

Cognitive Behavioral Therapy for Social Anxiety Disorder



**Evidence-Based and Disorder-
Specific Treatment Techniques**

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CHAPTER 3

Session-by-Session Outline

With a conceptual model and elements described in previous chapters, this chapter provides a session-by-session accounting of treatment. A standard course of treatment is targeted weekly for 12 to 16 sessions. The treatment can be delivered in either 1-hour individual sessions or 2.5-hour group sessions (with two therapists and four to six individuals per group). Group treatment has a number of advantages over individual therapy, but it also presents a number of unique challenges. Advantages include a ready-made social group for exposure practices. The group provides an audience, a forum for feedback, and an opportunity for supportive discussions. Yet, although the group provides ample opportunities to learn from others (and understand the global nature of negative thoughts and self-defeating social expectations and interpretive biases), it also diffuses the intensity of focus from what can be provided in individual therapy. As is explicated later, individual therapy also requires the use of other confederates (others who can provide a social exposure audience) or the sort of public exposures (e.g., buying then returning a CD) that do not require confederates but do require a trip from the therapist's office. In this chapter, we provide a primary focus on providing treatment in the context of a group, but the treatment protocol can also be delivered as an individual treatment with relatively minor modifications.

Because of the focus on the provision of objective feedback and the use of objective goals for the exposure, we recommend the use of a white board in treatment offices. This white board can be used for presentation of aspects of the model of the disorder and treatment, writing out specific dysfunctional thoughts for consideration, operationalizing a goal for exposure (in a way that allows verification after exposure), or drawing out the pattern of anxiety symptoms experienced by a patient. In individual sessions, a pad of paper can be substituted, but we have found a large, white board to be uniformly useful and efficient for group work.

GENERAL OUTLINE

The first two sessions of treatment are especially important for establishing a conceptual model to guide subsequent interventions. During these sessions, patients are introduced to the treatment rationale, with particular attention to the structure of exposure practice. It is in these sessions that the therapist is most directive, providing patients with a model and directly structuring the elements of exposure exercises and interactions between group members. As treatment progresses, the therapist shifts this responsibility to the group members; feedback on exposures, coaching around cognitive biases, and comments regarding social skills increasingly become the responsibility of the group members.

After the first session, which introduces the patient to the treatment, the therapist administers a fear and avoidance hierarchy that lists the most feared and avoided social situations. During Sessions 2 through 6, every group member will be asked to complete exposures, receive feedback from other group members, and watch the videotaped recording of his or her exposure. In most group settings, brief speeches are used for exposure. Speeches are generally toward the top of most patients' hierarchies and, hence, are an excellent method to provide a forum for learning for all group members. The group members have an important dual function in these exposures: (1) They provide emotional support and give positive feedback to the person doing the exposure, and (2) they are at the same time the reason for the person's distress because they serve as the audience during the first half of the treatment. Therefore, positive feedback from group members is very important. In most cases, the therapist should let the group members "do the talking" when support is needed. The therapist's role is then to redirect, focus, and clarify certain points relating to maintaining factors of social anxiety as discussed in the model. Sufficient time should be designated for group discussions.

The therapists and patients have a large degree of flexibility with the topics the patients choose for the videotaped speeches. Examples for speech topics may range from black holes and cloning for patients who are most uncomfortable when speaking about an unfamiliar and complicated subject to social rules of dating and what makes dating fearful, in case they want to target their fear of rejection. Furthermore, the treatment includes modeling (the therapist should not give perfect presentations; little mistakes are desirable), instructions and coaching, and self-monitoring as additional ingredients.

By the beginning of Session 7, participants shift from these speeches to *in vivo* exposure tasks individually tailored to the person to modify specific cognitive biases. These exposures continue to the end of treat-

ment, where strategies for relapse prevention are covered. In Session 7, exposures are chosen that involve simple interpersonal interactions (e.g., asking for directions). Beginning with Session 8, the patient will be asked to perform challenging *in vivo* exposure exercises that involve a component of social error or challenge (e.g., "accidentally" dropping on the floor a pastry that was just purchased at a cafe and requesting to get a new one, or returning to the same salesperson a book that it was just purchased from 5 minutes earlier) to ensure that fears of doing something "socially wrong" are fully addressed by treatment. The fear and avoidance hierarchy should be used to construct these exposures.

Across all of these sessions, assignment of regular home practice is essential for learning. Home practice helps ensure that therapy skills are learned independently of the safety cues inherent in the clinic and that skills are learned independently from the direct mentoring of the therapist. By reviewing home practice at the beginning of each session, therapists maintain a consistent focus on the importance of this work outside the session.

SESSION 1

General Introduction

The most important goals of the first session are to establish rapport, make group members comfortable with a socially challenging situation, and provide a general introduction to the treatment model with a specific emphasis on exposure strategies. An example for initiating the first group session follows:

Thanks to everyone for coming tonight. This is the first of 12 to 16 weekly group sessions. Each session will last approximately 2 hours, and the goal is to overcome social anxiety. Welcome and congratulations. Each one of you is here because you feel uncomfortable in social situations. And here you are, sitting in a group of people and willing to confront your anxiety. Coming here is therefore a very courageous act, and courage is one the most important conditions needed to overcome your anxiety. The fact that you are here despite your discomfort tells me that your desire and motivation to overcome your fear is stronger than your desire to avoid dealing with your anxiety. This is very good. You are on the right track. Before we begin, let me introduce myself to you. My name is Beverly. I am a postdoctoral fellow in clinical psychology and I am especially interested in

anxiety disorders. I have done many groups like this, and I have had intensive training in various empirically supported treatments for anxiety disorder, and I am looking forward to working with you for the next three months. And this is John (turn to cotherapist and let him introduce himself).

After John introduces himself, he may turn to the group member sitting next to him and say: "And what is your name and what do you do?" Each group member is encouraged to say as little or as much as desired. If a person is unable to say anything, the therapists should gently and empathetically introduce the person to everyone and mention something they know about the person. Humor helps to break the ice but should never ridicule or embarrass any group member. Following the general introduction, the therapist should discuss issues concerning confidentiality. An example is as follows:

Before we begin, I have one more important issue. We as therapists are bound by ethics and legal requirements that protect your privacy. For example, all identifying information that we have from you is kept in locked file cabinets and only staff members working at the center have access to this information. Furthermore, we cannot talk about anyone in this group to any outsiders in a way that any group member may be identified without your written permission [exceptions to this general rule—impending harm to self or others, insurance disclosures, and so forth—were discussed individually with patients]. We also ask each one of you to protect the privacy of everyone else. We call this confidentiality. So please don't mention the name of any group member to people outside the group.

Sharing of Individual Problems/Goals and Drawing Out Similarities

After the general introduction, patients are encouraged to speak briefly on their reasons for being in the group, that is, what are the concerns for which they have sought treatment, how the fear of speaking or other social fears affect their lives, what other fears they have, and what their goals are in the group. The purpose of this discussion is to demonstrate the similarity among patients and to build group cohesion. Each participant should be called on, in turn, by the therapists. The order should be different from the order in which group members originally introduced themselves.

Therapists should liberally provide prompts to help patients express themselves. The patients may be quite anxious and therefore find it difficult

to organize their thoughts and should be freely assisted. Any patient who is too anxious to speak at length should be given ample room to decline. Although patients may show a diversity of symptoms and eliciting situations, and although they may differ considerably in the amount of impairment of functioning they experience, all individuals will share at least the fear of public speaking and they may also have additional commonalities with other group members. It is important to point these out and make the point that the similarities outweigh the differences. Differences should not be ignored, but similarities should be highlighted as a means of bringing the group closer together. Specifically, therapists should point out

- Similarities among pairs of patients in the presenting problem, that is, that they wish to overcome their social anxiety
- Similarities among patients regarding bodily reactions they have during speech situations and other social situations
- Similarities among patients regarding how they think other people perceive them in social situations

Introducing and Discussing the Treatment Model

This is the single most important piece of the initial sessions. It is crucially important that group members understand and adopt a working model for treatment. For this purpose, therapists should distribute Handout 1: CBT model of SAD (Appendix A; see also Figure 3.1) to illustrate the treatment model. The therapist should spend as much time explaining this model as necessary. Furthermore, the therapist should refer back to the model as often as possible. An example for presenting the model follows:

After our discussion, we now have a common knowledge of what everyone is concerned about and what we all wish to accomplish. Next, we want to talk about the nature of social anxiety. Social anxiety, the fear of social situations, is something really interesting. You are all constantly confronted with social situations in your daily life. Just think about how often you interact with people during your day. And yet, in the absence of treatment, social anxiety can persist for many years or decades. What keeps this anxiety going? Why don't people get used to it? The figure in the handout will illustrate the reasons why.

Please take a few minutes to look at this figure. It is important because this provides an overview of the model of treatment we have adopted. I will go over it in detail. But please take a few moments to study it for yourself first.

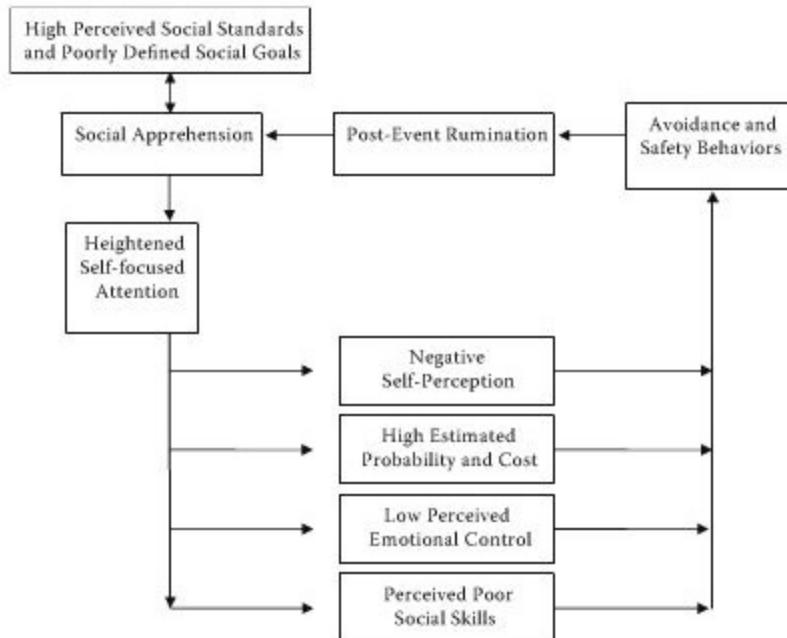


FIGURE 3.1 Handout 1: CBT model of SAD.

What you can see here is a big feedback loop that starts at social apprehensions and leads back via avoidance. Treatment will target all parts of this feedback loop. The figure shows that a social situation is in part anxiety provoking because the goals that you want to achieve in the situation are high or because you assume that the social standard is high. If nobody expected anything from you or if everybody performed very poorly, you would feel considerably less social apprehension than if everybody expected a lot from you and your goals were very high. During this treatment, you will realize that in general people do not expect as much from you as you think they do. Furthermore, you will learn how to define clear goals for yourself during a social situation and how to use this information to determine whether the situation was successful.

Once an individual experiences initial social apprehension, attention is typically directed inwardly—toward self-evaluation and toward sensations of anxiety. We know that this shift in attention makes the problem worse. You are now spending your mental resources scanning your body and examining yourself as well as trying to handle the situation. As part of this treatment, you will learn strategies to direct your attention away from your

anxious feelings and toward the situation in order to successfully complete the social task.

Some of you may focus your attention inwardly and notice aspects about yourself that you don't like when being in a social situation. In other words, you perceive yourself negatively and you believe that everybody else shares the same negative beliefs with you. "I am such an inhibited idiot" is an example of a self-statement that reflects negative self-perception. It is important that you become comfortable with the way you are (including your imperfections in social performance situations). You will learn strategies for how to change this negative view of yourself and become comfortable with the way you are. You will further realize that other people do not share the same negative view with you.

Major social mishaps with serious consequences are rare. Minor social mishaps are normal and happen all the time. But what makes people different is the degree to which these mishaps affect a person's life. Some of you believe that social mishaps have disastrous consequences for you. As part of this treatment, you will realize that even if a social encounter objectively did not go well, it is just no big deal.

Some of you notice the bodily symptoms of your anxiety a lot when you are in a socially threatening situation, and some of you may even feel paniclike anxiety that appears to get out of your control any second and that everybody else around you can see and sense your racing heart, dry mouth, sweaty palms, and so forth. You will realize that you have more control over your anxious feelings than you think. You will also realize that you overestimate how much other people can see what's going on in your body. Your feeling of anxiety is a very private experience; other people cannot see your racing heart, your sweaty palms, or your shaky knees.

Some of you may further believe that your social skills are inadequate to deal with a social situation. For example, some of you might believe that you are a naturally bad speaker and, therefore, feel very uncomfortable in most public speaking situations. During this treatment, you will realize that your actual social performance is not nearly as bad as you think it is and that poor skills are not the reason for your discomfort in social situations. In fact, there are plenty of people in this world whose social skills are much more limited than yours but who are not socially anxious.

As a result of these processes, you use avoidance strategies. Some of you avoid the situation, some of you escape, and some

of you use strategies that make you less uncomfortable. All of these activities (or lack thereof) are intended to avoid the feeling of anxiety. You will learn that using avoidance strategies (either active or passive) is part of the reason social anxiety is so persistent because you never know what would happen if you did not avoid.

But the problem is not over, even after the situation has passed. Some of you tend to ruminate a lot about a social situation after it is over. You might not only focus on the negative aspects but also on ambiguous things (things that could be interpreted as negative or positive), and some of you tend to reinterpret these things negatively. Again, this does not help and makes the situation much worse. You will realize that ruminating about past situations is a bad idea. What happened, happened; time to move on. Ruminating only make things worse and makes you more anxious and avoidant about future situations.

Some of this information is rather complex. But so is your anxiety. It is very important that you understand all aspects of your anxiety and what the maintaining factors are.

At this point, it is advisable to distribute Handout 2: Learning Objectives (Appendix B), which summarizes the points that were discussed, and Handout 3: Approach to Social Situations Scale (Appendix C). Handout 3 is intended to provide feedback to the therapist that can be used to tailor the intervention strategies to the individual patient. Handouts 1 and 2 are kept by the patients, and Handout 3 is returned to the therapist. The items of Handout 3 measure the degree to which an individual matches a particular component of the treatment model. Specifically, the instrument measures perceived social standards (Item 1), goal setting skills (Item 2), degree of self-focused attention (Item 3), self-perception (Item 4), estimated social cost (Item 5), probability estimation of social mishaps (Item 6), perception of emotional control (Item 7), perception of social skills (Item 8), overt avoidance tendencies (Item 9), post-event rumination (Item 10), and safety behaviors (Items 11 and 12). The patient's ratings can give the therapist an idea regarding how much weight needs to be placed on the various components of the model during treatment.

The Role of Avoidance for Maintaining Social Anxiety

The exposure model is the core element of the therapy. The therapist should repeatedly refer back to the basic concepts. Any alternative

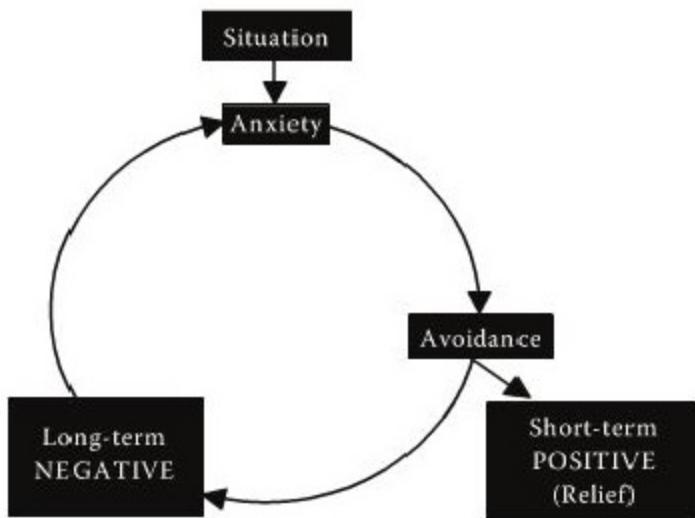


FIGURE 3.2 The vicious cycle model of avoidance.

biological or psychodynamic explanations offered by the patient should be discussed within the framework of the treatment model. Even if a patient does not agree with the model, the therapist should try to explain the model in such a way that it can be incorporated into the patient's personal beliefs about the etiological or maintaining factors of social phobia. In order to exemplify the contribution of avoidance to the maintenance of anxiety, show Figure 3.2 with the following explanation:

Let's say a colleague asks you to give a speech for him about a subject you don't know well in front of a lot of people. How would this make you feel? (Elicit physiological sensations.) When you are anxious and feeling this way, what do you typically do then? (Elicit examples.) Right, so you behave in some way to make yourself feel a little less uncomfortable. For example, you may tell him that you won't be able to do the speech for him, or you may give a very brief speech, or you may take medication or even alcohol to make yourself feel a little better. (Elicit further examples.) Or in other social situations you may not be calling someone for a date, not starting a conversation, or maybe choosing a job that won't put you into one of those situations. This is called avoidance. We define avoidance as anything that you do or don't do that prevents you from facing your anxiety. This includes not entering the feared situation, escaping out of the feared situation, taking medications, distracting

yourself, using breathing techniques, and so forth. This has two consequences. The first one is that you feel some relief from your anxiety. This is a short-term positive consequence. However, there is also a long-term negative consequence of avoidance: You will always feel anxious in this particular situation. Avoidance preserves your anxiety. In addition, avoidance tends to spread to other social situations and takes over more and more areas in your life. In sum, social anxiety is so persistent because of a bad habit, which is avoidance. Moreover, anxiety could not exist if you did not avoid. Let me explain this.

Let's imagine a fearful social situation we are all familiar with: public speaking. Let's assume you will have to give a very important presentation in front of hundreds of people. Let's imagine the following scenario: You are entering the room. People stop talking. Everybody has been expecting you. What would your anxiety be? (Elicit anxiety rating 1–9.) Let's say you are now standing in front of all these people; everybody is looking at you, waiting for you to start with your speech. You can feel your heart pounding, your palms sweating, and so forth. (Elicit anxiety rating 1–9.) What will you do if you can get out of the situation? You get out ... you avoid (Figure 3.3).

Now, what would happen if you did not avoid? Let's just assume that, just like pressing pause on your remote control button of your video equipment, you could remain in that situation for a while. So let's press the pause button on our imaginary remote control. What would your anxiety be after 2 minutes

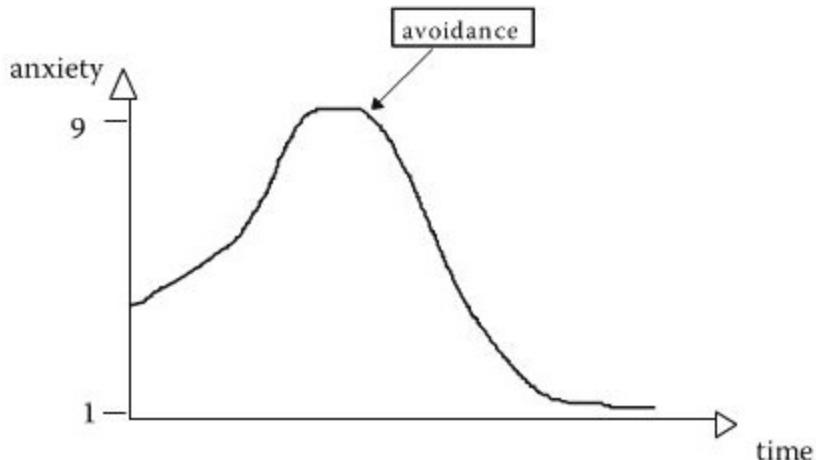


FIGURE 3.3 Anxiety episode with avoidance.

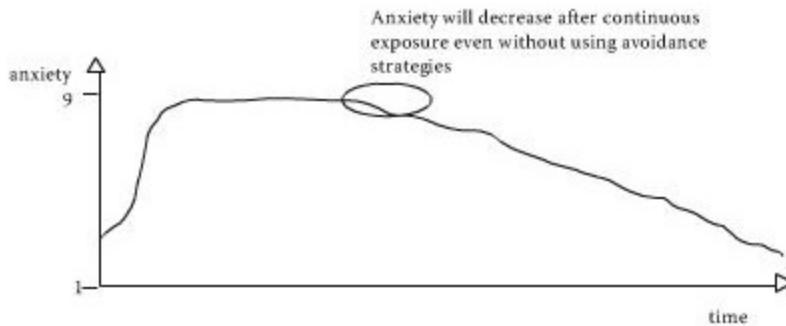


FIGURE 3.4 Anxiety episode without avoidance.

(10 minutes, 60 minutes, 2 hours, etc.)? Eventually, anxiety will go down just by itself if the person does not avoid. This is how your body works ... anxiety doesn't kill you (Figure 3.4).

What would your anxiety be if we repeated the same situation over and over again? That is, we rewind the tape of our imaginary video equipment and do the scene over and over again (Figure 3.5)?

The therapist should make the following points (in layman's terms) that after repeated exposure:

1. Anticipatory anxiety will decrease.
2. Maximum anxiety will decrease.
3. The time the maximum anxiety stays on a plateau will decrease.
4. Recovery will be faster.
5. This is how the body works.

The conclusion of this discussion is that anxiety can be effectively overcome with repeated and prolonged exposure to fearful social

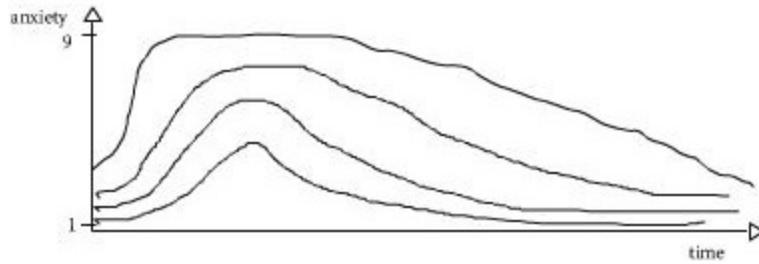


FIGURE 3.5 Anxiety after repeated exposure to the same situation.

situations without using avoidance strategies. The working definition of avoidance is, therefore,

Avoidance is anything you do or don't do that prevents you from facing your fear of anxiety. This includes not entering the feared situation, escaping out of the feared situation, taking medications as needed, distracting yourself, using breathing techniques, or behaving in a way that makes you feel more comfortable (safety behaviors).

Importance of Exposure

Exposure situations serve a number of different purposes.

1. Exposures provide an opportunity to practice goal settings and reevaluate social standards. For this purpose, the therapist should discuss with the patient what the social expectations (standards) of a given situation might be and should help the patient to state at least one clear (e.g., behavioral, quantifiable) goal (e.g., asking a particular question). At the beginning, it is important to provide very clear instructions as to what the exposure task should look like. The therapists' role during these early exposures is similar to that of a movie director who provides the patient with a clear script of his or her expected behavior. If the situation requires a complex social interaction (e.g., returning an item to the same salesperson minutes after it was purchased), the therapist should clearly specify when a particular action should be shown. For example, rather than simply instructing the patients to "return a book minutes after you buy it," the therapist should instruct the client to "purchase the newest Harry Potter book, walk with it toward the exit door, and when reaching the exit doors, turn around, find the same salesperson again, and ask for a refund for this book by saying: 'I want to exchange this book that I just bought because I changed my mind.'" The goal of this task may be to say this particular sentence and not to apologize.
2. Exposures provide an opportunity to demonstrate the effects of attentional focus on subjective anxiety. Before every exposure situation, the therapist asks the patient to focus his or her attention toward the self and the anxiety symptoms and to give an anxiety rating (0–10). The therapist

should then ask the patient to direct his or her attention to his or her physical sensations, to describe the feelings, and to rate his or her anxiety. Finally, the patient should be instructed to direct his or her attention to the task (e.g., speech topic, script of exposure task) and to rate his or her anxiety again.

3. Exposures provide an opportunity for the patient to reevaluate his or her social self-presentation. For this purpose, video feedback will be used to reexamine the patient's prediction of his or her performance. Specifically, this technique includes a cognitive preparation prior to viewing the video during which patients are asked to predict in detail what they would see in the video. They will then be instructed to form an image of themselves giving the speech. In order to compare the imagined/perceived self-presentation with the actual self-presentation, individuals will then be asked to watch the video from an observer's point of view (i.e., as if they were watching a stranger). Additional strategies to target self-perception include mirror exposure exercises and listening to their own audiotaped speech. During the mirror exposure, patients are asked to objectively describe the appearance of their mirror image and to audiotape this description. This audiotaped description will then be assigned to independent clinicians to listen to. In addition, patients will be asked to audiotape an impromptu speech about the same topic from the group session and to listen to this speech daily. The reason for these exercises is to correct the person's distorted self-perceptions and to become used to one's own appearance.
4. Asking patients to watch their own videotaped speech performances will provide them with the opportunity to reexamine their social performance. By adding a cognitive preparation prior to watching the videotaped speech, the cognitive dissonance between actual and perceived performance is further increased.
5. In vivo exposure situations that model social mishaps (e.g., dropping a pastry on the floor) provide an ideal opportunity to test distorted assumptions about the social cost of situations.
6. Exposure situations without the use of any avoidance strategies create a high level of emotional arousal, which provide the patient with the opportunity to use acceptance strategies to cope with anxiety.

Nature of Exposure Situations

Effective situations for individuals with SAD differ from exposure situations to treat other phobic disorders. First, they often require performance of complicated chains of interpersonal behavior during exposure. Second, the social phobic patient's specific anxiety-eliciting situations are not always available. For example, an agoraphobic individual may go for a walk away from home at almost any time, but the social phobic may confront that feared staff meeting only once weekly. Other situations may occur only sporadically and be beyond the individual's realistic control. Therefore, the treatment at the beginning will use public speaking situations in the group. This provides the therapist with a maximum degree of control over the situation (e.g., by choosing different speech topics or modifying the situation by bringing in additional audience members or instructing the audience to behave in a certain way). At the beginning of treatment, the therapist should state the following three reasons why the focus will be on public speaking:

1. Public speaking anxiety is often very severe and is the most commonly feared social situation among people with social phobia. It is also one of the most common fears in general. Therefore, all group members share the same type of social fear.
2. A reduction of anxiety related to public speaking (one of the most challenging social tasks) also leads to a reduction of other social fears. This generalization effect can also be seen when treating other fears. For example, a child who is afraid of dogs can overcome his or her fear of dogs if he or she becomes comfortable with the neighbor's dog, especially if the neighbor's dog is friendly but very big and scary looking.
3. In contrast to many other social situations (e.g., dating, maintaining or initiating a conversation), it is fairly easy to create a realistic and uncomfortable public-speaking exposure situation in session.

Later in treatment, exposure tasks will involve more challenging *in vivo* situations to encourage generalization of treatment gains. This can be achieved first by making the performance situations in group more challenging via changing situational conditions (e.g., adding new audience members, instructing exposing members to act in a disapproving manner) or nature of the task (e.g., interrupting patients at various points or asking them to talk about a sensitive topic, such as their most embarrassing situation). Later in treatment, patients will be asked to engage in a number of challenging social tasks outside of the group setting that

create some actual social mishaps or that involve social behaviors that are inconsistent with the patient's perceived social standard.

The fear and avoidance hierarchy (Appendix H) handed out during the first session should serve as a basis to construct the exposure practices for individuals. Later exposure tasks should be designed to specifically create undesirable social mishaps, which provide the patient with the opportunity to examine their actual consequences. Examples were provided in chapter 2 (Table 2.1; see also Appendix K). When conducting these exposures, it is important to discourage patients from using any safety behaviors or other forms of avoidance strategies.

Practical Issues and Goals

In addition to establishing rapport with the patient and discussing the treatment model, the first session also has an important motivational goal. Discussing the treatment model, the role of avoidance for the maintenance of SAD, and the importance of exposure practices can generate a great degree of distress and increase the likelihood of avoidance tendencies and even treatment drop out. Therefore, it is important to inoculate the patient for avoidance behaviors.

Specifically, the therapist should explain that not doing exposure practices in sessions and home practice assignments (i.e., tasks to be completed between sessions every week after the second session) and missing sessions are all forms of avoidance behavior. For example, the therapist might introduce this issue as follows:

Before we end this session, I would like to say something very important. Come to every session, be on time, and do your home practice out of fairness to yourself and other members. Let me tell you why. Avoidance has many faces. And sometimes it might be difficult to recognize a behavior as avoidance behavior. This is partly because avoidance has developed into a habit, and habits occur on a subconscious level. Avoidance behaviors are particularly hard to identify if you can give yourself other reasons why you avoided. That way, you can avoid doing something unpleasant and at the same time tell yourself that you didn't do it, not because of your anxiety but because your car broke down, you had a deadline at work, or your dog had really bad diarrhea. Your avoidance is as intelligent as you are and will always find reasons why you can't do it; some might be more convincing to yourself and other people than others. But the bottom line is you are avoiding. Period. Every time you avoid, you are making

a decision against an independent and anxiety-free life and for a life that is controlled by your anxiety. And every time you don't avoid, you are courageous and choose the hard way with the goal to free yourself from your anxiety. I want you to be fully aware of this. So get your priorities straight for the upcoming weeks. Nothing should be more important than coming to these sessions and practicing the home practice exercises. Nothing. Not even your dog's diarrhea.

One more thing: This treatment is not just to make you feel more comfortable in social situations, such as speaking situations. It is much more than that; it entails a change in lifestyle. Clearly saying no to avoidance also means choosing the hard way with the goal to live a better life, a life without anxiety. This applies to virtually all areas in your life.

So when you find yourself debating whether you should go to the next session or clean your house, I want you to be fully aware that at the same time you are making a decision for or against an anxiety-free life. It is your life and you can do what you want. But if you really want to free yourself from your anxiety, I strongly recommend you don't avoid, come to every session, come on time, and do your home practice. Your avoidance may soon whisper in your ear, "Don't go to these sessions anymore; don't do the exposure exercises; it is not going to work." In this case, tell your avoidance that you will do it anyway because you never know unless you try it. Give it a shot and get your priorities straight. You don't have anything to lose but your avoidance and your anxiety.

Home Practice

Home practice assignments will be given at the end of each treatment session to consolidate new skills, attitudes, and emotional responses. As part of these home practice assignments, patients may be asked to perform behaviors or place themselves in situations that were previously avoided or tolerated only with excessive anxiety. In accordance with the treatment model, patients will be instructed to enter a variety of challenging social situations with the goal to reevaluate a number of assumptions (as outlined earlier) while experiencing a maximum level of anxiety without the use of any avoidance strategies. Before and after each exposure situation, the patient will be asked to fill out a monitoring form to aid the reevaluation process. Patients should be told that home practice is a very important element of this treatment and that not doing the home practice is a form of avoidance.

After each successful exposure, patients are instructed to reward themselves by doing something special or buying something. Discussion of the home practice is an opportunity to reinforce successful behavior and for the therapists to identify the parameters of the patients' feared situations. In addition, it provides an opportunity for the therapists to reinforce the model.

Flexibility for Dealing With Problems

The exposure assignments should be designed to be challenging for all patients. With group support and motivation by the therapist, most patients should be able to perform the assigned exposure tasks. Some patients, however, may feel unable to conduct the exposures. In these cases, the therapist should show an adequate degree of flexibility and modify the tasks accordingly. People severely anxious about public speaking, for example, might answer simple questions that the therapist or audience members ask rather than giving an impromptu speech, or they may be asked simply to read a paragraph in front of the audience. Conversely, the situation should be made more challenging if the patient does not experience enough anxiety or discomfort. For example, the patient may be asked to give a presentation about a negative personality characteristic rather than a speech about hobbies. Simple physical exercises prior to the exposure task (e.g., push-ups) that induce intense physical sensations and sweatiness can further heighten the anxiety during an exposure exercise (see chapter 6). The optimal level of anxiety during the anticipation phase of a social task is between 5 and 7 on a scale from 0 (no anxiety) to 10 (extreme anxiety), and the therapist should feel free to alter the social topic, interaction, symptom level, or degree of social error of the exposure in order to provide initial practices within this range.

SESSION 2

Review of Home Practice From the Past Week

The therapist should start every week with a brief review of the past week using the weekly worksheet (Handout 4, Appendix D).

The figures (Figures 3.1–3.5) that were created during the previous session should be used to illustrate the maintaining variables of social anxiety. The home practice review for each patient should be as brief as possible and focus on only the most anxiety-provoking situation in order to have sufficient time for the more therapeutic in-session exposure practices. Patients

should be discouraged from giving long and elaborate descriptions of the situation. Instead, the situation should be summarized succinctly followed by specific and guided questions with the following purposes:

1. Identify anxiety-provoking aspects of the situation. Summarize what exactly made the situation so anxiety provoking.
2. What was the main goal the patient wanted to achieve, and what did the patient think other people's expectations were?
3. What kind of social mishap was the patient afraid of, and what would have been the social consequences?
4. Examine perceptions of control over anxiety: How visible was anxiety to other people? Examine perceptions of social skills: How was the patient's performance?
5. Examine self-focus and self-perception in the situation: Did the patient focus on self and anxiety? What impact did the situation have on his or her self-perception?
6. Identify safety behaviors and other avoidance strategies. Conduct a cost (maintenance of vicious cycle) and benefit (short-term relief) analysis of avoidance. Use simple phrases to illustrate this point, such as "avoidance is your anxiety's best friend" and "anxiety cannot exist without avoidance."
7. Explore post-event rumination: How long did the situation and its feared consequences "linger"? To what extent will this situation change the patient's future life?

Group members who exposed themselves to a fearful situation should be rewarded warmly. If the patient used any safety behaviors or avoidance strategies, the therapist should encourage the patient to repeatedly expose him/herself during the following week while fading these behaviors/strategies (but if the patient does not feel ready to do that yet, the therapist should not push any further). To maximize self-efficacy, the patient should have a maximum degree of control over the nature of the exposure exercise as part of the home practice assignment. However, avoidance strategies should be clearly acknowledged and the negative impact discussed. If the patient shows repeated avoidance behaviors during her or his home practice assignment, the therapist may ask questions such as:

- How did you feel after you avoided X?
How do you think you would have felt if you had not avoided X?
Doesn't it bother you that you avoided X?

The therapist should help the patient to perform a cost-benefit analysis after he/she avoided the situation. It should become very clear

that the benefit of avoidance (short-term relief) does not outweigh the costs (maintenance of the vicious cycle of social anxiety). Phrases such as “avoidance is your anxiety’s best friend” and “anxiety could not exist without avoidance” often help patients to fully understand this principle. Often patients claim that they avoided for some other (seemingly rational) reasons. The therapist may then point out that “avoidance is as intelligent as you are” (meaning that there are always reasons why the patient could not expose himself or herself); but whatever the reason, the anxiety won at this point. The therapist may compare this to a soccer match: Whenever the patient avoids, anxiety scores a goal, and the more often the patient avoids, the more difficult it then becomes to win the match. Social anxiety may be portrayed as a wild and vicious beast that, when examined in more detail, is only a harmless kitten. But one can only realize this if the patient stops running away from it. Using such phrases and figurative examples often helps patients to understand and better consolidate the exposure rationale.

If most participants have not done their home practice, discuss why not and point out the importance of home practice assignments for the therapy outcomes. If possible, refer again to the model (vicious cycle, Figure 3.2) and point out the short- and long-term effects. Socially reward group members who exposed themselves to a fearful situation and analyze the situation in detail (what was the situation, how did you feel at the beginning, what did you do, how did other people react, how did you feel at the end, etc.). Give positive feedback and refer again to the model (vicious cycle).

Review of Treatment Model

Before the exposure practices, ask group members to explain the treatment rationale by using the figures (Figures 3.1–3.5) from Session 1. These figures should already be on the board prior to the beginning of the session. This should be done with minimal therapist involvement. The therapist will ask guided questions (e.g., what are the components of social anxiety and why is it maintained; what are examples of avoidance and safety behaviors and what are the consequences?). The following messages need to be conveyed:

- The more you think other people expect from you, the greater your anxiety. These expectations may not be correct.
- It is important to clearly define the goals of a social situation. Otherwise, we don’t know whether we have reached them and whether the social situation has been a success.
- The more you focus on yourself in a social situation, the more anxious you feel.

attentional shift, elicit anxiety ratings. This exercise is designed to illustrate how changes in attentional focus influence the level of anxiety.

If the patient's anxiety is very high at the beginning (>6), the therapist may ask the patient to just stand quietly in front of the audience and let the therapist know when his/her anxiety decreases. Each and every speech should be followed by applause from the therapists and the group members, by immediate positive reinforcement (i.e., telling the speaker what the audience liked about the talk), by asking the speaker about his/her experience during the speech, and by asking the group members to give their feedback. Negative feedback from any of the group members (which happens very rarely) should be restated and modified by the therapists with the support of other group members.

Following the initial discussion, the therapist should play the videotape for the group. This videotape should be saved. It will be watched again during Session 12. Prior to watching the videotaped speech, patients will undergo a cognitive preparation period, which consists of (1) a prediction of social performance (3 minutes per performance); (2) imagining of social performance (2 minutes); and (3) identifying and challenging incorrect predictions (2 minutes). Handout 5: Cognitive Preparation for Video Feedback (Appendix E) provides some examples for instructions for each of these phases (see also Harvey et al., 2000).

When doing cognitive preparation, choose three of the most extreme performance indicators to discuss with the patient (see also chapter 5). For example:

You gave yourself an 8 for trembling. What part of your body was trembling? (If hands) How much did you tremble ... this much (demonstrate exaggerated hand tremble) ... this much (demonstrate again). Or: You gave yourself a 9 for boring. What are the behaviors that go along with it? Did you speak really slowly? Did you repeat yourself over and over again?

If blushing was one of the patient's concerns in the past, make sure that there is something red and pink in the frame of the video picture. Then if the patient gives an extreme score on blushing, ask: How blushed were you ... as red as that ... or more pinkish like that? Write the patient's specific predictions next to the performance ratings.

Home Practice

Patients should be asked to prepare a speech about what they do for living. In addition, patients should be asked to give a speech with the same topic they gave during session (i.e., treatment rationale) in front of the

mirror every day and to record the speech on an audiotape. Patients are told that this tape may be given to one of the staff members who will listen to it (ensure confidentiality).

SESSIONS 3–6

The structure of Sessions 3–6 are very similar to Session 2. At times, it can be difficult to induce sufficient anxiety for the exposure tasks, especially after numerous trials of speech exposures. Anxiety can be raised by:

1. Asking the person to talk about a very personal topic (e.g., their most embarrassing situations)
2. Asking the person to talk about a topic he/she knows little about (e.g., black holes, cloning)
3. Bringing in new audience members
4. Interrupting the presenter at various points
5. Asking the presenter to do push-ups, rapid breathing, or stair climbing before the speech to induce intense physical sensations and make the person sweat (see chapter 6)
6. Having the patient sing a children's song or play an instrument

For earlier sessions, the therapists should choose easier topics, such as a presentation about the patient's profession (what do you do for a living?) in order to break the ice. Other topics (in the order of increasing difficulty) are: hobbies (with visual aids such as golf iron, fishing poles, etc.), local politics (e.g., Boston's Big Dig), highly controversial political issues (the war in Iraq), and highly sensitive personal issues (opportunities I passed up because of my social anxiety).

The exact topics should be adapted flexibly to each individual. The important point is to raise the individual's anxiety/discomfort level. For example, if a person is very uncomfortable in a dating situation, he/she may choose to give a speech about dating. The patient should have a maximum level of flexibility for choosing his/her speech topic.

For all home practice assignments, patients should be asked to speak in front of a mirror about a random topic of interest every day and to audiotape one of the speeches. The therapist should ensure on a regular basis whether the practices were being performed and elicit feedback on their efficacy.

It is critically important that patients are supported and encouraged in their home practice exposures. It is equally important that their success is acknowledged and their failures be interpreted in a reasonable

- People cannot feel anxious if they feel comfortable the way that they are in social situations.
- Social mishaps are normal; it is no big deal if they do happen.
- Other people can't see how anxious you are, and you're more in control of your anxiety than you think you are.
- Your social skills are most likely better than you think they are. If not, then adjust your standards.
- Safety behaviors and other avoidance lead to the maintenance and worsening of anxiety.

In-Session Exposures: Explaining the Treatment Model and Rationale

Each member of the group should be asked to give a videotaped talk in front of the rest of the group about what he or she learned in the previous session (i.e., the anxiety model, the role of avoidance for the maintenance of social anxiety, the importance of exposure practices) and how this applies to his or her own anxiety. The therapist needs to be aware that the very first exposure is the worst. Therefore, the therapist should select a group member who is neither the most severe nor the least severe case in the group. If the first speaker is too anxious the situation may be traumatizing to the speaker and the other group members, and if the speaker is too comfortable, other group members might feel intimidated. In both cases, patients are then likely to drop out of group. This issue may be directly discussed with the group members in case a "traumatizing" situation occurs during the first exposure task.

The therapist should give very clear instructions, such as:

Please give a 3-minute talk about what you learned about social anxiety and on what aspects a successful treatment has to focus. Please illustrate these points by referring to the model and offering concrete personal examples.

Before the speech, patients are asked to specify their personal goals (e.g., maintaining eye contact with at least three people for at least 2 seconds). These goals should be clearly quantifiable, and group members should be recruited to determine whether the goals were reached based on these criteria (e.g., count number and length of eye contacts).

Before and after the speech performance, therapists should ask the subjects to rate their subjective anxiety (0–10). Furthermore, the therapist should ask the patients to (1) focus on and describe anxiety symptoms and self (30 seconds); (2) focus on and describe the environment (30 seconds); and (3) focus on and summarize the speech (30 seconds). After each

way. Thus, the discussion of home practice assignments is very important. Patients should be briefly questioned about what they did and how it went. Home practice assignments that were attempted but did not work out very well should be framed as providing valuable information that will allow us to work all the more effectively on that patient's problems in the future. This latter statement should be followed up by inquiring about the specific problems that arose and giving the patient the opportunity to work on such situations again.

SESSION 7-END

Beginning with Session 7, the therapist should introduce *in vivo* exposure situations outside of the group environment. Before each exercise, patients should be asked to give the following predictions:

1. What will be the maximum and average level of anxiety during the exposure task?
2. What will be the outcome of the situation (i.e., what will the interaction partner say, how will she/he behave)?
3. How long will consequences persist (e.g., in case of a social mishap)?

These situations should be individually tailored to the patient and created based on the fear and avoidance hierarchy. They can be relatively simple and straightforward at the beginning (e.g., asking for directions, returning an item to a store after a week, etc). However, beginning with Session 8, the therapists should "push" patients to do situations that would be uncomfortable to most people and/or that create social mishaps. Examples of these situations can be found in chapter 2 (Table 2.1; also see Appendix K).

Toward the end of treatment, it is recommended to include a session that addresses relapse prevention. As part of the home practice review, the therapist should introduce the relapse prevention component as follows:

You have all made great improvement, and I am very proud of you (go around the group and give some examples for everybody). However, since the treatment is almost over, I need to tell you one very important thing. For some of you, there might be times when your anxiety comes back and the avoidance sneaks up on you again, sometimes for no apparent reason. But for others, this might not happen. But if it does, don't be discouraged.

Improvement never follows a straight line. It always has its ups and downs, and some days are better than others. Rather, the improvement curve looks like the Dow Jones on Wall Street. Although there are ups and downs, the tendency goes upward. The important point is not to confuse a lapse (a temporary slip or blip; the recurrence of symptoms after a period of improvement) and a relapse ("I am back at square one," "all my gains are lost," "all my efforts were for nothing"). Anxiety symptoms can reappear, and that is just no big deal. It will depend on the person's response to the lapse whether or not it turns into a relapse. A relapse can be prevented if you use effective coping strategies. Get back on the horse, and come up with a list of exposure situations to help you beat the disorder.

LAST SESSION

In general, the last session is a low-key way to close the group. When summarizing the progress of each group member, emphasis should be placed on independent functioning and the positive skills each patient has learned. Each person should say something constructive to anyone else in the room (therapists or group members). In a group format, the discussion of what has been learned should be a rather informal affair and should be dominated by the patients. Topics may include what anxieties have been overcome, what anxieties remain, and what patients intend to do on their own to combat any remaining anxieties. Remember that the job of the therapist is to teach patients the model of the disorder and the model of treatment. Not all patients will have completed the full course of treatment by the end of this course of 12–16 sessions (see chapter 6), but the therapist will have succeeded if he or she has helped patients become their own CBT therapists, so they can guide treatment individually from this point forward. Chapter 7 provides a more comprehensive accounting of final session strategies and booster sessions, should they be needed.