COGNITIVE THERAPY FOR SOCIAL ANXIETY DISORDER IN ADOLESCENTS

Eleanor Leigh & David M Clark

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TABLE OF CONTENTS

CHAPTER 1. SOCIAL ANXIETY DISORDER IN YOUNG PEOPLE........................... 7
1.1. What is social anxiety disorder and how does it present in young people?........ 7
1.2. Diagnostic issues................................................................................................... 9
1.3. How common is social anxiety disorder in young people? .............................. 12
1.4. When does it usually start and how long does it last? .................................... 13
1.5. What other disorders commonly co-occur? .................................................... 14
1.6. How does it interfere with young peoples’ lives? ........................................... 15
1.7. What causes social anxiety disorder? .............................................................. 15

CHAPTER 2. THE COGNITIVE MODEL OF SOCIAL ANXIETY DISORDER ...... 17
2.1. Cognitive models of social anxiety disorder in adults .................................... 17
2.2. Applying the cognitive model to adolescents .................................................. 24
2.3. Treatment targets ............................................................................................ 32
2.4. Overview of treatment .................................................................................... 33
2.5. Illustrative case examples .............................................................................. 36
2.6. Evidence Base for CT-SAD.............................................................................. 51

CHAPTER 3. DIAGNOSTIC ASSESSMENT ........................................................... 56
3.1. Tools to assess Social Anxiety Disorder......................................................... 58
3.2. Initial family meeting.................................................................................... 62
3.3. Young person meeting .................................................................................. 62
3.4. Parent(s) meeting ......................................................................................... 63
3.5. Concluding family meeting........................................................................... 63

CHAPTER 4. CASE FORMULATION AND GETTING STARTED ......................... 64
4.1. Establishing a good working relationship ....................................................... 65
4.2. Reviewing standardized questionnaires ......................................................... 66
4.3. Description of the current social anxiety problem ........................................... 67
4.4. Deriving an individualised version of the cognitive model ........................... 80
4.5. Homework and summing up ......................................................................... 93
4.6. Interviewing parents/carers.......................................................................... 93
CHAPTER 5. SELF-FOCUSED ATTENTION AND SAFETY BEHAVIOURS

EXPERIMENT ................................................................................................................. 97
  5.1. Overview of the general procedure ................................................................. 98
  5.2. Setting up the experiment ............................................................................. 100
  5.3. Instructions for the conversations .................................................................. 101
  5.4. Ratings ........................................................................................................... 103
  5.5. Initial observations and reflections ................................................................. 106
  5.6. Homework ..................................................................................................... 106
  5.7. Troubleshooting ......................................................................................... 107

CHAPTER 6. VIDEO AND AUDIO FEEDBACK .......................................................... 110
  6.1. Setting up the recording .............................................................................. 111
  6.2. Preparing to view the video ......................................................................... 113
  6.3. Viewing and discussing the video ................................................................. 115

CHAPTER 7. ATTENTION TRAINING ...................................................................... 122
  7.1. Overview of training steps ........................................................................... 124
  7.2. Setting up the training .................................................................................. 125
  7.3. Instructions ................................................................................................... 126
  7.4. Key learning points ..................................................................................... 131
  7.5. Homework .................................................................................................. 135

CHAPTER 8. BEHAVIOURAL EXPERIMENTS ......................................................... 136
  8.1. Aims ............................................................................................................. 138
  8.2. Setting up behavioural experiments ............................................................. 140
  8.3. Example behavioural experiments .............................................................. 151
  8.4. Troubleshooting ......................................................................................... 155
  8.5. Surveys ....................................................................................................... 160

CHAPTER 9. WORKING WITH SOCIALLY TRAUMATIC MEMORIES .................. 162
  9.1. Timing of memory techniques .................................................................... 163
  9.2. Discrimination training ............................................................................... 164
  9.3. Imagery rescripting .................................................................................... 168
  9.4. Troubleshooting ......................................................................................... 177
CHAPTER 10. ANTICIPATORY WORRY AND POST-EVENT PROCESSING...... 178
10.1. When to use worry and rumination techniques........................................ 180
10.2. Overview of techniques .............................................................................. 181
10.3. Advantages and disadvantages of worry and rumination........................... 182
10.4. Noticing and stopping worry and rumination............................................. 186
10.5. Reducing over preparation........................................................................... 189

CHAPTER 11. WORKING WITH PARENTS.............................................................. 190
11.1. Education for parents about social anxiety and treatment......................... 191
11.2. Supporting a child’s treatment .................................................................... 191
11.3. Unhelpful parental beliefs and behaviours................................................ 193
11.4. Parental social anxiety ................................................................................. 201

CHAPTER 12. ADOLESCENT PEER PROCESSES, PEER VICTIMISATION AND
BULLYING.................................................................................................................... 205
12.1. Anti-bullying interventions.......................................................................... 210
12.2. Working with perceptions of and responses to peers................................. 210
12.3. Romantic relationships................................................................................ 226

CHAPTER 13. RELAPSE PREVENTION & ENDING TREATMENT ...................... 233
13.1. Relapse prevention....................................................................................... 233
13.2. Follow-up sessions..................................................................................... 237
13.3. Ending therapy ............................................................................................. 237

CHAPTER 14. COMORBIDITY ............................................................................ 239
14.1. Depression................................................................................................... 239
14.2. Generalised anxiety.................................................................................... 240
14.3. Panic attacks............................................................................................... 240
14.4. Eating difficulties....................................................................................... 241
14.5. Body dysmorphophobia............................................................................. 242

REFERENCES ........................................................................................................... 244
List of Tables

Table 1. DSM-5 diagnostic criteria for social anxiety disorder ........................................ 11
Table 2. ICD-10 diagnostic criteria for social phobias .................................................... 12
Table 3. Safety behaviours associated with a fear of blushing ....................................... 21
Table 4. Social fears and commonly associated safety behaviours .............................. 26
Table 5. Overview of 14-session CT-SAD-A programme ............................................. 35
Table 6. Anxiety Disorders Interview Schedule for Children and Parents ..................... 60
Table 7. Adolescent self-report social anxiety measures .............................................. 61
Table 8. Standardized questionnaires that are useful for collecting information in advance of the clinical interview .................................................................................. 66
Table 9. Summary of information to be covered in the clinical interview ..................... 67
Table 10. Summary of goals of the interview with parents .......................................... 94
Table 11. Common unhelpful parental beliefs and behaviours .................................. 95
Table 12. Overview of the self-focused attention and safety behaviours experiment ..... 99
Table 13. Record sheet summarising two of Matt’s behavioural experiments ............. 147
Table 14. Record sheet summarising two of Chloe’s behavioural experiments .......... 149
Table 15. Examples of behavioural experiments to test common fears ....................... 153
Table 16. Summary of differences between ‘Then’ and ‘Now’ for discrimination training with Martha .......................................................... 167
Table 17. Kevin’s evidence for his encapsulated belief and updated perspective .......... 170
Table 18. The advantages and disadvantages of worry for Lara ................................ 185
Table 19. Techniques for working with unhelpful parental beliefs and behaviours ...... 193
Table 20. Behavioural Experiment Record Sheet for Sienna’s mother ........................ 197
Table 21. Behavioural Experiment Record Sheet for Gaby’s mother .......................... 203
Table 22. Behavioural experiment record for Mark ..................................................... 212
Table 23. Useful questions to develop the prejudice model ......................................... 220
Table 24. Zoe’s positive data log ............................................................................... 221
Table 25. Behavioural experiment record for Zoe ..................................................... 223
Table 26. Behavioural experiment record for Nina .................................................... 231
Table 27. Main points of the relapse prevention plan ............................................... 234
Table 28. ‘Therapy Blueprint’ for Sienna ................................................................. 234
List of Figures

Figure 1. Cognitive model of social anxiety disorder....................................................... 17
Figure 2. Differential effects of peer presence on risk taking as a function of age ........ 30
Figure 3. Age differences in resistance to peer influence.............................................. 31
Figure 4. Example of a personalised version of the model with an 11-year-old girl....... 39
Figure 5. Example of a personalised version of the model with a 16-year-old boy ...... 46
Figure 6. Efficacy of standard and brief versions of CT-SAD compared with other treatment conditions in trials conducted by Clark, Ehlers and others....................... 52
Figure 7 Example of a personalised version of the model with a young man ............ 84
Figure 8. ‘Mind map’ of Lara’s worry process............................................................. 183
Figure 9. Lara’s flashcard summarising the disadvantages of worry ....................... 187
Figure 910 Lara’s flashcard summarising the disadvantages of and alternatives to worry ................................................................................................................................. 188

List of Appendices

Appendix A. List of measures ....................................................................................... 260
Appendix B. Self-report process measures................................................................. 261
Appendix C. How to Score the Questionnaires .......................................................... 272
Appendix D. Goals Worksheet ..................................................................................... 274
Appendix E. Blank model sheet .................................................................................. 276
Appendix F. Information Sheet for Young People ....................................................... 277
Appendix G. Information Sheet for Parents ............................................................... 281
Appendix H. Self-focused attention and safety behaviours experiment record for the young person ........................................................................................................... 285
Appendix I. Self-focused attention and safety behaviours experiment record for stooge ......................................................................................................................... 287
Appendix J. Record sheet for noting behavioural experiments - Experiment Record ................................................................................................................................. 289
Appendix K. Therapy Blueprint .................................................................................... 290
Appendix L. Session and homework checklist................................................................ 294
CHAPTER 1. SOCIAL ANXIETY DISORDER IN YOUNG PEOPLE

1.1. What is social anxiety disorder and how does it present in young people?

Chloe is 15 years old. She has always been a slightly quiet girl, in comparison with her much ‘louder’ younger sister. Chloe enjoyed her small supportive primary school and was able to make and maintain a friendship group there. However, she found the transition to a large secondary school very difficult. None of her friends from primary school accompanied her to the new school and she struggled to form a new peer group. Chloe recalls finding the start of year 7 overwhelming and confusing, as if “everyone else knew what to do except for me”.

Chloe is seen in the clinic in response to concerns raised by her parents about her reluctance to attend school. At the assessment, her parents are interviewed to obtain a detailed family and personal history as well as their account of Chloe’s current difficulties.

Chloe is then interviewed alone. It is difficult to build rapport with her as she makes very little eye contact, responds with only brief answers, and speaks in a low voice. On questioning, Chloe describes intense fear of a range of social situations, including asking for help in class, taking part in group exercises, joining conversations at break and lunch, texting people, and going to social gatherings. Chloe is certain she will be unable to get her words out and she will blush and that people will think she is foolish and immature. To cope, she has started staying in the bathroom during break time, avoiding eye contact and keeping her head down in class, and trying to avoid school altogether. She has never spoken about these fears before and she is worried people will laugh at her if they know about
them. Life feels rubbish for Chloe at the moment. At times she feels hopeless and can’t see how anything will change.

Social anxiety disorder is a persistent and excessive fear of one or more social situations where embarrassment or humiliation may occur. Typical social situations can be clustered into those that involve interaction, observation and performance. Examples of social situations include:

- Talking to friends on the phone
- Joining conversations
- Meeting new people
- Entering a classroom when others are already seated
- Eating and drinking in front of people
- Asking the teacher for permission to leave the classroom
- Break times
- Asking and answering questions in class
- Playing a sport
- Taking part in a drama or dance performance in front of others
- Giving a presentation in class
- Working while being observed
- Using public toilets
- Buying items in a shop
- Using social media

Most young people will feel anxious about at least some of these situations. We know that social and evaluative concerns typically emerge during middle childhood. This may in part be due to the development of cognitive abilities such as perspective taking and self-consciousness around this age, as well as adolescents’ increasing autonomy from their parents and the growing significance of the peer group. Adolescence is a time when people are moving from a unique reliance on their family unit and are learning how to interact with peers in a way that will set them up for the rest of their life. For this reason, adolescence is normally a period of strong sensitivity to peer influence and this is a crucial phase of social learning.

It is therefore perfectly reasonable for anxiety about social peers to be triggered at this time. For most young people these worries are relatively transient, they can be overcome without much difficulty and they do not cause undue distress or impairment.
However, for some young people the anxiety is excessive and leads to avoidance and impairment in day-to-day life. These individuals will miss out on the social learning that is critical for the rest of their lives. It is therefore vital to intervene at this point.

Young people with social anxiety disorder fear that they will say or do something that they believe will be humiliating or embarrassing. Common concerns include the fear of sweating, shaking, blushing, stumbling over words, looking anxious, or appearing boring, stupid, or incompetent. Compared to adults, young people are often less able to see their concerns as irrational or excessive, even when away from the social situation.

Understandably young people with social anxiety disorder will therefore make every attempt to avoid the feared situations. However, this is not always feasible, particularly for young people for whom school attendance is compulsory and who may be compelled to engage in social situations by parents or carers. In these situations the situation is endured, often with feelings of intense distress.

Younger children may cry or ‘freeze’, have behavioural outbursts or tantrums, or may not speak at all. Adolescents may experience intense self-consciousness but struggle to articulate specific fears. Whilst many young people with social anxiety present with classic shyness and behavioural inhibition, others may display irritability or act in a ‘standoffish’ way. Sometimes belittling other people or aggressive/bullying behaviour can mask social anxiety. As a consequence it can be easy for parents and teachers to miss social anxiety.

1.2. Diagnostic issues

Fears of social performance and social situations have been documented throughout history. However, it was only recognised as a separate disorder in the mid 1960s, when Marks and Gelder (1965) described patients with a specific fear of eating in public as ‘socially phobic’. Following on from this it was introduced into the third edition of the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM-III; 1980) and was first described as ‘social anxiety disorder’ in DSM-IV (1994). Over time the diagnosis of social anxiety disorder has progressed in a number of ways. Firstly,  

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1 The term parents will be used to refer to parent(s) and/or carer(s) henceforth.
social anxiety is now viewed as a broad condition rather than a phobia (of a specific stimulus with associated circumscribed avoidance). Secondly, we have moved from seeing social anxiety as being only an adult entity with similar but distinct disorders for children and young people (‘avoidant disorder of childhood and adolescence’ and ‘overanxious disorder’) to recognising the validity of the disorder in children and young people. ‘Avoidant disorder of childhood and adolescence’ and ‘overanxious disorder’ have been removed and a diagnosis of social anxiety disorder can be applied to children with specific information about how it may present differently in youth now incorporated into the criteria. Thirdly, social anxiety disorder can now be diagnosed in addition to avoidant personality disorder (this was not allowed in DSM-III), with recognition that in fact there is considerable overlap between the two conditions. Section II of the DSM-5 states that the diagnosis of avoidant personality disorder may be applied to children or adolescents when ‘the individual’s particular maladaptive personality traits appear to be pervasive, persistent, and unlikely to be limited to a particular developmental stage or another mental disorder’ (APA, 2013, p. 647). However, clinicians are encouraged to restrict the diagnosis to ‘relatively unusual instances’ (p. 647). The diagnostic criteria for social anxiety disorder as described in the most recent, fifth, iteration of the DSM are shown in Table 1. The criteria for Social Phobias as described in the 10th edition of the World Health Organisation’s International Classification of Diseases (1992) are presented in Table 2.
Table 1. DSM-5 diagnostic criteria for social anxiety disorder

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).

Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.

B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating and embarrassing; will lead to rejection or offend others).

C. The social situations almost always provoke fear or anxiety.

Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.

D. The social situations are avoided or endured with intense fear or anxiety.

E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.

J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

Specify if: Performance only: If the fear is restricted to speaking or performing in public.
Table 2. ICD-10 diagnostic criteria for social phobias

Social Phobias (F40.1)

A. Either (1) or (2):

1. (1) Marked fear of being the focus of attention, or fear of behaving in a way that will be embarrassing or humiliating;
2. (2) Marked avoidance of being the focus of attention or situations in which there is fear of behaving in an embarrassing or humiliating way.

These fears are manifested in social situations, such as eating or speaking in public; encountering known individuals in public; or entering or enduring small group situations, such as parties, meetings and classrooms.

B. At least two symptoms of anxiety in the feared situation at some time since the onset of the disorder, as defined in criterion B for F40.0 (Agoraphobia) and in addition one of the following symptoms:

(1) Blushing.
(2) Fear of vomiting.
(3) Urgency or fear of micturition or defecation.

C. Significant emotional distress due to the symptoms or to the avoidance.

D. Recognition that the symptoms or the avoidance are excessive or unreasonable.

5. Symptoms are restricted to or predominate in the feared situation or when thinking about it.
6. Most commonly used exclusion criteria: Criteria A and B are not due to delusions, hallucinations, or other symptoms of disorders such as organic mental disorders (F0), schizophrenia and related disorders (F20-F29), affective disorders (F30-F39), or obsessive compulsive disorder (F42), and are not secondary to cultural beliefs.

1.3. How common is social anxiety disorder in young people?

Population rates of social anxiety disorder in children and young people have been investigated in several countries. As in adult studies, a range of methods has been used for diagnosis, which probably explains the wide variability in prevalence estimates. A large New Zealand 12-month prevalence study reported that 11.1% of 18-year-olds met criteria for social anxiety disorder (Feehan et al., 1994). A US-based study reported that 9% of adolescents (aged 13-18 years) met criteria for any social phobia in their
lifetime (Burstein et al., 2011). In line with this, another US-based lifetime prevalence study reported rates of 9.1% (13-18 years of age), with higher rates in girls compared to boys (11.2% vs. 7.0%, respectively) and increasing rates with age (Merikangas et al., 2010). However, a large British epidemiological survey (Ford, Goodman, & Meltzer, 2003) reported that just 0.32% (point prevalence) of 5- to 15-year-olds had the disorder, a rate that was higher than that for post traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD) and panic disorder, but lower than separation anxiety disorder, specific phobia and generalised anxiety disorder. Rates of diagnosis in this British study were higher in males than females, and increased slightly with age. A large US-based study reported very similar rates in 9- to 11-year-olds (Costello et al., 2003), while a German study estimated rates of 4% for 14- to 17-year-olds (Wittchen, Stein, & Kessler, 1999). Despite the variability, there is general agreement that anxiety disorders are common in children and adolescents and that social anxiety disorder is one of the most, if not the most, common of the anxiety disorders (Merikangas, Nakamura, & Kessler, 2009).

1.4. When does it usually start and how long does it last?

Social anxiety disorder typically starts before adulthood (Wittchen, Stein, et al., 1999). Prospective, longitudinal studies indicate that social anxiety disorder is relatively unusual in early childhood (Wittchen, Stein, et al., 1999). It most commonly occurs in early adolescence, with a median age of onset of 13 years (Kessler et al., 2005). Incidence increases through the adolescent years. After this peak period of onset, new cases are fairly rare after about the age of 25 years (Heimberg et al., 2000).

Several studies (Bruce et al., 2005; Reich, Goldenberg, Goisman, et al., 1994; Reich, Goldenberg, Vasile, et al., 1994) have followed up adults with social anxiety disorder for extended periods of time. These studies have generally found that it is a naturally unremitting condition in the absence of treatment. For example, Bruce and colleagues (2005) reported a community study in which adults with various anxiety disorders were followed up for 12 years. At the start of the study, individuals had suffered with social anxiety disorder for an average of 19 years. During the next 12 years
37% recovered compared with 58% for GAD and 82% for panic disorder without agoraphobia.

A 10-year prospective community study with over 3000 German adolescents and young adults (aged 14 - 24 years) (Beesdo- Baum et al., 2012) yielded very similar findings to those reported by Bruce et al. (2005): 56.7% of those with social anxiety initially were still reporting at least symptomatic social anxiety at follow up. Only 15.1% were completely remitted. There is some evidence that a proportion of socially anxious young people may outgrow the condition, although they continue to be at high risk for other anxiety disorders (Pine et al., 1998). It therefore appears that some of the individuals who develop social anxiety disorder in youth may recover before adulthood. However, this represents the exception rather than the rule, and for many individuals the chance of recovery in the absence of treatment is modest when compared with other common mental health disorders.

### 1.5. What other disorders commonly co-occur?

Comorbidity rates between anxiety disorders and mood and behavioural disorders in young people are very high (Ford et al., 2003). However, the specific comorbidities of social anxiety in this age group are less well delineated. In a large German sample of adolescents and young adults (14-24 years) 31.1% had a comorbid mood disorder, almost 50% an additional anxiety disorder, and 41.3% a comorbid substance misuse diagnosis (Wittchen, Stein, et al., 1999). It has been suggested that selective mutism is a severe form of social anxiety (Black & Uhde, 1992), and indeed between 60 and 70% of young people with selective mutism have a comorbid diagnosis of social anxiety disorder (Manassis et al., 2003; Manassis et al., 2007).

In terms of patterns of temporal comorbidity, social anxiety disorder preceded comorbid mood disorder in two thirds of cases (Kessler et al., 2005). Adolescents and young adults are three and a half times more likely to go on to develop depression or dysthymia compared to matched controls, and those with comorbid depression at baseline are more likely to remain depressed or experience a relapse in their depression (Stein et al., 2001). Social anxiety disorder also seems to preceded alcohol and illicit drug use. For example, in a 10 year prospective study of adults, presence of social anxiety increased the
risk of regular drinkers becoming alcohol abusers (Odds Ratio [OR] = 1.0) and those with alcohol abuse becoming dependent (OR = 2.9). Similarly, social anxiety disorder increased the risk of users of illicit drugs developing substance abuse (OR = 2.1) and those with substance abuse at baseline going on to develop dependence (OR = 1.9) (Swendsen et al., 2010).

1.6. How does it interfere with young peoples’ lives?

Social anxiety disorder should not be confused with normal shyness, which is not associated with significant disability and impairment (Heiser, Turner, & Beidel, 2003). Educational achievement can be undermined, with individuals at a heightened risk of leaving school early and obtaining poorer qualifications (Van Ameringen, Mancini, & Farvolden, 2003). One study (Katzelnick & Greist, 2001) found that people with social anxiety disorder had wages that were 10% lower than the non-clinical population. Naturally, social life is impaired. On average, individuals with social anxiety disorder have fewer friends and have more difficulty getting on with friends (Whisman, Sheldon, & Goering, 2000). They are more likely to be victims of bullying and peer victimisation (Acquah et al., 2015). They are less likely to marry, are more likely to divorce and are less likely to have children (Wittchen, Fuetsch, et al., 1999). Social fears can also interfere with a broad range of everyday activities, such as visiting shops, buying clothes, having a haircut and using the telephone. The majority of adults with social anxiety disorder are employed; however, they report taking more days off work and being less productive because of their symptoms (Stein & Kean, 2000). People may avoid or leave jobs that involve giving presentations or performances. The proportion of people who are in receipt of state benefits is 2.5 times higher than the rate for the general adult population.

1.7. What causes social anxiety disorder?

Whilst the aetiology of social anxiety remains little understood, there is good reason to believe that multiple interacting pathways are involved (Beidel & Turner, 2007). One pathway is via genetic transmission. Merikangas and colleagues (2003) report on data from two family studies. Evidence of considerable familial aggregation of social anxiety disorder was reported. Their findings also pointed to specificity in the expression
of social anxiety disorder in families; they found a significant association between proband social anxiety disorder and relative social anxiety disorder and a non-significant association between proband social anxiety disorder and relative panic disorder. Scaini, Belotti, & Ogliari (2014) carried out a meta-analysis of twin studies including 25 cohorts and over 40,000 subjects. Estimates of genetic influence ranged from 0.13 to 0.60, with a meta-analytic estimate of 0.41. Interestingly they noted that the genetic contribution was roughly half amongst adults than that in young people, which would suggest that genetic factors may be more important in the development of the disorder amongst children and adolescents.

Another pathway is via environmental factors. In the meta-analysis described above, non-shared environmental factors were also found to be significant in addition to genetics, with a contribution estimated at 0.54 (ranging from 0.31 - 0.78). We know that socially traumatic events in early life (for example, being bullied, familial abuse, public embarrassment or one’s mind going blank during a public performance) are commonly reported by people with social anxiety disorder (Erwin et al., 2006).

Parental modelling of fear and avoidance in social situations plus an overprotective parenting style have both been linked to the development of the condition in some studies (Lieb et al., 2000).

The success of selective serotonin reuptake inhibitors (SSRIs), serotonin and noradrenaline reuptake inhibitors (SNRI) and monoamine oxidase inhibitors (MAOIs) in treating social anxiety disorder suggests that dysregulation of the serotonin and dopamine neurotransmitter system may also play a role, but studies that establish a causal relationship for such dysregulation in the development of the condition have not yet been reported (see Mathew, Coplan, and Gorman (2001) for a review of the neurobiological basis of social anxiety disorder).

Neuroimaging studies so far suggest different activation of specific parts of the brain (the amygdala, the insula and the dorsal anterior cingulate – all structures that are involved in the regulation of anxiety) when threatening stimuli are presented in adults with social anxiety disorder compared with healthy volunteers (see Mathew et al. (2001) for a review of the neurobiological basis of social anxiety disorder).
CHAPTER 2. THE COGNITIVE MODEL OF SOCIAL ANXIETY DISORDER

2.1. Cognitive models of social anxiety disorder in adults

A number of cognitive models have been developed that seek to explain why, despite the fact that socially anxious individuals will regularly face social interactions and even though the vast majority of these experiences will be benign, their social anxiety persists (Clark & Wells, 1995; Heimberg, Brozovich, & Rapee, 2010; Hofmann, 2007; Rapee & Heimberg, 1997). These typically emphasise two problematic features: a fear of performance failure and of negative evaluation, and self-focused attention.

The treatment described in this manual is based on Clark and Wells’ (1995) cognitive model of social anxiety and the associated treatment programme, which we adapted for use with adolescents. Three factors are put forward in this model. The first relates to negative beliefs about the self and social environment. These activate a sense of threat when in a social or performance situation. The second concerns the use of safety behaviours and the third concerns processing of the self as a social object. The latter two factors inadvertently maintain negative beliefs and social anxiety. Pre and post event processing (worry and rumination) also play a maintaining role. The cognitive model is displayed in Figure 1. Considerable evidence has accumulated in support of this model with adult samples.

![Figure 1. Cognitive model of social anxiety disorder](image)
Negative Beliefs

Individuals with social anxiety believe that it is extremely important to make a good impression to others. They also strongly doubt their ability to do so. They hold assumptions about themselves ("I am boring", "I should always have something interesting to say", "if I am quiet people will think I’m dull") and their social environment ("other people will reject me") that lead them to believe they are under threat in particular social situations. Specifically they believe that they will behave in a way that is unacceptable or inept and this will lead to rejection, loss of worth, or some other catastrophic consequence.

When socially anxious individuals are faced with a social situation, negative beliefs about themselves and the situation are triggered, leading to a sense of threat. What follows is a series of cognitive, affective, and somatic responses that creates a closed system. This system draws confirmatory evidence from internal feelings and thoughts to the exclusion of objective, external, and most likely disconfirmatory information. The key processes that maintain this closed system are: (1) use of safety behaviours, (2) a shift to an internal focus of attention and processing of the self as a social object, and additionally (3) pre and post event processing.

Safety behaviours

Safety behaviours are things people try to do in order to prevent a feared outcome from occurring. If the feared outcome is realistic then safety behaviours make sense, for example taking an umbrella out with you when it is starting to rain to avoid getting wet. But if the fear is unrealistic then safety behaviours are a problem. One of the negative consequences of safety behaviours when the fear is unrealistic is they prevent the individual from discovering that the feared outcome was not likely to happen anyway. This is true of almost all safety behaviours used by socially anxious individuals. Examples of safety behaviours commonly used by individuals with social anxiety include avoiding eye contact, speaking less, asking lots of questions, preparing topics of conversation in advance, censoring oneself, staying on the edge of groups, using drugs or alcohol, and wearing lots of make-up.
Although described as safety *behaviours*, many of these are in fact mental operations. For example, an individual worried about being boring may prepare topics of conversation in advance. Should the situation pass reasonably well, this is attributed to their preparation (“if I hadn’t thought of those topics ahead of time I would have seemed so boring”). These mental safety behaviours are not visible to the observer, and so when working with people with social anxiety, we as clinicians need to get inside a person’s head.

The particular safety behaviours used will depend very much on the specific fears an individual holds. Furthermore, because the social fears people hold typically have many levels, there are usually a number of safety behaviours used (see Table 3 for a description of the multiple safety behaviours used by a woman with a fear of blushing). For example, someone fearful of being thought of as boring might engage in a range of safety behaviours: they may stay on the edge of a group to avoid being the centre of attention, prepare topics of conversation in advance in case they are asked a question, and then constantly monitor what they are saying if they are engaged in a conversation.

Clinical experience suggests that people will engage in a wide range of safety behaviours. Factor analytic studies with analogue and socially anxious adults point to two broad categories of safety behaviours (Hirsch, Meynen, & Clark, 2004; Plasencia, Alden, & Taylor, 2011): avoidance behaviours and impression management. Avoidance behaviours include actions designed to hide oneself, for example avoiding eye contact, talking less, standing on the edge of groups, avoiding talking about oneself. So-called impression management strategies include behaviours intended to present a more socially acceptable self, albeit one that is not wholly genuine. It includes strategies such as monitoring, preparing topics of conversation in advance, trying to act normal and keeping a tight control over one’s behaviour. Plasencia and colleagues (2011) asked adults with social anxiety to engage in a short conversation with a ‘stooge’. The authors found that avoidance safety behaviours were associated with higher state anxiety during the interaction and negative reactions from the ‘stooge’. In contrast, impression management strategies did not lead to negative reactions from the ‘stooge’ or higher state anxiety, but did prevent the socially anxious individual from correcting or updating their feared predictions.
Safety behaviours are unhelpful for a number of reasons. First, they prevent the individual from discovering that the feared outcome was very unlikely to happen. For example, if someone is frightened that people will think they are uninteresting they may strive to avoid pauses in conversation. Should the conversation go well they will most likely not attribute this to themselves (“oh, so maybe I am an interesting person who people want to speak to”) but instead assume that the only reason this occurred is because they used the safety behaviour (“if I hadn’t kept asking questions and avoided pauses they would have seen what an uninteresting bore I really am”).

Second, safety behaviours can heighten self-focus and monitoring. As an individual employs safety behaviours they may increase checking and monitoring behaviours to assess whether they are ‘working’.

Third, safety behaviours can actually cause feared symptoms. For example, clamping your arms down by your sides to hide any possible sweat marks is likely to make it more likely that you are going to sweat. Or similarly, trying to keep track of what you have said and what you are going to say next (‘censoring’) can make one more likely to stumble over ones’ words or lose track of the conversation. Likewise, some individuals describe gripping a cup tightly to try to prevent people seeing their hand shaking. Often the muscle tension involved in gripping the cup can make one shake more, or at least increase the feeling that one is shaking.

Fourth, the use of safety behaviours can make one appear withdrawn and unfriendly to other people. The adoption of certain safety behaviours can detrimentally affect social functioning and ‘contaminate’ social performance. If someone is worried about sounding stupid or coming across as a nerd whilst talking they will be monitoring what they have said and checking this against what they are about to say. The problem with this is that they will give the impression that they are not interested in the other person. It will seem that their mind is somewhere else, which of course it is: it is on this monitoring and checking. Similarly, safety behaviours such as avoiding eye contact and giving one-word answers may both give the impression to others that the individual is disinterested. Others do not realise that the individual is behaving in this way because they are anxious. Instead they get the impression that the individual is not interested in them and in turn they will be less friendly back. This is a real irony because the socially
anxious individual really wants to be accepted by other people and yet inadvertently conveys the message that they are not interested in them. Other people will ‘follow the script’ of what they understand the person wants. In this way the feared outcome becomes a ‘self-fulfilling prophecy’.

Fifth, safety behaviours can draw attention to feared behaviours (e.g. blushing, sweating) and oneself (e.g. speaking quietly). For example, if an individual speaks very quietly, others may need to attend more closely in order to hear what was said.

**Table 3. Safety behaviours associated with a fear of blushing**

<table>
<thead>
<tr>
<th>Feared Outcome</th>
<th>Safety Behaviour intended to prevent feared outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>“My face (and neck) will go red”</td>
<td>Keep cool (open windows, drink cold water, avoid hot drinks, wear thin clothes). Avoid eye contact. If in a meeting, pretend to be writing notes in order to look professional. Keep topic of conversation away from “difficult” issues. Tell myself the man isn’t really attractive; “He’s no more than a 2 (out of 10) for attractiveness”</td>
</tr>
<tr>
<td>“If I do blush, people will notice”</td>
<td>Wear clothes (scarf, high collar) that would hide part of blush. Wear make-up to hide the blush. Put hands over face; hide face with long hair. Stand in a dark part of the room. Turn away.</td>
</tr>
<tr>
<td>“If people notice, they will think badly of me”</td>
<td>Say something to suggest an alternative explanation for red face; viz. “It’s hot in here”, “I’m in a terrible rush today”, “I’m recovering from flu”, etc.</td>
</tr>
</tbody>
</table>

From Clark (2001, p. 409)

The notion of safety behaviours give a different perspective on the understanding of the inhibited or withdrawn behaviours of people who are socially anxious. Traditionally these behaviours have been interpreted as a sign people lack social skills. However, there is little evidence that this is the case. Treated individuals do not show
ongoing social skills deficits. When individuals are not anxious they do not show deficits in social skills. Any deficits in performance seem to be largely restricted to situations in which they are anxious, which suggests that they are an anxiety response rather than an indication of a lack of knowledge or ability. It seems likely that the apparent social skills deficits are in fact the observable safety behaviours.

**Processing of the self as a social object**

When faced with a social situation, individuals shift their focus of attention away from the external environment and onto themselves to undertake detailed monitoring of how they are coming across. But this self-observation is unhelpful for three reasons. Firstly, it enhances awareness of feared anxiety responses. Secondly, it interferes with one’s ability to process the situation and what others are doing. Thirdly, and very importantly, socially anxious individuals use this interoceptive (internally generated) information to create an impression of how they appear to others, which they then assume is how others see them. This is a ‘felt sense’ of how one appears; “I feel anxious therefore I must look anxious”. It can also be accompanied by images of how a person is coming across, for example ‘like a red tomato’, ‘face frozen and stone-like’. Rather than being from a ‘field perspective’ (from the person’s own viewpoint), the images are as if seeing the person from the audience’s view (the so-called ‘observer perspective’). So it is no surprise that a socially anxious individual is quick to assume this is how they do indeed look to others.

Hackmann and colleagues (2000) questioned adults with social phobia about their experience of socially phobic imagery. All participants reported experiencing recurrent images in social situations. Most images were linked to memories of unpleasant social events that clustered in time around the onset of the disorder. We know that socially traumatic events in early life (for example, being bullied, familial abuse, public embarrassment or one’s mind going blank during a public performance) are commonly reported by people with social anxiety disorder (Erwin et al., 2006). Hackmann and colleagues’ (2000) findings suggest that, for some people at least, an image develops after a socially traumatic experience, including an impression of how they think they appear, and this is repeatedly activated in subsequent social situations. When the image is
activated the individual often feels in as much danger as they did in the original traumatic event, even if this would not make sense to an outside observer. This in turn will impact on how they interact with others. For example, a 17-year-old young man with severe social anxiety had been badly bullied in early adolescence. In one particularly unpleasant incident, a classmate stole his shoes and slapped him in the face prompting laughter from some of the perpetrator’s associates. A number of years after the event, although the young man was at a different school and no longer being bullied, he experienced a recurrent image of himself cowering, shaking and bent double. When this image occurred he felt vulnerable, helpless and afraid. Even though he was not in current danger he felt as though he could be attacked at any moment just in the way it happened when he was an 11 year old. As a result he avoided eye contact with others, did not speak and shrank away from other people.

Socially traumatic memories constitute the feelings that were evoked at the time (for this young man it was feeling vulnerable, helpless and afraid) along with the image of how the person thought they came across at the time (in this case the young man pictured himself cowering, shaking and bent double). What is typically lacking is the rest of the memory, for example the young man did not recall the perpetrator, his associates or the other students in the classroom. As much of the source memory is missing it is much harder to evaluate and discount the negative memory, it is just a memory of the feeling and a picture of how one comes across. This has been described as ‘affect without recollection’ in the PTSD literature (Ehlers & Clark, 2000). As a result it is even more difficult to update and ‘slips under the radar’.

**Anticipatory worry and post-event processing**

Associated unhelpful processes include anticipatory worry and post-event processing. Most people with social anxiety experience high levels of anxiety when anticipating a social situation. Before the event they will review what they think is going to happen in detail. This triggers anxiety and a proliferation of negative thoughts, including recollections of past failure, negative images of how they think they will appear, and negative predictions of how they will come across. These are usually experienced as overwhelming and unstoppable and can lead the individual to abandoning
the social event entirely. If they do manage to go it is likely that negative thoughts and a self-focussed mode of processing will dominate before and during the event.

Although there may be some relief immediately after leaving a social situation most people describe continued negative thoughts and distress. Social situations are by their very nature ambiguous and the socially anxious individual is unlikely to have received an unequivocal sign of social approval. This ambiguity often prompts a ‘post-mortem’ in the aftermath. The event and interactions will be reviewed in detail. Because socially anxious individuals are usually self-focussed and consumed with negative thoughts and images during social interactions it is likely that these will dominate the post-mortem. Unfortunately the individual will most likely draw an excessively negative conclusion about the social interaction and their performance, and this will be stored along with other past ‘failures’. Feelings of shame and humiliation predominate and individuals often replay in their mind the moments during the interaction that they perceive to be particularly humiliating. This post-mortem process can continue for days and sometimes weeks after an event.

2.2. Applying the cognitive model to adolescents

We know that social anxiety disorder typically emerges in early adolescence, and there is increasing support for Clark and Wells’ (1995) cognitive model in explaining the persistence of social anxiety disorder in teenagers. Evidence has accumulated in relation to the cognitive (appraisal and information-processing aspects) and behavioural processes implicated in the maintenance of social anxiety. It is also likely that developmental factors (such as language abilities, increased self-consciousness and adolescent peer processes) as well as family factors (such as parental attitudes and behaviours) will need to be considered with this population.

Negative cognitions and interpretation biases

Although we know that young people often find it harder to articulate their social fears, there is good clinical and research evidence that they are present in young people with social anxiety. Young people might be fearful that they will get picked on or teased, or that others will not want to be friends with them. In line with this, numerous studies
have demonstrated that children and young people with social anxiety or elevated symptoms of social anxiety hold more negative social cognitions and make more negative predictions of and appraisals about their social performance compared to non-anxious peers (Blöte et al., 2014; Cartwright-Hatton, Tschernitz, & Gomersall, 2005; Hodson et al., 2008; Kley, Tuschen-Caffier, & Heinrichs, 2012; Miers et al., 2008; Ranta et al., 2014; Rheingold, Herbert, & Franklin, 2003; Schreiber et al., 2012; Tuschen-Caffier, Kühl, & Bender, 2011). Some of these have been questionnaire-based studies, for example Hodson et al. (2008) and Schreiber et al. (2012) gave questionnaires assessing social cognitions to schools-based samples in the UK and Germany respectively. Both found that young people with scores in the upper quartile on a measure of social anxiety endorsed significantly more frequent and strongly held negative social cognitions compared to those in the lower quartile. Others have demonstrated this experimentally. For example, Tuschen-Caffier et al. (2011) asked young people with social anxiety, elevated symptoms, and non-anxious controls to engage in two social-evaluative tasks (having a conversation with a stranger and giving a speech). Although independent observers were unable to differentiate between the three groups based on their task performance, socially anxious youth reported significantly greater negative thoughts about their social performance than the elevated symptom group, who endorsed more negative thoughts than the non-anxious controls.

_Safety behaviours_

Our clinical experience suggests that just like adults, adolescents with social anxiety use a wide range of overt and covert safety behaviours (see Table 4 for a summary of the safety behaviours commonly associated with some typical social fears). The safety behaviours that are common in both adults and adolescents include checking that you are coming across well, trying not to attract attention, avoiding eye contact, planning topics of conversation in advance, gripping cups tightly, talking less or talking more, avoiding asking questions or asking lots of questions, and trying to ‘act normal’. Some of the additional behaviours we might pick up in adolescents include wearing clothes to fit in with others, listening to all the ‘right’ music to talk about with peers,
getting others (such as friends or family members) to speak for them, checking their phone to seem busy, or avoiding putting their hand up in class.

Only a small number of studies have investigated the role of safety behaviours in social anxiety in young people. In line with the cognitive model these have found that on self-report questionnaires young people with elevated symptoms of social anxiety report using more safety behaviours more frequently than their less socially anxious peers (Hodson et al., 2008; Kley et al., 2012; Ranta et al., 2014; Schreiber et al., 2012). In addition, Kley and colleagues (2012) investigated whether the self-reported use of safety behaviours mediated the relationship between general social anxiety and state anxiety in response to a social-evaluative performance task. This hypothesis was not supported, however as the authors point out this could be because a measure of general safety behaviours was taken (rather than of those safety behaviours used during the performance task). In addition, safety behaviours are assumed to maintain social anxiety in the long-term as they preclude assimilation of corrective information, but they may well reduce anxiety in the short-term (as assessed in the study here).

Table 4. Social fears and commonly associated safety behaviours

<table>
<thead>
<tr>
<th>Social Fear</th>
<th>Safety Behaviours often used to prevent feared outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I’ll look stupid”</td>
<td>Planning things to talk about before a conversation</td>
</tr>
<tr>
<td></td>
<td>Censor what you are going to say</td>
</tr>
<tr>
<td></td>
<td>Avoid pauses in speech</td>
</tr>
<tr>
<td></td>
<td>Ask lots of questions</td>
</tr>
<tr>
<td></td>
<td>Avoid speaking</td>
</tr>
<tr>
<td></td>
<td>Check that you are coming across well</td>
</tr>
<tr>
<td></td>
<td>Monitoring</td>
</tr>
<tr>
<td>“I’ll blush”</td>
<td>Wear clothes or makeup to hide blushing</td>
</tr>
<tr>
<td></td>
<td>Hide your face</td>
</tr>
<tr>
<td></td>
<td>Position yourself so as not to be noticed</td>
</tr>
<tr>
<td></td>
<td>Avoid eye contact</td>
</tr>
<tr>
<td></td>
<td>Monitoring</td>
</tr>
<tr>
<td>“My hands will shake”</td>
<td>Try to control shaking</td>
</tr>
<tr>
<td></td>
<td>Grip cups or glasses tightly</td>
</tr>
</tbody>
</table>
Keep still
Try to stay in control of your behaviour
Try not to attract attention
Monitoring

“I’ll babble/talk funny”
Make an effort to get your words right
Talk less
Rehearse sentences in your mind
Avoid asking questions
Avoid eye contact
Monitoring
Let parents talk for you

Processing of the self as a social object

Evidence has accumulated demonstrating the negative consequences of self-focussed attention in maintaining social anxiety in youth (Anderson & Hope, 2009; Blöte et al., 2014; Higa & Daleiden, 2008; Hodson et al., 2008; Kley et al., 2012; Schmitz et al., 2012; Schreiber et al., 2012). For example, in a community sample of 161 adolescents asked to give a speech to a pre-recorded neutral audience, Blote and colleagues (2014) found that, in line with the cognitive model, the higher the young person’s social anxiety the more negative were their perceptions of the audience. Furthermore, this relationship was partly mediated by negative expectations of performance and self-focussed attention (as assessed by self-report questionnaire).

A handful of studies have also found self-images to be more negative and frequent amongst young people with social anxiety or elevated symptoms. Following on from the work of Hackmann and colleagues (2000) with adults, Schrieber and Steil (2013) asked young people with social anxiety and controls about images that came to mind when recalling a previous event when they felt embarrassed or anxious. They found that the socially anxious young people reported more frequent, vivid and distressing spontaneous imagery than healthy controls. Also, these images were more likely to be from the observer- than the field- perspective for the socially anxious group.
Anticipatory and post event processing

Using similar designs, both Hodson et al. (2008) and Schreiber et al. (2012) found that young people scoring high on a measure of social anxiety endorsed more pre and post event processing compared to low-scoring peers. Both studies used a simple Likert scale to measure pre and post event processing. In two studies with younger children (aged 10-12 years), Schmitz and colleagues (2010; Schmitz, Kraemer, & Tuschen-Caffier, 2011) asked participants to undertake a social task. Post-event processing and perceived task performance were assessed by self-report in the hours or days afterwards. Both studies found that children with social anxiety (or elevated symptoms) reported more negative post-event processing than controls. In addition, this was associated with social anxiety and perceived task performance independent of depression.

Parental cognitions and behaviours

Anxiety disorders cluster in families. Transmission of anxiety between generations is likely to be via multiple mechanisms. In addition to genetic heritability, family factors including family functioning, parental beliefs and behaviours may be involved (Bögels & Brechman-Toussaint, 2006). Very few studies have investigated family and parental factors in relation to the development and maintenance of youth social anxiety specifically. Parental over-control (sometimes called over-protection) has been the most frequently studied dimension of parenting behaviour in relation to social anxiety. It is defined as a pattern of parental behaviour involving overly protective, directive, and controlling behaviours, even when the situation does not require it, and discouragement of independent problem solving. A number of studies suggest that greater child perceived parental over-control is associated with higher levels of social anxiety (Bögels et al., 2001; Festa & Ginsburg, 2011; Greco & Morris, 2002; Knappe et al., 2009). As suggested by Rubin and colleagues (2009) it is likely that over-controlling parenting practices are motivated by particular beliefs the parent(s) holds about their child and his/her environment.

Some parents may view their child’s social environment as hostile and/or something their child is unable to cope with it, leading to over-protection. For example, one mother was very reluctant to let her socially anxious son visit the halls of residence at
the University where he had been accepted to undertake his undergraduate studies. On questioning, she expressed her fear that he wouldn’t be able to cope living away from home.

In contrast, others may believe that children should learn to be ‘centre-stage’ and as a result push their child too hard. For example, one young person with socially anxiety was pushed to engage in public speaking on a weekly basis by her mother. Her mother described the importance of “getting on with it and going for it” as a way of overcoming social anxiety and succeeding. Whilst well intentioned, this parenting style had the effect of maintaining anxiety in the young person as well as confirming her perception of being a failure and disappointment to her mother.

Adolescent peer processes

Adolescence is a period during which social interactions take on a different value. Peer relationships are especially important, and there is an orientation away from parental relationships and towards peers. The forming of successful peer relationships plays a central role in adolescents’ emotional and social development. When in adulthood we pay attention to what others think but there is a certain resistance to peer influence. In contrast during adolescence this resistance is far weaker, with young people showing a strong susceptibility to peer influence. This can present as conformism to fashion and music trends, the so-called ‘herd or pack mentality’. A study examining the effects of peer influence on risk taking in adolescents and peers bears this suggestion out (Gardner & Steinberg, 2005). When playing a driving-based video game, youths took significantly more risks when with peers than when alone, whereas adult risk-taking behaviour was not affected by the presence of peers (see Figure 2). Studies looking at resistance to peer influence tell a similar story. As can be seen in Figure 3, at the beginning of adolescence this resistance is low and only gradually increases to adult levels (Steinberg & Monahan, 2007). Susceptibility to peer influence in adolescence is likely to be adaptive, as it will provide the opportunity to form strong social bonds and learn vital lessons about relationships. However, for young people with social anxiety who crave social approval but strongly doubt their acceptability, adolescence will be a particularly challenging time. Young people with social anxiety may be especially likely to conform to peers in an
indiscriminate manner, for example by avoiding disagreeing with others or expressing difference in tastes or likes. This can lead to peer rejection, for example one young socially anxious girl was accused of being a “beg friend”, a “suck-up” and “wannabe”.

Social anxiety can impact on the ability of young people to establish successful relationships in other ways. Gross avoidance may limit the contact a young person has with others thereby reducing opportunities to develop friendships. Negative beliefs and safety behaviours will distort interactions with the social environment potentially making them more vulnerability to peer victimisation.

![Figure 2. Differential effects of peer presence on risk taking as a function of age](image)

[Higher scores indicate more risk taking (Gardner & Steinberg, 2005)]
The social environment can be particularly hostile during adolescence, more so than in childhood or adulthood. Problematic peer relations will also contribute to the development of adolescent psychopathology including social anxiety (e.g. De Los Reyes, 2004; Inderbitzen, Walters, & Bukowski, 1997; La Greca, Davila, & Siegel, 2008; La Greca, 2005). Peer victimisation can occur in different forms. It can be overt, involving physical aggression or threats of physical harm. It can be relational, in which relationships are used to hurt a peer. This might involve deliberately isolating or excluding a peer. For example, being told, “you’re not my best friend”, not being invited to a party, being excluded from a WhatsApp or Facebook group, or being left without a seat at your peer group’s table in the school cafeteria. It can be reputational, whereby efforts are made to damage a person’s reputation in the wider peer group, for example by spreading rumours. One young girl experienced reputational bullying online, with peers accusing her of posting unpleasant comments about others on social media. In a prospective longitudinal study of 228 adolescents, peer victimization was strongly associated with social anxiety, and relational victimization explained additional unique variance (Siegel, La Greca, & Harrison, 2009).
Alongside the relatively bleak picture of adolescence as a time of acute sensitivity to social anxiety disorder, it may also be a period of opportunity. Enhanced susceptibility to peer influence and an orientation away from parents (and towards peers) marks adolescence out as a special time to learn about relationships. The avoidance associated with social anxiety has two implications. First, socially anxious youth will miss out on learning opportunities. Second, if socially anxious teens can be helped to counter their fears and avoidance it is likely that this will be an optimal time to intervene (Haller et al., 2015) precisely because of the heightened learning and flexibility occurring in the teenage years (Crone & Dahl, 2012).

2.3. Treatment targets

The cognitive model of social anxiety in young people is helpful because it specifies key maintaining factors. Treatment aims to reverse the maintaining factors by:

1. Identifying and modifying negative cognitions and assumptions about the self and the social world that the young person holds.
2. Correcting distorted self-images or impressions.
3. Shifting attention away from the self when in social situations in order to access new information.
4. Dropping safety behaviours that prevent disconfirmation of negative beliefs, exacerbate anxiety symptoms, and/or contaminate social interactions.
5. Dealing with socially traumatic memories.
6. Identifying the unhelpful effects of pre and post event processing and stopping these processes.
7. Identifying and modifying parental beliefs and behaviours that may inadvertently maintain the problem.
8. Identifying and modifying unhelpful perceptions of and responses to peers and developing positive peer groups. Negative or victimising peer relationships are identified and the young person is supported in developing alternative social networks.
2.4. Overview of treatment

Treatment comprises 14 weekly sessions each lasting 90 minutes. Booster sessions are provided at one, two and six months post-treatment. The focus of the first session is on establishing a collaborative relationship with the young person and parents, normalising difficulties, developing a personalised version of the model, and setting treatment goals. Sessions then focus on helping the young person discover the unhelpful consequences of self-focussed attention and safety behaviours (through an in-vivo behavioural experiment), and updating distorted self-impressions using video feedback. Systematic attention training is provided to help the young person shift their attention away from themselves and onto their surroundings. Much of later sessions are taken up with behavioural experiments, in clinic and outside, designed to test particular beliefs the young person holds. Other therapy components include use of surveys; memory work; reduction of anticipatory and post event processing; working with parental beliefs and behaviours; managing peer victimisation and bullying; and school liaison. The inclusion and timing of these components will depend on the case formulation and the young person’s progress in therapy. The final session comprises a review of therapy and relapse prevention strategies, summarised in a therapy blueprint. Booster follow-up appointments are held at one, two and six months post-treatment in order to review progress and successes and to identify and overcome set-backs. The content of the 14-session CT-SAD-A programme is summarised in Table 5. Session checklists to facilitate therapy sessions are provided in Appendix L (p. 294). These must be used in conjunction with close reading of the manual.

Several CBT procedures that are commonly used in other treatment programmes are NOT used in CT-SAD. These are: repeated exposure to promote habituation; exposure hierarchies; rating anxiety in feared situations (SUDS); thought records; rehearsal of rationale responses in social situations (self-instruction); and social skills training.

Questionnaires are an essential aspect of treatment. We explain this to families as well as the importance of completing questionnaires in advance each session. Young people are required to complete a small number of questionnaires for every weekly session and a slightly greater number of questionnaires at the start, middle and end of
treatment (see Appendix A, p. 260 for a list of measures, Appendix B, see p. 261 for reproduced measures, and Appendix C for scoring instructions, p. 272). Therapists should always try to review the questionnaires before the session begins and then discuss scores with the young person. Normally, we mail (or email) a set of questionnaires to families in advance of Session 1 and ask them to either mail back the completed questionnaires or bring them to the appointment. In following sessions young people are provided with a pack of questionnaires to take home each week and bring back completed to the following session. If they have not done so, the young person is asked to complete them in the reception room before the session begins. Specific obstacles to questionnaire completion are discussed and solutions identified. These strategies result in extremely high completion rates. Parents complete questionnaires at the beginning, middle, and end of treatment.

All sessions are videotaped. Sessions are typically on an individual basis. Nonetheless, parents often play a key role in treatment. They are almost always involved in the assessment process (both the diagnostic assessment as well as Session One). Parents are usually kept informed of progress in therapy and are often recruited as co-therapists, for example to support homework completion. We usually do this by inviting parents to join the last 10 minutes or so of sessions. This provides parents the opportunity to provide their feedback from the week and hear their child summarise learning points from the session. Agreement around homework tasks can be reached and any potential obstacles identified and overcome. When young people attend alone we stay in contact with parents (with the agreement of the young person) via telephone between appointments. When specific parental cognitions or behaviours are identified that are unhelpful, parents are invited to attend for additional sessions, usually alone but sometimes with their child if this is indicated. School liaison is undertaken to provide psychoeducation about social anxiety and treatment, to facilitate CT-SAD-A in the school environment (e.g. to set up particular behavioural experiments that may be undertaken in class) and to address specific issues such as bullying and non-attendance.
Table 5. Overview of 14-session CT-SAD-A programme

<table>
<thead>
<tr>
<th>Session</th>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Psychological Assessment</td>
<td>Identify main feared and avoided situations; thoughts; anxiety symptoms; self-focus; safety behaviours; images; pre and post event processing</td>
</tr>
<tr>
<td></td>
<td>Developing the model</td>
<td>Development of personalised version of model</td>
</tr>
<tr>
<td></td>
<td>Goals</td>
<td>Establish short, medium, and long-term goals</td>
</tr>
<tr>
<td></td>
<td>Introduce questionnaires</td>
<td>Explain role of regular questionnaire completion as core part of treatment.</td>
</tr>
<tr>
<td></td>
<td>Information provision</td>
<td>Provision of information about the nature and treatment of social anxiety disorder.</td>
</tr>
<tr>
<td>2</td>
<td>Self-focused attention &amp; safety behaviours experiment</td>
<td>Experiential exercise by which young person can discover the unhelpful consequences of self-focused attention and safety behaviours for themselves</td>
</tr>
<tr>
<td>3</td>
<td>Video and photographic feedback [introduced in session 3 &amp; then used throughout therapy sessions 4-14]</td>
<td>Updating distorted negative images and self-impressions. Session 3: video of safety behaviour &amp; self-focused attention experiment. Session 4-14: used throughout therapy in Behavioural Experiments.</td>
</tr>
<tr>
<td>4</td>
<td>Attention training</td>
<td>Systematic training in externally focused non-evaluative attention. This starts by attending to external non-social stimuli (street sounds, music, colours) and progresses to social situations.</td>
</tr>
<tr>
<td>2-14</td>
<td>Behavioural experiments</td>
<td>To test out specific beliefs. During experiments, safety behaviours are dropped and attention is focussed externally in order to gather new information.</td>
</tr>
<tr>
<td>6-14</td>
<td>Surveys</td>
<td>To discover other people’s view of the feared outcome.</td>
</tr>
<tr>
<td>6-14</td>
<td>Dealing with socially traumatic memories</td>
<td>Memory rescripting or discrimination training for memories of upsetting social experiences related to current self-images.</td>
</tr>
<tr>
<td>6-14</td>
<td>Worry and post-event processing</td>
<td>Establish unhelpfulness of processes and then test out inhibiting them through distraction.</td>
</tr>
<tr>
<td>13-14</td>
<td>Relapse prevention</td>
<td>To reflect on what was learned in therapy and plan how to continue to use new skills and identify and overcome future challenges.</td>
</tr>
<tr>
<td>When indicated</td>
<td>Parent work</td>
<td>Interventions aimed at helping parents to identify unhelpful cognitions and related behaviours that help maintain child’s anxiety.</td>
</tr>
</tbody>
</table>
Therapists should have weekly supervision with a senior, experienced cognitive therapist. Supervision will involve elements common to all good cognitive therapy supervision, including: detailed review of questionnaires (symptom and process measures) on a weekly basis; regular review of videotaped therapy; close adherence to the cognitive model; and planning of the next session.

2.5. **Illustrative case examples**

The way in which the various procedures are provided in therapy is illustrated in the following two case examples.

*Case 1: Sienna*

Sienna was an 11-year-old girl with a two-year history of panic attacks, angry outbursts and social anxiety. She had been receiving counselling for one year to little effect. She spent most of her time at home and her school attendance was at 20%. At the initial assessment she spoke little, giving one-word answers and looking to her mother to respond to the clinician. She had experienced bullying for a number of years in primary school, which had persisted into secondary school and was ongoing. Sienna’s main fears were that “I will talk funny”, “I am boring”, “I am weird” and “people will reject me”. In social situations she had an image of herself “looking lost, clueless”. She could trace this image back to when she lost control of her bowels in the classroom aged 7 years and she felt ashamed and helpless. Safety behaviours included always agreeing with others, allowing others (particularly her mother) to speak for her, censoring what she was saying, avoiding eye contact, speaking less, following the dominant peer group and staying on
the edge of groups. Sienna avoided a wide range of situations for fear of social rejection. At times she avoided school outright, but when she did attend, she would not put her hand up in class, avoided speaking to teachers, stopped writing if she thought she was being observed and avoided participating in group activities. Out of school she would avoid joining clubs or groups, she travelled only with her mother or older sister and tried to avoid family gatherings. Her score of 88 on the Liebowitz Social Anxiety Scale for Children (LSAS-CA) at the beginning of treatment indicated very severe social anxiety. The 22-item Social Cognitions Questionnaire indicated that Sienna experienced high levels of negative social cognitions before starting treatment. The average frequency score was 3.9 (with 0 indicating ‘the thought does not occur at all’, and 5 indicating ‘the thought always occurs when anxious’) and mean belief rating was 79.1 (with 0 indicating ‘I do not believe this thought’ and 100 indicating ‘I am completely convinced that this thought is true’). Sienna endorsed the use of many safety behaviours and this was reflected in her high mean score of 1.9 (ranging from 0 ‘never’ to 3 ‘always’) on the Safety Behaviours Questionnaire. Sienna struggled to concentrate on learning, as indicated by the low score of 25% on the concentration scale (ranging from 0 ‘not at all able to concentrate’ to 100 ‘completely able to concentrate’). Short-term goals included speaking for herself, attending family gatherings, and texting her friends. Medium-term goals included attending school on a reduced timetable, putting her hand up in class, speaking to teachers, and completing work in class. Long-term goals included attending school every day and travelling alone. Treatment was given in 14 weekly 90-minute sessions.

Treatment began with the therapist and Sienna reviewing a recent time when she had felt socially anxious and then deriving a personalised version of the model. Although progress was slow as Sienna was only 11 years of age with a low average IQ, using repetition, clear language and a large white board (which also helps to reduce self-consciousness), a personalised version of the Clark and Wells’ model covering a recent situation when Sienna felt socially anxious was developed (see Figure 4). For homework Sienna was asked to take note of the times she felt socially anxious during the week, and to add any additional details about thoughts, images and safety behaviours to her
personalised model. For example, Sienna noticed that she let her Mother speak for her and she added this under Safety Behaviours.

Once the model had been developed, at the next session Sienna and her therapist planned a behavioural experiment to help her discover the unhelpful consequences of self-focused attention and safety behaviours. She took part in two conversations with a young member of clinic staff, one in which she was encouraged to focus on herself and use her safety behaviours and the second in which she was instructed to “lose herself in the conversation” and let go of her safety behaviours. The experiment was most illuminating for Sienna: she had always assumed that monitoring how she was coming across and using her safety behaviours were helpful both for her anxiety and to ensure she came across better. However, the experiment revealed to her that she felt less anxious when she focused externally and dropped her safety behaviours and also that she thought she came across better. Sienna was greatly encouraged by this but pointed out to her therapist that her conversation partner was very polite and quite different to her peers! She and her therapist agreed she would try repeating the exercise in an informal way with her cousin during the week as homework. Care was taken by the therapist to help Sienna identify a peer who would provide helpful feedback. Sienna was steered away from trying it out at school with victimising peers.
The next session focused on helping Sienna to discover that her perception of how she came across was excessively negative and unrealistic, even when not focusing on herself or using safety behaviours. To do this, Sienna and the therapist reviewed the videos of her conversations from the previous session. First her feared predictions (i.e. how she thought she came across to other people) feared predictions and her self-images

Figure 4. Example of a personalised version of the model with an 11-year-old girl
were identified. The therapist then encouraged her to watch the videos in an unbiased way, as though watching a stranger, and compare what she saw with her predictions. Sienna smiled as she watched the videos. She described surprise that the person on the video was her, as she did not look like the “weirdo” she had expected to see, nor did she seem unable to speak or engage in conversation. The belief that she looked like a “boring, weird outcast” reduced from 100% to 30%. Whilst the video clearly helped Sienna see her view of how she came across was excessively negative, the therapist was slightly surprised that it was still at 30% as she had been in the room during the conversation and had observed a very positive interaction with little difference between Sienna and the stooge. Therefore the therapist enquired why this was not lower and Sienna raised two points. First, she said she had noticed that she seemed very fidgety and had made lots of movements during the interaction. She was concerned that this made her appear strange. The therapist suggested they review the interactions again to check these concerns out, looking at both Sienna and her conversation partner. Pausing and focusing in on particular moments during the conversations, Sienna and her therapist were able to determine that although Sienna did indeed move, for example gesturing with her hands, shifting in her seat and rearranging her legs, her conversation partner seemed to move even more than her. However, Sienna had not even noticed the movements of her conversation partner and had simply judged her to be a very nice person. Second, Sienna pointed out that during the first conversation she had seemed to avoid eye contact at times and was a little quiet and again was concerned these were signs she was boring. Through discussion and comparison of the two conversations, the therapist helped Sienna to see that there was no sign that her conversation partner considered her to be boring and that her reduced eye contact did not reflect a personal characteristic such as being a boring person but was simply a consequence of being absorbed in performing her safety behaviours. The latter of course was a particularly important discovery as she could choose to drop her safety behaviours in future conversations.

These two sessions helped Sienna to see that the strategies she had been using to help her manage her social anxiety were inadvertently making it worse and that her self-images were excessively negative. So the rest of therapy involved a search for a more accurate image of how she came across and for more information about how she came
across if she did not hide or cover up. This essentially involved a lot of behavioural experiments in order to discover what happened when she was ‘just herself’. Of course for the experiments to be effective Sienna needed to observe others’ reactions to learn how she was coming across. Therefore a prelude to the experiments was training to help her become more externally focused. A session followed involving systematic training in external attention, to which Sienna brought her own music and reading material to use for the training exercises. For homework Sienna practiced the attention training and in addition she and her therapist planned a behavioural experiment for her to do. 

Sienna often felt self-conscious and worried that people were staring at her. She described travelling on busy buses with her eyes rooted to the floor whilst feeling as though she was the centre of attention. As an experiment, Sienna agreed to go on a bus and when she spotted this feeling to notice it and then rather than staring at the floor to look around her “like a hawk” to find out whether the felt sense of being watched was accurate. Sienna returned the next week thrilled by what she had discovered. She explained to the therapist that not only had she managed to do it and found most people were looking elsewhere, but the one woman who looked at her was sitting with her baby who kept smiling at Sienna.

The way was now paved for Sienna to update her negative images and predictions through watching other’s reactions. Particularly powerful behavioural experiments for Sienna included watching the therapist intentionally babble to a newsagent and observe the shopkeeper’s helpful and friendly response. She then repeated the experiment herself. Sienna’s belief that people would laugh at her and think she was weird reduced from 100% to 40% after the first experiment and to 5% after the second experiment. Sienna undertook a behavioural experiment testing out her feared prediction that “if I disagree with someone they will not like me” by volunteering her own opinion about a popular song to a group of friends. To her surprise she discovered people were interested in her view of the song and in fact another girl agreed with her opinion. Her belief rating that “if I disagree with someone they will not like me” reduced from 90% to 0%.

Sienna’s mother was invited into a session and she agreed that she would not step in and speak for Sienna. This meant that Sienna was able to test for herself her belief that “I will talk funny” or “I will say the wrong thing”. The therapist helped Sienna and her
mother plan the experiment and identify what each of them would do differently in terms of dropping their safety behaviours and focusing externally. The experiment was very revealing for both Sienna and her mother. Sienna discovered her feared predictions did not come true and belief ratings reduced considerably (her belief that “I will talk funny” reduced from 90% to 5%, and her belief that “I will say the wrong thing fell from 100% to 10%). Sienna’s mother was surprised to discover how accustomed she had become to stepping in for Sienna when in fact Sienna could manage fine independently. This was discussed in more detail in an individual meeting with Sienna’s mother described below.

The therapist helped Sienna to join a youth theatre and dance group in which she was able to undertake the majority of her behavioural experiments. This provided a positive peer group in which to disconfirm her fears (distinct from the victimising peers at Sienna’s school), for example Sienna tried out participating in group activities and discovered she could speak, be understood and be accepted by others. Similarly Sienna tested out her fear of being laughed at and rejected by asking a fellow group member for their telephone number. When she did these experiments she ensured she dropped her safety behaviours (she made sure she did not avoid eye contact, speak quietly or plan what she was going to say) and watched her peers’ reactions carefully to gather new information.

Sienna’s scores on the LSAS-CA reduced session by session. The therapist reviewed the questionnaire before every session. Improvement in scores on specific items was discussed with Sienna and linked to the planned or naturalistic behavioural experiments she had undertaken. For example Sienna had spontaneously tried putting her hand up in class and answering a question. She had discovered that nobody laughed at her and the teacher praised her. Her fear and avoidance ratings for the LSAS-CA item “answering questions in class” reduced from 3 and 3 to 1 and 0 respectively. Items (e.g. asking questions in class) that remained high were identified and the underlying beliefs specified and then targeted in further behavioural experiments.

In parallel the therapist worked closely with Sienna’s school and family to tackle the on-going issues with peer victimisation and bullying and reintegrate Sienna into school. Sienna increasingly disengaged from the negative peer group (“I can choose my friends based on people I want to be with, not on who I need to be ‘okay-ed’ by”) and
began developing new relationship in the school environment. Her head of year oversaw this to help Sienna make positive friendships.

Towards the end of therapy the therapist met with Sienna’s mother to help her identify her own anxious thoughts and behaviours. Her mother noticed she often spoke for Sienna and did not encourage her to try out new things for fear Sienna would be treated badly or rejected. Sienna’s mother believed that “Sienna is vulnerable and cannot cope with her peers.” The therapist first discussed and validated Sienna’s mother’s reasons for this belief given the chronic bullying that Sienna had experienced. The therapist then encouraged her to look at the consequences of parental behaviours such as speaking for Sienna or barring her from social media. The unintended consequences of these were identified, for example preventing Sienna from learning she could speak for herself, or from learning how to manage relationships online. The therapist and Sienna’s mother agreed a series of experiments to test out her belief that “Sienna is vulnerable and cannot cope with her peers.” These included allowing Sienna to speak for herself (as mentioned above) and allowing Sienna to use social media. Sienna’s mother’s original belief reduced from 70% to 10% and she concluded that “Sienna is able to cope and make friendships and the more she does the more confident she becomes.” Sienna’s LSAS-CA scores reduced further as she was able to undertake behavioural experiments in situations her mother would previously have been reluctant for her to face.

At the end of treatment Sienna seemed a different person. She invited her therapist to watch her in her dance group’s Christmas performance that was being held in a busy town square. She was attending school every day and back engaging in online social media with her friends. Her mother said angry outbursts had stopped and Sienna was her happy self. Sienna met all of the goals she had set at the start of treatment. In line with this, Sienna’s scores on the self-report questionnaires had improved considerably. Her score on the LSAS-CA was 5. The mean frequency and belief ratings on the Social Cognitions Questionnaire were 1 (range: 1 – 5) and 2 (range: 0 – 100) respectively. Sienna was no longer using safety behaviours in social situations, as evidenced by her much reduced mean score of 0.3 on the SBQ. Similarly Sienna’s ability to concentrate in class had improved enormously and she now rated this at 95%.
Case 2: Matt

Matt was a 16-year-old boy with a four-year history of social anxiety, depression and obsessive compulsive disorder (OCD). He had received CBT with Exposure and Response Prevention for OCD that had proved helpful in reducing OCD symptoms and he had been commenced on Fluoxetine 40mg od for depression. Unfortunately, he was still severely disabled by social anxiety disorder and so he was referred to us for assessment and treatment. At assessment he was slow to speak and tearful, often covering his face with his hand and looking away. His parents encouraged him to speak at every opportunity. Matt’s main fears were that “I am boring”, “I won’t be able to speak”, and “I will go red”. In social situations he had an image of himself looking “like a tomato, dumb and bright red” and feared people would laugh at him. He could trace this image back to when he had been about 12-years-old at a family party and a family friend had pointed to him saying “look how sweet, you’ve gone bright red!” in front of girls and boys of his own age who then laughed. He had felt humiliated by this. Safety behaviours included avoiding talking, avoiding eye contact, staying on the edge of groups, planning topics of conversation in advance, censoring what he was saying, and also covering his face with his hands. He worried in advance of social situations, for example worrying about whether he would have anything to say, thinking about what others would think about him and recalling previous negative social experiences. He would also go over social situations repeatedly afterwards. He would think about things he thought he had done wrong, dwell on the feelings of shame and embarrassment he had experienced in the situation and picture himself looking red and foolish. This processing before and after social situations often triggered feelings of shame and sadness. Matt avoided a wide range of situations for fear of social rejection. He did not telephone or message friends. He avoided using social media. He did not arrange to meet friends. He felt unable to initiate a romantic relationship, despite being attracted to one of his female friends.

As with all young people entering CT-SAD-A, Matt completed a number of questionnaires before treatment (which were repeated throughout treatment). His score of 79 on the LSAS-CA indicated severe social anxiety. He showed elevated negative social cognitions on the Social Cognitions Questionnaire. The average frequency score was 3.7 (ranging from 1, never to 5 always) and the average belief rating was 52.6. The use of
safety behaviours was elevated, with an average score of 1.4 on the SBQ. Matt was still achieving extremely high grades in school but reported difficulty keeping up with the classroom learning. This was reflected in his score of 31 on the concentration scale (ranging from 0 ‘unable to concentrate at all’ to 100 ‘completely able to concentrate’). Matt’s short-term goals were to initiate texts with friends, engage in text conversations, to initiate conversations with peers in school and use social media. Medium-term goals included telephoning friends, initiating arrangements with friends and attending parties. Long-term goals included hosting a party and initiating a romantic relationship. Treatment was given in 14 weekly 90-minute sessions.
Therapy started with present-focused techniques as described in Case 1. The first step involved developing a personalised version of the Clark and Well’s model covering a recent situation when Matt felt socially anxious (see Figure 5). This led onto the safety behaviours and self-focused attention behavioural experiment in Session 2. He discovered that trying to think of topics in advance of the conversation and censoring
what he was saying seemed to have the opposite effect to that intended. He noticed that he felt more anxious and thought he came across less well when using safety behaviours and focusing on himself.

The following week he and his therapist reviewed the videos of the conversations. Matt discovered that he did not appear boring at all and both he and his conversation partner seemed animated and interested. He had also predicted he would “blush like a tomato”. The therapist had brought a paint colour chart to the session and Matt had selected the colour he thought he would see on his face in the video. Matt was able to appreciate the stark difference between the vivid red colour he had imagined he had gone and the normal pinkish skin colour that he saw on the video. Matt and his therapist also reviewed the written feedback from the stooge (conversation partner). What he read further emphasised what he had seen on the video. The stooge had been asked her general impression of Matt, whether she had noticed him blushing at all and what she had made of his blushing if she had noticed it. Matt had anticipated she would have found him a dull and nervous conversation partner and he was certain she would have noticed he hardly spoke and blushed bright red. However, the stooge commented on the friendliness of Matt and the interesting conversation she had enjoyed with him. She had not noticed any blushing at all. Matt was particularly interested to read that whilst she had noticed he was quiet at times, she had interpreted this as a sign he was a good listener and genuinely interested in her. From this experiment he was able to learn a number of key points. Firstly, that his safety behaviours were inadvertently backfiring. Secondly, that his self-images and impressions were excessively negative and inaccurate. Thirdly, that anxious feelings are an unreliable indicator of how people are responding to him. After these first three sessions Matt’s score on the LSAS-CA had reduced to 49.

Matt was keen to discover how other people really did respond to him, given that his feelings and self-images seemed inaccurate. The stage was therefore set to undertake behavioural experiments. In preparation for this and to ensure he would be able to fully process and evaluate how others react to him he received a session of training in an external attention mode that he continued practicing at home.

Matt and his therapist agreed that behavioural experiments would target two cognitions that were prominent for Matt and which he rated particularly highly on the
SCQ. On the questionnaire Matt indicated that he *always* had the thoughts “I will go red” and “People will think I am boring” when he felt anxious and believed them 100%. A series of behavioural experiments were therefore planned and undertaken to address these cognitions.

Behavioural experiments were planned to target Matt’s fear being boring. These were initially aimed at reducing his belief that people saw him as boring. He tried joining conversations and “going with the flow”, whilst making a conscious effort to let go of preparation, monitoring and censoring and watching out for others’ reactions. Building on the success of these experiments he agreed to try saying something he thought would be perceived as ‘boring’ and examine the consequences. He predicted that people would stop talking and the conversation would end immediately. However he was pleasantly surprised to discover that his ‘boring’ topic of conversation was of interest to a friend and sparked a new conversation! By reviewing the LSAS-CA and his goal list, Matt and his therapist planned further experiments to test out his belief, for example he spoke up in larger groups of people, he engaged in conversations with acquaintances and not just close friends, and he tried speaking to girls at parties. His belief that people thought he was boring reduced from 100% to 5%.

Behavioural experiments were designed to target Matt’s fear of blushing. To begin with he arranged to attend a fast food restaurant (which had the bright fluorescent lightning that Matt would normally try to avoid) with friends. When there he was encouraged to keep his hands away from his face and not drink copious amounts of cold drinks to keep cool. He focused on the conversation rather than himself and observed others’ reactions closely. He had expected his friends to stare at him and start elbowing each other and laughing. To his surprise he found out that nobody seemed to pay any unusual attention to him at all and the conversations seemed to continue as normal. When reviewing the experiment with his therapist Matt commented that he had been pretty certain he was going to blush and felt quite anxious at the beginning. As they went through the event in detail it emerged that when Matt had first entered the restaurant he had thought “the lights are really bright, so I will be like a really shiny red tomato if I blush.” He had felt anxious and experienced the image associated with the memory of being pointed and laughed at aged 12 years. Matt’s therapist used video feedback to
target Matt’s distorted image of himself as a ‘red tomato’. For example, in session she paused at moments when he had felt anxious and he thought he had looked very red. They then played back the corresponding moments on the video contrasting what he saw on the screen to Matt’s image in his mind’s eye. Matt’s belief that he blushed reduced from 100% to 40%.

Despite the substantial progress Matt made with the present-focused techniques (video feedback, attention training and behavioural experiments) there were still two outstanding problems that needed to be addressed. The first was the distressing socially traumatic memory and the second was the tendency to engage in anticipatory and post-event processing.

Work on the socially traumatic memory was undertaken as Matt continued to experience a distorted negative image of himself as a “tomato, dumb and bright red” in social situations that was clearly tied to the memory of the specific socially traumatic even aged 12. Therefore the socially traumatic memory and linked belief and images were targeted in treatment. Using stimulus discrimination techniques (one of the methods of working with socially traumatic memories) Matt was encouraged to discover whether his feelings were accurate to what was happening in the present or actually linked to a memory from the past. There were clear differences between the memory (‘Then’) and ‘Now’. He identified three key differences with his therapist. First he was 12-years-old at the time of the memory, just starting secondary school and not yet 5 feet tall. At the time of therapy he was a 16-year-old, finishing his GCSE’s, and 6 feet tall. Second, the people were different, they looked different and they actually were different people. Third, in his memory people were laughing at him whereas now his friends were kind to him and did not humiliate him. Matt was encouraged to recognise times when he had the same feelings he had experienced in the memory and see this as a golden opportunity to push his attention outwards in order to observe how people responded to him in the present. To do this Matt looked out for times when he felt the same as he had done in the past. In those moments he reminded himself that ‘this is not the same situation, I am older and taller now’, and to notice that the people were different and that no one was laughing at him, in fact people were being nice to him. Making a distinction between ‘Then’ and ‘Now’ allowed Matt to see that his belief that he would be laughed at was no longer true.
and to update the negative self-image, and as a result his feelings of anxiety reduced further. After the work on the socially traumatic memory further decatastrophizing behavioural experiments were planned in which Matt put red blusher on his face and the reactions of other people in the town centre was observed and recorded by the therapist. His belief that he would blush and others would laugh reduced down to 0%.

Matt spent a lot of time worrying in advance of social situations and going over them afterwards. As a result he experienced feelings of shame, anxiety and hopelessness. He would often be kept awake at night with these thoughts. Matt was helped to identify these worry and post-event processing processes. The therapist and Matt mapped out the advantages and disadvantages of thinking in this way. There were relatively few advantages that Matt and his therapist were able to identify. Matt thought that by going over what might happen it helped him to prepare in case things went wrong and by reviewing what went wrong in a social situation he could try to stop it happening in the future. There were many disadvantages Matt and his therapist could identify. They noticed that it tended to increase anxiety as it brought up failures in the past and so it seems more likely that this event will also go wrong. It tended to increase a self-focus, which Matt already knew backfired. It made worries seem like catastrophes. Sometimes, after a couple of weeks of worrying in advance Matt avoided the situation altogether because he became so sure it was going to go wrong. Dwelling on social situations and replaying them often resulted in Matt feeling very low and kept him awake at night, which affected his sleep.

As a result Matt came to the conclusion that it was probably not helpful. However Matt was reluctant to stop thinking in this way altogether as he still wondered if it might serve a useful function. Matt weighed up the advantages and disadvantages of this thinking with his therapist. Once Matt listed the many unhelpful effects of worry and rumination he agreed to try tackling it. He noted down all of the disadvantages on his phone and the therapist created a flashcard with them on. Matt planned to check over the disadvantages at times when he found himself thinking in this way. He and his therapist agreed that the next step was to turn worries and ruminations into behavioural experiments to be tested. Matt intended to do this by noticing the worrisome fear or ruminative conclusion and considering these to be predictions to be tested out in action.
He and his therapist then compiled a list of distracting activities he could engage in until he had an opportunity to try the experiment. When the therapist was reviewing how the experiment had gone the next week Matt appeared rather sheepish. He explained that on the first day he had found simply spotting worry and rumination when it happened and reminding himself of how unhelpful it was had provided such a relief from negative emotions that he had not completed the other part of the plan!

At the end of treatment Matt had recovered from social anxiety disorder and the residual symptoms of depression had also lifted. He had become an active participant in his social network, initiating contact with friends and making arrangements with them. He had begun his first romantic relationship. He had planned a party that was scheduled to take place just after the end of treatment. His score on the LSAS-CA had reduced from 2. In terms of social cognitions, the average frequency score reduced from 3.7 to 0.1 and average belief rating reduced from 52% to 1%. Matt no longer used safety behaviours, as reflected in the score of 0 on the SBQ. Matt was finding school learning much more manageable and his ability to concentrate in class had increased from 31% to 95%.

2.6. Evidence Base for CT-SAD

Adults

Eight randomised controlled trials have examined the efficacy of individual cognitive therapy in adults with social anxiety disorder. Taken together, the trials indicate that CT-SAD is a highly effective treatment that is superior to interventions that control for non-specific therapy factors (credible rationale, therapist attention, homework etc) and compares favourably with a wide range of alternative psychological and pharmacological interventions. The psychological interventions that individual CT-SAD has been shown to be superior to are: group CBT (Mörtberg et al., 2007; Stangier et al., 2003), exposure therapy (Clark et al., 2006), interpersonal psychotherapy (Stangier et al., 2011), and psychodynamic psychotherapy (Leichsenring et al., 2013). The pharmacological interventions that CT-SAD has been shown to be superior to include fluoxetine (Clark et al., 2003), which is one of the most widely prescribed selective serotonin reuptake inhibitors (SSRI). CT-SAD has also been shown to be superior to a
flexible medication regime in which psychiatrists were allowed to choose the medication (mainly antidepressants) that they considered the most appropriate for each patient (Mortberg et al, 2007) and to pill placebo (Clark et al, 2003). The figure below shows the magnitude of the improvements in social anxiety achieved with various versions of CT-SAD delivered by the Oxford-London cognitive therapy team in comparison to the results obtained with alternative treatments in the RCTs.

Figure 6. Efficacy of standard and brief versions of CT-SAD compared with other treatment conditions in trials conducted by Clark, Ehlers and others.

Mean change in social anxiety (and standard error, Liebowitz Social Anxiety Scale, LSAS) for waitlist, placebo, interpersonal therapy (IPT), fluoxetine (SSRI), psychodynamic therapy (PDT), exposure therapy, standard CT-SAD (CT), self-study assisted CT-SAD (ssaCT), Internet CT-SAD (iCT). Standard and brief versions of CT-SAD do not differ in efficacy and are superior to the comparison treatments.

A recently published network meta-analysis (Mayo-Wilson, 2014) analysed data from 101 RCTs that had tested a range of psychological and pharmacological treatments and constructed a table in which the effect size of each treatment against no treatment was compared. CT-SAD was the most effective treatment. The network inferred that in addition to being superior to the alternative treatments to which it has been directly
compared (see above), CT-SAD is probably also superior to several treatments to which it has not been directly compared. These include: mindfulness, social skills training, exercise therapy, guided self-help and non-guided self-help. All of these treatments were associated with substantially smaller effect sizes than CT-SAD.

Although four of the randomised controlled trials that have evaluated CT-SAD were conducted by the Oxford-London team that developed the treatment, there is impressive evidence that the treatment is also superior to other interventions when delivered by independent teams working in other countries. The Mortberg et al (2007) trial was conducted by a team in Sweden. The Stangier et al (2003, 2011) and Leichsenring et al (2013) trials were conducted by teams in Germany.

Although CT-SAD trials have been remarkably consistent in showing that CT-SAD is superior to alternative psychological treatments, the absolute magnitude of clinical improvement that is observed with CT-SAD varies within and between trials. Some of the sources of this variability have been identified. Ginsberg et al (2013) showed that there is a strong correlation between the competence with which CT-SAD is delivered and the outcomes that are achieved. The Clark and Stangier teams have also compared information on differences in the way in which CT-SAD was implemented in the UK and German trials. Behavioural experiments, which are considered crucial for the effective implementation of CT-SAD, were used significantly less frequently in German trials that showed smaller effect sizes. Another key difference was that therapy sessions were ninety minutes long in the UK trials but only sixty minutes long in the German and trials. It seems likely that this is also an important variable. In the standard protocol it is recommended that sessions should be ninety minutes long in order to ensure that therapists have sufficient time to set up, conduct, and discuss within session behavioural experiments conducted both in the office and outside of the office.

Do the effects of CT-SAD persist after the end of therapy? Several studies have included follow-ups of patients one or more years, with the longest follow-up being 5 years (Mortberg et al. 2013). The gains observed in therapy are well –maintained.

Finally, two randomised controlled trials (Clark et al. 2015, 2016) have evaluated variants of CT-SAD in which a substantial amount of the key ideas in the therapy are conveyed to patients through self-study, rather than in face-to-face therapy sessions.
Clark et al (2015) showed that it was possible to approximately double the amount of clinical improvement per hour of therapy by giving patients specially designed self-study modules to work on between therapy sessions. Stott et al (2013) built on these self-study modules to create an Internet-assisted version of CT-SAD, which uses the multimedia features of the Internet (recordable video calls, etc) to implement most of the key procedures of treatment. Clark et al (2016, submitted) found that Internet-assisted CT-SAD produced similar results to face-to-face CT-SAD while reducing therapist time by around 80%.

Young People

Only two randomised controlled trials have been undertaken examining the effectiveness of therapeutic interventions based on the cognitive model of Clark and Wells (1995) with children and young people. One of these involved children. 44 socially anxious young people aged between 8 and 14 years of age (Melfsen et al., 2011) were randomly allocated to individual therapy based on the cognitive model or to a wait-list control group. The authors reported medium to large effects of individual therapy compared to wait list control on clinician reported (German version of the Anxiety Disorders Interview Schedule; Hedge’s G = 0.94) and self-reported outcomes (German version of the Social Phobia Anxiety Inventory; Hedge’s G = 0.89). The results are certainly encouraging. However, the treatment did not represent a full implementation of CT-SAD. For example, five to six sessions were dedicated to psychoeducation. In CT-SAD we would usually spend no longer than 15 minutes on this in session. Critical components such as the safety behaviour and self-focused attention behavioural experiment that is undertaken in session two of CT-SAD were not included. In addition, the trial was with children not adolescents. Ingul, Aune, and Nordahl (2014) undertook a randomised controlled trial with socially anxious adolescents in which individual therapy based on the cognitive model was compared to the adolescent group version of Coping Cat (The CAT Project) and an attention placebo. The attention placebo involved group meetings in which socially anxious young people interacted with peers and adults to a similar degree to the treatment arms, but did not receive any of the hypothesized active components of the two treatments. A large effect of individual therapy was found on the
Social Phobia Anxiety Inventory (SPAI) post-treatment (Hedge’s corrected $d = 2.96$). Surprisingly there was no effect of Group CAT on self-reported SPAI ($d = -0.10$) and a small effect of attention placebo ($d = 0.50$). The benefits of individual therapy were maintained at follow-up. The results are promising with regards individual therapy, however treatment was not wholly consistent with CT-SAD. For example, the first three sessions comprised psychoeducation about anxiety, drawing up a broad model of anxiety maintenance, developing an anxiety thermometer and hierarchy, and learning about negative thoughts and thinking errors. An individualised version of the cognitive model was not introduced until session four (compared to session one in CT-SAD).

Findings from these two trials are an encouraging indication that CT-SAD may be helpful for young people. However, neither trial tested the full implementation of CT-SAD-A.

In response to this, we undertook a treatment development case series to test preliminary feasibility of CT-SAD with adolescents (Leigh & Clark, 2016). CT-SAD was delivered to five adolescents, all of whom had severe and chronic social anxiety disorder as well as comorbid difficulties at the start of treatment. Four of the five had already received a standard course of CBT without apparent response. By the end of treatment, symptoms of social anxiety, as well as associated anxiety and depression, had reduced to subclinical levels and these gains were maintained at three to six month follow-up. All the young people also showed improved functioning, as evidenced by increased social participation and 100% school attendance at follow-up. Excitingly, we had the first indication that social anxiety treatment may also have a positive impact on classroom concentration, as evidenced by the self-reported improvement across all five patients. The average change (79%) on the primary outcome measure (the Liebowitz Social Anxiety Scale) (Liebowitz, 1987) was greater than observed in our trials of CT-SAD in adults (57% and 63% in Clark et al., 2003, 2006).

Whilst the evidence base is extremely small, the results converge to suggest CT-SAD may have important promise for adolescents with social anxiety disorder.
CHAPTER 3. DIAGNOSTIC ASSESSMENT

When undertaking an assessment of an adolescent, careful consideration and assessment of social worry and anxiety should always be included.

Children and young people rarely refer themselves to services because of symptoms of social anxiety. In a large community study of over 3000 14-24 year olds, only 30% of those with social phobia (pure or comorbid) had sought help for their difficulties in the previous 12 months. This figure was even lower for those with pure social phobia, at 12.3% (compared to 28% of those with comorbid social anxiety disorder) (Wittchen, Stein, et al., 1999). Due to the very nature of social anxiety, issues such as shame, fear of stigma or of negative evaluation may prevent individuals seeking help. In addition, parents may not recognise the extent of disability and impairment caused (Kashdan & Herbert, 2001) or think the social anxiety is just a temporary phase that the young person will “grow out of” (Masia-Warner et al., 2001). When problems are picked up by parents or indeed school staff, it is typically in response to particular areas of interference such as difficulty attending school or refusal to attend social gatherings, peer difficulties or bullying, or due to other comorbid problems. Many young people may be engaging in impression management strategies in response to their social anxiety, which will make it even more difficult for parents and teachers to detect social anxiety. As described in Chapter 1 there are high rates of comorbidity between social anxiety disorder and other anxiety disorders and with depressive disorders in young people. In these cases, the comorbid anxiety or depressive disorder may be recognised by healthcare professionals without detecting the underlying and more persistent social anxiety disorder. In the large US National Comorbidity Survey (Costello et al., 2014), only adolescents with specific phobia were less likely to receive services than those with social anxiety disorder (compared to anxiety, mood, behavioural and impulse, and substance misuse disorders).

It can clearly be extremely difficult for adolescents with social anxiety to navigate the health system and receive treatment. As clinicians we therefore have two key tasks to improve case identification and assessment. Firstly, it is important to always ask the
young person about social concerns or worries. NICE (2013) suggest the following questions that might be helpful in case identification:

“Do you/does your child get scared about doing things with other people, like talking, eating, going to parties, or other things at school or with friends?”

“Do you/does your child find it difficult to do things when other people are watching, like playing sport, being in plays or concerts, asking or answering questions, reading aloud, or giving talks in class?”

“Do you/does your child ever feel that you/your child can’t do these things or try to get out of them?”

Secondly, when an individual indicates they do have social concerns, it is important we undertake a careful and detailed assessment of social anxiety disorder including a diagnostic assessment.

When young people first present to clinic they receive a diagnostic assessment (in advance of and in addition to the 14-session treatment programme). In addition to creating a warm and empathic environment, the aims of the diagnostic assessment are to:

1. Establish the young person’s main diagnosis
2. Determine the presence of additional (co-morbid) problems and the links between these problems and the main diagnosis
3. Assess for neurodevelopmental difficulties e.g. Autism Spectrum Disorders (ASD), Attention Deficit Hyperactivity Disorder (ADHD), Learning Disability (LD)
4. Assess speech, language, and communication skills
5. Identify physical health problems
6. Assess personal and social functioning
7. Establish the presence of peer victimisation or social ostracism (past/current) and determine school and parental response.
8. Identify educational and occupational goals
9. Establish parent/carer needs (inc. mental health difficulties)
Before the assessment the clinician will review referral documents, correspondence and measures that have been completed in advance (e.g. the DAWBA [see below for description], self and parent report questionnaires). The assessment typically involves seeing the family all together at the beginning, in order to explain the assessment process. Separate adolescent and parent interviews are then undertaken (either in parallel or sequentially, depending on whether there are one or two clinicians undertaking the assessment), supported by standardised semi-structured interview tools. The family are seen together at the end of the assessment to provide feedback, begin the psychoeducation process and share the treatment plan.

3.1. Tools to assess Social Anxiety Disorder

*The Development and Well-Being Assessment (DAWBA)*

The DAWBA (Goodman et al., 2000) is a package of interviews and questionnaires designed to generate ICD-10 and DSM-IV psychiatric diagnoses on 5-17 year olds. It covers the common emotional, behavioural and hyperactive disorders, including social anxiety disorder. The package includes an interview with parents of 5-17 year olds, an interview with 11-17 year olds themselves, and a questionnaire for teachers. The package can be administered in person but can also be delivered effectively via computer. This has the advantage of reducing clinician and family burden and increased convenience for families.

Information from the different informants is drawn together by a computer program that also predicts the likely diagnosis or diagnoses, generating probability bands indicating the likelihood of having a particular diagnosis. These probabilities can be used as a useful starting point to inform the clinician’s face-to-face interview. The DAWBA has been shown to be valid (Goodman et al., 2000).

In our clinic, we ask families (and teachers were possible) to complete the computerised DAWBA in advance of the face-to-face assessment meeting. The assessing clinician(s) will review the information in conjunction with relevant clinical documents and other questionnaires that may have been completed before they meet the family.
Semi-structured interview

Semi-structured interview tools improve diagnostic reliability and accuracy. They are typically comprised of a series of questions that map onto diagnostic criteria (more commonly from the DSM classification system than ICD). The interviews available for use with children and young people include the Diagnostic Interview Schedule for Children – Revised (DISC-R; Shaffer et al. (1993)), the Kiddie Schedule for Affective Disorders and Schizophrenia – Present and Lifetime Versions (K-SADS-PL; Kaufman et al. (1997)), the Diagnostic Interview for Children and Adolescents (DICA; Reich, Welner, and Herjanic (1997)), the Child and Adolescent Psychiatric Assessment (CAPA; Angold, Prendergast, et al. (1995)), and the Anxiety Disorders Interview Schedule for Children (ADIS-C; Silverman and Albano (1996)). All of these interviews include a child and parent component, map onto the DSM-IV classification system and span a wide age range from young children to older adolescents. None except the K-SADS-PL has been revised in response to the new DSM-5 as yet. Otherwise there are many points of distinction amongst them, for example in structure, length, and level of detail of information obtained about the anxiety problem.

We typically use the Anxiety Disorders Interview Schedule for Children and Parents (fourth edition), described in Table 6. We find it useful when assessing young people with suspected social anxiety for the following reasons. Firstly, it provides a detailed and comprehensive assessment of the anxiety disorders. Secondly, it asks a series of questions about the young person’s peer relationships, which is particularly relevant for this population. Thirdly, it opens with a series of ‘warm-up’ questions and is intermediate in structure providing the interviewer opportunity to settle the anxiety we might expect in interviewees.
**Table 6. Anxiety Disorders Interview Schedule for Children and Parents**

<table>
<thead>
<tr>
<th>Description</th>
<th>Anxiety Disorders Interview Schedule for Children and Parents, Fourth Edition (ADIS-C/P; Silverman and Albano (1996))</th>
</tr>
</thead>
<tbody>
<tr>
<td>This consists of two semi-structured interviews (a child version and a parent version) designed to assess anxiety and other childhood disorders in line with the DSM-IV. There is considerable overlap between the two versions, but the parent version also includes sections relating to additional disorders (e.g. ADHD, ODD, CD, and enuresis), and more detailed questions about the history and consequences of particular problems. The child version aims to elicit more information about symptoms and is adapted to be developmentally sensitive (e.g. simpler wording). Screener questions are asked at the start of each section. If the child or parent responds in the affirmative to the screener, questioning continues to obtain further information about symptomatology, including frequency, intensity and interference ratings. These ratings aid the assessor in determining which diagnostic criteria are met for the child.</td>
<td></td>
</tr>
</tbody>
</table>

**Psychometric Properties:**

Recent examination of the ADIS-C/P (for DSM-IV) has yielded acceptable to excellent 7- to 14-day test-retest reliability estimates regarding child (aged 7–16; \( \kappa = 0.61–0.80 \)), parent (\( \kappa = 0.65–1.00 \)), and combined (\( \kappa = 0.62–1.00 \)) diagnoses (Silverman, Saavedra, & Pine, 2001). Interrater agreement for earlier versions of the ADIS have shown greater variability, with some cases reaching the acceptable to excellent range using videotape (\( \kappa = 0.45–0.82 \); Rapee et al., 1994) and live observer paradigms (\( \kappa = 0.35–1.00 \); Silverman and Nelles, 1988). Concurrent validity is good, with high correspondence between ADIS social anxiety diagnoses and social anxiety subscale scores on the Multidimensional Anxiety Scale for Children (MASC; March (1997)) is high (Wood et al., 2002).

**Self and parent report measures**

Self and parent report measures provide a quick method of assessment that affords individuals the opportunity to report on their anxiety from their own perspective. This is particularly relevant for adolescents with internalised social worries, for whom much of the problem may be unobservable. There are numerous self and parent report measures available. Some assess social anxiety solely. Others assess anxiety more generally but include a social anxiety subscale. It is beyond the scope of this book to review each
measure here, but those self-report measures that focus specifically on social anxiety in adolescents are summarised in Table 7.

### Table 7. Adolescent self-report social anxiety measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liebowitz Social Anxiety Scale for Children and Adolescents</td>
<td>Masia-Warner et al. (2003)</td>
</tr>
<tr>
<td>(LSAS-CA)</td>
<td></td>
</tr>
<tr>
<td>Social Phobia Inventory</td>
<td>Connor et al. (2000)</td>
</tr>
<tr>
<td>Social Anxiety Scale for Adolescents (SAS-A)</td>
<td>La Greca and Lopez (1998)</td>
</tr>
</tbody>
</table>

We ask young people and parents to complete a short battery of questionnaires. Young people complete the Liebowitz Social Anxiety Scale for Children and Adolescents (LSAS-CA; Masia-Warner et al. (2003)) as a measure of social anxiety (see Appendix B, p. 261 for LSAS-CA reprinted with permission of the authors). To assess general anxiety and depression we either administer the Revised Child Anxiety and Depression Scale (RCADS; Chorpita et al. (2000)), or the Screen for Anxiety and Related Disorders (SCARED; Birmaher et al. (1999)) and the Mood and Feelings Questionnaire (MFQ; Angold, Costello, et al. (1995)). Parents are given the parent versions of the RCADS or of the SCARED and MFQ. The choice of general measure(s) of anxiety and depression may depend on the particular requirements of the service in which the young person is being treated. Parents are also given the Hospital Anxiety and Depression Scale (HADS; Zigmond and Snaith (1983)) as a quick gauge of their own anxiety and depression levels.

Liebowitz Social Anxiety Scale for Children and Adolescents (LSAS-CA; Masia-Warner et al. (2003))

The LSAS-CA is adapted from the adult scale (Liebowitz, 1987). Young people are presented with a series of 24 situations involving performance or interaction (e.g. writing while being watched). They are asked to rate each situation in two ways. Firstly, in terms of how anxious they would feel in the given situation (from none [0] to severe [3]) and secondly, in terms of how often they would avoid it (from not at all [0] to always...
This yields seven scores: (1) anxiety related to social interaction, (2) performance anxiety, (3) total anxiety, (4) avoidance of social interaction, (5) avoidance of performance situations, (6) total avoidance, and (7) a total score. A total score of 22.5 or more is suggested to be in the clinical range (Masia-Warner et al., 2003). The LSAS-CA was originally designed as a clinician administered tool. It has been used successfully in self-report version in French (Schmits, Heeren, & Quertemont, 2014) and Spanish (Olivares, Sánchez-García, & López-Pina, 2009). We use it in this format in our clinic.

3.2. Initial family meeting

In the initial meeting with the family, ask everyone to introduce him or herself and then give a description of your clinic. Explain to the family what they can expect from the day: how long the meeting will last, the structure, and when they will have a break. It can be helpful to explain that there will be lots of questions, but it is really important and helpful for us to get as much information as possible. Thank the family for completing the DAWBA and other questionnaires in advance if they have done so and explain that you have reviewed this important information carefully. Explain to the family the referral pathway to the clinic, and then ask them openly and curiously what has brought them to the assessment. Try to elicit a shared list of presenting problems and history of presenting problems from the family at this point.

3.3. Young person meeting

Explain to the young person that you will be asking more about some of the things that they are finding difficult, but first you would like to get to know a bit more about them. Ask about their family, interests, hobbies, extra-curricular activities, and experience of school. This gives the young person time to warm up. We then undertake the ADIS-C with the young person in order to establish the main diagnosis and the presence of any additional (co-morbid) disorders that might also require treatment. Once the diagnostic interview has finished, ensure there is sufficient time for the young person to ask any questions they may have. It can also be a useful time to ask the ‘magic wand’ question: what change could make the biggest difference to their life right now? This is useful in assessing insight into their difficulties, the leading diagnosis where there is comorbidity, and motivation to change. Ask about previous experiences of treatment and
what has been more or less helpful. Many young people will have had treatment failure in
the past and therefore it will be important to identify what they received and in what way
any new treatment regime will differ.

3.4. Parent(s) meeting

During the interview with the parent(s) we undertake the parent version of the
ADIS to determine the young person’s diagnoses. In addition it is important to take a full
developmental, medical, personal, school/academic and family history.

3.5. Concluding family meeting

At the end of these interviews and usually after a short break, there is a final
meeting with the family altogether. The feedback given to the family should include: a
working diagnostic formulation (explaining primary and secondary problems, their
development, onset, maintenance, and protective factors); an explanation of any further
assessments that may be required (e.g. cognitive assessment, information from school,
screening for autism); treatment recommendations, include reference to the evidence
base; and a plan. There should be opportunity for the family to ask questions and respond
to the feedback.
CHAPTER 4. CASE FORMULATION AND GETTING STARTED

Session 1 of the treatment programme is aimed at providing a much more detailed assessment of the young person’s social anxiety problems. The session has the following aims:

1. Establish a good, supportive working relationship with the young person and parents.
2. Obtain a detailed account of the current social anxiety problem and how it developed.
3. Introduce the young person to the measures that will be used to monitor progress.
4. Provide information about social anxiety and cognitive therapy.
5. Set treatment goals.
6. Develop an individualized version of the cognitive model that will be used as a guide to treatment.

A camcorder, set up discreetly in the clinic room, should be prepared before the session. It is placed at right angles to the therapist and adolescent’s eye line so it is not in the normal field of view. Ensure that the video is set up to record the whole interaction, that is, both therapist and young person. At the beginning of Session 1 explain that as part of the treatment all sessions are videotaped so that the therapist can review sessions afterwards and ensure good quality treatment. It is explained that this is routine procedure for all young people and the video will not be shared beyond the clinical team. We seek written consent from parents and young people. Once permission for the recordings has been obtained, video material can be used for video feedback, a core component of CT-SAD-A, later in therapy. We also encourage adolescents to take audio recordings of the sessions for them to review afterwards, as we find this is a very good way of maximizing learning.
4.1. Establishing a good working relationship

Adolescents with social anxiety pose particular problems for the therapeutic relationship. Therapy is itself a social interaction. For this reason, in the early stages of treatment socially anxious adolescents may behave in therapy sessions in ways which are similar to how they behave in other feared social situations.

First, some young people may appear withdrawn, uninterested, or dismissive. It is important that the therapist does not take offence or personalise these behaviours. Instead they should be viewed as the observable side of the adolescent’s safety behaviours and as dysfunctional, fear-driven, self-presentation manoeuvres. For example, a young person who is afraid of showing anxiety because it may be viewed as a sign of weakness might appear distant and cold.

Second, increasing the intensity of social interaction in a therapy session may produce more mental blanks and enhance the young person’s self-consciousness. This is particularly relevant in the clinical interview and the first few therapy sessions when the therapist is trying to obtain detailed information about the things the adolescent thinks might happen in feared social situations in order to develop an individualized version of the cognitive model and to target the treatment procedures. Because adolescents with social anxiety habitually process felt sense, they can initially find it difficult to specify what would be so bad about blushing, shaking, sweating, making a mistake etc. Usually when a young person is having difficulty accessing a thought and appears to be anxious while doing so, cognitive therapists tend to lean forward in their seats, look at the young person more directly and adopt a warm, empathic stance. This response can make adolescents with social phobia feel even more self-conscious and block their thinking. For this reason, therapists need to be sensitive to eye contact and perhaps reduce eye contact at such moments in order to help the young person feel less self-conscious and scrutinized. Working with a whiteboard can be particularly helpful in this context and we would recommend that the individualized version of the cognitive model is always developed on a whiteboard or on a large sheet of paper that therapist and young person can simultaneously view.
4.2. Reviewing standardized questionnaires

Much of the information needed for developing a clear picture of the current social anxiety problem can be obtained from standardized questionnaires and we would strongly recommend their use. Therapists are encouraged to spend 30 minutes or so reviewing the questionnaires before the start of the interview in Session 1. Table 8 lists the questionnaire that we have found particularly useful. These questionnaires are all reproduced in Appendix B (see p. 261). They are not a substitute for a good clinical interview but rather are used as guides to help focus questioning in the interview. To facilitate this, we find it useful to summarize the information from the questionnaires on a sheet of paper under the headings: feared situations, avoided situations, negative thoughts (worst fears), safety behaviours. In this way, it is possible to save a considerable amount of time in the initial interview. A further advantage of the questionnaires is that some young people find it easier to first identify their thoughts and safety behaviours when completing the questionnaires alone than in a face-to-face interview where they are likely to feel more self-conscious.

Table 8. Standardized questionnaires that are useful for collecting information in advance of the clinical interview

<table>
<thead>
<tr>
<th>Questionnaire</th>
<th>What it assesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Report</td>
<td></td>
</tr>
<tr>
<td>LSAS-CA</td>
<td>Fear and avoided social situations</td>
</tr>
<tr>
<td>Social Phobia Weekly Summary Scale</td>
<td>Social anxiety, social avoidance, self-focused</td>
</tr>
<tr>
<td></td>
<td>versus external attention, anticipatory processing, and post-event rumination</td>
</tr>
<tr>
<td>Social Cognitions Questionnaire</td>
<td>Negative thoughts in feared social situations</td>
</tr>
<tr>
<td>Social Behaviours Questionnaire</td>
<td>Safety behaviours</td>
</tr>
<tr>
<td>Social Attitudes Questionnaire</td>
<td>Problematic beliefs about social behaviour, social situations and patient’s evaluations of their social self. Beliefs fall into three categories: excessively high standards,</td>
</tr>
</tbody>
</table>
4.3. **Description of the current social anxiety problem**

After asking the adolescent to briefly summarise the current problem as he/she sees it, the adolescent is asked a series of questions to help expand on and clarify the details that have been gathered from the questionnaires. Table 9 summarizes the main information that will be needed for treatment planning.

**Table 9. Summary of information to be covered in the clinical interview**

<table>
<thead>
<tr>
<th>Description of Current Social Anxiety Problem.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Situational Anxiety</td>
</tr>
<tr>
<td>1.1. Feared Social Situations and Avoided Social Situations</td>
</tr>
<tr>
<td>1.2. Negative automatic thoughts</td>
</tr>
<tr>
<td>1.3. Anxiety Symptoms</td>
</tr>
<tr>
<td>1.4. Focus of attention</td>
</tr>
<tr>
<td>1.5. Content of self-image/impression</td>
</tr>
<tr>
<td>1.6. Safety Behaviours</td>
</tr>
<tr>
<td>1.7. Anticipatory Processing</td>
</tr>
<tr>
<td>2. Concentration (0-100)</td>
</tr>
<tr>
<td>2.1. Ability to concentrate in the classroom over the last week</td>
</tr>
<tr>
<td>3. Social Participation &amp; Satisfaction</td>
</tr>
<tr>
<td>3.1. Participation in a range of social activities and satisfaction with social relationships.</td>
</tr>
<tr>
<td>4. RCADS-C</td>
</tr>
<tr>
<td>4.1. General anxiety and depressed mood</td>
</tr>
<tr>
<td>5. RCADS-P</td>
</tr>
<tr>
<td>5.1. General anxiety and depressed mood</td>
</tr>
</tbody>
</table>

2. Clark et al. (2003) Adolescent version reproduced in Appendix B.
6. Alden and Taylor Reproduced in Appendix B.
7. Chorpita et al. (2000)
1.8. Post-event processing

2. Social Network, Peer Victimisation

3. School Functioning (attendance, attainment)

4. Medication, Alcohol and Recreational Drug Use

5. Problematic social beliefs

<table>
<thead>
<tr>
<th>Development and course of the problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Treatment (types, whether successful)</td>
</tr>
<tr>
<td>Beliefs about what can be changed (treatability)</td>
</tr>
<tr>
<td>Co-morbidity (and the magic wand question)</td>
</tr>
<tr>
<td>Family structure</td>
</tr>
<tr>
<td>Goals for treatment</td>
</tr>
<tr>
<td>Develop individualised version of the cognitive model</td>
</tr>
</tbody>
</table>

Feared social situations and avoided situations

A list of feared and avoided situations is required to identify the extent to which social anxiety interferes with a young person’s life. Inspection of the LSAS-CA provides a preliminary assessment of situational fear and avoidance, which can be supplemented by asking:

“What are the main types of social situations that make you feel anxious?”

“Do you avoid (specify the situation) or ‘grit your teeth and bear it’?”

“I see from the questionnaires that you find (read out the list of situations) make(s) you feel anxious. Are there any other social situations that make you feel anxious that we have missed out?”

Contextual factors that make a situation more or less manageable should also be assessed. Examples are: an event being formal versus informal; the presence or absence of people that the young person knows; a pre-planned event versus a spontaneous event; light versus dark rooms (symptoms such as sweating and blushing may be less visible in the latter); and hot versus cool rooms (sweating and blushing may be more feared in one than the other. Which is more feared varies from person to person. If the greatest fear is whether or not one blushes or sweats, a hot room may be more aversive. If the greatest
fear is what people might think about one’s sweating or blushing, a cold room might be more feared as sweating or blushing may seem less explicable in a cold room).

**Negative automatic thoughts**

Once a feared situation has been identified, the next step is to identify the young person’s negative thoughts, that is to say, what they fear might happen (e.g., “I’ll blush”, “I’ll shake”, “I’ll sound stupid”) and what such things would mean if they did happen (“People will think I am weird”). Inspection of the adolescent’s completed Social Cognitions Questionnaire provides good leads. In the early part of the interview, further identification of thoughts is relatively brief and aims to give the therapist a more comprehensive impression of the key cognitive themes. More detailed thought identification occurs later in the interview when a specific situation, or set of situations, is discussed in detail in order to elicit an individualised version of the cognitive model.

Some particularly useful questions for identifying negative automatic thoughts during the interview are given below:

- *What went through your mind?*
  - *What were you thinking*
    - before you entered the situation?
    - as you entered the situation?
    - as you noticed X symptom?
- *What was the worse that you thought could happen?*
- *What did you think people would notice/think?*
- *What would that mean? What would be so bad about that?*

Although some young people are able to access their negative thoughts quite quickly, we often find that they will initially indicate that their main fear is that they will feel embarrassed. As they tend to focus on how they feel in social situations embarrassment is the thing that is most easily remembered. Additional questioning is required to help them identify the specific thoughts (e.g., “I look weird”, “people can see I am anxious”, “I am making a fool of myself”) that underlie the embarrassment.
Anxiety symptoms

Helpful questions for identifying the anxiety symptoms that are triggered by negative thoughts in social situations are:

- *When you think* (specify negative automatic thought), *how does that make you feel?*
- *Do you become more anxious/scared?*
- *What do you notice happening in your body as you become more anxious/scared?*
- *What sensations do you feel in your body?*
- *What do you notice in your body?*

Adolescents with social anxiety tend to be more concerned about anxious symptoms that they think other people might be able to see (e.g. blushing, trembling, sweating) than symptoms that cannot be observed (e.g. increased heart rate). Once a list of anxiety symptoms has been elicited, it can be helpful to ask the young person to specify which symptoms are most feared and to identify the thoughts associated with those symptoms (e.g., “people will think it weird for me to sweat when it’s not a hot day and I’m just talking to them”).

Focus of attention

Helpful questions for identifying the increase in self-focussed attention and self-monitoring that occurs in anxiety provoking situations are:

- *When you are afraid* (specify feared catastrophe) *will happen, what happens to your attention?*
- *Do you become self-conscious?*
- *Do you start focussing your attention on yourself and how you think you might appear?*
- *Are you monitoring/checking how you think you come across?*
- *Are you more or less aware of what other people are doing right then?*
- *Do you get caught up in your head?*
- *Do you feel separate from the people around you?*
Contents of self-image/impression

Once the shift to increased self-focussed attention has been identified, the contents of the young person’s self-image/impression can be elicited by asking questions such as:

- As you focus your attention on yourself, what do you notice?
- Do you have an image of yourself?
- Do you have a picture in your mind’s eye of what you look like?
- Do you have an image of how you think you appear?
- How do you feel that you appear?
- Do you have an impression/sense of how you feel you are coming across?
- If you had not done (specify a safety behaviour), how would you look to others?
- At the moment when you are trying to hide your symptoms (specify particular feared symptoms), how do you think you look to others?

The general aim of all of these questions is to elicit the young person’s impressions of how they think they appear to others, based on their self-focus and self-observation. If the young person is finding it difficult they can be asked to close their eyes and recall a recent time when they felt socially anxious and to describe the image that accompanied it. Sometimes, specific visual images are elicited (e.g. seeing oneself with terrified looking eyes and white globules of sweat on the forehead). At other times a more general impression of how one appears or a felt sense might be elicited (e.g., feeling distant and apart from people you are with and interpreting the feeling as evidence that you don’t fit in/ are not accepted by them). When somebody identifies an impression rather than an image, asking them to capture that impression and then paint it as if painting a picture is usually effective in generating a clearer image.

Safety behaviours

Safety behaviours are defined as behaviours or mental operations that are intended to prevent or minimalise a particular feared catastrophe. For this reason, questioning about safety behaviours needs to take into account adolescents’ particular
negative thoughts. Remember to specifically ask about mental operations as well as behaviours you might observe. Impression management strategies, for example rehearsing conversations, preparing topics of conversation in advance, keeping a tight control of one’s behaviour and trying to ‘act normal’, should also be explicitly probed for as they are often less easy to spot than avoidance safety behaviours on observation.

Useful question for eliciting safety behaviours include:

- When you thought (specify feared outcome) might happen/was happening, did you do anything to try to stop it from happening? Did you do anything to try and prevent people from noticing.
- Is there anything you do to try and make sure you come across well?
- Do you try to put on a “front”. For example, trying to appear more in control/smart/calm than you feel? How do you do that?
- Do you do anything to avoid drawing attention to yourself?
- Do you monitor/check how you are coming across? Do you try to work out how you are coming across?

As young peoples’ safety behaviours are often fairly automatic habits, young people can forget to mention some safety behaviours when asked the questions above in the interview. For this reason, it is helpful for the therapist to have the young person’s completed Social Behaviours Questionnaire in front of him/her when asking the questions. Often young people have endorsed an item on the questionnaire that they would not have spontaneously mentioned.

Anticipatory processing

Prior to a social event adolescents with social anxiety will review in detail what they think might happen. As they start to think about the event, they become anxious and their thoughts tend to be dominated by recollections of past failures, by negative images of themselves during the event, and by other predictions of poor performance and rejection. It is therefore important to ask the young person how they typically think about social situations before they occur, with questions such as:
- When you have a social event coming up, do you tend to think about it in advance/ahead of time?
- Do you tend to go over and over the event in your mind?
- What kinds of thoughts do you have?
- Do you find yourself remembering things that have happened in the past? What are these like?

Post-event processing

After social interactions, young people commonly undertake a “post-mortem” of the event. The interaction is reviewed in detail. During this review, the adolescent’s anxious feelings and negative self-perception are likely to figure particularly prominently. Useful questions for identifying post-event processing include:
- After the event do you tend to go over and over the event in your mind?
- Do you find yourself replaying what went on in lots of detail?
- What kinds of thoughts do you have?
- Do you find yourself remembering things from the past? What are these like?

Social network, peer victimisation and bullying

Young people with social anxiety commonly avoid peer interactions and are more likely to experience peer rejection and bullying. The therapist should seek to understand the young person’s social relationships and whether the young person is satisfied with them as they are. Do they have some friends? Do they have a best friend, a peer group? Are these relationships in or out of school? If they do have friends, what is the quality of these relationships? For example:
- Can you rely on your friends?
- Do you have friends you would turn to for help, or if you were upset?
- Are there arguments or fall-outs in your friendship groups?
- Are there friends you would like to spend more time with or get to know better? If so, what is holding you back at the moment?
The therapist should ensure they ask about peer victimisation and bullying that the young person may be experiencing. Is the young person being excluded from their peer group or victimised in other ways? Are they currently experiencing bullying and if so, what form is this taking? Is it verbal or physical, in person or online? Do not assume it is not occurring if the young person does not report it spontaneously. Adolescents are often ashamed about being victimised or excluded by their peers and so demonstrate reluctance to talk about it with others.

Does anyone else know that the young person suffers from social anxiety? If the answer to the latter question is, “No”, the therapist may wish to remember this point for later discussions of the adolescent’s beliefs about how visible their anxiety is to other people.

**School functioning**

School can be a particularly challenging environment for young people with social anxiety. Whilst it is not uncommon for young people with social anxiety to conceal symptoms in school, aspects of school functioning and attendance are often affected. This can manifest as refusal or reluctance to attend school, or difficulty transitioning from home to school. Young people may spend excessive time in the nurse’s room or in the library or computer room. Obtain an accurate attendance record (these figures are updated by schools on an on-going basis and given to parents routinely) and assess the proportion of classes they are attending. If there are certain classes that are being avoided or endured with more distress than others, try to identify what is particularly difficult about them (e.g. more involuntary pupil participation, more group work). Socially anxious youth may also avoid extra-curricular activities. Try to ascertain which situations are particularly anxiety-provoking at school to target in future behavioural experiments. We also want to assess whether the young person’s academic functioning: what is their academic attainment at present for example recent exam or coursework marks; is this in line with expectations? A crowded classroom can make socially anxious youths self-conscious, making it difficult for them to follow what the teacher says, and consequently undermine academic performance.
Family structure and relationships

The family responses to an adolescent’s social anxiety can inadvertently maintain the problem and may interfere with treatment. It is therefore important to assess this early on. Begin by learning about the family structure from the young person: who is in the family home; are there other relatives living elsewhere who are important; are there other people in the young person’s close circle (such as family friends) who are important to them. We then want to get a quick understanding of the quality of these relationships, for example how close and how positive they are perceived to be.

Questions might include:

- How often do you see ‘x’?
- What things do you do together?
- How well do you generally get along?
- Are you able to talk about problems and personal things with ‘x’?
- How close are you to ‘x’?
- Would you like to be closer to them? If so, what gets in the way?

Then the therapist can ask the young person how the key relatives (most typically parents) respond and react in situations in advance of, during and after anxiety-inducing situations. This will help to inform the role of parental beliefs and behaviours in the adolescent’s social anxiety.

Prescribed medication, alcohol, and recreational drug use

Some young people have already been started on prescribed medications (such as selective serotonin reuptake inhibitors) when they are referred for psychological treatment. If they are continuing to experience marked social anxiety, we will liaise closely with the prescribing Child & Adolescent Psychiatrist and typically medication will be continued at the same dose until the young person has developed confidence that they can deal with their social anxiety through psychological means. Once this has happened, most adolescents and parents are keen to gradually withdraw from their medication. In the rare situation where prescribed medication (such as benzodiazepines) is being taken on a situation-by-situation basis and very little social anxiety is being
experienced, it is often helpful to encourage young people to resist taking medication before entering a feared social situation in order to help them learn more about how to deal with their anxiety. We would not normally advise starting a new medication during a course of cognitive therapy as this is likely to undermine adolescents’ ability to discover that they are acceptable as they are, which is one of the main aims of the treatment. However, if after an adequate course of cognitive therapy (say 8 – 10 sessions) there has been very little improvement, one of the treatment options that might be considered in routine clinical practice (as opposed to clinical trials) is combining cognitive therapy and medication. This decision would only be made after a review with a psychiatrist and if this is pursued, particular attention needs to be paid to developing a rationale for the combined treatment that does not undermine either approach.

Some adolescents with social anxiety use alcohol to help control their social anxiety (for example they may have a drink in order to be able to go to a party or gathering). Recreational drugs can be taken for similar reasons. As treatment progresses, young people need to be encouraged to reduce their alcohol and recreational drug use in order to help them discover that they can be accepted in social situations without such props.

Problemsocial beliefs

Inspection of the Social Attitudes Questionnaire provides invaluable information about problematic beliefs that may make an individual vulnerable to experiencing social anxiety in particular situations. The questionnaire covers excessively high standards (e.g. “I must not show signs of weakness to others”, “I must appear intelligent and witty”), conditional beliefs (“If people see I am anxious they will humiliate, ridicule and discount me” and “If people look at me it means they are thinking negative things about me”) and unconditional beliefs/core assumptions (e.g. “I am a boring person”, “I am odd/peculiar”). Once the therapist has reviewed the questionnaires relatively brief questioning can be used to clarify the particular meaning of endorsed beliefs for the adolescent and also identify any additional assumptions. Further assumptions are likely to be revealed during the course of therapy when treatment focuses on particular social situations and the reasons why a young person finds them difficult.
Development and course of the problem

The circumstances surrounding the onset of social phobia and the way in which the disorder has fluctuated during its course should be briefly reviewed. Some adolescents report that they have always felt shy and cannot identify any particular events linked to a worsening of their anxiety. However, most adolescents are able to identify some early experiences which either exacerbated a long-standing tendency to be shy or triggered social evaluative concerns when they had not previously been anxious. Bullying at school, criticism by parents, teachers, or peers; exclusion from an “in” group; a moment of intense embarrassment (e.g. blushing while reading a poem out loud); and modelling of social evaluative concerns by a parent are common events linked to onset. Once an event has been identified, it can be useful to see whether the young person developed a negative self-image at around that time. As outlined earlier, Hackmann, Clark, and McManus (2000) found in an interview study that many of the self-images that adults with social phobia experience in social situations are linked to memories of adverse social events that clustered around the time of the disorder. Identifying such links can be helpful as it allows adolescents to see that their current view of their social self may be distorted in the sense that it is a memory of an earlier self-perception that has not been updated in the light of experience.

Previous treatment

Prior treatment should be assessed in order to identify expectations about therapy. For example, adolescents who have received psychodynamic treatment or medication only treatment may need more extensive socialisation into the active problem-solving orientation of cognitive therapy, including the extensive use of homework assignments.

Beliefs about what can be changed (treatability)

Some adolescents feel that social anxiety is an aspect of their personality and that personality cannot be changed. For such individuals, therapy is unlikely to be successful unless there has been a preliminary discussion of the fact that cognitive therapy works with individuals who have experienced social anxiety from very early childhood.
**Co-morbidity**

Comorbidity with other psychiatric disorders is common in social anxiety disorder. If a co-morbid disorder was identified in the intake diagnostic interview, therapists should try to determine whether the co-morbid disorder is functionally linked to the social phobia or independent. Clarifying historical patterns (e.g. which disorder started first?, has one disorder persisted even when the other was in remission?, has worsening of one disorder tended to be associated with a worsening or improvement of the other?) is often helpful.

Another particularly useful question is the “magic wand question”. Once two conditions have been identified (say social phobia and depression) the therapist asks: “Imagine I had a magic wand which would allow me to completely remove your social anxiety. If that happened do you think you would still be depressed in a way that needed professional help?” If adolescents reply NO, they are usually correct, their depression is secondary to the social phobia and largely resolved with successful treatment of social phobia. If young people reply YES, additional treatment focussing on the depression should be planned. In cases where depression and social anxiety are perceived to be equally problematic, it is usually better to begin by treating the social anxiety first because treatment outcomes for social anxiety are more favourable than those for depression. Depression symptoms are monitored throughout and additional treatment for depression can be provided at the end of CT-SAD-A should symptoms persist. In cases where depression is very severe (and impedes engagement in CT-SAD-A) or the young person views depression as the primary problem, it may be necessary to provide a discrete NICE (2015) recommended intervention for depression before moving onto CT-SAD-A.

For a more detailed discussion of comorbidity, see Chapter 14 (p. 239).

**Goals of treatment**

Before therapy starts, it is important to agree a set of goals that therapist and young person can work towards. In order to monitor progress, it is important for the goals to be as specific as possible. Goals also need to be realistic in the sense that they do not
represent an impossible standard (for example, “to never feel anxious in a social situation”), a feat that is perhaps only achievable by a psychopath or a dead body). We often ask young people to identify short-, medium- and long-term goals. Short-term goals are what we might hope to achieve in four to six weeks; medium-term goals in three to four months; and long-term goals in six to 12 months (Goal Sheet in Appendix D).

As treatment progresses it is important to return to the goals that the young person set. We will usually review the goals worksheet once or twice during therapy. This is for three main reasons. First, young people have told us that returning to goals and ticking off those that have been achieved is a powerful motivator to persist with treatment and undertake more challenging behavioural experiments. Second, some young people find it difficult to identify long-term goals at the beginning of treatment. As they experience some symptom relief and improvement in functioning it is often easier to specify these longer-term aims. Third, goals often change through treatment, for example goals that were rated as long-term may be achieved earlier than anticipated. Reviewing the goals mid-way through treatment provides an opportunity for the therapist and young person to amend the worksheet and add new goals if they are identified.

Interestingly, clarifying goals alone at the start of treatment can have some therapeutic value because it may help a young person to identify distortions. The transcript below briefly illustrates goal setting.

Therapist What would be your goals for therapy?

Patient To overcome the social anxiety. I know I’ll never get over it completely but I’d like to stop feeling anxious with everything I do.

T OK, so to be less anxious in social situations (summary). I think you are very perceptive to think you will never get rid of the anxiety completely. In fact, we would say that if someone wants to get rid of it completely, we would call that a “dead man’s goal”. It is something you can only achieve if you are dead. For most of us, some anxiety is common, including at times anxiety about meeting people and expressing one’s point of view. However, it is manageable and doesn’t prevent them from
doing what they want to do. So, if you were to reduce your social anxiety, what things would you hope to be able to do that you can’t currently do?

P Give a presentation at college and have people understand what I have been working on. Normally, my mind goes blank and I can’t express myself.

T Give a presentation. Anything else?

P Going out dating and that sort of thing.

T OK. Any more day-to-day social activities as well? Do your fellow students tend to have lunch together?

P Yes. I sometimes go along but I just sit in the corner and feel self-conscious.

T So, another goal might be to join in the lunchtime conversation and eventually enjoy it?

P Yes, definitely.

T I say “eventually” enjoy it, because at the start of therapy confronting fears can be stressful but as you learn more the fear declines and fun can take it’s place. Anything else? Anything we’ve missed? So far we’ve got (summarizes): to be generally less anxious in social situations; to give presentations which clearly convey what you think about a topic even if you are feeling somewhat anxious: to ask people out for a date and go on dates; and to talk with other students over lunch. If we could achieve those would you be a happy person?

P Yes.

4.4. Deriving an individualised version of the cognitive model

The assessment interview usually concludes by deriving an individualised version of the cognitive model with the young person. This is used to guide treatment and help the young person understand why they are anxious in social situations and why the anxiety persists.
An anxiety provoking social situation is identified (e.g., joining a table in the lunch hall, answering a question in class, eating in restaurants, going to a party, etc.) and recent examples of that situation are reviewed in order to identify negative thoughts, anxious feelings, safety behaviours, the focus of attention and the contents of the self-image. Occasionally, more than one example of the problematic situation/task needs to be reviewed because the young person’s avoidance/escape means that not all of the processes in the model were activated on every occasion. Sometimes adolescents have marked difficulty recollecting key information required for the model. For these young people, it can be useful to use role-play to create an analogue of the feared situation in the clinic in order to identify all the key information. For example, someone who has difficulty with public speaking might be asked to stand up and give a brief impromptu presentation.

We would recommend developing the model in an interactive fashion using a whiteboard or a large sheet of paper that can be seen by both the therapist and the young person. There are three reasons for using a white board or large sheet of paper. First, the model makes quite subtle distinctions between different aspects of social anxiety. If the adolescent and therapist are both looking at the same evolving diagram it is easier for the young person to understand what type of information is being requested at different stages. Second, the active writing on the board slows things down, making it easier for adolescents to break down global experiences (such as feeling embarrassed) into the specific elements in the model (e.g., negative thoughts, anxious feelings, self-consciousness) and to start to see the links between the elements. Third, writing on the board is a good way of helping the adolescent feel more comfortable when discussing the problem because it feels less like being interrogated by the therapist. Instead, there is a feeling that both young person and therapist are looking at something outside the adolescent, the problem on the whiteboard. In this way, self-consciousness is reduced.

Once a feared situation has been identified, the first step is to identify the young person’s thoughts in that situation, that is to say, what they fear might happen and what these things would mean if they did happen. Key questions for identifying negative thoughts are given above. As adolescents sometimes have difficulty in identifying thoughts, this step should be taken slowly. Once the young person’s key negative
thoughts have been identified, the three elements that follow from the negative thoughts (anxious feelings, negative self-image/impression and safety behaviours) can be identified. Questions for identifying each of the other elements in the model are also outlined above. It is important that therapists draw on the whiteboard arrows from negative automatic thoughts to anxious feelings, to the negative self-image/impression and to safety behaviours as each are identified. The arrows that go backwards from these processes to negative automatic thoughts can be developed as follows:

For the arrow from self-image/impression:

“As you notice the picture in your mind (describe the adolescent’s negative self-image) does that make you more or less certain that (specify feared outcome) will happen/is happening?”

For the arrow from anxious feelings to self-image/impression and then negative thoughts:

“When you notice yourself feeling (specify feared anxiety symptoms) how did that affect the way you saw yourself?”

“As you became aware of (specify feared symptoms) what did that do to your fear that (specify negative thought)? Did you become more or less sure that (specify catastrophe)?”

For the arrow back from safety behaviours to self-image/impression the most helpful questions capitalise on the fact that performing many of the safety behaviours increases self-monitoring and self-focus. As a consequence, the safety behaviours make young people more aware of their negative self-impression and negative self-judgements. Given this point a useful set of question is:

“As you (specify safety behaviours) does that make you more or less self-conscious?”

The process of developing an individualised version of the cognitive model using the questions that we have outlined is illustrated in the following (abbreviated) transcript with a young adult. The model that was being developed on the whiteboard is shown in Figure 7. Notice the therapist’s repeated encouragements, the frequent use of summaries, the high level of detail, and the fact that it takes quite a few questions before the young person is able to fully identify his key thoughts.
Therapist starts by identifying a suitable situation

Therapist: *What we want to do now is try to work out what happens when you get anxious in a social situation. I want to focus on a situation that happened recently where you got pretty anxious but stayed in the situation for a while. Can you think of a situation?*

Patient: *There was a time last week. One of the students was leaving. Everyone went into the seminar room and she was given the leaving presents. There were loads of people in the room. I got really, really anxious. It was alright to start off with but I suppose it was all the laughing and the joking and it got really, really bad.*

T: *OK. Well, let’s see if we can work out together what was going on. Do you want to take a seat so you can see the whiteboard? I’ll write things out as we discover them and you can correct me if I get anything wrong. So the situation was someone was leaving. Who was leaving?*

P: *Alice*

Therapist probes for the young person’s negative thoughts in the situation.

T: *You were in the room with lots of other people. As you started to feel uncomfortable, what sort of thoughts went through your mind? What was the worst that you thought might happen?*

P: *“People will notice”*
Figure 7 Example of a personalised version of the model with a young man
T (repeats back the thought to prime more thoughts) People will notice

P “People will ask me something, or the attention might go on me”.

T So, “attention might go on me”. OK and that could be because they ask me something or they just notice me in some other way? And if that happens, what would be bad about that?

P Everyone would look, I would be the centre of attention.

T OK, “everyone will look”. And what were you afraid they would see?

P The anxiety and embarrassment

T So, one of the thoughts is, “They will see I am anxious and embarrassed”. Great, well done. Any other negative thoughts? If they did see that you were anxious and embarrassed, what would that mean?

P “I’ll look stupid”.

T OK, (summarizes) “They will see I am anxious and embarrassed, I’ll look stupid”. Do you have any thoughts about what they might be thinking if they see you anxious and embarrassed?

P “What’s up with him, what’s his problem?”

T “What is his problem?” That’s a sort of question. When they are asking themselves that question, what sort of answers do you think might be in their mind?

P I don’t think I will be able to answer that question.

T So they are thinking, “What’s his problem?” Might they be thinking, “He’s Einstein?”

P No, why do you say that?

T I said, “He’s Einstein”, because some people might say, he is different, he is a genius. It doesn’t sound as if that is going through your mind?

P I don’t think they would know what was up with me. Unless they knew about social phobia.

T So, they would just be puzzled? Or would it be more negative? Would they think badly of you?

P Yes, I think so. They wouldn’t take me seriously. I suppose, “They would think I am not as good as them”.

85
Great. That’s very good. It can be difficult to spot ones thoughts but you’ve managed to get hold of quite a number.

Therapist establishes the link from negative thoughts to anxious feelings

(points at the thoughts on the whiteboard) As you have the thoughts, “Attention might go on me. Everyone will look. They will see I am anxious and embarrassed. They will think, ‘what is his problem’. They will think, ‘I am inferior’”. How does that make you feel? Do you start to feel anxious?

Yeah, it makes me feel worse.

I’ll write ANXIOUS here (writes on whiteboard and draws and arrow from Thoughts to Anxious). How do you feel the anxiety, what do you notice happening in your body? Do you notice things happening in your body at the moment?

Yeah, I feel as if I am blushing and twitching (young person points to his mouth).

OK, so you feel a blush and twitching round mouth. Anything else? Do you feel as though you are sweating?

I feel hot.

Hot. Do you also feel your heart racing?

A little bit, it feels as if it is racing but not pounding

So that’s not something that worries you very much?

No

Do you get your stomach churning?

Yeah, I feel sick

Anything else? Do you feel dizzy?

No.

And the things in this list that you find particularly upsetting are the first two (blushing and mouth twitching), is that right?

Yeah
So it is the things that you think other people might be able to notice that are particularly upsetting?

Yeah

OK so we will mark them stars.

Therapist introduces the concept of safety behaviours and establishes the link between negative thoughts and safety behaviours.

When people are worried that something bad might happen, they often do things to try to stop it from happening or to make it less serious. We call these safety behaviours because they are things you do to try and make yourself safe. (Therapist writes term ‘safety behaviours’ on the board and draws an arrow from ‘thoughts’ to safety behaviours). What sort of things would you do in this situation to try to stop attention coming to you? (therapist points to the first thought on the whiteboard).

I wouldn’t say anything.

OK and the reason for that is so not to attract attention?

Yeah

And is that what you did on this occasion?

Yeah

Any other things that you do?

Yeah, I try to hide behind others if there are other people.

Anything else?

I don’t look at people.

What do you look at instead? Do you put your head down or do you just stare straight ahead?

I’m not really concentrating on what I am looking at, I am just concentrating on my thoughts.

So another thing you are doing is concentrating on yourself. Could we call that “becoming self-conscious” – is that the right term for you?

Yeah
Sounds like you are saying your attention shifts from other people onto yourself?

Yeah.

We are going to come back to self-consciousness later because as you will see it is very important. It’s good that you spotted that. Now, if we go back to the thought that other people might see that you are anxious, is there anything you do to hide the signs of anxiety. What about the blushing and the trembling about your mouth?

I put my hand over my mouth and cheeks.

I guess that is to try to hide the blushing and trembling? Do you also do anything to try to control them?

I try to stop the twitching but it doesn’t work. Loads of times I have tried to think of other things, good things or whatever.

So you try to control the symptoms by distracting yourself, but it doesn’t generally work. Did you also speak at all on this occasion?

I spoke to a few people at first when the anxiety wasn’t bad but not after that.

Now because we want this diagram to be a bit more in general than this particular event, can I ask you to think about being in a similar situation but also speaking a bit when you are anxious? Is there is anything you would do while you were speaking to make you sound less stupid? Any sort of strategies you have to do that?

Do you mean think about what I am going to say?

Yes, that’s a good one, think about what you are going to say. When you do that, what are you trying to decide? Is it whether what you will say sounds interesting enough?

Yes, but also will it offend people. I’m scared to say anything that might offend.

OK. So we’ll write on the board, “Evaluate what I am about to say. ‘Is it good enough?’ ‘Will it offend people?’”. Do you also check how you are coming across, while you are talking?
What, by observing other people?

I was wondering how you might check. I guess there are lots of ways people might do it. Some people might say: I’m listening to myself, I am trying to visualise what I look like. Other people might say: I observe other people but I don’t do that much because I am also looking away from them.

Yeah, it’s as if I have made up my mind that is how I am. I look stupid.

So you are sort of telling yourself, “I look stupid” and are not really checking out other people’s reactions much?

Yeah

Any other safety behaviours we’ve missed out?

Avoid the situation completely.

Therapist returns to self-consciousness and identifies the contents of the young person’s self-image and self-impression.

Earlier you mentioned that when you think that other people will see you are anxious and think you are stupid, you become very self-conscious. Your attention is focussed more on yourself than on others. As your attention focuses on yourself, what sort of things are you aware of?

Physical symptoms, particularly the blushing and trembling.

OK, so you are very aware of the feelings we’ve marked with asterisks. What is your impression of how you appear?

I appear humiliated and embarrassed.

Do you get any mental images of yourself? Some people, for example, see themselves getting very red or see themselves looking pretty deflated and hopeless.

Sometimes I imagine what I look like.

What does that imagining look like?

Upset, on the verge of breaking down.
T  If I was a film director and I had to instruct an actor to look the way you
think you look, what instructions should I give the actor? What would,
“on the verge of breaking down” look like?
P  Well, it’s when your face looks like you are going to cry but you are not
really. It’s the face muscles, twitching face muscles.
T  Which ones would be twitching?
P  All of them.
T  What about the colour of your face.
P  Red. Looking nervy. My hands also shaking.
T  Anything else?
P  Not making eye contact.
T  So avoiding eye contact. What do you think it looks like when someone
avoids eye contact?
P  Not interested in what you are saying.
T  So avoiding eye contact would make you look as if you are not interested.
What else would be visible that would make you look humiliated? If we
have got to instruct this actor to look humiliated, what has he got to do?
P  I’m not sure
T  Is this question something you haven’t really thought about before?
P  I guess so. Thinking about it the being humiliated bit is more of a feeling.

Therapist summarizes the Self Image/Impression and establishes links to the Self
Image/Impression from both Anxious Feelings and Safety Behaviours. Also the link from
the Self Image/Impression to Negative Thoughts.

T  So to summarize. Your attention focuses on yourself. You become very
self-conscious and as that happens you have the impression that your
appear embarrassed and humiliated. Part of the impression is an image of
yourself with a red, twitching face, not looking at people and being on the
verge of tears. Another part of the impression is being humiliated but as
we’ve been talking we’ve become to realise that is more a feeling that you have rather than something that might be visible to others. Is that correct?

P  Yes

T  A lot of the impression seems to be based on the anxious feelings we have marked with an asterisk so I am going to draw an arrow from Anxious Feelings to the Self-Image.

P  OK

T  If we look again at the list of safety behaviours we have produced, it includes: making a point of not saying anything; trying very hard not to attract attention; trying to hide and evaluating what you are about to say. As you are concentrating on doing all of those things, does that make you more self-conscious?

P  Yes, definitely.

T  OK, so we’ll draw an arrow from Safety Behaviours to Self-Consciousness and Self-Image because doing the safety behaviours makes you more self-conscious and more aware of your negative self-image. Can we also look at the relationship between your negative self-image and your thoughts? As you become aware of this image of yourself with a red face, twitching, on the verge of tears and feeling humiliated, what does that do to thoughts like, “Everyone will look at me”, “They will see I am embarrassed, they will think I look stupid and am inferior?” Does that make you more or less convinced that those things will happen or indeed already are happening?

P  More convinced.

T  OK, so we’ll draw an arrow from the negative self-image back to the negative thoughts to show that having the image makes you more convinced about the thoughts.

P  Yes.

T  If we look at the diagram on the whiteboard, does it capture what was happening when you get so anxious at the leaving do? Is there anything we’ve missed out?
Just that I was pretty convinced that I was going to get anxious before I went into the room.

Were you thinking similar thoughts before you went into the room?

Yes

OK, so what we have missed out is that many of the thoughts happen in advance and that that is also part of the problem. I’m glad that you pointed that out.

The therapist ends by establishing a link between early traumatic social experiences and the content of the self-image that the young person currently experiences in social situations. This process is facilitated by the young person having identified a traumatic incident at school as an event associated with a marked worsening of his social-evaluative concerns when he was a child, especially a fear of doing or saying the wrong thing. Identifying such a link can help young people to get distance from their negative self-images by seeing them as rather like a ghost from the past. However, it is not always possible to establish the link and is not necessary for therapy to progress.

Can I ask you a little more about the image you had of yourself at the leaving do?

Have you had that image before?

Yes, I often see myself that way when I’m anxious in social situations.

When is the first time you had an image of yourself looking red, face twitching and on the verge of tears?

Probably the time I told you about when I was beaten up at school by an older boy and everyone else just seemed to stand around and stare. I still don’t know why he picked on me. I hardly knew him. Maybe he thought I was staring at him. He banged my head against a wall, I was bleeding and felt humiliated. I wanted to burst out crying but couldn’t with all the other boys watching.

So do you think the image you get now is based on that experience, sort of like a ghost from the past?
Maybe.

OK, let's add that very distressing school attack to our model and draw an arrow from the attack to your image as the it might be one of the reasons you experience the image. Of course, sometimes things that are relevant when we are children are not so relevant when we are older and our life is different. So, we’ll probably want to look at how realistic the image is now when we start treatment.

4.5. Homework and summing up

Once the model has been developed on the whiteboard, it is usual for therapists to conclude the assessment by setting homework to help the young person to further elaborate and consolidate the model. With this in mind, the young person is given a copy of the model that was developed on the whiteboard and asked to review it before the next session to check whether any details are missing. We usually ask young people to write out the model on a blank copy of the model (See Appendix E) and some like to take photographs of the model drawn with their mobile phone. If additional thoughts, safety behaviours, etc. are identified, they should be added to the model. In addition, adolescents are usually given several blank copies of the model and asked to fill them in for any new social anxiety provoking situations that they encounter before the next session. The young person is also given an information sheet about social anxiety disorder and CT-SAD-A (see Appendix F). Finally, the assessment usually concludes by explaining to the adolescent that the aim of therapy will be to develop ways of breaking into the vicious circles in the model that seem to be generating and maintaining social anxiety.

4.6. Interviewing parents/carers

After seeing the young person alone, the parents/carers are interviewed alone. The main goals of this meeting are summarised in Table 10.
Table 10. Summary of goals of the interview with parents

<table>
<thead>
<tr>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage parents</td>
</tr>
<tr>
<td>Obtain further information about current social anxiety problem</td>
</tr>
<tr>
<td>Provide psychoeducation about social anxiety</td>
</tr>
<tr>
<td>Assess the family structure and relationships</td>
</tr>
<tr>
<td>Assess parental mental health (including anxiety and depression)</td>
</tr>
<tr>
<td>Assess unhelpful parental beliefs and behaviours</td>
</tr>
<tr>
<td>Give a rationale for and overview of treatment</td>
</tr>
</tbody>
</table>

With the young person’s permission, let the parents know what was discussed with their child. Ask parents about additional feared situations and avoidance behaviours that the young person did not identify (it is very common for young people to feel embarrassed about some of their difficulties at this early stage in treatment). During this first meeting with parents we provide psychoeducation about social anxiety, although we often find this process continues through the early sessions. Explain to parents what social anxiety is and the effects it can have on a young person’s daily life, in terms of distress and impairment. This often provides a good opportunity to help parents make sense of behaviours that can seem challenging and hard to manage, for example refusal to attend family gatherings, reluctance to come downstairs when the family has visitors, irritability, and arguments with friends. If young people tend to use impression management strategies, then parents may well not have recognised the extent of the young person’s anxiety. It is therefore important to inform parents about these behaviours and their function. Parents may be anxious about their child’s performance in school and this can be a common source of arguments. In this instance it can be helpful to think through how social anxiety can make school-life difficult, for example anxiety about engaging in group tasks, reluctance to ask for help from a teacher. Once we have done this, we find it helpful to provide information about how common social anxiety is in the population.

Ask the parents about their own mental health. Assess current mental health needs and the extent to which these are being met (how are they coping with any mental health needs; are they receiving professional help; do they have a good support network; are there unmet mental health needs?) as well as history of mental health difficulties and
treatment. Completion of a measure of parental mental health, such as the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983) is recommended.

Very importantly, we use this interview with parents as an opportunity to identify parental beliefs and behaviours that may impact on the child’s social anxiety. We find it helpful to begin this process in an open and curious way. For example when we ask about the family structure and relationships within the family this can open up a conversation about the extent to which each parent is similar or different to their child with social anxiety. Ask parents how they find socialising; is it something they enjoy or do they experience anxiety, or ‘put on a front’. What were the parents like themselves when they were young? We then ask the parents how they cope with their child’s anxiety: what do they do when their child is refusing to take part in a social event or a performance activity? What is their interpretation of their child’s response? How do they manage the situation? Look out for common unhelpful beliefs and behaviours summarised in Table 11.

Table 11. Common unhelpful parental beliefs and behaviours

<table>
<thead>
<tr>
<th>Parental Beliefs</th>
<th>Parental Behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Being loud and confident is the way to get on in life’</td>
<td>Interprets quiet style of interaction negatively</td>
</tr>
<tr>
<td></td>
<td>Expresses disappointment at the social or performance ability of the young person</td>
</tr>
<tr>
<td></td>
<td>Does not consistently reward the effort or attempt</td>
</tr>
<tr>
<td></td>
<td>The young person is encouraged to engage in social/performance activities that they feel unable to manage</td>
</tr>
<tr>
<td>‘My child is vulnerable, others are threatening’</td>
<td>Young person is discouraged from engaging in social situations</td>
</tr>
<tr>
<td></td>
<td>Young person is given permission to avoid</td>
</tr>
<tr>
<td></td>
<td>Parent takes control of social activities</td>
</tr>
</tbody>
</table>

Finally provide information to parents about social anxiety disorder and CT-SAD-A (see Appendix G). This will include information about the practicalities of treatment,
such as sessions, parental involvement, liaison with school and the importance of homework. We also provide information about the evidence base for Cognitive Therapy and the NICE (2013) guidelines.
CHAPTER 5. SELF-FOCUSED ATTENTION AND SAFETY BEHAVIOURS

EXPERIMENT

Once the therapist and young person have agreed on a working version of the cognitive model, begin by manipulating key elements of the model. A particularly good way to start is with an experiential exercise that helps people to discover the unhelpful effects of their safety behaviours and self-focus. Rather than starting by explaining their unhelpful effects, we like people to discover it themselves as this helps to bring the therapy alive.

The young person is asked to engage in a social interaction in the session. The social task that is chosen will depend on the young person’s particular fears, but the general principle is to choose a situation that is relevant to their concerns, that will make them feel anxious, but that is not so anxiety provoking that they feel unable to do it. They are asked to undertake this interaction under two conditions. In the first condition they are asked to focus their attention on themselves and keep on thinking how they are coming across to the other person, whilst also using several of their safety behaviours. In the second condition they are asked to do the opposite, that is to say, to try to get out of their heads and lost in the conversation whilst dropping their safety behaviours. The effects on how anxious they feel, self-consciousness, and how they think they came across (including how anxious they think they looked) are compared. The experiment is undertaken in Session 2.

The experiment aims to help the young person discover two key points. First, that self-focussed attention and safety behaviours make them feel more anxious and think they come across worse, and second, that when they shift to an external focus of attention and drop their safety behaviours they tend to feel less anxious and think they come across better.

With adults, the experiment has been shown to be remarkably consistent in its ability to achieve these aims, when set up carefully (McManus, Sacadura, & Clark, 2008; McManus et al., 2009; Schreiber et al., 2015). For example, in the study of McManus and colleagues (2009) of 34 consecutive referrals with social anxiety disorder, 32 of the 34 patients felt less anxious and felt they came across better when they focussed externally.
and dropped their safety behaviours. In the remaining two patients there was no difference, largely because they were not able to shift their focus of attention.

5.1. Overview of the general procedure

Some preparation in advance of Session 2 will help to ensure the smooth running of the experiment. Before the session, identify a suitable colleague and ask if they can act as the “stooge”. Explain that this will involve having a brief social conversation with a young person. We usually try to ask one of our younger colleagues to act as the stooge, to minimise the age difference with the socially anxious adolescent. All sessions are videotaped and it is essential that this experiment be recorded. Before the session ensure that the video equipment is set up to capture the whole interaction (all parties involved in the conversation, full length, and the entire duration).

In session the therapist sets up the experiment with the young person. This involves providing a rationale, identifying a suitable social interaction, and making predictions and ratings (see Section 5.2.). Following this, the therapist provides instructions to the stooge and young person for Conversation 1. This is done separately with the stooge and with the young person (see Section 5.3.). The young person is not informed that they will be taking part in two conversations until after the first conversation. To begin the first conversation the therapist brings the stooge into the room and provides brief introductions. The therapist then sits discreetly in the room whilst the conversation takes place. After the first conversation the therapist takes the stooge out of the clinic room and asks them to wait outside. The therapist then returns to the clinic room to debrief with the young person and make ratings of Conversation 1 (see Section 5.4.). The therapist can then give instructions for Conversation 2 (see Section 5.3.) to the young person. Once this has been done the stooge is given instructions about Conversation 2 and then brought back into the clinic room. When Conversation 2 is finished, the therapist takes the stooge out of the clinic room, thanks them for their time and gives them a rating form to complete (see Section 5.4.). The therapist then returns to the young person to debrief and make ratings of Conversation 2 (see Section 5.4.) before undertaking a full debrief and discussion with young person about the experiment as a
whole with a review of the ratings (see Section 5.5.). An overview of the experiment in shown in Table 12.

The therapist remains seated in a discreet position in the room throughout both conversations. The therapist will gain valuable insight into how the experiment unfolded and the observable consequences of the young person being self-focused and using safety behaviours and of being externally focused and dropping safety behaviours, which will inform the questions they ask afterwards. It also allows the therapist to intervene quickly in the rare event that a young person becomes too highly anxious during the conversation.

Table 12. Overview of the self-focused attention and safety behaviours experiment

<table>
<thead>
<tr>
<th>Order</th>
<th>Element of Behavioural Experiment</th>
<th>Refer to section</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Develop rationale</td>
<td>5.2.</td>
</tr>
<tr>
<td>2</td>
<td>Identify a suitable social interaction</td>
<td>5.2.</td>
</tr>
<tr>
<td>3</td>
<td>Make predictions and ratings with the young person</td>
<td>5.2.</td>
</tr>
<tr>
<td>4</td>
<td>Conversation 1 instructions to young person and stooge separately</td>
<td>5.3.</td>
</tr>
<tr>
<td>5</td>
<td>Conversation 1</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Debrief and ratings of Conversation 1 with young person</td>
<td>5.4.</td>
</tr>
<tr>
<td>7</td>
<td>Conversation 2 instructions to young person and stooge separately</td>
<td>5.3.</td>
</tr>
<tr>
<td>8</td>
<td>Conversation 2</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Debrief and ratings of Conversation 2 with young person</td>
<td>5.4.</td>
</tr>
<tr>
<td>10</td>
<td>Ask stooge to complete the feedback form about the two conversations</td>
<td>5.4.</td>
</tr>
<tr>
<td>11</td>
<td>Full debrief and discussion with young person about the experiment with review of ratings</td>
<td>5.5.</td>
</tr>
</tbody>
</table>
5.2. Setting up the experiment

Develop rationale

Normally the second session will start by checking with the young person that the model derived in the first session still makes sense and then discussing any information the young person has added to the model for homework, for example additional thoughts or safety behaviours that they had spotted. Then the therapist might summarise this, saying: “last session we drew out a model together of what we think happens when you are anxious in a social situation. What I’d like to do in this session is explore a bit more how things work in that model, and we have found the best way of doing that is by having a social interaction here in the clinic and discussing a bit more how that went and what was happening. So let’s try to think of something we could do in this session that would normally make you somewhat anxious but not so anxious that you feel you couldn’t do it.” Do not inform the young person that they will be taking part in two conversations.

Identify a suitable social interaction

Try to identify a social situation that is moderately anxiety provoking. On a scale from 0 to 100, where 0 is not at all anxiety provoking, and 100 is totally anxiety provoking, find social interactions that are in the range of 40 to 60. Select an interaction that is relevant to the young person and their specific concerns. Interactions might include: conversations with a stranger (you can ask the young person if they would prefer to choose a topic of conversation or if they would prefer to go with whatever comes up); reading aloud to an audience (as if in class); and giving a talk to an audience (as if in school assembly). The conversation partners or audience members are usually colleagues from clinic. The situation can be adapted to ensure it is suitably anxiety provoking, for example additional conversation partners or audience members can be added to make it more difficult. With most young people the conversation (with or without a pre-agreed conversation topic) seems to work well.

Predictions and ratings with the young person

Then ask the young person to clarify what they would normally be afraid would happen in this situation (e.g. “I will look anxious, “I will sound stupid”), and the safety
behaviours they would usually use (e.g. “I would avoid eye contact”, “I would ask lots of questions”). To find out about the young person’s feared outcomes, ask them what they think will happen. You can then review formulations from Session 1 and homework and questionnaire responses to check you have not missed anything. Fears are typically of showing signs of anxiety (e.g. stuttering, blushing, trembling) and/or coming across badly (e.g. being boring, having nothing to say, seeming stupid). Similarly, to find out about safety behaviours, ask the young person what they would normally do to stop the feared outcomes from occurring, other people noticing, and/or other people making a negative judgement. Remember to probe for mental operations as well as more observable safety behaviours. You can then review formulations from Session 1 and homework and questionnaire responses to check you have not missed any safety behaviours. We then remind the young person of the self-focussed, evaluative attention they typically use in social situations by referring back to the idiosyncratic formulation.

5.3. Instructions for the conversations

Conversation 1: Young person

Once predictions have been made with the young person explain to them that they will now have a brief conversation with someone (if that is the agreed social interaction).

Ask them to focus on themselves as much as possible during the conversation; monitoring and checking how they think they are coming across. Ask the young person to do some of their safety behaviours. Do not ask them to do a long list of these as they will then be preoccupied with remembering their list of safety behaviours rather than following the instructions. Instead choose a few key safety behaviours that fit with self-focus, for example monitoring what they are saying, avoiding eye contact, and sitting on their hands if they are concerned about shaking. The following transcript outlines the instructions given for the first conversation with a 17 year old young man who worried about running out of things to say.

Therapist In this conversation what I would like you to do is to focus as much as possible on yourself and on how you are coming across. Check how you think you are doing. And can we try to do some of the safety behaviours as
well? So that might be rehearsing topics in your mind, monitoring what you are saying during the conversation, and avoiding eye contact.

Patient: Ok, so that sounds kind of like what usually happens to me when I talk to people.

T: Yes, exactly. So as you do in conversations everyday, let’s work really hard in this conversation to stay focused on how you are coming across.

Conversation 1: ‘Stooge’

Ahead of the first conversation outside of the therapy room, the therapist explains to the stooge that they will have a brief conversation with a young person. Ask them to treat the conversation as a normal interaction with a stranger. Suggest the conversation topic (if this was agreed with the young person).

Do not provide any further instructions or indication of the young person’s fears. It is important that the stooge behaves with the young person as they would with anyone else they happen to meet in a social situation as this is meant to mimic real world interactions. It is obviously likely to be the case that the stooge knows the adolescent has come in for treatment of a psychological problem, but you do not want this to be the focus of the conversation because this is not how conversations are in the real world. Therefore do not tell the stooge about the young person’s individual concerns such as “I will blush”, “I will sound stupid.” Instead ask them just to behave as they would with anyone else. You do not want them to be looking out for any particular signs or indications of the young person’s anxiety, as this does not happen in normal conversation.

Conversation 2: Young person

Before the second conversation, explain to the young person that they are going to have another brief conversation (selecting another topic if one was used in Conversation 1). This time we ask the young person to just “go with the flow” and really “lose themselves in the conversation”, focusing on the other person and the conversation, “not thinking about how they are coming across, that’s something we can discuss afterwards, but at the time let’s not focus on it”. Avoid running through the young person’s safety
behaviours here, highlighting what they should not be doing (e.g. “don’t avoid eye contact, don’t check how you are coming across, don’t avoid asking questions”), as this can have the paradoxical effect of making the young person extremely self-focussed as they try to ensure they are not engaging in their safety behaviours. Instead keep the instructions focussed on encouraging the young person to “let go” and “get absorbed in everything that is said”. The following transcript outlines the instructions given to the same young man:

**Therapist**  
I would like us to try something a bit different now. We are going to have another conversation with Claire, but this time I want you to really just go with the flow, to lose yourself completely in the conversation and absorb yourself in everything that’s being said. Just really go with it, stepping out of your head and into the conversation.

**Patient**  
Ok, I can try. It will be hard not to think about what I’m like.

**T**  
That’s ok, shall we just see what it is like to leave those thoughts about how you’re coming across to one side, to ‘park them’ during the conversation. You and I can talk about that afterwards, but for the conversation shall we just put those thoughts in the “sin-bin” for a few minutes? [a rugby analogy was chosen as the young man was an enthusiastic rugby player]

*Conversation 2: ‘Stooge’*

Ahead of the second conversation ask the stooge to undertake another conversation, in just the same way as they were instructed before the first interaction. The therapist might say: “we’re now going to have another conversation, in just the same way as the last. As if you are meeting this person at a party for the first time.”

**5.4. Ratings**

After each of the conversations the therapist takes the stooge out of the clinic room (after Conversation 1 when outside the clinic room the therapist asks the stooge to
wait there until the second conversation, and after Conversation 2 the therapist gives the stooge instructions about completing the rating form [see below]).

**Young person**

When the therapist and young person are alone in the clinic room the therapist can ask the young person to rate: how much they thought that their social fears came true (‘‘how much did X happen from 0 ‘not at all’ to 100 ‘as much as possible’?’’); how anxious they felt during the conversation (‘‘how anxious did you feel from 0 ‘not at all’ to 100 ‘totally’?’’); how anxious they thought they appeared (‘‘how anxious do you think that you appeared from 0 ‘not at all’ to 100 ‘totally’?’’); how well they think they performed (‘‘how well do you think you performed from 0 ‘very badly’ to 100 ‘very well’?’’); and whether they experienced an image of how they came across (yes or no).

It is important to check that the young person was able to follow the instructions and, depending on the condition, either focus more on themselves and do their safety behaviours, or focus less on themselves and do the safety behaviours less. Young people rate the extent to which they were focussed on themselves or the conversation. In the self-focussed attention and safety behaviour condition, ask young people:

> “Were you able to focus on yourself and how you were coming across in that conversation? If I was to ask you to rate on a scale of self-focus, from -3 (entirely focused on myself and how I was coming across) to + 3 (entirely focused on the other person and not focused on myself), with 0 in the middle (equally focused on myself and the conversation, where would you put your attention during that conversation”

Similarly for the second, externally focussed conversation, ask:

> “While you were having that conversation, were you able to get out of your head, lost in the conversation and more focused on what was going on around you? If I was to ask you to rate on a scale of self-focus, from -3 (entirely focused on myself and how I was coming across) to + 3 (entirely focused on the other person and
not focused on myself), with 0 in the middle (equally focused on myself and the conversation, where would you put your attention during that conversation."

Young people also rate the extent to which they used their safety behaviours. For the first, self-focus and safety behaviour condition, ask:

“Were you able to do some of your safety behaviours? Which ones did you do? If I was to ask you to rate on a scale of use of safety behaviours, from 0 (didn’t use safety behaviours, any of the time) to 100 (did all of my safety behaviours, all of the time), where would you put yourself for the conversation?"

For the second conversation shifting attention externally and dropping safety behaviours, ask:

“Were you able to do less of your safety behaviours? What did you do less of? If I was to ask you to rate on a scale of use of safety behaviours, from 0 (didn’t use safety behaviours, any of the time) to 100 (did all of my safety behaviours, all of the time), where would you put yourself for the conversation?"

If someone does not report a difference in anxiety or perceived performance between the two conversations it is often because they continued to focus their attention on themselves and use safety behaviours in the second condition. To check whether this is the case, review the ratings of self-focused attention and safety behaviours. If the young person was not able to shift their attention out or drop their safety behaviours then we would do some practice and then plan a third conversation (see section below ‘Troubleshooting’). Rating sheets with scales for the young person can be found in Appendix H.

Stooge

At the end of both conversations we ask the stooge to think back to each interaction in turn and to provide written feedback. The stooge is handed a two-sided form as they leave the therapy room. The first side is largely blank, and simply asks:
“What was your impression of (young person’s name)? How did you find (specify the situation)?” On the second side the stooge is asked some more specific questions. They are asked to rate the extent to which they noticed the young person’s fears (0-100%), for example “Did you notice X blush?” “If you did notice X blush, what did you make of it?” Finally they are asked explicitly whether or not they made a negative evaluation and if so, why, e.g. “Did you think they were foolish, and if so, why?” (0-100%) It can also be very helpful to ask the stooge to rate how anxious he/she felt. This feedback is not reviewed with the young person until Session 3.

Rating sheets with scales for the stooge can be found in Appendix I.

5.5. Initial observations and reflections

After the young person has completed both conversations and the therapist and young person are alone, first praise them for having taken part, acknowledging that it can be a very scary experience. We then review and compare the ratings they made after each conversation, drawing their attention to any differences in ratings between the two. Usually two key points can be established quite easily. First, to young people’s considerable surprise, they discover that focusing on themselves and doing their safety behaviours seems to be associated with feeling more anxious, not less anxious. Second, when focus externally and not doing safety behaviours they think they come across better and think they come across as less anxious. Ratings of how anxious they think they appear and how well they think they performed closely follow the ratings of how they felt, indicating that they are using their feelings and other interoceptive information to infer how they appear to others.

5.6. Homework

Young people are asked to practice shifting to an external, non-evaluative focus of attention and dropping their safety behaviours with peers and others.
5.7. Troubleshooting

This experiment is powerful and usually works very well, however some challenges can present themselves.

“They were both the same”

Occasionally a young person will not acknowledge any difference, in terms of subjective anxiety, self-consciousness, or perceived observable self, between the two conversations. In this situation we first review ratings of safety behaviour use and self-focussed attention (described above under Ratings) for the two conversations to examine whether these differ. If they do not, then this may be a sign that the young person was unable to shift their attention externally and drop their safety behaviours. In this case, have a conversation with the young person there and then to help them practice becoming externally focused and letting go of safety behaviours. Encourage them to focus on the sound of your voice, what you are saying, suggesting they let their hands rest on their legs if they are sitting on them and so on. Then you can bring the stooge in for a third time with the young person again shifting their attention externally and dropping their safety behaviours. The therapist can reduce the likelihood of a young person being unable to shift attention outwards by asking them how confident they feel about their ability to follow the instructions before the second conversation. If the young person is not confident, then a quick role-play usually allows them to engage successfully in the second conversation. Should the young person continue to struggle, we might suggest setting up a less anxiety-provoking social situation as it may have been too difficult of the young person to ‘go with the flow’ in the situation first planned.

“But they were an adult”

We nearly always use an adult stooge because of practical limitations. We often find that whilst we can establish the key learning points with young people, they sometimes express hesitation over whether the findings would be the same if the conversation were with a peer. Comments include “adults are nicer”, “it’s a doctor lady so they’re going to be softer aren’t they?”, or “it’s not the same”. When this situation arises two steps are helpful. First, we want to preserve the learning from the more
controlled behavioural experiment undertaken in session. To do this we praise the young person for having completed the experiment and having gained new and valuable information, especially given how challenging it had seemed before they did it. Second, we want to encourage feedback from young patients and active engagement in treatment. To do this we praise their “detective work” in spotting the limitation. We can then collaboratively plan a further behavioural experiment, in which the experiment is repeated (in a less formal way) with a peer during the week.

“But it is because I’d got used to it the second time”

Occasionally young people will identify that the second conversation was better than the first, but they attribute this to a practice effect. Should this arise, discuss the two possible explanations (that the difference is due to practice effects or to the change in self-focus and safety behaviours) and plan an experiment to test the competing hypotheses out. The following transcript demonstrates this point:

Patient  

But that’s because it was the second time I’d done it and I was getting used to doing it.

Therapist  

Ok, that’s a really good point, and we can definitely do lots of practice if that is the case. But there was also something you did differently between the two conversations to do with your focus of attention. So it might be that it got better because of practice, but it might be because of what you were doing with your focus of attention. This sounds like a really important thing to check out, doesn’t it? So can we have another go at the conversation, but this time switching your attention back to yourself and how you are coming across. If it is down to practice, then you’ll feel better still, because it will be the third time of trying it. But if it is to do with attention, then it will feel more challenging again. Does that make sense?

Typically people do not want to do this third social interaction with self-focus and use of safety behaviours. This in itself suggests that the improvement is unlikely to be due to practice effects. However encourage the young person to complete the
experiment with the additional condition in order to experience for themselves a second time the consequences of self-focused attention and safety behaviours compared to ‘going with the flow’.

“I don’t want to do it”

Most young people realise that sooner or later they will need to start facing social situations, however from time to time young people are reluctant to engage in the experiment. This situation tends to arise when a young person has been forewarned of the experiment. In this case they are likely to have spent the preceding week worrying about it and so come to the session extremely anxious. For this reason the first time we talk about the experiment is in Session 2 just before we do the experiment, and not before. Occasionally young people are still reluctant to take part. In this situation, we would first check the anxiety rating for the situation, as it might be too high. You might need to modify the plans to make it more manageable (try to find a moderately anxiety-provoking situation, around 5/10). Second, remind the young person that the conversation is brief and you will be present throughout. Third, review the formulation to ensure the young person has a solid working understanding of the model and the rationale for testing it out. Fourth, identify specific fears that might be stopping the young person from taking part and discuss these. For example one young girl was particularly socially anxious with males, and once we had confirmed that the stooge was a female the situation, whilst still anxiety provoking, was manageable and we proceeded with the experiment.
CHAPTER 6. VIDEO AND AUDIO FEEDBACK
Emma Warnock-Parkes, Jennifer Wild, Richard Stott, Nick Grey, Anke Ehlers and David M Clark

Video feedback is a key component of CT-SAD-A. It is a present-focused technique that aims to help young people obtain a more realistic view of how they appear to others, to gain insight into the way their safety behaviours appear to others, and to update distorted negative self-images. Video feedback is associated with positive benefit both for adults (McManus et al., 2009, amongst others) and young people (Parr & Cartwright-Hatton, 2009). For example, Parr and Cartwright-Hatton (2009) examined the effect of video feedback amongst highly socially anxious adolescents. Young people who had received video feedback after a conversation rated their performance as significantly better than those who had not received the feedback. They also reported less anxiety and better judgements of their performance in a subsequent conversation.

Video feedback is used in a range of different ways during the course of CT-SAD-A. It is used in the clinic room and when we are carrying out behavioural experiments in the real world. Although all previous sessions will have been videotaped, the first time that video feedback is introduced and used is in Session 3 following on from the manipulation of safety behaviours and self-focus experiment. In Session 3, video feedback of the two social interactions is used to help young people compare their predictions of how they think they came across with how they actually came across.

The first learning point for young people from this experiment is that self-focused attention and safety behaviours make the problem worse, not better. In particular they tend to increase anxiety, make it more difficult to focus on the interaction, and give young people enhanced access to internal information (negative images and feelings) that lead them to think that they are coming across to other people more poorly than they

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2 This chapter is an extract from an article by Warnock-Parkes et al (2016) that describes video feedback in detail. The full text, which also includes photographs and a link to an illustrative video can be accessed at http://dx.doi.org/10.1016/j.cbpra.2016.03.007
really are. The additional points that young people often learn from viewing the videos include: 1) that they come across more favourably than they think in both conditions; 2) some of the aspects of their behaviour that they do not like are the unintended, observable consequences of their safety behaviours rather than an intrinsic feature of themselves. When used at other times in therapy, video feedback has a similar function. It is also a very good way of helping young people discover that they are less the subject of other people’s critical attention than they think.

When video feedback is used, it is necessary to pay attention to the way in which the video recording is set up, how the young person is prepared in advance of viewing the recording, and how the video is subsequently viewed and discussed. With suitable attention to each of these aspects, it is often possible to overcome the substantial processing biases that have prevented socially anxious adolescents from overcoming their negative self-perceptions before they entered therapy.

6.1. Setting up the recording

Using the video camera

As explained in Chapter 4 video recording is made a routine aspect of therapy, rather than something that is just introduced on an occasional basis for video feedback. As well as making the video less intrusive, routinely recording all sessions allows one to capitalize on unplanned therapy events that can be immensely informative. For example, when talking about a topic in the session adolescents may spontaneously mention that they feel they blushed a lot, had a panic, stuttered or talked nonsense. In each case they can be asked to specify how they think they looked or sounded, before comparing their prediction with what was captured on the video. A similar process can be applied to the therapist’s behaviour. For example, the young person may feel that one must always be perfectly fluent in one’s speech in order to be accepted. Being aware of this belief, the therapist may pause for a while in mid-sentence before carrying on or may start one sentence and then move onto another without completing the first sentence. Chances are that the adolescent is unlikely to have noticed this and will be surprised to discover that it happened. Reviewing the video with the therapist afterwards helps the adolescent see that
the dysfluency had no real significance, even though the young person would have felt it was a serious social mistake if she had done it herself.

One of the main aims of video feedback is to allow young people to see their behaviour in context. For this reason, when videoing an interaction it is best to show both people in the interaction, rather than zooming in on the young person. The latter tends to make it difficult for the adolescent to avoid feeling self-conscious when subsequently watching the video, and also prevents an appreciation of the true significance of behaviours. For example, young people who are concerned about fidgeting might notice their hands or feet moving in a zoomed-in shot and think this indicates that they are very fidgety. However, in a zoomed-out shot they are likely to see that the other person is also moving to a similar extent.

It is important to elicit adolescents’ main concerns before setting up the video as knowledge about these concerns may have implications for the way in which the video is set-up. Whilst all sessions will have been videotaped and consent will have been obtained in the opening session, there is a particular way in which video feedback is done that is used in this session and that will be used subsequently in video feedback. It is important that the video allows the person the maximal opportunity to spot that their concerns are excessive. For example, with young people who are concerned about blushing it is important to have a colour chart or other objects in the field of view that show different shades of red. This is not usually explained to the young person in advance (as it would make them excessively self-conscious). However, if they feel that they do blush during the recording they can subsequently be asked to point to the shade of red that they think matched the blush. Invariably they point to a much darker shade, which is a wonderfully graphic way of helping them discover that their blush is less severe than they feel. Main concerns can be elicited through direct questioning in Session 1 when developing the personalised version of the model and through inspection of the SCQ.

Behavioural experiments conducted outside of the office but in a public space can easily be recorded on a smartphone, tablet, or other domestic camera so that video feedback can be used to enhance the value of these exercises. The principles for setting up and viewing such out of the office videos are essentially the same as those that apply to in the office videos.
Other participants taking part in social tasks

During a course of CT-SAD-A socially anxious adolescents are likely to have multiple interactions with other people in therapy sessions (conversations with a stranger, a presentation to a small audience etc.). As well as viewing the video of such interactions with their therapist, young people can also benefit from written feedback from the other participants (‘stooges’) in the interaction. As explained in the description of the self-focused attention and safety behaviours experiment in Chapter 5, in order for this feedback to meaningfully reflect everyday life, it is important that the stooges are not informed about the adolescent’s personal fears as this would not be information that other people would have in a routine conversation. The stooge is encouraged to treat the young person like anybody else that they would meet in life outside of the therapy session rather than somebody whom they are trying to scrutinize in a way that would not be normal.

6.2. Preparing to view the video

Identifying young peoples’ predictions in advance of viewing

Before viewing a video, it is important to identify the young person’s predictions of what they think they will see and to get them to visualize what these things look like. This provides them with the maximum opportunity to see the difference between their self-perceptions and reality.

Young people are asked to rate (on 0-100 scales) the extent to which they thought their feared catastrophes occurred (“how anxious do you think you looked?” “How boring?” “To what extent do you think you sweated?” etc.) and to indicate how they think that will look. They should be as specific as possible. For example if somebody says “I will look in a state – just awful” we would want to get a more specific description of how they think they will look on video, so that this can be compared to the actual video image. For things like shaking, blushing, underarm sweating, dysfluent speech, it is helpful to ask the person to demonstrate on video how they think it looked so this can be compared with how it actually looked in the original video recording. For example, by intentionally shaking one’s hand or lips, pointing to the relevant shade of red in a colour chart, indicating the size of a sweat patch, or recreating a pause. Once the young person’s
predictions have been clearly articulated, it is often helpful to ask them to close their eyes and create their own internal video by visualizing how they think they will appear. It is sometimes also useful to ask people to write short notes on how they think they will appear.

*Preparing an unbiased mode of viewing*

It is common for young people to re-experience some of their anxious feelings while watching the video. These feelings may influence their perception of the video. For example, if they feel shaky they may see shaking in the video that would not be seen by others. To get round this problem, we explain to young people that how one looks and how one feels may not be the same but it is impossible to discover this unless the two are kept separate. In order to do this, young people are asked to view themselves in the video as though they are watching a stranger, only making inferences about how they appear by using what they see and hear on the video, ignoring their feelings. To help them do this, we may encourage them to imagine they are watching a television show, and when discussing the video with the therapist to refer to themselves as “that person” or to give themselves a different name.

Some young people re-experience feelings from socially traumatic memories (such as being laughed at, ridiculed, or bullied) while watching the video. These feelings may also distort their perception of the video. If the therapist and young person have identified this problem, the young person can be asked to specifically look for things in the video that are inconsistent with the past social trauma to help them clearly distinguish between then and now. For example, focusing on everything about the current people they are interacting with which is different from the people with whom they had a traumatic experience.

Some people find that it is very difficult not to turn on their habitual self-critical commentary when watching themselves. After discussing how this can take them away from what actually happens on the video, it can be useful to ask them to watch the video from a more compassionate stance, perhaps as they would if they were watching a close friend or somebody they like and respect. They can be asked to recall the last time they had a conversation with this friend and to consider how they would view their friend:
Therapist  
*How do you listen when your friend Alex is talking? Do you just go with the flow of what he says or do you zoom in on how he says every word and ask yourself “How boring does Alex sound?” “How weird does he look?”*

[use young person’s own beliefs]

Patient  
(laughs) No! I just go with the flow.

T  
*Ok, we would like you to watch the people on the video in a similar way.*

Some people find that when they hear the sound of their own voice this automatically triggers the similar sounding self-critical commentary that they normally have in social situations. If the person is highly self-critical, to prevent this mode being activated as soon as the video starts, it can be helpful to watch the first 30 seconds or so with the sound off. This will help them to see that they look as normal as anybody else on the video. When the sound is then turned on, they are in a more appropriate cognitive set. A similar manoeuvre can be used for people who are highly critical of their physical appearance and find it difficult to look at anything else in the video. For these people, the therapist may initially cover up the young person’s image and let them focus on how other people are responding to them. After a minute or so, they can also be revealed. There is a risk that people may selectively zoom in on themselves looking for any imperfection, rather than watching the interaction in context. To get round this the therapist may say something like: “Imagine you walk into a coffee shop and see a conversation happening, look at the whole group, not just one person.”

### 6.3. Viewing and discussing the video

Once the young person has clearly articulated their negative self-image and they have been carefully prepared for viewing the video, therapist and adolescent watch it together. Sometimes the whole interaction is initially viewed in one go. For highly self-critical adolescents it can be helpful to pause early in the viewing to check: “Are you watching yourself as you would anyone else, or are you watching yourself as your worst critic? Are you looking at other people and how they respond, as well as yourself?”
**Rewinding the video to capture key moments.**

Once the video has been watched all the way through, it can be very helpful to rewind the video to look at particular moments that have significance to the person. For example, rewinding to the moment when they thought they had a panic attack, when they thought they paused for a long time, looked particularly anxious, looked fidgety or felt that they sweated. They can then be asked to compare how they looked at that moment with their expectation. Other helpful questions may include: “Does the other person seem to have noticed? Are they reacting as if they have seen a big mistake? Do the people on screen look markedly different from each other? Is the other person also moving their legs and fidgeting? If an alien was looking at this would they think one of these people looked really odd?” As the therapist will be aware of the adolescent’s own self-images and has also seen how they actually behaved, the exact choice of questions will be determined by the therapist’s goal of helping the young person see which aspects of their self-image are distorted.

**Gaining insight into the impression that safety behaviours convey to other people**

Adolescents are often unaware of the way that their safety behaviours appear to other people. Video feedback provides an ideal opportunity for them to gain insight, which in turn can help motivate them to drop the safety behaviours. For example, a young person who was concerned that his schoolmates might see his hand shaking while drinking often turned his back to them before taking a sip. This made him feel less self-conscious and so seemed a good way of coping with the situation until he saw what it looked like on the video. He then realized it will have appeared odd and may have conveyed to his friends that he was not really interested in them, when the exact opposite was the truth. As turning his back was an intentional strategy, he was able to choose not to do it in future. Similarly, a young person who was concerned that other people might think she was stupid tended to run through a pre-prepared list of topics during conversations and to be distracted from the conversation by mentally monitoring how she thought she was coming across. On viewing the video, she realized that she was conveying the impression that she was not interested in other people and was just giving them a lecture. This was the opposite of the impression that she wanted to convey, so she
experimented with just saying what came into her head and responding spontaneously to what people said. When she watched this on the video she realized that dropping her safety behaviours allowed her to come across to others in the open and friendly manner that she wished.

Comparing ratings before and after viewing the video

A key aspect of video feedback involves comparing young peoples’ ratings of how they thought they would appear with how they actually appeared once the video has been viewed. This comparison usually involves looking at all the specific predictions that the young person made. The initial 0-100 ratings that young people made in advance of viewing the video are compared with their ratings of the same concerns (looking anxious, sounding boring etc.) after they have watched and discussed the video. To facilitate comparison a two-column table is constructed. Once the discrepancies have been tabulated, the young person is asked:

<table>
<thead>
<tr>
<th>Therapist</th>
<th>What do you notice when we compare these two sets of ratings?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>I look so much better than I thought I was going to. I look OK, not really that scared, even though I felt it.</td>
</tr>
<tr>
<td>T</td>
<td>Even though you felt it inside, is that right?</td>
</tr>
<tr>
<td>P</td>
<td>Yeah, that’s true.</td>
</tr>
<tr>
<td>T</td>
<td>So what does that tell us about how much it is possible to see anxiety?</td>
</tr>
<tr>
<td>P</td>
<td>Maybe it can’t be seen that much. I might look ok.</td>
</tr>
<tr>
<td>T</td>
<td>Uh huh, so if people can’t see your feelings, is it a good idea to use them as a judge of how you’re looking?</td>
</tr>
<tr>
<td>P</td>
<td>No, I guess not.</td>
</tr>
<tr>
<td>T</td>
<td>That sounds like a really important thing for us to learn, doesn’t it? So next time you are in a social situation and feel you are coming across badly, you may want to bring to mind the picture of how you actually looked on the video.</td>
</tr>
</tbody>
</table>
Eliciting feedback from other people

It can be very helpful to supplement video viewing with feedback from other people who might have been involved in an interaction. As described earlier, this is done routinely for the self-focused attention and safety behaviours experiment. In the open-ended written feedback on the first side of the form, stooges tend to make specific comments that make it evident that they were interested in the young person and noticed various things about them. But what they noticed was mainly what was talked about, not the specific fears that the young person had (such as “my lip was shaking”). The second side covers the adolescent’s specific predictions (such as “I’ll sound boring”), and usually the stooges’ ratings are similar to the young person’s ratings after they have viewed the video, but sometimes the stooge is even more positive. When this happens it can be useful to discuss with the adolescent why the stooge may have been more positive: “Is it possible that your ratings are still partly influenced by your private feelings. This may be information that nobody else could have”.

Therapists should use their discretion in deciding whether is it helpful or necessary to supplement video feedback with feedback from others. Most often we present feedback from others after young people have had a chance to view and discuss their video and it is essentially used as a way of further confirming the conclusions they have already reached. However, if the feedback is very positive and the therapist thinks that the adolescent’s self-criticism may make it difficult for them to view the video objectively, it can be useful to show the other person feedback first. This helps to establish a different cognitive set for viewing the video.

Freezing the moment of disconfirmation and consolidating learning

The aim of video feedback is to help adolescents see that they come across to others much better than they think. There are some moments in a video that illustrate this point more clearly than others. As video is a moving image, these moments can pass in and out of consciousness quite quickly. An excellent way of overcoming this problem is to capture the moment of disconfirmation as a still image. This can be done either by taking a still from the video or by taking a separate photograph. The latter is particularly useful in out-of-the-office behavioural experiments. For example, a young man reported
feeling self-conscious when walking in the street even when not interacting with other people. He thought he would look as if he was cowering, he would “stick out like a sore thumb” and people would look at him in a hostile way. He agreed with his therapist to test this out by walking through a busy shopping centre. The therapist accompanied and discretely took photographs on her mobile phone. The image captured convincingly disconfirmed his fears: he stood tall and upright, fitted in amongst the shoppers, none of whom showed a negative or hostile manner towards him. He saved the image on his mobile phone.

Still images involving other people, like the photograph just discussed, can be a helpful way to demonstrate to the young person that their feared concerns (I was boring, I looked sweaty, I looked shaky, I had nothing to say) were not as noticeable to others as they thought, or that even if others did notice they did not react as negatively as the young person feared. Capturing these moments of disconfirmation can be particularly powerful when the adolescent feels their feared concern happened naturally (e.g. they forgot what they were saying, they naturally blushed mid-sentence). It can also be helpful for decatastrophising experiments, where young people purposefully perform a feared concern in order to discover whether others react in the disapproving way they expect (such as adding water to their underarms to create the appearance of sweating, or purposefully trembling their hand when talking to a stranger). This can help young people to realize that they are much less the subject of other people’s critical attention than they initially thought.

Still images can also be a wonderful way to capture moments when young people realize they come across much better than their internal feelings and self-perceptions tell them they do (e.g. I look bright red, panicky, have wide scared looking eyes). For example, a teenager reported feeling she blushed 80% red whilst giving a presentation to a small audience during her therapy. Prior to viewing the video, she was asked to select the shade of red she felt she blushed at this moment using a colour chart. When a still image was captured from the video at the moment she felt she blushed 80%, the colour she selected from the colour chart was held next to this image, providing a clear disconfirmation of her belief. A second image was then created: this contained the still taken from the video at the worst moment for the adolescent (when she felt she blushed
red) side-by-side with the block of colour she predicted she blushed from the colour chart. She kept this photo on her mobile phone and looked at it over the week whenever she felt she was blushing, as a reminder that “My feelings are not as visible as I think”. The contrast between two images that depict how adolescents feel and how they actually looked on video may seem stark to an objective observer. However, some adolescents who re-experience strong anxious feelings and/or find it hard to switch off their habitual self-criticism when viewing images, may find it difficult to perceive contrasts that would be apparent to other people who did not experience their feelings or levels of self-criticism. In these instances, we have sometimes found it helpful to edit the image by removing identifiable features of the adolescent and isolating only the part of the person that they were most concerned about (e.g. showing a portion of their cheek that they felt went bright red; their smile that they felt looked like a grimace; their underarm that they believed was dripping with sweat etc.). This isolated feature in still image captured from the video can then be compared to a visual calibration obtained before viewing. Removing identifiable features of the young person can help prevent the projection of their feelings and self-criticism into the image, and help them perceive the contrast between their self-perception and reality.

Capturing two still frames from the video at different time points can also be another way to illustrate that adolescents’ internal feelings were not as noticeable as they thought. For example, one young person became extremely self-focused during a conversation with a stooge in therapy. He felt highly anxious at that moment and worried that his face looked odd. He and his therapist were able to isolate the moment on video and to also capture a still image from another part of the conversation when he did not feel particularly anxious, and was predominantly externally focused. The young person was amazed to discover that he couldn’t see any difference between the two images. This helped him realize that his feelings are largely private.

Creating a still image flashcard

In order to abstract key principles fitting the cognitive conceptualization of the young person’s social anxiety, and to consolidate and generalize learning, the young person and therapist may add some informative text to still images captured from the
video (e.g. “I felt 80% anxious but I don't look it – my feelings aren’t visible”, “I worried other people would laugh at me but they were friendly, this shows I’m acceptable”). Adding some of the key learning points in the young person’s own words, either handwritten on a printed copy or typed onto an electronic image that can be saved on a smart phone or tablet, can act as a powerful flashcard that the adolescent can use as a reminder the next time they enter a stressful situation.

*Rehearsing the way they looked on video*

Negative self-images are often habitual and well rehearsed. For some people it can be helpful for them to intentionally bring to mind the pictures of how they really appeared on video when they appear anxious so these can counteract their habitual negative self-images. They can also remind themselves of how they look before going into a stressful situation.
CHAPTER 7. ATTENTION TRAINING

Young people with social anxiety are habitually self-focused. The first sessions of CT-SAD-A (developing a personalised model, undertaking the self-focused attention and safety behaviour experiment, and viewing the videotape of the experiment) will have demonstrated that this tendency to focus on themselves, on how they are feeling and on how they think they are coming across is unhelpful. The next step in CT-SAD-A is to help the young person to shift to an external focus. There are two reasons for doing this. First, being externally focused reduces anxiety in general. Second, it also allows the individual to pick up information about how they are really coming across rather than how they imagine they are coming across. Simply instructing the young person to focus externally is rarely sufficient and so a session of training is required. Before beginning the therapist and young person should agree on why focusing externally is helpful.

As therapy proceeds there are two sorts of externally focused attention that the therapist will want to draw on for different purposes. One form is externally focused evaluative attention and the other is externally focused non-evaluative attention. Externally focused evaluative attention is used in behavioural experiments when the young person is intentionally testing fearful predictions. In behavioural experiments the young person is encouraged to actively observe the social interaction in order to discover how people actually behave and whether their prediction was true. Externally focused evaluative attention involves attending closely to what is going on in one’s social environment, observing what is happening and intentionally picking up clues about the situation and other people and their reactions.

Externally focused non-evaluative attention involves becoming absorbed in the social interaction without evaluating yourself or your performance. Phrases such as “losing yourself in the conversation”, “being in the moment”, and “getting lost in the here and now” capture this type of attention nicely. Young people without social anxiety usually attend to social interactions in this way ‘automatically’. In therapy, external non-evaluative attention is promoted as a general strategy in social interactions after the socially anxious adolescent has used externally focused evaluative attention to test out their fearful predictions in behavioural experiments. Clearly there are important
differences between the two types of external attention and the therapist will want to consider which they are encouraging and when during treatment. However, an ability to focus one’s attention externally is a prerequisite for both types and so training in an external focus is usually a necessary first step.

The programme of attention training that we have developed is comprised of a single session, usually provided in Session 4 of CT-SAD-A. Training begins with a relatively easy task involving non-social stimuli, attending to sounds with eyes closed, and progresses to a situation approximating to a social interaction, sitting facing the therapist as they read aloud. This allows the socially anxious adolescent to learn the skill in a setting that is not too anxiety provoking before transferring the skill to social situations.

It is emphasised that this is a skill to be learnt and therefore repeated practice is important. It is helpful to do the training as you are starting to do behavioural experiments because an external focus of attention will facilitate processing of the external situation rather than the self and one’s feelings and the more the young person is able to do this in behavioural experiments the more new information they will gain from social situations which is crucial for the correction of distorted beliefs and impressions.

Although few studies have directly investigated the efficacy of this component of treatment on its own, findings suggest that shifting to an external focus of attention is a helpful component in the overall programme, as it seems to reduce anxiety and facilitate processing of the external situation. For example, Wells & Papageorgiou (1998) reported a single session experiment in which socially anxious individuals were exposed to social situations with or without training in an external focus of attention. The addition of training in external attention led to significantly greater improvements in anxiety and reductions in negative predictions compared to exposure alone. Similarly, two trials of individual cognitive therapy with adults with social anxiety disorder have demonstrated that changes in self-focused attention mediated symptom improvement (Hedman et al., 2013; Mörtberg et al., 2015)
7.1. **Overview of training steps**

Young people are guided through a series of brief training exercises in which they are encouraged to selectively attend to aspects of the outside environment and compare this to short periods of self-focus.

Usually exercises are introduced in the order below:

Step 1: Sounds (with eyes closed)
Step 2: Colours
Step 3: Shadows/reflections or textures
Step 4: Music
Step 5: Therapist reading

We find this order works well as the training moves from the least challenging exercise, in which the young person focuses on sounds around them with their eyes shut, to exercises that are slightly more difficult, in which the young person is focused on non-social stimuli again but now with their eyes open, before progressing to quasi-social situations. However, these steps are not set in stone and there may be instances when the therapist deviates from this order or repeats certain exercises. For example, if a clinic room is exceptionally quiet the therapist may decide not to do Step 1, or may need to go to a different location to do it (for example a clinic room nearer the main reception, or the clinic garden if it is empty). Exercises may need to be repeated if the young person struggles to engage with the task.

For each of the steps the aim is for the young person to become completely absorbed with the particular stimulus and to compare this state with how they feel and how their environment seems when they are self-focused. Asking the young person to intentionally focus on themselves and their worries for a short period of time can act as a helpful counterpoint to the externally focused exercises and make the contrast between the two even clearer. It can also be helpful to ask the adolescent to intentionally shift their attention from an internal to an external focus during the training exercises. For example, the therapist can suggest the young person switches their attention each time the therapist
knocks on the table. This provides the adolescent the opportunity to practice intentionally redirecting their attention.

The following transcript demonstrates the therapist asking the young person to engage in self-focused attention. Then the therapist encourages the young person, whilst they are still in that mode of processing, to make a mental note of how they are feeling and how the external world seems.

Therapist:  
So let’s now close our eyes. Turn your attention onto yourself. Becoming very aware of yourself. Becoming self-conscious. And I want you to keep your attention on yourself for a while. Stay in your head, away from the outside world and perhaps when you feel that’s where you are, you could put up your finger or something, just so I know.

Great. And now I just want you to hold on to that feeling. Just take a mental note of how that feels, how safe and whole things are, how you feel in yourself. A sort of feelings scan if you like.

7.2. Setting up the training

Normally the fourth session would begin by reviewing the lessons learnt from the self-focused attention and safety behaviour experiment and the video feedback. Two points can be established/recalled. First that the young person focuses on themselves in social situations and uses their feelings and internal thoughts and impressions as evidence of how they are coming across. Second that this leads to excessively negative appraisals and increases anxiety. It is therefore important to instead attend to the external environment in social situations. This might be summarised with the young person as follows:

“So we have found out some really important things from our last two sessions. We know that focusing on yourself and your feelings is misleading and can trip you up in social situations. We now need to get more information about what is
happening outside of yourself and what is actually happening in social interactions rather than what you are imagining might be happening. But if we stay lost in our head, not observing what is happening then that isn’t helpful because we won’t be able to spot new information. So why don’t we spend a bit of time getting tuned into things? Getting out of your head and into the world. Does that sound ok?”

To reduce the young person’s self-consciousness for attention training we find the following strategies are helpful. First, the therapist explains to the young person that they will do the exercises (outlined below) together with them. Second, position the chairs at angles to each other so the therapist and young person are not directly facing each other but towards different corners of the room. Third, the therapist starts with the listening to sounds exercise in which both the therapist and the young person have their eyes closed. The therapist closes their eyes and fully takes part in the exercises. These points might be made in the following way with the young person:

“If you want to make yourself comfortable and then let’s have a go. If you just close your eyes and I’d like you first to just let your attention be wherever it is with your eyes closed.”

7.3. Instructions

Step 1: Sounds

Once the therapist and young person have closed their eyes, the exercise can begin: “Ok, so shall we try to get out of our heads for a little bit? Why don’t we first try tuning into sounds? I’d like you to close your eyes and try to become aware of as many sounds as you can outside of you. So let’s do a sort of ‘listening scan’ if you like. What are all the sounds you can hear? And count them, and then when you think you’ve got them all, try and become as absorbed as you can in each sound, one by one.”

Young people may well find this difficult to begin with and give vague answers. The therapist can encourage them to attend more closely to each sound they hear, as demonstrated in the following transcript. The therapist starts by asking the young person
what they have noticed when they have had their eyes closed for a while. They then ask the young person to describe the sounds more specifically before the therapist suggests particular sounds that they themselves have heard. The therapist counts the sounds for the young person, encouraging them to identify further sounds as the exercise progresses.

Therapist    What sounds are you noticing?
Patient      Cars outside and something in the building.
T  So, cars outside…when you say ‘something in the building’, what sort of sounds are you picking up? Is it one sound or several sounds?
P  It’s like the sound of…a few things like the sound of people shutting doors or moving around.
T  Great, so shutting doors, people moving around. Can you pick up a background air-conditioning type sound?
P  Yeah.
T  Okay, good, that’s 4 sounds. And with the cars, can you hear any difference between cars and buses?
P  Yeah, a big difference.
T  You can? Okay. Any other traffic sound besides the car and the bus?
P  Maybe some music coming from outside?
T  Ahaa. So, music. Did you hear a motorbike?
P  Yeah.
T  Good. That’s 9 sounds I think we’ve got so far.
P  A truck coming.

The therapist will then ask the young person how able they were to focus their attention externally. As can be seen in the transcript below, the therapist uses the focus of attention Likert scale (ranging from -3 to +3) that was used in Session 2 (in Appendix H). This can be used for all of the attention training steps.

Therapist    Great, okay. Let’s just open our eyes for a moment. Good. So how did you find that as an exercise? Where was your attention during that?
Most of the time I was really focusing on the sounds outside, I was definitely getting out of my head and I was noticing quite a lot of things.

T And if we were looking at how much your attention was on sounds outside, and how much was on you and how you were feeling, where would you put that? Shall we use that scale again? Here it is.

Um, I'd say about a two.

The therapist can then ask the young person for their observations and reflections. First, ask the young person how they felt during the exercise. Almost all young people describe feeling less anxious or more calm, in contrast to the feelings of anxiety, fear or tension that they usually experience when in their habitual self-focused mode. Although it is usually very clear from what the young person says that they have noticed a pronounced difference between the two states, it can sometimes be helpful to ask them to give you a rating on a 0 – 10 scale of how they felt during the period of external focus to compare with how they feel when focusing on themselves. This might be particularly helpful with adolescents who are younger or less cognitively able. For example one early adolescent girl used the words “suffocated and stressed” to describe how it felt when she was self-focused so we used this on her rating scale. Second, ask how the external world seemed to the young person during the exercise. Many young people describe experiencing the world as less overwhelming and less threatening and more real or whole when their attention was focused externally compared to when self-focused. Again, a rating scale can be helpful here, using the young person’s own words to quantify their impression.

If the adolescent is able to notice that the world appears differently depending on what they are focusing on then it is a wonderful insight as it illustrates that the most threatening place is actually in one’s own head. In the transcript that follows the therapist encourages the young person to compare how the external world seems to them when they are self-focused and when they are externally-focused. The therapist then helps them to label the different modes of attention.

And how did the outside world seem to you then?
Patient: *It seemed interesting, there was a lot going on!*

T: *Did it seem a threatening or dangerous place?*

P: *No, not at all, I kind of felt part of it and safe and it all seemed whole if you know what I mean?*

T: *Aha, so more safe and the outside world seemed whole? That sounds really different to when you were focusing on yourself, doesn’t it?*

P: *Yeah, it all seemed so dark and horrible when I did that.*

T: *Ok, so when you concentrate on yourself the outside world seems dark and horrible, but when you step out into the world you feel more safe and included?*

P: *Yeah, like it is all ‘okay’.*

T: *That is so interesting isn’t it? Do you think that might also be to do with, what we could call ‘being in the moment’*

P: *Yeah.*

T: *Ok, so we’ve got ‘being in the moment’ and ‘things are dark and horrible’. Are those opposites? And if you get into the moment, things feel less dark and horrible and more whole or complete? And as you said, ‘it is all okay’?*

P: *Yes, like I don’t need to change anything or worry?*

T: *Aha, so this mode is not building up with worries and it sounds a much more comfortable place to be.*

P: *Yes.*

T: *Great, so I wonder if now we can do a few more exercises where we work on you getting out of that mode, into a more uncomfortable, self-mode, and then try and get you to switch out again.*

**Step 2: Colours**

This step gives young people the opportunity to become absorbed in what they can see. This will be important because young people will need to develop the ability to shift their attention to the external world with their eyes open. In this exercise young people are asked to focus their attention on what they can see and focus in on the colours.
they notice. The therapist takes part in the exercise with the young person. In the instructions the young person is encouraged to becoming fully absorbed in the colours around them, without concerning themselves with the names or types of objects. The therapist can suggest to the young person that they turn everything they see into colour charts or paint colours.

Therapist: *I'd like you to look for as many different colours as you can, and really be absorbed not so much in what it might say on the books, or exactly what the objects are, but the colours themselves. As though you're trying to turn everything into colour charts. And just try and become as absorbed as you can, as interested as you can, in all the colours around. Just note all the different types of colours there are. Are some of the colours faded? Are some of the colours strong? Are some of them pastel, some of them more primary colours? Also, what are the different shades within a colour; different shades of red, different shades of blue. Does it look faded or bright?*

**Step 3: Shadows/reflections or textures**

Step 3 provides a different opportunity to become absorbed in visual stimuli. When young people have spent some time engaging in the colours around them, the therapist can encourage them become absorbed with reflections and shadows. They are asked again to not focus on the names, types, or colours of objects that they see, but instead to absorb themselves as much as possible in reflections and shadows and how the light is falling on objects in the room.

Therapist *And now I'd like you, while still looking round the room, to shift. I want you to keep on looking at visual things, but now I want you to take in as much as you can of reflections, and shadows. Of where you can see a shadow in the room, where you can see a reflection. Some light bouncing off something. Whether it's a plastic spine of a book, or a mirror, or a*
When instructing the young person to focus on textures, the therapist can suggest:

“Notice the surfaces around you. Some might be rough, some smooth. Others might be bumpy or uneven. Don’t worry about what the objects are or about colours, we just want textures.”

**Step 4: Music**

We ask young people to select a piece of music from their mobile phone or device. As the music is playing they are instructed to repeatedly shift their attention back and forth between the music and themselves and their worries every time the therapist indicates, for example by knocking on the table. We then might ask the young person to select one instrument or vocal and attend to this. They can then play around with switching between different instruments.

**Step 5: Therapist reading**

In Step 5 the therapist reads aloud to the young person. The therapist explains that they would like the young person to switch their attention between the narration and their thoughts and worries:

Therapist  

*What I’d like to do, is I’d like to read a bit of it, and I’d like you firstly, for the first couple of paragraphs just to get absorbed in listening to me reading it, what it's about, the tone of my voice. And then after a couple of paragraphs, I'm going to go like that, and I'm still reading it, but I'd like you to get lost in your head instead.*

7.4. **Key learning points**

“The scariest place is in your head”

A powerful point that young people often pick up and that echoes what they will have learnt in the ‘self-focused attention and safety behaviours experiment’ is that often
the scariest place to be is in their head. Young people often say this is a useful ‘mantra’ that can remind them to step away from negative thoughts and self-focus and shift to an external focus. We might remind the young person that self-focused thought per se is not unhelpful. The therapist can help the young person to appreciate that there are times when they are self-focused in order to engage in constructive thinking and decision-making and that this will be helpful. However these are different from times when they are self-focused whilst trying to do something else, like concentrate on a lesson or take part in a conversation. The following transcript demonstrates the therapist explaining this point to a young person:

Therapist: So what's uncomfortable? Is it the world, or is it your head?
Patient: Yeah, your own head.
T: Yes it does look like that doesn’t it. And of course sometimes we need to make choices and decisions. But is it useful to be freewheeling thinking about them when you're involved in other stuff, or is it to think about them when you're going to think about them 100%?
P: It's better to think about them when the time comes really. To make a decision, as opposed to letting things swirl round in your head.

“Getting out of your head and into the here and now”
A related learning point is that a shift of attention can change these negative feelings and perceptions. The idea here is that there is an interesting and rich world waiting for the young person if they can attend to it. Here the therapist is explaining this point to a young person:

T: So swirling around when you're not really focusing on it, just takes you out of the world, makes you feel unsettled and uncomfortable? So if you notice yourself feeling unsettled and uncomfortable, then I guess you could ask yourself, is this a moment to really sit and think about my future? Or am I just swirling around? In which case, why don't I get into somewhere more interesting, which is the here and now. Because what we
seem to have been finding in our experiments is that when we do get out of our heads and into the here and now things are often more comfortable and more interesting. What a great thing to find out! And how great that just by changing our attention we can change how we feel and our perspective.

Identifying and labelling a cue to shift attention

After stepping through the exercises it will be important to help the young person select a readily noticeable cue to shift their attention externally. This may be a feeling or sense, but often with young people they find using a physical sensation easiest, for example one girl said she noticed she was becoming self-focused when she felt a tightening in her chest. The following transcript demonstrates the therapist helping this young person select a cue:

Therapist  So what's the cue? How are you going to spot the state that you catch yourself in, where you think now this is a moment for action: 'I am now going to get into the world'?

Patient  Like the sign that I’m stuck in my head?

T  Ok, so it’s like ‘I’m stuck in my head’? What’s the tell tale sign that you are getting stuck in your head?

P  It is like a feeling here, in my chest I guess.

T  Tell me a bit more about that, what does it feel like?

P  Like a hand is pushing on it, it feels kind of heavy and tight.

T  Okay, great. So you catch yourself feeling a tightness and heaviness in your chest, and spot yourself getting ‘stuck in your head’. Sometimes we need to think about things but it sounds like there are times when it isn’t so helpful and it is stopping you being in the here and now. So first let’s spot that, label it, and it sounds like the label is ‘I’m stuck in my head’ and ‘I can feel it in my chest’.
Developing a plan of action

The therapist and young person can then develop a clear stepwise plan of action to help the young person shift their attention once they notice they are becoming self-conscious:

Therapist: And then what form of action do you think you'll try and take, at that moment?

Patient: I think the best one is closing your eyes. Sometimes you can't do that, in public situations. I don't think it would look very good doing that in class! In most situations, that would be the best thing to do, but also concentrating on sounds or whatever.

Therapist: I think you can do that without having to close your eyes.

Patient: Especially at school. It's very easy to listen to other people's conversations, what the teacher is saying and stuff. And then concentrating on colours, and then I think the reflections. Not because that was the order we did it, but I think that's the easiest way of doing it.

Attention is like a muscle

Young people with social anxiety are habitually self-conscious. It is therefore difficult to shift their attention to the outside world, especially at first and particularly when anxious. It is important to anticipate this challenge with young people during the session. The analogy of attention being like a muscle can be very helpful in conveying two messages. First, to view being self-conscious as a golden opportunity to try shifting their attention externally (and flexing the attention muscle). Second, that practice is vital. To continue the gym analogy this can be explained as taking regular trips to the ‘attention gym’ (homework tasks are described below). The following transcript shows how to introduce this idea:

Therapist: So you're there in the moment, sort of thing.

Patient: Yeah.
And then you may find yourself ‘getting stuck in your head’ again. What are you going to do then?

Concentrate on sounds maybe?

Great plan, yes! So this is a bit like doing press-ups or something isn’t it? It's like, we don't mind if you find yourself getting stuck in your head again, because that's another opportunity to fine tune the skill of getting out of the drift.

Yeah.

Whereas if you get out of your head, and stay out of it for the next three hours, it's no practice, because you've only practised once. So don't feel disappointed if you find yourself getting stuck in your head again because that's a golden opportunity to fine tune the skill of getting out.

Yes exactly.

So it sounds to me like we need to make sure you hit the attention gym every day – just like you do your dance practice, right? So maybe we can think about some helpful exercises to do every day, to get that attention muscle really strong.

7.5. Homework

There are two settings in which the young person is asked to practise shifting to an external focus of attention as homework. First, when they are on their own. Second, situations when they are interacting with other people. When they are alone, they should try to do an exercise for 15 minutes or so every day. It might involve one or a few of the exercises covered in the session, depending on what they found helpful. Agree with the young person what they will try, perhaps adding the task along with a reminder onto their phone. When they are interacting with other people, ask the young person to try to get absorbed in the conversation and the social interaction, rather than focusing on how they are coming across. Encourage them to make notes about the homework tasks to discuss at the next session.
CHAPTER 8. BEHAVIOURAL EXPERIMENTS

“We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.”
T.S. Eliot, Four Quartets

As in other cognitive-behavioural therapies, in CT-SAD-A young people are encouraged to systematically confront feared and avoided social situations and interactions. However, exposure is conducted rather differently from the way it is done in most of the traditional child and adolescent CBT programmes. In CT-SAD-A, exposure to feared and avoided situations is undertaken in behavioural experiments. In behavioural experiments predictions about what might happen and how other people might react are made and these predictions are tested out by facing feared situations, focusing attention externally and dropping safety behaviours, and then looking out for people’s reactions. Later on in therapy the young person might actually perform the feared outcome and look at the effects. Simple repetition of an exposure assignment is not considered to be helpful in itself. Exposure hierarchies and on-going rating of anxiety in feared situations are not undertaken. Instead, in CT-SAD-A the situation chosen to be confronted will depend on what would provide a good test of the fearful concern in question (ensuring a situation that is also manageable for the young person).

The principle of behavioural experiments is not habituation per se, but a cognitive change framework in which exposure is used either to demonstrate the adverse consequences of some psychological process or coping strategy, or to test specific predictions the young person has regarding what happens in social situations and how people respond to them. The principal experiment used to demonstrate the adverse consequence of a psychological process and coping strategy in CT-SAD-A is the self-focus and safety behaviour experiment undertaken in session 2. To test specific predictions both video feedback and additional individualised behavioural experiments are used. Video feedback is used to test predictions young people have about how they
come across to others and to discover how they actually appear and how others react. The individualised behavioural experiments carried out in CT-SAD-A involve designing experiments to test out the young person’s specific fearful predictions to learn what happens in social situations and how people respond.

The fundamental idea to be tested in behavioural experiments is “I am unacceptable” or “I am unlikeable”. It is only by dropping safety behaviours and showing their true self that the person can find out whether this true or not. This highlights a key feature of behavioural experiments (as compared to exposure). Behavioural experiments have the particular aim of helping the young person to discover that when they are just themselves, without hiding away or putting on a special front, in other words by dropping their safety behaviours, they are acceptable. Benefits of simple repetition of an exposure assignment may be limited as it is likely to demonstrate to the young person what they already know – that they do not come across particularly well, because really what is being tested in simple exposure is ‘my safety behaviours put people off’. As a result nothing new is learned. It is only by allowing other people to get to know them, by dropping safety behaviours, that the adolescent can discover that they are acceptable as they are.

Behavioural experiments are an essential part of CT-SAD-A. Experiments should be undertaken in almost all sessions after the model has been developed. Behavioural experiments can use a variety of different means to gather information, including video recording, stooges, role-play, audiotape and so on. Once the young person and therapist have begun undertaking behavioural experiments in session they should also be scheduled as homework. The therapist will help the young person to plan a programme of behavioural experiments to complete between sessions, ideally on a daily basis. To capitalise on the increased motivation and self-efficacy that young people often feel following a session, we try to plan the first homework task to be completed by the young person straight after the session, for example on the way back home or to school.

After the self-focus and safety behaviours experiment which is in session 2, the next behavioural experiment we usually undertake is designed to test the common fear that “everyone is staring at me” in public places. This is often completed in Session 2 or 3
and repeated for homework. It is described in Section 8.3 ‘Example Behavioural Experiments’.

8.1. Aims

Behavioural experiments are designed to test specific predictions, for example “People are staring at me”, “If I feel anxious, people will think I’m weird”, “I’ll blush/sweat and people will notice”.

Behavioural experiments tend to focus initially on discovering that the things one fears are less likely to happen than originally thought. For example, Matt worried that people would think he was a ‘weird loser’ and as a result he used a lot of safety behaviours. He thought carefully about ‘cool’ and interesting things he could talk about beforehand and would mentally run through this list before joining his peers at break time. He would talk through this list quickly not allowing the conversation to stay on one topic for very long. He did this because he thought people would get bored otherwise. Also, he would memorise what he had just said and compare it to what he was about to say. As a behavioural experiment Matt decided to meet his peers at break time and join their conversation without doing his safety behaviours. Specifically he was going to try to not prepare topics in advance, ‘follow the conversation’ rather than quickly changing topics, and not monitor what he was saying. He planned to watch ‘like a hawk’ for his friends’ reactions rather than focusing on himself. He agreed that this was the best way that he could discover how the others would regard him if he spoke without preparing in advance. His feared prediction was “If I just say things that come to mind, without preparation, my friends will think I’m a weird loser” which he believed 90%. Matt tried this out between sessions. He discovered that when he had watched for others’ reactions, his friends had shown interest in what he had talked about, and the conversation had naturally moved onto varied and unexpected topics. They all seemed to enjoy the conversation (including Matt!). From this, Matt learned that he was acceptable as he was, and did not need to prepare before conversations, his conviction in his original belief reduced to 10%.

A teenage girl, Chloe feared she shook in social situations and as a result she would hold her phone with both hands in case she dropped it when using it with friends.
An early behavioural experiment involved standing with her group of friends and openly holding her phone with one hand, without gripping tightly. She then checked out whether she dropped her phone and how her friends reacted. To Chloe’s surprise she discovered that holding the phone less tightly actually made her feel less shaky and she did not drop her phone. Her friends had shown an interest in the photographs on her phone that she had told them about but not any particular interest in her.

Later on in therapy behavioural experiments focus on decatastrophizing, i.e. if the worst happened, what would be so bad about that? Returning to the example of Matt, he often thought that he had to constantly say “interesting” things in order to avoid people thinking he was boring. This led him to monitor what he was thinking of saying and often decide not to speak. To help him discover that it is not necessary to always say something that you judge as “interesting”, Matt and his therapist agreed that he would intentionally say something that he thinks is “boring” to his friends and then observe their reaction. At break time he joined his friends and joined the conversation. He decided on something he thought was boring and then introduced this into the conversation and watched how the others responded. He chose to talk about aggregate and building materials. This was a very revealing experiment for Matt, as to his surprise, one of his friends engaged enthusiastically with this conversation topic, explaining that he was thinking of doing an apprenticeship with a builder. The conversation continued positively. Matt learned that even when he says something he thinks is “boring”, people respond warmly to him and can even find the topic interesting. This illustrated the fact that talking in general is not usually considered to be boring. Talking about a particular topic does not elicit the notion of being boring but rather it is usually due to not saying anything at all, or due to repetitively going over the same topic.

Returning to the example of Chloe, later on in treatment she decided to test out intentionally shaking her hand and dropping her phone in front of her friends then evaluating their reaction. She had feared everyone would stare at her and laugh. Instead one girl picked up her phone and returned it to her and another showed Chloe her own phone with cracks on it whilst she helped Chloe check that hers was still working. Chloe was able to conclude that even if she did shake and drop things, people did not stare or laugh. Instead people were helpful and also other people drop their phone as well.
8.2. Setting up behavioural experiments

Whilst behavioural experiments will take many different forms and aim to test out many different fears, there are six key steps involved in planning, executing and learning from a behavioural experiment which are described in detail below: identifying fearful concerns; situation; prediction; experiment; outcome; learning.

Step 1: Identifying fearful concerns

The specifics of the behavioural experiment to be undertaken will depend on the belief that is to be tested, and these will vary from person to person. The therapist and young person will have identified social cognitions when developing the model and throughout the early sessions. The process is greatly helped with the use of the Social Cognitions Questionnaires (SCQ), which is undertaken every week. It is a good idea to select one or two of the beliefs from the SCQ that have particularly high belief ratings and target these in behavioural experiments.

Step 2: Situation

Once the therapist and young person have agreed the target belief from discussion and the SCQ, the next step involves identifying the situations that activate this thought. Young people are usually able to explain when the thoughts tend to arise.

Early on, the therapist and adolescent can usually make quite a lot of progress in behavioural experiments with this strategy of specifying cognitions from the SCQ and identifying common activating situations. It can then be useful to review the LSAS-CA to determine which items (which refer to different situations) have reduced in terms of fear and avoidance and which have persisted. Those that persist often relate to situations that activate a constellation of beliefs. These situations can then be specifically targeted in behavioural experiments. For example, a high rating on the item “Putting my hand up in class” may activate the belief that “I will go red and everybody will laugh at me” as well as “If I give the wrong answer everyone will think I am stupid.” Several beliefs might be relevant. The therapist and young person might draw on other experiments they have already done but they may need to do something slightly different as the constellation of beliefs may be a little different.
As the aim is for the young person to complete the task and learn something new, try to find a situation that is anxiety provoking for the young person but which they are confident they will be able to complete. One teenage girl decided to test out making a comment on social media, whilst a young man who was somewhat more avoidant decided to try out ‘liking’ someone else’s post to begin with. Selecting social situations that are in line with goals will make the experiment feel more meaningful to the young person and increase motivation to complete the task. The following transcript shows the therapist agreeing on a situation with a 15-year-old girl, Tiffany.

**Therapist**  
So we’re thinking about how we can begin to test out your social worries and in particular the fear that people will think you are weird or boring. Your idea of taking part in a WhatsApp chat as a way for us to start doing this is great. Am I right in thinking that one of your short-term goals was to be able to have more of these conversations with your friends?

**Patient**  
Yeah, but it’s a bit scary.

**T**  
Yes, I can imagine it might be at the moment, but at the same time it also sounds like something you would really like to be able to do? Have I got that right?

**P**  
Yes exactly.

**T**  
So it sounds like there’s a really good reason for us to try it. But first, what do we mean by taking part in a WhatsApp chat? I’m an old person you see, and not very good at social media! So you have to help me understand how it works.

**P**  
There are about 15 people invited and maybe up to ten people in the chat at any one time. Some people just comment non-stop, but others might just say things once or twice and other people just like occasionally put an emoji in or something.

**T**  
Ok, so there is a whole range of activity that might mean ‘taking part in a WhatsApp conversation’. I see, and what could we try out in our experiment? We want to make a good experiment or test of that fear that
“I am weird and boring.” What kind of activity could you do in the conversation, that would be a good test of this but also manageable?

P So there’s no way I could start off a chat.

T Uh huh, that feels too challenging right now?

P Yes definitely.

T Okay, so what might be a better first step in testing this out?

P Someone usually asks what people are up to, I guess I could answer that?

T Fantastic, that sounds like a great situation for us to test out some of those social worries. Shall we start off by writing that down in your record sheet? [the use of Record Sheets is explained below]

**Step 3: Prediction**

The central aim of behavioural experiments is to test specific predictions the young person has about how they will come across in social situations and how other people will respond, when they do not do their safety behaviours. Or later in therapy with decatastrophizing experiments, the aim is to find out what would happen if the young person actually created some of the feared outcomes such as pausing or stumbling over their words. It is therefore important to specify exactly what the young person’s believe will happen in the agreed situation, how others will react or respond, and also how the young person would know. Also the therapist can ask the young person what evidence against the prediction would look like. For each prediction take a percentage belief rating, from ‘not at all’ to ‘totally’.

The following transcript shows the therapist identifying the predictions Tiffany has about the situation identified above. The therapist asks what she thinks will happen if she makes a comment. Young people often have more than one prediction about what will happen as can be seen here, and the therapist helps specify each of these. The therapist then encourages Tiffany to focus on what she predicts will happen in the social environment rather than with her feelings and emotions. The therapist helps Tiffany to operationalize how she will know that people have reacted in the way she fears. Finally, they suggest writing these predictions down and making belief ratings on a percentage scale.
Let’s take a moment now to think about taking part in the WhatsApp conversation and responding to the question about what you are up to. You thought this would be a good test of the fear that people will think you’re boring or weird. Ok, so when you think about doing this, what runs through your mind?

I don’t know. I guess I’ll feel scared.

Right, so you’ll feel scared. And what else do you think will happen?

I won’t be able to say anything or if I do it will just go wrong.

Uh huh, so let’s unpack that a little bit. So first you think your mind will go blank and you won’t be able to say anything at all? Is that right?

Yes.

Okay, and then you also think if you do say something, it will all just go wrong. What do you mean by that?

I’ll make some comment that is really lame and stupid and everyone will think I’m a loser.

“Everyone will think I’m a loser”, that sounds like a horrible thought to have, I can really understand why it feels so hard to take part in these chats at the moment. So it sounds like something really important for us to find out about – we might call it a golden opportunity to learn something new. I’m just wondering how we would know that everyone thought you were a loser after you made the comment? What would happen?

I’d feel rubbish.

You’d feel rubbish, ok and that’s really important, but would it be ok if we just parked feelings for a moment because we know they can sometimes trip us up can’t they? How could we tell, from the outside, that people thought you were a loser?

I guess everyone would stop chatting.

Like, leave the WhatsApp chat?

Yeah.
T 
Right, so that’s a really helpful way of checking out whether everyone thinks you’re a loser. We can see whether everybody stops chatting and leaves the WhatsApp conversation. Would that happen immediately or how, because I guess the conversation can’t go on forever!

P 
Yes, like within a minute of my comment.

T 
And when the conversation isn’t naturally ending anyway right? Okay, shall we write this down in our record now? And let’s think about how certain you are these predictions are going to come true on our scale.

**Step 4: Experiment**

In Step 4 the therapist and young person agree on exactly how they are going to test out the young person’s predictions. A number of common feared predictions and useful experiments to test these out are shown in section 8.3. Experiments can take many different forms, and the particular type will depend on the exact prediction to be tested. For example, experiments can be:

- Undertaken in session or as homework.
- In the clinic or in the local area.
- Modelled by the therapist with the young person observing people’s reactions.
- Videotaped. We find it can be extremely helpful to video experiments and watch them back in session afterwards.
- With a stooge. This can be particularly helpful in ‘decatastrophizing’ experiments that might be difficult for the young person to do in ‘real life’ interactions at first.
- Involve observation of members of the public and peers
- Use surveys (see section 8.5.)

Behavioural experiments are opportunities for young people to learn something new about themselves and their social environment. In order for this to happen they need to do two things in particular. First the young person needs to process the external situation (including others’ reactions) as closely as possible, rather than how they are coming across and their feelings. When explaining this to the young person it can be helpful to suggest that they “watch like a hawk”. Second young people will need to let go
of their safety behaviours. Once this has been explained to the young person, it can be helpful to think through exactly what they might need to do differently. For example, a young person that planned topics of conversation in advance and then monitored what they were saying for fear of being boring was encouraged to say the first thing that came to mind without preparation or planning and then to focus on the conversation in the here and now and observe the effects. Similarly, a young person who was scared of shaking tended to sit on her hands, and instead she was encouraged to leave her hands visible and unrestrained.

Step 5: Outcome

After the experiment review what actually happened, not what the young person felt. Then the young person should compare what actually happened with their original prediction. The original prediction can be re-rated in light of the new information.

Step 6: Learning

Reflect with the young person what they have learnt, what they discovered from dropping their safety behaviours (in terms of how they felt and what happened). Be curious with the young person: were they surprised by what happened, did people think and act different to how they had expected? Ask the young person how the findings impact on their original belief and how they fit with their overall view of themselves. If the findings point to a very different conclusion (for example: “I am an interesting person that people want to speak to”), ask the young person to rate this new belief. The lessons that people tend to learn from behavioural experiments are along the lines of: “I am acceptable as I am. I don’t need to cover up, hide, or do my safety behaviours. I can trust myself. I am the most critical person in my universe. My head is more threatening than the social environment.”

Having reflected on the findings the next experiment can be planned. The nature of the experiment and prediction to be tested will depend on the findings and stage of therapy. It may involve a refinement of the current behavioural experiment, for example when a young person struggles to drop their safety behaviours they are unlikely to discover very much and so the experiment will need to be rerun (in some form) without
the use of safety behaviours. This is described in more detail in section 8.4. The next
behavioural experiment may be an extension of the current experiment. For example, a
teenage boy had undertaken an experiment in which he tested his fear that “I will garble
my words and everyone will laugh at me” by putting his hand up in class to answer the
teacher’s question. The experiment had been a great success but the boy pointed out that
he had been sure of the answer to the question and so perhaps it had been less likely than
he had thought that he would garble his words. A further experiment was planned in
which he decided to put his hand up to try to answer a question of which he was unsure
of the answer. A subsequent experiment may instead test a related but different
prediction. For example Sumera was a young woman who believed that people were
disinterested in her and she therefore avoided speaking about herself. Having undertaken
a very revealing experiment in which she talked about her weekend plans with friends
without stopping herself or holding back, she and the therapist begun discussing how she
could build on this. They noticed that a related belief Sumera held was that “if I share my
difficulties and talk about feeling down, people will think I am weak.” For the next
experiment Sumera decided to speak to her closest friend when she felt upset.

Record Sheet for Noting Behavioural Experiments

Behavioural experiments are recorded in the Record Sheet for Noting Behavioural
Experiments (Appendix J). When planning behavioural experiments the young person
and therapist can complete the first three steps together. For in-session experiments they
can fill in the last two steps together once the experiment has been completed. For
behavioural experiments that are completed at home, the young person should try to fill
in the last two steps on the record as soon as possible after completing the experiment.
Some young people find it easier to have an electronic version of their record on their
phone (as adolescents invariably have their phones with them). The record sheets for
Matt and Chloe are shown in Tables 13 and 14.
Table 13. Record sheet summarising two of Matt’s behavioural experiments

<table>
<thead>
<tr>
<th>Situation</th>
<th>Prediction</th>
<th>Experiment</th>
<th>Outcome</th>
<th>What I learned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Break time with friends at school</td>
<td>If I speak without planning stuff or checking what I’m saying they will think I’m a weird loser. 90% They will roll their eyes, look away, snigger.</td>
<td>Say the first thing that comes to mind and watch my friends like a hawk. Don’t focus on myself - it trips me up and I can’t check out what my friends are doing.</td>
<td>I did it and looked around. The chat flowed. We ended up talking about how three of us are comic fans but didn’t know that about each other beforehand! No one sniggered or rolled their eyes or looked away. It went on until class bell rang. [Original belief 10%]</td>
<td>I am not a weirdo. I am fine. [New belief 65%] I don’t need to think up topics beforehand for people to want to talk to me. Try outside school</td>
</tr>
<tr>
<td>Break time with friends at school</td>
<td>If I say something boring people will think I am a weird loser and not want to be my friend. 99% Roll their eyes, look away, snigger. Conversation will stop,</td>
<td>Intentionally say something I think is boring about building materials and then watch everyone like a hawk, not focusing on myself. Find out</td>
<td>I did it and it was a real surprise. It turns out Tom is keen on building and started talking about his plans for an apprenticeship. He and I chatted about it for a bit and then the conversation changed.</td>
<td>It is okay to say boring things, no one reacts negatively to me. And what I think might be boring is probably interesting to someone! [New belief 60%]</td>
</tr>
<tr>
<td>go silent, they'll leave.</td>
<td>what happens.</td>
<td>[Original belief 20%]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 14. Record sheet summarising two of Chloe’s behavioural experiments

<table>
<thead>
<tr>
<th>Situation</th>
<th>Prediction</th>
<th>Experiment</th>
<th>Outcome</th>
<th>What I learned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standing with friends outside school</td>
<td>Unless I hold my phone tightly with both hands I will shake and drop it and everyone will think I’m a nervous wreck. 80% They will stare at me and my hands, and then make eyes at each other.</td>
<td>I held my phone loosely in one hand (I know that holding it tightly can actually increase tension in my muscles). Don’t focus on myself. Watch what happens.</td>
<td>Holding the phone less tightly actually made me feel less shaky and I didn’t drop my phone. Nobody stared at me or my hands. My friends had shown an interest in the photographs on my phone that I had told them about but that’s it. [Original belief 5%]</td>
<td>People are interested in me and don’t think I’m a nervous wreck. I am going to make sure I don’t grip things when I’m worried about shaking because it doesn’t help. [New belief 55%]</td>
</tr>
<tr>
<td>At a cafe with friends</td>
<td>If people see me shaking they will think I’m a nervous wreck. 70%</td>
<td>I’m going to intentionally shake and drop my mobile phone and watch for my friends’ reactions.</td>
<td>My friends were so kind! Lucy picked up my phone and gave it to me then Claire showed me her phone with cracks on it whilst she helped me check mine was still working. No one stared at me or my hands.</td>
<td>Even if I shake and drop things, people don’t stare or laugh. My friends are kind. We all drop things sometimes. People are interested in me and don’t think I’m a</td>
</tr>
<tr>
<td>[Original belief 0%]</td>
<td>nervous wreck. [New belief 60%]</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8.3. Example behavioural experiments

Socially anxious young people often feel that they are being stared at when they are in a crowd of people. This feeling is usually a consequence of their heightened self-focused attention. They are essentially staring at themselves and then thinking they are the subject of everyone else’s attention. If young people do have this feeling that everybody is staring at them, we find that this is useful thing to tackle very early on in therapy. If this thought is not changed it can be very difficult for the young person to be externally focused in social situations and so new learning will be undermined. The fear of being stared at is therefore often the focus of the first behavioural experiment to be undertaken after the self-focused attention and safety behaviours experiment.

Begin by identifying the situations in which the young person thinks they are being stared at and assess what they are doing in those situations. This might be on a crowded bus, train, underground tube, or in a shopping centre. The young person can then be asked when they most often experience this feeling of people looking at them: is it when they are looking at other people, or is it when they are looking at the ground, preoccupied with their shoes or bag? We find that it is nearly always the latter. It is therefore suggested to the young person that it would be great to do an experiment to test this out.

The therapist and young person choose one of the situations in which they experience the feeling of being stared at. When the young person is in the situation the therapist explains that they should pause and for a few moments look down to their feet. They are asked to capture how they are feeling and what they think everyone else is doing at that moment (usually they feel like everyone is staring at them). When they have noticed this felt sense, ask them very intentionally to look up and look around ‘like a hawk’ to check objectively who is staring at them. People usually discover that although they felt as though everyone was staring at them in fact when they looked up this was not the case. Another instance when they might think people are staring at them is when keeping an eye on people from corner of eye but not looking at them directly. So again, if they spot this happening, it will be about noticing this feeling, pausing and making a prediction, and then looking.
Of course young people do often find some people were looking at them. It is helpful to prepare young people for this and discuss the possible explanations for this. It is useful to do this in advance of the experiment because otherwise if they do notice someone looking at them they may jump to the conclusion that it means the people were staring (rather than looking) and thinking badly of them.

First it may not be ‘staring’ but rather people glancing over as they look around. Young people with social anxiety often confuse the two because if they look up and see someone looking at them they often look away again immediately. Encourage the young person to repeat the experiment, this time resisting the urge to look away if they see someone looking over in order to find out whether the person continues looking or their glance shifts to someone or something else. Second, the person might be ‘eye-parking’. ‘Eye-parking’ is something we often do in a crowd. Constantly moving our eyes around is tiring and so eyes tend to ‘park’ themselves somewhere. When choosing where to ‘park’ their eyes, they often choose another person because people are far more interesting than the floor or wall. This is different to staring in that people are not usually evaluating what is in front of them when they ‘eye-park’ but rather resting their eyes. Normally people look away if you catch their eye when they have been ‘eye-parking’. Encourage the young person to try being an observer in a busy area and try to spot instances of ‘eye-parking’ with other people. This is something they often find easy to do because it involves watching how other people are behaving rather than watching how other people respond to them. They can be an impartial observer rather than feel like the centre of attention. Third, the young person might find that someone has been looking at them in a sustained way. If so, it can be helpful to think with the young person why they might have been doing this. Ask the young person whether people generally try to seek out boring, uninteresting or unpleasant things to look at, or in fact people prefer to attend to interesting and appealing things.

This is a powerful experiment for a number of reasons. First because it demonstrates the important idea that our feelings are not reliable indicators of what is going on in our environment. Second because it reminds the young person of the unhelpful effects of safety behaviours such as looking away. Third because it reinforces the point that self-focused attention is unhelpful. Fourth because it is not too challenging
for most young people, it is easy to set up and the outcome is reliable. One of the nice things about this experiment is that it can be done multiple times a day. Using the feeling of self-consciousness as a cue to do the experiment. That is, when the young person notices this feeling they are encouraged to use this as a prompt to act. Because it is such a frequent feeling the experiment can be done multiple times and so considerable data can be amassed quickly.

There are countless behavioural experiments that can be devised to test different predictions. Some examples of good behavioural experiments designed to test common fears are shown in Table 15.

Table 15. Examples of behavioural experiments to test common fears

<table>
<thead>
<tr>
<th>Key fear</th>
<th>Safety behaviour</th>
<th>Prediction</th>
<th>Experiment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blushing</td>
<td>Covering face with hands/hair</td>
<td>If I don't cover my face then people will see me blush and I’ll be laughed at/rejected</td>
<td>Wear hair up and don’t cover face with hands. Don’t sip water to keep cool. Focus on the conversation. Observe others’ reactions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If people see I am red they will laugh at me/reject me</td>
<td>Intentionally put blusher on cheeks. Don’t cover face and observe other’s reactions.</td>
</tr>
<tr>
<td>Having nothing to say</td>
<td>Prepare topics of conversation in advance</td>
<td>If I don’t prepare topics of conversation in advance I’ll have nothing to say and people will think I’m boring.</td>
<td>Start up a conversation without any preparation and just ‘follow the conversation’. Observe others’ reactions. See if others are being quiet at times also.</td>
</tr>
<tr>
<td>Being boring</td>
<td>Censoring</td>
<td>Unless I censor what I am saying all the time I will sound boring.</td>
<td>Engage in a conversation and drop any attempts at censoring. Observe others’ reactions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Engage in conversation and</td>
</tr>
<tr>
<td>Appearing weird</td>
<td>Keeping still</td>
<td>If I move about or use hand gestures when I talk people will think I’m weird and unnatural</td>
<td>Speak to someone and move about freely. Observe others’ reactions. Speak to someone and move arms and hands more than usual. Observe others’ reactions.</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Trying to avoid attention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appearing uncool or weird</td>
<td>Avoiding disagreements with others</td>
<td>If I don’t agree with my friends’ opinion or don’t know the music/film/tv show they are talking about, they will think I’m a loser and not want to hang out with me</td>
<td>Give opinions openly and honestly whether they are in agreement with other peoples’ views or not. Observe others’ reactions. Observe how people behave in the following days.</td>
</tr>
<tr>
<td>Not being fluent in speech</td>
<td>Avoid pauses in speech</td>
<td>If I am not always 100% clear and fluent when I speak, then people will think I am stupid</td>
<td>The therapist can introduce ums and has into their speech and find out if the young person spots this. Invariably they do not and it can provide a nice demonstration of the experiment before the young person tries it themselves.</td>
</tr>
<tr>
<td>Always try to be 100% fluent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appearing weird</td>
<td>Avoiding</td>
<td>If I give the wrong</td>
<td>Observe what happens when</td>
</tr>
</tbody>
</table>

introduce a ‘boring’ topic of conversation and observe what happens.
<table>
<thead>
<tr>
<th>stupid</th>
<th>revealing not knowing something</th>
<th>answer in class everybody will point and laugh at me</th>
<th>peers give incorrect answers in class.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intentionally give the incorrect answer to a question in class. Observe others’ reactions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Shaking</th>
<th>Sit on hands</th>
<th>Grip cups tightly</th>
<th>If I shake people will know I am nervous and think I am pathetic</th>
<th>Relax hands on lap during conversation and then try picking up a cup without gripping it. Observe others’ reactions.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Intentionally shake hands when holding a cup. Observe others’ reactions.</td>
</tr>
</tbody>
</table>

### 8.4. Troubleshooting

**Refusal to do the task**

Behavioural experiments are designed to test out predictions that elicit anxiety in situations that are manageable. Despite careful planning to identify a suitable situation, from time to time young people will find they are unable to go through with the experiment. Although this may be disappointing, this should be seen as useful information to inform further behavioural experiment planning. First, it is important to review what happened; what was it that stopped the young person from trying the experiment? Often their conviction that the feared outcome would occur was too high and so it was too difficult to do the experiment. In this situation, the therapist and young person can agree on how they should proceed. This may well involve a revision of the experiment in order to test out the original prediction in a more manageable way. For example, the therapist may undertake the experiment initially with the young person observing. The young person is then usually able to carry out the experiment him or herself. Similarly if the experiment involved a conversation with a peer or stooge, the therapist and young person could undertake a quick role-play before undertaking the
actual experiment. Second, the therapist should check that the prediction to be tested is still meaningful and relevant to the young person; are they still motivated to try an experiment?

**Little cognitive change**

Sometimes we find that young people undertake the task but cognitive change is limited. This is often because they continued to use safety behaviours, failed to shift their attention out, or used their feelings as a basis for their opinion. Review the situation in detail with the young person, paying particular attention to the use of overt and covert safety behaviours and to shifts in attention. It can sometimes be helpful to draw out a personalised version of the model. For example, a teenage girl, Lara returned to session having attempted an experiment in which she expressed disagreement with a friend about likes and dislikes to test out her fear she would be rejected. She reported that it had gone, “okay” but she was not convinced, and her belief rating that her friends would become angry and not want to continue spending time with her had only shifted from 90% to 80%. The following transcript demonstrates the therapist first praising the young person for trying the experiment. They then review the interaction in detail, with the therapist asking questions about use of safety behaviours and self-focus. The therapist and young person map this out in a model before planning the next behavioural experiment based on what they have learnt.

**Therapist**  
So you said it went okay, but you weren’t convinced? I guess the first thing to say is really well done for having a go. Fantastic stuff. But I wonder if we could spend a bit of time trying to figure out what happened during the conversation, would that be ok? So can you talk me through it from the beginning?

**Patient**  
I was sitting with Bea and Molly in the cafeteria. We were just talking and it was going really well. I was kind of going with it, and really enjoying myself, just saying what I thought, and we were all involved, chatting…

**T**  
And did you try disagreeing with someone?

**P**  
Yeah, I said I wasn’t massively into Bea’s favourite band!
Eleanor Leigh & David M Clark

CT-SAD-A Manual

T  Wow, well done! And what happened?
P  Actually Molly said she kind of agreed with me! Then we talked about other bands and what festivals we want to go to this summer.

T  Ha great! Okay, so you noticed some important things here, can I check I’ve heard you right? You were in a conversation with Bea and Molly, and it sounds like you were focusing your attention on the conversation rather than yourself and how you were coming across. It also sounds like you were not holding back, or censoring yourself, you were saying what you thought? And in fact, you did the experiment we planned which was to disagree with Bea? What a great test. And then, watching Bea and Molly really closely we found out that rather than Bea and Molly not wanting to talk to you or getting angry with you, Molly agreed with you and the conversation then carried on. Is that right? It sounds like things then changed but let’s hold on to this first bit of learning because it is really important new information you got. Okay, so what happened next?
P  Yeah that’s right and I see what you mean, yeah. But then, I don’t know. There was like a brief pause after I said something, I think I suggested we should all go to a gig. And then it all went awkward and awful.

T  Can I slow us down a bit there? Did any thoughts go through your mind in the pause? What came up? Try to replay it slowly in your mind’s eye.
P  So I thought, “I’m just a idiot, what have I done, just been going on like a fool, they won’t want to go with me.” I don’t know, something like that.

T  Ah hah, so there was a brief pause and you had one of those negative thoughts whizz through your head. So what happened then? What did you start focusing on? If I thought I had been going on like a fool I might start checking on myself.
P  Exactly, so I started watching myself I guess, I kind of went into myself.

T  And then what did you start doing to cope?
P  I stopped talking, I just nodded agreement. I avoided eye contact.

T  And then what happened.
P  I don’t know, it was just so awkward. I just wanted it to end. Then the bell for lessons went.

T  I see. So the conversation had gone really well, and you had really been finding out that disagreeing with people is ok, and actually keeps a conversation interesting maybe? But then you had a ‘thought wobble’ if I can call it that, and you started focusing on yourself and using your safety behaviours, making sure you didn’t disagree with people, really trying to hide away? I just wonder, it sounds like your experience of the conversation and how it went then followed the same old path? Because I guess we were back to using feelings to judge how it was going and we know they are not very reliable. Also by hiding away from the conversation we don’t get to find out what is really going on, do we? Shall we just map this out so we are clear on it?

Therapist and young person draw out personalised version of the model

T  Okay, so we have learnt some really important things here haven’t we? And we’ve really been reminded about how troublesome safety behaviours and self-focus can be in social situations. How can we build on this now? What do you think we need to do next?

Negative reactions from other people

Despite careful planning for a successful behavioural experiment it is impossible to control other peoples’ reactions and occasionally a young person will report that other people behaved in a way which they thought was negative. If this occurs it will be important to try to understand with the young person exactly what happened in order to plan the next step.

Often the perceived negative reaction from others is in fact ambiguous and there are alternative interpretations of their behaviour. In this situation further behavioural experiments may be indicated. For example, one teenage boy took his first steps into messaging his friends to test out his fear that they would not reply because they were not interested in him. He returned to session very upset as he had messaged one friend but not had a reply all weekend. On discussion the therapist and young man agreed that whilst it
might be because his friend is not interested in him, it could also have been because his friend was busy or had not spotted the message (especially given his friend had messaged him in the past). A further behavioural experiment to test out these competing ideas was agreed. The young man went into school and asked his friend if he had got his message. To the young man’s relief it transpired that the friend was switching to a new phone and had no phone service or Internet connection that weekend, but was glad to hear he had been messaged.

Often we find adolescents may engage in ‘banter’ with each other that can be perceived as hostile but in fact reflects peer acceptance. In this scenario the therapist would encourage the young person to engage in some observational behavioural experiments, watching how their peers interact with one another, and looking out for instances of ‘banter’ to learn when and why it happens (see Chapter 12).

A common reason for a reaction from others that is not wholly positive is that the young person was still using their safety behaviours and these contaminated the social interaction. For example, Sienna had tried joining her friends’ conversation during the break in dance club. She had agreed to test out her fear that “if I talk they will think I am weird and I will know this because they will stare at me and then not talk to me.” Sienna came to session and talked about the behavioural experiment she had done as planned during the week. She was a little upset though, explaining that she had gone and joined the others, but they had hardly spoken to her. The therapist carefully reviewed the behavioural experiment with Sienna, paying close attention to any safety behaviours that she had struggled to drop. It transpired that Sienna had managed to join the conversation, said hello but she had then looked at the floor and not spoken. The therapist asked Sienna what she thought the effect of these safety behaviours might have been on her friends. Discussion helped Sienna to recognise that her friends may in fact have simply been ‘following her script’ and responding to Sienna as she was indicating that she wanted them to behave. A further experiment was planned in which Sienna joined the conversation as before, but this time worked hard to drop her safety behaviours and look for her friends’ reactions. This yielded a very different, more positive reaction from them.

In some situations the negative reactions are intentionally cruel and targeted at the young person. This is very likely to occur for at least some of our young socially anxious
patients and specific guidance can be found in Chapter 12. This is perhaps more likely with adolescents than adults, amongst whom bullying and peer victimisation is more common.

8.5. Surveys

Surveys are observational, data-gathering behavioural experiments intended to collect a broad sample of information or opinions about a particular concern the young person has. They allow adolescents to check out what people think about symptoms and other feared outcomes. For example, why people blush, causes of sweating, or what a pause in conversation means.

When mapping out the survey questions, begin with open-ended questions about the young person’s concerns before progressing to increasingly specific queries about their particular catastrophic interpretation. For example, as we mentioned earlier, Sumera believed “If I share my difficulties and talk about feeling down, people will think I am weak”. A survey was planned with the following three questions, which moved from a broad enquiry to Sumera’s specific belief:

1. Why do people share problems and feelings with their friends?
2. What would you think of a friend if they shared a problem or feelings with you?
3. Would you think badly of a friend who shares a problem or feelings with you, or not want to spend time with them?

Surveys are can be conducted by the young person or the therapist. There are pros and cons to both. When undertaken by the therapist the answers are often perceived as less convincing to the young person because the respondents are adults. However, adolescents often feel unable to conduct the survey themselves with their peers due to embarrassment. Therefore it can be often be best for the survey to be undertaken by the therapist in the first instance. Armed with some valuable information from the responses, the young person can then go and question one or two of their friends or relatives about their opinions. The therapist and young person can then review all the responses together in session and compare the information with the young person’s original belief.
When undertaken by the therapist it is helpful that the kind of people to be approached (number, gender etc.) is agreed with the young person. For example, one young man held a firm belief that other males believed men should not show signs of weakness (such as expressing emotion). It was therefore agreed that males would be questioned in the survey for him.
CHAPTER 9. WORKING WITH SOCIA LLY TRAUMATIC MEMORIES

“Now I know what a ghost is. Unfinished business, that's what.”
Salman Rushdie, The Satanic Verses

Most individuals with social anxiety disorder experience recurrent negative images of the way they think they appear to other people and how they anticipate other people will respond. Research suggests that these images are often linked, in terms of their content and meaning, to memories of earlier socially traumatic events (Hackmann et al., 2000). The socially traumatic memories typically relate to incidents in which individuals felt criticised or humiliated. For example, one girl, Martha recalled being reprimanded by her teacher in front of the class when she arrived late. A young man recalled his peers laughing at him for blushing when a girl said hello to him. The negative images tend to carry the essence of the memory of being criticised or humiliated. In particular, how the person thought they appeared when being criticised or humiliated. Research shows that these self-images are excessively negative and people look much worse in their image than they really appear. For example, Martha had an image of herself as ‘unable to speak, lip wobbling and about to burst into tears’, but this image of herself was far worse than the reality of how she came across to others. Similarly in social situations, the young man had an impression of himself with his cheeks on fire and felt he was being laughed at by others even though this did not tally with the reality of how he was coming across and how others were responding. The images are activated repeatedly in social situations and are not updated even in light of contradictory information.

Updating negative self-images is a key aim of several present-focused techniques in the treatment, such as video and photographic feedback, behavioural experiments, and surveys. These have been described in earlier chapters. For many young people with social anxiety these techniques will be sufficient to correct negative images and develop more accurate positive images, and memories of earlier events are spontaneously updated. Some socially anxious youth describe negative images in the absence of a linked event and for this subset of patients the present-focused techniques are also likely to be the most helpful.
However, for some individuals use of the present-focused techniques does not change the negative imagery as much as one would like. As the negative images are often linked to socially traumatic events in the past, there is therefore the additional option of using memory-focused techniques that we have found helpful. There are two interventions that the therapist can use to help the young person to discriminate between what happened in the past, what they fear will happen now, and what actually happens. Derived from Cognitive Therapy for PTSD (Ehlers et al., 2005), these are: discrimination training and imagery rescripting. Discrimination training is usually tried first, but if the problematic memory persists then the therapist might proceed to imagery rescripting.

A number of studies have reported on the effectiveness of imagery rescripting for adults with social anxiety disorder. Compared to a control session in which images and memories were discussed but not updated, Wild, Hackmann, and Clark (2008) reported that a session of imagery rescripting led to greater improvement in negative beliefs, image and memory distress and vividness, fear of negative evaluation and anxiety in feared social situations one week later. This was consistent with findings from another study investigating the effect of imagery rescripting on negative social beliefs, vividness and distress of the image and early memory, and in self-report measures of social anxiety amongst adults with social anxiety disorder. Significant improvements in all measures were seen after imagery rescripting (Wild, Hackmann, & Clark, 2007).

9.1. Timing of memory techniques

When used, memory techniques are usually introduced later in therapy, after the young person has attended at least five or six sessions of therapy. By then the adolescent will have experienced some of the present-focused techniques, including video feedback and behavioural experiments. This will be helpful for two reasons. First, the therapist will be better positioned to assess the extent of the response to present-focused techniques to determine whether memory-focused interventions are indicated. If the young person continues to experience the image after the video feedback and some behavioural experiments and the therapist has been able to identify a clear link between the trauma and the image, then it is well worth trying the technique. Second, the therapist and young
Discrimination training aims to help the young person to assess their current situation without it being coloured by negative memories of the past. The problem is that people feel as though they are under as much threat in the current situation as they were in the socially traumatic event in the past, even though that it is not the case. It is as if they are being haunted by the event in the past. The first step is to help the young person to intellectually recognise that their present fears are partly based on re-experiencing some of the feelings that they had in the past trauma, rather than present objective reality. The next step is to break that link emotionally. To do this they are encouraged to discriminate between ‘Then’ (the negative social memory) and ‘Now’ (how people respond to them in the present). Returning to 15-year-old Martha, who had a fear of being shouted at or told off and had a negative self-image of herself being very small, a “little child”, unable to speak, with a “trembling lip about to burst into tears.” These were related to an event in the past, when Martha was 10 years old. She recalled being reprimanded by her teacher in front of the class when she arrived late and some classmates sniggering at her when she became upset. Her negative self-image dated from this event. When the negative image is triggered in the present, Martha experiences the same feelings of humiliation she did as a 10-year-old girl and feels that she will be shouted at or rejected as she was then.

**Step 1: Identifying the negative image, belief and associated socially traumatic memory**

The first step of discrimination training involves helping the young person to identify the negative image, belief, feelings and the socially traumatic memory that these are associated with. Some of this information will already have been gathered in therapy and can be referred to, for example from developing the personalised version of the model.

The therapist might explain:
“We’ve been talking about what goes through your mind when you’re anxious in social situations. We’ve found out that there is often a mixture of thoughts (like sentences or statements) and pictures or images that pop up. Can we spend a bit of time talking about the pictures, images or impressions that come to mind when you’re anxious? Let’s remind ourselves what they are.”

The young person is asked to describe their negative self-image or impression.

Once the image or impression has been described the adolescent is asked to describe the belief or meaning of the image/impression, for example they might be asked: “and what was so bad about that image for you? What do you think it said about you as a person?” and the associated feelings. To identify the associated memory the young person can be asked: “when did you first feel the way you did in the picture you have just described?” The young person is asked to briefly talk through their memory of the event. To determine the meaning of the memory, the young person can be asked: “What is the worst thing about the memory? What does it say about you?” The meaning of the image and memory can be summarised and the young person asked to provide a short sentence or two that ‘encapsulates’ the meanings.

It can be helpful to summarise this information, making clear that the image, feelings and beliefs that occur ‘Now’ are driven by a socially traumatic memory from the past. The following transcript demonstrates the therapist linking the current image, thoughts, and feelings to a past memory for Martha and identifying the ‘encapsulated belief’:

Therapist  Can I just make sure I’ve understood you right? So when you express an opinion or give a view, for example about fashion with friends or the answer to a question in class, you get a particular feeling, an impression of how you appear to others and how they will behave towards you. The feeling is of you very small, a “little child”, and as you picture yourself you see you are unable to speak, with a “trembling lip about to burst into tears.” That makes you feel really humiliated and foolish. You feel that you will be shouted at or people won’t want to talk to you. Is that about right?
Step 2: Identifying differences between ‘Then’ and ‘Now’

The therapist and young person can then work together to identify as many differences as they can between the memory from the past and how people respond to them now. This process helps to break the link intellectually. It often helps to give the young person some distance from their negative image or impression and see it more as a memory from a time past. Differences might include factual information, for example
age, people present, height, school, but also how people respond to them now and what they have learnt in therapy. For Martha there were a number of differences between ‘Then’ and ‘Now’ which are summarised in Table 16. There were three main differences. First at the time she was 10 years old and in year 6 of primary school. Now she is 14 years old and in year 9 at secondary school making her GCSE choices. Second her teachers are now different people. Third, her teacher at the time had been strict and severe. She now has a very good relationship with her head of year and head of pastoral care. Fourth, her classmates are different now and none of them are unfriendly.

**Table 16. Summary of differences between ‘Then’ and ‘Now’ for discrimination training with Martha**

<table>
<thead>
<tr>
<th>‘Then’</th>
<th>‘Now’</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was 10 years old, in year 6 at primary school.</td>
<td>I am 14 years old, in year 9 and making my GCSE choices.</td>
</tr>
<tr>
<td>My teacher was called Miss Marks.</td>
<td>Miss Marks isn’t in my new school. I have lots of different teachers now and none of them look like her.</td>
</tr>
<tr>
<td>Miss Marks was strict and severe.</td>
<td>My current teachers are more easy-going and I have really good relationships with them.</td>
</tr>
<tr>
<td>Miss Marks used to shout at me when I did something wrong.</td>
<td>When teachers speak to me now they don’t shout at me, even if I’ve made a mistake.</td>
</tr>
<tr>
<td>Some of my classmates didn’t like me and laughed at me and stared.</td>
<td>I have different classmates now. Most of them are friendly and they do not laugh or stare at me.</td>
</tr>
</tbody>
</table>

**Step 3: Break the link between ‘Then’ and ‘Now’**

The next step is to help the young person to break the link emotionally. We do this by encouraging them to look out for times when they experience the same feelings they had felt in the memory. These moments can be seen as golden opportunities to shift attention outwards and carefully observe how people are responding in the present. The young person is encouraged to spot the differences between what is happening ‘Now’ and what happened ‘Then’ (the socially traumatic memory). For example, Martha often
experienced the image of herself as a “little child, unable to speak” in class. During class she therefore looked out for times she experienced the image and anxious feelings. Her first step was to notice the impressions and feelings, and label them as a ‘ghost from the past’. She then worked hard to notice differences between then and now, including the teacher, her age, her classmates, clothes, height, and how the teacher was treating the pupils (politely and with respect). She was able to appreciate the difference between her impression and expectations and the reality. The more the young person is able to attend to the present and gather new information that conflicts with ‘Then’ the more the memory will fade and a more realistic social self-image can be developed. Stimulus discrimination can start in vivo with the young person and then be carried out as homework.

9.3. Imagery rescripting

Imagery rescripting (Arntz & Weertman, 1999; Wild & Clark, 2011) aims to transform the distorted image or impression from the past based on current information. This is done by updating the earlier memory that is the source of the socially anxious adolescent’s negative image and belief. Imagery rescripting typically takes a full 90 minute session and is comprised of a number of steps. First, the images or impressions the person experiences now when they are anxious are identified, linked to a past event(s), and the ‘encapsulated meaning’ of the memories and current image is identified. Second, cognitive restructuring of the encapsulated belief is undertaken. Third, the new meanings derived from cognitive restructuring are incorporated into the memory in order to reduce the distress that it causes and to help the young person. Each step is discussed in detail below. A useful description of the procedure with adults is provided in Wild and Clark (2011).

**Step 1: Identifying the negative image, belief and associated socially traumatic memory**

This step proceeds in the same way as described in Step 1 of Discrimination Training above. The first stage is to identify the meaning of the young person’s current image and the socially traumatic event to which it is linked. We call this the encapsulated meaning or belief. Young people are asked to bring to mind their current image and the social trauma and think about what they tell them about the way in which they see
themselves and other people see them. Common examples of encapsulated beliefs are: “I am stupid”; “people think I am dumb”; “people will reject me and laugh at me”; “I’m a fool, an idiot”; “I am inferior and people will reject me”.

**Step 2: Cognitive Restructuring**

The ‘encapsulated belief’ linking the negative image to the socially traumatic memory is the focus of the cognitive restructuring. The aim is to look at the evidence for and against the belief in order to change the negative belief and develop a more benign perspective. Before beginning the restructuring work, the therapist asks the young person how strongly they hold the belief (from 0, ‘not at all’ to 100, ‘completely’). The therapist and young person then discuss all the evidence for and against the belief. This will include evidence they have gathered since the event as well as things they have learnt from therapy so far (for example from video feedback, behavioural experiments, and surveys). The information is written up on a whiteboard. The therapist helps the young person to question the meaning of what happened in the past and the relevance it has for the present. This can be done by asking the young person to identify times when, for example, a teacher has spoken kindly to them, instances when they were not rejected, or alternative explanations for why a teacher might speak severely to a pupil. Cognitive restructuring can take 30-45 minutes to carry out.

For example, Kevin was a 17-year-old young man with severe social anxiety who had been badly bullied in early adolescence. He had a recurrent image of himself cowering, shaking and bent double which made him feel vulnerable, helpless and afraid. This related to an event around the age of 11 when a classmate stole his shoes and slapped him in the face prompting laughter from some of the perpetrator’s associates. The encapsulated belief was “I am a vulnerable weirdo. Everyone will laugh at me and reject me.”

The therapist pointed out to Kevin that although he feels he is a ‘vulnerable weirdo’ when the image comes to mind, the event is in the past and things are different now. To help Kevin make this distinction, the therapist asked Kevin questions such as: ‘Why do children bully other children?’; ‘What does this say about the classmate who hit you?’; ‘can you think of times recently when you have been accepted?’. The therapist also
reviewed evidence from behavioural experiments with Kevin that demonstrated numerous incidents when he had been accepted. They reviewed video and photography feedback and Kevin was encouraged to ask himself whether he saw a “vulnerable weirdo” (which was not the case). The cognitive restructuring was summarised in a table on the whiteboard (as shown in Table 17).

Table 17. Kevin’s evidence for his encapsulated belief and updated perspective.

<table>
<thead>
<tr>
<th>Evidence for old view - 11 years old</th>
<th>Evidence for updated view – 17 years old</th>
</tr>
</thead>
<tbody>
<tr>
<td>He came over to me and stole my shoe from me.</td>
<td>He is a loser; the kind of people I respect have better things to do with their time. Although I was getting a lot of it, I know he was bullying lots of other kids too. It was not just me.</td>
</tr>
<tr>
<td>He slapped me around the face in front of everyone.</td>
<td>He must have really felt the need to prove himself to do that. It’s not that I’m a vulnerable loser; it is that I don’t believe in being aggressive and he knew that. I’ve lost touch with him now, but I don’t think he’s going to get very far in life because people don’t like people who behave that way. He’s the loser in life. I know I’m not a vulnerable loser because: people want to get to know me and spend time with me. I am doing really well now, I’ve been accepted into University; I have seen the video and photo footage of myself and I don’t stand out. I look like a regular confident young man.</td>
</tr>
<tr>
<td>No-one did anything and some people laughed.</td>
<td>Later on some people did come and ask if I was ok, and told me what an idiot he is. At the time they were probably scared he would bully them too. Nobody laughed at what happened, except the bully’s little gang, and they probably only did so because they were just as</td>
</tr>
</tbody>
</table>
Step 3: Imagery rescripting

Imagery rescripting aims to update the socially traumatic memory with the new information derived from cognitive restructuring. It is a three-stage process that involves reliving the memory and inserting the new meanings that were developed during cognitive restructuring.

To explain the rationale for the imagery rescripting to the adolescent we might say:

We have discovered that because of the event(s) in the past you hold particular beliefs about yourself. And you think people will react to you in the here and now in a similar way to back then. It’s almost like the pause button was pressed and you have been seeing things now on the basis of what happened then. But what’s really important is that we’ve been finding out that things are different now. For example, you don’t get bullied or rejected and people want to be around you. And the memory is upsetting but maybe doesn’t tell the whole story about what happened. So what we need to do now is to add this really important new information to the memory, to update it so it takes into account who you are now. And the way we do this is by rewinding and returning to the memory. We start off by you talking through the memory in the first person (“I”) and in the present tense (”I am”) as though it were happening to you again. We can then bring in the new information that we know now, as Kevin the young man. You could help by talking to the younger you, or by intervening in some other way, for example by talking to other people there. What we want to do is to update the memory so it is in the past and no longer interferes with how you see things now. I’ll step you through it all, and I might make suggestions or ask questions as we go along, does that sound okay?
So the first thing to do is to remind ourselves of the memory and the feelings that come along with it. And then we can bring the new information in. But to begin with let's just bring the memory to mind.

In the first stage the event is relived from the age at which it occurred. To begin, the therapist asks the young person to close their eyes and to talk through the memory from the perspective of the age they were when the event occurred. The therapist might interject to encourage the young person to describe the image in detail and identify their thoughts and feelings as well as what happens. Questions might include: What can you see? What can you hear? What is going through your mind right now? How are you feeling? By remaining in the present tense when asking questions, the therapist encourages the young person to do so. If the young person is slipping into the past tense, it can be helpful if the therapist asks a question in the present tense to remind them, for example “and what is happening now?” The following transcript outlines how the first stage proceeded with Kevin.

Therapist  
So closing your eyes and when you are ready, take yourself back. To the classroom, aged 11, you are sitting there and it is break time…can you tell me what is happening, as it unfolds now…

Patient  
I am sitting in the classroom in break. There are people around, in groups. Some are chatting, some are doing some work. I am sitting on my own. Luke, Josh and that lot are sitting on one side of the classroom. Luke is sitting on the desk. They are laughing and talking loudly. I am just sitting with my head down. Then I start to notice that they are pointing at me, I kind of know that they are joking about me. I hear words but can’t hear everything they are saying, they say “weirdo” and “loser” and “freak”. I think, “here we go” and I tell myself “head down and hopefully they’ll move on soon.” Then out of the corner of my eye I see Luke get up. He gets up and walks slowly over. Fear takes over me and I think “what is he going to do to me? He is going to shout at me, or hit me. In front of everyone.” Then, then…
Great Kevin, well done. So Luke is walking over to you and you think “he is going to shout at me or hit me. In front of everyone”. And how are you feeling now, are you feeling afraid, can you give me a rating? What happens next?

Yes, I’m really scared. Like a 10.

Ok, just stay with it, well done.

Then it happens really quickly. He is right there and he has grabbed my shoe off my foot. He is holding my shoe high up in the air, to show everyone. He says, he says “I’ve got loser Kevin’s shoe – gross, smelly and cheap. Did your mummy buy them for you, Kevin?” I can hear people laughing. I feel so small, so pathetic. I don’t know what to do right now and I don’t know what Luke is going to do next. I think he is going to hurt me. And then...um...

Well done, Kevin, stick with it...

And then he comes close and slaps me. I feel the hot sting on my face.

And how are you feeling?

Ashamed, so ashamed and humiliated.

OK. And what happens next.

I can’t believe what he’s done. I hear laughter again. I feel like some vulnerable freak, I cower down. I don’t want him to hurt me again but I don’t think I can stop him. I just wait and then he walks off, I hear the sound of my shoe landing near me. I feel so pathetic. After a while the bell goes and a teacher comes in. I peer around and reach for my shoe and put it on. I want the day to end and to be able to go home. At the end of the lesson a couple of people quietly ask if I’m alright.

With careful questioning the therapist was able to access the original memories and the painful feelings associated with it. The second stage of reliving involves reliving the event from the person’s current perspective, observing what is happening to their younger self. The therapist can ask the young person to imagine that they are in the room watching events unfold.
Ok, you’re doing really well Kevin. And now, keeping your eyes closed we’re going to move onto the next stage. What we’re going to do is run through the event again, but this time as though you, as you are now, are there in the classroom, watching the events happen. So you might say “I see Kevin sitting in the classroom.” Tell me what you can see happening...

Kevin is sitting on his own in the classroom at break time. There are quite a few people in the room, some just sitting and chatting or working. He is getting on with some homework. A group of the school bullies are sitting making loud, rude jokes about everyone. I can see other people look awkward as Luke shouts stuff out. No one wants to make eye contact with them. They start making jokes about me. About Kevin. I can see they’ve picked the person who is quiet and on their own. They are making nasty comments. Kevin doesn’t look up either, just like his classmates. They are such idiots! You can tell everyone in the room is thinking that. Why don’t they occupy themselves and leave Kevin and everyone else alone?

Yes, they are such idiots! What happens next?...

Luke doesn’t leave Kevin alone, he starts walking over towards him. You can see Kevin is trying not to be noticed. He’s doing what any normal person would do. But Luke keeps coming. Then it is just insane – Luke takes Kevin’s shoe off! I mean, what the…?? Who would do that? He is just an idiot. Luke is making horrible comments about Kevin, trying to humiliate him. And then it gets even worse – poor Kevin! Luke slaps him in the face. And it’s like he’s pleased or something? Like he’s trying to prove how big and strong he is by hurting someone who wouldn’t behave like that.

And what else can you see? What about the other people in the room?

I can see Luke’s idiot mates laughing along. But almost like they are trying to please Luke or something. How lame. And then everyone else looks like they don’t know what to do. They look shocked. No one is laughing. They
look a bit scared themselves and kind of glance over but then look away.

Oh poor Kevin. And later a couple of people come to check on him.

In the third stage the event is relived from the age at which it occurred again. This time the older self is with the young self. The older self can intervene, provide support, or offer new information.

Therapist: You are working so hard Kevin, well done. And we’re nearly done. We’re going to go through the event one last time. This time I want you to imagine you are back there again, 11 years old, and the events are happening right now, but this time your older self is there as well, in the classroom. He has all the information learned in our therapy, and he can intervene if you would like, remind you of things, talk to Luke or your classmates or whatever you might find helpful. Does that sound ok? Shall we get going? So you’re in the classroom during break time…

P: I’m in the classroom during break time, sitting at my desk. There are quite a few people around, sitting chatting or working. Luke and his mates are making loud, rude jokes about everyone. People look uncomfortable. I wish they could be told what losers they are – that no one finds them funny.

T: Great, Kevin, is that something your older self could say now?

P: Yeah, so I say “Luke, why are you acting like this? Nobody finds it funny, and I don’t think you do either. Why don’t you treat people with respect and you might get to make some real friends. I am sure you’re a nice person underneath. I wonder whether you’ve been treated unkindly to act like this?”

T: And how does Luke react? What can you see?

P: He kind of looks like he wants to be defensive but also like he knows what I’m saying is true. I kind of feel sorry for him.

T: Great, keep rolling…
So then he has thrown the shoe at me and slapped me. I feel so small, vulnerable and like a freak, bent double…

And how can your older self help right now?

He can remind Kevin that he is a kind, gentle person and what his behaviour shows right now is someone who does not believe in violence, who respects others. As a result he chose not to fight back.

Great and what does that show about Kevin?

Strength I guess.

And what does older Kevin know now about how younger Kevin looks? Does he look like a ‘vulnerable freak, bent double’?

No, he’s a regular person, who can stand up tall. Who has friends. He is going to get away from this group of bullies and go onto be accepted into university.

And how about Kevin’s classmates. Is there anything we need to remind younger Kevin about them? Do they reject him?

So they come and talk to him afterwards, and explain that they wished they had stepped in. But they were scared to, they did not want to be picked on by Luke and his gang either. They tell Kevin that they all feel the same about the bullies and say they thought he coped really well. They didn’t reject him.

Is there anything else that younger Kevin needs to know right now?

I guess just that this was one period in time. That he moves on and grows up and is absolutely fine. That he makes friends, does really well with his studies, and is going to go to university. That he makes it.

That is really just great, and can you just notice for moment how that feels?

Yes, it feels really good.

Lovely. So take a moment, and when you are ready, open your eyes and come back to the room.
At the end the young person is asked to open their eyes. The therapist praises the young person. They can reflect on the process with the therapist, in particular noticing how they feel and how the memory feels now, before re-rating the original encapsulated belief. A useful way of checking that the memory has really changed is to do one final brief reliving from the young person’s perspective to make sure that the emotions have changed.

9.4. Troubleshooting

Is it a memory from the past?

Memory work is unlikely to be effective if the threat to the young person is realistic, for example when bullying is on-going rather than in the past. Under these circumstances the therapist may decide that the best course of action is to work with schools and family to target the bullying specifically in the first instance. This is described in Chapter 12 (p.205).

Multiple socially traumatic memories

Some young people will have multiple socially traumatic memories that are distressing. In this situation, the therapist can help the young person identify the most distressing and complete imagery rescripting with this memory to begin with. Cognitive themes (e.g. of humiliation) are often common across the different memories. As such we often find that once rescripting has been completed with one memory, the other memories also improve without direct intervention. However if this does not occur, then additional imagery rescripting can be completed with the other memories.
CHAPTER 10. ANTICIPATORY WORRY AND POST-EVENT PROCESSING

“Oh do not ask ‘what is it’, let us go and pay our visit.”

T.S. Eliot, The Love Song of J Alfred Prufrock

Before and after social situations many socially anxious adolescents spend considerable time thinking about the interaction, their perceived social failings, and what others think of them. In advance of a social situation socially anxious adolescents often describe thinking about what might go wrong, about the worst things that might happen, similar situations in the past that went badly, and what people might think about them. They also often notice that they feel anxious when thinking about forthcoming social situations and tend to interpret this feeling as an indication that they will perform badly. They may also try to think how they can prevent these negative outcomes from occurring, or how they could avoid or leave the situation. Similarly, post-event processing or rumination after a social encounter is common. Many young people find that they dwell on their memory of what happened. They may go over what they recall having said and things they did that were ‘wrong’. They compare their memory of what they said and did with how they think they should have behaved. These post-event thoughts often evoke feelings of shame, humiliation and foolishness and negative self-images.

Repetitive thinking in anticipation of and following social interactions is unhelpful. Anticipatory worry is unhelpful in the following ways. Firstly, it tends to bring to mind memories of negative social experiences from the past. These memories are anxiety provoking and cause the individual to fear the upcoming situation will be similarly negative. Secondly, worrying increases self-focused attention. The self-focus enhances awareness of anxious feelings and negative thoughts. The internal information is used to form a negative self-impression of how the individual things they will come across. Thirdly, when an adolescent worries about an upcoming social interaction they tend to catastrophise, that is, focus on the worst possible outcomes of the situation. This will increase anxiety and self-focused attention further. Fourthly, as a result of the anxiety and negative thoughts adolescents usually feel impelled to devote considerable time to
planning the use of safety behaviours and avoidance strategies. An individual may avoid the situation altogether.

Rumination or going over a social situation after it has happened is also unhelpful. Rumination leads adolescents to think a social situation went far worse than they had originally concluded. The main reason for this is that when one thinks about a situation afterwards the thinking is dominated by feelings and images. There is a lack of the objective information that was available at the time. One is reliant on the memories of how one felt and self-images with no possibility of corrective information because one is no longer in the situation. The images and feelings are usually negative and because these are the main focus of rumination, one’s appraisals of the situation become even more negative. So whilst one may have initially judged a situation to have gone ok, after engaging in post-event rumination, scrutinising the worst moments and feelings, one may end up concluding “I made a fool of myself and I can’t face these people again.” In this way the situation is re-written in a more negative fashion. Rumination also increases anxiety and a sense of shame. These feelings are used as evidence of how badly the situation went.

Lara fears she will be rejected because she is boring. As a result she tends to agree with others and rarely offers her own opinions. Lara struggles to sleep at night. She usually lies awake carrying out ‘post-mortems’ of the social interactions she has had at school that day. For example, one particular night she recalled an interaction earlier in the day. Her friends had been talking about a film that they had all seen except for her. That night Lara remembered sitting nodding along whilst the others chatted about the movie, feeling she had nothing to contribute and feeling uncomfortable and nervous. She kept picturing herself looking blank and gormless. She could just imagine the others wondering why they even hung out with her. These memories, images and thoughts made Lara squirm with shame and she felt increasingly anxious and low. She wondered what she could do to stop messing up like this. She spent time thinking of topics she could talk about and she wondered whether she should try to avoid school completely tomorrow. Lara ended up feeling defeated and hopeless.
10.1. **When to use worry and rumination techniques**

Although pre and post event processing is common in social anxiety, it is not something that will need to be targeted in treatment for all young people. However, the therapist should closely monitor worry and rumination as it has the potential to damage progress in therapy. For example, successful behavioural experiments can be undermined by the negative replaying and rewriting of the event in rumination. Sometimes a completely different (and negative) message can replace the positive learning. Similarly, a young person might not come to a session because they have been worrying so much about the possibility of undertaking a behavioural experiment.

The main things to look out for when determining whether you need to specifically target worry and rumination are how prominent they are and the extent to which the processes are not changing in treatment as you focus on the standard techniques. An assessment of worry and rumination should be undertaken as part of the initial psychological assessment (see Chapter 4, p. 64). Questions that can be helpful in eliciting problematic worry include:

- “*Before a social situation [insert specific feared situation here] do you find yourself thinking about it?*”
- “*What are these thoughts like?*”
- “*How do they make you feel?*”
- “*What sensations do you notice in your body?*”
- “*Do you tend to focus on things that might be enjoyable in the upcoming situation? Or on what might go wrong?*”
- “*When you think about what might go wrong, what happens then?*”
- “*How hard is it to break out of this type of thinking?*”
- “*How often does it happen?*”

Questions that can be helpful to elicit problematic rumination include:

- “*After a social situation [insert specific feared situation here] do you find yourself re-playing it in your mind?*”
- “*What are these thoughts like?*”
- “*How do they make you feel?*”
“What sensations or body feelings do you notice in your body?”

“Do you tend to focus on what went well in the conversation, what was enjoyable, or on what, in your mind, did not go so well?”

“What happens then?”

“How hard is it to stop dwelling in this way?”

“How often does it happen?”

In the psychological assessment it is also helpful to look at the Social Phobia Weekly Summary Scale that has two separate items relating to worry and rumination to see if the young person is endorsing high scores (see Table 8 and Appendix B). Keep a close eye on this early on in therapy. If the psychological assessment and SPWSS show worry and/or rumination is high initially, then monitor it (through questioning and tracking the SPWSS scores) to see if levels reduce with the standard components of treatment. If it persists, then it is a sign that specific work on worry and rumination will need to be introduced soon.

Another indicator that specific work on worry and rumination is needed is if a young person comes to a session expressing disappointment at previous behavioural experiments that the therapist knows to have been successful at the time. This is often a sign that the young person has been ruminating about the experiment in the intervening week, ‘re-writing’ it into a more negative experience.

If young people are reporting persistently poor sleep then the therapist should be alert to the possibility that this is due to worry and rumination.

Finally, for young people with comorbid generalised anxiety disorder (GAD) additional work on worry and rumination is likely to be needed. Young people with comorbid GAD are likely to repetitively ruminate about a wide range of topics including their social interactions so it is likely to be a focus of therapy to some extent.

10.2. Overview of techniques

Many adolescents will see their worry and rumination as a useful strategy to cope with their social difficulties and improve their social performance. Therefore the first step in treatment is to help the adolescent to recognise that it has disadvantages and then to
weigh up the disadvantages and advantages of thinking in this way. When this is done, it soon becomes evident that the disadvantages outweigh the advantages.

For many adolescents worry and rumination become habitual and automatic. For this reason, they may not always manage to recognise it when it occurs. So the second step is to help young people to notice worry and rumination whenever it occurs. Once they have spotted it, they are encouraged to remind themselves of the disadvantages of worry in the moment. Then they can convert their fears (about how they came across/will come across) into specific predictions to be tested as a third step. This will provide the young person with the opportunity to access objective information about how they are coming across, rather than using the predominantly misleading and negative biased information in worry and rumination. Then fourthly, the young person can decide to put their concerns to one side (i.e. not to worry or ruminate) until the prediction can be tested.

Techniques to target worry and rumination usually take no more than one therapy session. The young person can then undertake homework tasks to try out the techniques in practice. Homework tasks can be reviewed and obstacles discussed in subsequent sessions.

10.3. Advantages and disadvantages of worry and rumination

Start by helping the young person to describe and understand their experience of worry and rumination. Do this by asking the young person to recall a recent typical time when they worried in advance of a social situation or undertook a post-mortem afterwards. Then the therapist and adolescent can map out the advantages and disadvantages of worrying and rumination.

In the case of worry, ask them what situation they were worrying about, what they feared would happen. Then probe for images that occurred during the worry. The therapist can ask:

Did you have an image or impression of how you thought you were going to look?
If you did, what was it like?
If someone else could see the image what would they see?
It can be useful to draw this out on a mind map with the young person. Lara’s mind map of worry is shown in Figure 8.

![Figure 8. ‘Mind map’ of Lara’s worry process](image)

Then the effects or consequences of worrying can be elicited. The points to establish are that worrying increases anxiety, reduces confidence in social abilities, and generates specific negative predictions about the upcoming situation. The young person is then asked to draw up a list of the advantages and disadvantages of worry.

Initially the young person will most likely be unaware of the disadvantages of worry and rumination. It is therefore important for the therapist to help identify these with Socratic questioning. The following transcript shows the therapist helping Lara to identify the unhelpful effects of worry:

**Therapist**  
*So you are worrying as a way to try to prepare for social situations and to make sure you don’t mess up. Tell me about what happens when you are worrying. Can you think of a recent time?*

**Patient**  
*I was thinking about a reading task we’ve been set in school for next week. And it has been really stressing me out because it is in front of everyone. So I have been thinking about it a lot, especially at night time.*
T  Ok, and what kind of thoughts go round your head when you’re thinking about it?

P  I keep picturing myself making an idiot of myself, not being able to speak, choosing a lame bit of text to read.

T  So you find yourself focusing on everything that might go wrong, the worst-case scenarios. Do you ever think about what might go well?

P  No!

T  Ok, so you are focused on bad outcomes. And what then? Is your mind drawn to other similar situations in the past?

P  Yes, all the other horrible times I’ve had to do public speaking.

T  It sounds like you remember the times that didn’t go so well, not the times that went ok. Is that right?

P  Yes, they all come flooding back. Then I start thinking about what I need to do to stop that happening. I think I should change my choice of reading, practice more. I think about whether I can get out of it somehow. I just don’t think I can do it.

T  Right, so these thoughts make you think you have to do your safety behaviours or avoid the situation and it sounds like they make you feel really unconfident about your abilities. So how do you end up feeling?

P  Urgh, so stressed and panicky.

T  Stressed and panicky. And this is all at night-time? If I was feeling like that I might struggle to get to sleep afterwards. Does that happen to you?

P  Yeah, I lie there feeling rubbish and I can’t switch off. Then I start worrying about being tired the next day so I get more stressed.

T  Ok, can I just pause there and check in that I’ve understood you right? It sounds really tough and well done for explaining it so clearly, great job. On the one hand you said you think worrying helps you to prepare and not mess up. But on the other hand, worrying makes you focus on what might go wrong (rather than what might go well) and in fact makes you feel pretty certain the situation will go badly. When you worry you are flooded with memories of previous times things haven’t gone so well (forgetting
times it has gone fine). You end up feeling really unconfident about your abilities. And then understandably you start thinking you need to do your safety behaviours, which we know are unhelpful, or avoid the situation, which we also know doesn’t change anything. And all of this makes you feel stressed and so you can’t sleep. Is that about right?

P I think so. But when you put it like that it doesn’t sound so helpful.

T No it doesn’t does it! So do you think we should work out how to side step worry?

P Yes, but I don’t think I can. It is just something I do.

T I guess there are a couple of things there. Firstly, just because it’s a habit it doesn’t mean it is helpful (what about thumb sucking or biting fingernails?!). But secondly, can people break habits? What about habits like thumb sucking? I know lots of adults who sucked their thumbs as kids but learnt to break the habit – how about you? Can you think of anyone? How do you think they broke their habits?

Lara and her therapist then summarised the list of advantages and disadvantages in a table, shown here in Table 18.

Table 18. The advantages and disadvantages of worry for Lara

<table>
<thead>
<tr>
<th>Advantages of worry</th>
<th>Disadvantages of worry</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Helps me prepare and to think of strategies to cope.</td>
<td>• Worrying doesn’t really help me to prepare. It makes me feel more anxious and like I can’t cope.</td>
</tr>
<tr>
<td>• Helps to me make sure I don’t mess up in the same way as usual.</td>
<td>• Worry makes me think it’s all going to go wrong. It makes me want to avoid the situation and just not to do it.</td>
</tr>
<tr>
<td>• It’s just what I do.</td>
<td>• Just because it is a habit, doesn’t make it helpful (what about thumb sucking or biting fingernails?!)</td>
</tr>
<tr>
<td></td>
<td>• It makes me remember times when situations didn’t go so well rather than the times they went fine</td>
</tr>
</tbody>
</table>
which makes me more worried.
- I get focused on myself. I get a picture of myself blank and gormless.
- It makes me feel I have to do my safety behaviours even though I know they don’t help. So I start preparing topics of conversation to cope with school the next day.
- I miss out on sleep, which means I’m tired and stressed the next day.
- I feel pathetic because I keep asking my best friend for reassurance. And I reckon she’s getting annoyed with me doing it.

A very similar process is used to identify the advantages and disadvantages of rumination. First the young person is asked to recall a time when they were ruminating recently. Ask them to describe the situation they were worrying about and what they were worried had happened. Then find out if the young person was focusing on how they were feeling at the time, and if so, what that feeling was. Images of self-impressions can then be identified. Ask the young person what they thought other people noticed and what they thought of them. Ask if memories of previous incidents came to mind, and what these were like. Finally ask about the effects of thinking in this way. This includes the effects on how the young person feels and how confident the young person felt to engage in further social situations, as well as interference with day-to-day activities.

10.4. Noticing and stopping worry and rumination

Once the adolescent has recognised the unhelpful effects of worry and rumination, the next step is to break the habit.

Noticing worry and rumination

Worry and rumination is likely to have become habitual. The young person will need to become accustomed to recognising it whenever it occurs before they can shift away
from it. There may be particular times when it occurs, for example at bedtime. The young person can keep a daily log of worry and rumination as a way to help them to look out for it.

**Bring the disadvantages of worry and rumination to mind**

When the young person spots themselves ruminating they can bring to mind the disadvantages of the thinking process that they came up with earlier in session. Some young people find it difficult to do this in the moment. It can therefore be helpful to summarise the disadvantages on a flashcard that they keep handy for these moments. The flashcard could be in card form kept in a wallet or pocket or else stored as an electronic reminder on a smartphone. Lara’s flashcard (which she chose to keep both in paper and electronic format) is shown in Figure 9.

![Worrying makes me:
- Feel more anxious and like I can’t cope.
- Tired and stressed the next day.
- Is an unhelpful habit!
- Stops me remembering my successes.
- More self-focused](image)

**Figure 9. Lara’s flashcard summarising the disadvantages of worry**

**Convert worry and ruminations into predictions to be tested**

One of the main problems with rumination is that it is based on misleading information that is negatively biased. When out of the situation and engaging in worry, the young person cannot focus externally and look around to search out objective information to test their fears. It is therefore important to help the socially anxious adolescent to articulate the particular fear or concern that they are ruminating or worrying about. They can then plan a behavioural experiment to test it out when objective information is available. These alternative strategies for dealing with worry were added to Lara’s flashcard for her to refer to whenever she needed to (shown in Figure 10).
For example, in bed at night Lara often worried about school lunch breaks with her friends. She would go over and over what might happen the next day. Lara talked about this with her therapist. The night after her session, when she began to worry she told herself “there you are again, as always, same old worry, playing tricks on me” and brought out the flashcard that was on her bedside table. She spotted the fears in her worry, in particular that she would freeze and have nothing to say, get flustered if asked her opinion on something, give a boring response to questions, and be laughed at. She jotted these down on a notepad to test out the next day in school.

**Worrying makes me:**
- Feel more anxious and like I can’t cope.
- Tired and stressed the next day
- Is an unhelpful habit!
- Stops me remembering my successes.
- More self-focused

**Instead:**
- Look for evidence (not feelings)
- Turn it into an experiment!
- Then do something else (something fun or relaxing)

**Figure 910 Lara’s flashcard summarising the disadvantages of and alternatives to worry**

*Put worry to one side and distract*

Once the adolescent has spotted the worry, identified their particular fear and converted this into an experiment to be completed when possible, the next step is to ban any further worry. This can be difficult to do and so we generally recommend they engage in a pleasurable or distracting activity to help. For example, after Lara had noted down her fears and the behavioural experiment she intended to do the next day, she decided to read the new magazine that she had bought herself on the way home from her therapy session.
10.5. Reducing over preparation

Some adolescents over prepare for presentations. Of course everybody will spend some time preparing for an upcoming talk, for example reviewing ideas or preparing slides, but some socially anxious youth will worry excessively in advance. When the therapist identifies this they can ask the young person to undertake a behavioural experiment in which they deliver an off the cuff speech in the clinic room and examine the effects of not preparing on their anxiety, negative thoughts and images, and on how they actually performed and came across.
CHAPTER 11. WORKING WITH PARENTS

All parents should be involved in their child’s treatment to some degree. The extent to which they are involved will vary from case to case. For some young people, parental involvement is modest. For example, attending the initial session and the relapse prevention session or joining the end of a session for a debrief if the parents are bringing a young person to each session. However, for some young people the parent(s) may need to have a more substantial, active role in treatment. The degree of parental involvement will depend on a number of factors. These include the age or developmental stage of the adolescent (greater parental involvement is usually needed for younger children), how much help and encouragement the adolescent requires to complete homework tasks and attend sessions, and how able parent(s) are to help (which may depend on their own physical or mental health needs). More targeted parental work is indicated for parents who hold unhelpful beliefs about their child or others, which may interfere with therapy if not tackled.

There is no research data on the involvement of parents in cognitive therapy for anxiety disorders and empirical evidence supporting the inclusion of parents in other CBT for anxiety disorders in youth is modest. Four large reviews have failed to detect differences in CBT outcomes for anxious youth with and without parental involvement (In-Albon & Schneider, 2007; Reynolds et al., 2012; Silverman, Pina, & Viswesvaran, 2008; Spielmans, Pasek, & McFall, 2007). However the type of parental involvement varied considerably between studies. A fifth review included a re-analysis of individual participant data from trials of CBT for child anxiety (Manassis et al., 2014). Whilst outcomes were comparable with or without parental involvement, there was evidence for better long-term outcomes for CBT with parental involvement where parents were encouraged to support and reward their child in systematically confronting feared situations.

Taken together, existing studies do not support including parents throughout the treatment of all young people. We recommend that the decision about how much to involve parents in treatment is made on a case-by-case basis. It does seem desirable to include parents sufficiently to help them learn about social anxiety, its effects, and
treatment at the beginning of therapy and to learn about relapse prevention at the end. Beyond this, they should be involved when they are identified as an important resource (for example, in completing experiments, in helping to support school reintegration, or target bullying). When their beliefs and behaviours are thought to be maintaining the young person’s difficulties in some way and are not changing, it is essential to address this to some extent.

Very occasionally a young person will attend clinic without a parent, carer or adult relative. In this situation we would always try to meet with the parents at least once early in the course of treatment. This will allow the therapist to gather historical information, acquire an additional perspective on the child’s difficulties, screen for parental mental health problems, as well as sharing the formulation with parents and providing them with appropriate psychoeducation. A few young people are resistant to involving their parents in treatment. Similarly, some parents are reluctant to engage. The extent to which we will still try to involve the parents in such circumstances depends on the age and capacity of the young person, and what is possible.

11.1. Education for parents about social anxiety and treatment

During the first session, information about social anxiety and treatment is provided to parents. Explain to parents that their child’s difficulties are very common and that an effective treatment is available. Let them know how their child’s current symptoms and behaviour are very much part and parcel of social anxiety disorder. It is helpful for parents to understand that some of their child’s behaviours, such as reluctance to attend school or refusal to answer the telephone, are classic examples of activities that people with social anxiety find difficult (see Chapter 4, section 4.6, for further details). While behaviours such as these can be frustrating for parents, it is important that they understand they are not a reflection of the young person having a weak character, being lazy or oppositional. Rather, they are the consequence of an anxiety disorder that is eminently treatable.

11.2. Supporting a child’s treatment

For most young people, parents will be involved in helping them to attend sessions on time. They can also be asked to remind their child to complete the weekly
sessional questionnaires. It is important that the young person brings their therapy folder with them to every session and parents may also help with this.

Often parents are asked to join at the end of each session so that the therapist and young person can explain what they have done in the session and the homework tasks that have been agreed for the following week. It is helpful to discuss the homework assignment with parents as it provides the opportunity to ensure they are in agreement with the task(s) and to identify and overcome potential obstacles to their completion. Parents are given the role of ‘facilitators’ in homework tasks and the therapist encourages the young person to identify how parents can support them. For example, by reminding them of the tasks during the week, or arranging a time to sit down and talk through the behavioural experiment, or by helping the young person to organise a planned social activity. Parents are discouraged from pushing or cajoling as this can undermine the adolescent’s developing self-efficacy. The adolescent is encouraged to take the lead and to take responsibility for homework tasks. This conveys the message that it is their therapy. The involvement of parents will partly be determined by the age of the young person, with middle and late teenagers often preferring less involvement by parents. Sometimes this joint meeting is followed by a brief individual meeting with the parent to discuss difficulties that the child may be underreporting, for example bullying or problems with schoolwork.

Towards the end of therapy, parents can be invited to attend a session (or part of a session) to hear the therapy blueprint their child has developed (see Chapter 14 for details of relapse prevention). The young person is encouraged to take the lead in this. They explain to the parents what they have learnt about the development and maintenance of social anxiety, how to tackle it, the progress they have made and future goals, and how to manage setbacks. The ways that parents can support the young person in preventing relapse can be identified and discussed. This process can be very powerful for parents. It is often the first time they have witnessed their child taking the lead and speaking in a ‘public’ (non-home) setting. In this way, for both parents and young person, it can often represent a ‘graduation’ of sorts from treatment.
11.3. Unhelpful parental beliefs and behaviours

The beliefs parents hold will impact on how they behave towards and interact with their child. Of course, parents want the best for their child but some parenting behaviours may inadvertently maintain a child’s difficulties. Some parents will hold well-intentioned beliefs that lead them to be overprotective or conversely to push their child beyond what they feel able to cope with. Unhelpful parental beliefs and behaviours are usually identified in the psychological assessment (Chapter 4) although sometimes they may only be detected later during the course of treatment. For example, an adolescent may not complete a behavioural experiment because their parent suggested the task might be too difficult or unsafe. Likewise, a young person may lose motivation in therapy because their parent has expressed disappointment that they are not making progress more quickly. Sometimes parental beliefs and behaviours will shift in response to positive changes in the adolescent and so we would suggest that initially the therapist identifies and monitors parental beliefs and behaviours. If these do not appear to be changing then it will be important to intervene directly.

One or two individual sessions with the parent can be helpful in these cases. This will be in addition to (and not a substitute for) the weekly individual sessions with the child. Where possible both parents should attend these sessions. The therapist can use the sessions to begin to modify the maladaptive beliefs that one or both parent holds about their child’s social behaviour and their expectations for their child. Table 19 summarises strategies that can be useful when dealing with common parental beliefs and behaviours. These are all described in more detail below.

Table 19. Techniques for working with unhelpful parental beliefs and behaviours

<table>
<thead>
<tr>
<th>Parental Beliefs</th>
<th>Parental Behaviours</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘My child is vulnerable, others are</td>
<td>Young person is discouraged from</td>
<td>Surveys</td>
</tr>
<tr>
<td>threatening’</td>
<td>engaging in social situations</td>
<td>Behavioural experiments</td>
</tr>
<tr>
<td></td>
<td>Young person is given permission to avoid</td>
<td>Role play</td>
</tr>
<tr>
<td></td>
<td>Parent takes control of social activities</td>
<td>Therapist modelling</td>
</tr>
</tbody>
</table>
‘Being loud and confident is the way to get on in life’

<table>
<thead>
<tr>
<th>Interpretation</th>
<th>Sample Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interprets quiet style of interaction negatively</td>
<td>Surveys, Information provision, Metaphors</td>
</tr>
<tr>
<td>Expresses disappointment at the social or performance ability of the young person</td>
<td>Role play, Therapist modeling, Behavioural experiments</td>
</tr>
<tr>
<td>Does not consistently reward the effort or attempt</td>
<td></td>
</tr>
<tr>
<td>The young person is encouraged to engage in social/performance activities that they feel unable to manage</td>
<td>Information provision, Behavioural experiments</td>
</tr>
</tbody>
</table>

Working with the belief that ‘my child is vulnerable and their social environment is threatening’.

Some parents may be overprotective towards their child. Common overprotective parental behaviours include discouraging a child from engaging in social situations, facilitating a child’s social avoidance, and interference or over control in a child’s social interactions. Often underlying these parenting behaviours is the belief (that one or both parents may hold) that their child is vulnerable and in some way unable to cope with their peers and any potentially hostile responses. Clearly, such beliefs have the potential to maintain the child’s social anxiety and limit progress in a treatment that explicitly involves facing up to feared situations. It is therefore important to address parental beliefs of this kind and to encourage parents to test out alternatives. This will usually be done in session(s) with the parents alone.

The first step in this process involves identifying the behaviours and underlying beliefs with the parents and developing a shared understanding of how they may impact on their child’s social anxiety. For example, Sienna’s mother was able to recognise that she tended to speak for Sienna when in public and did not encourage her to try new things. With the therapist she identified that she behaved in these ways because she believed that “Sienna is vulnerable and cannot cope with her peers.” It is important to spend time understanding the reasons for these beliefs. Sienna’s mother felt that her
belief had come about in response to the very significant bullying Sienna had experienced. Other parents may link their parenting attitudes to their own anxiety, or memories of their own friendship difficulties in adolescence. Looking for the reasons for parenting beliefs provides the opportunity for the therapist to explain to the parent that it is understandable that this belief developed, given the child’s (or parent’s own) earlier experiences, but things are different now and it may not be so helpful. This can help to ensure parents do not feel criticised or blamed as well as providing a rationale for change.

Both the intended consequences (usually to protect their child, ensure they are not hurt) and unintended consequences of the parental behaviours can be established. By drawing out both intended and unintended consequences, the therapist communicates two important points to parents. First, they are trying very hard to do the best for their child, and second, that unfortunately some of their attempts are backfiring. For Sienna and her mother, the unintended consequences of overprotection were that Sienna missed out on the opportunity to discover she could speak for herself and have her needs met, and that others would accept her. Her mother also spotted that by being with Sienna so much of the time she may be discouraging other girls from approaching Sienna. Determining what is and is not ‘overprotection’ will vary depending on the developmental stage/age of the young person, on the cultural context for that particular family, and specific issues in the environment (for example, local gang culture) or issues particular to the young person (for example, specific learning difficulties may confer additional vulnerability).

Once the parent’s fearful concerns and the unhelpful consequences of these have been established, the therapist and parents can plan behavioural experiments aimed at testing these fears out. Early experiments might involve surveys whereby parents can benchmark what other parents allow their children (of similar ages) to do. The behavioural experiments will often involve parents allowing their child to engage in new activities. The therapist can hold in mind previously avoided activities that the young person has expressed a desire to do and these may be good to target with parents. It can be helpful to invite the young person into the room when agreeing the finer details of the behavioural experiment, as these decisions will of course impact on them. The therapist can use this meeting as an opportunity to model to parents how they can encourage their child in ‘approach’ behaviours. For parents who struggle to offer positive encouragement
to their child to approach feared situations, it can be helpful to *role-play* this with them and then ask them to practice it in the clinic with their child so that the therapist can observe and advise. They can then they practice it at home.

When undertaking behavioural experiments parents are asked to complete the Behavioural Experiments Record Sheet, just as young people do. The therapist should ensure they follow up the behavioural experiments in a session or via the telephone. This will allow the parent to reflect on what they have learnt, identify any obstacles and overcome them, and plan further experiments. It can be powerful to have a joint meeting (it need not be long) in which the young person can describe to their parents the effects of the parental shift in behavior.

For example, Sienna’s mother decided she would allow Sienna to join Facebook again. She feared that Sienna would upload pictures and comments and face a stream of negative comments from known and unknown people, as had happened before. Sienna’s mother was encouraged to speak to school staff for guidance about responsible Internet use for adolescents. A joint meeting with Sienna was arranged and Sienna’s mother was able to discuss safe and unsafe use of social media with Sienna. An agreement was reached whereby Sienna would start a new Facebook account but this would be private and Sienna would only allow friends to see her page. Her mother would have access to the account. Sienna was enthusiastic about returning to social media. The therapist met with Sienna’s mother one week later. The experiment had gone well, however the therapist identified that Sienna’s mother was checking Sienna’s account on a daily basis. The effect of this safety behaviour on maintaining the belief Sienna’s mother held that Sienna would be victimised and on her anxiety was discussed. She agreed to stop checking the account and instead planned to initiate regular conversations with Sienna about her social media use. At a telephone check-in a week later, Sienna’s mother noted that this had reduced her belief that Sienna could not cope and the associated anxiety, and also led to positive conversations with Sienna. A Behavioural Experiments Record Sheet is shown in Table 20.
Table 20. Behavioural Experiment Record Sheet for Sienna’s mother

<table>
<thead>
<tr>
<th>Situation</th>
<th>Prediction</th>
<th>Experiment</th>
<th>Outcome</th>
<th>What I learned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sienna’s use of social media</td>
<td>Sienna will post a picture of herself and be trolled.</td>
<td>Sienna will create a new Facebook account. This time it will be private. She now knows about safe internet use and will only invite trusted friends.</td>
<td>It went well, nobody was mean to Sienna online. I am sure she can cope, as long as I keep an eye on things.</td>
<td>I learned that now Sienna understands how to use social media she is less vulnerable. I need to stop checking so much to really test it out though. [New belief 20%]</td>
</tr>
<tr>
<td></td>
<td>People will call her names and she will not cope. She will cry non-stop and refuse to go to school again. 80%</td>
<td></td>
<td>[Original belief 40%]</td>
<td></td>
</tr>
<tr>
<td>My supervision of Sienna’s social media use</td>
<td>If I do not check Sienna’s Facebook page every day, she will be trolled. 70%</td>
<td>I did not check her account. I agreed with Sienna that we would have a ‘check-in’ once a week to see how social media use</td>
<td>It was surprisingly difficult! I had to resist the urge to check, but I did. Nobody trolled Sienna. She was pleased. I think felt like I trusted her and thought she could cope with stuff.</td>
<td>I learnt that it is good for Sienna to feel I trust her and also, the more I do so the more confidently she seems to manage things herself.</td>
</tr>
<tr>
<td>is going.</td>
<td>[Original belief 10%]</td>
<td>[New belief 60%]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Working with the belief that ‘being loud and confident is the way to get on in life’.

Some parents may encourage their child to engage in social or performance activities that are too anxiety-provoking given the child’s current social anxiety symptoms. Often underlying these parenting behaviours is the belief (that one or both parents may hold) that the way to get on in life is to be “centre-stage” and being quiet is a disadvantage or sign of weakness in some way. This belief can be quite common in some cultures but is unhelpful for helping a socially anxious child recover. The belief may lead parents to push their child to take part in excessively challenging activities. Parents may struggle to reward attempts their child does make and any modest progress in treatment. A parent with these beliefs may also find it difficult to appreciate that their child may be more introverted by temperament, even when free from social anxiety. It is therefore important to address parental beliefs of this kind and to encourage parents to test out alternatives. This will usually be done in session(s) with the parents alone.

Behaviours might include drawing a negative interpretation of a quiet interaction style, expressing disappointment at the social or performance ability of the young person, not consistently rewarding effort or attempt, or encouraging their child to engage in social/performance activities that they feel unable to manage. For example, Gaby’s mother said that she thought it helpful to push Gaby to lead the reading at church every Sunday, although she observed that Gaby always tended to mumble and look very awkward without improvement. She believed strongly that being able to “stand up and speak for yourself” was important in being successful and happy in life, and was keen to help Gaby do this for herself. Looking at the reasons for her belief, Gaby’s mother explained that she had come to the United Kingdom alone and raised three children as a single mother. She believed she had managed this because she had been able to speak up for herself. Other parents may link parenting attitudes such as these to their own social anxiety. One father recalled being acutely socially anxious as an adolescent and coping by using impression management techniques such as ‘acting the joker’ and being the ‘clown’. He therefore believed that his child would overcome their own social anxiety by using the same strategies.
Both the intended consequences (usually to help their child overcome anxiety, to achieve their goals) and unintended consequences of the parental behaviours can be established. For Gaby’s mother, the unintended consequences of her behaviour was to increase Gaby’s withdrawal from her mother, to cause irritability and discord in the family home, and to induce a repeated sense of disappointment and failure in both Gaby and her mother. Furthermore, it was not helping Gaby overcome her anxiety, as was evidenced by the lack of change in her ability to do the reading at church.

Once the parent’s beliefs and the unhelpful consequences of these have been established, it is helpful to revisit information about social anxiety and its effects with parents. Remind them about the goals of treatment, explaining that it is aimed precisely at helping the young person to engage in social and performance activities that they are currently avoiding, in a stepped way that is manageable for them. This can convey two important points to parents. Firstly, it makes it explicit that in many ways the treatment goals of the young person and the hopes of the parents are aligned. Secondly, it communicates to parents that they may need to modify their expectations so that they are appropriate to their child’s current levels of anxiety.

Parents may benefit from *psychoeducation* about different temperamental styles and the values that are associated with each. For example, if everybody were loud and exuberant, who would quietly organize, get things done, and be cool and calm? Parents can be directed to popular reading material such as ‘Quiet’ by Susan Cain. Metaphors, such as “still waters run deep” or “the deepest waters flow with the least sound” can also help.

*Behavioural experiments* are then planned. These often involve parents rewarding their child for making an effort, rather than just for being successful. Parents may be unfamiliar with providing praise, and *role-play* can be helpful here. The therapist can first play the role of the parent and the parent can take the role of the child. The therapist shows the parent how to praise effort. The therapist and parent can then switch roles to give the parent a chance to practice. Effective praise should be delivered in an enthusiastic and sincere voice, it should be specific, and should include non-verbal behaviour such as a pat on the back or arm.
Parents may undertake data-gathering experiments in which they look out for people in their lives who are quiet and notice what their strengths are and what benefits there are to having a quiet temperament. Joint sessions with parent and young person might involve the therapist *modelling* to parents how to praise attempts and the therapist helping young person and parent agree on behavioural experiments together. Gaby’s mother met with Gaby’s therapist for a session to plan a behavioural experiment. Gaby’s mother planned to stop putting Gaby forward to do the reading in church. Instead, in a joint meeting with Gaby and her mother, Gaby suggested she would prefer to hand out the music sheets to the congregation as they entered the church. Gaby’s mother was able to praise Gaby for this suggestion, as she had practiced role-playing with the therapist. The record sheet for this behavioural experiment is shown in Table 21.

### 11.4. Parental social anxiety

Children of parents with social anxiety are almost five times more likely to develop social anxiety. Therefore many parents of socially anxious children may be struggling with symptoms of social anxiety themselves. The parents can also become disheartened by the fact that their own life is not progressing as positively as they would like because of the restrictions imposed by their social anxiety. Such disappointment can result in significant episodes of depression which are a further strain for the parents and can have a negative impact on the child.

Parents are screened routinely for anxiety and depression as part of the initial intake assessment. A history of parental mental health difficulties and treatment uptake will also have been obtained at the initial assessment. Should mental health difficulties be present, it is often worth spending time learning about whether these are current, what support the parent has (both informal and formal), and how these difficulties affect day-to-day life including interactions with the child.

For those parents whose symptoms of social anxiety or depression are mild it can be helpful to provide some information about social anxiety disorder in adults and the commonalities with social anxiety disorder in young people. This can help parents understand their child’s difficulties better. Some parents may benefit from being provided with advice on self-care and can be directed to self-help material (e.g. Overcoming Social
Anxiety and Shyness by Gillian Butler). Other parents may have more significant or impairing symptoms and it will be important to discuss options for their own treatment with them. Parents wanting to pursue treatment should be supported in doing so. For example, the child’s therapist can send a letter of support to their family doctor or the parent(s) can be encouraged to self-refer to their local Improving Access to Psychological Therapies (IAPT) service. It can be helpful for the child’s treatment if parents are encouraged to seek treatment swiftly should they suffer with significant symptoms; some research suggests that parental psychopathology negatively affects CBT treatment outcome for anxious children (Cobham, Dadds, & Spence, 1998). If parents are in contact with adult mental health services, then close liaison between child and adult services is helpful. For example, it is helpful that adult services are aware that their patient has a child receiving treatment from a CAMHS service and vice versa and for information to be shared on issues around risk management and safeguarding.
Table 21. Behavioural Experiment Record Sheet for Gaby’s mother

<table>
<thead>
<tr>
<th><strong>Situation</strong></th>
<th><strong>Prediction</strong></th>
<th><strong>Experiment</strong></th>
<th><strong>Outcome</strong></th>
<th><strong>What I learned</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gaby’s participation in church</strong></td>
<td>Gaby will just go more and more into her shell if I don’t push her. She will speak less, take part less. 65%</td>
<td>I stopped pushing her to read in church. I praised her when she suggested handing out the song sheets instead.</td>
<td>She did not read, but she did go ahead with the task she said she would do. And she smiled at people, and even made a few comments. When I told her well done later, she looked really pleased. We didn’t have an unpleasant journey home from church like usual.</td>
<td>Maybe I need to let her pace herself, rather than pushing her. That gives me the chance to notice the things she is trying to do, and she seems to respond really well to that.</td>
</tr>
</tbody>
</table>
CHAPTER 12. ADOLESCENT PEER PROCESSES, PEER VICTIMISATION AND BULLYING

Adolescence is a critical period in social development. With the transition to adolescence, teenagers typically expand their social networks, place greater importance on their peer relationships, and begin to develop romantic relationships. Parent relationships are often overshadowed by peer relationships during this time. Peer relationships represent an important source of social support, help adolescents to learn about social relationships and contribute to the development of the sense of self. As a result, peer acceptance is important. It is therefore perhaps no surprise that bullying and victimisation in youth is associated with a host of negative mental health outcomes, including social anxiety. Social anxiety is seen to have a two-way relationship with peer victimisation, in that it is a common consequence of peer victimisation as well as conferring vulnerability to being victimised.

Peer victimisation can take different forms. Broadly it has been categorised into three types. *Overt victimisation* or bullying describes overt acts of aggression directed towards an individual(s). It can be verbal or physical. Examples include being called names, being sworn at, threatened, being pushed, and being hit. Boys, who tend to view physical aggression as most hurtful, are more commonly involved in this form of victimisation. *Relational victimisation* refers to the use of one’s relationship to harm another. Examples include deliberately excluding a peer from conversations, not inviting a peer to a social engagement, or telling a peer “you can’t be my friend unless…” *Reputational victimisation* describes actions aimed at damaging a person’s reputation within a larger peer group. Examples of this include spreading rumours and being humiliated in front of others. Peer victimisation can occur in different settings. It can take place in school, at home, and online.

As social relationships become increasingly sophisticated in adolescence so too does the nature of peer victimisation. Direct and overt victimisation tends to decline whilst relational and reputational victimisation often increases. For example, whilst younger children may simply tell someone “you can’t sit with us”, adolescents are more likely to use covert methods of victimisation. This may involve spreading rumours, subtle
exclusion from the group (for example, tending to put down or mock an individual’s suggestions in front of peers), or talking behind the person’s back (‘badmouthing’). Interest in romantic relationships and sexuality becomes more prominent during adolescence and this can become a focus of victimisation. For example, gossip might be spread about one’s sexual orientation or the frequency or nature of sexual experiences, or criticism might be focused on weight, body shape, and attractiveness.

Historical bullying that is no longer on-going can be managed well with CT-SAD-A, using the methods already described in previous chapters. Memories of bullying are commonly linked in meaning and content to negative self-images experienced by socially anxious youth. Problematic negative self-images can often be effectively targeted with present-focused techniques. Video and photographic feedback is aimed at helping the young person to obtain a more realistic view of how they appear to others and to update distorted negative self-images (described in Chapter 6). Behavioural experiments and Surveys (see Chapter 8) also inform the adolescent’s understanding of how they come across to other people. Very often these techniques are sufficient to correct negative images, and the memories of earlier events (such as bullying) are spontaneously updated. For some young people the images do not fully correct with the present-focused interventions. In these cases, memory-focused strategies are indicated to directly address the origins of the unhelpful images. Chapter 9 describes two methods of working with socially traumatic memories: Discrimination training and Imagery rescripting.

When a socially anxious teen is reporting on-going peer victimisation, additional interventions that help the young person deal with the adverse social environment are also required. Before starting these interventions it is important to undertake a careful assessment of the peer victimisation. This should determine the nature, frequency and severity of the behaviour, the situations in which it is occurring, and the number of perpetrators, as well as the social support and interventions already in place. From there, a central aspect of the intervention will usually involve directly targeting the bullying behaviour by working closely with schools and parents. A further aspect will focus on the socially anxious adolescent’s own perceptions and behaviours in response to their peers and their peers’ victimising behaviour, as some of these can make the individual more
vulnerable to, or more likely to elicit, unfriendly or victimising treatment by others. The perceptions and behaviours may take various forms that are outlined below.

Firstly, the social attitudes that the socially anxious young person holds are likely to impact the way they perceive (or misperceive) their peers’ behaviours and interactions. An anxious child can perceive behaviours or interactions as victimising when in reality they were not intended in that way. For example, good-hearted boisterous or teasing behaviour (‘banter’) may be interpreted as criticism or bullying. Understandably the young person may respond in turn in a brittle manner and then this can elicit actual bullying. So in this way relationships that may have shown some promise initially end up being problematic. For example, Mark had a particular aptitude for maths. He started a new school and his schoolmates called him “spod” and “brainiac”, often with laughter and a friendly pat on his shoulder. Mark initially thought his classmates were criticising and mocking him and so he avoided eye contact and did not respond to peers when they used these nicknames. Of course, it would not have occurred to Mark at the time that perhaps his classmates were expressing their admiration of him. As a result they perceived his lack of reaction as a sign that he was “dissing” them. In turn his classmates started making comments about Mark’s sensitivity to criticism, such as “ooh, bit touchy are we Mark? Are you going to go and cry to the teacher?” In this way, Mark’s misreading of friendly banter (and occasional complimentary comments) resulted in him actually being victimised by his peers. Treatment to target perceptions/misperceptions of others aims to help the young person appreciate there may be alternative explanations for the peers’ behaviour and to recognise the impact of their responses to peers. Techniques including role-play and behavioural experiments are used to do this.

Secondly, beliefs such as “other people will reject me” are extremely common amongst socially anxious teenagers and often heighten the susceptibility to peer influence that is present amongst most adolescents. This can lead an anxious child to copy others in order to be accepted, to ‘go along with the crowd’ for fear of being rejected. For example, they may copy others in how they dress, their turns of phrase, music interests, or even minor choices such as what to eat. The individual(s) being copied or agreed with usually finds it irritating. The choices that adolescents make are usually attempts to show what is unique about them and their identity and this is undermined when they are copied or seen
to be doing the same as someone else. One young person described her reaction to a friend she thought was copying her: “I feel like she is a copycat and I can’t stand it. It makes me feel like she is trying to somehow tell me she is better than me or she is trying to be me. But I am a unique person.”

As a result the anxious youth may elicit criticism and peer rejection. For example, Jaida feared she would be rejected by others and so made great efforts to fit in with her friends. She would buy her clothes from shops her friends had mentioned, choose music based on their preferences, and delay giving her opinion until she had heard what her friends think. This behaviour led to her friends calling her a “beg friend” and Jaida heard her friends commenting that she was “vanilla” (to imply that she was bland). She explained to her therapist: “I just want to fit in so much that I try to be exactly the same as everyone else and sometimes this turns into copying people”. Treatment to counter beg friend behaviour aims to help young people to learn that mimicking others can have a number of unhelpful effects and they may be more likely to be accepted by being themselves. Role-play and behavioural experiments are useful techniques here.

Thirdly, socially anxious youth usually see themselves as unacceptable to others in some way. This belief can lead the young person to gravitate towards and seek acceptance from the dominant peer group, irrespective of whether the individual likes or relates to the group. The young person is like a ‘moth to the flame’ because by trying to affiliate themselves with a group of individuals very different from themselves they are in fact more likely to be victimised and rejected. As a result their negative social attitudes will be confirmed. For example, Sienna was by nature a quiet, thoughtful girl. She believed that others would reject her and that she was vulnerable and unlikeable. She attended a very large inner-city all-girl secondary school. There was a very dominant peer group in her year. Despite being temperamentally very different to the predominantly loud, extrovert group, Sienna sought to be accepted by them. The mismatch was clear and elicited negative reactions and repeated exclusion from the peer group. Treatment for moths to the flame aims to help the socially anxious teen identify what they value in friendships and then find ways to help them to develop and foster these relationships.

Fourthly, negative social cognitions drive individuals to engage in a variety of safety behaviours when in social situations. Some safety behaviours contaminate the
social situation. As a result they elicit less friendly and potentially hostile reactions from others. For example, a teenage boy, Tom, tended to hide his face and avoid all eye contact for fear that people would notice him and think he was weird or different in some way. Unfortunately the safety behaviours themselves resulted in Tom seeming quite different and elicited comments such as “freak” and “loner”. Young people can be perceived to be ‘standoff-ish’ or like an ‘ice queen’ because safety behaviours such as avoiding eye contact, speaking less, or not asking questions are misinterpreted by others. The core technique to reduce the use of unhelpful safety behaviours is behavioural experiments that aim to help the young person test out how others react to them when they drop their safety behaviours.

Finally, it will perhaps not be a surprise that many socially anxious adolescents who have been subjected to peer victimization or bullying will have low self-esteem. Whilst unconditional assumptions such as “I am weird” are common in social anxiety, when young people experience bullying these beliefs are repeatedly (and sometimes explicitly) confirmed by peers, leading to more general low self-esteem. As a result young people with low self-esteem will see themselves in a negative light in multiple domains of life (not just in relation to their social skills). Low self-esteem is maintained by the biases in perception and interpretation of events and information that the young person makes. Biases in perception mean that individuals will often notice perceived flaws or failings. This may relate to aspects of the individual’s character (for example, “you are not funny enough”), physical appearance (for example, “your legs are too stubby”), mistakes (for example, “how could you have got that answer wrong in class, you fool”), or unfavourable comparisons with others or some ideal (for example, “everyone else can talk to boys but you can’t, why are you still like a kid?”). Biases in interpretation mean that adolescents will interpret any negative event however small as evidence for how useless they are as a person (for example, getting a bad mark on a test is seen as a sign of being a stupid, useless person). In addition, any positive event will be minimised or dismissed. For example, a compliment is read as “someone just feeling sorry for me”, a good grade is seen as “a fluke, a one-off”. Low self-esteem can be targeted in a number of ways. Common techniques include helping the young person to
recognise that the bullies are not the arbiters of their self-worth and to appreciate other domains of life in which they are successful.

12.1. **Anti-bullying interventions**

*Work with parents and schools*

A joined-up approach involving close working with schools and parents is important in managing on-going bullying. This will involve regular contact with school and parents via email and telephone, as well as more formal face-to-face meetings. These will be in addition to individual cognitive therapy sessions. Everybody should be clear and agree on the nature and extent of the victimisation and bullying; young people will often minimise the extent of their difficulties. All schools will have policies to tackle bullying. Specific anti-bullying interventions planned for the anxious adolescent should be consistent with the policy of the child’s school, ensuring that it is sufficient, that it is being implemented effectively and in a way that is sensitive and non-stigmatising for the young person. Useful information is available at [https://www.gov.uk/bullying-at-school](https://www.gov.uk/bullying-at-school). The therapist can help to educate the school and parents about the child’s needs and work with school to ensure that systems are in place to meet these. For example, identifying a named teacher to be available for the young person to report incidents of bullying and to provide in-house support. Working together the therapist, school and family can identify and implement strategies to reduce cyber-bullying as well as bullying outside school. Interventions should be closely monitored and reviewed on a regular basis. The young person themselves can be directed to helpful websites such as [http://www.bullying.co.uk/](http://www.bullying.co.uk/).

12.2. **Working with perceptions of and responses to peers**

The socially anxious adolescent may be more vulnerable to unfriendly or victimising treatment due to their appraisals of others and the negative beliefs they hold. These cognitions can be targeted in therapy.

As a prelude to this work the therapist should communicate to the young person that they view the bullying or peer victimisation as distressing and unfair, and that it is being taken seriously. Then the possibility that the young person’s own perceptions and responses may be backfiring can be introduced without conveying blame or criticism.
Perceptions/misperceptions

Adolescents with negative social cognitions are more prone to misperceiving the actions of others. An initial overture from peers that is offered in a well-meant (although possibly boisterous) way can be seen as critical. The aim here is to help the young person to question their initial interpretation of other’s actions and to enable them to accept what may actually be an offering of friendship.

The young person is encouraged to look at alternative explanations for people’s behaviour. The therapist can talk through example vignettes with the young person, asking them to think of all possible reasons why people might behave like that (which will include bullying/teasing, but also showing admiration, expressing social interest etc.). The young person can undertake a data-gathering behavioural experiment, to determine whether peers make these comments to others, and how people on the receiving end react to it.

Next it is helpful to undertake role-plays with the young person. The young person can take the role of the other person whilst the therapist plays the role of the young person (engaging in avoidant behaviours in response to a comment). This will demonstrate to the young person that they are conveying a particular message to others when they feel they are being criticised or mocked. In particular, others may feel belittled or ‘dissed’ by the young person’s response to what may be a well-intentioned comment. The role-play can help to determine what responses would convey a better message to others.

Finally behavioural experiments are planned which test out the effect of accepting an initial overture from a peer and responding in kind. For example, Mark and his therapist planned a behavioural experiment to test out the hypothesis that his peers were not intending to criticise or upset him when calling him ‘spod’ or ‘brainiac’. This is summarised in Table 22.
Table 22. Behavioural experiment record for Mark

<table>
<thead>
<tr>
<th>Situation</th>
<th>Prediction</th>
<th>Experiment</th>
<th>Outcome</th>
<th>What I learned</th>
</tr>
</thead>
<tbody>
<tr>
<td>In class when Tom or one of the others makes a comment, such as “alright, spod”</td>
<td>They think I am a fool and a bore. If I laugh or smile they will look at me as if to say “what do you think you’re doing, we don’t want to be your mate” 69%</td>
<td>I went into class and sat doing some maths homework (because that’s when they normally make that kind of comment).</td>
<td>Josh came over and said “haven’t finished yet, what’s wrong with you?!” Even though I felt like looking away and burying my head in my work, I looked up, smiled, and said, “yeah, I must be losing my touch!” Josh seemed to laugh. I smiled and carried on with my work and Josh sat down.</td>
<td>I can’t believe it. I really thought they were being mean but now I realise that maybe they weren’t, that’s just how they act. And Josh seemed to find me funny! [New belief 51%] I’m going to try chatting next time.</td>
</tr>
</tbody>
</table>

[Original belief 0%]
Beg friends

Socially anxious adolescents often conceal their own views, opinions and preferences for fear of rejection by others. Instead, they may agree or go along with their peers. This can elicit less friendly responses. The goal here is to help the young person learn that others will accept them and perhaps be more interested in them when they are themselves.

To begin with the young person can be helped to see this mimicry as a behavioural strategy aimed at preventing rejection by others. The unintended (and unhelpful) effects of the mimicry are then drawn out. First, it prevents disconfirmation of the belief. Second, it enhances self-consciousness and anxiety. Third, it elicits an unfriendly reaction from others.

Then the therapist can help the young person to learn that actually they need to be themselves, because this is what people like. Ask the young person to identify what they find interesting in their friends. Is it that they all say the same thing or does the young person enjoy the diversity and breadth of opinions that are shared? The therapist can encourage the young person to examine what happens when peers have differing opinions. It will become clear to them that peers often disagree with each other, for example on opinions about music preference, but this typically generates a richer conversation rather than rejection and discord. The message here is that openly expressing oneself and one’s individual preferences, be that in clothing, music, food, mannerisms, or speech, is more appealing to others.

Once this idea has been established, the young person is likely to need help to do this. Role-play is usually a good starting point. The therapist role-plays a young person in two different ways. In the first role-play they behave in the way that the young person is currently interacting with their peers. In the second role-play the therapist expresses different opinions. The young person is asked to reflect on what it is like being on the receiving end of these interaction styles. The following transcript shows the therapist undertaking the role-play with Jaida.

Therapist Let’s just start off with a bit of a role-play, I’m going to play a young person behaving a bit like you’ve described. What I want is for you to go with it,
chat with me, and just try to notice what it feels like for you. Is that ok? You really like vlogging, don’t you, and you’ve started making your own? So shall we talk about that? Ok, great.

So, which vloggers do you like at the moment?

Patient

I still really like Zoella, she’s great, really open about her issues and stuff but also really funny too. Who do you like?

T

Yeah, I like Zoella too.

P

You do? Which of her vlogs have you seen recently? Did you like ’awful car singing’?

T

I’m not sure, but yeah, I really liked awful car singing too.

….

T

Ok, Jaida, so let’s wrap that role-play up. How did you find it?

P

It was quite hard going! I felt a bit like I was talking to myself, like the other person wasn’t really giving anything, and I had to do all the work. And that made it feel quite an effort. I also don’t feel like I got to know anything about her.

T

Ok, great noticing. So you found it hard work, like “talking to yourself”, and you didn’t get a sense of the other person. Just remember the reaction. And now we’re going to do something a little different. Let’s have another role-play. So go with it just like you did last time.

So, which vloggers do you like at the moment?

P

I think Zoella is great, I’m still a big fan. Who do you like?

T

I used to be such a Zoella fan, but don’t you think she’s sold out since hitting the big time? I don’t think she’s so genuine now…

P

Do you think? I can kind of see your point, and I know that’s what loads of her original followers say, but I think she’s still good, and also good on her for making it.

T

That’s true, we’d probably all do that wouldn’t we! But I liked her because I used to think her life was probably quite like mine, but now it is so different.
Ok, so how was that conversation?

I didn’t want it to stop! It was really interesting and made me think about the vlogger more.

Uh-huh, so tell me what was interesting about the conversation for you?

Well, I think there is an issue about vloggers selling out. And part of what makes vloggers good is them talking about stuff that relates to you. But at the same times I still find Zoella fun to watch.

Ok, so it sounds like when the other person was suggesting their own views, which happened to be different to yours, this made for a more interesting conversation, one that encouraged you to think more, and one which you wanted to continue?

Yeah, that is so true.

So, when you’re in a conversation and the other person agrees with everything you say without giving their opinion you find it hard work. In contrast, when you are in a conversation and the other person gives their own views, even if they are different to yours, you find it interesting and want it to carry on. Why then wouldn’t that be the same for yourself?

For adolescents who are still holding back from sharing their views in the two role-plays, a third role-play can be useful in which they are instructed to be as open as possible. A couple of points should become clear to the young person through the role-plays. Firstly, others do not reject them when they share their views. Secondly, being open often elicits more friendly reactions and generates a richer more enjoyable conversation. Thirdly, it is associated with less self-consciousness and anxiety. 

*Behavioural experiments* are then planned in which the young person tests this out day-to-day life.

*Moths to the flame*

For young people who seek validation and acceptance from a dominant group the preliminary step is for the young person to recognise this as a response to their negative
social belief. The therapist can help the young person to create a list of what is important to them in a ‘friend’. They can then compare this list to the features of their current peer group relationships. For example, Sienna wrote down that she wanted a friend who was kind, loyal, funny, shared the same interests, and liked animals. It was quite an eye-opener for her when she observed that these were not characteristics or preferences she recognised in her current peer group. This exercise provided the opportunity for the therapist to have a conversation with Sienna about the reasons that she had sought out the dominant peer group. Sienna agreed that she was seeking to be “okay-ed” or get the “seal of approval” from the cool group, rather than affiliating with them for who they were as individuals. Stepping on from this, the young person can be encouraged to seek out and develop new friendships that match up more closely to the list they created. The therapist can help them to do this, for example, by liaising with school or helping the young person to join out of school clubs. The new social relationships can then provide the setting in which the young person can undertake behavioural experiments and learn meaningful lessons about themselves and how others respond.

Unhelpful safety behaviours

Many of the safety behaviours that a socially anxious teenager engages in can inadvertently elicit a less friendly response from others. Behavioural experiments will be key here (see Chapter 8) and represent the central mechanism of change. However, minor adaptations may be needed where peers are reacting in a hostile way and when the young person has been stereotyped or labelled. The first thing to do is a reverse role-play (in which the therapist plays the patient and the adolescent role plays a peer) so the young person can discover the message they are sending with safety behaviours. Then the next step will be to test out dropping safety behaviours with other young people. In the first instance the young person might be encouraged to carry out their behavioural experiments with those peers who are less likely to respond in an unfriendly or hostile manner. This might be with peers from outside school, for example with family friends. Alternatively, experiments can be repeated a few times in order to give the adolescent’s peers the opportunity to recognise the script has changed and shift their response to the young person. For example, Tom and his therapist planned behavioural experiments to
test out the belief he was weird or different and Tom agreed he would drop his safety behaviours. Initially Tom said that little had changed in the reactions of his peers. However, the therapist wondered whether Tom’s peers might take a little time to spot the change in his behaviour and whether they were still ‘reading the old script’. Tom agreed to persist with this experiment and indeed, over time his classmates no longer made comments such as “loner” and began nodding and smiling at him when he made eye contact with them.

Low self-esteem

There are many interventions aimed at improving low self-esteem. We have provided a fairly comprehensive list of techniques here. It is not necessary to target low self-esteem with the majority of socially anxious adolescents. Whilst many young people will present with low self-esteem at the start of treatment, it typically improves with standard CT-SAD-A. However, a minority of socially anxious adolescents will present with low self-esteem that is present in multiple domains of life, distressing and impairing, and resistant to standard CT-SAD-A. For these young people, the strategies below may be useful. Self-esteem work should be undertaken towards the end of treatment, after the core CT-SAD-A components have been delivered. It will usually take a maximum of one to two sessions of therapy.

Understandably, for many adolescents the experience of being victimised and bullied has a profound effect on their self-worth. This is particularly so when the bullying has been long-standing, involved multiple perpetrators, and/or has been repeated in separate settings. For individuals with low self-esteem, thoughts such as “I am useless”, “I am inadequate”, “I am bad”, “nobody likes me” are not confined to social situations but are seen to be true most of the time. Interventions will involve challenging the idea that the bullies are the arbiters on one’s worth; viewing low self-esteem as a form of self-prejudice; and techniques to develop more positive beliefs about the self. Additional techniques that can be helpful include the assertive defence of the self and targeting the self-critical voice.

Commonly the adolescent has internalised the repeated negative comments of bullies and is using this as evidence of their worth as an individual. Encourage the young
person to question the opinion of someone who bullies. Using a *third person perspective* can be a good way to undermine the weight of the bullies’ opinions and comments. For example, asking the young person to imagine what they would think if a friend or sibling were being bullied. The following transcript demonstrates this.

**Therapist**  
So I’m just wondering something. Let’s imagine that someone was bullying your friend. They were telling them that they were a loser, an idiot, ugly. What would you tell your friend? Would you say, yeah, of course they are right?

**Patient**  
No, of course not! That person is just trying to hurt them. It is totally not true.

**T**  
Ok, so you’d tell them that it’s not true what they are being told, that they are saying that just to hurt them?

**P**  
Yes, of course. My friend is lovely, I’d remind her of that.

**T**  
So you’d be telling her to listen to the people who are really her friends? To the people who know her properly, have I got that right?

**P**  
Uh-huh.

**T**  
So if you would tell your friend to ignore these bullies, why wouldn’t you do the same for yourself?

Another good strategy to undermine the weight of the bullies’ comments is to encourage the adolescent to look beyond the bullies’ comments to other sources of information for evidence about their self-worth. Identify areas of life in which the adolescent is successful and encourage them to link this in to their sense of self. For example, they may be good at dancing, baking, football, or gaming. This work will help to demonstrate the point that the young person is not defined solely by the ways in which this particular group of people are treating them at this point in time. The young person can draw out a mind map or spider diagram to illustrate this.

Once the idea that bullies are not the arbiters of one’s self-worth has been established, the work will focus on teaching the young person about the processes that
maintain low self-esteem. A good way to do this is to use the metaphor of a prejudice. This technique has been described in detail by Padesky (1993). Essentially it involves a series of questions that aim to highlight to the young person that they are currently self-prejudicial in their thinking and behaviour. The therapist starts out by developing the adolescent’s understanding of what a prejudice is. The adolescent is then asked to identify someone that they know who has a prejudice (which they do not agree with themselves). For example, 15-year-old Zoe had very low self-esteem. The following transcript demonstrates the therapist introducing the prejudice analogy. At first Zoe struggles to understand what a prejudice is, and so the therapist uses alternative phrases such as ‘being judgemental about something’, being a ‘judger’ and a ‘hater’.

Therapist  Now we’re going to talk about something a bit different. We’re going to talk about prejudice. Do you know what prejudice is?
Patient  Err, no.
T  A prejudice is a bit like having a strong but unfair judgement against something, being a hater or a judger. So for example, have you learnt about racism at school?
P  Yes, we had an assembly on it last term.
T  Yes, and do you know what racism is?
P  So, is it like thinking that people are less good just because of the colour of their skin or something?
T  That is a great explanation. So racism is a kind of prejudice. It is discriminating against others. Now can you think of someone who has a prejudice. One of those really strong views? And one you don’t agree with?

The biases in information processing that are active and which prevent updating of the negative beliefs can then be identified. These might include discounting, distortion, seeing the observation as an exception, the exception that proves the rule, and not noticing/ignoring. The following example shows the therapist stepping through the metaphor with Zoe. Zoe identified that her uncle had a prejudice against Muslims. She
said she strongly disagreed with this and found it really upsetting. The therapist questions Zoe about how her uncle would react when faced with examples of a Muslim person not doing a task very well. Zoe says he would say “there, you see, just like I say”. The therapist continues and asks what her uncle would say if he was faced with an example of a Muslim person doing a task well. Zoe thought he would say: “well, that’s a one off” (*the exception that proves the rule*), or “yeah, but I’m sure they’ve got bad intentions really” (*distortion*), and “and anyway, it wasn’t that impressive a job really, was it?” (*discounting*). Zoe is asked whether her uncle would usually even spot these examples of Muslim people performing well. She thought he would tend to ignore them (*not noticing*). The final steps involves asking the young person how they would change the person’s prejudice and linking the metaphor back to their own experiences. The steps are summarised in Table 23.

**Table 23. Useful questions to develop the prejudice model**

- Do you know what prejudice is?
- Can you think of a person in your life that has a prejudice that you don’t agree with?
- Imagine that person saw somebody that they were prejudiced against do a task badly/well. What would they think? What would they say?
- How would you go about changing that person’s opinion? What would you need to ask them to do?
- Why do you think we’ve been talking about this? How might this link to your experiences?

Once the link between the metaphor and the young person’s own low self-esteem has been made, the therapist can explain that as a result of the distorted ways in which the adolescent is dealing with evidence contradicting their prejudice, the young person is not taking it into account. This is despite the fact that there may be lots of data inconsistent with their self-prejudice.

The therapist explains that the way to overcome this is to look out for any evidence that could possibly be seen as consistent with the alternative positive belief. The
data or evidence can then be reviewed and evaluated in detail. By recording or logging anything that could conceivably be evidence that (for example) the adolescent is likeable, the therapist and young person are able to overcome the processing bias. The young person may eventually discount the data when they review it in detail, but they are asked to write it down in the first instance and not to discount it straight away. In this way we are asking the young person to suspend their judgement and to show a bias in the opposite direction.

The young person is asked to record all evidence on a positive data log. To begin, the therapist and young person define or spell out what would count as evidence for the young person’s positive belief. What should the young person be looking out for? What would someone who was likeable/interesting/worthwhile do? How might people treat them? With the example of being likeable, this might include somebody texting, smiling, or helping them out. Take time on this exercise in order to generate a full list. Usually when the young person brings in their completed data log the evidence does not need to be reviewed and evaluated in detail because the young person is so overwhelmed by the sheer number of data points. An example positive data log for Zoe is shown in Table 24.

Table 24. Zoe’s positive data log

<table>
<thead>
<tr>
<th>“I am a likeable person”</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smiles at me</td>
<td></td>
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<td></td>
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<tr>
<td>Says hello</td>
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<tr>
<td>Gives me a compliment</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Laughs if I make a joke</td>
<td></td>
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<tr>
<td>Asks me a question</td>
<td></td>
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<tr>
<td>Texts me or replies to a text</td>
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<tr>
<td>Makes space for me in class or at lunch</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helps me when I ask for it*</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Invites me to something

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Shares something with me</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*It turns out someone offered to help me every time I asked!*

Behavioural experiments are another important method of tackling low self-esteem. Previous behavioural experiments can be reviewed to gather evidence for positive beliefs about the self. Further experiments can be planned testing out the positive beliefs. For example, Zoe believed she was unlikeable. As a result she avoided arranging things with friends for fear of being rejected. Her behavioural experiment record is presented in Table 25.
Table 25. Behavioural experiment record for Zoe

<table>
<thead>
<tr>
<th>Situation</th>
<th>Prediction</th>
<th>Experiment</th>
<th>Outcome</th>
<th>What I learned</th>
</tr>
</thead>
<tbody>
<tr>
<td>With my friends</td>
<td>What exactly did you think would happen? How would you know? (e.g. what would other people do or say?) Rate belief: 0-100%</td>
<td>How did you test it out? (remember to focus on what actually happens rather than your feelings and let go of Safety Behaviours)</td>
<td>Where was your attention focused? What actually happened? Was the prediction correct?</td>
<td>Balanced view Rate belief: 0-100% What I learned in general about myself in social interactions. How can I build on this?</td>
</tr>
<tr>
<td></td>
<td>If I suggest meeting up this weekend they will all pretend they have plans and say they can’t come. This is because I am unlikeable. 70%</td>
<td>On Monday I suggested meeting up this weekend to go to the cinema. I then watched to see how my friends reacted.</td>
<td>One of my friends, Sara said she was busy this weekend. But then when Chloe said she would like to come, Sara asked if we could organise it for the weekend after so she could come too! I guess my original prediction wasn’t right.</td>
<td>Maybe I am likeable. People want to spend time with me.  [New belief 45%]</td>
</tr>
</tbody>
</table>

With my friends
If I suggest meeting up this weekend they will all pretend they have plans and say they can’t come. This is because I am unlikeable. 70%

On Monday I suggested meeting up this weekend to go to the cinema. I then watched to see how my friends reacted.

One of my friends, Sara said she was busy this weekend. But then when Chloe said she would like to come, Sara asked if we could organise it for the weekend after so she could come too! I guess my original prediction wasn’t right.  

[Original belief 10%]
Often teenagers with low self-esteem are highly self-critical. As a result they may not treat themselves in a kind or caring manner. This will perpetuate the perception of low worth. To target this, self-compassion and self-care techniques can be introduced. For example, for one teenager a cheerleading analogy was used to convey the message that her on-going self-criticism was unhelpful. She was able to see that she had been on the opposing team up to now, shouting herself down. She planned to “be on my team” and “cheer myself on”. The important idea was to treat herself as she would treat a friend. She planned positive enjoyable activities, including painting her nails, watching her favourite movie with her sister, treating herself to a magazine, and taking regular exercise.

Padesky (1997) advocates the use of a technique she terms the *assertive defence of self*. Individuals with low self-esteem will be sensitive to criticism, particularly when it resonates with or echoes their own negative beliefs. This technique aims to help clients manage criticism from others when it occurs. It is not something we have found a need to use with young people yet, but it is something to bear in mind as a potentially useful strategy. Firstly, the negative beliefs are identified with the young person. Secondly, the therapist and young person take part in a *role-play*. The young person first takes the role of the critic (the criticism usually echoes the young person’s negative beliefs) and the therapist role-plays how to talk back to the criticism in an assertive manner. For example, the criticism may be: “You look so nervous, you loser”. The therapist could reply by saying: “Well, it is true that I’m anxious. Anxiety is not a sign of being a loser or of weakness. In actual fact, anxiety is really common. Most people are anxious about something.” Once the young person has a good handle on the assertive responses, they can try out responding to the criticisms out loud. This technique is not necessarily something to be played out in real life, but is used to discount the critic in one’s own head. The technique can be helpful in two ways. First, it can reduce self-criticism. Second, should someone criticise the young person in real life, they will be better able to overcome it using the internal assertive talk, rather than internalising the negative comments.

Young people with low self-esteem will often experience a critical inner voice. The inner voice often reflects an internal bully, comprising the young person’s negative
beliefs and self-judgements. One of the problems is that much of this self-criticism is accepted automatically and without question. It can be helpful to target the self-critical voice in therapy where it is spotted as a frequent problem.

Help the young person to first spot the self-critical voice when it occurs. The next step is to help the young person to tune out of this voice. They can do this in two ways. They can then remind themselves that what they have learned from therapy so far is that what is important (and accurate) is how they are coming across to people in reality, not their routine voice. Therefore when they detect the self-critical voice, this is taken as a cue to shift their attention externally and see how others are responding to them in the here and now. The other strategy is to remind themselves that this is the ‘same old negative voice’, ‘here it is again’ and instead to choose to be compassionate towards themselves.

12.3. Romantic relationships

Most adolescents find their maiden sexual and romantic relationships to be stressful. Initially these experiences are characterised by lots of uncertainty and naivety. Teenagers will be learning about themselves and about how romantic and sexual relationships work. For young people with social anxiety this process can be even more complicated in a number of ways. It is helpful if the therapist is alert to this so that they can normalise and then give appropriate advice. The domain of romantic and sexual relationships will not be relevant for all young people, either because they are not yet interested in developing romantic relationships or because it is not an area affected by social anxiety. Clues to suggest that social anxiety is affecting a young person’s romantic relationships can be gathered from the Social participation and satisfaction questionnaire (see Appendix B) as well as from therapy sessions.

Asking a socially anxious adolescent about their romantic and sexual interests unprompted, or out of the blue, will not be helpful. Indeed, there is a chance the adolescent will not come back to the next session. Instead it is preferable if this work is child-led. If the therapist and young person identify romantic experiences as an area of difficulty, then some specific interventions, described below, may be of use. The majority of these will map onto standard CT-SAD-A interventions already described in previous
chapters. Work with negative self-images may be important and behavioural experiments are also likely to be critical (see Chapters on Video and photographic feedback [Chapter 6] Behavioural experiments and Surveys [Chapter 8]).

Two steps are important before intervening. Firstly, undertaking a sensitive assessment of the young person’s romantic relationships, romantic experiences, and understanding of sexual orientation and identity. This might include a benchmarking process to assess the type of romantic relationships the young person’s friends are currently engaging in as well as family and cultural attitudes towards romantic relationships. Secondly, normalising feelings of anxiety and confusion, which are part and parcel of adolescence.

**Typical adolescent romantic relationship development**

One of the hallmarks of adolescence is the emergence of romantic relationships. This coincides with the onset of puberty and the increased affiliation with mixed-gender groups. Romantic relationships have an intensity that distinguishes them from other peer relationships and they are usually associated with anticipated or current sexual behaviour. Romantic experiences are common in adolescence and describe a broader set of behaviours and beliefs. They include crushes, fantasies and brief sexual encounters.

With adolescence, most teenagers experience an increasing interest in members of the opposite/same sex (depending on their sexual orientation). Furthermore, for adolescents, having a boyfriend or girlfriend is often a sign of ‘fitting in’ and confers social status. However, learning how to navigate romantic relationships is challenging and early forays into romantic relationships are typically awkward experiences. Individuals need to decide whether they would like a romantic relationship or friendship. They will be recognising and trying to work out their sexual desires, which will include questions about their sexual orientation. Concerns about their peers’ reactions to their behaviour are often at the forefront of their minds. For example, how friends will view a relationship or romantic interest.

Through adolescence the focus of interest of the romantic relationship changes. Early on, young people are primarily interested in determining their sexual interests, their own attractiveness, how to interact with those they are interested in, and how the peer
group responds. Only later does sexual fulfilment and partnership become more of a focus.

The impact of social anxiety on the development of romantic relationships in adolescence

For teenagers with social anxiety, romantic experiences and relationships will be more challenging.

Many will actively avoid relationships of this sort because they perceive them to be even more threatening than peer relationships. As a result socially anxious adolescents miss out on opportunities to learn about their emerging sexuality and about how to establish romantic relationships. This avoidance will, in turn, maintain negative social cognitions. Once identified as a problem, the therapist begins by undertaking a sensitive assessment. The next step is to normalise the anxiety and uncertainty the young person feels. Then the therapist should encourage the young person to talk about what they would like in terms of their romantic relationships. The specific predictions preventing a young person from either initiating a relationship or agreeing to engage in a romantic relationship are identified. This will then set the stage for planning behavioural experiments to test these fears out.

Often the safety behaviours that adolescents with social anxiety engage in will put off admirers. For example, avoiding eye contact and speaking less will convey a lack of interest and may be perceived as a sign of rejection. Interventions include role-play with the therapist to learn about the unfortunate effects of safety behaviours, video and photography feedback to correct any negative self-images identified, and behavioural experiments to test out the effect of dropping unhelpful safety behaviours.

Many socially anxious adolescents see themselves as unacceptable. As a result, some are excessively yielding and acquiescent with peers in order to be accepted. This behaviour may also occur in relation to romantic relationships. Some socially anxious teenagers find themselves agreeing to enter into romantic relationships due to a desire for acceptance (from the admirer or their peers or both) rather than their personal choice. As a result they may make themselves vulnerable to engaging in unequal or coercive relationships. Similarly they may develop intense romantic relationships at the expense of other relationships.
Interventions will need to be carefully delivered to ensure the young person does not perceive the therapist to be criticising their relationship or choice of partner. Strategies that may be useful here include those that are helpful in targeting the ‘moths to the flame’ effect and low self-esteem (described in Chapter 12, Section 12.2.). For example, the young person can be gently helped to see their behaviour (whether that is compliant behaviour or engagement in a relationship at the expense of other friendships) as a response to their negative social beliefs (for example, “if he accepts me then I am ok as a person”, “no one else would have me”, “I am safe with her because she won’t reject me so I don’t need anyone else”). The adolescent and therapist can work to identify how the young person would like their relationships to be (both in terms of the specifics of their romantic relationship but also whether they would like friendships in addition to their romantic relationship etc.). The young person can then be supported in making changes to their interpersonal relationships.

Some adolescents will engage in brief sexual relationships as a less anxiety-provoking alternative to developing an emotionally intimate relationship. For example, one 17-year-old girl, Nina, explained that “It is back to front, usually you want to get to know someone first, but for me it was impossible to say more than "Hi". I so want to talk but I can’t – I just get freaked out, blush and fall over my words. So I started drinking when I was out with friends. The first time it happened we were in the park with loads of people and a boy came up to me and started kissing me. We went off and did stuff. And it was so much easier…no awkward conversation; I didn’t feel like a total failure. But now, I feel like nothing is changing. I just have these flings or whatever, and then that’s it. Although I would like to be with someone properly I’ve kind of boxed myself in a corner: I still don’t know how to talk to boys and they all think I’m easy now and that’s why they approach me.”

Difficulties such as this can often be overcome through standard CT-SAD-A techniques. As the adolescent learns that they are socially acceptable as they are, then this will usually generalise to people they are sexually attracted to. If this does not happen then specific behavioural experiments can be planned. For example, Nina had done well in CT-SAD-A. She was developing close relationships with female friends and had recently begun speaking to a male peer, Thomas, when in a group setting. He was unlike
the boys she would usually have flings with. According to Nina, he seemed quieter and had not made any attempts at physical contact. Nina thought she might like Thomas but felt intense anxiety at the prospect of getting to know him. She explained to the therapist that she did not know how to interact with him if they were alone without initiating a physical relationship. The therapist and Nina planned a behavioural experiment. She decided to go to a party and have a conversation with Thomas and not engage in any physical contact with him. She had thought the conversation would dry up, that he would lose interest and she would be left alone. In contrast, although she had felt anxious and awkward to begin with, she managed to focus externally and drop her safety behaviours. She had a 10-minute conversation with Thomas and he asked for her phone number at the end. Nina noted down the behavioural experiment in a record, shown in Table 26.

Adolescent romantic interests are often fast changing; a young person may obsessively like someone one week before moving onto someone else the next. This can be difficult for all young people, but for young people with social anxiety it can be particularly distressing if it resonates with negative social beliefs such as “I will be rejected”. Helpful techniques are similar to those used to target perceptions and misperceptions of peers (Chapter 12, Section 12.2). The aim is for the young person to recognise this switching of romantic interest as common and without ill intent, rather than indicative of a personal rejection. Data-gathering behavioural experiments will be useful to determine whether this also happens to peers. Surveys can be undertaken to assess first, whether other young people find their romantic interest changes and second, how they react if someone stops being interested in them.
Table 26. Behavioural experiment record for Nina

<table>
<thead>
<tr>
<th>Situation</th>
<th>Prediction</th>
<th>Experiment</th>
<th>Outcome</th>
<th>What I learned</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sasha's party. Thomas will be there.</strong></td>
<td>What exactly did you think would happen? How would you know? (e.g. what would other people do or say?) Rate belief: 0-100%</td>
<td>How did you test it out? (remember to focus on what actually happens rather than your feelings and let go of Safety Behaviours)</td>
<td>Where was your attention focused? What actually happened? Was the prediction correct?</td>
<td>Balanced view Rate belief: 0-100% What I learned in general about myself in social interactions. How can I build on this?</td>
</tr>
</tbody>
</table>

| | | | | |
| The conversation will dry up, he will lose interest and I will be left alone 80% | I went to the party and didn't have anything to drink. I was trying to build up the courage to go over to Thomas when he came over to me. I felt really nervous but went with it, and didn't resort to touching him or flirting like normal. | We spoke for 10 minutes or maybe more! It was scarier at first to just talk to him rather than doing my usual flirting routine. But the conversation was so nice, and he seemed to want to talk to me. Just to talk to me! Then he asked for my number and I have not stopped smiling… | I can talk to boys, and to boys that I am interested in. And they might be interested in me as a person. I don't have to start something physical straight away for someone to like me. [New belief 35%] | Keep getting to know Thomas and holding off from jumping into a physical |
relationship.
CHAPTER 13. RELAPSE PREVENTION & ENDING TREATMENT

13.1. Relapse prevention

Occasionally young people can experience a return of symptoms after successful treatment. This may be precipitated by a stressful experience such as bullying, illness, or a significant transition (for example going to university). Long-term follow up studies in adults have generally found that people who are treated with Cognitive Therapy maintain or further improve on the gains they make in treatment. Although some individuals who have responded to Cognitive Therapy for social anxiety disorder do relapse, this seems to be relatively rare. For example, (Clark et al., 2003) reported a relapse rate of 5% a year after Cognitive Therapy compared to 40% after treatment with antidepressants. Part of the reason for the low relapse rate may be the routine inclusion of a relapse prevention programme in the later stages of treatment. The key principles are to consolidate the learning that has occurred in treatment and to anticipate setbacks and to have a plan for how to deal with them. All of this information is incorporated into a personalised blueprint that the patient develops with the therapist and as homework. The ‘Therapy Blueprint’ template is in Appendix K.

We usually introduce the principle of relapse prevention in session 13. The young person is reminded that CT-SAD-A is a treatment which aims to give them new skills for tackling their anxiety and learning about how the world really works. It is explained that as treatment is coming to an end, it is useful to review the lessons learned in therapy and to summarise this in written form. This will mean that the young person has a resource that they can go to in order to continue working towards their long-term goals, to manage setbacks should they occur, and to nip social worries in the bud should they emerge. In the session the therapist works through a series of questions and the young person writes down the answers on their Therapy Blueprint. The main areas to be covered are summarised in Table 27. As a homework task after session 13 the young person is asked to read over and finish their Therapy Blueprint. The completed therapy blueprint for Sienna is shown in Table 28.

At the final appointment parents are invited to join the session. Whenever possible, we encourage the young person to take the lead and talk through the Therapy
Blueprint with their parents (see Chapter 11 on ‘Working with parents’ for further information on how and why we do this).

Table 27. Main points of the relapse prevention plan

- What were the main problems at the beginning of treatment?
- What kept the difficulties going (i.e. the maintenance factors in the model)?
- What were your key negative social thoughts?
  - How can you answer back to these?
  - What is the evidence to support your answers?
- What did you learn in therapy (specifying unhelpful beliefs and strategies and helpful alternatives)?
- What progress have you made in therapy? How are things different now?
- What challenges do you anticipate in the near future and how will you overcome these?
- What are your future goals?
- What advice would you give another young person who had social anxiety?

Table 28. ‘Therapy Blueprint’ for Sienna

<table>
<thead>
<tr>
<th>MY THERAPY BLUEPRINT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How your social anxiety developed.</strong></td>
</tr>
<tr>
<td>Can you remember when it started? Was anything important or significant happening at that time? Were there any later experiences that made your social anxiety worse?</td>
</tr>
<tr>
<td>My social anxiety started when I was 9. I was bullied in my first primary school and so I didn’t feel confident. Then I lost control of my bowels in class and that made it all worse. People started being even nastier to me. I changed primary schools but still found it difficult. When I went to secondary school I had hoped things might get better but some of the girls from primary came to my new school and it all started again. They were a big strong group.</td>
</tr>
<tr>
<td><strong>What kept it going.</strong></td>
</tr>
<tr>
<td>Here it might be useful to mention focusing on yourself/self-monitoring and any difficulties that caused the safety behaviours you used and the difficulties that</td>
</tr>
<tr>
<td>234</td>
</tr>
</tbody>
</table>
caused; and the importance you attached to the way you felt, rather than how you behaved at the time. Did you avoid situations?

Every time I had to go to a social situation I had negative thoughts like “I’m boring”. These made me feel really anxious. Then I got stuck in a cycle. I focused on myself and on how I was coming across. I thought that because I FELT anxious that meant I LOOKED anxious to everyone. I did lots of unhelpful safety behaviours, like checking how I was coming across, agreeing with everyone, plan what to say, and get my mum to speak for me.

Your main negative thoughts.
Think about: What were the most important negative thoughts and beliefs – what are the answers to these?

<table>
<thead>
<tr>
<th>Negative thoughts</th>
<th>Answers to these</th>
<th>Evidence for these answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am boring</td>
<td>I am interesting</td>
<td>When I go up to people to chat without preparation they are interested and want to spend time with me.</td>
</tr>
<tr>
<td>I will talk funny</td>
<td>I talk clearly but even if I spoke funny it wouldn’t matter</td>
<td>When I speak in class or shops or with friends people listen and help. We tried speaking strangely but no one seemed to care!</td>
</tr>
<tr>
<td>I am weird</td>
<td>I am fine just as I am</td>
<td>When I drop my safety behaviours and just act as I am, no one looks at me strangely or as if I’m weird.</td>
</tr>
<tr>
<td>I am inferior</td>
<td>I am as good as everyone else</td>
<td>I have lots of talents in lots of areas.</td>
</tr>
<tr>
<td>People will reject me</td>
<td>People want to be with me</td>
<td>I am invited to things by people who I want to spend time with. My friends respond when I text, message or invite them to things.</td>
</tr>
</tbody>
</table>

What you learned in therapy.
Think about: What have you found helpful? What did you learn about the role of Safety Behaviours? What did you learn about focusing in on yourself and the images you had of yourself?

I learnt that I am fine as I am! Part of the problem was using all the safety
behaviours. These stopped me finding out my fears aren’t true. They made me feel more anxious. They can actually make my fears more like to happen. Like trying to keep track of what I’m saying makes me more likely to trip over my words. They can put people off. Like avoiding eye contact makes people think I don’t want to talk to them. Focusing on myself doesn’t help either. It makes me feel more stressed. I don’t notice what is really going on and what other people are doing. It makes me notice how I’m feeling and the horrible picture in my head (of me looking lost and clueless). Then that is what I think I really look like on the outside. In therapy I learnt to go out into social situations and drop my safety behaviours and push my attention outwards. I can then find out how people really respond. And it is positive! I also learnt that horrible picture isn’t really what I look like, it’s more a ghost from the past. I actually look totally fine!

**How to deal with any future setbacks.**

Think about: What things might happen in the future to knock your confidence? Will specific thoughts pop up again? Would you start to focus on yourself? Might you mistake how you feel for how you appear to others? What should you do if you notice a setback beginning – list the strategies that might be helpful. At this time, what would be the key things to remember and do? What experiments would help you get back on track?

Things that could knock my confidence include if someone was mean to me, or didn’t invite me to something. But what I know now is that something like this might happen (they happen to everyone occasionally) but that is doesn’t mean there is anything wrong with me. If I notice I start to think badly about myself, like “I’m weird” and lose confidence in social situations, and focus on myself and do old safety behaviours, then I need to:

1. READ THIS (MY THERAPY BLUEPRINT)!
2. Test out the fears that I spot in behavioural experiments.
3. Focus on the outside
4. Drop safety behaviours
5. Remind myself that “I am just FINE as I am”

**How to build on what you have learned.**

Think about: What do you need to do to keep up these changes and improvements? What is there still left to work on – an action plan might be helpful here. Are there still problem areas - anything you are still avoiding? How can you now “steal the limelight”, experiment with being the centre of attention – what future experiments would really take it all forward? How much do you really believe your new thoughts and way of seeing things – are there still any doubts – what can you do to target the doubt? Given what you have learnt, what would really help you maintain your new beliefs in the future?
I am going to keep ‘putting myself centre stage’ and ‘taking up space’! In the short term I am going to give a presentation with two friends in class assembly. In the medium term I am going to audition for one of the main roles in the next performance with my dance drama group. These will help to keep testing out what I have learnt: that I am fine as I am, interesting, and just as good as the next person!

13.2. Follow-up sessions

Follow-up sessions are held at 1, 2 and 6 months post-treatment. The content of the follow-up sessions will vary depending on progress the young person has made, whether they are still experiencing residual symptoms, and if they face obstacles during the follow-up period. Questionnaires should be completed at these sessions as well. This data allows the therapist to assess maintenance of gains. Should some symptoms persist, the data will provide important information about persistent problematic beliefs or safety behaviours that need to be targeted.

The sessions should begin with a review of social anxiety achievements the young person has made. If the young person has faced a difficulty in relation to their social anxiety this can be reviewed and the reasons for this discussed. The problematic situation can be mapped out on a schematic of the cognitive model. This may then lead to role-play exercises, video feedback review, or planning of further behavioural experiments. The process of reviewing a challenging situation and working to overcome it should be undertaken in a clear and transparent manner with the young person. The young person is encouraged to take the lead as much as possible. The therapist can help them to think how they would manage the same challenge should it happen in the future. The Therapy Blueprint could be revised to include this information. Finally, if behavioural experiments have been planned, or potential challenges have been recognised (for example, a school prom), then these should be discussed in the next session.

13.3. Ending therapy

At the end of therapy we convey to the young person how far they have come in treatment and thank them for their bravery and hard work. A therapy letter is usually
prepared that summarises the specific skills they learnt in treatment and how they used them.
CHAPTER 14. COMORBIDITY

Social anxiety disorder rarely occurs alone. The CT-SAD-A manual is written for the therapist who is treating an adolescent with a confirmed primary diagnosis of social anxiety disorder. Therefore CT-SAD-A should be provided. However, many socially anxious youth will have other presenting problems. This chapter provides some guidance on how to manage disorders that commonly co-occur with social anxiety.

The essential first step is to undertake a comprehensive diagnostic assessment before commencing treatment (as described in detail in Chapter 3). The information gathered in the diagnostic assessment should allow the clinician to identify the disorders that are present and then to develop a formulation of how the problems developed, why they are perpetuated, and the relationships amongst the disorders. The diagnostic formulation will provide the clinician with vital information about which disorder to treat first.

14.1. Depression

Depression is very commonly present with social anxiety disorder. When depression is secondary to social anxiety disorder, the social anxiety should be targeted first with CT-SAD-A. Usually the depression resolves with successful treatment of social anxiety. Depression symptoms are monitored throughout and additional treatment for depression can be provided at the end of CT-SAD-A should symptoms persist.

If the judgement is that the young person has a distinct depressive disorder in addition to social anxiety that neither the young person nor the therapist thinks would resolve with the social anxiety treatment, then the young person will need to receive an evidence-based treatment for depression. NICE (2015) recommended psychological treatments for depression include CBT and interpersonal psychotherapy for adolescents (Mufson et al., 2004). Whether this is done before or after the CT-SAD-A has got going is a decision to be made based on clinical judgement, discussion in supervision, and in collaboration with the adolescent.

In some cases the depression is so severe that it requires treatment before CT-SAD-A. This may be because a young person is at risk of suicide or self-harm due to
depression. Or it may be that the symptoms of depression are of a severity such that they would impede the effective delivery of CT-SAD-A. For example, poor concentration may impact on the ability to attend to and retain information in sessions. Lack of motivation may impact on the young person’s willingness or ability to engage in therapy, for example they may struggle to complete behavioural experiments or homework tasks. Similarly, if a young person is having difficulty with their daily activities and getting out of the house due to lack of energy and anhedonia, then this should be targeted first. In such cases it may be necessary to provide a discrete NICE (2015) recommended intervention for depression before moving onto CT-SAD-A.

14.2. Generalised anxiety

Many adolescents with social anxiety disorder also worry about other topics, such as the future, doing well at school, their family, health, harm coming to them or their loved ones, disasters or world events in the news. When these worries are frequent, uncontrollable and associated with physical symptoms such as muscle tension, then a diagnosis of generalised anxiety disorder (GAD) may be appropriate.

For young people with comorbid generalised anxiety, we would generally recommend starting with CT-SAD-A. This is because making progress in reducing social anxiety often boosts the adolescent’s confidence and that in itself may make them less prone to worry. The section in the manual on targeting anticipatory worry and post-event processing (Chapter 10) also teaches some useful skills for working with worry in general. Therapists may wish to apply these across a wider range of concerns.

If troublesome symptoms of GAD persist after CT-SAD-A then the adolescent may need treatment for this in its own right. The work can build on the skills learnt in CT-SAD-A. CBT for GAD might include: psychoeducation about worry, help identifying worrisome thoughts, learning to differentiate fears from problems, reducing intolerance of uncertainty with behavioural experiments, and problem-solving skills.

14.3. Panic attacks

Adolescents with social anxiety disorder may experience panic attacks when they feel extremely anxious in social situations. Anxiety symptoms are often misappraised as a sign of imminent psychological catastrophe, such as loss of control, and fear of the
negative social consequences of this, for example “everyone will stand and laugh at me”. If panic attacks are restricted to social situations, then CT-SAD-A should be started. We usually find that as the adolescent’s social cognitions change with treatment, they become less anxious in social situations and so panic attacks occur less often. In addition, the behavioural experiments in CT-SAD-A will be targeting cognitions that cluster around similar themes to those underpinning the socially driven panic attacks. Particular emphasis should be placed on instances when the young person feels panicky. This commonly occurs in public speaking situations. In these moments the adolescent can be encouraged to shift to an external focus of attention and to focus on what others are doing. Shifting to an external focus of attention will allow the adolescent to gain more information about others and their responses. The therapist may also want to grade situations more in terms of difficulty. It can be difficult for the young person to learn new information about other people and their reactions in the midst of a panic attack. By grading situations in terms of difficulty the therapist can facilitate new learning and build in more success experiences.

If a young person experiences panic attacks out of the blue (and so the panic attacks are not restricted to social situations) and they worry about further attacks, then an additional diagnosis of panic disorder may be appropriate. In such attacks the misappraisal of anxiety symptoms is more likely to focus around physical catastrophes (such as fainting or having a heart attack) as well as psychological catastrophes. For these young people the panic disorder can interfere with CT-SAD-A and therefore a course of Cognitive Therapy for panic disorder should be considered initially.

14.4. Eating difficulties

Anxiety about weight and shape are fairly common in young people with social anxiety disorder. They can often be a reflection of anxiety about being acceptable to peers and potential romantic suitors. For example, girls have reported concerns such as “I wish I was thin like the other girls” or “he will never be attracted to me when my thighs are so big”. Boys have described worries such as “I’m too scrawny, without any muscle, everyone thinks I’m a loser”. These kinds of cognitions often go along with perfectionism
and high standards for the self. Some young people will have a diagnosed eating disorder whilst others will have eating difficulties that fall short of an eating disorder.

Adolescents with an eating disorder should be referred to a Child and Adolescent Eating Disorder Service. Once weight and eating habits have been managed CT-SAD-A can be started.

For those who have eating difficulties (rather than an eating disorder) and social anxiety disorder, CT-SAD-A can be a good starting point. First, self-confidence can be gained from increased interactions with others and provides a better form of personal validation than weight and shape. Second, learning how to shift focus of attention away from one’s body is an important part of CT-SAD-A. This can really reduce concerns about weight and shape. Young people will start to recognise that others are not really looking at their thighs or body, as they believe them to be. In fact, this is a function of their self-focussed attention creating a felt sense of being stared at and scrutinised. In this way, the effect of attention on both their perception of how they are coming across to other people and their perception of body and shape can be determined. When focusing on themselves it is likely they think they come across less well (e.g. more boring) but also look less acceptable (e.g. fatter). When undertaking CT-SAD-A with a young person who also has eating difficulties their weight, eating habits and physical health should be monitored throughout treatment.

14.5. Body dysmorpophobia

Adolescents with social anxiety disorder will often have concerns about particular aspects of their appearance. Social anxiety disorder commonly co-occurs with body dysmorphic disorder (BDD). For example, a boy was concerned that “I’m boring and dull and all anyone sees is my huge nose when they look at me.” Similarly, a teenage girl believed that “no-one wants to be my friend because I am so nervous and don’t know what to say and because my skin is ugly and disgusting”.

The first step is to determine which is the primary disorder. A primary diagnosis of BDD is more likely if the young person is principally concerned that others will reject them because of their perception of their body. Most of their negative thoughts in a socially situation will be related to the negatively appraised body part. If this is the case,
then BDD may be primary and so an evidence-based treatment for BDD should be commenced first. Social concerns may respond well to CBT for BDD, but if it persists after treatment then CT-SAD-A may need to be offered at that point. If body concerns are a more minor component of their worries, and the young person is more preoccupied with concerns that people think they look stupid or anxious, then it is likely that social anxiety is primary and so CT-SAD-A can be started. Those appearance-related concerns that are present can be managed well by a number of techniques in CT-SAD-A. Video and photography feedback (Chapter 6), Attention Training (Chapter 7), and Behavioural Experiments (Chapter 8) aiming to help the young person face their feared situations whilst dropping safety behaviours and focusing externally are all central elements of CBT for BDD (Veale, 2001; Wilhelm et al., 2014). If BDD persists after CT-SAD-A, then this should be treated in its own right afterwards.
REFERENCES

Uncategorized References


247


disorder. *Behavioural and Cognitive Psychotherapy, 43*(1), 63-73. doi: 10.1017/S1352465813000738


## APPENDICES

### Appendix A. List of measures

<table>
<thead>
<tr>
<th>Measures to be completed weekly</th>
<th>By whom?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liebowitz Social Anxiety Scale – Child &amp; Adolescent</td>
<td>Young person</td>
</tr>
<tr>
<td>Social Summary Weekly Rating Scale – Adolescent Version</td>
<td>Young person</td>
</tr>
<tr>
<td>Social Cognitions Questionnaire – Adolescent Version</td>
<td>Young person</td>
</tr>
<tr>
<td>Concentration Scale</td>
<td>Young person</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measures at pre, mid &amp; post treatment and at 1, 3 &amp; 6 month follow-up</th>
<th>By whom?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liebowitz Social Anxiety Scale – Child &amp; Adolescent</td>
<td>Young person</td>
</tr>
<tr>
<td>Social Summary Weekly Rating Scale – Adolescent Version</td>
<td>Young person</td>
</tr>
<tr>
<td>Social Cognitions Questionnaire – Adolescent Version</td>
<td>Young person</td>
</tr>
<tr>
<td>Concentration Scale</td>
<td>Young person</td>
</tr>
<tr>
<td>Social Behaviour Questionnaire – Adolescent Version</td>
<td>Young person</td>
</tr>
<tr>
<td>Social Attitudes Questionnaires – Adolescent Version</td>
<td>Young person</td>
</tr>
<tr>
<td>Social Participation &amp; Satisfaction Questionnaire</td>
<td>Young person</td>
</tr>
<tr>
<td>RCADS-C (or MFQ-C and SCARED-C)</td>
<td>Young person</td>
</tr>
<tr>
<td>RCADS-P (or MFQ-P and SCARED-P)</td>
<td>Parent</td>
</tr>
</tbody>
</table>
### Appendix B. Self-report process measures

**Liebowitz Social Anxiety Scale for Children and Adolescents (LSAS-CA):** *(Modification of the Liebowitz Social Anxiety Scale by Carrie Masia-Warner, Rachel Klein, and Michael Liebowitz, 2003)*

<table>
<thead>
<tr>
<th>Items</th>
<th>Anxiety</th>
<th>Avoid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Talking to classmates or others on the telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Participating in work groups in the classroom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Eating in front of others (e.g., school canteen, restaurants)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Asking an adult you don’t know well, like a shop assistant, headteacher, or policeman for help (e.g., for directions or to explain something that you don’t understand)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Giving a verbal report or presentation in class</td>
<td></td>
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</tr>
<tr>
<td>6. Going to parties, dances, or school activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Writing on the chalkboard or in front of others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Talking with other kids you don’t know well</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Starting a conversation with people you don’t know well</td>
<td></td>
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</tr>
<tr>
<td>10. Using school or public bathrooms</td>
<td></td>
<td></td>
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<tr>
<td>11. Going into a classroom or another place (e.g., Church, canteen seating) when others are already seated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Having people pay close attention to you or being the center of attention (e.g., your own birthday party)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Asking questions in class</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Answering questions in class</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Fear or Anxiety**

- 0 = None
- 1 = Mild
- 2 = Moderate
- 3 = Severe

**Avoidance**

- 0 = Never (0%)
- 1 = Sometimes (1-33%)
- 2 = Often (34-67%)
- 3 = Usually (68-100%)
<table>
<thead>
<tr>
<th>Items</th>
<th>Anxiety</th>
<th>Avoid</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Reading out loud in class</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Taking tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Saying “no” to others when they ask you to do something that you don’t want to do (like borrow something or look at your homework)</td>
<td></td>
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</tr>
<tr>
<td>18. Telling others that you disagree or that you are angry with them</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Looking at people you don’t know well in the eyes</td>
<td></td>
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<tr>
<td>20. Returning something in a store</td>
<td></td>
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<tr>
<td>21. Playing a sport or performing in front of other people (e.g., gym class, dancing school recital, musical concert)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Joining a club or organization</td>
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<tr>
<td>23. Meeting new people or strangers</td>
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<td></td>
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<tr>
<td>24. Asking a teacher permission to leave the classroom (like to go to the bathroom or to the nurse)</td>
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<tr>
<td><strong>Total Anxiety (Sum Anxiety S and P Scores)</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Total Avoid (Sum Avoid S and P Scores)</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Anxiety &amp; Avoid Social (white cells) Scores</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Anxiety &amp; Avoid Performance (shaded cells) Scores</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>TOTAL SCORE (Sum Total Anxiety and Avoid)</strong></td>
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</tbody>
</table>
**ADOLESCENT SOCIAL SUMMARY WEEKLY RATING SCALE**

a) Please circle a number from the scale below that best describes how much of a problem social anxiety has been for you in the last week:

<p>| | | | | | | | | |</p>
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<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>No problem</td>
<td>Slight problem</td>
<td>Definite problem</td>
<td>Marked problem</td>
<td>Severe problem</td>
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</table>

b) Please circle a number from the scale below to show how often in the last week you have avoided social situations or doing something in those situations.

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<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Not at all</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
<td></td>
<td></td>
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</tbody>
</table>

c) For social situations *in general*, please choose a number from the scale below to show how much your mind was focused on yourself (‘self focused’) or on other people and what was going on around you (‘externally focused’) in the last week.

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<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Entirely externally focused</td>
<td>Both equally</td>
<td>Entirely self focused</td>
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<td></td>
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</tr>
</tbody>
</table>

d) For social situations *that you found difficult*, please choose a number from the scale below to show how much your mind was focused on yourself (‘self focused’) or on other people and what was going on around you (‘externally focused’) in the last week.

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<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Entirely externally focused</td>
<td>Both equally</td>
<td>Entirely self focused</td>
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</tbody>
</table>

e) Over the past week how often have you gone over in your mind things that you think might go wrong in a social situation *before* entering the situation.

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<tbody>
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<td>0</td>
<td>1</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Not at all</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
<td></td>
<td></td>
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</tbody>
</table>

f) Over the past week how often have you gone over social interactions in your mind *after* they have finished.

<p>| | | | | | | | | |</p>
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<tbody>
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<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Not at all</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**ADOLESCENT SOCIAL COGNITIONS QUESTIONNAIRE**

Listed below are some thoughts that go through people’s minds when they are nervous or frightened. Indicate, on the **LEFT** hand side of the form, how often in the last week each thought has occurred; rate each thought from 1-5 using the following scale:

1. Thought never occurs  
2. Thought rarely occurs  
3. Thought occurs during half of the times when I am nervous  
4. Thought usually occurs  
5. Thought always occurs when I am nervous

How often do you have this thought? (Rate from 1-5)  
How much do you believe this thought? (Rate from 0-100)

<table>
<thead>
<tr>
<th>How often do you have this thought? (Rate from 1-5)</th>
<th>How much do you believe this thought? (Rate from 0-100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I will be unable to speak</td>
<td></td>
</tr>
<tr>
<td>I am unlikeable</td>
<td></td>
</tr>
<tr>
<td>I am going to tremble or shake uncontrollably</td>
<td></td>
</tr>
<tr>
<td>People will stare at me</td>
<td></td>
</tr>
<tr>
<td>I am being an idiot</td>
<td></td>
</tr>
<tr>
<td>People won’t want to be friends with me</td>
<td></td>
</tr>
<tr>
<td>I will be frozen with fear</td>
<td></td>
</tr>
<tr>
<td>I will drop or spill things</td>
<td></td>
</tr>
<tr>
<td>I am going to be sick</td>
<td></td>
</tr>
<tr>
<td>I am not good enough</td>
<td></td>
</tr>
<tr>
<td>I will babble or talk funny</td>
<td></td>
</tr>
<tr>
<td>I am not as good as others</td>
<td></td>
</tr>
<tr>
<td>I will be unable to concentrate</td>
<td></td>
</tr>
<tr>
<td>I will be unable to write properly</td>
<td></td>
</tr>
<tr>
<td>People are not interested in me</td>
<td></td>
</tr>
<tr>
<td>People won’t like me</td>
<td></td>
</tr>
<tr>
<td>People will make fun of me</td>
<td></td>
</tr>
<tr>
<td>I will sweat/perspire</td>
<td></td>
</tr>
<tr>
<td>I am going red</td>
<td></td>
</tr>
<tr>
<td>I am weird/different</td>
<td></td>
</tr>
<tr>
<td>People will see I am nervous</td>
<td></td>
</tr>
<tr>
<td>People think I am boring</td>
<td></td>
</tr>
<tr>
<td>I will embarrass myself</td>
<td></td>
</tr>
<tr>
<td>People will be angry with me</td>
<td></td>
</tr>
<tr>
<td>I will wet myself/have diarrhoea</td>
<td></td>
</tr>
<tr>
<td>I will get picked on and teased</td>
<td></td>
</tr>
<tr>
<td>I will look stupid</td>
<td></td>
</tr>
<tr>
<td>I will be forced to do things I don’t want to do</td>
<td></td>
</tr>
<tr>
<td>People will laugh at me</td>
<td></td>
</tr>
<tr>
<td>Other thoughts not listed (please specify):</td>
<td></td>
</tr>
</tbody>
</table>

When you feel anxious how much do you believe each thought to be true. Please rate each thought by choosing a number from the scale below, and put the number which applies on the **RIGHT** hand side of the form.

<table>
<thead>
<tr>
<th>I do not believe this thought</th>
<th>I am completely convinced this thought is true</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>10</td>
<td>90</td>
</tr>
<tr>
<td>20</td>
<td>80</td>
</tr>
<tr>
<td>30</td>
<td>70</td>
</tr>
<tr>
<td>40</td>
<td>60</td>
</tr>
<tr>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>70</td>
<td>30</td>
</tr>
<tr>
<td>80</td>
<td>20</td>
</tr>
<tr>
<td>90</td>
<td>10</td>
</tr>
<tr>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>
### ADOLESCENT SOCIAL BEHAVIOUR QUESTIONNAIRE

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

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Try not to attract attention</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make an effort to get your words right</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>Check that you are coming across well</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Avoid eye contact</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>Talk less</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Avoid asking questions</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Try to picture how you appear to others</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>Grip cups or glasses tightly</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>Position yourself so as not to be noticed</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Try to control shaking</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Choose clothes that will prevent or hide sweating</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>Wear clothes or makeup to hide blushing</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>Rehearse sentences in your mind</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Check what you are going to say</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Blank out or switch off mentally</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>Avoid talking about yourself</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>Keep still</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Ask lots of questions</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Stay on the edge of groups</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>Avoid pauses in speech</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Hide your face</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>Try to think about other things</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Use alcohol/drugs to manage anxiety</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Talk more</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Try to fit in and ‘act normal’</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Try to stay in control of your behaviour</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>Make an effort to come across well</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Planning things to talk about before a conversation</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>Wear clothes so I blend in.</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Seek reassurance from my friends and family</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>Get other people to speak for me or do things for me</td>
<td>Always</td>
<td>Often</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td>Look busy (checking phone etc.)</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>Have an excuse or ‘get out’ planned</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
</tbody>
</table>
**ADOLESCENT SOCIAL ATTITUDES QUESTIONNAIRE**

This questionnaire lists different attitudes or beliefs which people sometimes hold. Read EACH statement carefully and decide how much you agree or disagree with each statement.

For each of the attitudes, show your answer by putting a circle round the words which BEST DESCRIBE HOW YOU THINK. Be sure to choose only one answer for each attitude. Because people are different, there is no right or wrong answer to these statements.

To decide whether a given attitude is typical of your way of looking at things, simply keep in mind what you are like MOST OF THE TIME.

<table>
<thead>
<tr>
<th>I don’t need everyone to accept me.</th>
<th>TOTALLY AGREE</th>
<th>AGREE</th>
<th>VERY MUCH</th>
<th>SLIGHTLY</th>
<th>NEUTRAL</th>
<th>SLIGHTLY</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>TOTALLY DISAGREE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>I must not show signs of weakness to others</th>
<th>TOTALLY AGREE</th>
<th>AGREE</th>
<th>VERY MUCH</th>
<th>SLIGHTLY</th>
<th>NEUTRAL</th>
<th>SLIGHTLY</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>TOTALLY DISAGREE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>If I make a mistake in a social situation people will not want to be friends with me.</th>
<th>TOTALLY AGREE</th>
<th>AGREE</th>
<th>VERY MUCH</th>
<th>SLIGHTLY</th>
<th>NEUTRAL</th>
<th>SLIGHTLY</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>TOTALLY DISAGREE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Everyone will stare at me and think I’m strange if I don’t act normally</th>
<th>TOTALLY AGREE</th>
<th>AGREE</th>
<th>VERY MUCH</th>
<th>SLIGHTLY</th>
<th>NEUTRAL</th>
<th>SLIGHTLY</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>TOTALLY DISAGREE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>I’m unlikeable</th>
<th>TOTALLY AGREE</th>
<th>AGREE</th>
<th>VERY MUCH</th>
<th>SLIGHTLY</th>
<th>NEUTRAL</th>
<th>SLIGHTLY</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>TOTALLY DISAGREE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Other people are more anxious than I am</th>
<th>TOTALLY AGREE</th>
<th>AGREE</th>
<th>VERY MUCH</th>
<th>SLIGHTLY</th>
<th>NEUTRAL</th>
<th>SLIGHTLY</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>TOTALLY DISAGREE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>I’m different</th>
<th>TOTALLY AGREE</th>
<th>AGREE</th>
<th>VERY MUCH</th>
<th>SLIGHTLY</th>
<th>NEUTRAL</th>
<th>SLIGHTLY</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>TOTALLY DISAGREE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Other people are better at getting it right socially than me</th>
<th>TOTALLY AGREE</th>
<th>AGREE</th>
<th>VERY MUCH</th>
<th>SLIGHTLY</th>
<th>NEUTRAL</th>
<th>SLIGHTLY</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>TOTALLY DISAGREE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>I must appear funny and intelligent</th>
<th>TOTALLY AGREE</th>
<th>AGREE</th>
<th>VERY MUCH</th>
<th>SLIGHTLY</th>
<th>NEUTRAL</th>
<th>SLIGHTLY</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>TOTALLY DISAGREE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>I look as anxious as I feel</th>
<th>TOTALLY AGREE</th>
<th>AGREE</th>
<th>VERY MUCH</th>
<th>SLIGHTLY</th>
<th>NEUTRAL</th>
<th>SLIGHTLY</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>TOTALLY DISAGREE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>If other people think I’m not as good as them, then I’m not</th>
<th>TOTALLY AGREE</th>
<th>AGREE</th>
<th>VERY MUCH</th>
<th>SLIGHTLY</th>
<th>NEUTRAL</th>
<th>SLIGHTLY</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>TOTALLY DISAGREE</th>
</tr>
</thead>
</table>
I’m unacceptable
| TOTALLY | AGREE | AGREE | DISAGREE | DISAGREE | TOTALLY |
| AGREE   | VERY MUCH | SLIGHTLY | NEUTRAL | SLIGHTLY | VERY MUCH | DISAGREE |

Anxiety is not a sign of weakness
| TOTALLY | AGREE | AGREE | DISAGREE | DISAGREE | TOTALLY |
| AGREE   | VERY MUCH | SLIGHTLY | NEUTRAL | SLIGHTLY | VERY MUCH | DISAGREE |

Other people are more sorted and able to cope than I am
| TOTALLY | AGREE | AGREE | DISAGREE | DISAGREE | TOTALLY |
| AGREE   | VERY MUCH | SLIGHTLY | NEUTRAL | SLIGHTLY | VERY MUCH | DISAGREE |

Others are more acceptable and likeable than me
| TOTALLY | AGREE | AGREE | DISAGREE | DISAGREE | TOTALLY |
| AGREE   | VERY MUCH | SLIGHTLY | NEUTRAL | SLIGHTLY | VERY MUCH | DISAGREE |

My anxiety is obvious to other people
| TOTALLY | AGREE | AGREE | DISAGREE | DISAGREE | TOTALLY |
| AGREE   | VERY MUCH | SLIGHTLY | NEUTRAL | SLIGHTLY | VERY MUCH | DISAGREE |

If someone doesn’t like me, it is my fault
| TOTALLY | AGREE | AGREE | DISAGREE | DISAGREE | TOTALLY |
| AGREE   | VERY MUCH | SLIGHTLY | NEUTRAL | SLIGHTLY | VERY MUCH | DISAGREE |

To be worthwhile, I don’t need approval from other people
| TOTALLY | AGREE | AGREE | DISAGREE | DISAGREE | TOTALLY |
| AGREE   | VERY MUCH | SLIGHTLY | NEUTRAL | SLIGHTLY | VERY MUCH | DISAGREE |

I must not let anyone see I am anxious
| TOTALLY | AGREE | AGREE | DISAGREE | DISAGREE | TOTALLY |
| AGREE   | VERY MUCH | SLIGHTLY | NEUTRAL | SLIGHTLY | VERY MUCH | DISAGREE |

People think I am uninteresting
| TOTALLY | AGREE | AGREE | DISAGREE | DISAGREE | TOTALLY |
| AGREE   | VERY MUCH | SLIGHTLY | NEUTRAL | SLIGHTLY | VERY MUCH | DISAGREE |

If others really get to know me, they won’t like me
| TOTALLY | AGREE | AGREE | DISAGREE | DISAGREE | TOTALLY |
| AGREE   | VERY MUCH | SLIGHTLY | NEUTRAL | SLIGHTLY | VERY MUCH | DISAGREE |

Unless I appear calm and cool, people will not want to be friends with me
| TOTALLY | AGREE | AGREE | DISAGREE | DISAGREE | TOTALLY |
| AGREE   | VERY MUCH | SLIGHTLY | NEUTRAL | SLIGHTLY | VERY MUCH | DISAGREE |

I’m not as good as others
| TOTALLY | AGREE | AGREE | DISAGREE | DISAGREE | TOTALLY |
| AGREE   | VERY MUCH | SLIGHTLY | NEUTRAL | SLIGHTLY | VERY MUCH | DISAGREE |

I’m vulnerable
| TOTALLY | AGREE | AGREE | DISAGREE | DISAGREE | TOTALLY |
| AGREE   | VERY MUCH | SLIGHTLY | NEUTRAL | SLIGHTLY | VERY MUCH | DISAGREE |

Other people are less anxious than I am
| TOTALLY | AGREE | AGREE | DISAGREE | DISAGREE | TOTALLY |
| AGREE   | VERY MUCH | SLIGHTLY | NEUTRAL | SLIGHTLY | VERY MUCH | DISAGREE |

People can see right through me, and see my weakness
<table>
<thead>
<tr>
<th>Statement</th>
<th>TOTALLY AGREE</th>
<th>AGREE</th>
<th>VERY MUCH</th>
<th>SLIGHTLY</th>
<th>NEUTRAL</th>
<th>SLIGHTLY</th>
<th>DISAGREE</th>
<th>DISAGREE</th>
<th>TOTALLY DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t need to be liked by everyone</td>
<td>TOTALLY AGREE</td>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>DISAGREE</td>
<td>DISAGREE</td>
<td>TOTALLY DISAGREE</td>
</tr>
<tr>
<td>I’m a weird person</td>
<td>TOTALLY AGREE</td>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>DISAGREE</td>
<td>DISAGREE</td>
<td>TOTALLY DISAGREE</td>
</tr>
<tr>
<td>If people see I’m anxious, they will pick on me and humiliate me</td>
<td>TOTALLY AGREE</td>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>DISAGREE</td>
<td>DISAGREE</td>
<td>TOTALLY DISAGREE</td>
</tr>
<tr>
<td>If I disagree with someone, they will think I am stupid or will not want to be friends with me</td>
<td>TOTALLY AGREE</td>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>DISAGREE</td>
<td>DISAGREE</td>
<td>TOTALLY DISAGREE</td>
</tr>
<tr>
<td>I’m odd/weird</td>
<td>TOTALLY AGREE</td>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>DISAGREE</td>
<td>DISAGREE</td>
<td>TOTALLY DISAGREE</td>
</tr>
<tr>
<td>I’m important to other people</td>
<td>TOTALLY AGREE</td>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>DISAGREE</td>
<td>DISAGREE</td>
<td>TOTALLY DISAGREE</td>
</tr>
<tr>
<td>People see anxiety as a sign of weakness</td>
<td>TOTALLY AGREE</td>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>DISAGREE</td>
<td>DISAGREE</td>
<td>TOTALLY DISAGREE</td>
</tr>
<tr>
<td>I have to do things right to be accepted</td>
<td>TOTALLY AGREE</td>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>DISAGREE</td>
<td>DISAGREE</td>
<td>TOTALLY DISAGREE</td>
</tr>
<tr>
<td>Unless I am funny and interesting, people won’t like me</td>
<td>TOTALLY AGREE</td>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>DISAGREE</td>
<td>DISAGREE</td>
<td>TOTALLY DISAGREE</td>
</tr>
<tr>
<td>If I keep up appearances, I might just about get by</td>
<td>TOTALLY AGREE</td>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>DISAGREE</td>
<td>DISAGREE</td>
<td>TOTALLY DISAGREE</td>
</tr>
<tr>
<td>My opinions mean nothing</td>
<td>TOTALLY AGREE</td>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>DISAGREE</td>
<td>DISAGREE</td>
<td>TOTALLY DISAGREE</td>
</tr>
<tr>
<td>When people see that I’m anxious, they see the real, second-rate me</td>
<td>TOTALLY AGREE</td>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>DISAGREE</td>
<td>DISAGREE</td>
<td>TOTALLY DISAGREE</td>
</tr>
<tr>
<td>I’m attractive</td>
<td>TOTALLY AGREE</td>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>DISAGREE</td>
<td>DISAGREE</td>
<td>TOTALLY DISAGREE</td>
</tr>
<tr>
<td>If people notice I am anxious they will think I am odd</td>
<td>TOTALLY AGREE</td>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>DISAGREE</td>
<td>DISAGREE</td>
<td>TOTALLY DISAGREE</td>
</tr>
</tbody>
</table>
People will take advantage if they spot a sign of weakness

<table>
<thead>
<tr>
<th>TOTALLY</th>
<th>AGREE</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>DISAGREE</th>
<th>TOTALLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>VERY MUCH</td>
</tr>
</tbody>
</table>

If someone thought that I was not as good as them, I couldn’t stand it

<table>
<thead>
<tr>
<th>TOTALLY</th>
<th>AGREE</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>DISAGREE</th>
<th>TOTALLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>VERY MUCH</td>
</tr>
</tbody>
</table>

If I am quiet, people will think I’m boring

<table>
<thead>
<tr>
<th>TOTALLY</th>
<th>AGREE</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>DISAGREE</th>
<th>TOTALLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>VERY MUCH</td>
</tr>
</tbody>
</table>

I’m not good enough

<table>
<thead>
<tr>
<th>TOTALLY</th>
<th>AGREE</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>DISAGREE</th>
<th>TOTALLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>VERY MUCH</td>
</tr>
</tbody>
</table>

If people see that I’m anxious, they will think I am weak or second-rate

<table>
<thead>
<tr>
<th>TOTALLY</th>
<th>AGREE</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>DISAGREE</th>
<th>TOTALLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>VERY MUCH</td>
</tr>
</tbody>
</table>

I’m interesting

<table>
<thead>
<tr>
<th>TOTALLY</th>
<th>AGREE</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>DISAGREE</th>
<th>TOTALLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>VERY MUCH</td>
</tr>
</tbody>
</table>

If people look at me, it means they are thinking negative things about me

<table>
<thead>
<tr>
<th>TOTALLY</th>
<th>AGREE</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>DISAGREE</th>
<th>TOTALLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>VERY MUCH</td>
</tr>
</tbody>
</table>

I’m a boring person

<table>
<thead>
<tr>
<th>TOTALLY</th>
<th>AGREE</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>DISAGREE</th>
<th>TOTALLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>VERY MUCH</td>
</tr>
</tbody>
</table>

Even if people see my anxiety, it doesn’t mean that I am not as good as them

<table>
<thead>
<tr>
<th>TOTALLY</th>
<th>AGREE</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>DISAGREE</th>
<th>TOTALLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>VERY MUCH</td>
</tr>
</tbody>
</table>

I must always live up to other people’s expectations

<table>
<thead>
<tr>
<th>TOTALLY</th>
<th>AGREE</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>DISAGREE</th>
<th>TOTALLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>VERY MUCH</td>
</tr>
</tbody>
</table>

If I make a mistake in a social situation people will laugh at me or be angry with me

<table>
<thead>
<tr>
<th>TOTALLY</th>
<th>AGREE</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>DISAGREE</th>
<th>TOTALLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>VERY MUCH</td>
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</tbody>
</table>

If people see I am anxious I will be forced to do things I don’t want to do

<table>
<thead>
<tr>
<th>TOTALLY</th>
<th>AGREE</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>DISAGREE</th>
<th>TOTALLY</th>
</tr>
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<tbody>
<tr>
<td>AGREE</td>
<td>VERY MUCH</td>
<td>SLIGHTLY</td>
<td>NEUTRAL</td>
<td>SLIGHTLY</td>
<td>VERY MUCH</td>
</tr>
</tbody>
</table>
**HOW IS MY CONCENTRATION?**

Over the last week, how well have you been able to concentrate on what the teacher is saying and what you are learning in class at school?

Choose a number between 0 and 100 for how able you are to concentrate (with 0 being not at all able to concentrate and 100 totally able to concentrate.)

---

Not at all  |  |  |  |  |  |  |  |  | Totally
0%  |  |  |  |  |  |  |  |  | 100%

___%
**Social Participation***

Please answer the following questions about your participation in social activities **during the past month.**

<table>
<thead>
<tr>
<th>Over the past month, how often did you…</th>
<th>Not at all</th>
<th>Occasionally</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. socialize with friends?</td>
<td>1</td>
<td>2</td>
<td>3  4  5  6  7</td>
</tr>
<tr>
<td>2. attend work- or school-related social events?</td>
<td>1</td>
<td>2</td>
<td>3  4  5  6  7</td>
</tr>
<tr>
<td>3. have a friendly conversation with co-workers or classmates?</td>
<td>1</td>
<td>2</td>
<td>3  4  5  6  7</td>
</tr>
<tr>
<td>4. speak up in group situations?</td>
<td>1</td>
<td>2</td>
<td>3  4  5  6  7</td>
</tr>
<tr>
<td>5. invite someone else to get together for lunch, coffee, or drinks?</td>
<td>1</td>
<td>2</td>
<td>3  4  5  6  7</td>
</tr>
<tr>
<td>6. ask others for help or information?</td>
<td>1</td>
<td>2</td>
<td>3  4  5  6  7</td>
</tr>
<tr>
<td>7. initiate a social conversation?</td>
<td>1</td>
<td>2</td>
<td>3  4  5  6  7</td>
</tr>
<tr>
<td>8. make small talk with people you didn’t know well?</td>
<td>1</td>
<td>2</td>
<td>3  4  5  6  7</td>
</tr>
<tr>
<td>9. talk about a meaningful personal experience with others?</td>
<td>1</td>
<td>2</td>
<td>3  4  5  6  7</td>
</tr>
<tr>
<td>10. attend a social gathering?</td>
<td>1</td>
<td>2</td>
<td>3  4  5  6  7</td>
</tr>
<tr>
<td>11. accept an invitation to do something socially?</td>
<td>1</td>
<td>2</td>
<td>3  4  5  6  7</td>
</tr>
<tr>
<td>12. share your opinions and ideas with others?</td>
<td>1</td>
<td>2</td>
<td>3  4  5  6  7</td>
</tr>
<tr>
<td>13. approach others in a social setting?</td>
<td>1</td>
<td>2</td>
<td>3  4  5  6  7</td>
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</tbody>
</table>

**Social Satisfaction**

How *satisfied* are you with your relationships with the following types of people…

<table>
<thead>
<tr>
<th></th>
<th>Not at all satisfied</th>
<th>Somewhat satisfied</th>
<th>Very satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Acquaintances</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
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<tr>
<td>15. Co-workers/schoolmates</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
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<tr>
<td>16. Friends</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
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<tr>
<td>17. Close friends</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Romantic partners</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
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</table>

*Alden & Taylor (2011)*
Appendix C. How to Score the Questionnaires

LSAS-CA (Masia-Warner, Klein & Liebowitz, 2003)
Scores can be presented in the following four ways. *We use the Global Score only.*
A Global Score totaling anxiety and avoidance for all 24 items (48 ratings). This total score has been the most routinely used as a primary outcome measure in adult and child psychopharmacological trials. An LSAS-CA cutoff score of 22.5 represented the best balance of sensitivity and specificity when distinguishing between individuals with social phobia and normal controls, while a cutoff of 29.5 was optimal for distinguishing social phobia from other anxiety disorders.
Separate Anxiety and Avoidance Scores for all 24 items. These tend to be highly correlated.
Separate Performance and Social Scores that combine anxiety and avoidance totals for the P and S items respectively
Four separate scores for Performance Anxiety, Performance Avoidance, Social Anxiety and Social Avoidance. This may provide a discrimination of symptom patterns before and after treatment. Individuals with generalized social anxiety will usually score high on all the scales, while those with more limited social anxiety disorder will usually score high only on the performance sub-scales.

SPWSS
The Social Phobia Weekly Summary Scale (SPWSS; Clark et al., 2003) was used as an additional measure of social anxiety. This was designed for use with adults but has been used successfully with youths. Each item is viewed individually. No summing or averaging is undertaken.

SCQ
The Social Cognitions Questionnaire (SCQ) is a 22-item scale covering negative automatic thoughts that are commonly reported in social anxiety provoking situations. Two subscales scores are obtained: a mean thought frequency, ranging from 1 (thought never occurs) to 5 (thought always occurs when I am anxious); and a mean belief rating
ranging from 0 (I do not believe this thought) to 100 (I am completely convinced this thought is true).

**SBQ**
The Social Behaviour Questionnaire (SBQ) is a 29-item scale measuring how often individuals use a range of common safety-seeking behaviours in social situations. The frequency with which each behaviour is used in social situations is rated from 0 (never) to 3 (always), and a mean score is obtained.

**SAQ**
The Social Attitudes Questionnaire (SAQ) is a 41-item scale measuring social anxiety related beliefs. Each item is rated from 1 (totally disagree) to 7 (totally agree). Eight items are reverse scored (see list below). A mean score is obtained.

Reverse scored items on the SAQ:
- Other people are more anxious than I am.
- Anxiety is not a sign of weakness.
- To be worthwhile, I don’t need approval from other people.
- I don’t need to be liked by everyone.
- I’m important to other people.
- I’m attractive.
- I’m interesting.
- Even if people see my anxiety, it doesn’t mean I’m not as good as them.

**Concentration**
Concentration in class is assessed by asking young people to rate their ability to concentrate on class or learning activities using a visual analogue scale ranging from 0 (not at all) to 100 (totally). No summing or averaging is undertaken.

**Social Participation and Satisfaction Questionnaire (Alden & Taylor)**
The SPS questionnaire assessed the degree to which an individual is engaging in social activities and the satisfaction they derive from their relationships. A total participation and a total satisfaction score are obtained by summing the items in each subscale.
Appendix D. Goals Worksheet

**MY GOALS FOR TREATMENT**

Ask yourself the following questions to help you think about your goals for treatment:

- How would you like your life to be different by tackling social anxiety?
- What would look different in terms of your relationships, day-to-day life, and school/college/work life?
- What would you be able to do that you don’t do or you try to avoid doing at the moment?

Try to make your goals **SMART**: Small, Measurable, Achievable, Realistic, and Time-bound.

Don’t worry if it is hard to think of long-term goals at the moment. We will come back to this ‘My Goals for Treatment’ worksheet throughout treatment and we can make additions or changes at any time.

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<th>SHORT TERM (4-6 weeks)</th>
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<table>
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<tr>
<th>MEDIUM TERM (by the end of treatment)</th>
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<table>
<thead>
<tr>
<th>LONG TERM (by 6 months)</th>
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</table>
Appendix E. Blank model sheet

UNDERSTANDING WHAT KEEPS MY SOCIAL ANXIETY GOING

Situation:

Negative thoughts:

Opsetting memories from the past:

Feeling self-conscious.
How I think I look to other people.

Safety behaviours:

Anxious feelings:
Appendix F. Information Sheet for Young People
A Guide to Cognitive Therapy for Social Anxiety

What is social anxiety?

It is really common to feel a bit nervous or uncomfortable in some social situations. For example, many teenagers tell us that they feel anxious when they have to speak in front of a big audience, like a school assembly. Even professional actors and teachers can feel anxious in situations like this.

For some teenagers this kind of anxiety and fear can happen in more usual, day-to-day social situations. For example, you might feel anxious having a conversation in a group, it might feel difficult to eat or write in front of other people, to put your hand up in class, or to make a comment on social media. You might worry about showing signs of anxiety like shaking, sweating, or blushing. These are all examples of social anxiety. People with social anxiety worry about doing badly in social situations or making a fool of themselves in some way.

Common Worries and Anxious Feelings

Different teenagers have different worries when they are in social situations and will feel different anxiety symptoms. Some symptoms are physical: shaking, sweating, blushing, crying, dizziness, faster heart rate, shaky voice, dry mouth. Other symptoms include difficulty concentrating, getting words wrong, difficulty thinking, mind going blank and so on.

Avoiding Things

Young people with social anxiety will usually try to avoid or stay away from social situations. This is really understandable because of the anxiety and worry that social situations cause. You might completely avoid some situations, or you might go into social situations but find them really difficult throughout. You might find that your anxiety is triggered by particular things or that you feel anxious in a wide range of social situations.
Common problems that social anxiety causes

Social anxiety can cause problems at home, at school, with friends, in our romantic relationships and in day-to-day life. For example, many teenagers tell us that:

- The anxiety and avoidance can cause arguments with their parents. Young people often find it hard to talk to their parents about their social worries and so parents can find it hard to understand the difficulty in taking part in social situations.
- At school it can be hard to concentrate in class because young people feel so self-conscious. Adolescents can find it hard to keep up in class because they avoid asking for help and taking part in class activities.
- Friendships can feel really difficult. Young people very often avoid spending time with other people, even though they feel lonely and would like to be able to be close to others. Some young people tell us that they are being teased or bullied which can make their social worries even worse.
- Young people often start to become interested in developing romantic relationships and this can be anxiety provoking for everyone. For adolescents with social anxiety it can be especially difficult.
- Everyday activities such as ordering a takeaway, using public transport or going to the shops can all be challenging for young people with social anxiety. Many young people tell us that this is upsetting because they would really like to be more independent.

What is Cognitive Therapy?

How our thoughts and actions keep anxiety going

The way you think and what you do when you feel anxious in social situations is what keeps our feelings of anxiety going. A couple of examples might be:

Sarah

Sarah notices that she hasn’t said much in a conversation with a group of friends and she has the thought “I’m being too quiet, they must think I’m boring”. This makes her even more self-conscious and anxious to the point where she begins to feel like she sticks out or like she is out of place. Sarah then says less or makes an excuse to leave the situation.
Jack

Jack is worried that he might blush in a class at school or college if the teacher asks him a question. When the teacher speaks to Jack, it makes him feel very anxious and he tries to focus on his face to see if he can stop the blush from growing. This makes Jack’s face feel even hotter. He is then sure that everyone can see him blushing, and thinks he is stupid. He feels as if all eyes are on him, but he doesn’t look around to check whether this is true (which it is not). Jack misses the next class just in case it all happens again. So, some of the things Jack is doing are backfiring and making the problem worse, without him realising it. In this way there is a vicious cycle keeping the social anxiety going.

Research shows that negative thoughts and certain things people do in social situations are a key to understanding feelings of anxiety. In therapy you will work with your therapist to identify key thoughts and behaviours that keep your problem going. Special techniques are used to help you work out how realistic your thoughts are, to find out what to do to change the way you feel in social situations, and to improve the way you see yourself.

What does Cognitive Therapy involve?

Cognitive therapy has been shown to be an effective treatment for anxiety problems in adults. It is quite a quick treatment and you will be offered up to 16 sessions over a period of 4 months. Each will last about an hour to an hour and a half. After you have completed the treatment you will be seen again several times during the year after treatment ends. This should be helpful to you and us in monitoring how much progress you have made during treatment, and how well you have been able to keep this going, or even improve upon it during follow-up.

Making a session plan

At the beginning of each therapy session you and your therapist will make a plan for that session, so that you can make the best use of your time together. This will involve looking at the situations you have faced in the past week, and the strategies that you have tried to use in overcoming your anxiety, and the problems that are left. Once you have set
the plan try to stick with it, and avoid jumping from one issue to another. You will usually achieve more by working on one issue at a time.

*Independent Work (Home practice)*

Therapy is only for one hour a week, but there are twenty-four hours in a day, and there will be lots of things you will want to do between sessions. Your therapist will ask you to complete certain home practice tasks between sessions, in order for you to learn new things about your social anxiety and ways of overcoming it. This will speed up your progress in learning to be more confident in social situations. It can be hard to find time to fit home practice in so it can be helpful to set aside 10 to 15 minutes every day to review the independent therapy task you have done that day and plan the task for the next day.

*Be your own therapist*

One of the most important goals of cognitive therapy is for you to learn how to be your own therapist. You will learn to identify and challenge problematic thoughts, beliefs and behaviour. This will help you to make progress even when your treatment has ended.
Appendix G. Information Sheet for Parents

A Parents’ Guide to Cognitive Therapy for Social Anxiety

What is social anxiety?

It is common for adolescents to feel nervous or uncomfortable in certain social situations. For example, many teenagers tell us that they feel anxious when they have to speak in front of a big audience, like a school assembly. Even professional actors and teachers can feel anxious in situations like this.

For some teenagers this kind of anxiety and fear can happen in more usual, day-to-day social situations. For example, they might feel anxious having a conversation in a group, it might feel difficult to eat or write in front of other people, to put their hand up in class, or to make a comment on social media. Young people may worry about showing signs of anxiety like shaking, sweating, or blushing. These are all examples of social anxiety.

People with social anxiety worry about doing badly in social situations or making a fool of themselves in some way.

1. Common worries and anxiety symptoms

Different teenagers have different worries when they are in social situations and will feel different anxiety symptoms. Some symptoms are physical: shaking, sweating, blushing, crying, dizziness, speeded heart rate, shaky voice, dry mouth. Other symptoms include difficulty concentrating, getting words wrong, difficulty thinking, mind going blank and so on.

2. Avoidance

Young people with social anxiety will usually try to avoid or stay away from social situations. This is really understandable because of the anxiety and worry that social situations cause. They might completely avoid some situations, or they might go into social situations but find them really difficult throughout. Anxiety might triggered by particular things or in a wide range of social situations.

3. The difficulty spotting social anxiety
Often parents are unaware that their child has social anxiety. This is because many teenagers will not disclose their worries and anxieties. It is very common for young people to feel embarrassed and ashamed about their social fears.

4. Common consequences of social anxiety

Social anxiety can cause problems at home, at school and with friends. At home, young people might refuse to answer the telephone, to attend family gatherings, or they may remain in their bedroom when guests visit. It can sometimes appear to parents that their child is being defiant in these situations, but we know that in fact it is due their intense distress. School life can also be a challenge. Adolescents with social anxiety often find it difficult to concentrate in class because they feel so self-conscious. It is common for young people to avoid participating in class, for example showing reluctance to answer or ask questions, not asking for help or participating in group exercises. Sometimes young people will feel unable to manage going to school at all. Academic attainment is often affected. It can be difficult for parents and teachers to manage these behaviours. Sometimes they are misunderstood as disobedience when in fact they are a sign of intense anxiety and distress. Friendships are very often affected by social anxiety. Adolescents might turn down invitations, not respond to text or telephone calls, and avoid being with peers at break times in school. As a result young people with social anxiety can end up losing friends and may sometimes become the victim of teasing and bullying. Young people (whether or not they have social anxiety) are often reluctant to talk to their parents about their friendships and so it can be difficult for parents to know the details of their child’s social relationships, including whether they are being bullied.

It is common for adolescents to have some social worries and to feel self-conscious from time to time. These are often short-lived and do not impact on day-to-day life. Some young people have more severe social fears that stop them doing what they need or want to do. Research suggests that young people with social anxiety disorder do not usually grow out of their fears. It is therefore important to treat these difficulties.
What is Cognitive Therapy?

1. Thoughts and behaviours maintain social anxiety

The way adolescents think and behave when they feel anxious in social situations is what maintains feelings of anxiety. A couple of examples might be:

Matt notices that he hasn’t said much in a conversation with a group of friends and he has the thought “I’m being too quiet, they must think I’m boring”. This makes him even more self-conscious and anxious to the point where he begins to feel conspicuous and out of place. They then say less or make an excuse and leave the situation.

Iona is worried that she might blush in a class at school or college if the teacher asks her a question. When the teacher speaks to her, she feels very anxious and tries to focus on her face and see if she can stop the blush from spreading. This makes her face feel even hotter. She is then sure that everyone can see her blushing, and will think she is stupid. She feels as if all eyes are on her, but she doesn’t look around to check whether this is true (which it is not). She misses the next class just in case it all happens again. So some of things Iona is doing are backfiring and making the problem worse, without her realising it. In this way a vicious cycle is established.

Research shows that negative thoughts and certain behaviours in social situations are a key to understanding feelings of anxiety. In therapy your child will work with us to identify key thoughts and behaviours that maintain the problem. Special techniques are used to help them determine how realistic their thoughts are, to find out what to do to change the way they feel in social situations, and to improve the way they see themselves.

2. What does Cognitive Therapy involve?

Cognitive therapy has been shown to be a very effective treatment for anxiety problems. It is relatively quick treatment and your child will be offered up to 16 sessions over a period of 4 months. Each session will last about an hour to an hour and a half. After your child has completed the treatment they will be seen again several times during the year after treatment ends. This should be helpful to them and us in monitoring how much progress they have made during treatment, and how well they have been able to maintain this, or even improve upon it during the follow-up period.
3. How can you help your child in treatment?

We ask that you help support your child through their treatment. This will involve: helping your child to attend sessions regularly and on time; ensuring your child has completed questionnaires for every appointment; supporting your child in completing homework tasks between sessions; and attending sessions as agreed.
Appendix H. Self-focused attention and safety behaviours experiment record for the young person

[Two records are to be completed by the young person, one for each conversation.]

- How much did ………………………….. happen?

Not at all | Totally
---|---
0% | 100%

- How anxious did you feel?

Not at all | Totally
---|---
0% | 100%

- How anxious do you think you appeared (looked)?

Not at all | Totally
---|---
0% | 100%

- How well do you think you did?

Not at all well | Really well
---|---
0% | 100%}

- Did you get a picture of how you think you looked?

Yes | No
---|---

- How focused were you on yourself and how you were coming across or on the outside and the other person/people?

Totally self-focused | Equally focused on myself and the outside | Totally focused on the outside
---|---|---
-3 | 0 | +3

- How much did you use your safety behaviours?
Appendix I. Self-focused attention and safety behaviours experiment record for stooge

[Two records are to be completed by the stooge, one for each conversation.]

What was your overall impression of <<insert child's name here>>?
Did you notice <<insert observable behaviour that the young person had predicted would be noticed e.g. blushing; no facial expressions; not asking questions>>?

If so, what did you make of it?

How much do you think that they came across as <<insert the young person’s specific fears about how they will come across, e.g. “boring”>>? How much would you rate this from 0-100% and why?
Appendix J. Record sheet for noting behavioural experiments - **Experiment Record**

<table>
<thead>
<tr>
<th>Date</th>
<th>Situation</th>
<th><strong>Prediction</strong></th>
<th>Rate belief: 0-100%</th>
<th><strong>Experiment</strong></th>
<th>Rate belief:</th>
<th><strong>Outcome</strong></th>
<th>Rate belief: 0-100%</th>
<th><strong>What I learned</strong></th>
<th>Rate belief: 0-100%</th>
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<tr>
<td></td>
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<td>What exactly did you think would happen? How would you know? (e.g. what would other people do or say?) 0% = you don't believe this at all; 100% = you really believe this to be true</td>
<td></td>
<td>How did you test it out? (Remember to focus on what actually happens rather than your feelings and let go of Safety Behaviours)</td>
<td></td>
<td>Where was your attention focused? What actually happened? Was the prediction correct?</td>
<td></td>
<td>Balanced view What I learned in general about myself in social interactions. How can I build on this? 0% = you don't believe this at all; 100% = you really believe this to be true</td>
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Appendix K. Therapy Blueprint

MY THERAPY Summary

How your social anxiety developed.
Can you remember when it started? Was anything important or significant happening at that time? Were there any later experiences that made your social anxiety worse?

What kept it going.
Here it might be useful to mention focusing on yourself/self-monitoring and any difficulties that that caused; the safety behaviours you used and the difficulties that caused; and the importance you attached to the way you felt, rather than how you behaved at the time. Did you avoid situations?

Your main negative thoughts.
Think about: What were the most important negative thoughts and beliefs – what are the answers to these?

<table>
<thead>
<tr>
<th>Negative thoughts</th>
<th>Answers to these</th>
<th>Evidence for these answers</th>
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What you learned in therapy.
Think about: What have you found helpful? What did you learn about the role of Safety Behaviours? What did you learn about focusing in on yourself and the images you had of yourself?

How to deal with any future setbacks.
Think about: What things might happen in the future to knock your confidence? Will specific thoughts pop up again? Would you start to focus on yourself? Might you mistake how you feel for how you appear to others? What should you do if you notice a setback beginning – list the strategies that might be helpful. At this time, what would be the key things to remember and do? What experiments would help you get back on track?

How to continue making progress.
Think about: What do you need to do to keep up the great changes and improvements? What is there still left to work on, is there anything you are still avoiding? An action plan might be helpful here. How can you now “steal the limelight” and be the centre of attention – what experiments would really take it all forward? How much do you really believe your new thoughts and way of seeing things – are there still any doubts – what can you do to target the doubt?
How can your parents or carers help you to deal with any future setbacks? How can they help you continue to make progress?

Think about: How have your parents helped you to challenge your social anxiety during treatment? What things have they said? What can they remind you to do? What actions can they take to support you? Are there things that it would be helpful for them to do less of or to do differently? You might also think about how they can help support you in going back to your Therapy Summary and Therapy folder.

Top Tips

Think about: What are the first three things you need to remind yourself of if you notice yourself feeling a bit self-conscious or anxious in social situations. What is your ABC action plan? This might include: reading your Therapy Summary, reminding yourself that your feelings are not a good guide to how you are coming across, or testing your fears out in a behavioural experiment.

1.

2.

3.
Appendix L. Session and homework checklist

Here is a brief checklist of things to do in each session. It is important that for any given item you have read how to do this in detail in the relevant chapter of the manual. The checklist is not a substitute for understanding the detail of how to deliver these techniques as described in each chapter. Page references for each technique or therapy task are provided in the checklist to direct you to the relevant section of the manual. What is presented here is a rough guide to the sessions but there is flexibility, particularly for example with regards to behavioural experiments, as some may well be brought into early sessions. The particular experiment will depend on the specific individual.

Sessions 1 to 4 typically follow a fairly predictable course. Therefore for each of these sessions there is a separate checklist that includes the tasks that need to be completed. In contrast, the content of sessions 5 to 14 (and of follow-up sessions) may vary considerably between treatment cases. Session checklists for sessions 5-14 (and follow-ups) include reminders about essential equipment to bring, questionnaires that should have been completed and reviewed, and a list of possible treatment components that the therapist may wish to include (e.g. behavioural experiments; working with socially traumatic memories). For each treatment component there is an additional checklist summarising the steps involved.
CT-SAD-A SESSION 1: CASE FORMULATION [ADOLESCENT MEETING]

See Chapter 4, p. 64 of CT-SAD-A Manual

**MATERIALS TO PREPARE IN ADVANCE**

- Spare set of sessional questionnaires
- Video camera
- Whiteboard and pens
- Blank copies of Personalised Version of the Model
- Empty therapy folder

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Review questionnaires in advance of the interview (p. 66):</strong></td>
<td></td>
</tr>
<tr>
<td>LSAS-CA</td>
<td></td>
</tr>
<tr>
<td>SPWSS</td>
<td></td>
</tr>
<tr>
<td>SCQ</td>
<td></td>
</tr>
<tr>
<td>SBQ</td>
<td></td>
</tr>
<tr>
<td>SAQ</td>
<td></td>
</tr>
<tr>
<td>Social participation &amp; satisfaction</td>
<td></td>
</tr>
<tr>
<td>Concentration</td>
<td></td>
</tr>
<tr>
<td>RCADS</td>
<td></td>
</tr>
<tr>
<td><strong>Populate draft cognitive model using answers from questionnaires</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Assess current social anxiety problem (p. 67):</strong></td>
<td></td>
</tr>
<tr>
<td>Situational anxiety (p. 68)</td>
<td></td>
</tr>
<tr>
<td><em>Feared/avoided situations</em></td>
<td></td>
</tr>
<tr>
<td>Thoughts</td>
<td></td>
</tr>
<tr>
<td>Sensations</td>
<td></td>
</tr>
<tr>
<td><em>Focus of attention</em></td>
<td></td>
</tr>
<tr>
<td><em>Self-image/impression</em></td>
<td></td>
</tr>
<tr>
<td>Safety behaviours</td>
<td></td>
</tr>
<tr>
<td><em>Worry and rumination</em></td>
<td></td>
</tr>
<tr>
<td>Social Network, Peer Victimisation (p. 73)</td>
<td></td>
</tr>
<tr>
<td>School Functioning (attendance: %, attainment; p. 74)</td>
<td></td>
</tr>
<tr>
<td>Family Structure and Relationships (p. 75)</td>
<td></td>
</tr>
<tr>
<td>Medication, Alcohol and Recreational Drug Use (p. 75)</td>
<td></td>
</tr>
<tr>
<td>Problematic social beliefs (p. 76)</td>
<td></td>
</tr>
<tr>
<td><strong>Development and course of problem (p. 77)</strong></td>
<td></td>
</tr>
<tr>
<td>Previous treatment (p. 77)</td>
<td></td>
</tr>
<tr>
<td>Beliefs about what can be changed (p. 77)</td>
<td></td>
</tr>
<tr>
<td><strong>Goals for treatment (p. 78)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Develop individualised version of the model (p. 80)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Homework Task for Session 1 (p. 93):</strong></td>
<td></td>
</tr>
<tr>
<td>Essential: Elaborate and consolidate the model over the week</td>
<td></td>
</tr>
<tr>
<td>Additional Homework Tasks? Specify.</td>
<td></td>
</tr>
</tbody>
</table>
CT-SAD-A SESSION 1 contd. [PARENT MEETING (if they attend)]

*See Chapter 4, p. 93 of CT-SAD-A Manual*

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage Parents</td>
<td></td>
</tr>
<tr>
<td>Obtain further information about current social anxiety problem</td>
<td></td>
</tr>
<tr>
<td>Provide information about social anxiety</td>
<td></td>
</tr>
<tr>
<td>Assess the family structure and relationships</td>
<td></td>
</tr>
<tr>
<td>Assess unhelpful parental beliefs and behaviours, including parental anxiety</td>
<td></td>
</tr>
<tr>
<td>Give a rationale for and overview of treatment</td>
<td></td>
</tr>
</tbody>
</table>
CT-SAD-A SESSION 2: SELF-FOCUSED ATTENTION AND SAFETY BEHAVIOUR EXPERIMENT

See Chapter 5, p. 97 of CT-SAD-A Manual

<table>
<thead>
<tr>
<th>MATERIALS TO PREPARE IN ADVANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Arrange for a stooge to join the session</td>
</tr>
<tr>
<td>- Spare set of sessional questionnaires</td>
</tr>
<tr>
<td>- Video camera</td>
</tr>
<tr>
<td>- Materials to be used as objective measures of feared anxiety symptoms (e.g. colour chart if fear of blushing)</td>
</tr>
<tr>
<td>- Ratings forms for young person for Conversation 1 &amp; 2 (blank)</td>
</tr>
<tr>
<td>- Feedback forms for Stooge for Conversations 1 &amp; 2 (blank)</td>
</tr>
<tr>
<td>- White board and pens</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review questionnaires:</td>
<td></td>
</tr>
<tr>
<td>LSAS-CA</td>
<td></td>
</tr>
<tr>
<td>SPWSS</td>
<td></td>
</tr>
<tr>
<td>SCQ</td>
<td></td>
</tr>
<tr>
<td>Concentration</td>
<td></td>
</tr>
<tr>
<td>Review Homework Tasks set in Session 1</td>
<td></td>
</tr>
<tr>
<td>Essential: Review the model and any additions/elaborations</td>
<td></td>
</tr>
<tr>
<td>Additional homework tasks?</td>
<td></td>
</tr>
<tr>
<td>Develop rationale for behavioural experiment (p. 100)</td>
<td></td>
</tr>
<tr>
<td>Identify a suitable social interaction (p. 100)</td>
<td></td>
</tr>
<tr>
<td>Make predictions and ratings with the young person (p. 100)</td>
<td></td>
</tr>
<tr>
<td>Conversation 1 instructions to young person and stooge separately (p. 101)</td>
<td></td>
</tr>
<tr>
<td>Conversation 1</td>
<td></td>
</tr>
<tr>
<td>Obtain ratings (with form) and impressions of Conversation 1 with young person (p. 103)</td>
<td></td>
</tr>
<tr>
<td>Conversation 2 instructions to young person and stooge separately (p. 101)</td>
<td></td>
</tr>
<tr>
<td>Conversation 2</td>
<td></td>
</tr>
<tr>
<td>Obtain ratings (with form) and impressions of Conversation 2 with young person (p. 103)</td>
<td></td>
</tr>
<tr>
<td>Give stooge the feedback form to complete about the two conversations to be picked up later (p. 103)</td>
<td></td>
</tr>
<tr>
<td>Compare ratings of Conversation 1 &amp; 2 and draw conclusions with young person (p. 106)</td>
<td></td>
</tr>
<tr>
<td>Consider completing ‘Staring’ Behavioural Experiment if sufficient time (p. 151). If not undertaken, consider in another session. Should be done early in treatment if indicated.</td>
<td></td>
</tr>
<tr>
<td>Homework Task for Session 2 (p. 106):</td>
<td></td>
</tr>
<tr>
<td>Essential: To practice shifting to an external, non-evaluative focus of attention and dropping their safety behaviours with peers and</td>
<td></td>
</tr>
</tbody>
</table>
### Additional Homework Tasks? Specify.

If ‘Staring’ behavioural experiment has been completed in session, ask the young person to repeat this during the week and note down what they have learnt.
CT-SAD-A SESSION 3: VIDEO FEEDBACK OF EXPERIMENT

See Chapter 6, p. 110 of CT-SAD-A Manual

<table>
<thead>
<tr>
<th>MATERIALS TO PREPARE IN ADVANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Spare set of sessional questionnaires</td>
</tr>
<tr>
<td>- Video camera</td>
</tr>
<tr>
<td>- White board and pens</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review questionnaires:</td>
<td></td>
</tr>
<tr>
<td>LSAS-CA</td>
<td></td>
</tr>
<tr>
<td>SPWSS</td>
<td></td>
</tr>
<tr>
<td>SCQ</td>
<td></td>
</tr>
<tr>
<td>Concentration</td>
<td></td>
</tr>
</tbody>
</table>

Review Homework Tasks set in Session 2

- Essential: Review experience of shifting to an external, non-evaluative focus of attention and dropping safety behaviours with peers and others
- Additional Homework Tasks? Specify.
- Review ‘Staring’ Behavioural Experiment if set in Session 2.

Identify predictions in advance of viewing (with % ratings, p. 113)

Prepare an unbiased mode of viewing (p. 114)

View the video (p. 115)

Comparing ratings before and after viewing the video (p. 117)

Review feedback from stooge (if appropriate/needed, p. 118)

Homework Task for Session 3:

- Essential:
  1. To practice shifting to an external, non-evaluative focus of attention and dropping their safety behaviours with peers and others.
  2. Ask adolescent to bring some music and a book they enjoy to next session.

- Additional Homework Tasks? Specify.
CT-SAD-A SESSION 4: ATTENTION TRAINING


MATERIALS TO PREPARE IN ADVANCE

| - Spare set of sessional questionnaires |
| - Music device |
| - Book |
| - Video camera |
| - White board and pens |

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review questionnaires:</td>
<td></td>
</tr>
<tr>
<td>LSAS-CA</td>
<td></td>
</tr>
<tr>
<td>SPWSS</td>
<td></td>
</tr>
<tr>
<td>SCQ</td>
<td></td>
</tr>
<tr>
<td>Concentration</td>
<td></td>
</tr>
<tr>
<td>Review Homework Tasks set in Session 3</td>
<td></td>
</tr>
<tr>
<td>Essential: Review experience of shifting to an external, non-evaluative focus of attention and dropping safety behaviours with peers and others</td>
<td></td>
</tr>
<tr>
<td>Additional Homework Tasks? Specify.</td>
<td></td>
</tr>
<tr>
<td>Set up the rationale (p. 125)</td>
<td></td>
</tr>
<tr>
<td>Step 1: Sounds (with eyes closed; p. 126)</td>
<td></td>
</tr>
<tr>
<td>Step 2: Colours (p. 129)</td>
<td></td>
</tr>
<tr>
<td>Step 3: Shadows/reflectios or textures (p. 130)</td>
<td></td>
</tr>
<tr>
<td>Step 4: Music (p. 131)</td>
<td></td>
</tr>
<tr>
<td>Step 5: Therapist reading (p. 131)</td>
<td></td>
</tr>
<tr>
<td>Suggested order as above, but this may vary depending on particular case, stimuli around etc.</td>
<td></td>
</tr>
<tr>
<td>Essential Homework Task for Session 4 (p. 135):</td>
<td></td>
</tr>
<tr>
<td>When alone: 15 min/day attention exercises</td>
<td></td>
</tr>
<tr>
<td>When with others: ask YP to get absorbed in the conversation and the social interaction, rather than focusing on how they are coming across. To take notes.</td>
<td></td>
</tr>
<tr>
<td>Additional Homework Tasks? Specify.</td>
<td></td>
</tr>
</tbody>
</table>
CT-SAD-A SESSIONS 5 – 14 (+ FUP sessions at months 1 & 3 months)

SESSION NUMBER: …..

MATERIALS TO PREPARE IN ADVANCE
- Spare set of sessional questionnaires
- Video camera
- White board and pens

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review questionnaires:</td>
<td>When?</td>
</tr>
<tr>
<td>LSAS-CA</td>
<td>Every session</td>
</tr>
<tr>
<td>SPWSS</td>
<td>Every session</td>
</tr>
<tr>
<td>SCQ</td>
<td>Every session</td>
</tr>
<tr>
<td>Concentration</td>
<td>Every session</td>
</tr>
<tr>
<td>SBQ</td>
<td>Session 1, 7, 14; FUP 1, 3 m</td>
</tr>
<tr>
<td>SAQ</td>
<td>Session 1, 7, 14; FUP 1, 3 m</td>
</tr>
<tr>
<td>Social participation &amp; satisfaction</td>
<td>Session 1, 7, 14; FUP 1, 3 m</td>
</tr>
<tr>
<td>RCADS</td>
<td>Session 1, 7, 14; FUP 1, 3 m</td>
</tr>
</tbody>
</table>

Briefly review Homework Tasks set in Previous session

Content of Session (tick off all the procedures that were used): SELECT:
- Identify goals for session: target beliefs; situations; change of attention etc.
- Video feedback
- Behavioural experiments
- Surveys
- Work with socially traumatic memories
- Targeting worry and rumination
- Addressing peer processes, victimisation and bullying
- Relapse prevention
- Other? Specify

Homework Task for Session: specify
CHECKLIST FOR VIDEO/STILL PHOTOGRAPHY FEEDBACK

See Chapter 6, p. 110 of CT-SAD-A Manual

<table>
<thead>
<tr>
<th>MATERIALS TO PREPARE IN ADVANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Video camera</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify predictions in advance of viewing (with % ratings; p. 113)</td>
<td></td>
</tr>
<tr>
<td>Prepare an unbiased mode of viewing (p. 114)</td>
<td></td>
</tr>
<tr>
<td>View the video/still photograph (p. 115)</td>
<td></td>
</tr>
<tr>
<td>Comparing ratings before and after viewing the video (p. 117)</td>
<td></td>
</tr>
<tr>
<td>Consider freezing the moment of disconfirmation (p. 118)</td>
<td></td>
</tr>
<tr>
<td>Consider creating a still image flashcard/storing an image on the</td>
<td></td>
</tr>
<tr>
<td>young person’s phone (p. 120)</td>
<td></td>
</tr>
<tr>
<td>Consider helping the young person to rehearse the way they looked</td>
<td></td>
</tr>
<tr>
<td>on video (p. 121)</td>
<td></td>
</tr>
</tbody>
</table>
CHECKLIST FOR BEHAVIOURAL EXPERIMENTS

See Chapter 8, p. 136 of CT-SAD-A Manual

<table>
<thead>
<tr>
<th>MATERIALS TO PREPARE IN ADVANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Behavioural Experiment Record Sheet</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify fearful concerns (p. 140)</td>
<td></td>
</tr>
<tr>
<td>Agree situation (p. 140) [note on record sheet]</td>
<td></td>
</tr>
<tr>
<td>Identify a prediction (p. 142) [with % rating; note on record sheet]</td>
<td></td>
</tr>
<tr>
<td>Plan the experiment (p. 144) [note on record sheet]</td>
<td></td>
</tr>
<tr>
<td>Complete the experiment [whilst dropping safety behaviours and shifting attention externally; note on record sheet]</td>
<td></td>
</tr>
<tr>
<td>Review outcome (p. 145) [re-rate original belief with % rating; note on record sheet]</td>
<td></td>
</tr>
<tr>
<td>Reflect on learning and next steps (p. 145) [identify new belief with % rating; note on record sheet]</td>
<td></td>
</tr>
</tbody>
</table>

**Homework Task after sessions including Behavioural Experiments:**

Essential: Plan further experiments building on what has been learnt. Complete first THREE columns of record sheet with young person (Situation, Prediction, Experiment columns).
CHECKLIST FOR WORK WITH SOCIA LDY TRAUMATIC MEMORIES

See Chapter 9, p. 162 of CT-SAD-A Manual

MATERIALS TO PREPARE IN ADVANCE
- Nothing additional

<table>
<thead>
<tr>
<th>TASK</th>
<th>SELECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discrimination training</td>
<td></td>
</tr>
<tr>
<td>Imagery rescripting</td>
<td></td>
</tr>
</tbody>
</table>

DISCRIMINATION TRAINING (p. 164)

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify the negative image, belief and associated socially traumatic memory (p. 164)</td>
<td></td>
</tr>
<tr>
<td>Identify differences between ‘Then’ and ‘Now’ (p. 166)</td>
<td></td>
</tr>
<tr>
<td>Explain how to ‘break the link’ between ‘Then’ and ‘Now’ (p. 167)</td>
<td></td>
</tr>
<tr>
<td>Practice breaking the link in vivo (p. 167)</td>
<td></td>
</tr>
<tr>
<td>Homework Task after sessions including Discrimination Training:</td>
<td></td>
</tr>
<tr>
<td>Essential: Practice ‘breaking the link’</td>
<td></td>
</tr>
</tbody>
</table>

IMAGERY RESCRIPTING (p. 168)

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify the negative image, belief and associated socially traumatic memory (p. 168)</td>
<td></td>
</tr>
<tr>
<td>Cognitive restructuring (with % belief ratings; p. 169)</td>
<td></td>
</tr>
<tr>
<td>Imagery rescripting (p. 171)</td>
<td></td>
</tr>
<tr>
<td>Stage 1: The patient relives the event from the age at which it occurred</td>
<td></td>
</tr>
<tr>
<td>Stage 2: The patient relives the event from the perspective of their current older age observing what is happening to their younger self</td>
<td></td>
</tr>
<tr>
<td>Stage 3: The patient relives the event from the age at which it occurred again. This time their older self is with them, may intervene, offer new information, and take a compassionate stance towards the younger self.</td>
<td></td>
</tr>
</tbody>
</table>
### CHECKLIST FOR TARGETING WORRY AND RUMINATION

*See Chapter 10, p. 178 of CT-SAD-A Manual*

#### MATERIALS TO PREPARE IN ADVANCE

- Nothing additional

#### TASK

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describing what worry/rumination is (consider creating mind map)</td>
<td></td>
</tr>
<tr>
<td>Map out advantages and disadvantages or worry/rumination (p. 182)</td>
<td></td>
</tr>
<tr>
<td>Explain steps to notice and stop the process (p. 186)</td>
<td></td>
</tr>
<tr>
<td><strong>Step 1. Rationale for noticing worry/rumination and introduce importance of practice (consider setting up a daily log as homework)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Step 2. Bring disadvantages to mind. Plan with adolescent how they will do this in the moment (consider creating flashcard; smartphone/paper copies)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Step 3. Convert worry/ruminations into testable predictions (practice doing this in session with common worries/ruminations)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Step 4. Put worry to one side and distract (plan effective distraction methods)</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Homework Task after sessions including Worry/Rumination Work:**

- Daily log of worry/rumination
- Setting up behavioural experiments and recording these
- Noting down effective distraction methods
CHECKLIST FOR WORK WITH PEER PROCESSES, AND ONGOING VICTIMISATION AND BULLYING

See Chapter 12, p. 205 of CT-SAD-A Manual

<table>
<thead>
<tr>
<th>TASK</th>
<th>SELECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing ongoing bullying and peer victimisation (p. 210)</td>
<td></td>
</tr>
<tr>
<td>Targeting perceptions and behaviours in response to peers (p. 210)</td>
<td></td>
</tr>
<tr>
<td>Romantic experiences (p. 226)</td>
<td></td>
</tr>
</tbody>
</table>

ONGOING BULLYING AND PEER VICTIMISATION (p. 210)

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE? Frequency?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact with school/college</td>
<td></td>
</tr>
<tr>
<td>Contact with parents</td>
<td></td>
</tr>
<tr>
<td>Joint meetings with education and parents</td>
<td></td>
</tr>
<tr>
<td>Content:</td>
<td>SELECT:</td>
</tr>
<tr>
<td>Information provision</td>
<td></td>
</tr>
<tr>
<td>Agreeing anti-bullying plan</td>
<td></td>
</tr>
<tr>
<td>Monitoring, reviewing and revising plan</td>
<td></td>
</tr>
</tbody>
</table>

PERCEPTIONS OF AND RESPONSES TO PEERS (p. 210)

<table>
<thead>
<tr>
<th>TASK</th>
<th>SELECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceptions/misperceptions (p. 211)</td>
<td></td>
</tr>
<tr>
<td>Content:</td>
<td></td>
</tr>
<tr>
<td>Identify alternative explanations for peer behaviour</td>
<td></td>
</tr>
<tr>
<td>Role-play</td>
<td></td>
</tr>
<tr>
<td>Behavioural Experiments</td>
<td></td>
</tr>
<tr>
<td>‘Beg friends’ (p. 213)</td>
<td></td>
</tr>
<tr>
<td>Content:</td>
<td></td>
</tr>
<tr>
<td>Identify unhelpful effects of this behaviour</td>
<td></td>
</tr>
<tr>
<td>Help adolescent learn that individuality is liked by others</td>
<td></td>
</tr>
<tr>
<td>Role-play</td>
<td></td>
</tr>
<tr>
<td>Behavioural Experiments</td>
<td></td>
</tr>
<tr>
<td>‘Moths to the flame’ (p. 215)</td>
<td></td>
</tr>
<tr>
<td>Content:</td>
<td></td>
</tr>
<tr>
<td>Identify behaviour as response to negative social belief</td>
<td></td>
</tr>
<tr>
<td>Help adolescent identify what is important in a friend and compare to current peer group</td>
<td></td>
</tr>
</tbody>
</table>
Support in developing new friendship groups (may include joining clubs etc)

**Behavioural Experiments**

**Unhelpful safety behaviours (p. 216)**

**Content:**
- Identify unhelpful effects of this behaviour
- Role-play
- Behavioural Experiments (consider peer group with whom these are undertaken)

**Low self-esteem (p. 217)**

**Content:**
- Challenge the idea that the bullies are arbiters of one’s worth (consider using 3rd person perspective; identify other sources of information about self-worth)
- Prejudice metaphor
- Positive data log
- Behavioural Experiments
- Assertive defence of the self

**SELECT:**

**ROMANTIC EXPERIENCES (p. 226)**

**TASK**

**DONE?**

**Assessment (with sensitivity)**

**Normalise**

**Content:**

**SELECT:**

- Surveys
- Behavioural experiments
- Video feedback
- Role-play
- Moths to the flame work
- Low self-esteem work
CHECKLIST FOR RELAPSE PREVENTION & ENDING THERAPY

See Chapter 13, p. 233 of CT-SAD-A Manual

First Relapse Prevention Session (usually Session 13, p. 233)

<table>
<thead>
<tr>
<th>MATERIALS TO PREPARE IN ADVANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Blank Therapy Blueprint</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce principles of relapse prevention</td>
<td></td>
</tr>
<tr>
<td>Work through key relapse prevention areas</td>
<td></td>
</tr>
</tbody>
</table>

- Main problems at beginning of treatment
- What maintained the difficulties (i.e. factors in the model)
- What are key negative social thoughts (and responses to these)
- What was learnt in therapy
- What progress has been made in therapy
- Anticipated challenges and plans to overcome
- Future goals
- Advice to another adolescent with social anxiety

Begin written Therapy Blueprint

Homework Task after Relapse Prevention Session:

- Complete Therapy Blueprint

Second Relapse Prevention Session (usually Session 14, p. 233)

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and complete written Therapy Blueprint</td>
<td></td>
</tr>
<tr>
<td>Adolescent shares Therapy Blueprint with parents</td>
<td></td>
</tr>
</tbody>
</table>

Follow-up Sessions (months 1, 3, 6; p. 237)

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review social anxiety achievements</td>
<td></td>
</tr>
</tbody>
</table>

Identify and review difficulties

**Content:**

- Develop schematic of recent difficulty using cognitive model
- Video feedback
- Behavioural experiments
- Surveys
- Work with socially traumatic memories
- Targeting worry and rumination
- Addressing peer processes, victimisation and bullying

<table>
<thead>
<tr>
<th>Task</th>
<th>Done?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SELECT:</td>
</tr>
<tr>
<td></td>
<td>Develop schematic of recent difficulty using cognitive model</td>
</tr>
<tr>
<td></td>
<td>Video feedback</td>
</tr>
<tr>
<td></td>
<td>Behavioural experiments</td>
</tr>
<tr>
<td></td>
<td>Surveys</td>
</tr>
<tr>
<td></td>
<td>Work with socially traumatic memories</td>
</tr>
<tr>
<td></td>
<td>Targeting worry and rumination</td>
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<tr>
<td></td>
<td>Addressing peer processes, victimisation and bullying</td>
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</tbody>
</table>
Ending Therapy (p. 237)

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy letter (to send after treatment)</td>
<td></td>
</tr>
</tbody>
</table>

Other? Specify
CHECKLIST FOR ADDITIONAL PARENT SESSIONS

See Chapter 11, p. 190 of CT-SAD-A Manual

Total Number of Additional Parent Sessions: ..... 

Dates of Additional Parent Sessions: ..... 

<table>
<thead>
<tr>
<th>MATERIALS TO PREPARE IN ADVANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Behavioural Experiment Record Sheet</td>
</tr>
<tr>
<td>- Relevant psychoeducation material/references</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TASK</th>
<th>DONE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify the behaviours and underlying beliefs with the parents</td>
<td></td>
</tr>
<tr>
<td>Develop a shared understanding of how these beliefs and behaviours may impact on their child’s social anxiety: review intended and unintended consequences.</td>
<td></td>
</tr>
<tr>
<td>Plan behavioural experiments to test fears out</td>
<td></td>
</tr>
</tbody>
</table>

Other techniques that may be used: 

- Information provision
- Survey
- Role-play
- Modelling

**Homework Task after sessions including parent work:** 

- Essential: Review Behavioural Experiments