



Oxford Centre for Anxiety Disorders and Trauma

**Cognitive Therapy for Social Anxiety Disorder (CT-SAD):
Guidance for conducting treatment remotely during the
Coronavirus Pandemic (Version 2)**



People with Social Anxiety Disorder (SAD) are afraid of doing or saying something that may be humiliating or embarrassing. As a consequence, they tend to hold back in social interactions and completely avoid some social situations. We are all being asked to become more physically distant from other people in order to reduce transmission of COVID-19. Clinicians may therefore think social distancing is likely to come as a relief to people with SAD and, as a consequence, that there may be less of a need to offer SAD treatment until the COVID-19 pandemic has receded. Certainly, people with SAD will be required to have fewer face-to-face interactions than usual. However, social isolation in a time of crisis can have a very negative effect on mental health, even for people with SAD. To avoid this, mental health guidance strongly encourages people to compensate for reduced face-to-face social contact by making an active effort to become more connected to others through digital means. Unfortunately, the fears of people with SAD are likely to also make it difficult for them to connect with others digitally, making them particularly vulnerable to extreme isolation and depression. There is therefore a need for services to continue to offer treatment for SAD during the pandemic. However, treatment needs to be adjusted so it can be offered remotely, with a particular focus on the social interactions that are currently possible, and on blocks to those interactions. This guide provides suggestions about how to achieve these aims.

SAD and online communication

We have long known that many people with SAD experience anxiety during remote interactions, such as speaking on the phone. Our recent research has shown that the same is true for social media.

- When people with SAD interact with others using social media, their social fears and anxiety are activated. For example, they may fear that their online post will come across as boring or stupid, that they will have nothing to say, or they will blush or shake during a video conference call.
- This leads people with SAD to behave online in the same, often self-defeating ways they behave in face-to-face interactions. Patients utilize online safety behaviours linked to their social fears. For example, a patient who worries they will come across as boring may use social media passively, avoid posting or commenting, hold back and not connect with others, not say much about themselves, try to come across well, spend excessive time preparing what to write in a message etc. As a consequence, their fears of online communication persist and digital communication fails to give them the social connectedness and acceptance that they desire.

This is particularly problematic during the COVID-19 pandemic because holding back (e.g. not reaching out to people, or sharing with others) is a barrier to obtaining offers of help or friendship from others. The absence of such offers can then give people with SAD the incorrect impression that others do not care about them, leading to further feelings of isolation, rejection and depression.

Treating SAD during the COVID-19 Pandemic

Many people with SAD are used to putting others' needs before their own. This may lead patients to suggest they discontinue, or not start, treatment in order to avoid drawing on NHS resources at a time of crisis. Therapists should be aware of this and discuss with patients the importance of social connection, and that overcoming their anxiety can be of benefit to both themselves and others as they become more socially connected and active.

A central part of any cognitive-behavioural treatment for SAD is the use of behavioural experiments in which patients are encouraged to systematically increase their engagement with social activities in order to discover that their fears are excessive. In the context of social distancing, this might involve the patient reaching out to friends, neighbours or others they have not been in contact with for some time, making a prediction in advance about the worst that they fear might happen, dropping their safety behaviours and then recording the outcome. When people are following guidelines on social distancing there are two types of interaction you can work with in treatment to set up behavioural experiments: (1) reaching out to others using social media and the phone and (2) practising giving speeches using virtual audiences. Both can be helpful in treatment.

Cognitive Therapy for SAD

Cognitive Therapy for SAD (CT-SAD) based on the Clark and Wells (1995) model is recommended by the National Institute for Health and Care Excellence as a first-choice treatment for SAD (NICE, 2013). Although CT-SAD places a strong emphasis on behavioural experiments, it is a multi-faceted treatment with several other components. The research literature suggests that the other components come together to create an overall treatment package that is more effective than straightforward exposure or behavioural experiments alone. This is because the treatment starts with helping patients to understand the processes that maintain their social anxiety and encourages them to drop these dysfunctional processes before starting behavioural experiments. It is possible to do the full treatment remotely and this guide will show you how.

Guidance for therapists when working with CT-SAD remotely

Remember that the therapist is a phobic object. The treatment of people with SAD is complicated by the fact that the therapist is, at least initially, a stranger and so may be seen as a phobic object. The fears the person experiences with others may also be experienced with the therapist. In routine face-to-face therapy this is a complication that therapists need to be aware of, and make adjustments for, if they are to establish a good therapeutic relationship. For example, by being warm and accepting but having slightly less eye contact early in treatment so that patients do not feel put on the spot. Similar issues arise when therapy is delivered by video or over the phone. Simple adjustments can help, such as: not staring straight into the video camera when asking the patient a question in early sessions; using screen share to develop the cognitive model together at the start of treatment, so both of you are looking at the model rather than into each others eyes; reassuring patients that they are not being judged; and, providing a friendly photograph of the therapist if treatment is delivered by telephone.

Setting up video conference call. Video conference calls are the optimal way to deliver CT-SAD remotely. When conducting therapy through a video link (Skype, Zoom, Microsoft Teams, etc) it is important to ensure that the video is set up at the patient end so the patient just sees the therapist / people they are talking with. If the patient can also see a picture of themselves during the call this is likely to make them feel very self-conscious

and interfere with concentrating on the session itself. Depending on the video conferencing system used, it is possible to turn off the self-view, minimize it and/or drag it with your mouse off screen.

You can use the normal CT-SAD treatment components in their typical order during video call sessions:

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| Use of self-report questionnaires | In face-to-face CT-SAD therapists are encouraged to give patients a measure of social anxiety and measures of some process variables (belief in negative thoughts, focus of attention, safety behaviours) regularly throughout treatment. The same measures should be used to guide remotely delivered therapy. Word versions can be downloaded from the OxCADAT resources website and emailed to patients for completion before sessions. Patients can return the completed questionnaires by email so the therapist can review them with the patient in session, perhaps via share screen. |
| Engagement | Identify goals; reassure people their needs matter and connection is especially important now; attention to therapeutic relationship. |
| Individualised cognitive model | Collaboratively draw out & share digitally during remote session on paper or screen (e.g. Zoom white board or screen share on Microsoft Teams or drawing out then emailing a model during a phone session). A video showing how to develop an individualized cognitive model is available (see https://oxcadatresources.com). A blank version of the model in Word can be downloaded from the same web address. |
| Self-focused attention and safety behaviours experiment | <p>Patients have two video conference conversations with a stranger in the relevant treatment session: the first while focusing attention on themselves and doing their safety behaviours, the second while focusing externally, not monitoring their performance and dropping safety behaviours. (see illustrations on https://oxcadatresources.com). If therapists are working from home, it might be possible to add a colleague at a different location into the video call. If not, the therapist will need to roleplay the stranger.</p> <p>If the patient consents, some video conferencing platforms (such as Zoom) have the option of recording the calls so they can be used for video feedback in a subsequent session. If the patient records the call they should hold off from watching the conversations until their next therapy session when video feedback can be carefully set up and suitable instructions for viewing the video given.</p> <p>Feedback from the conversational partner(s) can be also be obtained and shared by email (see guidance on https://oxcadatresources.com)</p> |
| Video or audio feedback | Video feedback is an essential technique in face-to-face CT-SAD and is possible in video conference delivered CT-SAD, if the video conference facility supports recording. However, getting the recording to work in a way that is likely to be therapeutic is technically challenging. This is because to reduce self-focus and self-consciousness we recommend that the video is set up at the patient end so the patient just sees the therapist / people they are talking with. However, for video feedback to be effective, video footage of both the patient and the people they were speaking to needs to be captured for later viewing. There are a number of possible ways around this depending on the video conferencing facility used. |

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| | <p>Therapists may want to practise the set up with a colleague before trying with a patient. In a footnote, we describe how to do this in Zoom¹</p> <p>When doing video feedback, therapists help patients make observable predictions about what they think they will see on the video, prepare them to watch the video as if they are watching a stranger talking, and then view recordings together using screen share. Different ways of using video feedback are outlined in a clinical guide and training video on the oxcadatresources.com website and via the following link: www.ncbi.nlm.nih.gov/pmc/articles/PMC5627505/</p> <p>Patients can also record themselves giving a presentation to a virtual audience (see https://oxcadatresources.com) and review the video afterwards, having made predictions first.</p> |
| Attention training | <p>A range of attention training practices (noticing sounds, colours, listening to different instruments in a piece of music, reading aloud) can be done together remotely. Therapists could end this session by having a brief normal conversation with patients (e.g. about films you have seen) while patients switch focus from themselves (e.g. asking themselves ‘how am I coming across?’) to getting lost in what the therapist is saying.</p> <p>Several videos with source material that can be used in attention training treatment sessions are available in the Social Anxiety Disorder Training Videos section of our website. For guidance on how to use them, please see the video illustration of “attention training” in the same section.</p> <p>A YouTube link to 8 attention training videos is also provided if therapists wish to send patients attention training materials to practice with during homework assignments. This link can be found under ‘Social Anxiety Disorder Questionnaires and Therapy Materials’ on our website.</p> |
| Behavioural experiments | <p>Even when in social isolation experiments can be done during video calls, on the phone, or in social media (e.g. reaching out to people that patients have not seen for a while), giving speeches to virtual audiences (see resources section below for more information about how to use virtual audiences) , or using the Houseparty app. See table below for ideas.</p> <p>Set up experiments together (share screen can be used to complete record sheets), ensure predictions are observable. Help patients to generalize their learning: <i>“what does this tell you about how you come across more generally in social situations/to others?”</i></p> |
| Work on socially | <p>For example, screen share or whiteboard features can be used (depending on the video conferencing platform) to write out differences between</p> |

¹ If using Zoom with the therapist hosting the call, the therapist will need to give the patient permission to record (in ‘Manage Participants’). Ideally, the recording that is played back should show both the patient and the person/people they were talking with. This is possible if the patient includes their video image in the gallery view in Zoom during the recording call. However, when the patient’s video image is made visible to them on screen this can be unhelpfully distracting and increase self-focus during a conversation / presentation. There are a few ways to get around this, for example, dragging another document from their desktop over the top of the image of just themselves on screen (leaving their conversational partners visible), or to put a sticky note or piece of paper over the image of themselves during the recording session.

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| traumatic memories | THEN and NOW. Patients may benefit from having access to things at home that show them how different things are now compared to their memory (e.g. photos of them with friends showing they are no longer being bullied). |
| Therapy Blueprint | Can be emailed to patients to complete and viewed on share screen or discussed on phone. |

Ideas for behavioural experiments without physical contact that can be done during session or for homework:

| Fear | Example Experiments |
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| I'm boring | <ul style="list-style-type: none"> - Group conversation with two strangers on webcam. Speak spontaneously and focus on how they respond. - Join online choir. Be myself rather than only saying witty things. - During WhatsApp chat purposefully say things I think are boring and see how my friend responds. |
| I'm stupid | <ul style="list-style-type: none"> - Message a colleague on Slack and do not prepare things I think sound intelligent to say, just write whatever comes to mind. - Ask a question I think is stupid to customer services of an online store. - Say something to a friend on FaceTime I think is stupid – observe their reaction. |
| I'll freeze | <ul style="list-style-type: none"> - Call an online store to enquire about a purchase (e.g. ask if I can send it back if it does not fit). Do not prepare what to say, speak spontaneously. - Virtual audience presentation and record doing this – notice if I freeze. - Purposefully pause when calling a friend/customer services. |
| I'll blush | <ul style="list-style-type: none"> - Speak to a stranger via the webcam, observe reactions if I feel red. Take a screen shot if possible. - Put blusher on cheeks before work video conference call and observe reactions. |
| I'm sweaty | <ul style="list-style-type: none"> - Do not wear my jacket during a work Google Hangout. Ignore how sweaty I feel and focus on reactions. - FaceTime a friend with water on my armpits. Focus on reactions. If possible take a screen shot to capture their reactions. |
| I shake | <ul style="list-style-type: none"> - Give a presentation to a virtual audience while loosely holding my cup and not focusing on how shaky I feel. Record this on phone. Rate how shaky I felt. Watch video back and compare to my feelings. - Purposefully shake during a webcam chat with a stranger and observe their reactions. |

Resources:

There are a number of helpful resources at www.oxcadatresources.com including:

- Video of a full day clinical workshop on CT-SAD for adults and adolescents
- Numerous short (5-15 mins) video clips illustrating articular therapeutic techniques
- Self-study modules that can be sent to patients to complement remote therapy sessions

- Word versions of various materials that can be sent to patients to complete as part of therapy, including: the key process and symptom measures; the cognitive model; and the behavioural experiments record sheet.
- A YouTube link to 9 virtual audience videos that can be used live in therapy sessions for behavioural experiments and can also be provided for patients to use for homework. A training video for clinicians on using virtual audiences as part of CT-SAD is also available.
- A YouTube link to 8 attention training videos that can be used live in therapy when doing attention training and also provided for patients to use when practicing attention training for homework. The YouTube links can be found in the 'Social Anxiety Disorder Questionnaires and Therapy Materials' section.

You will need to register as a therapist to access the training videos. There is no charge. The website materials focus on the distinctive features of CT-SAD and are intended for therapists who have already learned the core generic features of cognitive behaviour therapy.

The SAD NICE guideline, is available at <https://www.nice.org.uk/guidance/cg159>

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