Cognitive Therapy for Social Anxiety Disorder

A guide for NHS Professionals

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UNIVERSITY OF OXFORD

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Cognitive Therapy for Social Anxiety Disorder (CT-SAD): A Clinician's guide

Introduction

> *"For most of my life I felt like I was a prisoner in my own head. I was never myself with others, constantly worried how I was coming across and holding back in conversations. Over years like that I started to feel like I didn't deserve to be there (in the social situation). After treatment, I feel free for once. I can finally be myself with others"- Natasha after having CT-SAD*

Social Anxiety Disorder is a persistent fear of one or more social situations in which the individual fears they will act in a way that will lead to social embarrassment, humiliation, or rejection. As SAD has a devastating impact on sufferers lives and is the most persistent of all mental health problems, freeing people from their SAD and is one of the most rewarding yet challenging jobs that therapists face. Before we begin by describing Cognitive Therapy treatment for SAD (CT-SAD), it is key for clinicians to have a good grasp of some of the unique challenges in treating SAD.

Social Anxiety Disorder (SAD) is one of the most common and persistent mental health problems *(Merikangas, Nakamura, & Kessler, 2009)*, with a lifetime prevalence of 12% and 12-month prevalence around 7% (Kessler et al., 2005). SAD tends to start in early life, the median age of onset of SAD is 13 years old (Kessler et al., 2005), and is often chronic in the absence of treatment. In a study by Bruce and colleagues (2005), only 37% of SAD sufferers recovered over a course of 12 years, compared to 82% with panic disorder without agoraphobia. This means that most people you see for treatment will have suffered across their lifetime. This is made worse by the fact that many patients with SAD do not get timely access to treatment. In a recent trial of Cognitive Therapy patients had suffered for an average of 18.4 years before their

therapy (Clark et al., 2023). Why is this? Firstly, seeing a doctor or therapist is a feared social situation that many patients avoid. Secondly, many people with lifelong SAD view their difficulties as part of their personality, rather than a treatable condition that can overcome. The longstanding nature of SAD means that the negative patterns of thinking about the social self and the associated behavioural strategies have been reinforced over many years and are often quite entrenched by the time the person seeks help.

SAD is also associated with significant disability and impairment, more so than other disorders (Lochner et al., 2003, Quilty et al., 2003). There are high rates of underemployment (Wittchen, Fuetsch, Sonntag, Müller, & Liebowitz, 2000), lower pay (Stein et al., 2000), poorer educational achievement (Schneier et al., 1994), increased chances of dropping out of school (Stein & Kean, 2000 and relationship impairments (Sparrevohn & Rapee, 2009).

Comorbidity with SAD is common. Given the significant impact SAD has on patients' day to day lives, relationships, work etc., it makes sense that additional mental health difficulties might follow, such as depressed mood fueled by to negative thoughts about the impact of SAD (e.g 'I am a failure', 'I have never done the things I wanted to'). Community studies show up to 90% of patients with SAD report other comorbidity (Koyuncu et al., 2019). SAD occurs first in the timeline in the majority of cases (Kessler et al., 1999). Depression is commonly comorbid with SAD (Nice, 2013) and SAD precedes a comorbid mood disorder in two thirds of cases (Kessler et al., 2005). Presence of social anxiety also increases risk of later alcohol abuse and drug abuse or dependency (Swendsen et al., 2010).

Therapists are a phobic object. In addition to being one of the most persistent mental health problems to treat with high levels of disability and comorbidity, therapists face a further challenge in treating SAD, which is that the therapist is, at the start of treatment, a stranger. Therapy itself is therefore an anxiety provoking situation for a patient. This can impact of the treatment as many of the unhelpful processes that patients use to cope with anxiety provoking situations (such as focusing on themselves and using safety behaviours, such as keeping quiet

or censoring themselves for fear of saying something stupid) can prevent therapists from getting into the patient's head and developing a good understanding of the difficulties.

It is helpful for clinicians to keep the above in mind when reading through this guide as many of the interventions described here have been carefully developed to help clinicians and patients overcome these challenges. Despite being such a chronic and debilitating problem, the majority of patients will recover after receiving a good dose of CT-SAD (Clark et al., 2004; 2006; 2023). When anybody feels acceptable as they are around other people, it allows them to live more fulfilling and enjoyable life. There really is no greater gift you can give a patient than that.

Throughout this guide you will find:

Helpful questions therapists can ask and example transcripts
Exercises for therapists to help deepen your learning
Links to helpful training videos and other resources
Key take home points

There are also several helpful therapy tools and materials in the appendices.

Therapist training videos and resources

Videos demonstrating all the core interventions of CT-SAD are freely available on the OxCADAT website: https://oxcadatresources.com. Therapists might find it helpful to review these brief demonstration videos as part of their training and in advance of delivering key interventions. In addition to this guide, several clinical guidance papers are also available to download from the website including guides on how to deliver treatment remotely (Warnock-Parkes et al., 2020, use video feedback throughout therapy (Warnock-Parkes et al., 2017) and imagery rescripting (Wild and Clark, 2011). The website also includes word copies of all the recording sheets and self-report questionnaires used in the treatment, many of which are included here in the Appendices.

Part 1: The cognitive model – your map for therapy

The Clark and Wells (1995) cognitive model of social anxiety underpins NICE recommended CT-SAD. Effective therapy follows from having good understanding of the model and the key processes that drive and maintain social anxiety, which provides an essential map for treatment. The model has been described in detail elsewhere (see Clark & Wells, 1995; Clark 2001; Warnock-Parkes et al., 2022). Therapists can also see Professor David Clark describing the model during this workshop video on the oxcadatresources.com site: https://oxcadatresources.com/ct-sad-for-adults-and-adolescents-clinical-workshop/ (timestamp 13.30). The key processes Clark and Wells described are summarized in the text and figure below. It is beyond the scope of this guide to describe the research evidence for the model, but interested readers will find a useful summary in Clark (2001).

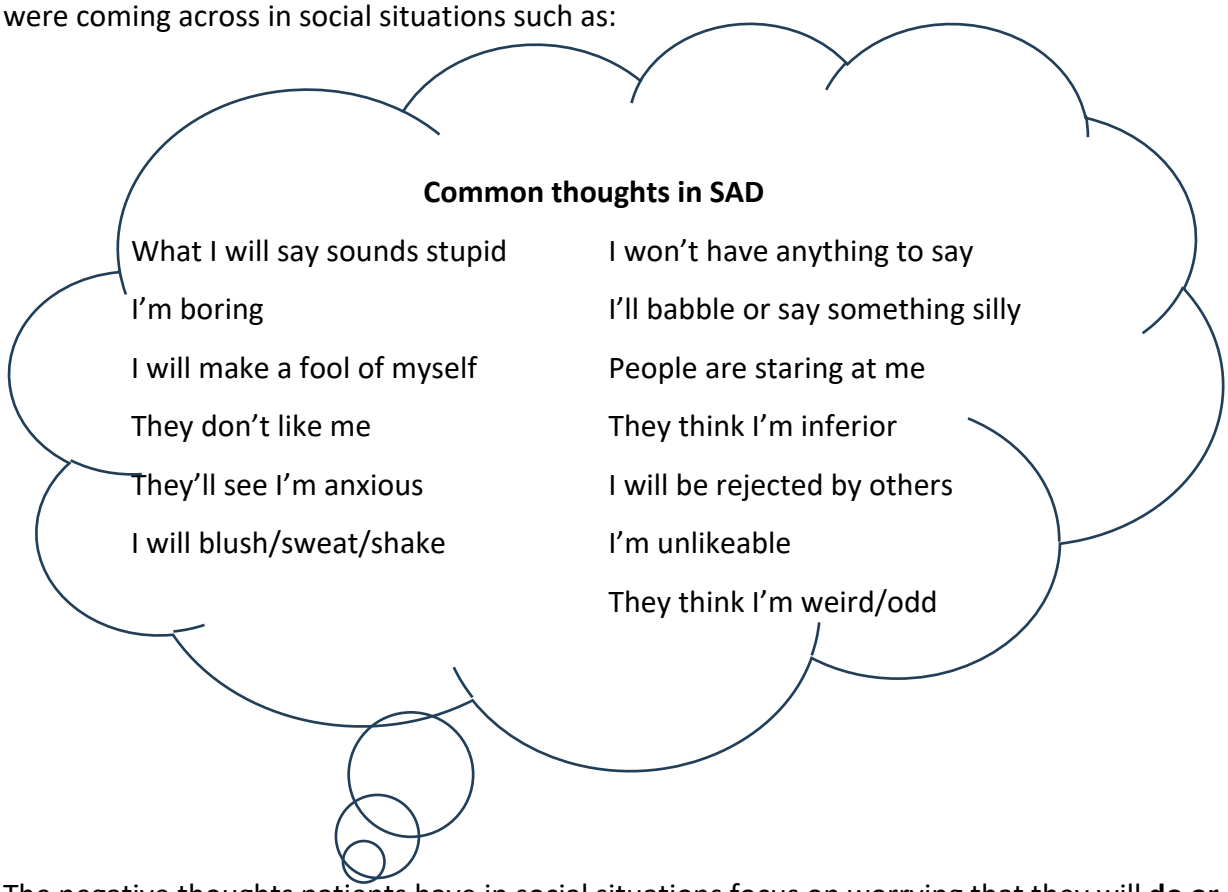
The puzzle of persistent social anxiety

Social Anxiety Disorder is the most persistent of all mental health problems. The mean duration of the current episode of social anxiety was 18 years in a recent clinical trial (Clark et al., 2023) conducted in NHS Talking Therapies Services. The remarkable persistence of SAD is a puzzle. We all live in a social environment. People with SAD cannot avoid people, they usually meet them every day. Repeated exposure to feared situations is a well-established therapy procedure. So why doesn't this daily exposure to others help people overcome SAD? To answer this puzzle, we need to get inside the heads of patients with SAD and understand what is happening when they are in a social interaction which prevents them from benefited from naturalistic exposure. Three things seem to be important. First, what patients are thinking. Second, what they focus their attention on in social situations, and 3) how their fearful thoughts change their behaviour. If we can understand how negative thinking, changes in attention and changes in behaviour combine together, we can understand why social anxiety is so persistent and what we need to change to help people overcome it.

To get to the bottom of the puzzle of SAD, Clark and Wells interviewed many people with SAD to try to get into their heads and work out what was happening in social situations. They discovered three key things.

1) Negative thoughts in social situations

Firstly, that people with SAD tending to experience lots of negative thoughts about how they were coming across in social situations such as:



The negative thoughts patients have in social situations focus on worrying that they will **do or say something**, that will be humiliating or embarrassing and will lead to their rejection by other people (Stopa & Clark, 1993). The most common thought is that other people will see that they are anxious and think that there is something odd about them for that reason. So, in a sense, social anxiety is a fear of fear, or at least a fear of other people seeing your fear. However, as we can see from the bubble above, there are a range of other thoughts as well.

Imagine for a moment that you had some of these thoughts going into a social situation (e.g. speaking up in a meeting, a work party, a meeting with friends). How do you think you would

be feeling? Relaxed? Calm? Or Anxious and on edge? Clearly the thoughts are likely to generate anxiety before and during social interactions.

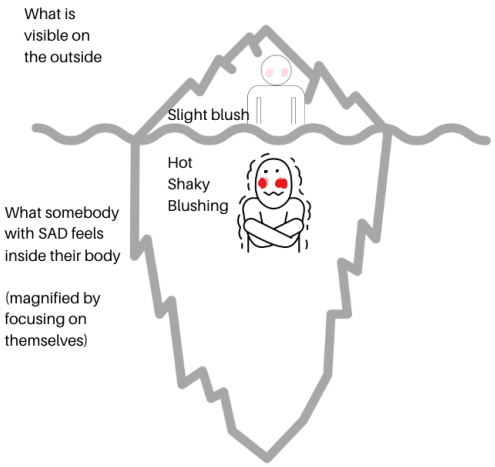
2. Self-focused attention (spotlight of attention turns inwards)

When people with SAD are interacting with other people, a lot of their attention is on themselves, rather than the other person. They focus on how they are feeling and how they think they are coming across, rather than being fully involved in the conversation. This shift to a more self-focused type of attention is probably one reason why naturalistic exposure doesn't work. Even if the conversation goes well and other people show interest in the person with SAD, the chances are that the person won't notice, as they lost in their heads, focusing on themselves. They are also likely to find it difficult to follow the conversation.

Unfortunately, self-focused attention does not just prevent people from benefiting from naturalistic exposure, it also gives them access to internal information (things in yourself) that seem to confirm their worst fears, although it is actually very misleading. What are the misleading types of internal information?

Anxious feelings. One of the most common thoughts people with SAD have is that others can see they are anxious. Clark and Wells asked patients with this thought whether other people had commented that they looked very anxious. Although a few people reported occasionally receiving such comments, most said no. Naturally, Clark and Wells then followed up by asking "if other people have not said it, what makes you think that you look very anxious?" Patients

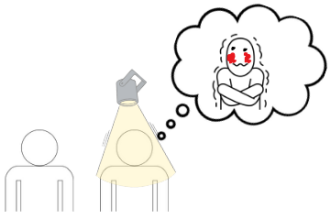
responded "I feel very anxious, so I must look very anxious." This might seem a reasonable conclusion. However, experimental work shows that we tend to look less anxious than we feel and that the difference between how we feel and how we think we look gets bigger the more anxious we feel (Mansell and Clark, 1999). This is not to say that one cannot notice some signs of anxiety and inhibition in people with SAD. However, what one notices is much less extreme than the patient believes.



Negative self-images/impressions. Unsurprisingly, peoples' concerns about how they appear to others lead them to develop images of how they appear. The images involve an observer perspective in which they see themselves as if viewed by other people. Unfortunately, what they see is not what they really look like, but rather their worst fears visualised (Hackmann, Surawy & Clark, 1998). For example, a patient may visualize themselves dripping with sweat and looking bright red, when only a slight blush would be noticeable on the outside, if at all.

Some self-images are experienced similar to a photo or video running in one's head (e.g. 'I see myself clearly shaking like a leaf'). However, many people say that it is not a vivid visual experience, but rather it is a form of implicit knowledge in which they can easily tell you how they think they appear and describe it in detail when asked. Given this point some patients prefer the term 'negative impression' rather than negative self-image.

Felt sense. In addition to misleading feelings of anxiety and distorted self-images/impressions, some patients also report feeling distant from other people and not fitting in during social interactions. They may be talking with a group of individuals but feel that the other people are all together and that they are separate and don't fit in. This felt sense is a consequence of self-focused attention. If one observes oneself from outside, it is easy to feel separate and excluded.



A product of watching yourself so closely is experiencing distorted, negative self-images or impressions based on your feelings. These further reinforce patients' fears.

Origins of negative self-images/impressions. Research shows that for many individuals their distorted negative self-images or impressions link to early socially traumatic experiences (e.g. bullying, being criticized by a parent or teacher) (see Hackmann, Clark, McManus, 2000). For example, a patient who sees themselves sweating and feels like they are about to be humiliated recalls being teased by classmates for having sweat patches when she was presenting in class. It is likely that for some patients these memories were the first time they experienced their negative self-images or impressions. However, for some patients these memories intrude on present day social situations. This is a little like a ghost from the past haunting the patient in the present. They might re-experience feelings from these memories without being consciously aware that the memory has been activated. This is a trauma-related phenomenon termed 'affect without recollection' (Ehlers & Clark, 2000). These feelings from the past can influence how patients perceive present day social situations. Patients can expect the same contingencies from the past to apply (e.g. 'I will be humiliated now, like I was in school'; 'I will mess this up again, just like I did back then').

In social situations patients find themselves in a closed system. They are not paying much attention to the social situation, they are focusing so much on themselves that they do not pick up on many cues from other people (e.g. smiles, nods of agreement etc), but are instead hyper aware of information that seems to confirm their fearful beliefs (their negative thoughts/anxious feelings/negative self-images/impression, or socially traumatic memoires). This certainly helps us to understand why SAD can be so persistent and why simply spending time with others does not help patients overcome their fears. Unfortunately, a further process (safety behaviours) also comes into play.

3. Safety behaviours

A safety behaviour is something that patients do to try to prevent or minimise a feared catastrophe. Such behaviours occur in all anxiety disorders and have the universal consequence of preventing patients from disconfirming their fears. For example, if patients are worried that they may sound stupid when talking to other people, they are likely to think in advance about interesting topics that they might talk about. While speaking, they are also likely to be memorizing what they have already said and comparing it with what they are about to say in order to check it is clever enough. They may conclude that the thing they were about to say is not clever enough and therefore decide not to say it. If the conversation goes okay, the patient is unlikely to benefit from this experience because they think they only got away with avoiding sounding stupid because they prepared topics in advance and carefully censored what they were saying. They therefore had no opportunity to discover that if they had just been themselves and said whatever came into their head, they would have been accepted by others. Similarly, if patients are worried that they might shake while holding objects (e.g. glass of wine, cup of coffee, piece of paper) they grip the objects tightly and monitor how shaky they feel. They may also turn so other people cannot see their hands and the object.

It is important for therapists to be aware that many of the safety 'behaviours' patients with SAD use are mental operations (things they are doing inside their heads), such as censoring what they are going to say, monitoring how they think they are coming across and putting on a front. For example, running through a stock series of jokes at a party to appear confident and prevent

people from asking you questions about yourself. Safety behaviours become habitual and as a consequence may not always be mentioned by patients during a clinical interview. However, we have noted that such behaviours are very likely to be reported if patients have an opportunity to fill in a questionnaire (such as the Social Behaviours Questionnaire) in their own time.

In addition to preventing patients from disconfirming their fears, safety behaviours have a number of other unfortunate consequences.

Additional problems with Safety behaviours

- **Contaminating the social interaction.** For example, a person who is constantly monitoring whether they are coming across as boring may appear to have their mind somewhere else when talking to a conversation partner and therefore not be interested in the conversation. The partner may then respond to this non-verbal cue by being less friendly in return. This is ironic because the person with social anxiety very much wants to be liked by their conversation partner. However, their safety behaviour is inadvertently giving the message that they are uninterested in the partner.
- **Draw unwanted attention to fearful concerns.** Patients often try to cover up signs of anxiety. Paradoxically, the attempt to cover up can elicit unwanted attention. A patient who covers her face when she feels she is blushing draws more attention to herself by doing this. A patient who turns away every time he drinks his coffee for fear others will notice him shaking may appear somewhat weird to his friends.
- **Causing feared symptoms.** Patients attempts to hide feared symptoms can sometimes make the symptoms worse. For example, a patient wearing extra layers to cover sweat then sweats more, or a patient gripping his cup excessively tightly will notice trembling in his arm more.
- **Increasing self-focused attention.** Planning and executing safety behaviours takes up a lot of attentional capacity and as a consequence tends to further increase self-focused attention. For example, when somebody is rehearsing their sentences in advance for fear

of making a mistake, they are completely focused on themselves rather than the conversation and find it hard to follow the chat.

There are two main types of safety behaviours. The first category is *avoidant* safety behaviours. These include things like, keeping quiet, not asking questions, not sharing much about yourself, avoiding eye contact, covering ones face, sitting on the edge of groups etc. The second category is *impression management* strategies. These are things that patients do in an attempt to convey a more positive impression of themselves. For example, making an effort to get your words right, check that you are coming across well, running through a series of pre-prepared jokes and rehearsing interesting stories to share. Both the avoidant and the impression management safety behaviours prevent patients from discovering that their fears are unrealistic and that they will be accepted even without their safety behaviours. Compared to avoidant safety behaviours, impression management safety behaviours are less likely to have a negative impact on the way others respond to patients. The table below gives some example safety behaviours demonstrating how these are idiosyncratically linked to patient's feared concerns.

Key fear	Common safety behaviours
Being boring	Keeping quiet, avoiding speaking up, stay on edge of groups, don't go to parties or large gatherings. Censoring, planning interesting things to say, trying to come across well, self-monitoring.
Appearing stupid	Keeping quiet, avoiding speaking up, stay on edge of groups, don't go to parties or large gatherings. Avoiding revealing not knowing something, censoring self, preparing intelligent things to talk about, monitor how stupid I sound.
Blushing	Avoiding situations that may trigger a blush, such as being centre of attention. Looking down and avoiding eye contact when feeling a blush. Covering face with hands/hair, wearing excessive make up to cover the blush. Avoiding wearing red clothes. Wearing scarves to cover neck or chest.

Appearing weird	Keeping still, trying to avoid attention, self-monitoring, keeping tight control of behaviour, trying to come across well/normally.
Sweating	Avoiding situations that may trigger sweating. Wearing layers to hide sweat, wearing dark clothes, trying to keep cool, wearing patches to absorb sweat, avoiding eye contact, avoiding being centre of attention, avoiding shaking hands, holding arms down by sides, monitor how sweaty I am.
Shaking	Avoiding situations that may trigger shaking. Sit on hands, grip cups tightly, sit very still, avoid eye contact, monitor shaking.

Why do some people experience more negative thoughts and social anxiety in social situations?

Most social situations are ambiguous. Others do not tend to give us consistently positive feedback about our social selves. Think about the last social interaction you had. Did the person tell you "You are fantastic! I love being in your company! You are so interesting and acceptable as a person!"? We are guessing not. Because this is not how social situations work. However, for socially anxious people, they tend to interpret ambiguous things (e.g. somebody they are talking to glancing out of a window mid-conversation) in a negative way. They might jump to the conclusion 'I am boring them' or 'they don't like me'. Somebody without social anxiety might interpret the same behaviour in a very different way. They may not notice it at all or conclude 'they are thinking very carefully about what I am saying', or 'Oh I wonder what has happened outside that is of interest'. So why is it that patients with SAD will jump to a negative conclusion or think negatively about social situations whereas others might not? This is because of their negative beliefs about their social self and the nature of social interactions.

Negative beliefs and assumptions about your social self and the social world

Patients with SAD hold underlying negative beliefs and assumptions about their social self and their social world which make them prone to interpret social situations in a negative way. People with SAD tend to think of social interactions as a performance and assume that they will only be accepted if they perform well. They hold, excessively harsh, rules about what constitutes an acceptable performance. Such as:

- ***High standards for social performance.*** People with SAD hold unnecessarily high standards for what they consider to be an acceptable social performance. For example, 'I must never show signs of anxiety', 'I must always speak fluently', 'I must always be interesting' etc. The problem is that these are difficult to achieve and so a constant source of anxiety.
- ***Conditional rules about what would happen If they did not live up to these standards***. People with SAD also tend to hold conditional rules (If… Then…) about what they need to do to be accepted in social situations. For example, 'If I show signs of anxiety then I will be rejected', 'If I disagree with others, they won't want to know me.'

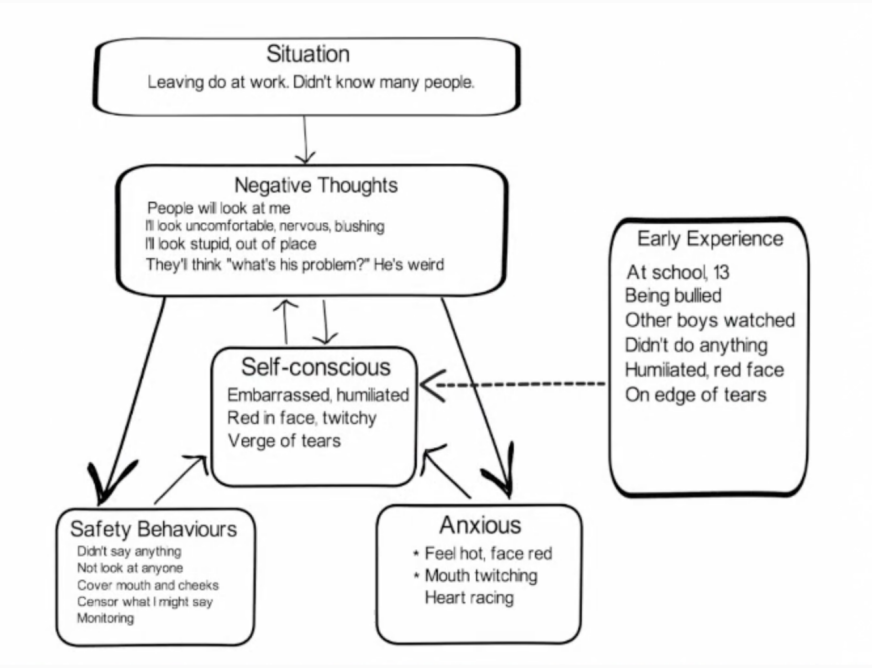
In CT-SAD we want to move patients towards breaking their rules to discover what would really happen if they did so. Understanding what rules patients hold is key as these become sources of powerful experiments. Experimenting with breaking the social rules that patients hold, for example, somebody who believes they must always perform perfection might purposefully make mistake, somebody else who believe they must never show signs of anxiety might shake a little when giving a presentation, is a powerful way to discover when you show your human side to others you are accepted as you are.

Negative beliefs about one's social self

In addition to the rules about what people think is an acceptable social performance, patients also tend to hold generally negative beliefs about their social acceptability. These are held in part because patients do not think that can live up to their excessively unrealistic social rules (e.g. I must never show signs of anxiety/must always be interesting). For example, 'I am weird', 'I am unlikeable', 'I am inferior', 'I am boring'. These act like a lens that patients look at social situations through. Although the person might also find themselves thinking this way before or after a difficult social situation (e.g. in the days after a job interview has gone badly or in the run up to a party), they would be unlikely to hold these beliefs if alone on a desert island and they never had to face another person. For some patients these beliefs have been present since the onset of

their social anxiety and for others these have developed after years of struggling with social anxiety. These can be thought of like core schemas that are activated in social interactions (Padesky, 1994). **These negative beliefs about the person's social self are a core part of SAD** that are addressed in CT-SAD, it is not a separate problem requiring a different treatment. All the interventions in CT-SAD are used to change them.

The figure below shows an example of the Clark and Wells cognitive model that has been drawn out with a patient.



Consider the individual's culture and circumstances when mapping the model and planning treatment. Good cognitive therapists try to work out what is going on inside the mind of their patients. When looking at the thoughts and beliefs identified in any patient's model clinicians need to consider if any person would feel anxious if they had the same cognitions. If the answer is no, then this could indicate that something is missing about the meaning of the thoughts. This could be to do with the cultural context of the person. It is important to always be curious as a cognitive therapist when finding out about the lens the patient views the world through, especially when working with patients from of a different ethnicity or culture. For

example, one patient who spoke English as a second language and was concerned about acceptance in the country feared 'I will make a mistake in English and people will think I'm stupid and won't want to know me.'

Optional Therapist exercise

From experience in teaching, we have found that some people find it helpful to reflect on a time when they felt anxious in a social situation and map out the thoughts, images and safety behaviours they had in that situation. It can help deepen understanding of the cognitive model. You may want to try this out. Think of a social situation when you felt embarrassed or anxious in your own life (e.g. a job interview, giving a presentation). Try filling in some of the boxes in the cognitive model for this situation. See Appendix 1 for a blank version of the cognitive model.

Aims of Treatment derived from the cognitive model

CT-SAD has been developed to target the progresses in the cognitive model. The treatment aims to help patients:

1) **Develop an individualized version of the cognitive model** which has the same boxes and arrows as the generic model but in which the content relates to the patient's particular concerns and behaviours in their feared situations.
2) **Discover for themselves the unhelpful effects of focusing on themselves and using safety behaviours** by engaging with an experiential exercise early in treatment when they use and then drop these strategies in a social interaction and compare their experiences. As the aim is for the person to discover the unhelpful effects through experience, the therapist does not explain what is likely to happen in advance.
3) **Update negative self-images and impressions** by helping patients to compare how they think they appear with how they actually appear using video and still image feedback. This helps them to discover that the feelings they are using to decide how they appear are not a reliable guide about how they are really coming across to other people.

4) **Train external focus of attention** to enable patients to become fully involved in social interactions and able to test their negative beliefs in those situations, rather than relying on their unhelpful self-perceptions.
5) **Test negative social fears and beliefs** by together planning and carrying out a range of individualised **behavioural experiments** in most sessions and for homework to help patients discover that when they drop their self-focused attention and safety behaviours others do not respond to them in the negative way they predict. An important part of each experiment is guided discussion exploring what the outcome means about how the patient comes across to others and the patient's social acceptability more generally Experiments purposefully doing/saying some of the things the person is fearful of (**decatastrophising**) later in treatment are also a powerful way of freeing patients from their fears and shifting their negative beliefs, rules and assumptions about themselves and their social world.
6) **Breaking the link between past social trauma and the present** using memory focused techniques such as Then Vs Now and Imagery Rescripting to prevent past adverse social experiences influencing feelings and behaviours in the present.
7) **Spotting and dropping other maintaining processes** such as excessive worry in advance of social interactions, post event rumination and harsh self-criticism.

Part 2: Assessment Considerations

How does SAD typically present?

SAD is an excessive and persistent fear of doing or saying something that you fear will lead to your embarrassment, humiliation and/or rejection by others. The range of situations that trigger social anxiety vary considerably from person to person. A fear of public speaking is very common but for many people it is possible to arrange one's life so that public speaking is not necessary. As a consequence, most people who present for treatment also fear a wider range of social situations. These can include: meetings strangers; informal conversations at work, family events, the pub and restaurants; talking on the phone or in video conferences; speaking up in groups, dating, using public toilets, going to a party, sharing on social media etc.

Most people you will see in clinic with SAD will have experienced the problem for many years before seeking treatment. In a recent study in NHS Talking Therapies Services the average duration of the current episode of social anxiety was 18 years (Clark et al., 2023). SAD typically starts in childhood or adolescence but a few people may develop it later in life. Onset can be gradual and insidious. It is common for people to say 'I always felt shy'. However, for a fair number of people moving from shyness to a clinical problem may have been triggered by some socially traumatic events, such as bullying or humiliation in front of peers.

Helpful assessment questions

Helpful assessment questions include

"Is feeling anxious and tending to avoid social situations the main problem you want help with?"

"When you feel anxious in social situations, do you mostly worry that you will come across to other people in a way that will be embarrassing or humiliating?"

"What do you want to achieve by the end of therapy?" (check these goals are linked to social situations)

Assess the person's social network. Does the person have friends that they can do things with? What is the range of their social contacts, both at work and outside? This is valuable information for planning homework assignments. If the person's social network is very restricted, there will need to be a strong emphasis on in-vivo social assignments in therapy sessions.

Assessing Comorbidity

Differentiating between SAD and other anxiety disorders

Feelings anxious in social situations can also be a feature of other anxiety disorders so it is important to consider differential diagnosis. For example, people with Body Dysmorphic Disorder often feel anxious in the presence of others but this is because they are dissatisfied with some aspect of their physical appearance (disliking their nose, their face overall etc.), rather than being concerned that they will **do or say something** when they are anxious which will lead to their embarrassment/humiliation/rejection (for example, by blushing, sweating, shaking, coming across as boring or weird, or saying something stupid etc.). The table below illustrates how the social fears in SAD differ from the social concerns that can be present in other anxiety disorders.

Social fears in SAD compared to other anxiety disorders	
When the main problem is…	**Common fears in social situations are…**

Social Anxiety Disorder	Focused on being judged by others for something you do/say or for showing signs of anxiety. (e.g. 'I'll look anxious, I'll blush, sweat, shake, appear foolish, say something boring or stupid, freeze'…)
Body Dysmorphic Disorder	Focused on physical aspects of the person's appearance, not social performance (e.g. 'I hate my nose'). Social fears will focus on appearance (e.g. 'others will think I'm ugly').
Vomit Phobia	Focused on vomiting (e.g. 'I will start vomiting and I won't be able to stop, will feel out of control'). The person may also be concerned about what others may think of them if they vomit but the social concerns are restricted to fear of vomiting.
Panic Disorder	Focused on fear of having a panic attack, rather than social situations *per se.* Fearful thoughts focus on the physical or mental catastrophes that people think may happen in an attack (e.g. 'I will faint/have a heart attack/die/stop breathing/go mad'). There may be some secondary thinking about how people might respond if they see one having a panic attack (e.g. 'others will crowd around me if I faint') but that is not the primary concern. SAD would only be considered the primary problem if the person's panic attacks are entirely restricted to social situations and/or anticipation of such situations.
Specific fear of losing control of bladder or bowels	Focused on losing control of bladder/bowls. People may fear what others would think about this (e.g. 'If I wet myself others will think I'm disgusting') but their social concerns are restricted to incidences where concern about loss of control of the bladder or bowels occurs.
Generalized Anxiety Disorder	Worries cover a wide range of topics (work, bills, family, health, future etc). May include some social worries but these will not be the primary focus.

Obsessive Compulsive Disorder	Some obsessions may occur more around other people (e.g. others are contaminated, I might hurt other people). Content of obsessions can at times be socially related (e.g. 'I will shout something racist'), but distress is focused on intrusive, upsetting thoughts, impulses, or images (obsessions) and acts to try to counteract/put them right (compulsions).
Post Traumatic Stress Disorder	People with PTSD may describe feeling anxious in the presence of certain people, but their fears specifically relate to their traumatic experiences or the aftermath of the trauma. Examples include when patients misinterpret their PTSD symptoms (e.g. 'others will think I'm mad if I have a flashback'); experience an overgeneralized sense of danger (e.g. 'Others will attack me'); are ashamed (e.g. 'Others will look down on me because of what happened in the trauma'); or have permanent physical injuries (e.g. 'Others think my scars are disgusting').

Differentiating between SAD and depression

It is common for people with SAD to also be depressed when they present for treatment. Before progressing with the treatment plan it is important to determine the relationship between the SAD and the depression.

Establish a timeline. A good way to start will be to establish the timeline of both complaints. One might start by summarising that it seems you currently are experiencing two problems. You feel anxious talking to other people are tending to avoid social interactions when you can (social anxiety). In addition, your mood is low, you are having difficulty motivating yourself and are feeling quite hopeless (depression). When the patient agrees with this summary, one can then ask 'when did you start having difficulty talking to other people? Did you become anxious in social situations before you became depressed or has this largely only been a problem since

you became depressed? If the patient answers, that talking to other people has only been a serious problem since they became depressed, social anxiety is likely to be secondary to the depression, reflecting the general loss of confidence that often accompanies depression. In such cases pressing on with treatment of depression is likely to resolve the social anxiety difficulties without the need for a full social anxiety treatment. However, if the person reports that they were frequently anxious in social situations before they became depressed, and this was a disabling condition, then the person has a primary SAD which will require treatment in its own right.

Establishing whether concurrent depression is secondary or a separate problem. If the person indicates that they were experiencing SAD before they became depressed, the next step involves determining if the depression is simply secondary to the SAD, with the person becoming disheartened about the way the SAD is interfering with their life, or the depression is a separate distinct clinical condition. The easiest way to determine this is to ask the **magic wand question** 'If I had a magic wand, and if I waved it and you no longer felt anxious talking to other people, do you think you would still be depressed?'. If the person says probably not, then it is likely that the depression is secondary to SAD and would improve if SAD was treated.

Assessing whether the severity of the depression would impact on the treatment of SAD. If the assessment identifies that the patient has secondary depression, the clinician should enquire whether the severity of the depression symptoms would impact on the patient's engagement with CT-SAD (e.g. 'Is your mood so low that it would mood prevent you from attending treatment for social anxiety, focusing on the treatment or carrying out therapy related tasks?'). If the answer is yes, then the client might benefit from some initial treatment focused on improving their mood (e.g. behavioural activation).

Autism and SAD

Reported prevalence of SAD in autistic adults is high (Spain et al.,2016) but can be complicated by diagnostic overshadowing. For example, an autistic adult might report avoiding social situations due to the unpredictable nature of the situation or sensory sensitivity that makes them feel anxious and uncomfortable. It can be helpful to explore whether any anxiety in social situations an autistic person experiences is driven by characteristics of their autism and/or a disproportionate fear of social judgement from others related to something they would do/say. If the anxiety they feel in social situations is only related to autistic characteristics (such as sensory sensitivity/ preference for routine and predictability etc.) without also having a disproportionate fear of judgement, this indicates that the primary problem is not SAD. However, if the person also describes social fears that they will do or say something that might lead to their embarrassment, humiliation or rejection then SAD might also be present and benefit from treatment using this approach.

Part 3: CT-SAD Treatment Guide

Evidence base for CT-SAD

CT-SAD is based on the Clark and Wells (1995 cognitive model) and is one of two high-intensity cognitive behavioural therapies that NICE (2013) recommends as first-line treatments for the disorder. This recommendation is based on a series of clinical trials conducted in the UK, Sweden, Norway, Germany and Japan, which have shown that CT-SAD is superior to a wide range of other interventions including exposure therapy (Clark *et al*., 2006), group cognitive behaviour therapy (Ingul *et al*., 2014; Mörtberg *et al*., 2007; Stangier *et al*., 2003) interpersonal psychotherapy (Stangier *et al*., 2011), psychodynamic psychotherapy (Leichsenring *et al*., 2013), selective serotonin re-uptake inhibitors (Clark *et al*., 2003; Nordahl *et al*., 2016), medication-based treatment as usual (Mörtberg *et al*., 2007; Yoshinaga *et al*., 2016), pill placebo (Clark *et al*., 2003) and psychological placebo (Ingul *et al*., 2014).

Number of sessions

The treatment is recommended to be delivered in up to 14 weekly 60-90 minute therapy sessions over 3-4 months. In our experience some patients may get improvement quickly, but most require a full dose of treatment to recover from SAD. In our clinics we have also found that patients benefit from a booster phase. We have typically offered a further 3 sessions monthly after the initial treatment phase to help consolidate and build on learning.

Setting up Treatment

It is optimal to deliver CT-SAD in person, but the treatment can be delivered remotely. For specific guidance on delivering CT-SAD remotely see our clinical guidance paper (Warnock-Parkes et al., 2020).

Establishing a good working relationship

The therapist is a phobic object Treatment of SAD can be complicated by the fact that patients fear social situations and as a stranger the therapist could be viewed as a phobic object for the patient, particularly early in therapy. We often use the analogy of a spider phobic going to see a tarantella for therapy. This can have several knock-on effects. First, some patients 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 patients' fear driven safety behaviours (e.g. a patient who fears being judged as stupid may say little during early sessions).

Second, the intense nature of a therapy session (sitting opposite a stranger, talking about personal things the patient may feel ashamed about) can be challenging for patients with SAD and may increase their feelings of self-consciousness. Usually when a patient 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 patient more directly and adopt a warm, empathic stance. This response can make patients with SAD feel even more self-conscious. For this reason, therapists need to be sensitive to eye contact and perhaps reduce eye contact at such moments to help the patient 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 patient can simultaneously view. Looking together through questionnaires the patient has completed (see below) can also help to prompt and obtain more information if patients are finding it hard to talk openly early in treatment.

Finding conversational partners to assist in treatment

Delivering CT-SAD effectively replies on in-session exposure to social situations to test patient's fears in behavioural experiments, and this can be challenging at times for therapists to set up and can require some advance planning ahead of sessions. When experiments remain brief (5-10 minutes) we have found many colleagues who are happy to have a break in their day and join your session to assist in an experiment. Whether working in person or remotely, we recommend having a network of colleagues in your service who are happy to be approached to

take part in brief in-session social conversations (either in person, remotely via video camera link or telephone. Include staff who might be more readily available (e.g. administrators, research assistants etc). We have found it helpful to set up an email or whatsapp group of willing participants who could be called upon, particularly when working remotely. See later guidance on helpful instructions to give conversational partners.

Recording therapy sessions

Video feedback is an effective component of CT-SAD and is used frequently throughout therapy to help update distorted negative self-imagery. Given the nature of social anxiety, patients can become self-conscious about being recorded and so it is best to make video recording a routine part of weekly sessions and obtain consent to do so at the start of therapy (see Warnock-Parkes et al., 2016, pg 5 for a description of how to set this up). As it is hard to remember the details of any 60-90 minute treatment session, we also encourage patients routinely audio record their sessions and reviewed these for homework to help consolidate new learning. As patients with SAD are self-conscious and can be habitually self-critical it is important to give a health warning about listening to session recordings to 'listen to the sessions as if it is two strangers talking and if you find you are being self-critical I suggest you stop listening and discuss with me in the next session.'

Using Questionnaires to guide therapy

Questionnaires are an important tool in monitoring outcomes and guiding treatment by spotting key problematic beliefs and maintaining processes that need to be targeted. In addition to any routine service questionnaires, include a measure to track mood such as The Patient Health Questionnaire-Depression scale (PHQ-9; Kroenke, Spitzer and Williams, 2001). All questionnaires are available to download from oxcadatresources.com. The table below outlines the SAD specific questionaries we recommend using in treatment.

Table showing recommended questionnaires to help guide CT-SAD and their frequency

Measure	Variables measured	Recommended Frequency
Symptom measures		
Social Phobia Inventory (Connor et al., 2000)	Outcome measure of severity of social anxiety	Each session
Process measures		
Social Cognitions Questionnaire (SCQ; Clark, 2005)	Negative cognitions in social situations (e.g. I am blushing) (frequency and belief)	Each session
Social Phobia Weekly Summary Scale (SPWSS; Clark et al., 2003)	Avoidance, self-focused attention, anticipatory anxiety, post-event rumination	Each session
Social Behaviours Questionnaire (SBQ; Clark, 2005)	Safety behaviours used in social situations	Start, middle* and end of therapy
Social Attitudes Questionnaire (SAQ; Clark, 2005)	Common beliefs about the self that fall into three categories: excessively high standards for social performance, conditional and unconditional beliefs	Start, middle* and end of therapy

Mid-treatment review

A standard part of CT-SAD is to give a whole range of process measures at the mid-treatment point to identify any beliefs and safety behaviours that are still active and any situations that continue to be avoided so that these can be targeted in the second half of therapy. Time is set aside during this mid-treatment session to look at these measures in detail and develop a collaborative plan with the patient to ensure these are addressed in the remaining sessions.

Key treatment procedures in CT-SAD

We will now describe some of the key treatment interventions used to target all the processes in the Cognitive Model of SAD. The table below summarizes these and when they are most

typically introduced in treatment if working with somebody whose primary problem in SAD. Please note cognitive therapy is always tailored to meet individual patient needs and this order is varied accordingly.

Table showing when CT-SAD core interventions are most typically introduced in therapy

CT-SAD Core Interventions	**Most typically when introduced in therapy***
Drawing out and individualized version of the cognitive model	Session 1
Self-focused attention and safety behaviours experiment	Session 2
Video feedback of the self-focused attention and safety behaviours experiment	Session 3
Attention training and introducing behavioural experiments	Session 4
Behavioural experiments dropping safety behaviours and self-focus	Sessions 5-14 (weekly in session and for homework)
Surveys to find out what others really think	From session 5 onwards
Decatastrophizing experiments	Typically done later in therapy after several experiments dropping self-focus and safety behaviours have been done and the person's confidence is growing
Addressing pre/post event processing and self-criticism	Done as needed
Memory focused technique: Then Vs Now discrimination training	Done as needed, typically later in treatment, if memories from past social trauma are impacting on the present
Memory focused technique: Imagery rescripting	Done as needed, typically later in treatment, if memories from past social trauma are impacting on the present and continue to be problematic after Then Vs Now Discrimination training
Therapy Blueprint	Given out before therapy ending and reviewed in last treatment session

**Please note cognitive therapy is always tailored to meet individual patient needs and this order is varied accordingly*

1) Identifying treatment goals

Treatment starts with developing some clear, realistic, observable goals such as 'To be able to phone and book an appointment', 'To go to the pub with a friend and not worry about what people think of me when I'm there', 'To ask a question in a tutorial at University'. Many patients come telling us they want to 'never feel socially anxious again', which, given all humans will feel social anxiety at times, would be unrealistic. Here we gently encourage the person to consider what they would be *doing differently* if they felt more socially at ease and to focus on these more observable goals.

2) Developing an individualized version of the cognitive model

The first session is predominantly devoted to developing a personalized cognitive model, drawing upon a recent anxiety provoking social situation (for example see Figure below). A blank version of the model is also available in Appendix 1. The person having treatment has a chronic negative and distorted sense of how they come across socially. They think they come across in a socially unacceptable way and that others are judging them negatively. The model provides an alternative and less threatening way of thinking about the problem: that the patient has an overly negative way of thinking/seeing themselves socially that is maintained by overly focusing on themselves in social situations and using a range of understandable safety behaviours. However, the therapist's job during the first session is not to convince the patient of this alternative explanation. It is to get into the patient's head and get a good description of what happens in an anxiety provoking social situation. It is during the sessions that follow during the experiential exercises that the person will discover for themselves how the cognitive model works in practice.

To reduce feelings of self-consciousness that are coming in SAD patients are given time to think about her thoughts and feelings as the therapist draws the model on the whiteboard (see image below) or via screenshare if done remotely.

A video illustration of developing the cognitive model in SAD is available at oxcadatresources.com.

The transcript below gives an example of how this was done with one patient. The diagram drawn on the whiteboard of their individualized cognitive model is also presented below:

The therapist starts by identifying a suitable social 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 post-docs was leaving. Everyone went into the seminar room and she was given the leaving presents. There was champagne and 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 at work. Who was leaving?

P: Alice

The therapist then proves for the patient'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"

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 inferior".

T: Great. That's very good. It can be difficult to spot ones thoughts but you've managed to get hold of quite a number

The therapist next establishes the link from negative thoughts to anxious feelings:

T: (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?

P: Yeah, it makes me feel worse.

T: 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?

P: Yeah, I feel as if I am blushing and twitching (patient points to his mouth).

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

P: I feel hot.

T: Hot. Do you also feel your heart racing?

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

T: So that's not something that worries you very much?

P: No

T: Do you get your stomach churning?

P: Yeah, I feel sick T Anything else? Do you feel dizzy?

P: No.

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

P: Yeah

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

P: Yeah T OK so we will mark them asterisks.

The therapist introduces the concept of safety behaviours and establishes the link between negative thoughts and safety behaviours:

T: 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).

P: I wouldn't say anything.

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

P: Yeah T And is that what you did on this occasion?

P: Yeah T Any other things that you do?

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

T: Anything else?

P: I don't look at people.

T: What do you look at instead? Do you put your head down or do you just stare straight ahead? P I'm not really concentrating on what I am looking at, I am just concentrating on my thoughts T So another thing you are doing is concentrating on yourself. Could we call that "becoming self-conscious" – is that the right term for you?

P: Yeah

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

P: Yeah.

T: 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?

P: I put my hand over my mouth and cheeks.

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

P: 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.

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

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

T: 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?

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

T: 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?

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

T: 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?

P: What, by observing other people?.

T: 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.

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

T: So you are sort of telling yourself, "I look stupid" and are not really checking out other people's reactions much?

P: Yeah

T: Any other safety behaviours we've missed out?

P: Avoid the situation completely.

The therapist returns to self-consciousness and identifies the contents of the patient's self-image and self-impression.

T: 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?
P: Physical symptoms, particularly the blushing and trembling.
T: OK, so you are very aware of the feelings we've marked with asterisks. What is your impression of how you appear?
P: I appear humiliated and embarrassed.
T: 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.
P: Sometimes I imagine what I look like.
T: What does that imagining look like?
P: 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, its 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.

The Therapist summarizes the Self Image/Impression and establishes links to the Self Image/Impression from both Anxious Feelings and Safety Behaviours and 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, do 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?

P: Just that I was pretty convinced that I was going to get anxious before I went into the room.

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

P: Yes

T: 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 any early traumatic social experiences and the content of the self-image/self-impression that the patient currently experiences in social situations (e.g. in this case a traumatic incident at school associated with a marked worsening of his social-evaluative concerns when he was a child). Identifying such a link can help patients 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.

T: Can I ask you a little more about the image you had of yourself at the leaving do? Have you had that image before?
P: Yes, I often see myself that way when I'm anxious in social situations.
T: When is the first time you had an image of yourself looking red, face twitching and on the verge of tears?
P: 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.
T: So do you think the image you get now is based on that experience, sort of like a ghost from the past?
P: Maybe.
T: OK, lets 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 adults and our life is different. So, we'll probably want to look at how realistic the image is now when we start treatment.

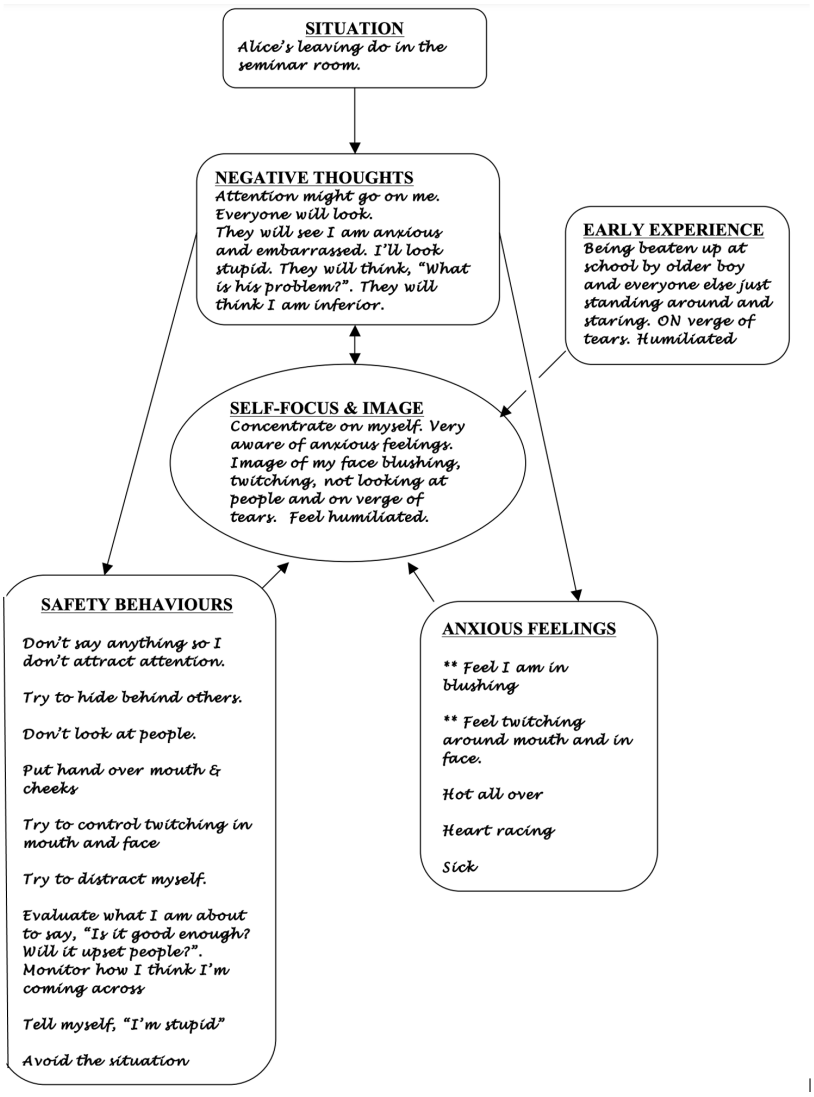
Summary of helpful questions for developing the patient's individualized cognitive model

Identifying negative thoughts	'In this situation, what were you worried would happen? When you thought you were sweating what did you think people would make of it?' It is also worth probing for negative self-evaluations if patients do not spontaneously mention them: 'Many people who feel anxious in social situations find they sometimes have upsetting thoughts or feelings about themselves socially, for example seeing

	themselves as unlikeable, weird, or inadequate etc. Did you have any of these kinds of thoughts about yourself in this situation? Or have you at other times?' Questionaries such as the SCQ and SAQ are used here to amplify the information.
Identifying anxiety symptoms	'When this was going through your mind how were you feeling?'
Identifying safety behaviours	Did you do anything to try to prevent people from noticing… [insert patient's fear]? Is there anything you did to try to ensure you came across well? The Social Behaviours Questionnaires is used add additional safety behaviours patients commonly use.
Identifying focus of attention	'When all this was going through your mind was your attention focused mostly on the conversation, or on yourself and how you were coming across?'
Identifying negative self-imagery	'Did you have an image, impression or sense of how you thought you were coming across at the time? Can you describe how you imagined you looked to others at the time? If I was a film director telling an actor to play you in these moments, what would I tell them to do? How would I tell them to look/behave? '
Identifying relevant early experiences	When was the very first time you recall having that image or impression of yourself socially?

The model continues to be developed across therapy. New thoughts and beliefs that are spotted are added as treatment progresses. Excessively high standards and conditional beliefs for social performance (e.g. "I must always appear interesting and intelligent"; "if I disagree with somebody they will not want to know me") might be added in subsequent sessions rather than included early on.

An example personalized cognitive model drawn out with a patient in session 1 (based on the above transcript) is shown below:



Key messages that patients might take away from developing the model. It can help to ask the person about the outcome of the social situation they have described (e.g. did the people totally reject you as you predicted?). If they say no, then this can be used to explore: "Your thoughts were telling you that this was going to happen. So I wonder, where does this tells us might be the more threatening place to be: the social situation or inside your head?". This helps the patient to develop a key take home point that: 'The problem might be that I'm too much in my own head', 'maybe my head is the most threatening place to be'.

Suggested Homework after developing the cognitive model. Patients take a copy of their model and are asked to map out another using a second social situation for homework.

Key points: developing the individualized cognitive model

- The first session of treatment is devoted to collaboratively developing the patient's individualized model
- Use a recent example and amplify it with others
- Take time and use a white board or screen share to reduce the intensity of the interaction as patients may feel self-conscious
- Use the questionnaires (such as the SCQ/SBQ) to prompt the patient for relevant beliefs and behaviours
- Try different ways to ask about negative images/self-impressions, as many patients describe this as a felt sense rather than clear image
- Look at the model like a puzzle – all the pieces should fit together. Do the safety behaviours seem to fit the beliefs the individual has? If not, are you missing any?
- The patient takes a copy of their model away and tries mapping another social situation over the week for homework

3) The Self-Focused Attention and Safety Behaviours Experiment.

What is the aim of this experiment?

Discovery in therapy happens best through action. This is much more powerful than giving psychoeducational information alone. Furthermore, patients with SAD have usually suffered with the problem for most of their lives and so simply being told that focusing on themselves and using their safety behaviours maintains the problem is unlikely to convince them. Therefore, to discover more about how the cognitive model works in practice and the adverse effects of self-focused attention and safety behaviours on social anxiety, we use an experiential exercise. This exercise is typically done in the second session of CT-SAD. In this exercise the patient takes part in two social interactions (most typically having a conversation with a stranger, such as a colleague of yours from your service, who comes into the session briefly). These two conversations are done under two different conditions: first, while focusing her attention on themselves monitoring their performance and using safety behaviours (such as preparing what to say). Second, while focusing externally, getting lost in the interaction (rather than evaluating themselves) and dropping their safety behaviors (e.g. speaking spontaneously).

When and how do we introduce this task?

Please note, to reduce anticipatory anxiety, patients are not informed in advance of the session that this exercise would be taking place. They are also not informed in advance of the task that they will be having two conversations, the second conversation is only introduced and set up after the first has ended. This is how we might typically introduce this task:

Therapist: To find out more about the impact of focusing on yourself and using these behaviours in social situations, we find it most helpful to try a small social task in order to bring on some anxiety, but not too much. Would you be willing to give that a go?

Patient: Maybe… What sort of task?

Therapist: Usually speaking to somebody you don't know, for just a few minutes. If I suggested something like that, how anxious would it make you from 0-100%?

Patient: Pretty anxious, about 60%

Therapist: I can imagine it would make you pretty anxious, but for this task we want to bring on some of the anxiety so we can learn from it and I think it could be quite helpful. What would your main fears be about having this conversation with a stranger?

What kind of social tasks are helpful?

We find that bringing in a stranger to have a brief 5 minute conversation (usually a colleague working in the service) will activate enough anxiety for most patients to learn something new. The colleague is asked to treat the interaction like they are meeting somebody new in day to day life. A topic is usually given by the therapist to start the conversation (e.g. what you both like about living in London, favourite holidays you have been on etc). The person who joins the session is not told about the patient's personal fears. The aim is to recreate a day to day social interaction as best as possible (see helpful instructions to give the person who is joining your session below). The interactions will be recorded to use in video feedback in the subsequent session and so the therapist must check that the person joining the call is happy to be recorded.

My patient says speaking to a stranger would not make them anxious at all. A minority of patients may say this would not make them anxious at all (e.g. if they predominantly fear presentations/large social groups). In these cases explore with the person what would activate enough anxiety that we could learn something from. This might be standing up and doing a short talk to you and another person, or to a virtual audience (link for these available at oxcadatresources.com).

My patient says speaking to a stranger would be too difficult for them. A small minority of patients will say that the idea of speaking to a would make them so anxious (e.g 90/100%) that they would feel totally unable to do it, even after the therapist has discussed ways that this could be made more possible (keeping the conversations very brief and giving reassurance that the therapist will remain in the session throughout). In these cases the therapist can play the role of the conversational partner.

Alternatives above may also be necessary on occasions when the therapist might be practically unable to find anybody to come into the session.

Helpful Instructions to give a conversational partner

We want to recreate an everyday social interaction as much as possible when bringing others into the sessions. Helpful Instructions to give conversational partners invited into the session include:

- Have an everyday conversation
- Be kind and friendly – treat the other person the way you would want to be treated
- Don't look for signs of anxiety, because that's not what we normally do in conversations
- If the conversation partner has psychological training, they should try to suspend this – we want an 'everyday' social interaction, not a clinical one
- Try to imagine this was someone you met for the first time in day-to-day life (e.g. having a chat over a cup of coffee)

Instructions given to the patient during the self-focused attention and safety behaviours experiment

As this experiment is all about the person discovering for themselves how social interactions can feel different when they drop their self-focused attention and safety behaviours, it is key that the patient is clear on what they are doing during the two interactions.

In the first conversation (using self-focus and safety behaviours), we might say: "Put the spotlight of your attention onto yourself. In the chat constantly monitor 'how am I coming across?'. Focus on yourself, rather than the chat." A couple of typical safety behaviours the patient uses that are linked to their fears about talking to the stranger elicited and they are encouraged to use those (e.g. a person who fears coming across as stupid if he does not rehearse all his sentences in advance is instructed to do that).

In the second conversation (dropping self-focus and safety behafviours), we might say:

"Really try to get lost in the chat. Move your spotlight of attention from yourself onto the other person. Imagine they are the most interesting person you have ever met. Really try to focus on them rather than yourself. This will be hard and your attention will naturally want to come back onto you but try to notice if it does and gently bring it back onto the other person again."

Practice dropping self-focus and safety behaviours between the two conversations. The point of this exercise is to help patients feel the difference between having a social interaction when they are focused on themselves and using safety behaviours (when they feel anxious and self-conscious) and then when they are more lost in the conversation and dropping their safety behaviours (when they feel less anxious and self-conscious and less concerned that they are coming across negatively. So the experiment will only work if the person has a notable difference in the amount they used/dropped her safety behaviours and internal self-focus between the two conversations. To ensure this happens, we recommend the therapist has a short role play conversation in between the two conversation, practicing dropping self-focused attention and safety behaviours.

Get ratings after both conversations. To help compare the patient's experience of the two different conversations, several 0-100% ratings are taken immediately after each conversation including:

- How much was your attention focused on yourself and how you were coming across?
- How much were you using your safety behaviours?

(Note - these first two ratings are important in order to check that the experiment worked and the person was able to drop their self-focus and safety behaviours in the second conversation)

- How anxious did you feel?
- How self-conscious did you feel?
- How much did you think x/y [patient specific fears, e.g. I came across as boring, I was shaking etc] happened?

To facilitate comparison, a two-column table is drawn up. A blank copy that can be edited for the person you are working with is in Appendix 2. A patient example of how this might look this is presented below:

	Conversation with self-focused attention and safety behaviours	Conversation externally focused attention and dropping safety behaviours
How much did you use your safety behaviours?	100%	30%
How much was your attention focused on yourself and how you were coming across?	100%	20%
How anxious did you feel?	100%	30%

How self-conscious did you feel?	100%	30%
How anxious did you think you looked?	100%	40%
How much did you think you looked sweaty?	80%	10%
How much did you think you came across as different/weird?	100%	20%
How much did you think you were boring?	100%	30%

Discussing the ratings. If the experiment worked well, examination of both sets of ratings helps the person discover that they felt less anxious and had a better impression of how they came across when they were more lost in the conversation and not using their safety behaviours:

Therapist: What do you notice looking at these two sets of ratings?

Patient: The second conversation was so much better – I felt that at the time actually

Therapist: Interesting, so what do you make of that?

Patient: Well, I guess I feel much better when I'm not in my head, its not good to be in my head or thinking about what I'm going to say. In fact, the second time it flowed much better.

Therapist: So does this give you any clues about how to overcome your anxiety?

Patient: Get out of my head, to try and go with the flow. I'm definitely going to try that this week.

If patients conclude that they felt better in the second conversation because they had met the person before a third conversation could take place whereby the patient increases their self-focus and uses their safety behaviours again. This usually demonsrates that despite meeting the same person for a third time their ratings increased.

These conversations need to be recorded as they will be used in the following session to provide some video feedback to help update the patient's negative self-image/impression. Be

sure that all people in the interaction are captured on camera. Also after the conversations ask the other people your patient spoke to to complete a feedback form. Guidance on this is found below.

Video illustrations of carrying out the self-focused attention and safety behaviours experiment are available at oxcadatresources.com

Key Points: Self-focused attention and safety behaviours experiment

- This is a powerful experiment done early in therapy to help patients discover for themselves the negative effects of self-focused attention and safety behaviours.
- To reduce anticipatory anxiety it is best not to give advance warning about this experiment prior to the session.
- Most patients are willing to have a short conversation with a stranger and this would elicit sufficient anxiety to be a useful learning exercise. Adaptations are used if not.
- Some short practice in between the two conversations (talking to the therapist while trying to drop safety behaviours and self-focus) makes it more likely that the patient will be able to have the second conversation in a different mode.
- The key take home point we want patients to leave with is that they feel less anxious and like they come across better when not using so much self-focused attention and safety behaviours.

4) Other Person Feedback

Getting helpful feedback from people your patient speaks to as part of their therapy provides important objective evidence about how your client comes across to others. Hopefully the client will find out that the person they spoke to had a positive overall impression of them and that their particular fears (e.g. that they came across as boring, blushed, sweated etc.) did not stand out to the other person. This can be extremely helpful information. Sometimes clients use words to describe themselves that are highly unlikely to be the conversation partner's impression of them (e.g. inadequate, inferior). Again, it can be extremely helpful to know that the conversation partner did not think this.

Feedback should consist of general comments from the conversation partner about their experience of talking to your client, as well as ratings of the specific feared outcomes that your client predicted beforehand. This is done in relation to each of the conversations completed during the experiment (usually two, though sometimes a third conversation is required). We recommend that you ask for this feedback as soon as possible after the experiment (once both conversations are complete), so that the conversation partner can respond while the conversations are fresh in their mind. A feedback template for the 'Self-focused attention and Safety Behaviours Experiment' is given in Appendix 3. Once you have received the feedback, read it carefully to check it is helpful and then you can send it to your client and discuss it with them in your next session or phone call.

Completed example of Other person feedback obtained after the self-focused attention and safety behaviours experiment

What was your overall general impression of the person you spoke to in your conversations today?

Jasmine was warm and friendly and interesting to talk to.

Conversation 1

Overall, how did you find this conversation?

I enjoyed it – I like films and it was nice to talk to someone with a similar interest. I think it took a little time at the start for us to get going but we soon got into it.

Please read each statement below, and rate each one from 0 (not at all) to 100 (extremely).

Please add any comments you think would be helpful.

The person I spoke to stumbled over her words - 0 I didn't notice this

The person I spoke to came across as boring – 0 not at all, I thought she was interesting to talk to!

The person I spoke to said something to offend me – 0 no never

The person I spoke to blushed bright red – 10

The person I spoke to seemed anxious – 20 a little at the start but not once we got chatting

I felt anxious – 30 yes I was a bit nervous

I enjoyed this conversation – 100 yes definitely

The person I spoke to came across well - 100

Conversation 2

Overall, how did you find this conversation?

I felt this conversation flowed easily, especially when we found out we'd both been to the same place on holiday! It was fun to chat, and Jasmine asked interesting questions.

Please read each statement below, and rate each one from 0 (not at all) to 100 (extremely).

Please add any comments you think would be helpful.

The person I spoke to stumbled over her words – 0 again, not that I was aware of

The person I spoke to came across as boring – 0 not at all

The person I spoke to said something to offend me – 0 no

The person I spoke to blushed bright red 0 – no I didn't notice this

The person I spoke to seemed anxious – 0 no she seemed relaxed and confident

I felt anxious - 20

I enjoyed this conversation – 100

The person I spoke to came across well - 100

Any other comments?

I'd be happy to continue our chat another time!

5) Video and Still Photograph Feedback

What is the rationale behind video feedback?

Patients have negative and distorted impressions and images about how they are coming across to others. A powerful way to update and disconfirm these is to provide patients with actual feedback on how they come across. This can be done using feedback from others they speak to and showing them how they actually come across in an interaction on video. Still images captured from these interactions can also be a powerful way to consolidate the key message: that the patient comes across much better than they think/feel/picture themselves. For a detailed therapist guide on using video feedback in CT-SAD see Warnock-Parkes et al., 2017). These techniques are used throughout therapy but the first time was used was to do video feedback of the two conditions experiment carried out in the previous session.

Setting up video feedback in a helpful way

If you have tried watching video of yourself (such as when viewing your own therapy during supervision) you may know from your own experience that when many of us first see ourselves on video we have a tendency to view ourselves more harshly than others. This can be a particular problem for people with SAD who might already be quite self-critical. Social anxiety related processing biases (such as self-criticism, re-experiencing the feelings the person felt at the time) can make it difficult for people to see the difference between their negative self-image and what is actually shown on video. Therefore, careful attention is paid to setting up and discussing the video recording to ensure that the patient watches the footage objectively and can see the discrepancy between their negative self-image/impression of themselves and what is visible on screen.

Make clear-cut, observable predictions in advance

Patients are first asked to bring to mind the conversation/s they had and make some clear-cut observable predictions in advance of viewing about how they think they would come across in

the experiment they did. It can help to calibrate their fears on 0-100% rating scales and ask them to show you any observable fears (e.g. can you show me how much you think you will shake/can you point out how red you felt on this colour chart).

After the self-focused attention and safety behaviours experiment we would ask about how they think they will come across in both conversations:

Therapist: On a scale of 0-100%, How boring do you think you looked in the first conversation?

Patient: I would say 100%

Therapist: If you did look 100% boring, what would we see on the video?

Patient: I guess the other person looking bored, disinterested, not paying me attention

When doing video feedback of the self-focused attention and safety behaviours experiment a four column table is drawn up including predictions in advance of viewing both conversations and then ratings of what they actually see on the video. A template is available in Appendix 4.

Getting into an objective mode to view the video

Secondly, as it is common for people to re-experience some of their original anxious feelings when viewing themselves on video, Natasha was encouraged to adopt a less biased mode of viewing:

Therapist: I'm going to encourage you to watch the screen like you are watching a television show, as if you are looking at two strangers and look at everybody in the conversation, not just one person. Try to focus on what you can see and hear rather than on how you feel.

Tips for helping patients who are highly self-critical

Many patients find they get into a self-critical mode when they see themselves on video and we have found that the following manoeuvres can be tried to help get them into a less critical mode and view the footage more objectively:

- Try turning the sound off for a few minutes and checking 'if you walked into a coffee shop and saw those two people chatting what would your overall impression be?
- Try covering the image of the patient and asking them to look at the reactions of their conversational partner
- Give them the conversational partner's feedback and ask them to watch the footage while keeping this in mind
- Ask them to think about a friend or colleague they like and respect and imagine they are watching them on screen
- Ask somebody else (e.g. a colleague of yours) to watch the conversations and give their ratings

Bekind rewind! Pause and rewind to look at moments of concern

After viewing themselves on video some patients might have moments of concern (e.g. a moment they felt they said something stupid or showed signs of anxiety, such as blushing). In these cases we pause and rewind the tape back to this moment:

Natasha: Oh yes (shudders), this is the moment, I can't believe I said something like that.
Therapist: So at this moment in the chat you are feeling very different and weird but let's take a look at how Richard (the other person she spoke to) is reacting, what do you notice?
Natasha: Actually he is just smiling and then he tells me where the country is.
Therapist: Does he seem to reacting as if he is judging you to be different or weird in some way?
Natasha: (Laughs) no, I guess not.
Therapist: So, what do you make of that?
Natasha: I guess maybe it was more about how I was feeling. I was feeling like that, but he isn't judging me like that.

Key learning points from video feedback

Once the ratings before and after viewing the conversations has been collated these are explored in discussion. The aim of this discussion is to help the patient discover for themselves

that they come across better than they think/feel they do: their feelings are not a reliable guide of how they are coming across.

Therapist: What do you notice when we compare these ratings?

Natasha: In reality I look much better than I do in my head.

Therapist: I think this is an important point. You said you were feeling 80% anxious, but looking at the screen does that lady look 80% anxious to you?

Natasha: Not at all! You don't really notice it, perhaps a tiny bit.

Therapist: So what does this tell us about how visible your anxious feelings are to others?

Natasha: Perhaps they aren't as visible as I think they are.

Sharing other person feedback

It is usually at this point we would share any feedback provided by the people that your patient spoke to during their experiment (see previous section for more details).

Video illustrations of carrying out video feedback after the self-focused attention and safety behaviours experiment, and at other times in therapy, are available at oxcadatresources.com

Still image feedback

Video feedback offers a powerful way to show patients that they come across much better than they think and feel they do. Capturing a still moment of the video in a photograph can be a powerful way to freeze these key moments of belief disconfirmation in therapy. For example, the moment when a patient felt they were boring but the person they are talking to is smiling and looking interested, or the moment a patient felt they blushed 100% but the blush is not nearly as noticeable as they predicted. These still images can be printed or stored digitally (e.g.

on the person's phone) as a reminder of some of their key take home points from video feedback. Turning these images into a flashcard by adding some text that captures their key take home can be a powerful reminder of their learning. This can be done in word, preview/adobe or any phone app the patient chooses. Some example images are provided below. For more examples see our detailed guide to video and still image feedback, Warnock-Parkes et al 2017.

Example still image flashcards created after video feedback, both in person and remotely

Key Points: Video, other person and still photo feedback

- Video and still photo feedback are powerful ways to update patient's distorted negative self-images and impressions.
- Video feedback needs to be carefully set up to maximise the chances the patient will see the discrepancy between their negative self-image and how they come across on screen (e.g. making clear predictions in advance).
- The therapist remains on the look-out for processing biases (such as self-criticism) and addresses these as they come up.
- Simple manoeuvres, such as watching for a few seconds with the sound off or covering the image of the patient and focusing on the reactions of the other person, can be powerful ways to switch off self-criticism when viewing video
- Taking still images from key moments of belief disconfirmation and turning these into a flashcard with the key take home points on can be helpful.
- Getting feedback from other people the patient talks to as part of their treatment can be a powerful way to find out what others are really thinking about how they come across.
- Video, other person and still photo feedback is first used to review video of the self-focused attention and safety behaviours experiment, but is also used throughout therapy after other behavioural experiments.

6) Attention training

The two manoeuvres used in the early sessions of CT-SAD (the self-focused attention experiment with video feedback) will have helped patients to discover that the information they have been using to decide how they are coming across to other people is misleading. Patients have hopefully discovered that focusing on themselves makes them more aware of their anxious feelings and their distorted images and less aware of how other people are really responding to them. The next step in CT-SAD involves helping patients to obtain more helpful information about how acceptable they are to others by carrying out behavioural experiments. During experiments patients need to switch their focus of attention onto the social interaction, in order to evaluate how others responded to them and whether their negative predictions happened or not. To help people with this it is useful to give them a session of training in externally focused attention. This is usually delivered in the session following video feedback (when treatment is being delivered in a typical manner this would come around session 4). Devoting a session to this is worthwhile as most people with social anxiety will have got into a habit of focusing attention on themselves and will tend to do this fairly automatically without some formal training of how to overcome it.

Aims and principles of attention training

The main aim of attention training is to help patients develop the skill of being able to switch their focus of attention from internally to externally focused. Patients are encouraged to become as absorbed as possible in particular things they can hear and see around them for short periods of time. In a series of systematic exercises they learn how to tune into particular sounds and sights and compare how they feel when they are absorbed in those stimuli in the present moment, versus how they feel when more self conscious and in their head. Patients are encouraged to feed back to the therapist how effective they were at shifting their focus of attention and to compare their experience of external focus to when their attention was focused more internal. In general patients report they feel more relaxed and less threatened

when externally focused. Patients are then encouraged to repeatedly practice and fine tune their skills in switching to external focus of attention.

To reduce the patient's self-consciousness for attention training we find it helpful for the therapist do the exercises (outlined below) together with them. Second, it can help to avoid looking directly at the patient as they practice the exerices. Try positioning the chairs at angles to each other so the therapist is not directly facing the person and when listening to sounds both the therapist and the patient can close their eyes so the patient knows they are not being watched. When looking at objects in the room the therapist can turn to look at the objects as well, so they are not looking directly at the patient.

Setting up the training

Ensuring a clear rationale for attention training. Normally the fourth session would begin by reviewing "what have we learnt from the self-focused attention and safety behaviours experiment and watching the video of those conversations?". Two key learning points can usually be recalled. First that the 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. In providing a rationale for using training exercise to improve the ability to switch attention, therapists may find it helpful to give the metaphor of a muscle that needs to be strengthened by regular exercise.

Overview of training steps

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. The exact order and type of exercise can be determined by the

therapist. However, we usually introduce the following exercises, ending with the therapist reading to the patient as this is most like a social interaction:

Step 1: Sounds

Step 2: Colours

Step 3: Shadows/reflections or textures

Step 4: Music

Step 5: Reading aloud to the patient

We find this order works well as the training moves from the least challenging exercise, in which the person focuses on sounds around them with their eyes shut if they feel comfortable to close their eyes, to exercises that are slightly more difficult, in which the 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 person struggles to engage with the task.

For each of the steps the aim is for the person to become 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 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.

Step 1: Sounds

Once the therapist and person have closed their eyes, the exercise can begin. It can help by starting to encourage patients to focus on themselves and their worries and to do a sort of 'feeling scan' and obtain a rating of how that feels on a 0-100% scale, so that patients can later

compare this to how it feels when they are externally focused and lost in the sounds. Patients are usually able to discover that they feel more comfortable or less anxious when focused externally, again demonstrating the importance of switching attention and attention training.

Patients may well find getting lost in sounds challenging. 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 person what they have noticed when they have had their eyes closed for a while. They then ask the patient to describe the sounds more specifically before the therapist suggests particular sounds that they themselves have heard. The therapist counts the sounds for the person, encouraging them to identify further sounds as the exercise progresses.

It can also help to ask how the external world seemed to the patient during the exercise. Many 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. If the patient 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.

Step 2: Colours

This step gives patients the opportunity to become absorbed in what they can see. This will be important because patients will need to develop the ability to shift their attention to the external world with their eyes open. In this exercise 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. In the instructions the person is encouraged to becoming fully absorbed in the colours around them, without concerning themselves with the names or types of objects. For example, "*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. 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?*"

Once again, once the patient had spent some time getting lost in the colours, the therapist would ask the patient to give a rating of "how much your attention was on colours in the room, and how much was on you, where would you put that from 0-100%?" If the person was finding it difficult to get lost in the sights and colours around them, the therapist may suggest some further practice, giving additional suggetions of how to get more absorbed.

Step 3: Shadows/reflections or textures

Step 3 provides a different opportunity to become absorbed in visual stimuli. When 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. For example, "*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 light fitting, and just become absorbed in reflections, and light and shade."*

Step 4: Music

The therapist could select a piece of music from their office computer, or this this was not available ask the patient to select a piece of music from their mobile phone or device. As the music is playing we might ask the patient to select one instrument or vocal and attend to this. They are then asked to move their attention onto a different instrument and get lost before then moving on again. When they have had some practice doing this, they are then asked to bring all the instruments together by getting lost in the track as a whole. For example. "*I would like you to try and follow one instrument for a while. Just on it's own...(leaves time to do this). Maybe switch to another instrument now….(leaves time to do this). Now maybe switch again to find another instrument and follow that .(leaves time to do this). Perhaps now try and get lost in the last instrument, the one you haven't listened to yet(leaves time to do this).*

Now I'd like you to try and bring all the instruments together and get lost in listening to the music as a whole."

Step 5: Listening to the therapist reading aloud.

In Step 5 the therapist reads aloud to the person. All of the exercises we have done so far and ones involving non-social stimuli. It is good to end the attention training on something that is close to a social interaction. We have found a helpful way of doing this is for the therapist to read out load a story while the patient is listening. This is similar to those types of conversations where one person is doing most of the talking and the other person is listening. The therapist explains that they would like the patient to switch their attention between the narration, listening to each sentence as it is said, going with the story moment by moment and their thoughts and worries. For example, "*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 and get lost in the story. And then after a couple of paragraphs, I'm going to tap the table like this (demonstrates tapping), and I'll continue reading it, but when I do this I'd like you to get lost in your head instead. After a while I'll then tap the table again and that is your cue to get absorbed again in listening to the story."*

Identifying and labelling a cue to shift attention.

After stepping through the exercises, it will be important to help the person select a readily noticeable cue to shift their attention externally. This may be a feeling, sense or physical sensation:

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'?*

P: *It is like a feeling of anxiety and tension 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 and I find myself worrying about what people think of me.*

T: *Okay, great. So you catch yourself feeling a tightness and heaviness in your chest, and spot yourself worrying what others think and getting 'stuck in your head'. 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'.*

A video illustration of attention training is available at oxcadatresources.com along with links to several attention training exercises on youtube that can be used in treatment and for homework.

Monitoring of self-focused attention throughout therapy.

Therapists will want to track to what extent patients are managing to focus externally across remaining sessions. Improvement in self-focused attention can be monitored each week using the social summary rating scale. If patients continue to struggle with externally focusing attention, they may need to engage in more attention training practice.

Key learning points and homework tasks

Some key learning that patients often take away from the session on attention training include:

The scariest place is in your head. A powerful point that 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 in a social situation is usually in their 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 person if they can attend to it.

Homework tasks. Patients often notice that in a short session of attention training they can already notice a change in how they feel between focusing on themselves and getting lost in sounds or colours in the outside world. This is encouraging to help them see the value of practicing attention training for homework. There are two settings in which the patient 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. For example, when people are walking alone around they could practice getting absorbed with sights and sounds around them and contrasting that with becoming more aware of themselves and their worries. When in a crowd, for example at a train station or on a busy high street, they could practice getting absorbed in observing other people, rather than thinking of themselves in the crowd. On the oxcadatresources.com website, and by clicking here, therapists will find a link to several attention training videos that can be shared with patients to use for homework practice.

When they are interacting with other people, ask the patient to try to get absorbed in the conversation and the social interaction, rather than focusing on how they are coming across. Agree with the person what they will try, perhaps adding the task along with a reminder onto their phone. Encourage them to make notes about the homework tasks to discuss at the next session.

Key Points: Promoting external focused attention with Attention Training.

- Learning to switch attention externally is vital for the success of later behavioural experiments when patients will need to observe the reactions of other people.
- Therapists and patients usually have a session of attention training exercises together that the patient continues for homework both when alone and in social situations.
- They are also encouraged to look out for signs they are internally focused in social situations and to use this as a cue to switch attention to the social interaction at hand.
- Monitor how well patients progress with externally focusing their attention across treatment using the social summary rating scale.

7) Addressing Social Cognitions: Loosening Beliefs

At the heart of the cognitive model is that patients have negative thoughts and images/impressions about how they are coming across to others and often unrealistic expectations of themselves/the social world that are maintained by focusing on themselves and using safety behaviours. For patients with SAD their beliefs and images of themselves in social situations have often been persistent across their adult lives. In our experience discussion techniques alone (such as guided discovery) will only get you so far in challenging these longstanding beliefs. We have found that experiential techniques, such as behavioural experiments, that allow patients to discover for themselves what happens when they stop using their self-focus and safety behaviours are the most powerful way to change negative social cognitions and overcome SAD. Therefore, although we will initially explore patient's beliefs with guided discover we spend most time finding ways to test beliefs in practice through surveys and behavioural experiments.

Which beliefs to address first?

Patients with SAD typically have a range of problematic beliefs and therapists often tell us they are unsure which beliefs to address first. In deciding which beliefs to start with, a cognitive therapist is guided by the formulation and considers:

1) Which are the highest rated emotion-linked beliefs that might lead to the biggest symptom improvement if changed?
2) Which beliefs are interfering the most in the patient's life right now?
3) Which beliefs does the patient wants to address first? Do any fit with their therapy goals?
4) Where all their beliefs are equally high, interfering and problematic, we might consider which beliefs may be easier to disconfirm and more likely to lead to an early success experience for the patient.

As patients often have multiple feared catastrophes, it is likely that when setting up experiments to test specific beliefs, other feared beliefs arise and will need to be included as predictions.

As mentioned earlier, giving the Social Cognitions Questionnaire (SCQ: Wells, Stopa & Clark, 1993) weekly is also a helpful guide in therapy in spotting which are the most problematic beliefs that need addressing next. We typically review this at the start of every session to help plan the agenda.

Helpful questions to loosen beliefs

"What have we learnt in treatment so far about the belief…?" It is usually helpful to prompt patients to recall learning from previous sessions, including the self-focused attention and safety behaviours experiment and video feedback. Therapists should use whatever questions they think might be helpful in loosening patients' beliefs. Helpful questions might include:

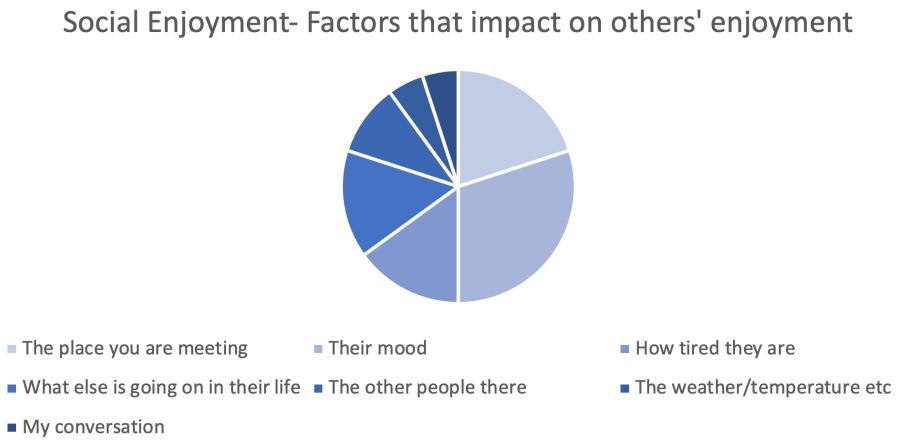
- *"What have we learnt so far in treatment about the belief 'I blush red and then people think I am weird?'"**
- *"What did you learn from the first experiment we did when you focused on yourself and then focused on the conversation?"*
- *"What did we see on the video when you felt you blushed red? What did this tell us about how visible this feeling is?"*
- *"What feedback did the people you spoke to give? Did they notice any blush? If so what did they make of it? What does this tells us about how weird people think it is when somebody blushes?"*
- *"In an early experiment you noticed the person you were speaking to blushed slightly, did you think this meant they were weird? What do you make of that?"*
- *"If you notice somebody blushing, would you think they were weird and decide you didn't want to know them? Why not?"*

- *"Blushing is often something you are focused on because it is a concern of yours, but how much do you think other people are focused on whether people around them are blushing or not? Do you think people leave their house thinking 'I wonder how many people are going to blush today??"*

**These questions can be adapted for most social fears and concerns people with SAD might have*

Pie charts

Drawing on other cognitive techniques can sometimes help to loosen beliefs. For example, if a patient feels 100% responsible for the social enjoyment of others it can be helpful to explore all the factors that might impact on anybody's enjoyment of a social event. Writing a list of these and assigning a percentage that they would impact on somebody's enjoyment, adding the patient at the end can help them to see that they do not hold the level of responsibility they often feel for the enjoyment of others. Drawing these factors out in a pie chart (see below) can be a helpful way to demonstrate and consolidate the key message that the patient is not completely responsible for others' enjoyment.



8) Using surveys

Because the nature of SAD is that patients fear, and often have excessively negative thoughts what other people think, surveys can be a helpful way to loosen patient's beliefs (e.g. If I sweat people will think I'm incompetent) and to normalize many of the physiological sensations patients worry about. A survey is where a patient and therapist put together some questions to ask other people to find out more about what other people experience and really think. A helpful paper describing using surveys in CBT has been written by Murray et al (2022). An important underlying principle when setting up a survey is that the questions address the patient's particular fears and concerns. For example survey questions to address the belief 'people will think I am weird if I sweat' might include: *Do you sweat? Have you ever noticed other people sweating? If you notice somebody sweating what do you think? How much would you think it meant the person sweating was weird 0–100%?*

Therapists should read survey responses before sharing with patients to ensure that respondents have understood the questions and responded helpfully. There are some images of famous people sweating and blushing online that patients may find normalizing to see. Some collated images are available on the OxCADAT resources website (oxcadatresources.com) that can be downloaded in PDF format and shared with patients during discussion to loosen their beliefs (e.g. *Do you think these people look anxious/incompetent*? *What do you make of that?*, etc.). Clinicians will also find some video surveys where we have asked people on the street some common survey questions on the oxcadatresources.com site that you might find it helpful to show a patient during a therapy session if the content is linked to their particular concerns.

Below is an example Survey sent out by a therapist on behalf a patient who believed that if she blushed others would think she was weak. This was shared by email with some of the therapist's colleagues and results were collated and shared with the patient. A selection of responses are included below to give you an idea of the kinds of responses we typically get.

Please complete this survey to help somebody I am currently working with. Please be honest.

1) Do you ever blush? If so when.

- *Yes, a lot – if I am embarrassed, if I speak up in front of big groups, If I am hot.*
- *Sometimes – if I am put on the spot*
- *Not much, but of course it does happen sometimes*
- *All the time, I can't help it.*

2) If somebody else blushes, how much do you pay attention to it?

- I don't tend to notice others blushing, I don't think much of it if I do
- Not much at all
- I don't tend to notice
- If I do notice I hardly register it

3) What are the reasons you think somebody might blush?

- Hot, embarrassed, somebody compliments them
- Passionate about something, unwell, hot, feeling shy
- I think we all do for different reasons -there isn't just one
- I don't usually think about why – I guess if you are put on the spot, warm day, not well

4) If you notice somebody blushing at work what would you make of it?

- Wouldn't think much about it
- Not much, might think they were hot
- Maybe they were feeling a bit shy
- Happens all the time, I don't think much on it

5) How much would you think they were weak? 0-100%, If so please explain.

- 0% - No! We all blush
- 0% - I blush, Im human I don't think it means Im weak. Just something we can't control
- 0%
- 0%

9) Behavioural Experiments Dropping Safety Behaviours and Self-Focused Attention

Early in therapy patients will have started to discover from video feedback that their internal feelings are not always a good guide of how comes across. We typically introduce the idea of putting our fears to the test in behavioural experiments after we have done some attention training exercises, around session 4. When introducing the idea of putting fears to the test using behavioural experiments we might do so suggesting that patients need to be more scientific in terms of how they are evaluating themselves socially:

Therapist: If a scientist developed a medicine and they felt it was safe, would you be confident to take it if it had not been tested first?

Natasha: No way!

Therapist: I agree. Their feelings would not be enough evidence to go on. Also, what did we learn about how reliable your feelings are from the video last week?

Natasha: We saw that my feelings can misguide me quite a bit.

Therapist: That is a good way to put it, they misguide you…

Seizing the moment – Experiments that we do not set up with the patient in advance

There are occasions in therapy when a naturally occurring event/situation presents itself to the therapist that will provide a good opportunity to discover something new or test a patient's fear in an unplanned experiment. For example, A therapist who is working with a patient who fears getting his words mixed up accidentally stumbles on his own words when talking. He then draws the patient's attention to this, asking 'did you notice that I just tripped over my words? If so, what did you make of it? Did you think it meant I was anxious and incompetent [insert patient's belief]? The therapist might also want to intentionally create these moments to make the most from them. For example, for a patient who fears disagreeing with others, the therapist might intentionally make a mistake prompting the patient to correct the therapist who might then explore 'How did I respond when you disagreed with me? What does that tell you about your belief that others will criticize you if you disagree with them?

Key steps in powerful prediction testing experiments

Behavioural experiment record sheets

Behavioural experiment record sheets (a blank example is provided in Appendix 5) are typically used when carrying out prediction-testing experiments. A completed example can be seen below. They provide a template that prompts therapists and patients through the key steps in doing an experiment, which we describe below, including: 1. Identify the best situation to test the belief; 2. Identify observable predictions; 3. Identify safety behaviours and other maintaining processes to drop and carrying out the experiment; 4. Recording the outcome and generalized learning; and 5. Plan how this will be taken forward to build on learning.

On some occasions, for example when multiple experiments are carried out spontaneously outside of the office, or if the predictions need to be made during the experiment itself (see later example of the staring experiment in CT-SAD), the record sheet may be filled in retrospectively after the experiment is complete. If possible, it is preferred for the patient to write on the experiment record sheet themselves with the therapist's support. Digital versions could be used, provided that the patient and therapist have access to these, and they can be available to refer to in future sessions. Keeping a record of experiments is essential in accumulating evidence across therapy to test negative beliefs and develop more helpful ones. This is particularly important when targeting persistent problematic beliefs.

1. Situation	**2. Prediction** What do you think will happen? How much do you believe it will, 0 - 100 % ?	**3. Experiment** What can you do to test the prediction? Remember to focus externally and drop your safety behaviours	**Outcome** What actually happened? Focus on what you saw/what happened not on how you felt. Re-rate my prediction	**What I learned?** What does this tell me about social situations more generally and how I come across? How can I build on my learning in the following week?
Speaking to a stranger during one of my sessions	If I say whatever comes to mind without preparing	Focus my attention externally and observe what is	They seemed interested in what I had to say, smiled	I can have a conversation without preparing in advance. Others find my

	in advance I will come across as boring and stupid – They will look bored, roll their eyes and try to end the chat 80%	happening. Say whatever comes to mind, don't prepare interesting/clever things to say – be myself	and it was a nice chat Re-rated belief - 40%	acceptable and likeable – and not boring (60% belief)

Step 1: Find a good situation to test the belief.

Once the most problematic fears to address next are on the table (see above), the therapists and patients together use their creativity to find situations that will best test them. The situation chosen to test the fear should be relevant to their life and treatment goals, the situation might also reflect one the patient typically avoids or endures with distress. These things will vary from patient to patient and we try to use our creativity to come up with social scenarios that have particular relevance for the individual. There is no checklist of behavioural experiments that exists for all patients. For example, a patient feared his hands shaking if he didn't hide his hands or grip things tightly. As he enjoyed playing board games, we had a colleague join the session to play a game for 5 minutes in order to see how they responded if he didn't hide his hands and held the game pieces loosely. The experiment was recorded for video feedback and feedback was obtained from the person who joined the session. Some other example situations that we have tried with patients include: Inviting one or more people into the session to have a social conversation with the patient; hosting a tea-party in a session; role playing a situation that the person struggle with in day-to-day life (such as a work meeting, group tutorial, introducing themselves in a group etc); going out of the office to a shop to ask a question; asking somebody for directions on the street; the patient giving a short talk/presentation to a real or virtual audience etc.

Patient and therapist collaboratively agree on a situation to carry out the experiment that is anxiety provoking but that the patient is willing to try. This therefore involves some degree of grading (for example, for most patients with SAD doing a presentation early in treatment as part of an experiment would be far too challenging). However, in our experience it is not necessary to develop a fear hierarchy, instead we are guided by what is the best test of a particular belief that the person feels able to do at that point.

Therapists put suggestions on the table. As the therapist will have more knowledge and experience of cognitive therapy than the patient, they will need to make suggestions of the kinds of situations that will be helpful to test the patient's relevant fear. For example, *'we find it can help if we bring somebody you have not met before in to have a short conversation, is that something you would be willing to try?'* Earlier in therapy, when patient's fears are at their strongest, therapists might play a larger role in generating ideas for experiments, but as treatment progresses patients may be able to generate ideas more independently (e.g. "what would be a helpful way to test this belief?", "In what situations could we test this out?").

The patient is always in control. The treatment of anxiety almost always involves facing up to your fears and can generate negative emotion. It is always important that whatever exercise is done is one that the patient agrees to do, they understand the purpose of it, and they feel in control. They should never feel coerced into doing an experiment.

Therapists take any concerns patients have seriously. This might involve taking time to discuss "*what might be the advantages of doing this experiment, even though it sounds challenging?".* It might be necessary to discuss making the experiment easier if patients did not think it was something they were able to try, by adapting it in some way (e.g. *"how about we have the conversations with a smaller group of people than we planned*?", or the therapist trying the experiment while the patient observes). It might be helpful to further loosen beliefs in preparation for the experiment, using cognitive techniques.

Do experiments together in sessions. In our experience, patients are more likely to do a challenging experiment with their therapist during a session than they would try alone for homework. An in-session experiment carried out together can lead to significant belief change that can be built upon in the week to follow. Doing experiments together live also provides an opportunity for the therapist to model the experiment, guide the patient to drop any safety behaviours that might otherwise limit belief disconfirmation, and elicit generalized learning from the observations. There are several video illustrations of this at the oxcadatresources.com website.

Case example - A patient with SAD fears that if they ask a stranger a question, the other person will get irritated with them. They first observe their therapist approaching a couple of people on the street to ask the time and for directions before then trying this themselves.

Get out of the office – make situations relevant. In CT we have found that the most powerful situations to carry out as experiments can be the ones that are most relevant to the patient's life. This often involves leaving the therapy office together to experiment in the world outside. Many 'out of the office' experiments take only a short time.

Be active – even at a distance. With some added creativity, and at times forward planning, all of the in-session experiments that can be done in person can also be done remotely. This might be done with the therapist providing support on the phone. At times co-therapists to go with the patient in person (such as a partner or loved one) can be helpful. Additional considerations include the fact that the therapist may have a limited view of the patient and need to ask more probing questions about their use of safety behaviours during the experiment. For example, a patient may be holding onto something off screen during an experiment to test fears about fainting in panic disorder. For examples of behavioural experiments that can be done remotely

for SAD and PTSD see Warnock-Parkes et al., (2020) and Wild et al., (2020)

Step 2: Identify Observable predictions.

As patients habitually focus on themselves and use their feelings to guide what is happening, we need to get more accurate information about whether their feared predictions happened or not. To do this, it is vital that patients make specific observable predictions about what they think will happen in a given situation (e.g. the prediction "I will be boring" could be made more specific and observable by adding "Other people will look away and stop speaking to me"). Then, during the experiment, they can focus on what is happening, rather than on themselves. Helpful questions therapists could ask to generate observable predictions include: *"How would we know if x/y happened?", "What would we see?", "Can you demonstrate that for me?", "How would others react?", "How would we know that?", "What would they do/say?". What would disprove your predictions/fears? What would we see then?*

Rate predictions of feared outcomes (not anxiety). In cognitive therapy, we are interested in helping people learn whether their feared catastrophes happen or not. Therefore, the 0-100% ratings that are taken during experiments are largely to do with whether the negative prediction occurred or not, rather than ratings of anxiety. Furthermore, people with anxiety disorders are 'emotional processors' and habitually focus on how they feel, which gives them unreliable information. Repeatedly getting patients to rate how anxious they feel is best avoided as it can buy into their style of emotional processing, lock them further into their head, and keep them focusing on their body rather than being externally focused. The only exceptions to this would be if the patient's belief in SAD is "I will look as anxious as I feel". In this situation, patients might be asked to rate how anxious they felt during a social interaction and then compare it to feedback given by the person they spoke to and how anxious they appeared when reviewing video footage of the interaction.

Step 3: Identify safety behaviours and other maintaining processes to drop and carry out the experiment

'If…Then' predictions can help. It is important that therapists and patients spend time to identify the safety behaviours linked with the feared belief that will need to be dropped during the experiment. Once patients are clear on exactly what they should be doing differently during an experiment, this is recorded on their experiment sheet. It can help to make IF…THEN predictions, based on what would happen if patients were to drop their safety behaviours. For example, 'If I drive like I used to before my trauma, without excessively checking my mirrors, then there will be an accident'; 'If I speak spontaneously, without preparing what to say, then people will think I'm boring and stop speaking to me'; 'If I keep standing when I feel panicky rather than sitting down, I will faint'.

Focusing on the outcome, not feelings. When carrying out the experiment, whether it is during a therapy session or for homework, it is essential that patients drop their safety behaviours and consider whether their feared catastrophe happened, rather than on how they feel.

Guide and prompt patients to drop safety behaviours *If* the therapist is present during the experiment (either in person or remotely) it helps to prompt the patient to keep dropping their safety behaviours and check for any other maintaining strategies as the experiment progresses. This is important as patients may not always be aware when they are using them. For example, patients with SAD often need reminding to keep their head up and observe other people, focusing externally rather than on themselves, when carrying out experiments in public places.

Step 4: Review the outcome and generalize the learning

After the experiment is over, patients and therapists discuss the outcome, focusing on what happened, rather than on how the patient felt. Patients sometimes need extra guidance in doing this if they were focused on their anxious feelings at the time. Therapists can support them to consider each prediction and review whether their fearful concerns happened, and if so to what extent.

Generalizing the learning makes the experiment more powerful. Patients do not tend to generate generalized learning automatically following an experiment. Following an experiment, patients typically focus on the outcomes and learning from that specific situation. It can be helpful to use guided discovery to encourage patients to also consider the *generalised* learning they are taking from the experiment, i.e. going beyond the specific situation to consider what the experiment outcome says more generally about them, others, and about the feared belief being tested. Following a conversation experiment, a patient with SAD is more likely to write down on their experiment record sheet outcomes and learning something like *"I predicted I would be ignored but others spoke to me",* than drawing more generalized learning, such as *"This shows me I'm acceptable and likeable".*

Helpful questions to elicit generalised learning include:

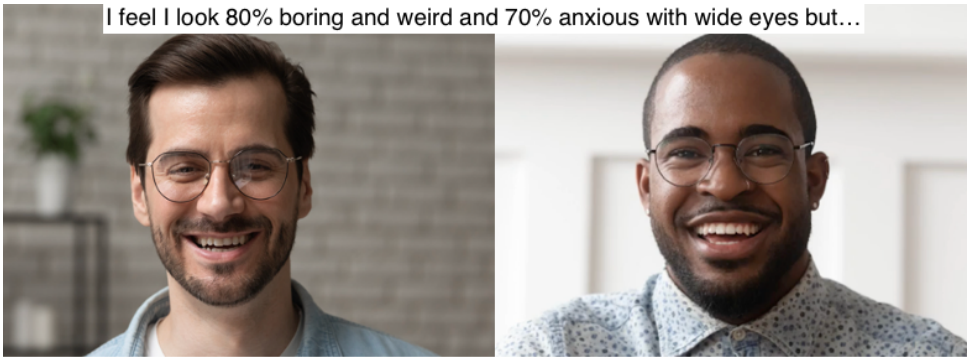
- *"What does this tell you about your belief x/y more generally?"*
- *"How does what we discovered fit with your belief x/y?"*
- *"What does this tell you more generally about… how you come across in social situations /how safe you actually are/what these sensations actually mean?"*
- *"What does this tell us about the impact of x/y behaviour/strategy more generally"?*
- *"What does this tell us about the future?"*
- *"What does this tell you about the image/impression you have of yourself coming across as x/y?".*

Rating the level of conviction in the alternative perspectives that arise from these questions (e.g. how much do you believe now you are a likeable person 0-100%) can lead onto a discussion of the next steps to build on this learning.

Consolidate the learning. In addition to writing down learning on behavioural experiment record sheets, making flashcards of important discoveries to use over the week to come can be helpful. Taking mental snapshots of key moments of discovery during the experiment, or preferably, creating still image flashcards from photographs taken at the time can be a

powerful way to update patients' negative images from their experiment learning. For example, *A person who pictures themselves looking boring and weird with wide eyes reviews video footage of several experiments they carried out across treatment to discover that although they often feel boring and weird, they come across acceptably to others and do not appear as anxious as they feel. A still image flashcard created from an experiment, showing them looking like any other 'normal' person, is used to update their negative self-image (see Figure below). They store this on their phone to look at over the week (for other examples of using still image flashcards during experiments in SAD see Warnock-Parkes et al., 2017).*

A still image flashcard used to freeze the moment of belief disconfirmation during a behavioural experiment with video feedback in SAD



Step 5: Build on the learning by planning follow up experiments

It is rarely the case that a single experiment will be sufficient to address a belief that has high emotion and conviction. Therefore, once an experiment has been completed patients and therapists will want to consider how they can build on the learning by planning follow up experiments. This may involve refining the in-session experiment. For example, if a patient was unable to fully focus externally or drop their safety behaviours, it may help to repeat the experiment, this time dropping all these strategies. If further experiments are being agreed for homework, they should not be significantly more challenging than the in-session experiment

just completed. Therapists and patients may want to discuss whether a friend or loved one could support the patient with experiments done for homework.

The art of cognitive therapy is listening for the doubt ('yes, but…'). Patients often have doubts about the outcome or learning from an experiment. Examples include: *"Maybe this means I am acceptable as I am".* Therapists may be tempted to ignore these and focus just on the positives from the experiment, but this means the doubts are likely to persist. It is important to listen out for, elicit, and welcome doubts so they can be explored and addressed. They often provide an invaluable source of ideas for the next experiment whereby the doubt is turned into a prediction. *For example, during discussion of a social experiment a patient expressed the following doubt: "It went well, but if I had been speaking to more people I probably would have made a fool of myself". This is then turned into a further experiment whereby the patient carries out the same experiment in a larger group.*

A case example – The staring Experiment

A patient called Natasha held a strong fear of being stared at and often looked down when she felts others looking at her. She and her therapist then carried out an experiment together, often called the staring experiment. This experiment helps demonstrates the impact of looking down when we feel stared at and can be a powerful way to test this fear if relevant for the patient. During this experiment Natasha walked down a busy public street with her therapist. She was told look down at the ground, a safety behaviour she often used when feeling self-conscious in public, bringing on the feeling of being stared at:

Therapist: So on the questionnaire here we can see you have strong belief that others are staring at you, is that right?

Natasha: Yeah, I often feel like that.

Therapist: Ok, Im sorry to hear that, when do you typically feel stared at Natasha?

Natasha: Walking down the street, when I go into a lecture, in the shops…

Thearpist: OK – and are these times when you are looking up and around and observing others?

Natasha: No, not at all, I look down when I feel stared at.

Therapist: Oh ok. That is interesting. I wonder if you would be happy to come for a short walk with me now so that we could find out a bit more about the impact of looking down when you feel stared at?

(They walk out of the clinic into a busier section of the street. Natahsa is asked to walk with her head down and bring on the feeling she is being stared at)

Therapist: Right now Natasha, how many people do you feel are staring at you?

Natasha: It feels like everybody is, say 80% of people.

Therapist: Ok, now I want you to focus externally and look up. I want you to look around you and ignore your feelings and tell me how many people are actually staring at you.

Natasha: Oh! Nobody is! 0%!

Therapist: What are people focused on?

Natasha: Mostly on their phones or just walking, not me actually

Therapist: So what does this tell you about how reliable your feeling is of being stared at?

Natasha: I guess it isn't that reliable.

Therapist: So the next time you get this feeling of being stared at what could you do?

Natasha: Look up and test it out – see if people are staring.

The patient can discover that the feeling of being stared at is an illusion, caused by focusing too much on herself. If the patient is concerned that somebody glanced in their direction during the experiment, it can help to explore this in discussion:

Natasha: I did think that one person did stare at me

Therapist: OK thanks for telling me – and what did you do at that point?

Natasha: I looked down at the floor again.

Therapist: So were you able to tell if she was staring at you or simply glancing at you?

Natasha: I guess I couldn't

Therapist: Actually when we all walk down the street we have to glance at things and people we pass. We have to rest our eyes somewhere - It is called 'eye parking'. What do you think would happen if people didn't briefly park their eyes on what was around them as they walked along?

Natasha: (Laughs) I guess they would bump into each other.

Therapist: Yes good point! Do you sometimes glance at people and things as you walk along?

Natasha: Yeah I do I guess

Therapist: And are you always thinking something negative about those people or things you glance at?

Natasha: No actually. I'm often thinking about something else entirely

Therapist: OK. So as we walk along now, how can we discover if the next person who looks in your direction is staring or just briefly parking their eyes in your direction?

Natasha: I guess I could glance back at them for a bit longer and see what happens – do they stare or look away?

An example of a behavioural experiment record sheet completed in an early treatment session following an out of office experiment to test the fear of being stared at.

1. Situation	**2. Prediction** What do you think will happen? How much do you believe it will, 0 - 100 % ?	**3. Experiment** What can you do to test the prediction? Remember to focus externally and drop your safety behaviours	**Outcome** What actually happened? Focus on what you saw/what happened not on how you felt. Re-rate my prediction	**What I learned?** What does this tell me about social situations more generally and how I come across? How can I build on my learning in the following week?
Walking down the street	When I walk with my head down I feel like 80% of people stare at me.	Look up, focus my attention externally and observe what is happening.	Nobody was staring at me. One man looked and then looked away. Re-rated belief - 0%	My feelings misguide me. When I think people are staring at me I am really staring at myself. I look more acceptable than I feel. I need to keep testing this whenever I feel stared at

Giving a presentation and Virtual audiences

For some patients giving a presentation is one of their treatment goals and would be a helpful situation to be able to approach with more social confidence. For other patients this is unlikely to be a situation they would come across in their daily lives, but they may still benefit from having a positive experience of speaking up in front of others as part of their therapy and possibly getting some video feedback of the experiment. As treatment progresses, and patients start to feel more socially confident, we may want to plan a presentation experiment to test

patient's social fears as part of a treatment session. This can be done by getting a small audience together or using a pre-recorded virtual audience (see image below). Links to these can be found by clicking here. These links, along with a video describing their various uses in treatment, are available on the oxcadatresources website. Patients with SAD tend to overly prepare for speaking up in front of others, such as writing detail scripts that they attempt to rehearse and repeat verbatim. It can be powerful for them to discover that they can speak more spontaneously without the need for excessive over preparation. For example, one patient who feared he would totally freeze if he didn't script every word of his presentations for practiced speaking up in front of 3 people during a therapy session on a topic he had been given just a few minutes to write a few bullet points down about. He was surprised to discover that he still had things to say and that the audience responded well to him.

An example image from one of our available virtual audiences:

In Appendix 10 we provide a table which summarises a range of common social cognitions that people with SAD have alongside several experiential exercises we have found useful to address each in CT-SAD. *Please note, there is no list of experiments to do with any one patient. We creatively design experiments that are going to be the best test for the individual we are working with based on their profile of social fears and concerns.*

Several video illustrations of behavioural experiments, conducted both in and outside the therapy office and remotely are available on oxcadatresources.com, alongside links to virtual audiences that can be used when testing patients' fears about speaking to large groups of people.

Key points behavioural experiments

- Behavioural experiments are the engine driving cognitive change in CT-SAD
- Experiments are carried out in most therapy sessions and in between sessions for homework to test patient's fears.
- Behavioural experiment record sheets are used to plan and record the outcome from experiments
- The key steps in carrying out a planned experiment include:

1. Identify the best situation to test the belief
2. Identify observable predictions
3. Identify safety behaviours and other maintaining processes to drop and carrying out the experiment
4. Record the outcome and generalized learning
5. Plan how this will be taken forward to build on learning.

10) Accumulating the Data – Using Golden Opportunities Logs and Zero Avoidance

Golden opportunities data logs

Some experiments that patients do across the week will have been planned. Others will be in response to what we call golden opportunities that patients notice in daily life. In these experiments a patient will be instructed to look out for key moments of concern over the week. For example, a person with SAD who believes they are boring is asked to notice any experiences when they feel like they are being boring. They are encouraged to use this feeling as a cue to make a quick prediction, drop their safety behaviours and observe how others are responding. These kinds of experiments can take 60 seconds or so and can happen multiple times a day, so they are a wonderful opportunity to accumulate data that patients are acceptable when they are just being themselves. The figure below shows a behavioural experiment record sheet used by Natasha to record data from several brief golden opportunity experiments. For further examples of using golden opportunity logs to address persistent negative self-beliefs in SAD, see Warnock-Parkes et al., (2022).

Situation	Prediction	Experiment	Outcomes	Learning
Golden opportunities this week – whenever I feel I'm unlikeable and different	If I focus externally in these moments, speak up for 60 seconds longer than I usually would and don't censor myself, people will think I'm unlikeable and different and give me a strange look or try to leave the chat 80%	Use the feeling Im unlikeable or being different as a cue to focus on others, speak up more without censoring myself.	Monday: Felt unlikeable speaking at lunch but got more involved in chat and they spoke back and seemed to enjoy it Tuesday: In tutor group felt different and unacceptable and wanted to stay quiet but I shared my ideas and people didn't reject them, they listened. Wednesday: At coffee shop with friends I felt unlikeable and wanted to sit quietly but instead spoke more about my day and my friends looked like they cared.	Maybe I'm more likeable than I think I'm not rejected when I speak up, I'm an acceptable person for who I am Friends do care about me, I'm more acceptable than I feel.

Zero avoidance

Later in therapy, if experiments are going well, the idea of a zero-avoidance week (or a day or afternoon if a week is too much) can be introduced for homework. The principle is like using golden opportunities, whereby patients across that week look out for the urge to avoid something, as this indicates a situation in which a problematic cognition would be triggered. Patients are encouraged to use this urge as a cue to engage, rather than avoid. They are asked to make a mental prediction, face the situation, drop their safety behaviours and discover what happens. They can retrospectively record their observations in a record sheet across the week. For example, a person who fears coming across as stupid spends a day noticing her urge to keep quiet and uses this as a cue to speak up for a minute or two longer than usual while dropping her safety behaviours. Keeping a record of this, in similar way to the golden opportunities record sheet (see above) continues to accumulate data of the self as acceptable.

Positive data logs

For patients who hold entrenched negative beliefs about their social self, continuing to keep a more traditional positive data log (see Padesky, 1994) can help to strengthen belief in a more positive alternative. However, we think it is first useful to ensure that patients are dropping their self-focus and safety behaviours in social situations (as in the above golden opportunities log), otherwise the evidence gathered will tend to be discounted (e.g. they only seemed like they liked me because I was putting on a front).

11) Decatastrophizing Experiments

As CT for SAD and progresses, patients learn that their feared catastrophes are much less likely to happen than anticipated. This is reflected in a reduction in their belief ratings and other measures. However, patients may still fear that if, in the unlikely event their feared catastrophe were to happen it would be catastrophic (e.g. I'm unlikely to say something stupid but if I did then people would reject me). If there is a distortion in their thinking, this is when decatastrophising experiments are introduced. This is where therapists and patients may intentionally demonstrate the specific worst feared outcome by faking it, rather than waiting for it to happen naturally. For example, purposefully something stupid or boring, creating the appearance of a blush, shake or sweat for and then observing reactions. This is because some of the things that patients worry about are unlikely to happen, but if they do occur naturally (such as forgetting their words) they often feel highly anxious and this can make them more self-focused and less able to observe the reactions of others. When intentionally acting out their fear, they are more likely to observe what is actually happening. When relevant for the individual and if done at the right point in treatment (usually later in therapy), these experiments are usually a powerful step in setting patients free from their fears, as they discover that even if their worst fears were to happen, it would not be as bad as they think. Example decatastrophising experiment carried out a remote CT-SAD session. An example is given below.

1. Situation	**2. Prediction** What do you think will happen? How much do you believe it will, 0 - 100 % ?	**3. Experiment** What can you do to test the prediction? Remember to focus externally and drop your safety behaviours	**Outcome** What actually happened? Focus on what you saw/what happened not on how you felt. Re-rate my prediction	**What I learned?** What does this tell me about social situations more generally and how I come across? How can I build on my learning in the following week?

Going for a walk to local coffee shop during a remote session with blusher on	If I wear blusher to create an appearance of redness the shade I feel I blush, then people will stare at me, give a weird look and may laugh – 60%	Put blusher on and walk to local shop with therapist on phone (headphones). Look up and around, focus externally. Observe reactions.	Nobody stared at me, a couple of people glanced but looked away. Nobody laughed. Re rate belief – 10%	This shows me blushing may not be as big a deal as I think it is. Not as noticeable and people do not care as much as I thought. I am acceptable even if I look red in the face. I believe this 60% I can try wearing the blusher again tomorrow when I go to the supermarket

Key tips for decatastrophising experiments:

- ***Target only things the patient is fearful of.*** These experiments are used to test patients' idiosyncratic feared catastrophes. So, do not do outrageous things simply to draw unnecessary attention to somebody. We have heard examples of these experiments not going to plan when therapists may have misunderstood the principle and asked patients to do something that is not linked to something they personally worry (e.g. putting on a funny accent, skipping down the street, screaming in public). None of these are things that patients with SAD would typically worry about. Only do things to test the patient's own fears (e.g. tripping over their words, blushing, sweating shaking etc).
- ***Start them in session.*** Decatastrophising experiments are challenging for patients to try. It is recommended that they are first carried out as in-session experiments alongside the therapist before being set for homework.
- ***Therapist fakes it first.*** It is often most useful if therapists model acting out or creating the appearance of the fear first so that patients can observe the responses of others when feeling less self-conscious. This usually means they feel more able to try the experiment themselves alongside the therapist. For example, for a patient who feared sweating, the therapist put water on their own forehead to test fears that others will stare with disgust which then helps the patient feel more confident to try this themselves.

- ***Don't go over the top.*** There is also no need to dramatically exaggerate the fear. We want to maximise the chances that the experiment will be helpful by recreating the fear to the level the patient is concerned about. For example, applying blusher to the shade they feel they turn red, or applying the same amount of water to their underarms to re-create the feeling they have when they feel sweaty.
- ***Specify what needs to be done and when.*** When the patient is doing the decatastrophising experiment themselves, it is usually helpful to agree exactly what the patient should do, how and when. This helps to avoid patients becoming too self-focused thinking about how they will carry out the task and less able to observe the reactions of others.
- ***Keep homework manageable.*** Any experiments set for homework should not be significantly more challenging than those the patient has already done in session.

In Appendix 10 we provide a table covering a range of social cognitions patients with SAD often have and ideas for decatastrophising experiments for each. Please note, there is no single list of experiments for any one patients, in devising an experiment we are guided by the patient's individual fears and concerns.

Exercise for therapists

Decatastrophising experiments are hard to do and can activate anxiety for many therapists and well as patients. We encourage therapist in our training workshops to try out any decatastrophizing experiments themselves that they would feel worried about doing with a patient. This is a helpful way to build your confidence using these in treatment. We have put together a helpful video for therapists on trying decatstrophizing themselves on the oxcadatresources.com website.

Video illustrations of carrying out decatastrophizing experiments are available at oxcadatresources.com

12) Addressing Pre/Post Event Processes: Worry, Rumination and Self-Criticism

Worry and rumination

Many patients with SAD will engage in anticipatory worry or post event rumination about their social interactions. This can take up much time and cause significant distress. It can keep patients up at night, which often becomes a vicious cycle as many then worry that their social performance will be adversely impacted by poor sleep. For many patients worry in advance and post-event rumination significantly reduce as they discover, through behavioural experiments and video feedback, that they come across as acceptable and much better than they think, and that others are not as focused on them as they thought. The Social Phobia Weekly Summary Scale (SPWSS; available to download from the oxcadatresources.com website) includes items on post-event rumination and worry in advance that can help monitor these processes as treatment progresses. If therapists spot that either of these processes are not reducing, helping patients to notice, label and disengage from worry or rumination by reminding themselves of its many disadvantages, can be useful.

We would usually start by exploring on the whiteboard (or via screen share) what the pros and cons of engaging in these strategies might be. It is worth noting that some patients do hold positive beliefs about worry or rumination, such as 'worry will help prepare me' or 'dwelling might prevent me from making a mistake in future'.

Advantages of worry	Disadvantages of worry
Some worry helps me prepare (but after a while this advantage disappears)	Makes me very anxious and on edge I start to feel low Makes it hard for me to sleep Takes me away from my kids and partner Doesn't give me reliable information about how it is going to go

	Takes all the joy out of work

A key message is that dwelling on social interactions or worrying in advance does not lead to reliable data about how the person comes across. The route to getting more reliable data is by turning their worry or self-critical thoughts into an experiment to put to the test. For example, a patient who thought he messed up when he presented at a work away-day decided rather than avoiding his colleagues afterwards and beating himself up, he would go and speak to them over the coffee break and see if they responded negatively towards him. To his surprise they were chatty and told him he did a good job.

Self-Criticism

Some patients with SAD experience thoughts in a self-critical way, with a harsh and attacking tone. This is problematic as when these patients project their thoughts into the minds of others, it gives the impression that others are thinking of them in the same derogatory and attacking manner, leading to other negative emotions including shame and sadness. If this process is activated during therapy sessions it can become a roadblock to belief change if not addressed. Simple manoeuvres, interwoven with standard CT-SAD interventions, can often help patients get into a less critical mindset. For example, some patients become highly critical of their appearance when doing video feedback of an experiment (e.g. 'I look awful, I look like a bloody idiot, my therapist must think I'm such a fool'). Therapists can help the patient recognise their thoughts as self-criticism, then switch off the video sound and/or covering the image of the patient so that they can only see the kind and friendly responses of the conversational partner.

Recognising the disadvantages of self-criticism. Patients can believe that beating themselves up is a helpful way to keep themselves in check and avoid making social mistakes in future. In these cases, exploring the disadvantages of self-criticism can be helpful. For patients who find it difficult to identify any downsides to self-criticism, it can help to ask them to consider a child in

their life and whether they would choose either a highly critical or a more compassionate teacher to guide this child's learning. When considering somebody else, patients are usually able to see that a harsh, critical approach does not facilitate learning. These patients may benefit from enacting how their inner critic speaks to them after a perceived social mishap. Hearing aloud how the self-critic sounds and exploring how anybody might feel if they experienced this harsh self-attack can make it easier for patients to recognise its negative impact and spot their inner critic in future (Gilbert, 2010).

Labelling the critic and speaking to the self with more kindness. As patients tend to project their self-criticism into the minds of others, it is particularly important that when patients start to recognise their inner critic, they remind themselves 'that's my inner critic, not what others think!' and then turn the content of the self-criticism into predictions to test in an experiment (the accurate data is in the moment, not in their head!). For those patients whose inner critic is an internalised person from their past (such as a critical parent), it can help to recognise that the critic is an echo from the past and label it as such (e.g. '*that is Dad's voice, not what others think now*'). Patients whose critical voice adopts a particularly harsh tone may need to be encouraged to practise speaking to themselves with more kindness and give themselves credit for achievements, however small, as treatment progresses.

Stepping out of your critical mindset and into the mind of others. Some highly self-critical patients find it difficult to stop projecting their self-critical thoughts into the minds of others. As they are spending considerable time beating themselves up for their perceived social flaws they assume others are doing the same. In these cases, we have sometimes tried drawing out a silhouette of the other person's mind and taking some time in a session to help the patient step into the other person's head, adding into the silhouette the various things that likely preoccupy the person they assume is thinking critically of them (e.g. has to look after 2 children; has a busy job – hundreds of calls and emails a week; has a sick father; partner has health issues; has to manage their bills/household etc). Encouraging the patient to step into the head of the other person for a moment, holding these things in mind can help them to see that the other

person is most likely not as focused or as critical on the thing that they are beating themselves up about:

Therapist: OK, so now we have drawn out all the things that are typically in Jen's mind. Let's take a moment to step into the head of Jen from work. On a day-to-day basis he she to manage several people, deal with customers and complaints, has multiple meetings and emails, has kids at home to care for, her mother has been sick, she is going through a divorce. Holding all those things in mind, how significant do you think it was to Jen over the week that for 30 seconds or so you weren't sure of the answer to something in a meeting last Wednesday?

Patient: Actually, probably not that significant. She might not even be thinking about it. I guess it was a tiny part of her week.

Therapist: Yes you are right, it was about 30 seconds wasn't it? How much time has passed since then?

Patient: Oh about 5 days.

Therapist: So how many minutes is that roughly? (they calculate this together 5days x 24 hours x 60 mins per hour =7200minutes)

Patient: Yeah ok the 30 seconds of what I said really is a tiny bit of the thousands of minutes since.

Therapist: That is a good point so, you are beating yourself up about this and have been all week, but is it possible that Jen may have moved on in all the time that has followed? That this is more like a grain of sand in the beach of Jen's mind?

Patient: Yeah, it probably is.

Be kind -rewind. Sometimes patients have stored events of perceive social mistakes in memory based on the self-critical thoughts and feelings they had at the time, rather than a more objective account of the event. In these cases, where patients have been unable to stop dwelling on an event, we have found it helpful to re-script the memory removing the voice of their inner critic and focusing more on what a video camera would have seen. We do this by:

1) First together writing out the story of the event on the white board together including how the patient felt at the time and their self-critical thoughts.
2) Secondly, redacting any self-critical thoughts or feelings, anything that a video camera would not have seen.

3) Thirdly, the patient is then encouraged to picture the event happening again through the view of a camera, rather than through their self-critical thoughts or feelings. Only viewing what factually happened and how others responded (not what their critic says).

For example, Amita could not stop beating herself up because she felt she said something stupid during a work meal. Below you will see her initial account of this memory and then the redacted account once she and her therapist removed the voice of her inner critic.

Version of the meeting with my inner critic:

I am sitting at the table with four colleagues and they ask me about the project. I tell them a bit about what we are doing and they carry on talking about different projects they are all working on. I think I am such an idiot, I totally messed that up and I should have said something more intelligent. They are all thinking I am so stupid and why have they employed me. I feel shit now. I always mess everything up. I'm so incompetent. Why can't I do anything right.

Version of the meeting with my inner critic removed – what a video camera would see:

I am sitting at the table with four colleagues and they ask me about the project. I tell them a bit about what we are doing and they carry on talking about different projects they are all working on. [redacted]

Assertive defence of the self. Occasionally people can find themselves in a highly critical environment at work or in the family. In cases such as this it is important to encourage them to explore social interactions outside of these contexts where they will have more of an opportunity to be appreciated. It can also be useful to use Christine Padesky's assertive defence of the self (Padesky, 1997).

10) Breaking the Link Between Past Social Trauma and the Present: Discrimination Training (Then vs Now)

Some patients with SAD have experienced past social traumatic experience, such as bullying, victimization, criticism from a parent or teacher, discrimination, racism etc. In the majority of cases (but not all) we find that these interpersonal traumatic experiences were around the onset of the patient's SAD and can intrude into present day social interactions and impact on the processing of the present-day event, a bit like the patient views the current situation through the lens of the past. We often talk to patients about this being like they are haunted by their past. This might play out with strong similar feelings reminiscent of how they felt during past social trauma being triggered in the present (e.g. strong feelings of humiliation or rejection), or images that are representative of how they felt at the time (e.g. an image of the self-looking small, vulnerable and blushing). This often happens without cognitive awareness that they are remembering the event (affect without recollection).

Many patients who have experienced social trauma will benefit significantly from the CT-SAD interventions we have already covered in this guide and their memories may cease to be problematic. However, some patients continue to experience feelings or memories from past social trauma in the present and this can limit their recovery if not addressed. In these cases there are two interventions we consider: Then vs now discrimination training and imagery rescripting. We tend to start with the former and only move onto the later if it is still needed.

Then *vs* Now discrimination training is a technique originally developed to treat trauma triggers in post-traumatic stress disorder (Ehlers and Clark, 2000) that we have found helpful with many patients with SAD over the years who experience strong feelings from past social traumas. It can help patients to process current social situations without being influenced by feelings or memories from past trauma. When using Then *vs* Now, therapists help patients to spot when memories from the past might be activated and to learn to look out for key differences

between THEN (their socially traumatic memories) and NOW (the present social situation). This helps break the link between the two.

Practicing Then vs Now in session. To introduce the technique we might typically spend some time in a session recalling a recent social situation that might have triggered affect or images from the past and then draw out on a white board (or via share screen if the sessions is remote) all the ways in which the present-day situation is different. An example is given below of a patient who was bullied at school by a group of girls who called her 'dull'. When around any group of people now she gets the feeling they are about to laugh at her and she feels very boring. She and her therapist drew out all the differences between her memory from school and a recent experience around a group of young people at University that triggered her memory.

	Then	Now
Similarities	Around group of kids	Around group
Differences	12 years old At school Group of mean kids calling me dull Laughing at me	19 years old At uni Group of young adults around Nobody calling me names Nobody laughing at me Discovered in experiments Im accepted now when Im just myself, people don't mock me

Using Then vs Now during social experiments. Patients are then instructed to look out for times that might trigger their memories or feelings from the past and then to actively look out for ways in which the present situation is different (e.g. "these are different people, adults, not my bullies, not ridiculing me, I'm an adult now"). Flashcards with key reminders of the differences that patients can keep handy on their mobile phone can be helpful here. Patients

are encouraged to look out for key differences when carrying out behavioural experiments over the week. Some differences could be written onto the behavioural experiments record sheet as a prompt.

Using Then vs Now during video feedback. For patients for whom traumatic memories often intrude in the present we have found it beneficial to review the outcome of experiments and any video feedback footage through the lens of focusing on what is different in the present, e.g 'Let's look at the other person you are talking to here, can you list all the ways in which they are responding differently to your critical mother used to?' The table below shows an example table drawn up when doing video feedback comparing the kinder responses of a conversational partner the therapist has brought into the session to the ways in which the patient's mother used to respond to her.

Ways in which my mother used to interact with me	Different ways in which the person I am talking to on the video is responding to me
• Screaming abuse at me • Stern face • Ignoring my point of view • Telling me I was stupid • Hitting me if I got something wrong	• Talking – not yelling • Smiling face • Listening to what I say- Interesting in me • Responding with respect • Not hitting me or hurting me

A video example of discrimination training is given on the oxcadatresources.com website

11) Breaking the Link Between Past Social Trauma and the Present: Imagery Re-scripting

After practice using the Then *vs* Now techniques many patients find they stop re-experiencing images or feelings from their traumatic past during present day social situations. They are then more able to learn that others are responding to them now as if they are acceptable in their experiments. However, if memories from the past continue to intrude then we have found that imagery re-scripting, as described by Wild and Clark (2011) can be useful to change the meaning patients have attached to early socially traumatic memories, to put these in the past and can also lead to a shift in the patient's negative view of their social self.

This technique was originally developed by Arnz and Wiertman (ref) to help people who experienced childhood abuse experience and is often used in treatment for PTSD. The general premise is that patients have attached overly negative meanings to their early traumatic experiences and that these need to be updated. For example, a young woman who was bullied by friends at school believed 'this means that I am stupid and inferior and will never have friends'. When these memories and the associated meaning are triggered in present day social situations, they leave her feeling small and inferior like she did during her bullying. The aim is to help the patient to discover that the behaviour of her bullies said more about then than it did about her, to update her memory with what she knows now and has discovered in therapy, so that it no longer intrudes in the present in a distressing way. This technique is typically delivered in several steps outlined below.

Step 1: Identifying a key memory to work on

The process begins identifying a key memory that links to the patient's present-day self-image/impression/felt sense. If the patient experienced multiple socially traumatic memories (e.g. daily bullying or regular criticism from a parent), they can be asked for a particularly upsetting memory to work on, or to work from a composite memory that would capture several of these experiences.

Step 2: Identify the meaning in the memory than links to the patient's current negative social beliefs self-image/impression.

The therapist and patient then identify the relevant negative meaning that patients have attached to the memory and rate this on a 0-100% scale. These will vary from patient to patient and tend to link to the patient's negative beliefs, self-image or impression of themselves (e.g. this means I'm weird, boring, unlikeable, I will never be accepted, I will always be humiliated etc.).

Step 3: Exploring alternative evidence for the negative meaning patients have attached to their socially traumatic memories.

The therapist and patient then explore alternative evidence for the personal meaning patients have attached to their experiences. This firstly involves reviewing evidence gathered in therapy to date that does not fit with the negative meaning. It can help to ask:

- '*What have we learnt so far in treatment about how others respond to you in social situations? (eliciting specific examples from experiments)*'
- '*What have we learnt so far in treatment about acceptable you are as person?*'
- '*Can you bring to mind an image of how you actually looked on the video?*')

Patients are then encouraged to reappraise the memory differently:

- '*If you knew another child aged nine (i.e. age patient was in the memory) who was being treated in this way, would you tell them it meant they were weird, weak and inferior? (add patient's specific meanings).*
- *Why not? What would you say to them instead?*'.

Patients are usually able to conclude that the actions of critical/bullying/prejudiced others did not mean anything negative about *them*, that they are an acceptable person in the world. The transcript below, with a patient whose bullies told her she was "dull" demonstrates this.

Therapist: What have we learnt so far in therapy about this belief that you are dull and will be rejected by others?

Natasha: Well people don't treat me like that now.

Therapist: OK, yes what have we seen on video when you have spoken to others and just been yourself?

Natasha: People like me and respond well to me.

Therapist: And what have others said in their feedback?

Natasha: That I'm totally likeable, interesting

Therapist: Excellent. Do you think these teenage bullies were reliable judges of character? If you wanted to employ somebody for a job would you ask a teenage bully to provide their job reference?

Natasha: (laughs) no, of course not! They aren't reliable, they are mean kids.

Therapist: At the time as a child it must have been very scary and lonely to be treated in that way. But let's think about how you might see this now as an adult.

Natasha: Yeah probably pretty differently.

Therapist: So if your 12-year-old cousin told you girls at school treated her in this way, would you tell her that this meant that she was different or dull and she will be rejected in future?

Natasha: Of course not! That is the last thing I would say to her!

Therapist: Right. What would you say to her?

Natasha: I would say they were the one with the problem. Them not you. You are wonderful just as you are.

Step 4: Imagery rescripting

This new updated information is then brought back into the memory through imagery rescripting carried out in three phases. Each phase involves the patient closing their eyes (if they feel comfortable to) and reliving the memory. This is done from a slightly different perspective in each phase:

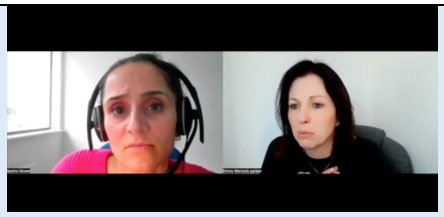
1. ***Through the eyes of the younger self in the memory*** experiencing the event in present tense (e.g. "I am walking into a classroom and a group of kids starts to yell at me…");
2. ***Through the eyes of the adult self, observing the event happen*** to the younger self (e.g. "I am standing in the corner of a classroom and I can see a young girl walking in, as she does a group of kids starts to yell at her…"). During this phase the patient is encouraging to intervene to bring in the updated information at key moments. This might involve the older self-showing the younger self some key discoveries they have made during their treatment, such as looking together at a still-image taken of the patient during a key behavioural experiment, reading other person feedback obtained in treatment; and giving themselves the care and compassion they needed at the time.

We find it can help to discuss in advance of phase 2 some ideas of what the patient would like to do or say to their younger self to help bring in the updated meaning.

3. ***Through the eyes of the younger self, who then experiences the older self-bringing the updated information*** in with compassion (e.g. "I am walking into a classroom and a group of kids starts to yell at me…I see an older woman walk over to me, she says…")

It can help to prompt patients to emotionally engage with the rescripting throughout and tune into some compassion for their younger self, e.g 'how do you feel watching your younger self be treated in this terrible way?', 'where do you feel that in your body?' etc.

0-100% belief ratings are taken after each phase of rescripting. We often find that after each phase belief ratings reduce. When imagery rescripting has been successful we often see that in the weeks that follow present-day social situations are no longer being processed through the lens of the past and patients can accumulate more evidence to disconfirm their beliefs.



A video illustration of imagery rescripting is available at oxcadatresources.com

Key points: Then vs Now and Imagery rescripting

- When patients have traumatic social memories that intrude on present day social interactions past focused techniques can be helpful
- Start with Then Vs Now discrimination training
- If improvements do not follow, then try imagery rescripting

12) Pulling it All Together and Planning for the Future: The Therapy Blueprint

At the end of therapy patients complete a therapy blueprint (see Appendix 6 for a blank example, one can also be downloaded from the oxcadatresources.com site). Patients are asked to complete a therapy blueprint for homework and bring this back towards the end of therapy, usually in final session. The patient and therapist review it and add to it. The blueprint includes key things she discovered and learnt in therapy, what the patient needs to keep working on and how to cope with setbacks in the future.

Booster Sessions. If follow-up sessions are offered (we recommend once monthly for 3 months) this is an opportunity to make a plan for this time. Many patients who have had long-lasting SAD may have lived rather restricted lives and the months that follow therapy are an opportunity to keep building on their achievements and broadening their social experiences. Some patients who have had longstanding avoidance have found it helpful to put together a challenge jar for themselves including several new social opportunities they may not have had the time to approach during treatment. They might decide to pick a new challenge each week in the months that follow their treatment. For some patients this is an opportunity to build the life they want to live now that they are free from their social fears.

A video illustration reviewing the therapy blueprint in CT-SAD is available at oxcadatresources.com

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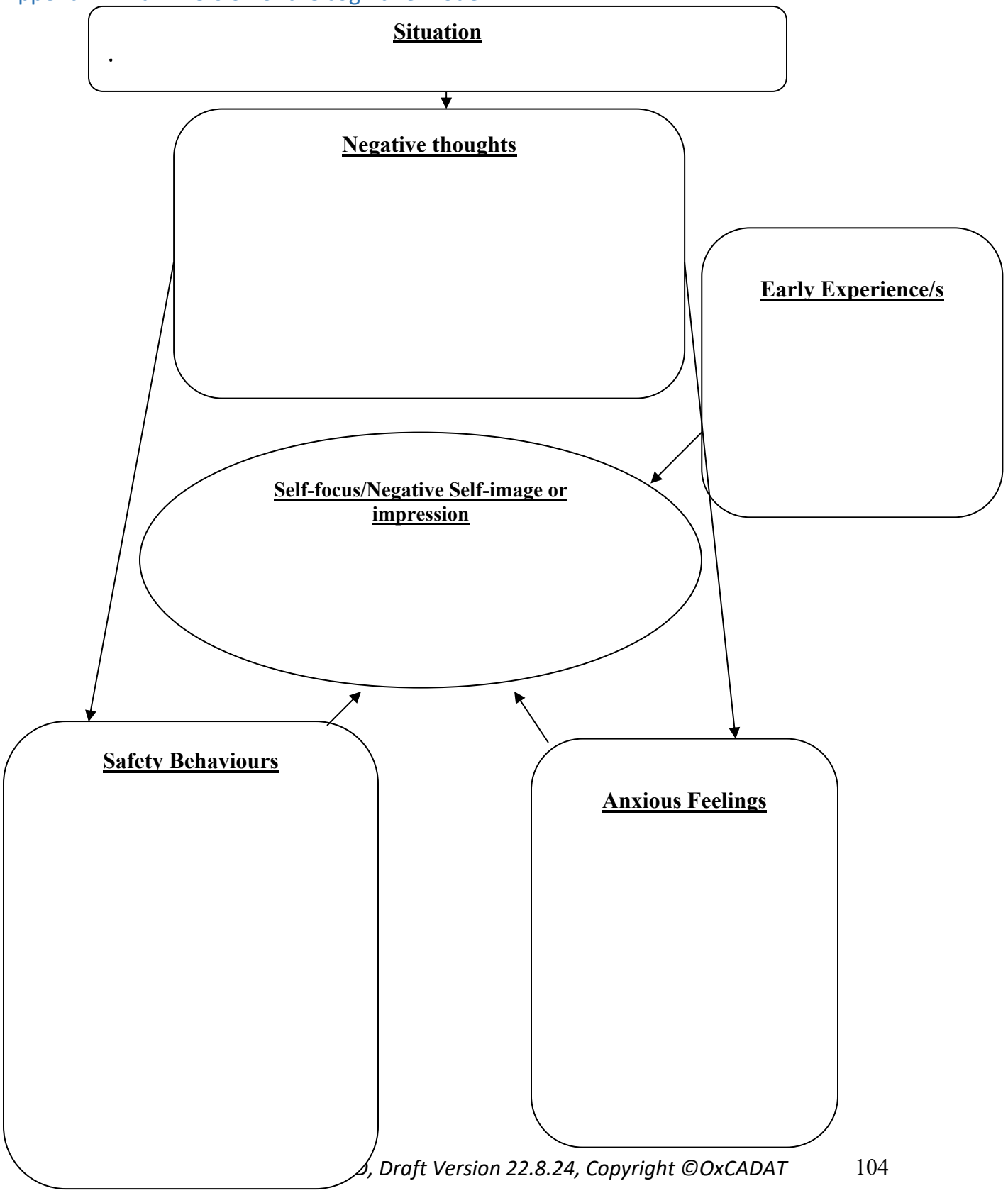
Appendices

Appendix 1 Blank version of the cognitive model



Appendix 2: My Self-Focused Attention and Safety Behaviours Experiment Record Sheet

My predictions in advance: What do I fear will happen in this situation? (0-100%

	Conversation with self-focused attention and safety behaviours	Conversation with externally focused attention and dropping safety behaviours
How much did you use your safety behaviours? (0=not at all 100%=all the time)		
How much was your attention focused on yourself and how you were coming across? (0=not at all focused on myself 100%=all the time)		
How anxious did you feel? (0-100%)		
How self-conscious did you feel? (0-100%)		
How anxious did you think you looked? (0-100%)		
How much did you think that……occurred? (0-100%)		
How much did you think that……occurred? (0-100%)		
How much did you think that……occurred? (0-100%)		
How much did you think that……occurred? (0-100%)		
How do you think the conversation went overall? (0=very badly -100% =very well)		

Appendix 3. Feedback Template for conversational partner after self-focused attention and safety behaviours experiment

Thank you for taking part in today's conversations.

First, we would like to know your overall impressions (e.g. they seemed kind, friendly, interesting to talk to), then we will ask for some more specific ratings about each conversation. Remember that the aim was to have an everyday friendly conversation, for example as if this was someone you just met and had a chat with over a cup of coffee. So please try to ignore the fact that the person you spoke to may be undertaking psychological therapy, and hold back any psychological knowledge or training you may have. Once complete, please return it to the therapist.Please note the person you spoke to will read your responses.

What was your overall general impression of the person you spoke to in your conversations today?

Conversation 1

Overall, how did you find this conversation?

Please read each statement below, and rate each one from 0 (not at all) to 100 (extremely).

Please add any comments you think would be helpful.

The person I spoke to [INSERT FEARED OUTCOME 1 e.g. 'ran out of things to say']

The person I spoke to [INSERT FEARED OUTCOME 2 e.g. 'came across as weird']

The person I spoke to [INSERT FEARED OUTCOME 3 e.g. 'looked sweaty']

(Continue as above for all feared outcomes)

The person I spoke to seemed anxious

I felt anxious

I enjoyed this conversation

The person I spoke to came across well

Conversation 2

Overall, how did you find this conversation?

Please read each statement below, and rate each one from 0 (not at all) to 100 (extremely).

Please add any comments you think would be helpful.

The person I spoke to [INSERT FEARED OUTCOME 1 e.g. 'ran out of things to say']

The person I spoke to [INSERT FEARED OUTCOME 2 e.g. 'came across as weird']

The person I spoke to [INSERT FEARED OUTCOME 3 e.g. 'looked sweaty']

(Continue as above for all feared outcomes)

The person I spoke to seemed anxious

I felt anxious

I enjoyed this conversation

The person I spoke to came across well

Any other comments?

Appendix 4 – Video feedback Record Sheet for the self-focused attention and safety behaviours experiment

Video feedback Record Sheet				
	Conversation using self-focus and safety behaviours		Conversation dropping self-focus and safety behaviours	
	Ratings before viewing	Ratings after viewing	Ratings before viewing	Ratings after viewing
How anxious did you think you looked/will look? 0 (not at all) – 100 (totally)				
How much do you think _____ will occur/occurred? 0 (not at all) – 100 (as much as possible)				
How much do you think _____ will occur/occurred? 0 (not at all) – 100 (as much as possible)				
How much do you think _____ will occur/occurred? 0 (not at all) – 100 (as much as possible)				
How much do you think _____ will occur/occurred? 0 (not at all) – 100 (as much as possible)				
How much do you think _____ will occur/occurred? 0 (not at all) – 100 (as much as possible)				

Appendix 5 Record Sheet for Noting Behavioural Experiments

Date	1. Situation	2. Prediction What do you think will happen? How much do you believe it will, 0 - 100 % ?	3. Experiment What can you do to test the prediction? Remember to focus externally and drop your safety behaviours	Outcome What actually happened? Focus on what you saw/what happened not on how you felt. Re-rate my prediction	What I learned? What does this tell me about social situations more generally and how I come across? How can I build on my learning in the following week?

Appendix 6: Blueprint for Social Anxiety

My Therapy Blueprint

1. How did the problem develop?
(What were the experiences that led to your social anxiety? Can you remember when it started? Was anything significant happening at that time? Were there any later experiences that made your social anxiety worse?)

2. 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/self protective strategies you engaged in 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 engage in anticipating what might happen and carry out post-mortems focusing on your feelings and discounting alternative feedback? Did you have a distorted image/impression of how you appeared based on the way you felt? Did you avoid situations?)

3. What were your main negative thoughts? What answers did you develop to these thoughts?

(What were the most important negative thoughts and beliefs – what are the answers to these? Summarise the negative thoughts on the left hand side of the page, write any answers you developed on the right hand side, and make notes about why you believe the answers (e.g. the specific behavioural experiments that helped changed them.)

4. What did you learn in therapy that was useful?

(What have you found helpful? Look back over the notes you have completed in your notes and remind yourself of key points learnt. Was there anything that particularly stands out for you? What did you learn about the role of Safety Behaviours? What did you learn about your internal focus of attention and the images/impressions you had of yourself? What did you personally find useful?)

5. How should I deal with social situations in the future, including any setbacks?
(How can you maintain your new social self, your new way of being? What things might happen in the future to undermine your confidence? Will specific thoughts re-occur? 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**?)

6. How could you build on what you have learned?
(What do you need to do to maintain 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?

Appendix 7: Attention Training – An exercise for the week

Although self-focused attention is unhelpful, it has probably become a habit. As with all habits, practice will be needed to help you turn off self-focused attention and shift your attention to what is happening in the social situation. Two types of practice are likely to help. First, practising focusing on the world around you, rather than on yourself, in non-social situations. Second, doing the same in social situations.

Because self-focus is particularly automatic when you are anxious in social situations, some people find it easiest to start practising focusing externally in less threatening, non-social situations. We suggest that you practise in non-social situations, for at least 10 to 15 minutes each day. However it is unlikely that you will be able to be fully externally focused during this time. Your attention may well repeatedly come back onto yourself. Don't worry about this. Simply focus externally again. Please record your practices in the tables below.

Instructions for practising external focus of attention

The world around us is full of different sounds, colours, objects, textures and events. During your practice sessions, we would like you to become more aware of what is happening around you. As you do so, you will probably find that you become less aware of yourself. Each practice session should have three components.

1. Becoming aware of different sounds/sights

In the first step, try to become aware of the range of different sounds and/or sights around you.

Practising inside

- Listen to a music CD or the radio: in turn pay attention to the different instruments that are playing (guitar, drums, piano, violin, clarinet, etc).
- Alternatively sit quietly and pay attention to the sounds in the room and any sounds you can hear outside.
- Now pay attention to what objects are around and the colours can you see? Where is there light and where is there shade? Pay attention to what it would feel like to touch these objects. What textures would they be? Would they be hard or soft?

Practising outside

- Go for a walk outside: pay attention to the sounds around you. What sounds can you hear nearby? What sounds can you hear further away? Can you hear cars, people, birds etc?
- Now pay attention to what buildings, plants, traffic and people are around? What colours and shading can you see? Pay attention to those. What are the different textures around you?

2. Switching your attention between the different sounds/sights

In the second step you need to switch your attention between the different sounds and sights. You can try this equally well indoors and outdoors

- Choose several different sounds.
- Start by focusing on one of the sounds, noticing all that you can about it and letting it fill your awareness.
- Don't worry if your attention shifts onto something else, gently bring it back to the first sound.
- After following the first sound for a little while (maybe a minute), shift your attention to another sound and become absorbed in following that.
- Do the same for a third sound.
- Now move on to colours, objects, or textures.

3. Pulling everything together

- Once you have spent time focusing on a number of different sounds and/or sights, try to become aware of all of them at once and for a few minutes let them all fill your attention.
- Let yourself get lost in the outside world.
- Don't worry if your attention drifts back on to yourself. Simply notice this and gently shift your attention back to the outside world.

We suggest trying this in many different situations. At this practise stage you can take it step-by-step. The final aim is to be able to simply focus your attention externally and be aware of what is really going on 'out there'.

Day / Date	Situation (including whether inside or outside)	What I focused my attention on	How long I practiced	Any other comments

This type of exercise can be quite difficult at first – and remember we don't expect that you'll immediately be able to be fully externally focused for long periods of time. It is common for people to find their attention keep coming back onto themselves. This is because it is like a habit that has been going for some time and, like any habit, isn't likely to change 'just like that'. One the most important thing about changing habits is to remind yourself to practise to do things differently, otherwise the old habits will just naturally continue. You can help remind yourself to practise focusing externally outside of sessions by using simple practical reminders. These include post-it notes in familiar places such as your desk, or small coloured sticky dots that you can put in places you look at a lot such as your watch or mobile phone. When you look at these they can act as a cue to practise focusing externally.

Appendix 9 Key Process Questionnaires to guide treatment

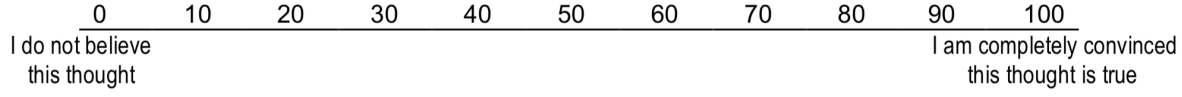
SOCIAL COGNITIONS QUESTIONNAIRE

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

___	I will be unable to speak	___
___	I am unlikeable	___
___	I am going to tremble or shake uncontrollably	___
___	People will stare at me	___
___	I am foolish	___
___	People will reject me	___
___	I will be paralysed with fear	___
___	I will drop or spill things	___
___	I am going to be sick	___
___	I am inadequate	___
___	I will babble or talk funny	___
___	I am inferior	___
___	I will be unable to concentrate	___
___	I will be unable to write properly	___
___	People are not interested in me	___
___	People won't like me	___
___	I am vulnerable	___
___	I will sweat/perspire	___
___	I am going red	___
___	I am weird/different	___
___	People will see I am nervous	___
___	People think I am boring	___
	Other thoughts not listed (please specify):	
___	_____	___

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 dotted line on the **RIGHT** hand side of the form.



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.

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

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.

I don't need everyone's approval

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I must not show signs of weakness to others

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If I make a mistake in a social situation people will reject me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Everyone will stare at me and think I'm strange if I don't act normally

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm unlikeable

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Other people are more anxious than I am

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm different

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Other people are better at getting it right socially than me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I must appear intelligent and witty

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I look as anxious as I feel

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If other people think I'm inferior, then I am

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm unacceptable

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Anxiety is not a sign of weakness

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Other people are more competent than I am

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Others are more acceptable and likeable than me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

My anxiety is obvious to other people

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If someone doesn't like me, it is my fault

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

To be worthwhile, I don't need approval from other people

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I must not let anyone see I am anxious

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

People think I am uninteresting

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If others really get to know me, they won't like me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Unless I appear calm, cool and collected, people will reject me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm inferior

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm vulnerable

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Other people are less anxious than I am

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

People can see right through me, and see my weakness

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I don't need to be liked by everyone

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm a weird person

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If people see I'm anxious, they will humiliate, ridicule and discount me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If I disagree with someone, they will think I am stupid or will reject me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm odd/peculiar

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm important to other people

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

People see anxiety as a sign of weakness

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I have to do things right to be accepted

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Unless I am witty and interesting, people won't like me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If I keep up appearances, I might scrape by

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

My opinions mean nothing

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

When people see that I'm anxious, they see the real, inferior me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm attractive

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If people notice I am anxious they will think I am odd

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

People are intolerant of signs of weakness

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If someone thought that I was inferior to them, I couldn't stand it

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If I am quiet, people will think I'm boring

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm inadequate

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If people see I'm anxious, they will think I am weak or inferior

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm interesting

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If people look at me, it means they are thinking negative things about me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm a boring person

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Even if people see my anxiety, it doesn't mean that I am inferior to them

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I must always live up to other people's expectations

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

SOCIAL PHOBIA WEEKLY SUMMARY SCALE

a) Please circle a number from the scale below that best describes how severe your social anxiety has been in the last week:

0	1	2	3	4	5	6	7	8
Not at all disturbing and/or disabling		Slightly Disturbing And/or Disabling		definitely disturbing and/or disabling		Markedly disturbing and/or disabling		severely disturbing and/or disabling

b) Please circle a number from the scale below to show how often in the last week you have avoided difficult social situations or aspects of those situations.

0	1	2	3	4	5	6	7	8
Not at all		Rarely		Sometimes		Often		Always

c) For social situations *in general*, please choose a number from the scale below to show the extent to which your attention was focused on yourself or on the external situation in the last week.

0	1	2	3	4	5	6	7	8
Entirely externally focused				Both equally				Entirely self focused

d) For social situations *that you found difficult*, please choose a number from the scale below to show the extent to which your attention was focused on yourself or on the external situation in the last week.

0	1	2	3	4	5	6	7	8
Entirely externally focused				Both equally				Entirely self focused

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.

0	1	2	3	4	5	6	7	8
Not at all		Rarely		Sometimes		Often		Always

f) Over the past week how often have you gone over social interactions in your mind *after* they have finished.

0	1	2	3	4	5	6	7	8
Not at all		Rarely		Sometimes		Often		Always

Appendix 10 Behavioural Experiments to target a range of Social Cognitions in CT-SAD

Thoughts	***Key points we want patients to discover in CT-SAD***	***Experiential exercises in CT-SAD to address negative thoughts***
Others stare at me	• Feeling stared at is often an illusion caused by staring at yourself (self-focused attention) • I am not the centre of others' attention. What I am doing is not headline news • Others are often lost in their own world • People have to 'park' their eyes somewhere but this is different to staring. • If somebody does glance at you for longer this is not always for a negative reason	**Staring experiment (manipulating self-focused attention and safety behaviours):** Start by walking with head down bringing on feeling being stared at until in a busy area, predict how many people are looking at you before looking up/around to find out how many people are actually staring. If somebody is glancing in your direction try to hold their gaze rather than immediately looking down to see if they are staring or just parking their eyes briefly on you. **Surveys:** Finding out what makes others look at somebody else for longer than usual – is it always a negative reason? **Use golden opportunities**: when feel stared at look up, observe others' reactions and record findings.
I am boring	• Feeling boring is a result of monitoring how boring you sound. • I am acceptable to others when I am just myself. • Most conversations are not fascinating, they are about shooting the breeze. • Others do not expect us to fascinate them all the time	**Self-focused attention and safety behaviours experiment:** Switch attention during a conversation from monitoring "how boring do I sound" to focusing on the chat and the other person, and compare the two conditions. **Video and Other person feedback:** Compare how boring they felt with how they actually appear and how others' respond on video. Get feedback from conversational parter on how boring the person came across **Observing others:** How fascinating are conversations you over hear on the bus/train etc? **Surveys:** Finding out what others think about having a less fascinating conversation. Would others think/behave in the way the patient expects? **Dropping Safety behaviours:** Speak spontaneously without preparing or monitoring. Observe others' responses. **Use golden opportunities**: when feel coming across as boring, observe others' reactions and record findings. **Decatastrophising:** Deliberately say something you think is boring and observe others' reactions
I am blushing	• When I focus on feeling red, I think I blush more	**Self-focused attention and safety behaviours experiment** Used to switch between focusing on blushing and using safety behaviours vs dropping these

	• Safety behaviours (such as hiding my face with my hair) can make the problem worse by drawing more attention to myself. • Blushing is part of being human and others mostly do not apply the same negative meaning to blushing as I do • Blushing is not as noticeable or significant to others as I think it is/is not headlines news. • Even if redness is noticeable people do not tend to react negatively as I predict	to disover that self-focused attention and safety behaviours are unhelpful. **Video feedback:** Compare how red patients felt (using colour charts) to how they appear on video. **Other person feedback:** Do others talking to the patient think they look as red as the patient feels? **Observing others:** Do others blush? How do others responds if so? **Surveys:** Finding out what others think about Blushing. Would others think/behave in the way the patient expects? **Dropping Safety behaviours experiments:** Wear hair up and don't cover face with hands. Don't sip water to keep cool. Focus on the conversation. Observe others' reactions and record findings. **Use golden opportunities**: when feel blush to look up/observe others' reactions and record findings. **Decatastrophising**: Intentionally put blusher on cheeks. Don't cover face and observe other's reactions. Helpful for therapist to model this first and do together in session.
I am sweaty	• When you focus on feeling sweaty, you think you sweat more • Safety behaviours (such as wearing extra layers) make the problem worse. • Sweating is part of being human and others mostly do not apply the same negative meaning to it as I do • Sweat is not as noticeable or significant to others as I think it is/is not headlines news. • Even if sweat is noticeable people do not tend to react as negatively as I predict	**Self-focused attention and safety behaviours experiment:** Used to switch between focusing on feeling sweaty and using safety behaviours vs dropping these to discover that self-focused attention and safety behaviours are unhelpful. **Video feedback:** Compare how sweaty patients felt to how they appear on video. **Other person feedback:** Do others talking to the patient think they look as sweaty as the patient feels? **Observing others:** Do others sweat? How do others responds if so? **Surveys:** Finding out what others think about Sweating. Would others think/behave in the way the patient expects? **Dropping Safety behaviours** Take off excessive layers, don't cover underarms. Don't sit near window to keep cool. Focus on the conversation. Observe others' reactions. **Use golden opportunities** when feel sweaty to look up/observe others' reactions. **Decatastrophising** Intentionally put water on underarms/foreheard. Don't cover underarms and observe other's reactions. Helpful for therapist to model this first and do together in session.

I shake	• When you focus on feeling shaky, you think you shake more • Safety behaviours (such as gripping things tightly) make the problem worse. • Feeling trembly/shaking at times is part of being human and others mostly do not apply the same negative meaning to it as I do • Shaking is not as noticeable or significant to others as I think it is/is not headlines news. • Even if shaking is noticeable people do not tend to react as negatively as I predict	**Self-focused attention and safety behaviours experiment:** Increasing then decreasing self-focus and safety behaviours (such as gripping things tightly) demonstrates then negative impact of these strategies. **Video feedback:** Patients rate and demonstrate how shaky they felt during an experiment and then video is reviewed to compare the feeling to what is visible on screen. **Other person feedback:** Do others talking to the patient think they look as shaky as the patient feels? **Surveys:** Finding out what others think about Shaking. Would others think/behave in the way the patient expects? **Dropping Safety behaviours:** Relax hands on lap during conversation and then try picking up a cup without gripping it. Observe others' reactions. **Use golden opportunities** when notice feeling of shaking to drop safety behaviours and observe others' reactions. **Decatastrophising**: Intentionally shake hands when holding a cup. Observe others' reactions.
I am stupid	• Feeling stupid is often a result of monitoring how stupid you sound. • Others do not expect you to know everything • Everybody makes mistakes – this is human and is the only way we learn • Even if we get something wrong people do not pay as much attention or tend to react as negatively as I predict	**Self-focused attention and safety behaviours experiment** Switch attention during a conversation from monitoring "how stupid do I sound" to focusing on the chat and the other person, and compare the two conditions. **Video feedback:** Video feedback is used to help patients discover how they actually come across and how others respond when they feel stupid. **Other person feedback:** Do others talking to the patient think they come across as stupid as the patient feels? **Surveys:** Finding out what others think about making mistakes. Would others think/behave in the way the patient expects? **Observation:** Observe what happens when others (could include therapist) give incorrect answers or do not know the answer to something. **Dropping Safety behaviours**: Stop preparing clever things to talk about or censoring what you say and observe reactions' of others. **Decatastrophising :** Intentionally ask for directions to the train station when standing in view of it; ask if they sell coffee in a coffee shop etc. Intentionally give incorrect answer or say "I don't know that" and observe others' responses.

I am weird	• Feeling weird is often a result of monitoring how weird you are coming across • No two people are the same, we are all different and many people find this interesting	**Self-focused attention and safety behaviours experiment** Switch attention during a conversation from monitoring "how weird do I sound" to focusing on the chat and the other person, and compare the two conditions. **Video feedback** Video feedback is used to help patients discover how they actually come across when they feel they look weird **Other person feedback:** Do others talking to the patient think they come across as weird as the patient feels? **Dropping Safety behaviours** Rather than agreeing with others all the time and trying to fit in, express more of your own options and observe reactions' of others. **Decatastrophising** Intentionally express an option you think others would find weird or unusual. Observe their reactions.