicted versus actual ratings for the "with safety behaviors" experiment and then, after covering up these ratings, move on to predicted versus actual ratings for the "without safety behaviors" experiment. The general idea that we hope to demonstrate to patients via these contrasts is that **they came across much better than they predicted that they would.** Overall, **this fact is new and questions all of the information that the individual had been working with until then regarding how they come across to others, and questions the foundation of their beliefs regarding their social anxiety.**

Patients often predict that they would come across much worse in the "without safety behaviors" experiment than in the "with safety behaviors" experiment. Often, the actual ratings end up being the reverse – that they looked much worse "with safety behaviors" than "without". This should be pointed out to patients and a discussion can ensue about the **costs and benefits of using safety behaviors and remaining self-focused.** Overall, the video feedback can reinforce this lesson.

Some patients do not see much difference between the "with" and "without" experiments. This does not mean that video feedback will be useless. While it can certainly be helpful for patients to see that they come across better without safety behaviors and while outwardly focused, the most important lesson from video feedback is for patients to SEE that

they come across very differently from how they see themselves in their minds' eye. In these cases, rather than spending time on contrasts between the two experiments, the therapist can instead emphasize the contrast between the predicted and actual ratings for the experiment that yielded the largest discrepancies.

It can also be useful to compare predicted ratings from the "with" and "without" safety behaviors experiment. For patients who left the previous exercise coming to "buy" the idea that self-focused attention and safety behaviors are detrimental might predict that they would come across better in the "without safety behaviors" experiment than in the "with safety behaviors" experiment. It can be interesting in these situations to look at patient's ratings from the experiment in the previous exercise and see if this pattern was reversed – in other words, that they thought they would come across better in the "with safety behaviors" experiment than in the "without safety behaviors" experiment. Patients can be asked what led to this shift. One factor for expecting that they will look better in the "without safety behaviors" experiment than in the "with safety behaviors" experiment is that patients *learned* from the experiment and that this learning translated to their predictions for the video feedback. Another factor can be the effect of seeing the first conversation. Even *with* safety behaviors, patients will often look much better than they expect to look and when then asked to make ratings for the "without safety behaviors" experiment, this altered perception "rubs off". These concepts should be discussed with patients.

b. Using the confederate's ratings

The discussion about safety behaviors and video feedback experiment is concluded with the addition of confederate feedback. After each of the two exercises, confederates are asked to provide written feedback about the interaction. It is best to ask confederates first to

write some open ended comments about their experience during the interaction, cueing them to comment on the difference (if any) between the first and the second interaction. Then, on the back of the paper, confederates are asked to rate the patient on the exact dimensions that patients rated themselves on. Two additional questions are also useful to include. First, confederates should be asked how anxious they themselves felt during the experiment. It can be very illuminating for patients to see that even non-socially anxious individuals can feel anxiety in novel social situations. Second, confederates should be asked a question that pertains to the patient's most feared consequence. For example, they should be asked "How likely is it that you would want to have another conversation with Sarah? or "How likely is it that you would want to be friends with Mike?" These responses can be very handy. Often, confederates rate patients as reasonably anxious, but still say that they would like to have another conversation or that they would like to be friends. This teaches patients the essential lesson that exhibiting anxiety does not have the costly implications that they expect it to have. Basically, confederate feedback can be used as another means of demonstrating to patients that how they *felt* in situations is not necessarily an accurate metric of how they actually came across.

It is important that confederates be trained to provide feedback that is likely to be useful. That is, although we want the feedback to be genuine, we also want it to be clinically useful. Confederates should therefore be trained to keep the feedback generally positive, while being honest and veridical. Moreover, therapists should be mindful that just because they collect confederate feedback does not mean that they *must* share every bit of it with the patient. At times, some particular aspect of the confederate ratings do not help to "sell" the message of the detrimental effects of safety behaviors and self-focused attention; at times,

these ratings may even run counter to the message. The therapist must consider which specific feedback is helpful and which is not. If confederate ratings serve as one more piece of support to the main message of the therapy, therapists should share them with the patients. If there is one piece of feedback that might benefit the patient, therapists should share that rather than sharing the entire document.

c. Summarize Treatment Rationale

As we have learned when we derived your social phobia model, there are a lot of situations that you are either completely avoiding or that you are going into, but in which you feel a great deal of anxiety and distress. In the remainder of treatment, we will focus on: (1) gradually helping you confront social situations that you have been avoiding and thus limiting your enjoyment and (2) helping you experience social situations that you don't avoid in a way that allows you to enjoy them. By shifting your focus of attention and not attempting to prevent negative outcomes, you will be able to learn that many of your feared consequences will not occur, and that in the rare event that they do, that they are not nearly as catastrophic as you currently think. Most everything we do will be working for you to test these ideas and provide you with data that you have not been able to gather previously due to your self-focus and avoidance behaviors.

6. Assign homework

There are 3 homework assignments:

1. Focus of attention walk
2. Attention and Safety Behaviors Monitoring Form (ask patient to record at least 3 entries during the upcoming week)

3. Patients are given a copy of their hierarchy and are asked to add additional items that come to mind during the week.

In the "Focus of Attention" walk, the therapist reinforces the message that self-focus is detrimental. Specifically, the therapist asks the patient to take two 5-minute walks (if the patient is extremely socially anxious, this should be in a relatively uncrowded place such as a park or a wooded area). In the first 5 minutes, the patient should focus on how they are coming across on the walk. They should notice how: they are breathing, their body is moving, they think they look, what is going through their mind, etc. In the second walk, they should use as many senses as possible to take in the world around them: notice the sounds, smells, textures, colors, feelings of the ground beneath their feet, etc. Many patients find this exercise useful in that it 1) shows them how much shifting focus can really affect their experience and 2) if they are extremely anxious in social situations, it may help them learn to manipulate their attention in a less threatening situation. If they selected a location without people, then the assignment should be reassigned the next session in a more populated location (e.g., a mall). By doing the exercise around others, the patient can learn that when self-focused, it feels like others are noticing them, but when they are outwardly focused, they see that others do not stare or notice them. Patients can also be asked to engage in behavioral experiments while they are self-focused if there are other people around. They can be asked to consider what they think others around them are focusing on and thinking, and then examine their predictions in the second experiment.

7. Summarize Session

Do you have any questions about today's session?

What did you learn from today's session?

* note to therapists: the first *in vivo* exposure will occur in the next session. It is appropriate at the end of the session to discuss with the patient what he/she might want to do in the next session. In this way, therapists can make preparations for the *in vivo* exposure (e.g., getting together a group of confederates if the patient wants to make a presentation).

Sessions Three to 12 (Social Phobia Modules)

These session are designed to last approximately 60 min.

Goals for each session:

- Review homework
- Set agenda
- Review any basic concepts
- Decide on situation for in vivo exposure
- Identify automatic thoughts
- Pick a single AT to focus on
- Label cognitive distortions
- Dispute automatic thought and generate rationale response
- Conduct exposure
- Process the experience in relation to the original AT
- Assign homework (including exposure exercises and Cognitive Self-Monitoring Form)
- Summarize session

General Comments

1. *In Vivo* Exposure

Following the safety behaviors experiment and video feedback, the agenda for subsequent sessions becomes somewhat more flexible. The basic goal is to work through patients' hierarchies using techniques outlined below. The major technique used will be *in vivo* exposure (both simulated and unsimulated), with integrated cognitive restructuring. Except in the most unusual circumstances (e.g. crisis, sudden significant worsening of depressive symptoms), exposure exercises should be conducted in each session, and in fact are the focal point of all subsequent sessions. In all *in vivo* exposures, patients will be asked to drop safety behaviors and shift focus of attention. Video feedback may be used when the patient appears to maintain extremely distorted views of him/herself even after the exposure. It is important to keep coming back to the idea that simply being in social situations does not

ameliorate difficulties with social anxiety – the way in which social situations are *experienced* is of greatest import.

Exposures can vary greatly in their nature. On the most basic level, exposures involve confronting a previously avoided or feared social situation. Patients might want to work on having casual conversations, disagreeing or discussing controversial topics, giving speeches, going for job interviews, asking someone on a date, etc. Many of these can be done with confederates if they are available. In fact, over the course of treatment more and more exercises are typically conducted with confederates rather than with the therapist him or herself. Confederates may be directed at times, in order to facilitate the patient dropping safety behaviors (e.g., asking the confederate to ask the patient about a topic, not to ask more than ½ of the questions, or to take an opposing viewpoint about a controversial topic). One exposure should always inform the next exposure. If a patient accomplished giving a prepared speech, but then reports, "But it would have gone much worse had I not prepared," this provides the perfect entrée to the next exposure. If the therapist identifies specific safety behaviors that the patient is engaging in, then the next exposure should be having the patient do something without that safety behavior. If the patient feels confident that the safety behavior is actually helping performance, than it can be tested by doing two exposures, one with and one without the safety behavior. The goal is to chip away at the behaviors and beliefs that are maintaining the patient's social anxiety. Furthermore, in session exposures should always be followed up with homework exposures. If a patient has a casual conversation during the session, she/he should be encouraged for homework to strike up conversations with three people during the upcoming week.

In *in vivo* exposures, patients can also exaggerate a feared behavior and examine the outcome of doing so. For example, if a patient fears that people will laugh at him if he sweats excessively, he can purposefully wet his armpits before going into a social situation or go into a social situation wearing a very heavy sweater on a warm day that he knows will make him sweat. By purposefully playing up this feared symptom, the patient can explore his beliefs about the degree to which people will notice his sweating and about the judgments that people will make based on the sweating.

In addition to *in vivo* exposures, another way of obtaining information that contradicts a patient's beliefs is to conduct surveys about things that the patient is afraid of. For example, a female patient was afraid that if she told someone about her interests in motorcycles, he would think they are strange. Therefore, we conducted a survey of 10 people, asking them 1) what did they think of women who had different interests, 2) what if the interests included things such as riding motorcycles 3) would you think this woman is strange? And 4) would you be willing to be friends with this woman? The information here was unanimous that a woman who rides a motorcycle would not impact one's interests in being friends.

2. Introduction to Cognitive Restructuring

A unique aspect of CBT for social phobia is the integration of formal cognitive restructuring with exposure exercises. Session 3 introduces the principles and techniques of cognitive restructuring, and concludes with the first *in vivo* exposure in which cognitive restructuring is fully integrated into the exercise. In all subsequent sessions, cognitive restructuring and exposure exercises are undertaken.

Cognitive restructuring is introduced through an exercise in which the patient is told to imagine a scene in which he or she is at a party where there are some people he or she would really like to meet. The patient decides to approach one of the people (someone who he or she is particularly attracted to). What thoughts come to mind? Emphasize that the patient should simply report whatever thoughts come to mind, without evaluating or changing them. Solicit examples along the lines of "I'm so nervous I won't be able to think of anything to say!" "They won't like me!" "I probably look really stupid!" "Everybody can see how nervous I am!" Next, ask if he or she stopped to evaluate these thoughts, or did he or she simply accept them as facts. If accepted as facts, they are what we call "automatic thoughts." Automatic thoughts (AT's) are discrete, specific thoughts that are usually negative, and that are accepted as fact.

Three points regarding AT's should be emphasized at this point. First, they occur automatically (hence the name). That is, they are not things that are deliberately thought about, but instead brief, discrete statements that one says to oneself. Second, they occur near or just below the awareness threshold. One is frequently unaware of the fact that one is even having many AT's, much less the specific content of the thoughts. Third, just because one has a thought does not make it "true." Examples are useful to illustrate this point. For example, I may have the thought that "the world is flat," but that does not mean it really is. I may have the thought that "everyone in this room thinks I am strange," but just because I think that does not make it correct.

The next step is to solicit examples from the patient of AT's in relation to a relevant situation from their fear hierarchy. These should be recorded on the white board. The AT's

need not be recorded verbatim; rather, the therapist should "translate" the AT's into brief, discrete phrases the capture the essential idea of the patient's thought.

Next, the therapist introduces the concept of cognitive distortions. The therapist explains that cognitive distortions are specific ways in which ATs might be biased or distorted. It is important to distinguish the concepts of ATs and cognitive distortions at this point. ATs are automatically occurring thoughts that occur on an ongoing basis in response to the immediate external or internal environment. Although ATs are often distorted (at least the ones associated with anxiety), they are not necessarily distorted. That is some ATs may in fact be accurate. Cognitive distortions are specific ways in which ATs are distorted.

Another key point is that just as there are often multiple ATs provoked by a given environmental stimulus, there are likewise often multiple distortions (typically 2 or 3) in a given AT.

Once the patient understands the general concept of ATs and cognitive distortions, the therapist provides the patient the list of cognitive distortions, (Form 14, adapted from Burns, 1980 & Sank & Shaffer, 1984). The therapist and patient then review this list together, briefly discussing each distortion. Next, the therapist and patient pick a few of the ATs previously generated, and examine how they are likely to be distorted. The abbreviation for each distortion (e.g., "FT" for fortune telling) is listed next to the AT on the white board. The ATs are not only classified in terms of cognitive distortions in this manner, but the way in which the distortion applies is briefly discussed. The goal at this stage is to orient the patient to the process of identifying ATs and cognitive distortions, and the therapist should avoid becoming overly concerned about how "correct" the specific distortions are.

The next step involves teaching the patient to "counter" or dispute his or her AT's. This is accomplished by generating "rational responses" to each automatic thought. Generation of rational responses can be quite difficult, and the process is facilitated by using a list of "Dispute Questions" or questions used to challenge the veracity of AT's. The rational response is essentially an answer to the question posed by the dispute question. As a general rule, only one rational response should be generated for each AT, even if there are several distortions in that AT. Ideally, rational responses should incorporate the notion of external focus and/or dropping safety behaviors (e.g., "I don't need to worry about every little thing I say – just focus on the conversation"). Following a brief discussion of the concept of dispute questions and rational responses, the following example is described to illustrate the process.

Exercise in Disputing Automatic Thoughts

Activating Event: Called into boss's office. Boss says, "I have a problem with work you turned in yesterday. Please see me in five minutes."

CONSEQUENCES OF AUTOMATIC THOUGHTS:

"I FEEL ANXIOUS."

"I HAVE STOMACH PAINS."

"I FEEL FROZEN IN MY CHAIR."

- Possible AT: "NO ONE APPRECIATES ME."

  Dispute Question: Is there truly no one who appreciates me?

  Rational Response: I can name several people who appreciate me.

- Possible AT: "EVERYONE WILL FIND OUT AND THINK LESS OF ME."

Dispute Question: Who is "everyone?" How likely is it that this will be reported to everyone? If people do find out, if they find out, will they think less of me? What if they do?

Rational Response: Our grapevine is not that efficient. I don't know for certain that finding out will make someone think less of me.

- Possible AT: "I'LL NEVER GET AHEAD"

  Dispute Question: Does having to do this work mean that I'll never get ahead? Do I know for certain that I'll never advance?

  Rational Response: Redoing one item of work doesn't designate me for stagnation.

- Possible AT: "I'M INCOMPETENT."

  Dispute Question: Do I always do incompetent work? Does having to redo work mean I'm incompetent?

  Rational Response: On occasion I've been complimented on the quality of my work. No one does their work perfectly all the time.

- Possible AT: "I'M GOING TO BE FIRED AND WILL NEVER FIND ANOTHER JOB THAT WILL SUIT ME."

  Dispute Question: What evidence is there that I will be fired for this? Do I know for certain that I couldn't find another job that will suit me?

  Rational Response: No one has been fired here for such a trivial matter. There are many attractive jobs for which I could qualify. I don't have a crystal ball.

<u>Effects of Dispute Questions and Rational Responses</u>:

"I FEEL LESS ANXIOUS."

"MY STOMACH PAINS HAVE VANISHED."

"I FEEL GOOD ABOUT MYSELF."

"I HAVE REGAINED CONFIDENCE IN MY WORK."

"I AM ABLE TO GET UP AND WALK CALMLY INTO THE BOSS'S OFFICE."

Upon completion of the exercise, the therapist and patient then turn their attention to the AT's written on the easel or blackboard from the homework. These thoughts, which were classified as to type of cognitive distortion prior to the above exercise, are now disputed. Rational responses are generated for each AT. The therapist should avoid arguing with the patient if he or she complains of difficulty believing the rational responses. Emphasize instead that the patient learn the skill even if it seems unbelievable right now.

It should be emphasized that this process is not the same as "the power of positive thinking." The point is not to trade negative thought for positive ones. Rather, the goal is to recognize the errors in one's thinking, then to correct those errors. In other words, patients will learn to recognize automatic, irrational thoughts and replace them with thoughts that are objective and reasonable.

As described below, this process of cognitive restructuring is integrated with all subsequent *in vivo* exposure exercises; see the following section (*in vivo* exposure module) for explicit guidelines for how to achieve this integration. Session 3 concludes with such an exercise.

3. Using the Optional Modules

Three "optional" modules are also included in this treatment program: imaginal exposure, social skills training, and assertiveness training. These modules are not required parts of the treatment; within each module, we have outlined the circumstances under which these techniques would be useful. They *should not* replace *in vivo* exposures, but rather

should be integrated into exposure exercises, as indicated. Regardless of the technique used, therapists should always leave sufficient time to process what patients learned from the exercise. The major goal of this treatment is not to make patients never again *feel* anxious in social situations, but rather to experience and think about social situations differently.

4. General Structure of Sessions

Regardless of techniques used, the general structure of sessions should be the same from session to session.

- The session-by-session questionnaires should be given to patients prior to each session.
- At mid-treatment, the Social Behavior Questionnaire should also be administered again to see what safety behaviors are still problematic.
- At the beginning of each session, measures and homework should be reviewed briefly, and patients should be given the opportunity to update therapists on their week. However, it is important to keep this review brief and focused, as it can easily consume much of the session time. Moreover, the therapist must beware of a subtle form of avoidance, whereby the patient uses general discussion to avoid more anxiety provoking exposure exercises.
- An agenda should be created and carried out. The primary focus should be on one or more *in vivo* exposure exercises, with cognitive restructuring and social skills training integrated into the exercise (see *in vivo* exposure module, below).

- Homework should be assigned for the next week. In general, homework will include exposures (*in vivo* and possibly imaginal) and the Cognitive Self-Monitoring Form.
- The session should be summarized. Patients should be asked: "Do you have any questions about today's session?" and "What did you learn from today's session?" should be added to the running list

In vivo exposure Module

(Required for all patients)

1. Selecting exposures

Using the patient's fear hierarchy, therapists should select a moderately anxiety-provoking situation for the patient's first in session exposure. If there are many moderately anxiety-provoking situations, the therapist should select the situation that best represents the core fears of the patient.

Subsequent exposures can be selected in a variety of ways. The hierarchy is, of course, a very useful tool for selecting subsequent exposures. However, therapists are cautioned against adhering strictly to the ordered items on the hierarchy. Patients might come in wanting to work on a situation that is coming up for them or that was difficult for them in the past week. One exposure might lead to a subsequent exposure that isn't necessarily on the hierarchy. Simply put, therapists should be flexible.

A general rule is that patients should become increasingly involved in designing their exposures as treatment progresses. A goal in CBT is to help patients to become their own therapists and they should have the opportunity to become accustomed to this role before treatment is over.

Some sample exposure scenarios include:

1. Striking up a conversation with someone of the opposite sex whom the patient finds attractive. This theme is a common one and has been implemented with several variations depending on the patient's specific fears. The receptiveness of the other

person, his/her warmth or aloofness, and whether or not the person notices the patient's anxiety have all been manipulated.

2. Asking for a date…over the phone or in person, of a familiar or unfamiliar person, being accepted, rejected, or receiving and ambiguous reply.

3. Actually going on a date.

4. Making a presentation at a staff meeting at work…about a comfortable or uncomfortable topic, expressing fact or personal opinion, to supervisors or peers who are critical or accepting.

5. Giving a book report to a college class.

6. Writing a check in a supermarket line while being observed by an attractive person who notices the patient's anxiety.

7. Speaking with others about the patient's phobia, asking for support and receiving a variety of positive and negative responses.

2. **Setting up the *in vivo* exposure** (use Form 10)

The key to effective exposures is the way in which the therapist sets them up. The primary goal of exposures is to help patients challenge their thoughts and beliefs about themselves and others in social situations. As such, exposures are most effective if ATs are clearly articulated before the exposure begins and then evaluated once the exposure is complete – ideally using objective data gathered during the exposure exercise.

Inherent in every exposure is that patients drop their safety behaviors and focus their attention outward on the situation at hand, rather than inward on themselves. It is expected that once patients learn in the first few sessions that safety behaviors are detrimental rather than helpful, they should be quite willing to drop them.

Prior to starting an exposure, a brief description of the situation is described (e.g., "okay, next we're going to practice you initiating a conversation with a stranger at a party, maintaining the conversation for a few minutes, and then terminating it"). The patient is told that this conversation will take place momentarily, and to focus on what it will be like to have this conversation. While the patient is anticipating the impending conversation, s/he is asked to speak aloud the ATs s/he is having. (If the patient is unable to generate ATs from anticipating the conversation, a quick role play can commence, with a pause for the therapist to gather the patient's in vivo ATs.) The therapist records ATs (paraphrasing as necessary) on the whiteboard. The therapist then picks a single AT on which to focus. The choice of AT should be guided by two principles: the thought that is most central to the patient's core concern, and the thought that lends itself most readily to disputation via data gathered during the role play. The therapist highlights this AT on the whiteboard, and then proceeds to assist the patient in identifying cognitive distortions in the thought, posing dispute questions about it, and finally generating a rational response. The rational response is then itself recorded on the whiteboard, and highlighted. Throughout the exposure exercise (e.g., at 1-min intervals), the patient is prompted to give a SUDS rating, and then to read aloud the rational response. He or she is then briefly prompted to keep his/her attention focused outwardly, and to drop any safety behaviors. Gradually, the reading aloud of the rational response is faded, and the patient is instructed simply to read the statement to him or herself.

Immediately following the exercise, the therapist and patient process the experience in relation to the original AT. In particular, data gathered during the exercise that contradicts the AT is highlighted and discussed.

As a general rule, the above process of cognitive restructuring should be used with all patients, during all exposure exercises. In addition, there are a number of related cognitive therapy techniques that may also be used, as indicated. For example, prior to an exposure the patient can be asked what his or her predictions are for that situation. As an example, consider a patient who predicts that he will come across as boring during a casual conversation with a stranger. Prior to deciding **how** to evaluate the veracity of predictions in the context of *in vivo* exposures, key concepts must be defined by patients. If the patient predicts, "He'll think I'm boring", he must then define what "boring" means to him. Questions to probe these definitions might include "What would you do that would make people think you are boring?" and "What qualities does a boring person have?"

Therapists should ask patients what kind of information they would need to confirm or disconfirm their beliefs. Exposures afford an opportunity to gather information from multiple sources:

- Patients can be asked what they might observe in others to confirm or dispute their beliefs (e.g, "If I saw him yawn, I'd know that he thought I was boring").
- Information can be solicited from participants in the exposure (e.g., asking the confederate to rate how boring he found the patient).
- Information can be solicited from objective observers (e.g., someone can be brought in to rate how boring the patient and the confederate were during the conversation).
- Patients can observe both themselves and confederates through video feedback. (e.g., if patient believed that the confederate yawned a number of

times during the exposure, or if he believed that he caused a large pause in the conversation, this could be assessed through video feedback)

Using multiple sources of information to examine predictions can have advantages and disadvantages. The advantage is that by using multiple sources of information, the biases in judgment often exhibited by patients with social anxiety can be corrected. For example, the use of video feedback helps patients to evaluate situations based on what actually happened in them, rather than by how they recall feeling in them. Interpretation biases can also be problematic when judging outcomes of situations. For example, basing all judgments on behaviors elicited by the confederate could be open to bias in that a single behavior can have numerous attributions. If a person yawns during a conversation, it could be because they are bored, but it could also be because they are tired. As such, gathering information from other sources (e.g., asking the confederate if he was bored; asking objective observers to rate the conversation; watching the video to see just how frequently the confederate yawned) can be helpful.

Therapists should be cautioned, however, about trying to achieve too much in one exposure. Gathering too much information can leave the patient feeling overwhelmed and without a clear "take-home message". The key is to figure out what the core concerns are for the patient. The patient who worries about being boring might be most concerned with non-verbal cues from the confederate (e.g., yawning, looking at his watch, etc) and might be less concerned about feedback that he would give in answer to a specific question ("Did you think this person was boring?") In this case, it might be more useful to have the patient make ratings before and after the exposure of the degree to which the confederate elicited

signs of boredom and perhaps also use video feedback to see if the patient's memory for the interaction was reliable.

Once predictions are made, patients can be asked to make ratings of how likely each prediction is. There is no set rule for making ratings – they should be idiosyncratic to the patient's predictions. If the patient predicts that the confederate will yawn during the conversation, he can rate on a scale of 0-10 how certain he is that this will occur. If the patient predicts that there will be long gaps in the conversation, he might predict how long these gaps will be (e.g., "I'll be so nervous about what to say that I just won't say anything for a couple of minutes"). Again, therapist flexibility is encouraged. The general rule is to solicit clear, easily measured predictions from the patient about feared outcomes in the social situation, to carry out the exposure, and to evaluate the evidence for/against the predictions. The exact means of accomplishing these goals will vary from exposure to exposure.

3. Post-exposure processing: Getting at the issue of probability

Post-processing is a crucial part of exposures. It is important to remember that patients put themselves in feared situations quite frequently and yet, their fears and negative beliefs remain. It is important after the exposure to make sure that the experience of the exposure translates into a useful learning experience for the patient.

After each exposure, the patient should be asked how self-focused he/she was during the interaction from 0 (completely outwardly focused) to 10 (completely self-focused). Similarly, they should be asked how successful they were at dropping their safety behaviors. Clearly, as treatment progresses, patients should report increasing levels of outward focus and less reliance on safety behaviors. If they are unable or unwilling to make these changes,

therapists should discuss this problem since being self-focused and continuing to rely on safety behaviors will perpetuate social anxiety. It might be necessary to introduce some exercises focused on helping patients become more accustomed to shifting attention outward and dropping safety behaviors. For example, patients can take a long walk, focusing half the time on themselves (how their feet feel on the pavement, how the wind feels in their hair) and half the time on what is around them (people who walk by, the sound of birds, etc.), or do similar exercises at home. When patients come to see this distinction, they can continue practicing their walks but making quicker shifts from self to outward focus.

In addition, motivational techniques can be used to help patients see the importance of making the changes necessary to get over social anxiety. Some patients will simply be too afraid to try to be in social situations in a different way. Reiterating how their current behaviors maintain social anxiety, and reflecting on ways that social anxiety is holding them back from what they want in life, can be helpful.

After obtaining a rating of focus of attention, it is time to process the focal AT, as described above. It is also often helpful to evaluate the evidence for the predictions developed for that specific exposure. As with the development of predictions and pre-exposure ratings, the way that post-exposure ratings are carried out will vary. The important point is that patients are helped to see the discrepancy between their predictions and what actually happened in the situation. Many times, this will be by correcting the likelihood that they will be rejected by others: in other words, getting at the cognitive error of probability overestimation.

4. Post-exposure processing: Getting at the issue of cost

At times, feared outcomes will occur during in-session exposures – or on a less extreme level, ratings will not be in the direction the therapist had hoped. Following our example, the confederate and/or the objective observers might in fact rate the patient as somewhat boring – perhaps even more boring than the patient expected to be rated. While these experiences give therapists a feeling of dread initially, they are actually extremely valuable, affording the opportunity to tackle the issue of "cost" – in other words, the patients' beliefs that if feared outcomes were to occur, it would a great catastrophe and they would be unable to manage it.

Before simply accepting that the feared outcome occurred, it is important to ask patients if they were doing anything to increase its likelihood. Specifically, they should be asked if they were using safety behaviors and/or focusing attention inward instead of outward to the situation at hand. If patients recognize that they were doing something to "sabotage" the exposure, it is a good idea to work through the exposure again without safety behaviors and with attention focused outward. Therapists should therefore be not only watching the exposure exercise to rate performance, but also watching the patient to see if any safety behaviors are evident.

If patients report that they had dropped safety behaviors and had focused attention outward, the arena is open for some good post-exposure processing of cost. Was the feared outcome as terrible as the patient expected? What does this feared outcome mean in the "big picture"? (e.g., does one person thinking you are boring mean that all people will think you're boring and that you will be rejected and alone? Has anyone ever called you boring in the past?) Did any other factors besides your own behavior play a role in the outcome of the

situations (e.g., perhaps the confederate wasn't doing his part to keep the conversation going, or perhaps he rates everyone negatively, or perhaps he was having a bad day?). Were you able to manage the situation despite the occurrence of an outcome you had hoped would not occur? The goal is to leave patients feeling that they can manage in social situations – even when the outcome is not desirable, and that furthermore, this undesired outcome is rarely as catastrophic as the patient predicted before it happened.

Another option to consider when patients report having dropped safety behaviors and focused attention outward, but still experience negative outcomes in social situations is social skills training. Guidelines on how to implement social skills training begin on page 57.

While feared outcomes sometimes naturally occur during exposures, it can also be very useful to purposefully engage in feared behaviors. Patients with social phobia have very high standards for their own behavior. Even when safety behaviors are dropped, patients with social phobia often remain quite concerned about their social behaviors (e.g., "I must never stumble over a word"). These excessively high standards are interesting to consider in the context of probability and cost. When people hold excessively high standards, there is a high probability that feared outcomes will occur – we all stumble over words, or forget what we were saying, or blush from time to time. Patients with social phobia exaggerate the costs of these occurrences. In order to overcome this bias, patients should be encouraged to purposefully engage in their feared behavior in order to learn if the consequences are as catastrophic as they expect. For example, if a patient fears sweating when giving a speech, he should be encouraged to wear a warm sweater to increase the likelihood of sweating. If a patient is afraid of forgetting what she is saying during a casual

conversation, she should be encouraged to purposefully "forget" her train of thought. When discussing these exposures, it is important to explore (a) how noticeable the behavior actually was and (b) what the consequences of engaging in the behavior were. Sometimes patients are amazed to see how little other people seem to notice and more importantly, how little impact some of these behaviors have even when they are noticed.

5. Designing subsequent exposures

Before moving on, it is important to consider how one exposure can be used to plan subsequent exposures. Often, patients carry out an exposure successfully, but are left with some questions or further concerns. For example, after having a conversation with a confederate, the patient might discount the exposure, believing that the confederate 'had' to be nice. This same exposure could then be assigned for homework in order to test out the belief that the successful exposure was due to the kind-heartedness of clinic staff. Similarly, a patient who fears sweating might carry out an exposure and not sweat profusely, but might explain this away by saying she was wearing a light shirt. Homework could involve doing the same exposure wearing a heavier shirt on a hot day or doing some activity that generates sweating immediately prior to the exposure assignment. Finally, if a patient has concerns about disagreeing with someone, there are multiple stages of disagreement that can be designed for a number of exposures. It can start with benign disagreements about favorite movies or music, go to questioning without outright disagreement about politics, and conclude with purposefully setting up exposures in which a confederate has an opposing viewpoint (or argues it even if he/she does not believe it) on a controversial topic such as abortion, death penalty, etc.

Imaginal exposure

(Optional)

1. When to use imaginal exposure

Imaginal exposure can be used in the treatment of patients with social phobia when patients hold a feared consequence that is unlikely to occur and yet so powerful that it feeds avoidance behavior. It can also be useful when patients hold beliefs about what will happen to them well into the future (e.g., "If I keep saying stupid things in social situations, people will keep reacting to me by berating and rejecting me for the mildly stupid things I say and therefore I'll be alone forever").

2. How to do imaginal exposure

The first step in doing imaginal exposure is to develop a script that captures the patient's concerns. This does not need to be something that the therapist uses verbatim. It should be a guideline that allows the therapist to be sure that he/she is tapping at the core fears of the patient. The patient can be asked to write a script for homework or the patient and the therapist can create it in the session. Imaginal exposures should always be delivered in the second person, present tense ("You are…."). The exposure should contain a lot of detail, including all the senses (sight, hearing, smelling, etc.), as well as how patients feel and think throughout the story. Therapists should feel comfortable creating exposures that sound somewhat absurd – after all, patients' fears are often driven by very catastrophic thoughts that are unlikely to ever actually happen. For most patients, the core concern is getting persistent negative feedback based on minor infractions or faux pas, especially in the context of trying to drop safety behaviors. The focus should be on others' feedback to the

patient more than the isolation and loneliness that the feedback creates. It is important to stay with the patient's general concern that others are going to reject them more than focusing on the implications if one is rejected. This be because the latter is truly negative and likely to occur if the former does. It is the former that is the most exaggerated part of most patient's concerns. In general, imaginal exposures must capture the patient's concerns and must be sufficiently vivid for them to become engaged as they listen to it.

Once the exposure is created, an audiotape should be made of it. Usually, the therapist records the story with significant details. The imaginal can be from 5 to 25 minutes long. It is usually about 15 minutes long and is repeated twice or three times to create a 30-45 minute tape (or digital audio recording). When the patient is listening to the tape for the first time, every 5 minutes (or at hot spots on the story) the therapist asks for SUDs rating and asks the patients "What is going through your mind?" This inquiry aims at insuring that the patient is engage with the image. If patients report having difficulty engaging with the image, the therapist can explore whether they would be more engaged if they narrated the story, or whether they are engaging in cognitive avoidance. If the former is the case, the story should be re-recorded with the patient narrating it. The key is to be flexible and use whatever methods necessary to ensure emotional engagement. (Use Form 11 to record SUDS during in session imaginal exposures).

The tape is given to the patents with instructions to listen to the tape daily, for 30-45 minutes at a time. Patients should record their SUDS at the beginning of the story, the end of the story, and the point at which their SUDS peaked. Patients should continue to listen to the tape until the narrative does not elicit much discomfort (e.g., until they experience about a 50% reduction in their SUDS). If the patient has other disturbing disastrous consequences

that interfere with progress in treatment, another tape is created in the same manner. (Provide patients with Form 11 to record SUDS during homework imaginal exposures).

An example of an imaginal exposure follows:

"You wake up in the morning and decide that you are going to apply all of the principles that you have been working on in therapy. You decide you are done with safety behaviors and are really going to try to work on focusing outward. After all, people have provided you with feedback in session that you are likeable, and that your anxiety is not as bad as you thought. You walk into work and say hi to the receptionist, who giggles when you say hi. You think it a bit strange, but keep walking towards your cubicle. As you walk by Frank, you say "good morning Frank!" who then looks at you and starts laughing. He then turns to Jane and says "did you see Joe say good morning to me this morning? What a fool!". You head further towards your cubicle when Sarah walks up to you and says "I can't believe you said hi to Frank. You are strange." You decide to keep walking. As you get to your cubicle, your boss calls you and tells you that you better stop bothering the other employees. You begin to state that you don't know what she means, but she hangs up. As Chris walks by, you say "Hi", and Chris looks at you with disgust. Five minutes later, your phone rings and it is your boss, saying that she told you to stop pestering the other employees, and that you are fired."

Social Skills Training

(SST; Optional)

1. When to use SST

There has been a great deal of controversy in the field of social phobia about whether patients with the disorder lack social skills or whether their anxiety in social situations interferes with them using skills that they do indeed have. It is our sense that the majority of patients with social phobia do have appropriate social skills, but some have difficulty putting them to use in anxiety-provoking situations due to dependence on safety behaviors and to the tendency to focus attention on the self. Safety behaviors can cause people with social phobia to look as if they are socially unskilled or socially awkward; self-focused attention can have the same effects and also cause patients to miss out on important cues in the environment that would help them to look and sound more attuned to the situation.

Once safety behaviors are dropped and attention is shifted outward to the situation at hand, most patients with social phobia will come across as quite socially skilled and will likely start to feel more confident about their skills as well. However, some patients, even when safety behaviors are dropped and focus of attention is shifted, might still either (a) continue to perceive that they lack social skills even when they come across as quite skilled or (b) come across as truly lacking social skills.

For patients who continue to perceive that they lack social skills even when they come across as quite skilled, there are a number of options. One is to make use of additional video feedbacks and/or ratings of confederates/observers. Cognitive techniques can be used to

examine the discrepancy between patients' own perceptions and those of others and between their "felt sense" and how they actually look on the video when they view it as an observer would. Another option is to use imaginal exposure to work on these fears of coming across in a very unskilled manner. Patients can also be asked to observe others. They might believe, for example, that they say "Um" much more than others. They can be asked to keep track during a meeting at work of how many times a few of their co-workers say "Um."

Social skills training can also be used if for no other reason than making patients feel as if they are practicing skills that they lack. Yet, it is best to start with the previously mentioned techniques and to continue to ensure that patients really have dropped safety behaviors and shifted focus of attention.

If the therapist is not sure if the patient is awkward due to continued engagement in safety behaviors or because of lack of social skills, the best solution is to ask. For example, if a patient continues to feel awkward initiating conversations with strangers and seems to also look rather awkward, the therapist should ask if the patient is engaging in any safety behaviors. If the patient says no, social skills training can be useful. When a patient states that he/she does not KNOW how to do something, the therapist would also want to consider using social skills training.

The issue of social skills can be more difficult when patients do not report deficits, but when the therapist recognizes them even after safety behaviors have been dropped and attention has been shifted toward to the situation at hand. Therapists should tread lightly here since pointing out a deficit (and particularly labeling it as such) can be quite embarrassing for the patient and might actually increase self-focus.

A good way to get into SST is for the therapist to use his/her own experience in the social situation as a way to encourage some exploration of skills with the patient. For example, when a patient speaks very quietly, the therapist can say, "You always have such interesting things to say, but because you're so quiet, sometimes I miss what you're saying completely. Why don't we try some role plays speaking in different tones of voice? I'll let you know how the different tones feel for me in the conversation and I'd like to hear your feedback too." In this way, the skills training is introduced in a very subtle way, but gets the therapist and patient on track for doing some good work on the target behavior.

2. How to do *In Vivo* SST

What types of skills are often the targets of social skills training for socially anxious patients? Skills training for these patients deals primarily with three types of target social skills: conversational skills, positive assertion and negative assertion. Conversational skills include the ability to initiate, maintain, and gracefully end conversations. Positive assertion refers to the expression of positive feelings to others. Examples include giving compliments, expressing affection, offering praise, and making apologies. Negative assertion refers to the expression of displeasure and standing up for one's rights. Examples include refusing unreasonable requests, requesting new behavior from others, compromise and negotiation, and expressing disapproval and annoyance. The target of social skills training can be speech content and can also be more subtle aspects of communication including mannerisms, eye contact, and body language.

Social skills training includes four stages:

1. Instructions: Instructions about the targeted social skills will be provided by therapists. This can be based on their own experiences with the patient (e.g., I'd

feel as if I was more connected to you during our conversation if you looked me in the eye as we chatted) or on general "rules" of conversation. For example, many patients need help with initiating conversations and we will discuss with patients who to do so (e.g., look at the context of the situation and find a similarity that might get things going – like, at a party, asking someone, "How do you know the host?" or in a class, "Have you had this professor before?")

2. Modeling: Therapists demonstrate the skill to the patient. It can be helpful to demonstrate to patients how they come across and how it would look to behave in a more skilled way (e.g., chat without eye contact and then with eye contact).
3. Role Playing: It is useful to do role-playing first with the therapist. Once the patient feels comfortable with the skill, a more formal exposure with a confederate can be used as another means of practice.
4. Feedback and Reinforcement: Therapist provides specific feedback and reinforcement (e.g., I felt so much more connected when you made eye contact, I really enjoyed our conversation).

3. How to Do On-Line SST

We have also been having success with "on-line" social skills training. This type of SST can be done with videos from exposures or by turning the camera on and looking at oneself on the TV in "real time". As we pointed out earlier, it can be "dangerous" for therapists to point out problems in social skill to patients because this can increase their self-focus. But, concerns about deficits are often voiced by patients themselves (e.g., "I never asked a single question during that exposure") or by the confederate (e.g., the confederate

might write, “He looked so bored during our conversation”). This type of feedback can be used to initiate on-line SST.

To begin, the therapist can say, “Well, why don’t we take a look at that.” In contrast to video feedback, where patients are instructed to watch that tape as if they are an objective observer without being self-critical, the goal here is for patients to identify problematic behaviors and think about ways they can change them. While this might be difficult for patients who are already overly sensitive about the impressions that they are making, it has been our experience that patients deal very well with this exercise. They see it is a unique opportunity to observe their own behavior accurately and make changes that might result in better social interactions.

Take for example, a patient who often responds to a confederate’s comments with, “Oh.” Instead of responding with something more substantive like, “That’s very interesting” or volleying back a comment of his own, this patient let conversations just stop in their tracks. In this sort of situation, the video can be watched and at times where the patient does not respond, the tape can be stopped and the therapist and the patient can discuss what he could have said to keep the conversation going.

As another example, the “real time” video can be used for patients who have difficulties dropping very noticeable safety behaviors. We had a patient who clutched her glass very tightly with both hands to avoid spilling when she drank at parties or dinners. We had this patient watch herself drink while using her safety behaviors. She was shocked at how unusual she looked! Unfortunately, it was very difficult for her to just drop her safety behaviors, so we had her rehearse holding her glass and drinking in different ways until she got the “feeling” of what looked “normal” on the video.

Assertiveness Training

(Optional) adapted from SMT manual by Hembree and Foa

1. When to use Assertiveness Training

Assertiveness training can be selected as a treatment technique under a few circumstances. First, some patients will specifically report that they have difficulties being assertive and will ask for some help with this. As with the broader social skills training, it is important first to explore the role that safety behaviors might play in holding people back from getting what they want/need in life. Even once safety behaviors are dropped though, some patients might have never tried to be assertive in their lives (or done so very infrequently and inconsistently). In these cases, therapy can be a good venue for trying out some new skills and exploring cognitions about what it means to be assertive.

In some cases, the therapist might suggest working on assertiveness. This might be the case if the therapist recognizes assertion to be a problem in the context of the therapeutic relationship. For example, a patient might repeatedly not do homework rather than telling the therapist that the assignment was too difficult or that too much homework was assigned. The therapist can use this experience to ask the patient about assertiveness in life outside therapy. In most cases, the patient will report that they have difficulties with assertiveness in other domains. This provides fertile ground for assertiveness training.

2. How to do assertiveness training

Many socially anxious people worry about communicating effectively with others, especially when they need to stand up for themselves, make requests of others, express opinions or disagree with others opinions. What aspects of communication are difficult for

you? What safety behaviors do you use to make communication with others less stressful for yourself? What impact do those safety behaviors have? Therapists should use Socratic questioning to help patients see that their safety behaviors make it difficult (if not impossible) for them to get what they want in life. Patients should be asked for specific examples of when a lack of assertiveness left them not getting something that was important to them (e.g., a raise or promotion at work, being treated more respectfully by a significant other, etc.)

In our session today, we are going to discuss assertiveness skills. First, let's discuss the distinctions between being passive, aggressive, assertive: (the following definitions taken from Jakubowski, 1973).

Many socially anxious patients use a **passive or non-assertive** communication style. A passive or non-assertive style can be associated with complete avoidance – simply not expressing honest feelings, thoughts, and beliefs or with more subtle avoidance – such as expressing your thoughts and beliefs in an apologetic, diffident, or self-effacing manner. There are also many nonverbal behaviors associated with passive communication. Can you think of any?

Might include:

- Evasive eye contact
- Body gestures like hand wringing, clutching other person, stepping back as assertive remark is made, covering mouth with hand, nervous gestures
- Voice overly soft or sing-song
- Speech pattern hesitant, filled with pauses

- Frequent throat clearing
- Laughs, smiles, winks when expressing anger

Do these types of behaviors remind you of anything else we've discussed in treatment? *(The intention here is to help patients to see that passive communication involves a series of safety behaviors and as with all safety behaviors, the effect is paradoxical – while intended to make the situation easier, they actually increase the likelihood that patients will not get what they want out of life).*

So, having established some link here to safety behaviors , tell me why some people communicate in this way? *(Patients should see that people use this mode of communication to appease others, avoid conflict, avoid negative evaluation from others).*

What effect does it have on you to communicate in this way? How does it make you feel about yourself? *(Patients should come to recognize that communicating in this way violates their own rights and denies them the opportunity to get what they want).*

What effect does this mode of communication have on people to whom you speak? *(Patients should recognize that being passive makes others disregard you, violate you, not give you what you want, etc.)*

A lot of socially anxious people worry that if they do make requests, disagree with people, or express opinions, they will be perceived as overly aggressive and judged negatively for that. Is this a concern for you?

Let's discuss what an aggressive communication style looks like. Being **aggressive** involves standing up for your personal rights and expressing thoughts, feelings, and beliefs in a way, which is often dishonest, usually inappropriate, and always violates the rights of the

other person. Aggressive behavior shows a lack of respect for others; the goal is domination and winning. What nonverbal behaviors are associated with an aggressive communication style?

Might include:

- Gestures that dominate or demean other person
- Eye contact that stares down other person
- Strident or overly-loud voice
- Sarcastic or condescending tone of voice
- "parental" body gestures such as excessive finger pointing

Why might some people communicate in this way? *(To dominate others, win over others, bully people).*

What effect would it have on you to communicate in this way? How would it make you feel about yourself? *(Might allow you to get your way, but also might make you feel badly about yourself because you did it at the expense of someone else's feelings).*

What effect does this mode of communication have on other people? *(Makes them feel as if their rights have been violated, might make them like you less).*

When you worry about being too aggressive, does your definition of aggressiveness map onto this definition? *(If relevant, help client see incongruence between their definition of aggressiveness and our definition of aggressiveness. For example, patients might see* ***any*** *eye contact as being a sign of aggressiveness.)*

There is a middle ground between passive and aggressive communication. Being **assertive** is standing up for your personal rights and expressing your thoughts, feelings, and beliefs in a direct, honest, and appropriate way which does not violate another person's rights. It involves respect for yourself and respect for the other person. What kind of non-verbal behaviors are associated with assertive communication?

Might include:

- Congruent verbal messages
- Support, strength, and emphasis to what is said
- Use of an appropriately loud voice
- Firm eye contact but not a show-down
- Body gestures denoting strength
- Clear and fluent speech

Why might some people communicate in this way? *(They want to get their point across, get what they want, etc… but without violating others).*

What effect would it have on you to communicate in this way? How would it make you feel about yourself? *(Would make me feel like I am going after what I want in life, would make me feel more confident, more in control, etc.).*

What effect does this mode of communication have on other people? *(They would respect me for sticking up for myself, they wouldn't mess with me anymore, they would react quite positively since I'd also be taking their needs into account).*

So, let's summarize. What type of communication style do you think most accurately represents you. What effect has this style of communication had on you and others? What would be the benefit of using an assertive style of communicating?

Putting assertive communication skills into action can be difficult at first for people who are not accustomed to communicating in this way. It can also be challenging to deal with the reactions that you might get from people who know you as being very passive. Let's go over some tips that should help you to exercise your assertive rights:

- The first technique is **basic assertion.** Basic assertion is a simple gesture of standing up for your personal rights, beliefs, feelings. It does not involve other social skills. An example is "Excuse me, I'd like to finish what I was saying" or "No, this is not a good time for you to visit me" or "I really like you."
- The second technique is **empathic assertion.** Empathic assertion is a statement that conveys recognition of the other person's position or feelings followed by another statement that stands up for the speaker's rights. An example is: "I know that you are trying to look out for my best interests, but I'd like you to stop questioning my judgment so much."
- The third technique is **escalating assertion**. Escalating assertion starts with a "minimal" assertive comment and when other person fails to respond, gradually escalating the assertion, becoming increasingly firm. For example:

(1) "That's nice of you, but we came here to catch up with each other….Thanks, anyway."

(2) "No thank you, we really want to talk just with each other."

(3) "As I have already told you, we really don't want your company. Please leave!"

- The fourth technique is **I-language assertion**. This technique is particularly useful for helping people to express negative feelings. The technique typically consists of four parts:

1. When……(speaker objectively describes other person's behavior.) Example: **When you reprimand me in front of colleagues, I feel humiliated.**

2. The effects are….(speaker describes how the other person's behavior concretely effects his life or feelings). Example: **The effects of your tardiness cause disruption to the meeting.**

3. I feel….(speaker describes his feelings) ***optional***(not always appropriate). Example: **I feel frustrated when you constantly find fault with my work and fail to praise what is also good about my work.** Inappropriate example: I feel horrible when you rant and rave like a maniac. (clearly violating another's rights).

4. I'd prefer….(speaker describes what he wants) Example: **I'd prefer you speak with me privately about the matter rather in front of the whole staff.**

Now, let's try out these skills. As in other exposures, the goal is to drop safety behaviors (e.g., saying less than one really wants to say, speaking quietly, avoiding eye contact, etc.) and instead, communicate in an assertive manner. It is also important to focus your attention outward so that you can be responsive to the other person's reactions to what you are saying and make adjustments as necessary. Can you select a situation that we could practice? *Exposures that involve assertive communication should be carried out in the same way as other exposures.*

Preparing for the End of Treatment

Discussion of Relapse Prevention and Goal-Setting (Required for all patients)

Termination in CBT should never come as a surprise. Patients come into this treatment program knowing that it lasts for 12 weeks. Always be mindful of concerns that can come up for clients about termination, such as "What if I am not 100% better by the end of treatment?" "How do I make sure that I don't go back to my old ways when treatment is over?" etc. Therapists should be prepared to deal with these issues as treatment progresses, but should also set aside time in the last session or two to discuss termination and the patient's plans for the future in a more concrete way.

The following issues should be covered:

- Having reasonable expectations for "recovery". Some patients come into therapy expecting that they will be "cured" by the end. It is important to set with patients realistic goals, framed in behavioral terms. The principal goal is to social situations that they were previously avoiding and to become more engaged in all social situations by shifting focus of attention outward and dropping safety behaviors. Subsequently, patients should get more out of their social interactions – having more meaningful conversations, feeling more connected with other people, etc…
- A related issue is helping patients to know what to do when they do experience anxiety in social situations. Their previous way of dealing with anxiety was either to avoid completely or to use safety behaviors as a means of trying to prevent negative outcomes from occurring. In the future, they must continue to be mindful of the importance of not avoiding and of refraining from using safety behaviors. This is

particularly important when patients are confronted with new situations that they might not have engaged in for many years or that they might have never engaged in before at all. Patients should treat these situations as opportunities to try out what they learned in the program.

- Some patients feel concerned at the end of therapy that they have not yet "conquered" all of their feared situations. Some patients also feel that they are not quite ready to stop working on their social anxiety in a concrete way, as they had been doing in treatment. A good way to deal with these concerns is to set some goals (use Form 13) – for two weeks from the end of treatment, a month from the end of treatment, six months from the end of treatment, and a year from the end of treatment. Again, these goals should be framed in behavioral terms (e.g., in two weeks, I want to send out some job applications and start interviewing for a new job; in six months, I am going to go on a bike trip with a group of people who I don't know). In the case of social anxiety, some goals cannot be accomplished immediately (e.g., making friends, getting into a relationship, going back to school) and doing some planning for how/when to accomplish them can help patients to keep on track with the things that are important to them.
- During the last session, it is also helpful to review with patients what they learned in the treatment. Going through the running list and having them rank order them in level of importance or highlighting the most important ones can be useful. Have them identify which techniques were useful and which they found less useful. Help them to see how they can continue to use techniques that they found helpful once treatment is over.

Setting the Framework for Treatment

Prior to conducting this treatment, all therapists should read the following materials:

Materials on Treatment of Social Phobia

- Clark, D.M. (2001). A cognitive perspective on social phobia. In W. R. Crozier, & L. E. Alden (Eds.), *International handbook of social anxiety: Concepts, research and interventions relating to the self and shyness (pp.405-430)*. New York: Wiley.
- Clark, D.M. Cognitive Therapy for Social Phobia. *(Unpublished treatment manual).*
- Herbert, J. D., & Dalrymple, K. (2005). Social anxiety disorder. In A. Freeman & S. Felgoise, A. M. Nezu, C. M. Nezu, & M. A. Reinecke (Eds.), *Encyclopedia of cognitive behavior therapy* (pp. 368-372). New York: Springer.
- Huppert, J.D., Roth, D.A., & Foa, E.B. (2003). Cognitive behavioral treatment of social phobia: new advances. *Current Psychiatry Reports, 5,* 289-296.
- Huppert, J.D., & Foa, E.B. (2004). Maintenance mechanisms in social anxiety: an integration of cognitive biases and emotional processing theory. In J. Yiend (Ed.)., *Cognition, Emotion, and Psychopathology* (pp. 213-231). Cambridge, UK: Cambridge University Press.

Forms

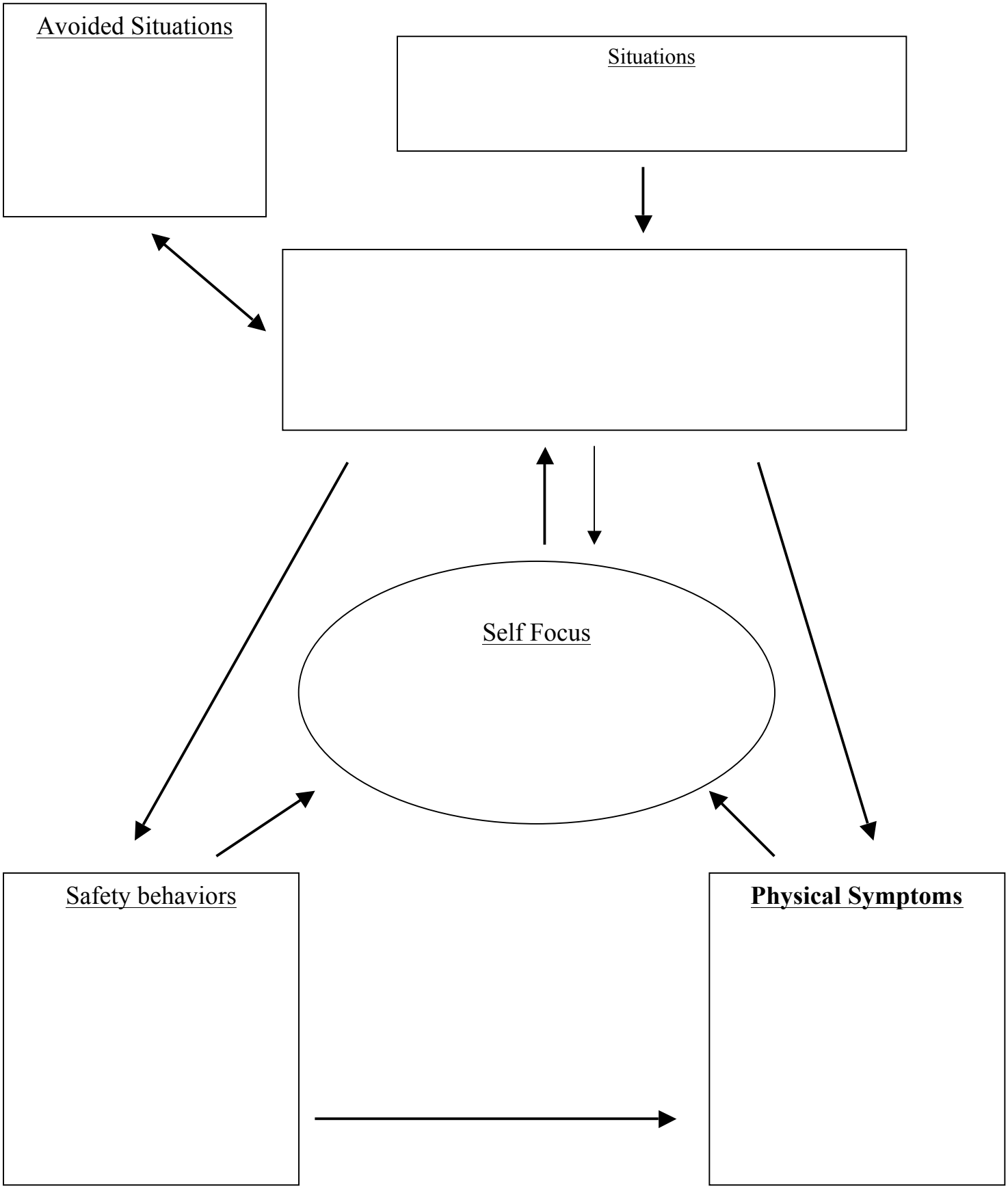
Record of Weekly Self-Report Measures

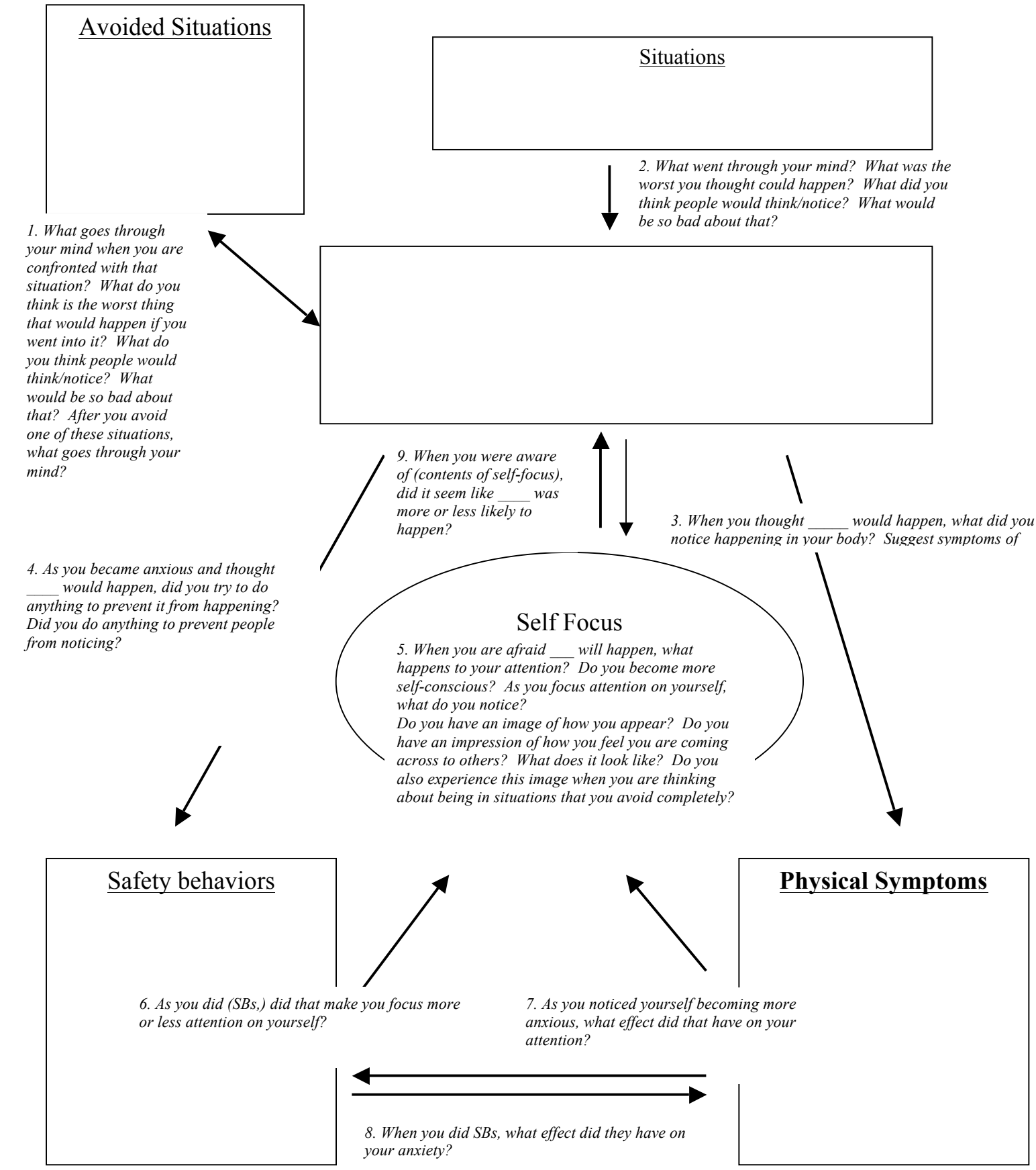
Social Phobia Treatment

Patient's Name
Intake LSAS=

Session	SSRS							BDI	QIDS	SCQ	SPIN
	Anxiety (0-8)	Avoidance (0-8)	Self-focus general (0-8)	Self-focus difficult situations (0-8)	Anticipatory Anxiety (0-8)	Post-Mortem (0-8)	Depression (0-8)	(0-63)	(0-27)	(22-110)	(0-51)
Assessment											
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
Post											

Form 1, Record of Weekly Self-Report Measures


Avoided Situations
Situations
Self Focus
Safety behaviors
Physical Symptoms



Form 3. Annotated Model of Social Phobia

Safety Behaviors Experiment and Video Feedback Recording Form

Description of situation:

Feared outcome(s) of situation:

Safety behaviors typically engaged in to prevent negative outcomes:
(please place a star (*) next to the most important/most relied upon safety behavior)

Ratings for safety behaviors experiment:

Rating (use 0-10 scale)		**With safety behaviors and self-focused attention**	**Without safety behaviors and with outwardly focused attention**
	Predicted	**Actual**	**Actual**
How self-focused were you during the experiment? (0 = completely outwardly focused; 10 = completely self-focused.)			
How anxious do you expect to feel/did you feel?			
How anxious do you expect to appear/think you appeared?			
How do you think your overall performance will be/went?			
Other –			
Other –			

- **The "Other" boxes should be filled in with individualized feared outcomes. Please do not leave blank.**

What did you learn from the exercise?

Video Feedback

Patients should be asked to close their eyes and vividly picture what they expect to see on the video. Predictions should be made along the same dimensions as with the actual experiment (e.g., look anxious, overall performance, other predictions that can be evaluated with video feedback), as well as any other predictions patients make based on their internal image of how they think they came across:

Rating (use 0-10 scale)	With safety behaviors and self-focused Attention		Without safety behaviors and with outwardly focused attention	
	Predicted (What I expect to see)	Actual (What I really see when I watch as an objective observer)	Predicted (What I expect to see)	Actual (What I really see when I watch as an objective observer)
How anxious do you think you appeared?				
How do you think your overall performance was?				
Other (from above, if applicable) –				
Other (from above, if applicable) –				
Other (based on what they expect to see in video) --				
Other (based on what they expect to see in video) --				

What did you learn from the video feedback?

Confederate Ratings

Ratings can be collected from the confederate at the therapist's discretion.

Some predictions will be best evaluated via the feedback of the confederate(s) who participated in the experiment with the patient. Confederates can be asked about the same dimensions as the patient examined during the actual experiment (e.g., feel anxious, look anxious, overall performance, other specific predictions), as well as any other predictions patients make that are based on what the confederate thinks of them.

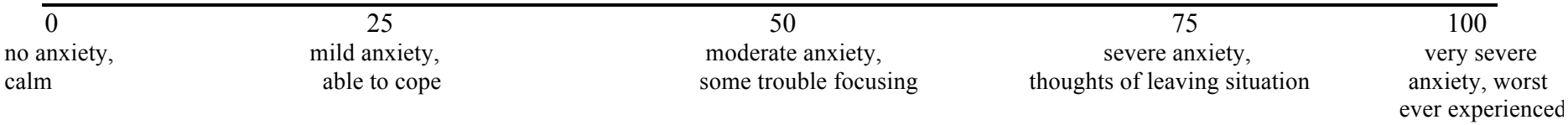
A few tips to consider:

- **It is a good idea to include some predictions that pertain to long-term consequences (e.g., "How likely is it that this person will want to chat with you again, be your friend, etc.)**
- **The confederate can also be asked to report on his/her own anxiety (or other symptoms, like blushing) during the exposure. The patient should be asked to rate the confederate on these dimensions as well.**

Rating (use 0-10 scale)	**Experiment # 1** ***(with safety behaviors and self-focused attention)***	**Experiment #2** ***(without safety behaviors and with outwardly focused attention)***
How anxious do you think that _____ felt?		
How anxious do you think that _____ appeared?		
How do you think _____'s overall performance was?		
How anxious were *you* during the exposure?		
Other –		
Other –		

For the patient: What did you learn from the confederate's feedback?

SUDS: Subjective Units of Discomfort Scale



Form 7, SUDS Scale

Hierarchy of Social Situations

Item	SUDS

Form 8 Hierarchy of Feared Social Situation

Worksheet for Exposures

Setting Up the Exposure

Description of exposure:

Predictions/feared outcomes of exposure:

How will you know if feared outcome has occurred and how will your predictions be evaluated?

USE NEXT PAGE TO RECORD RATINGS DURING THE EXPOSURE

Post-Processing

Summary of what was learned:

Plans for subsequent exposures:

Form 9 Worksheet for Exposures

Worksheet for exposures, Page 2

Ratings for exposures

How self-focused were you during the experiment? (0 = completely outwardly focused; 10 = completely self-focused.)

Rating (use 0-10 scale)	Predicted	Actual
How anxious do you expect to feel/did you feel?		
How anxious do you expect to appear/think you appeared?		
How do you think your overall performance will be/went?		
Other –		
Other –		

Video Feedback

Rating (use 0-10 scale)	Predicted (What I expect to see)	Actual (What I really see when I watch as an objective observer)
How anxious do you think you appeared?		
How do you think your overall performance was?		
Other (from above, if applicable) –		
Other (from above, if applicable) –		
Other (based on what they expect to see in video) --		
Other (based on what they expect to see in video) --		

Confederate ratings

Rating (use 0-10 scale)	Confederate Ratings
How anxious do you think that _____ felt?	
How anxious do you think that _____ appeared?	
How do you think _____'s overall performance was?	
How anxious were *you* during the exposure?	
Other –	
Other –	

Therapist Imaginal Exposure Recording Form

Name of Therapist_____ Date _____

Client _____

Exposure #_____ Session #_____

Description of exposure in imagination: _____

_____

_____

_____ start time	SUDS	Notes:
beginning	_____	
5 minutes	_____	
10 minutes	_____	
15 minutes	_____	
20 minutes	_____	
25 minutes	_____	
30 minutes	_____	
35 minutes	_____	
40 minutes	_____	
45 minutes	_____	
50 minutes	_____	
55 minutes	_____	
60 minutes	_____	

Form 10 Record Sheet for In-session imaginal exposures

Imaginal Exposure Homework Recording Form

Client _____ Date _____

Instructions: Please record your SUDS ratings on a 0 to 100 scale (where 0 = no discomfort and 100 - maximal discomfort, anxiety, and panic) before and after you listen to the audiotape of the imaginal exposure. You will also rate the exposure for vividness: how real it seemed to you when you listened to it (0 = couldn't get into it, not at all real; 100 = almost like it was happening again).

Tape #: _____

DATE & TIME				
SUDS Pre				
SUDS Post				
Peak SUDS				

DATE & TIME				
SUDS Pre				
SUDS Post				
Peak SUDS				

Form 11 Record Sheet for homework imaginal exposures

Goal-Setting Worksheet

Time-Frame	Goals	Steps needed to accomplish goal
Within two weeks		
Within one month		
Within six months		
Within one year		

Form 12, Goal Setting Worksheet

SOCIAL BEHAVIOUR QUESTIONNAIRE

Name:……. Date……...

Please circle the word which best describes how often you do the following things when you are anxious in or before a social situation:

Use alcohol to manage anxiety	**Always**	**Often**	**Sometimes**	**Never**
Try not to attract attention	**Never**	**Sometimes**	**Often**	**Always**
Make an effort to get your words right	**Never**	**Sometimes**	**Often**	**Always**
Check that you are coming across well	**Always**	**Often**	**Sometimes**	**Never**
Avoid eye contact	**Never**	**Sometimes**	**Often**	**Always**
Talk less	**Always**	**Often**	**Sometimes**	**Never**
Avoid asking questions	**Always**	**Often**	**Sometimes**	**Never**
Try to picture how you appear to others	**Never**	**Sometimes**	**Often**	**Always**
Grip cups or glasses tightly	**Never**	**Sometimes**	**Often**	**Always**
Position yourself so as not to be noticed	**Always**	**Often**	**Sometimes**	**Never**
Try to control shaking	**Always**	**Often**	**Sometimes**	**Never**
Choose clothes that will prevent or conceal sweating	**Never**	**Sometimes**	**Often**	**Always**
Wear clothes or make up to hide blushing	**Never**	**Sometimes**	**Often**	**Always**
Rehearse sentences in your mind	**Always**	**Often**	**Sometimes**	**Never**
Censor what you are going to say	**Always**	**Often**	**Sometimes**	**Never**
Blank out or switch off mentally	**Never**	**Sometimes**	**Often**	**Always**
Avoid talking about yourself	**Never**	**Sometimes**	**Often**	**Always**
Keep still	**Always**	**Often**	**Sometimes**	**Never**
Ask lots of questions	**Always**	**Often**	**Sometimes**	**Never**
Think positive	**Never**	**Sometimes**	**Often**	**Always**
Stay on the edge of groups	**Never**	**Sometimes**	**Often**	**Always**
Avoid pauses in speech	**Always**	**Often**	**Sometimes**	**Never**
Hide your face	**Never**	**Sometimes**	**Often**	**Always**
Try to think about other things	**Always**	**Often**	**Sometimes**	**Never**
Talk more	**Always**	**Often**	**Sometimes**	**Never**
Try to act normal	**Always**	**Often**	**Sometimes**	**Never**
Try to keep tight control of your behavior	**Never**	**Sometimes**	**Often**	**Always**

COGNITIVE DISTORTIONS

1. **All-or-Nothing Thinking**: You see things in black and white categories. If your performance falls short of perfect, you see yourself as a total failure.

2. O**vergeneralization**: You see a single negative event as a never-ending pattern.

3. **Mental Filter**: You pick out a single negative detail and dwell on it exclusively, so that your vision of all reality becomes darkened, like the drop of ink that discolors the entire beaker of water.

4. **Disqualifying the Positive**: You reject positive experiences by insisting they "don't count" for some reason or other. In this way you can maintain a negative belief that is contradicted by your everyday experiences.

5. **Jumping to Conclusions**: You make negative interpretations even though there are no definite facts that convincingly support your conclusion.

    a. **Mind Reading**: You arbitrarily conclude that someone is reacting negatively to you, and you don't bother to check this out.

    b. **The Fortune-Teller Error**: You anticipate that things will turn out badly, and you feel convinced that your prediction is an already established fact.

6. **Magnification (Catastrophizing) or Minimization**: You exaggerate the importance of things (such as you goof-up or someone else's achievement) or your inappropriately shrink things until they appear tiny (your own desirable qualities or the other fellow's imperfections). This is also called the "binocular trick."

7. **Emotional Reasoning**: You assume that your negative emotions necessarily reflect the way things really are: "I feel it, therefore it must be true."

8. **"Should" Statements**: You try to motivate yourself with "should and shouldn'ts," as if you had to be whipped and punished before you could be expected to do anything. "Musts" and "oughts" are also offenders. The emotional consequence is guilt. When you direct "should" statements toward others, you feel anger, frustration, and resentment.

9. **Labeling and Mislabeling**: This is an extreme of overgeneralization. Instead of describing your error, you attach a negative label to yourself. "I'm a loser." When someone else's behavior rubs you the wrong way, you attach a negative label onto him/her: "He's a goddam louse." Mislabeling involves describing an event with language that is highly colored and emotionally loaded.

10. **Personalization**: You see yourself as the cause of some negative external event for which, in fact you were not primarily responsible.
11. **Maladaptive Thoughts**: Thought that are not necessarily irrational or distorted, but are unproductive to dwell upon. Examples: "This is going to be difficult" and "It's not fair that it's so hard for me to overcome my anxiety."

Dispute Questions

Do you know for certain that _____ will happen?

Am I 100 percent sure of these awful consequences?

What evidence do I have that _____?

Does _____ have to equal or lead to _____?

Do I have a crystal ball?

What is the worst that could happen? How bad is that?

Could there be any other explanations?

What is the likelihood that _____?

Is _____ really so important or consequential?

Does _____'s opinion reflect that of everyone else?

Is _____ really so important that my entire future resides with its outcome?

Cognitive Self-Monitoring Form

Date / Situation	Automatic Thoughts / Cognitive Distortions	Rational Response

Attention and Safety Behaviors Monitoring Form

Date / Social Situation	How self-focused were you during the situation? (0 = completely outwardly focused; 10 = completely self-focused)	How much were you able drop your safety behaviors? (0 = not at all; 10 = completely)

Questions about your social anxiety

1. What sorts of things are you not doing or not enjoying that you would do if you didn't have social anxiety?

2. What opportunities have you missed out on because of social anxiety?

3. How will your life be different if you no longer have social anxiety? Be specific about what you would do or change.