

THE ADAPTATION OF THE CLARK (1997) TREATMENT  
FOR SOCIAL PHOBIA INTO  
A GROUP THERAPY FORMAT, AND  
A PRELIMINARY EVALUATION

A thesis submitted in fulfilment of the requirements for a degree of  
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SWETHA KANNAN

Rhodes University

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## **ABSTRACT**

Clark and Wells (1995) constructed a comprehensive cognitive model of social phobic behaviour, in terms of which social phobic behaviour is activated and maintained by a system consisting of negative thoughts and beliefs, anxiety symptoms, avoidance and safety behaviours, and processing of self as a social object. The interaction of these elements creates a series of vicious circles which escalate and which keep the phobic individual in a state of chronic disability, either because they chronically avoid significant social situations or because they find themselves incapacitated by anxiety when they enter them. The Clark and Wells (1995) treatment programme is designed to alleviate the social phobia by targeting the components that form the vicious maintenance cycle and replacing these by new patterns of cognition and behaviour.

This treatment programme was designed for individual treatment, and the present study adapted it to a group format. Seven social phobic university students participated in the adapted group treatment format over the course of 13, 2-hour group sessions. Regular assessment of participants' response to the programme was carried out weekly and at two follow-up assessments, with the use of a series of questionnaires. In addition, sessions were audio taped and videotaped, facilitators took notes during sessions and keep records made by participants of their homework exercises. Individual case studies were written for all participants (including two non-completers) in which case narratives were juxtaposed against their responses to each of the self-report questionnaires. These we used as a basis for evaluating the validity of the Clark and Wells theoretical model and in examining the effectiveness of the treatment programme in bringing to awareness and interrupting the cycles that maintained the phobic behaviour. It is concluded that the group programme showed evidence of being very effective and, a group treatment manual was constructed so that it can be employed clinically and in future research.

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## ABBREVIATIONS

APA	American Psychiatric Association
APD	Avoidant Personality Disorder
AR	Applied Relaxation
AT	Associate Therapy
BAI	Beck Anxiety Inventory
BDI-II	Beck Depression Inventory
CBT	Cognitive Behaviour Therapy
CBGT	Cognitive Behavioural Group Therapy
CBGT-A	Cognitive Behavioural Group Therapy for Adolescents
CGI	Clinical Global Impression
CR	Conditioned Response/ Cognitive Restructuring
CS	Conditioned Stimulus
CT	Cognitive Therapy
DSM	Diagnostic and Statistical Manual (II, III, III-R, IV)
ES	Educational Supportive Therapy
FNE	Fear of Negative Evaluation (Rating Scale)
GSP	Generalized Subtype of Social Phobia
GTP	Group Therapy Programme
ITP	Individualized Treatment Programme
LSAS	Leibowitz Social Anxiety Scale
RET	Rational Emotive Therapy
RU	Rhodes University
SAQ	Social Attitudes Questionnaire
SBQ	Social Behaviour Questionnaire
SBE	Safety Behaviours Experiment
SCQ	Social Cognitions Questionnaire
SCD	Self-Control Desensitisation
SD	Systematic Desensitisation
SIT	Self-Instructional Training
SP	Social Phobia
SRR	Systematic Rational Restructuring
SSR	Social Summary Rating (Questionnaire)
SSRI(s)	Selective Serotonin Re-uptake Inhibitor(s)
SST	Social Skills Training
SUDS	Subjective Units of Discomfort Scale
UCR	Unconditioned Response
UCS	Unconditioned Stimulus
VF	Video Feedback

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# CHAPTER 1

## SOCIAL PHOBIA: A REVIEW OF THE LITERATURE

# 1. SOCIAL PHOBIA: A REVIEW OF THE LITERATURE

## 1.1 INTRODUCTION

Social Phobia, also known as the neglected anxiety disorder (Liebowitz, 1987), will be referred to as SP following other researchers, such as, Herbert, Hope and Bellack (1992). SP received first recognition in the publication of the DSM-III (American Psychiatric Association, 1980) and has since been receiving increased recognition by researchers and therapists. SP is considered to be a psychological problem that affects approximately 13% of the general population (American Psychiatric Association, 1994). SP is one of the easiest disorders to relate to and understand. Everyone at some point in life has experienced increased anxiety in certain performance or social situations. In addition, unlike most other phobias, SP shows 6-month prevalence data amongst men (0.9% to 1.7%) and women (1.5% to 2.6%) as being fairly equal (APA, 1994).

SP is defined as a "marked and persistent fear of social or performance situations due to the individual's belief that he/she will act in a way which will be embarrassing or humiliating" (Clark, 1997, p. 123). Furthermore, these situations are then entirely avoided or endured with severe discomfort owing to the social phobic individual's fear of negative evaluation or judgment by others. Feared situations are, for example, speaking, eating, or writing in public, initiating or participating in conversations with people (of the same gender, and more often with the opposite gender), and urinating in public urinals. The disorder can be disabling because, if individuals suffer from fear of and/or avoid one or more given situations, this can interfere severely with their normal attainment of social and occupational goals (Liebowitz, 1987).

The onset of social phobia varies from early childhood to mid teens. However, most adolescents do not recognize that they have SP. They rather attribute their 'avoidances' and fears to personal characteristics that they will eventually overcome. It is only in their late 20s or early 30s that this problem is recognized as seriously debilitating and professional help is sought. Some individuals report that their shyness or social inhibitions as a child were early warning symptoms of what developed into SP (Bates & Clark, 1998). Others experience an abrupt onset due to an embarrassing or humiliating social encounter (APA, 1994).

One example where early warning symptoms were ignored is in a case study conducted by Bates and Clark (1998). Their patient only started therapy for her social phobias at age 29. In therapy however, it was discovered that her phobic symptoms began at age 17, and she regarded herself as having been a shy child. This can be regarded as one of the reasons why most studies that have been conducted on SP are with sample groups in their late 20s or older.

## **1.2 DIAGNOSIS OF SOCIAL PHOBIA**

### **1.2.1 Historical Overview**

Historically, SP has received increased recognition as a disorder over the last two decades. Research that primarily stems from studies and debates concerning the diagnosis of SP are discussed in order to conceptualise and understand the way in which SP emerged as a psychological disorder. In order to follow the development of this discourse, the various editions of the DSM (APA, 1980, 1987, 1994) will be used for reference, as this is the most commonly used diagnostic manual for mental/psychological disorders.

In 1966, Marks and Gelder were among the first to conceptualise SP. Their definition included fears of drinking, eating, vomiting, blushing, shaking, speaking or writing in the presence of other people. The central feature in their definition was the fear of appearing ridiculous to others (Clark & Wells, 1993). Though seemingly accurate, this definition has since been the subject of debate. Much research has been conducted since Marks' findings that have displayed understanding of additional factors relevant to the diagnosis of SP.

SP's essential definition has remained the same when traced through the DSM-III (APA, 1980), DSM-III-R (APA, 1987), and DSM-IV (APA, 1994), however, the diagnostic criteria have been changed considerably in each of these editions as is shown in the following Tables 1 to 3. Behind these changes lie heated debates regarding the diagnostic considerations of SP. These include the differential diagnosis of SP with Avoidant Personality Disorder, and the inclusion of the Generalized type of SP to the diagnosis of SP.

SP was not described with sufficient understanding in the DSM-III (APA, 1980). The DSM-III diagnosis (Table 1.1, below) does reflect the awareness of certain people experiencing

unnatural levels of fear owing to perceived negative evaluation or scrutiny upon observation. However, the DSM-III also reflects little knowledge about SP. One can see that SP was understood as occurring in a variety of isolated, disconnected social situations. This understanding is derived from criterion A in Table 1.1, with the fear or avoidance being in a situation, that is only one situation, rather than acknowledging the possibility of the same individual suffering fear and/or avoidance in many situations.

Individuals suffering from SP would have been diagnosed as only having a single social phobia that would not be severe or incapacitating. Those with multiple social fears were preferably diagnosed as having Avoidant Personality Disorder (Liebowitz, Gorman, Fyer & Klein, 1985). The differentiation between the two disorders was a must, as is clearly stated in criterion C in Table 1.1, and was made according to the DSM-III (APA, 1980) as follows. Social phobics avoid *specific situations* whilst people with Avoidant Personality Disorder avoid *personal relationships* (p. 324). This was the basic criterion for differentiation. It soon emerged that no such clear-cut distinction could be made between the two disorders.

**Table 1.1: DSM-III Diagnosis for Social Phobia**

DSM-III diagnosis	
A)	A persistent, irrational fear of, and compelling desire to avoid, a situation in which the individual is exposed to possible scrutiny by others and fears that he or she may act in a way that will be humiliating or embarrassing.
B)	Significant distress because of the disturbance and recognition by the individual that his or her fear is excessive or unreasonable.
C)	Not due to another mental disorder, such as Major Depression or Avoidant Personality Disorder.

(American Psychiatric Association, 1980, p. 323)

Amies, Gelder and Shaw (1983) and later Turner, Beidel and Larkin (1986) conducted studies on DSM-III diagnosed social phobics and discovered that these social phobics not only suffered with multiple social fears, but also found that the social fears created severe impairment in their daily functioning. This is possibly the reason why, as per the DSM-III-R's (APA, 1987), criteria for diagnosis of SP, criterion A (Table 1.2, below) refers to, "one or

more situations" that are recognized as feared situations, as opposed to criterion A in Table 1.1 that states, "desire to avoid, a situation". This finding would also accommodate criterion E (Table 1.2) in the DSM-III-R. It was also discovered in the above-mentioned studies that the socially feared situations would inevitably involve personal interaction with other people.

This proved that differentiating between avoiding specific situations and personal relationships was not the answer to differentiating SP from Avoidant Personality Disorder. It is research such as this that gave rise to the addition of the "generalized" subtype of social phobia (GSP) in the DSM-III-R (APA, 1987). This is abbreviated to GSP by other researchers, such as, Herbert, Hope and Bellack (1992). GSP includes most social situations as being feared situations for a social phobic. Another amendment to the DSM-III-R cautioned that the diagnosis of SP was not to be excluded even if the individual met all the criteria for diagnosis of Avoidant Personality Disorder as well (Herbert, Hope & Bellack, 1992).

The changes made in the DSM-III-R are present in the DSM-IV (APA, 1994) as well (Table 1.3, below). The criteria remain essentially the same, although rearranged and rephrased in order to increase clarity in diagnosis. The addition to be noted in the DSM-IV diagnosis is that, individuals under the age of 18 can be diagnosed with SP without considering the diagnosis of Avoidant Disorder of Childhood and Adolescence (F, Table 1.3, below), as was required in the DSM-III-R diagnosis (G, Table 1.2, below).

What is also noted in the DSM-IV diagnosis is the continuing confusion regarding the difference between Avoidant Personality Disorder and SP. Avoidant Personality Disorder will be referred to as APD, following researchers such as, Leibowitz, Gorman, Fyer and Klein (1985). The diagnosis of APD as per the DSM-IV (Table 1.4, below) continues to be additionally considered even if the diagnosis of SP is made. Heimberg (1996) raised two very important issues with regard to findings from other related studies and research on the difference between SP and APD.

Firstly, he stated that differentiating APD from SP inevitably challenges the relationship between Axis-I and Axis-II disorders, and between acute and chronic anxiety and distress. The inclusion of the generalized type of SP means that, the individual can in fact have prominent maladaptive personality features that can be viewed in impaired functioning in most social situations. Does this not mean that GSP is in fact a personality disorder that should be

included as an Axis II disorder. If it overlaps so much with Avoidant Personality Disorder that is an Axis II disorder, should GSP not be an Axis II disorder independent of SP.

**Table 1.2: DSM-III-R Diagnosis for Social Phobia**

<p>DSM-III-R diagnosis</p>	
A)	A persistent fear of one or more situations in which the person is exposed to possible scrutiny by others that he or she may do something or act in a way that will be humiliating or embarrassing.
B)	If an Axis III or Axis I disorder is present, the fear in A is unrelated to it.
C)	During some phase of the disturbance, exposure to the stimulus (or stimuli) almost invariably provokes an immediate anxiety response.
D)	The phobic situation(s) is avoided, or is endured with intense anxiety.
E)	The avoidant behaviour interferes with occupational functioning or with usual social activities or relationships with others, or there is marked distress about having the fear.
F)	The person realizes that his or her fear is excessive or unreasonable.
G)	If the person is under 18, the disturbance does not meet the criteria for Avoidant Disorder of Childhood or Adolescence.
<p>Specify generalized type if the phobic situation includes most situations, and also consider the additional diagnosis of Avoidant Personality Disorder.</p>	
<p>(American Psychiatric Association, 1987, p. 243)</p>	

Secondly, he questions whether there is a need for the existence of APD since SP (Table 1.3, below) has more information than APD (Table 1.4, below) in the DSM. He raises the question as to whether APD and GSP are in fact the same disorder. Rarely is an individual diagnosed with APD without the additional diagnosis of GSP. Conversely, there are several instances of people diagnosed with GSP without APD (Turner, Beidel & Townsley, 1992). Given these questions and findings, Heimberg (1996) concludes that these issues require further research.

**Table 1.3: DSM-IV Diagnosis for Social Phobia**

<p>DSM-IV criteria for Social Phobia (Social Anxiety Disorder)</p>	
A)	Marked or persistent fear of social or performance situations in which embarrassment may occur.
B)	Exposure to the social or performance situation almost invariably provokes an immediate anxiety response.
C)	This response can take the form of a situationally bound or situationally predisposed panic attack.
D)	Most often, the social or performance situation is avoided, although it is sometimes endured with dread.
E)	The diagnosis is only appropriate if the avoidance, fear, or anxious anticipation of encountering the social or performance situation interferes significantly with the person's daily routine, occupational functioning, or social life, or the person is markedly distressed about having the phobia.
F)	In individuals younger than 18 years, the symptoms must have lasted at least 6 months before Social Phobia is diagnosed.
G)	The fear or avoidance is not due to the direct physiological effects of a substance or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).
H)	If another disorder or general medical condition is present (e.g., Stuttering, Parkinson's disease, Anorexia Nervosa), the fear or avoidance is not limited to concern about its social impact.
<p>Specify if: Generalized: if this includes most social situations (also consider the additional diagnosis of Avoidant Personality Disorder).</p>	
<p>(American Psychiatric Association, 1994, pp. 411-412)</p>	

With reference to Table 1.3 (above), at present, the following guideline is used in the diagnosis of social phobics. The most obvious fear of individuals with SP is that they will act in a way that will cause embarrassment or show excessive anxiety symptoms; for example,

shaking, blushing sweating, stuttering. When exposed to a feared situation, individuals will typically experience a heightened level of anxiety or worse yet, suffer from a panic attack.

**Table 1.4: DSM-IV Diagnosis for APD**

<p>DSM-IV diagnosis for APD</p> <p>A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early childhood and present in a variety of contexts, as indicated by four (or more) of the following:</p> <ol style="list-style-type: none"> <li>(1) avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection</li> <li>(2) is unwilling to get involved with people unless certain of being liked</li> <li>(3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed</li> <li>(4) is preoccupied with being criticized or rejected in social situations</li> <li>(5) is inhibited in new interpersonal situations because of feelings of inadequacy</li> <li>(6) views self as socially inept, personally unappealing, or inferior to others</li> <li>(7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing</li> </ol> <p>(American Psychiatric Association, 1994, p. 664-665).</p>
--

In order to be diagnosed with SP, individuals should realize that the fear is excessive or unreasonable, and recognize that this fear causes them to avoid the situation(s) or endure the situation(s) with severe discomfort. This avoidance should inevitably be a strain in individuals' normal routine, thereby causing significant distress for them. The outlined symptoms should not be otherwise directly related to the effects of the use of a substance, explained as a general medical condition, or better accounted for by another mental disorder. Should another mental disorder or general medical condition be present, the heightened anxiety should not be considered as related (APA, 1994).

### 1.2.2 Differential Diagnosis

SP can be easily confused with various other psychological disorders. This is because these other disorders have similar anxiety and avoidance characteristics that are associated with the diagnosis of SP. Following are explanations with the use of researched studies as to how these disorders are differentiated from SP. In making a diagnosis, firstly and most basically, SP needs to be distinguished from what can be seen as normal levels of performance anxiety or shyness. For example, a person can experience an uncomfortable level of anxiety when making a presentation to a room full of important strangers. A person can also feel unnaturally shy when introduced to co-workers on the first day at a new work place. However, this cannot be considered "phobic" unless the anxiety or shyness is severe enough to cause prolonged distress regarding the feared situation to the extent that it interferes with the individual's normal daily functioning (Anthony, 1997).

When comparing SP with Schizoid Personality Disorder or depression, a notable similarity is in the avoidance of social situations. The difference however, is that, a person with Schizoid Personality Disorder prefers to be alone and is not distressed by this reality. A person with depression avoids social situations owing to lack of motivation or interest in socializing. The person with SP, however, avoids the situation owing to the anxiety experienced in socializing rather than the lack of desire to do so (APA, 1994). A desire definitely exists to socialize, and the inability to satisfy this desire causes severe distress for a social phobic.

In comparison to Panic Disorder with or without Agoraphobia, or Agoraphobia alone, it is found that people suffering with Panic Disorder or Agoraphobia will avoid a situation or crowded place owing primarily to the fear of having a panic attack. The level of anxiety experienced in all three disorders can be considered roughly comparable, however; the social phobic's anxiety is generated more from cognitions about appearing ridiculous, or saying the wrong thing rather than fear of experiencing enough anxiety to induce a spontaneous panic attack (Mannuzza, Fyer, Leibowitz & Klein, 1990).

When comparing SP with other disorders such as Pervasive Developmental Disorder, Separation Anxiety Disorder, or other disorders, the reason for avoiding a situation should be considered. A person with Pervasive Developmental Disorder might prefer to associate with people much younger than him/herself for fear of appearing ridiculous or humiliating oneself

when in company of people the same age. A person with separation anxiety disorder can experience tremendous anxiety when away from home or parents owing to the fear of living alone or away from what is familiar; and therefore have impaired social and occupational functioning.

A person with an eating disorder can experience anxiety when eating in front of others and therefore avoid eating at the dining hall at school or university, or at restaurants. A person with obsessive-compulsive disorder could avoid situations where people notice one's compulsive rituals. These are all examples where SP can be wrongly diagnosed when it is in fact better accounted for by another disorder with the similar characteristics of avoidance and/or heightened anxiety (APA, 1994). It must be mentioned however, that a person may receive both diagnoses if the criteria are met for both, the other given disorder and SP, provided that each diagnosis is independently met and unrelated to one another.

### **1.3. SELECTED THEORETICAL MODELS OF SOCIAL PHOBIA**

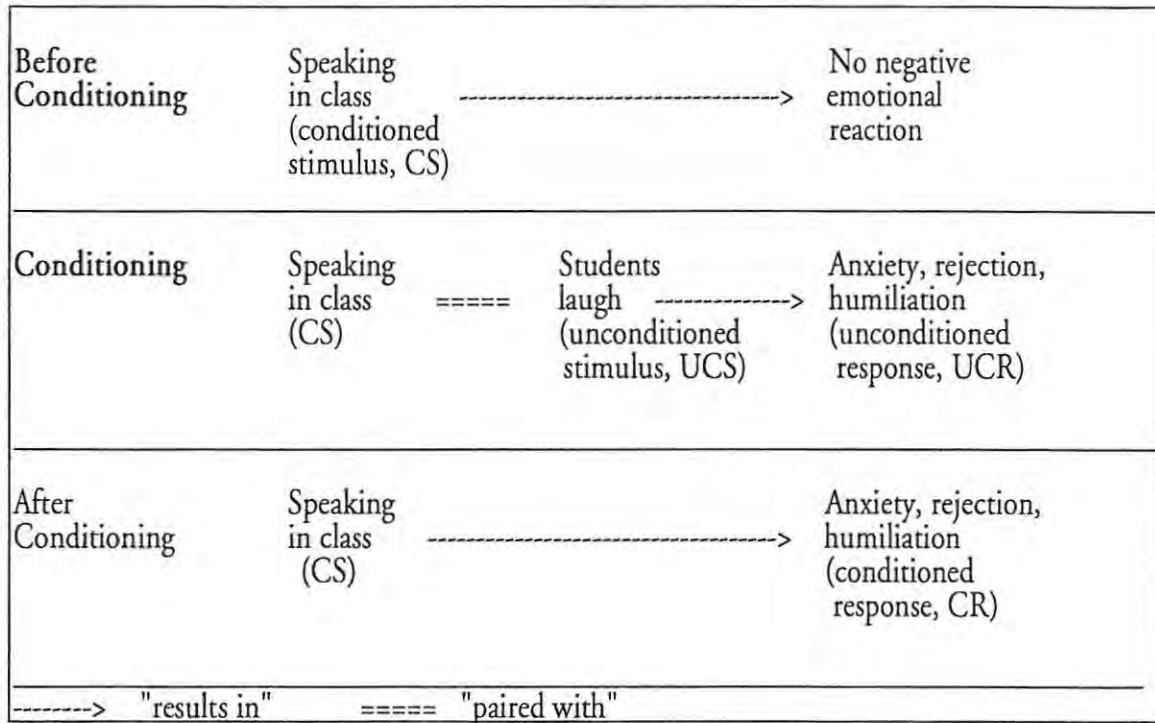
Several theorists have constructed models that explain the development and maintenance of social phobia and social anxiety. For the purposes of this study, five leading models will be reviewed before reviewing the Clark and Wells model, which is used as the main conceptual frame of reference in this study. These models serve as a useful framework within which cognitive-behavioural treatment of SP can be conceptualised.

#### **1.3.1 The Conditioning Model of Learning**

According to Mineka and Zinbarg (1995), SP can be conceptualised as developing due to a direct consequence of one or more traumatic conditioning experiences. This conceptualisation is similar to the way in which other specific phobias are believed to develop, through the process of classical conditioning, as explicated by Pavlov. The development of social anxiety can be understood as follows, with reference to Figure 1.1, below (Spiegler & Guevremont, 1998, p. 216). An individual acquires SP when directly faced with a traumatic event where the individual might have experienced humiliation, rejection or embarrassment. "Anxiety or fear develops when a neutral event (a conditioned stimulus, CS), one that does not elicit anxiety, is associated with an event that naturally causes anxiety (an unconditioned stimulus, UCS)" (Spiegler & Guevremont, 1998). The individual's experience in Figure 1.1 is an example of

how social anxiety is conditioned. An association is established between speaking in class (CS) and feeling embarrassed or humiliated. Other students laughing (UCS) is a sufficient stimulus to create anxiety (an unconditioned response, UCR) for the individual. Through 'reinforcement', the individual acquires the conditioned response (CR) of anxiety whenever confronted with the CS, which is explained further, with the following.

**Figure 1.1: Development of social anxiety through classical conditioning**



"Reinforcement refers to strengthening a behaviour so that it will continue to be performed" (Spiegler & Guevremont, 1998, p. 110). In other words, the greater number of times the individual speaks in class (CS) and gets laughed at by other students (UCS), the greater the probability that the individual will experience anxiety, rejection or humiliation (UCR). Subsequently, the UCR becomes the acquired or conditioned response (CR) whenever faced with the CS. A further association is then learned between speaking in class (CS) and feeling anxious, humiliated or rejected (CR) owing to previous traumatic experiences. However, it must be taken into consideration that, repeated reinforcement need not necessarily occur in order to acquire a CR. An isolated traumatic experience may be enough to acquire the CR.

**1.3.2 The Two-Factor Learning Theory**

According to Spiegler and Guevremont (1998), social anxiety is conceptualized in the Two-Factor Learning Theory through the understanding of how anxiety is developed and how the anxiety is maintained. Social anxiety is developed through classical conditioning (Section 1.3.1) where repeated reinforced CS-UCS pairing, results in the direct CS-CR association. However, classical conditioning theorists maintain that, it is not likely that at every instance for the rest of a socially anxious individual's life, the same UCS will follow the CS.

**Figure 1.2: Termination of social anxiety through extinction**

Before extinction humiliation	Speaking in class (CS)	----->	High anxiety, rejection, (CR)
Extinction (at first)	Speaking in class (CS)	----->	High anxiety, rejection, humiliation (CR)
(then)	Speaking in class (CS)	----->	Moderate anxiety rejection, humiliation (CR)
(then again)	Speaking in class (CS)	----->	Little or no anxiety rejection, humiliation (CR)
After extinction	Speaking in class (CS)	----->	No anxiety, rejection, humiliation (CR)
-----> "results in"			

Recapitulating the individual's case in Figure 1.1 (above), and referring to Figure 1.2 (above), there will be a point where the individual will speak up in class (CS) and nobody will laugh (UCS). This may be attributed to the fact that, the other students became bored of laughing at the same individual on a daily basis. Repeated reinforcement of this new CS-UCS association will result in a new CR of no anxiety. This process is known as extinction, which is defined as, "The process of eliminating (withdrawing or withholding) reinforcers" (Spiegler &

Guevremont, 1998, p. 139). However, in spite of the process of extinction, the anxiety is still maintained. This is explained further with the following. Social anxiety is maintained through operant (or instrumental) conditioning. Operant conditioning is the increase or decrease in a person's specific behaviour in order to elicit the desired systematic change in the CR. In the case of a person with acquired social anxiety, avoidance or escape behaviours systematically change the level of anxiety experienced. An association is formed between two occurrences. Individuals learn that, by changing a specific behaviour, a specific result is elicited. Thus, even before extinction is allowed to take place, the socially anxious individual will associate avoiding or escaping the CS with avoidance of the CR. These avoidance and escape behaviours are negatively reinforced, as they are associated with the omission or termination of anxiety (the CR). Thus the anxiety is not terminated permanently, but at least it is temporarily relieved through escape or avoidance.

**Figure 1.3: Maintenance of anxiety through operant conditioning**

Anxiety developed through classical conditioning	Speaking up in class (CS)	----->	High anxiety (CR)
Escape and avoidance behaviours learned	Avoid speaking up in class	----->	Little or no anxiety
Anxiety maintained through operant conditioning	Anticipation of speaking up in class	----->	Anxiety
-----> "results in"			

Using the example of the individual in Figure 1.1 (above), and referring to Figure 1.3, the individual will maintain his/her social anxiety through operant conditioning as follows. The individual may want to speak up in class. However, because the association has been formed between speaking up in class and experiencing anxiety, the individual will keep quiet. Keeping quiet is an avoidance behaviour that the individual learns in order to cope with the situation. By keeping quiet, the individual forms a new association between keeping quiet and experiencing no anxiety, as keeping quiet also means that nobody laughs. In this new association, the individual does not experience anxiety. However, this does not mean that the

individual will never experience anxiety when required to speak up in class at a given occasion. The anxiety will recur because, instead of speaking up a few times in class and ultimately realizing that people stop laughing, the individual avoids or escapes the event of speaking in class and maintains the association between speaking in class and being laughed at which is anxiety evoking. Thus, the anxiety is maintained and experienced each time the individual has the desire to speak up in class, as extinction of the anxiety is not allowed to take place.

### **1.3.3 Bandura's Social Learning Theory**

Both the models that have been summarized above place emphasis on one dimension of psychological functioning whilst neglecting others. Conditioning models are part of the rigid behaviouristic framework that is only concerned with overt, observable behaviour. Both models are founded on a conceptualisation in terms of learning through associations, that is, bonds between stimuli (S) and responses (R), or S-R connections that are seen as responsible for peoples' learned behaviours. However, insufficient understanding had been given to the nature of this S-R link (Reber, 1995). The assumption in both conditioning models is that, behaviour is primarily regulated by external events that are learned through these S-R associations. As Bandura (1974) explicates, "Conditioning is simply a descriptive term for learning through paired experiences, not an explanation of how these changes come about"(p. 859). Behaviour therapists assumed that these paired experiences or associations occurred mechanically. This mechanical association of two occurrences is rooted in the philosophical ideas of John Locke, who regarded the mind as functioning in a mechanical way. Behaviourists needed to keep in line with Locke's theories in order to appear respectable and on par with other schools of science, such as, Physics and Chemistry.

Behaviourists believed that the recognition that some mental activity exists would have been unscientific since it moved beyond observable cause and effect relationships. However, a new problem was raised with respect to the fact that associationism was far too simplistic. Bandura further examines this problem in his work on social learning theory. When examined closely, conditioning can be seen as cognitively mediated. "So-called conditioned reactions are largely self-activated on the basis of learned expectations rather than automatically evoked" (Bandura, 1974, p. 859).

From a cognitive perspective, a person recognizes that two events are occurring simultaneously on a repetitive basis because they are in fact somehow related. Therefore, if one event occurs, the other event can be expected to occur as well. This expectation implies prediction that is a cognitive activity. "Contrary to the mechanistic metaphors, outcomes change behaviour in humans through the intervening influence of thought" (Bandura, 1974, p. 850). Therefore, instead of the mechanistic S - R connection, Bandura proposed the S - cognition - R connection. Cognition comprises ideas, beliefs, thoughts, understanding, and knowledge. Thus learning would take place through changes in cognition.

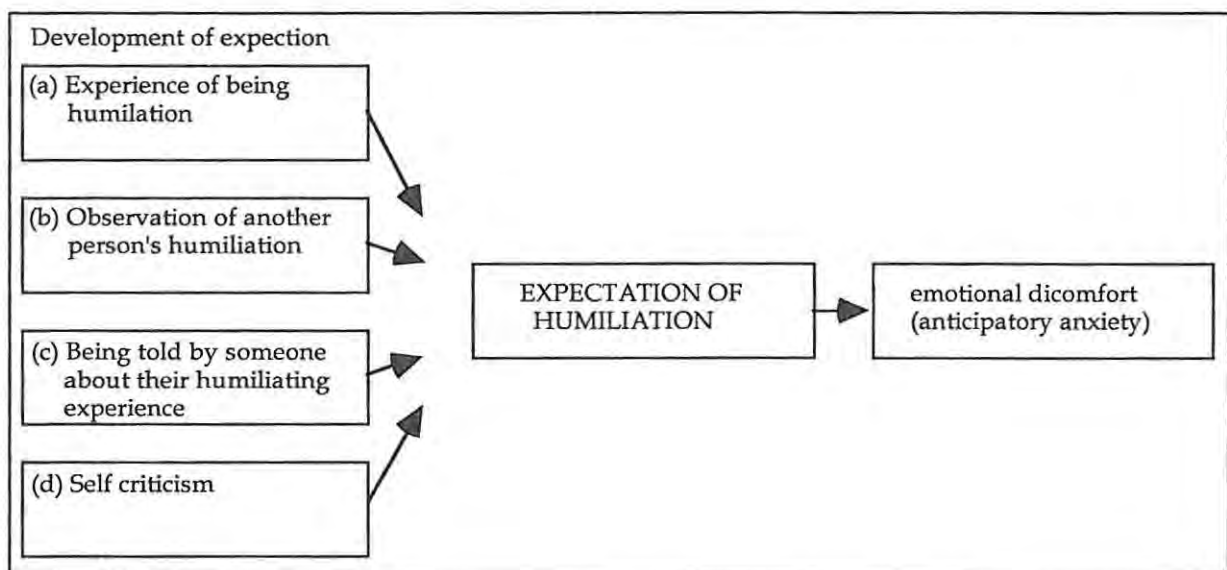
Bandura's social learning theory was one of the forerunners in the incorporation of learning by association with cognitive factors. Bandura develops two key concepts that contribute to a better conceptualisation of how cognitive factors can be integrated with the strictly behaviouristic framework (Rotgers, 1988). Firstly, self-efficacy is defined as "an individual's sense of their abilities, of their capacity to deal with the particular sets of conditions that life puts before them" (Reber, 1995, p. 702). Self-efficacy demonstrates that thinking patterns (cognitions) are closely related to emotions (e.g. anxiety) and behaviour, and that important personality traits can be consciously changed through learning new behaviour patterns. Most importantly, the conscious change in behaviour is enabled through one's belief in the ability to cope with the situations one is confronted with. It is simply the self-confidence an individual possesses. Relating self-efficacy to SP, individuals with low self-efficacy will be prone to social anxiety as they are unable to meet new challenges. These individuals will often avoid demanding and stressful situations.

Secondly, reciprocal determinism is the circular pattern with which the environment and individuals causally influence one another. Through intentional action, individuals construct their environment in order to be able to predict and anticipate consequences. The environment also influences individuals' behaviour such that the individual will keep constructing new ways of dealing with these influences (Rotgers, 1988). Applying this to the example of the individual in Figure 1.4 (below), the individual first recognizes that speaking in class is anxiety provoking. Through intentional action, the individual then constructs a way in which to use behaviours that are better suited to avoid this anxiety. In doing this, the individual is able to predict and anticipate future consequences. Although this process seems highly premeditated

by the individual, it is in fact an automatic cognitive change that needs to be analysed conceptually (as is explicated in Figure 1.4) in order to be understood theoretically.

In terms of self-efficacy and reciprocal determinism, people do not passively learn behaviours through conditioning. They can in fact regulate and self-determine their behaviour. Bandura (1974) explains that environmental influences also assist in shaping individuals' behaviour. However, these influences should not be considered as operating automatically. Conditioning models assume that environmental consequences are automatic determinants of individuals' behaviour. Bandura prefers to view these consequences as serving several functions. Most important of these functions is that they impart information. Reinforcement in social learning theory does not convey the same understanding as in the conditioning models. It is better understood here as "...changed from a mechanical strengthener of conduct to an informative and motivating influence" (Bandura, 1974, p. 860). Keeping this definition of reinforcement in mind, it is easier to understand how learning occurs through encoding of representational processes that an individual is exposed to.

**Figure 1.4: THREATENING SITUATION: Individual speaks up in class**



Representational processes delineate the occurrences through which individuals learn specific behaviours within the framework of the social learning theory. Learning takes place through encoding as a result of instruction (behaviours individuals are taught by significant others throughout life, especially in childhood), observation (behaviours learned through vicarious

learning), or imagined material (behaviours learned through imagination of given situations, and consequences that are possible in the situations). Modelling which is considered a key approach in learning behaviour derived from social learning theory is a representational process that will be discussed further.

In the process of modelling, individuals learn behaviours through observation. The basic requirements for the modelling process are "a model, who demonstrates some behaviour, and an observer, who attends to what the model does" (Speigler & Guevremont, 1998, p. 261). A model who is actually physically present is known as a live model, whereas a model who is observed indirectly is known as a symbolic model (e.g. on television, in books, through oral description). The observer will take mental note of the model's actions, and what the consequences of these actions are (that is, whether they are positive or negative). Depending on the consequences of the actions (vicarious consequences), the observer will choose whether to acquire the model's behaviour or not. If the behaviour is acquired, it is vicariously reinforced. In other words, individuals gain informed expectations from observed consequences (Bandura, 1974).

Taking the same example used (Figures 1.1- 1.3) in the conditioning theory models, social anxiety can be conceptualized in the modelling framework as follows. Individuals can develop social anxiety in a variety of ways as explicated in Figure 1.4. They can (a) directly experience being humiliated, or (b) through the modelling process, they can observe another individual's humiliation in a given experience, and therefore identify and anticipate how humiliation is possible for them in the same situation. Also as part of modelling, they can (c) merely be told by someone about their experience of humiliation, and expect and predict humiliation for themselves in the same given experience.

Furthermore, an individual sometimes engages in (d) self-criticism, whereby in spite of performing fairly well in a situation, the individual will make self-critical comments such as, "that speech was not good enough" or, "I could have performed better". This is known in social learning theory as self-punishment (the demotivating influence that is not necessarily an informed prediction of self conduct) as opposed to self-reinforcement in the reciprocal determinism cycle of behaviour acquisition. Such self critical comments induce anxiety in anticipation that the next such event will be equally badly presented if not worse presented, in spite of the fact that there is no evidence from the environment for this anticipation.

Once the informed expectation of humiliation is acknowledged, anxiety is anticipated. The individual then gauges their level of self-efficacy, in other words, their belief in the ability to cope with the anxiety-provoking situation. Depending on their level of self-efficacy, the individual will either maintain the expectation of humiliation, or overcome the expectation of humiliation. The expectation is maintained when the individual employs avoidance and escape behaviours [which shows low self efficacy] to cope with the situation. The individual can cope with the situation through self-mastery of the experience [which shows high self efficacy] thus overcoming the anxiety. The individual with low self efficacy will choose to ignore the coping role model and the self reinforcement statements as his/her belief in the ability to cope with the situation is suppressed by his/her belief that s/he will not be able to cope. This belief is the fundamental problem in learning to overcome the anticipated anxiety or humiliation. Changing this belief in self-efficacy is the key to anxiety relief in social learning theory.

#### **1.3.4 Beck's Cognitive Therapy (CT) Model**

Bandura's social learning theory and concepts such as, expectancy of reinforcement, self-efficacy, modelling, and vicarious learning catalysed the shift in behaviour therapy to the cognitive domain (Beck & Weishaar, 1989). Beck's cognitive therapy model emphasizes the acknowledgment of cognition as central to behaviour change processes. Cognitive therapy developed out of Beck's research on depression in the early 1960s. This research was conducted even before Bandura's work (late 1960s, early 1970s) on social learning theory. Therefore, Beck was not Bandura's successor. However, Beck developed a theory that conceptualises the role of cognitive factors in a more differentiated way.

According to Beck and Weishaar (1989), Beck's CT model is based on a theory of psychopathology that investigates the ways in which individuals process information from exposure to, or experience of various situations in life. Information processing includes, taking in relevant information, synthesizing it, and formulating a plan of action on the basis of that synthesis. This process is not always rational, and is generally automatic and outside of awareness. Information (data) is processed by means of several related coding systems. These coding systems are developed through learning processes that take place in childhood. Specific data is integrated, interpreted, and stored in memory as a selected sample of reference information that is used in dealing with current situations.

This sample of reference information is known as the primitive coding system that is developed in childhood. Conversely, mature coding systems involve rationally integrated and interpreted information. These coding systems are developed by individuals with age, and through new learning experiences that consolidate, refute, or compete with primitive coding systems. The development from primitive to mature coding systems can be understood with reference to 'Piaget's life stages'. Individuals' cognitive processes progress from the sensory-motor stage (birth- 2 years), to the pre-operational stage (2- 5 years of age), to the concrete operational stage (6- 11 years of age), and later to the formal operational stage (11 years and older). In this process, individuals advance from primitive to mature coding systems.

Beck's conceptualisation of cognitive processing and development is similar to that of Piaget. Beck's theory is concerned with the interaction between cognitive maturation, and continual encounters of old and new experiences (Reber, 1995). Following is an explanation of Beck's theoretical concepts, some of which Piaget also refers to, in his theory. Beck (1985) explicates that individuals analyse and assimilate information through the activation of *cognitive structures*. Cognitive structures are the complex organization or construction of a relatively stable configuration from many thought processes, and are founded within structural elements known as, *schemas* (Reber, 1995; Beck & Weishaar, 1989). Schemas are said to develop during childhood through personal experiences, or identification with significant others. The schemas help individuals to adapt to the given situation. They serve as guides for action, as structures for interpreting information, or as organized frameworks for solving problems (Reber, 1995).

Schemas are further organized into broader structures known as *modes*. Modes are motivational states that determine the specific schemas that are active. Modes represent adaptational principles that are utilized depending on the circumstance rather than the specific situation. Therefore, individuals have for example, a depressive mode, hostility mode, and fear (or danger) mode (Beck & Weishaar, 1989). The cognitive structure that is active in a specific situation is responsible for the various schemas that are active in the situation. However, the set of schemas that are activated may also be dependent on the dominant mode that is active at the time (Beck & Weishaar, 1989). Through the understanding of modes, the crucial difference between individuals diagnosed with situational SP and GSP becomes evident. In situational SP, individuals only activate cognitive structures or schemas relating to anxiety

they experience in the particular situation they fear. Generalized social phobics remain in the fear or danger mode. This in turn keeps the cognitive schemas relating to danger activated in most circumstances, thus impairing individuals' social and occupational functioning.

In the practice of CT, therapists have to deal with three types of cognition. These include, *automatic thoughts*, *underlying assumptions* and *core beliefs*. Automatic thoughts are conscious thoughts that spontaneously arise, that is, with no prior reasoning or reflection. At the time that these thoughts arise for individuals, they appear to be perfectly plausible, therefore explaining the impact they have on actions and emotions (Beck and Weishaar, 1989). Examples of these thoughts for socially anxious individuals are, "I'll look foolish", "I'll forget my speech", "They'll see me shaking". Negative automatic thoughts may persist even when objective evidence is contrary to these thoughts.

Underlying assumptions are attitudes, or unspoken rules that individuals live by. When individuals experience defeat or rejection, these underlying assumptions become relevant, and the individuals begin to believe in them (Beck & Weishaar, 1989). Whilst the activated schema generates automatic thoughts, underlying assumptions are a part of the activated schema. Core beliefs are early negative schemas that are central to individuals' psychological functioning. These are unconditionally accepted beliefs about the self, and others in relation to self, and are established at a very young age owing to personal experiences or identification with significant others (Beck and Weishaar, 1989). Core beliefs are deeply rooted maladaptive cognitive structures and therefore may be difficult to target and disconfirm. Examples of core beliefs that social phobic individuals may have are, "I am socially unacceptable" and "I am a social outcast".

Beck and Weishaar (1989) assert that individuals with emotional difficulties tend to make systematic errors in reasoning that bias their perception of objective reality in the direction of self-deprecation. Social anxiety for example, stems from commonplace maladaptive cognitive processing such as faulty thinking, making incorrect inferences from inadequate or incorrect information, and failing to distinguish between fantasy and reality. These characteristic logical errors in reasoning lead to faulty assumptions and misconceptions, which are termed cognitive distortions (Beck & Weishaar, 1989).

Referring back to primitive and mature coding systems, mature coding systems are not activated when individuals are in feared situations. The primitive coding system is spontaneously activated owing to its impact on individuals' cognitive development from childhood. "During psychological distress, the shift to a more primitive information-processing system is apparent in systematic errors in reasoning" (Beck & Weishaar, 1989, p. 23). Socially anxious individuals are predisposed to experience one or more cognitive distortions (Table 1.5) as a result of the interaction between certain dysfunctional attitudes and life situations.

**Table 1.5: Cognitive distortions associated with psychological disorders**

Cognitive Distortion	Definition	Example
Arbitrary inference	Drawing conclusions without sufficient evidence, or when the evidences actually contradictory	Believing that you have been retrenched because of personal incompetence although the company has gone out of business
Overgeneralization	Drawing a general conclusion on the basis of a single incident	Concluding that you will never succeed after failing on the first try
Selective Abstraction	Attending to a detail while ignoring the total context	Feeling rejected because a friend who was rushing to catch a bus didn't stop to talk
Personalization	Erroneously attributing an external event to yourself	Thinking that people who are laughing are laughing at you
Polarized (Dichotomous thinking)	Thinking in extremes in a black-or-white or all-or-none fashion	Believing that you are a pauper after having lost your wallet
Magnification and Minimization	Viewing something as far more or less important than it is	Thinking that you are a poor writer after getting back a paper with several corrections

(Speigler & Guevremont, 1998, p. 323)

Beck's main theories are incorporated into the models that follow.

### 1.3.5 Heimberg's Cognitive-behavioural model of anxiety in SP

A more detailed understanding of anxiety is addressed in Heimberg's model. Heimberg's model outlines features that allow a specialized understanding of SP in particular. This model was primarily constructed with the view to developing an effective treatment method for social phobics.

This model is based on three assumptions. The first assumption is that shyness, SP and APD are not qualitatively distinct disorders. All three disorders are related to one another and can be viewed as lying on a continuum from "low to extreme degrees of concern over social evaluation" as experienced by the individual suffering with social anxiety (Rapee & Heimberg, 1997; p, 742). Shyness would be placed at the lowest ranges on the continuum, SP in the middle, and APD at the upper extreme ranges of the continuum. This model would ideally be applied to individuals suffering in the middle to higher ranges of the continuum.

The second assumption is that SP has subtypes; namely GSP, and specific SP as per the DSM-IV. Qualitatively, the basic nature of both subtypes is similar in that, the individuals suffering from either subtype experience similar anxiety, appraisal of this anxiety, and specific dysfunctional behaviours owing to this anxiety. Quantitatively they differ in the number of situations feared by the individuals with GSP as opposed to specific SP. However, since both subtypes are similar in nature, the model can be applied to individuals with either subtype. The third assumption is that a thorough understanding of SP calls for a detailed examination of the individuals' experiences in the socially threatening situation. The model is summarized in Figure 1.5, and the components are discussed below.

#### A. Perceived audience:

In any given threatening or social evaluative situation, social phobics identify an audience. The audience may consist of one or more people and denotes one or more intentional observers perceived by the social phobic. The audience is/are considered the primary threat in the situation. The audience is/are perceived as the potential critic(s) of the social phobic individual's appearance and behaviours. The primary threatening outcome for the social phobic is negative evaluation from the audience.

In most situations the audience may not even be attending to the actual behaviour or appearance of the social phobic. For example, when a social phobic walks into a doctor's waiting room, s/he perceives other people in the room as the audience even though the others are not attending to his/her appearance or behaviour. The social phobic merely perceives that an audience exists, and this heightens the social phobic's level of anxiety. In other cases the audience does exist in reality, for example when the social phobic is making a public speech. In this case, the audience is genuinely attending to the social phobic's performance.

B. Mental representation of self as seen by the audience:

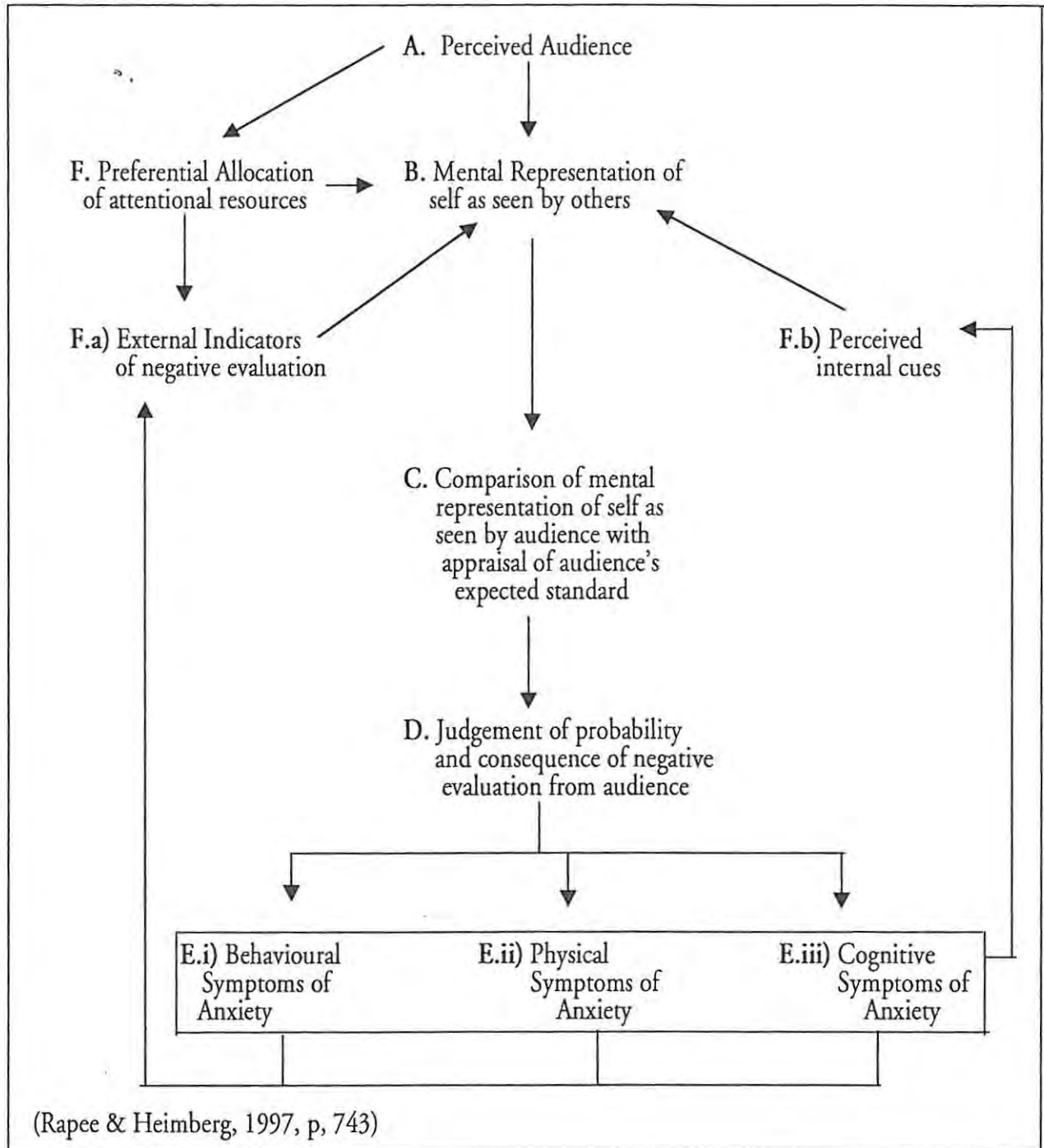
Social Phobics construct a mental representation of themselves with the use of several inputs that include, a pre-existing image of the self that is stored in long term memory, feedback from others, previous experiences in certain situations, and actual images of themselves (from photographs and their reflection in the mirror). This mental representation is not an objective image of oneself in reality. It is better described as a distorted image depending on biased, predominant inputs. Social phobics believe that this mental representation is the way in which the audience views them. The mental representation is constructed from a 'baseline image', which is the constant image of self as saved in long term memory. However, the mental representation is modified from moment to moment due to the preferential allocation of attentional resources. This is discussed in detail under component 'F' (below) of the model.

C. Comparison of mental representation of self as seen by audience with appraisal of audience's expected standard

Social phobics construct a mental representation of the self as seen by the audience. In addition, they construct a mental representation of themselves that the audience would expect to see. In other words, the social phobic makes predictions about the type and standard of performance, which is expected of them by the audience. Social phobics compare the mental representation of what they think the audience is seeing with the mental representation of what they think the audience expects to see. In comparing these two mental representations of the self, they analyse the extent to which there is a discrepancy between the two representations. There may be a positive discrepancy in that, the predicted self-representation as seen by the audience is better than the expected self-representation as is expected by the audience. There may be no discrepancy in that; the predicted and expected mental representations are the same. There may also be a negative discrepancy in that; the predicted

self-representation is not meeting the standard of the expected mental representation. For social phobics, more often than not the predicted discrepancy will be negative. In other words, they perceive themselves as not performing to the required standard expected by the audience.

**Figure 1.5: The Heimberg Model**



D. Judgement of probability and consequence of negative evaluation from audience:

Depending on the discrepancy between the mental representation of self as seen by the audience and mental representation of self as expected to be seen by the audience, whether positive or negative, social phobics anticipate whether they will be evaluated negatively or not. A positive discrepancy would denote no negative evaluation, whilst a negative discrepancy would denote definite negative evaluation. The greater the negative discrepancy, the greater the probability and extent of the negative evaluation. However, negative evaluation is biased by social phobics' established belief that everyone views them negatively even before entering the situation. The greater the anticipated probability of negative evaluation, the greater the anxiety experienced in the situation.

E. Symptoms of anxiety: Cognitive, Behavioural, Physical

i. *Cognitive symptoms of anxiety:*

Social phobics remain in a specific cognitive mode before, during, and after entering a socially threatening situation. The cognitive mode accounts for a pattern of negative self-statements (e.g. interference of cognitive activity, blanking out) that are a result of severe anxiety. These negative self-statements include "(1) thoughts of general social inadequacy, (2) concerns with others' awareness of distress, (3) fear of negative evaluation, (4) preoccupation with arousal or performance" (Heimberg, Dodge & Becker, 1987; p. 285). These negative self-statements hamper social phobic individuals' adequate methods of information processing. Due to this, their physiological responses, ultimate behavioural patterns, and others' perception of them, are all affected severely (Heimberg, Dodge & Becker, 1987).

ii. *Physical symptoms of anxiety:*

There are somatic symptoms that are particularly noticeable in social phobic individuals such as, blushing, shaking, sweating, and stammering. These symptoms feed back to the individual's mental representation of oneself and are considered especially salient with respect to potential negative evaluation. Social phobic individuals over-represent these symptoms, for example, expecting the audience to see their hearts pounding. As explained earlier, internal sensations or feelings such as, hot feelings might be mentally represented as rivers of sweat. Appraisal of such bodily sensations heightens the anxiety and makes the physical symptoms worse than they already are.

iii. *Behavioural symptoms of anxiety:*

Social Phobic individuals engage in subtle behaviours that are aimed at avoiding potential negative evaluation, for example, avoiding eye contact, speaking inaudibly, stammering or standing on the periphery of a group. The social phobic individual may even escape from the situation altogether by making a quick exit soon after entering the situation. This behaviour tends to be self-defeating as it only reduces effective social performance.

F. Preferential allocation of attentional resources:

As is noticeable with other anxiety disorders, SP is characterized by rapid allocation of attentional resources to the detection of threat. Allocation of attentional resources to the monitoring of mental representations of self-image as perceived by an audience is associated with the individual's perceived risk of negative evaluation from the audience. Social phobics engage in regular monitoring of their external appearance and behaviour thereby monitoring their mental representation of self-images. They monitor their "facial expressions, posture, actions, [and] internal feelings that may manifest in outward appearance (e.g. hot feelings resulting in sweating)" (Rapee & Heimberg, 1997, p. 744). Salient aspects of self-image are paid particular attention to by the social phobic. These aspects of self-image are perceived as potentially negative depending on the situation. Woody (1996) explicates that the allocation of attentional resources towards self-monitoring invariably exacerbates individuals' social anxiety. For example, a social phobic may construct a mental representation of making awkward facial expressions when in conversation with someone of the opposite sex. Attentional resources are focused on the following by the social phobic: the perceived external threat and internal cues that affect physiological functioning.

a) Attentional resources are allocated to perceived external threat in order to detect impending signs of negative evaluation in the threatening situation. Upon entering a threatening situation, the social phobic scans the environment for any impending signs of negative evaluation. Such signs are detected rapidly and the social phobic invariably suffers to disengage attention from them. Signifiers of external threat are for example, verbal and nonverbal responses from the audience. In a study conducted by Lundh and Öst (1996) social phobics reported that they examined other peoples' faces for expressions of criticism or disapproval. These faces were named the "critical faces" as they affected the social phobic's adequate performance in the situation, as they would picture themselves mentally as being inadequate owing to the

audiences' critical faces. These critical faces are an example of external indicators of negative evaluation for the social phobic.

b) Attentional resources are also allocated to the internal cues that affect physiological functioning. Internal cues are for example, proprioceptive information about actions, posture, and facial expressions. McEwan and Devins (1983) confirm that a major source of the perceptual bias of oneself involves the input from internal sensations. For example, hot feelings in a socially threatening situation may be depicted in the mental representation as clearly visible rivers of sweat. By allocating attentional resources to such feelings and sensations as well, the mental image is subsequently distorted further.

Ultimately, owing to the vast amount of attentional resources that are devoted to the detection of external threat, focus on bodily sensations, and monitoring of self-image, relatively few attentional resources remain for the successful completion of the task at hand. Therefore, social phobic individuals' performance in threatening situations is invariably unsuccessful, and anxiety levels are heightened as a result (Rapee & Heimberg, 1997).

#### Dynamic overview of the model:

In this model it is presumed that individuals are predisposed to social anxiety in one or more social situations as a response to perceived threat in the situation(s). Individuals with social phobia are seen to appraise specific cues, in varying extents, as predictive of threat regarding various situations. Special to this model is the way in which cognitive processes are conceptually analysed by speculating about how they influence threat appraisals in social phobic individuals.

Once a situation is indicative of threat for individuals with social anxiety, individuals become anxious and engage in several processes. These processes include the construction of a mental representation of self, and setting of standards that they feel the audience expects of them socially. As a result they anticipate negative evaluation from a perceived audience owing to their predictions of inability to match the audiences' expectations. This exacerbates their anxiety and leads them to engage in and display several symptoms of anxiety that are implicitly indicative of their lack of social fitness.

Ultimately, individuals engage in avoidance behaviours that serve to decrease their feelings of anxiety and protect them from possible negative evaluation, as the situation is avoided or escaped from. However, these avoidance behaviours do not assist in overcoming the anxiety permanently or nullifying the significant feelings of threat regarding the situation. Through the prolonged display of avoidance behaviours by either failure to enter situations, or escape soon after entry into the situations, social phobic individuals lose opportunities to attain appropriate feedback on performance expectations from the audience. Thus the negative mental representation of performance is maintained. In addition, anxiety is maintained through the lack of opportunities to experiment with reality testing of the threatening situations and the predicted negative outcomes of these situations.

Deficits in social performance of social phobic individuals are not viewed in this model as solely the lack of appropriate social skills. They are better viewed as the results of anxiety that can be attributed to limitations in cognitive capacity that are reflected in the avoidance behaviours. However, lack of social skills may be the reason for deficits in social performance based on three different forms of reasoning regarding social skills.

Firstly, prolonged avoidance over a period of time hampers the possibility of engaging in and experiencing effective social interactions. Therefore social skills are not effectively learned. For example, from childhood, individuals who avoid making friends or playing games with others whilst in school, would have missed the opportunity to learn social skills such as, making conversation, or being a part of a group that involves certain unspoken rules about group cohesion.

Secondly, individuals may never have been taught or expected to learn the required social skills that are necessary in specific social situations. The reason for this might be a simple difference in cultures where individuals descend from a culture where the specific social skills are not necessary or not even known. For example, individuals who belong to a culture that does not use cutlery at meals will suffer when they are invited to a business dinner with colleagues and everyone is expected to eat with the cutlery provided. Subsequently such a situation becomes anxiety provoking, as individuals do not know how or where to attain the required social skills.

Thirdly, individuals may possess the required social skills for a given situation; however, owing to one humiliating incident where the individuals were embarrassed in some way, they now experience anxiety in similar situations. For example, individuals who spilt a drink at a social event and were humiliated by their host for the mess created will become anxious when attending a similar social event for fear that they might spill their drink again. Therefore, even though the individual does possess adequate social skills for the given social situation, their anxiety hampers their successful use of the social skills.

### **1.3.6 The Clark and Wells Cognitive Model**

The Clark and Wells cognitive model of social phobia conceptualises social anxiety in a similar manner to that explicated in the Heimberg model. The Clark and Wells model is an advanced, comprehensive model that synthesizes several critical variables that pertain to the maintenance of SP. The model "pays particular attention to the factors that prevent social phobics from changing their negative beliefs about the danger inherent in certain social situations" (Clark & Wells, 1995; p. 69). According to Clark and Wells (1995) social phobics are essentially characterized by their strong desire to create a favourable impression of themselves to others, but are insecure in their ability to do so. Social phobics' belief in their inability to create a favourable impression is what causes their social anxiety. The Clark and Wells model is summarized in Figure 1.6 below.

#### **A) Assumptions and beliefs (self-schemata) in Social Phobia**

In order to understand how the model is constructed as is depicted in Figure 1.6, it is essential to understand the assumptions contained in self-schemata that are present for social phobics in any feared social situation. Clark and Wells (1995) explain this as follows. In the Clark and Wells model it is implicit that social phobics tend to recognize certain social situations as threatening owing to a series of dysfunctional beliefs or assumptions that are present in the various activated self-schemas. These assumptions account for the way in which social phobics believe they should act in social situations, and what they hold as true about themselves. The assumptions can be divided into three distinct categories namely, excessively high standards for social performance, conditional beliefs concerning social evaluation, and unconditional beliefs about the self.

*i) Excessively high standards for social performance*

Social phobics are highly concerned about the impression they create on other people in social situations. The social phobics create excessively high standards that they feel they need to live up to in order for acceptance from others. These high standards account for the cognitive distortions and/or underlying assumptions that social phobics experience. Examples of these high standards are, "I must get everyone's approval"; "I must not show any signs of weakness"; "I must not let anyone see that I am anxious"; and "I must appear intelligent and witty" (Clark & Wells, 1995; p. 75). These excessively high standards are difficult, if not impossible to achieve, and subsequently the social phobic's social anxiety is heightened.

*ii) Conditional beliefs concerning social evaluation*

Similar to what has already been expressed in the Heimberg model, in this model, social phobics assume and believe that other people see what the social phobics think they themselves see. Social phobics do not collect evidence about how they are seen by other people, as they do not pay attention to other peoples' observations. They rather make assumptions and create conditional beliefs about the way in which others evaluate them. Conditional beliefs have an "if-then" format for example, "If I show feelings (or make mistakes) then others will reject me"; "If others really get to know me, then they will not like me"; "If I disagree with someone, then they will think that I am stupid and will reject me"; "If someone does not approve of me, then it must be my fault" (Clark & Wells, 1995, p. 75/6).

*iii) Unconditional beliefs about the self*

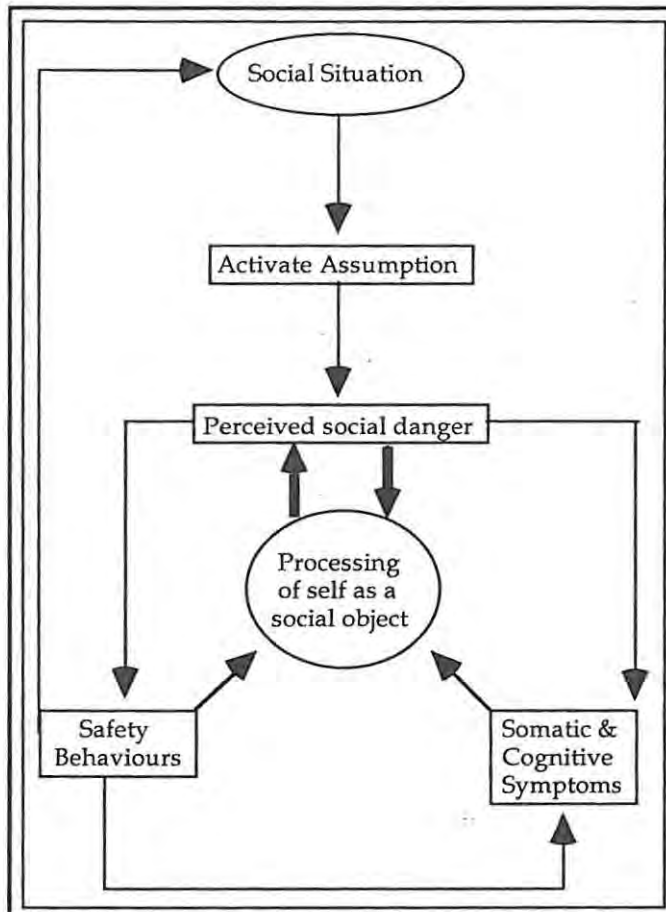
As is mentioned earlier in this chapter, the onset of social phobia is varied from one individual to the next. Unconditional beliefs constitute a large part of what ultimately predisposes individuals to social phobia. These are core beliefs about the self that are created very early in life owing to primitive learning experiences. These unconditional beliefs constitute the self-schemas that are present from childhood. Conversely, excessively high standards and conditional beliefs develop later as part of protective strategies against the social world. Individuals who have unconditional beliefs will automatically find it easier to expect negative evaluation from others owing to their beliefs about themselves that are reflected on how they think others see them. Unconditional beliefs are for example, "I'm odd/peculiar"; "I'm different"; "I'm a nerd"; "I'm unacceptable"; "I'm stupid"; "I'm unattractive"; "I'm vulnerable" or, "I'm inadequate". These are examples of negative beliefs that social phobics have about themselves regarding their worth or their value.

### B) Brief overview of the model

Having described the three types of assumptions/dysfunctional beliefs of social phobics, the foundation for explaining the synthesis of the model has been established. Figure 1.6 shows the processes that are suggested to occur when a social phobic enters a feared social situation. Owing to previous experience and innate behavioural predispositions, certain assumptions (as explicated above) are activated. These assumptions include assumptions about oneself and assumptions about the social world. The activated assumptions cause the social phobic to believe in the danger that is present in the social situation. Clark and Wells (1995) explicate that, in particular the social phobic believes that, "(1) they are in danger of behaving in an inept and unacceptable fashion, and (2) that such behaviour will have disastrous consequences in terms of loss of status, loss of worth, and rejection" (p. 69/70).

Once the social situation has been perceived negatively, an "anxiety program" is automatically triggered (Clark & Wells, 1995; p. 70). Since the danger that is perceived in the situation is more imagined than real, a large part of the experienced anxiety is inappropriate. The anxiety that social phobics experience is a constellation of cognitive, somatic, affective, and behavioural changes (explained in following paragraphs). These changes become a further source of perceived danger, as they are not useful in coping with the initially perceived danger. Instead, these changes merely contribute to a series of vicious circles that maintain, and worse yet, exacerbate the social anxiety experienced by the social phobic.

Firstly, somatic symptoms, for example, blushing are taken by social phobics as more evidence that they are making fools of themselves (Mulken, Bogels & Jong, 1999); or a racing heartbeat is evidence of impending loss of control. Such misconstrued evaluations by social phobics about themselves only serve to heighten the anxiety. Secondly, social phobics become preoccupied with their somatic responses and negative social-evaluative thoughts. Their preoccupations interfere with their ability to process social cues that might be useful in rectifying the perceived danger about the situation. Social phobics realize that they are not processing these social cues and this realization is cause for further anxiety, further evidence of social threat, and ultimately failure in the situation.

**Figure 1.6: The Clark and Wells model**

(Clark & Wells, 1995; p. 72)

Thirdly, social phobics' behaviour changes when in a threatening situation. They tend to behave less warmly, and in a less friendly or outgoing manner due to the high levels of anxiety that they are experiencing. This impacts on how others behave towards them as others will tend to respond similarly. The way others behave towards them is taken as evidence to confirm their fears of rejection and failure socially. This point is explained in greater detail when discussing "safety behaviours" below. Finally, the somatic symptoms, for example, racing heartbeat, produce further sensations. For example, the racing heartbeat may be related to behavioural symptoms such as talking quickly, which is accompanied by hyperventilation that results in further increased heart rate, dizziness, and blurred vision. This hampers the social phobics' ability to interact normally and thus, failure is predictable.

C) Four processes that prevent social phobics from disconfirming their negative beliefs about socially feared/threatening situations

Having established a basic outline of the model, Clark and Wells (1995) elaborate on the model with the explanation of four processes. These four processes prevent the social phobic from actively disconfirming their negative beliefs about the socially feared situations. In other words, the four processes explain the maintenance of social phobia. Three of the processes take place whilst in the situation, whilst the fourth process takes place before entering and/or after leaving the situation.

i) *Self-Focused Attention and the Construction of an Impression of Oneself as a Social Object*

Upon entering a social situation, social phobics perceive the danger of negative evaluation from others. In perceiving the danger, they significantly move their attentional focus to detailed monitoring and observation of themselves. This shift in attention has problematic repercussions, the first of which has already been described in detail in the outline of the model. Firstly, social phobics experience an enhanced awareness of their feared anxiety responses and this interferes with their processing of the situation and other peoples' behaviour. Secondly and most importantly, social phobics use the interoceptive information to produce impressions of themselves that are assumed to reflect what others are seeing (Woody, Chambless & Glass, 1996). This is similar to the "mental representation of the self" that is referred to in the Heimberg model.

Social phobics will often complain that they feel like they are the centre of attention in a social situation. However, they will explain this feeling with, "I don't know, I just felt like I was the centre of attention" rather than "everyone was looking at me" (Clark & Wells, 1995; p. 71). The social phobic will tend to make assumptions about everyone else's observations regarding how they are seen, instead of observing other people closely in order to arrive at these conclusions. Social phobics only pay attention to what they feel and think, and take these feelings and reflect them on what they think others are thinking about how they behave and appear. For example, social phobics will equate feeling humiliated with actually being humiliated by others; or feeling out of control with being observably out of control.

The negative impression about oneself that social phobics construct can best be described as a "compelling feeling" as it describes what they are feeling with what is possibly being seen

(Clark & Wells, 1995; p. 71). This impression is sometimes accompanied by images that represent the self from other peoples' points of view. The images are triggered whenever the social phobics experience particular feelings. For example, hot feelings are accompanied with an image of sweat running down one's face, which is observable by others. Images such as this lead to marked distortions of self-perception.

Another example would be if social phobic individuals have a strong shaky feeling in an arm or a leg, they assume that others see the arm or leg as shaking violently and uncontrollably. Meanwhile, others would see the arm or leg as having a slight tremor or nothing at all. Important to be understood is that, whether an image or a feeling accompanies the mental impression, what social phobics perceive about their appearance will always seem to be self-evidently true as it fits with a pre-existing belief.

The question that might be asked at this stage is that, "If the processing style above is maladaptive, why do social phobics use it?" (Clark & Wells, 1995; p. 72). There are two possible explanations. Firstly, when in social interactions whether individuals are socially anxious or not, they will generally find that most social cues are ambiguous regarding the ways in which others view them. People who are not socially anxious will either be confident enough to deal with these ambiguous cues, or they will not care to worry with these ambiguous cues. However, socially anxious individuals, who are always eager to be accepted socially, and who in some cases strive for perfectionism, which in their opinion is the key to acceptance, (Saboonchi, Lundh & Öst, 1999), will understand these ambiguous cues negatively (Stopa & Clark, 1998). As a result, their anxiety will heighten and they will feel negatively evaluated and disillusioned about their social fitness or feel rejected.

Secondly, owing to the various behavioural strategies that socially anxious individuals have adopted, they avoid gathering evidence about the relative safety that is present in the socially feared situations. For example, if socially anxious individuals were to increase eye contact, disclose more personal information, or actively participate in conversation, they would be at a better advantage of deciding whether others are genuinely interested in their company or not. However, by avoiding all of the above, they are only left with assumptions about how others perceive them. In addition, they are vulnerable to social ridicule owing to their socially inept behaviour.

ii) *The role of In-Situation Safety Behaviours in Maintaining Negative Beliefs and Anxiety*

Whilst in a social situation, socially anxious individuals adopt a wide range of safety behaviours. Safety behaviours are better described as behaviours that are aimed at reducing the risk of negative evaluation, for example, avoiding eye contact, speaking less, staying on the edge of groups. Depending on the specific feared outcome that social phobics are anticipating, relevant safety behaviours are utilized. Social phobics consider using safety behaviours to be the safest way to avoid embarrassment and humiliation that leads to negative evaluation and rejection. However, Salkovskis (1991) and Wells et al. (1995) show how the use of safety behaviours is self-defeating. They point out how safety behaviours are in fact problematic in two specific ways.

Firstly, by using safety behaviours social phobics avoid any direct experience of disconfirming negative assumptions/beliefs about how others perceive them in the given feared social interactions, or about the actual outcome of what is feared. Take for example, socially anxious individuals who fear that they will spill their drinks at a party. They assume that they will avoid spilling the drink with the help of a safety behaviour such as holding the glass tightly. They grip their glass tightly because they fear negative evaluation if they spill their drink. By holding the glass tightly, they do not allow the opportunity to actually test whether the drink in fact spills if they hold the glass normally. In addition, they never will know whether spilling a drink is in fact a criterion for negative evaluation.

Secondly, by utilizing safety behaviours, social phobics are in danger of making those specific feared outcomes more likely. For example, the individuals who grip their glass tightly will most likely discover that their hand is more likely to shake because of how tightly the glass is being held. Another example is that of individuals who fear that they will be negatively evaluated if they pause whilst making a speech. In order to avoid the pause, they rehearse the speech several times in their minds. When actually making the public speech, they are so preoccupied with avoiding the pause and remembering what was rehearsed that their minds might go blank (Liebowitz et al., 1992).

What can be derived from this is that, individuals are already anxious when they enter the social situation. The anxiety is heightened when they fear negative evaluation. The anxiety is

then further exacerbated when they actively engage in safety behaviours to avoid negative outcomes.

ii) *Anxiety-Induced Performance Deficits and Their Effects on Other People's Thinking and Behaviour*

Social phobics anticipate that others will negatively evaluate them for their performance in social situations. Invariably this anticipation of negative evaluation is overestimated (Rapee & Lim, 1992; Stopa & Clark, 1993). In addition the consequences of the negative evaluation are taken as detrimental by social phobics. However, Clark and Wells (1995) suggest that in some instances the fears that social phobics have are justified. Anxiety (and heightened levels of it) does produce behavioural and somatic symptoms such as, "blushing, an unsteady voice, sweating, and shaky hands" (p. 74). These symptoms make social phobics very conscious about themselves, as these may be criteria for negative evaluation.

Furthermore, owing to these symptoms, social phobics are constantly preoccupied with monitoring their appearance and performance. This involves the use of safety behaviours, which as already described, only hamper their performance further. For example, safety behaviours such as behaving in a less friendly manner, avoiding conversation, and avoiding eye contact make it difficult for others to approach social phobic individuals. Implicitly, the social phobic individuals' fears about rejection and negative evaluation are then confirmed. Through such confirmation, social phobics' beliefs, assumptions, and predictions are maintained, and the social anxiety persists.

iv) *Anticipatory and Post-event Processing*

Anticipatory anxiety has already been mentioned at several instances thus far. Social phobics report high levels of anticipatory anxiety before even entering the socially feared situation. Socially anxious individuals play the social event in their minds that is yet to even happen, as though it were a mental film. When they start to review the situation in this mental film, they experience anxiety. This is owing to the memories that they have regarding past failures, negative images about the self that they remember from previous situations, and anticipatory predictions of rejection and failure in the situation yet to happen.

In some instances, social phobics will entirely avoid the situation due to this anticipatory anxiety. However, if the situation is not entirely avoided, social phobic individuals will enter the situation in an anxious state and will already actively be processing and monitoring their self-images. Social phobics will expect failure, as the self-image that they have is not of a high enough social standard, and they will not recognize or notice any signs of social acceptance from others even though the signs may be obvious. They experience failure to focus on the task at hand. Subsequently social phobic individuals will not stay for long in the situation and will escape from it as soon as possible by either slipping away quietly, or making an excuse for leaving.

If social phobic individuals avoid or escape from the situation their anxiety levels are dramatically reduced. However, social phobics' negative thoughts and distress about the situation do not end as yet. They conduct a "post mortem" of the situation that they have just encountered (Clark & Wells, 1995; p. 74). The post mortem is active post event processing which involves replaying the encounter in their minds that has just taken place, and analysing it.

Usually, social phobics find that their appraisal of the encounter is worse than how they experienced the situation whilst in it (Alden & Wallace, 1994). This is simply because social phobic individuals' memories are dominated by the negative self-perception, and in retrospect, the negative self-perception is worsened owing to the feelings of failure and rejection. Social phobics may even experience shame once the anxiety has entirely subsided and the post mortem has been conducted. Thus, even though the social phobic individuals entered the situation, the experience was not pleasant and the memories of this situation are added to the list of previous unsuccessful encounters.

#### **1.4 TREATMENT OF SOCIAL PHOBIA**

##### **Preamble:**

Social Phobia is a one of the simpler phobias to describe. It is however, one of the more complex phobias to treat (Butler & Wells, 1995). This section presents a historical overview of the various treatments used for phobias is explicated. In addition, the best methods of treatment for social phobia that has been discovered through extensive research conducted

over the last two decades are explicated. Finally, a review of various individual and group treatment outcome studies for SP is reviewed. In this review of the treatment for SP, it becomes evident that although treatments have different names, they have considerable overlap. For the purposes of this section, the terms 'client' and 'patient' are used interchangeably as is used by other researchers such as, Heimberg, Liebowitz, Hope and Schneier (1995).

#### 1.4.1 Wide range of treatments since the 1950s:

Research into the treatment of anxiety has been taking place since the 1950s (even before the first publication of a DSM), where the focus of treatment was on specific behavioural associations (Sections 1.3.1/2) rather than on specific so-called disorders (Marshall, 1981).

##### i. *Systematic desensitisation:*

The most renowned principle for the treatment of anxiety was that established by Wolpe (1958) called the "reciprocal inhibition principle of psychotherapy". Wolpe explains this principle as follows, "If a response antagonistic to anxiety can be made to occur in the presence of anxiety-evoking stimuli so that it is accompanied by a complete or partial suppression of the anxiety responses, the bond between these stimuli and the anxiety responses will be weakened" (1958; p. 71). This principle was applied widely for three main anxiety-inhibiting responses namely, assertive, relaxation, and sexual responses. Most important of these anxiety-inhibiting responses in the history of SP treatment is that of relaxation responses. In 1939, Jacobson was the first to demonstrate how relaxation responses had an autonomic accompaniment opposite to anxiety responses. Wolpe (1958) further investigated relaxation responses to anxiety and constructed the technique known as "systematic desensitisation" (p. 139).

This technique is applied as follows: firstly, the therapist is required to identify the various categories of stimuli that evoke anxiety for the patient. Secondly, these categories of stimuli should be ranked in order of intensity of anxiety experienced. During the course of approximately six interviews, deep muscle relaxation training is taught to the patient in parallel with the above. Once this is successfully completed, the patient is made to relax completely (with the help of hypnosis if necessary), and is asked to imagine a situation with the least intense anxiety-evoking stimulus for a few seconds. This is repeated at short intervals for each

increasingly intense category of anxiety evoking stimuli until the patient's relaxation weakens and, ultimately, inhibits the anxiety-evoking potential of the various stimuli. With conscientious repetition of this process, even the stimulus with the most intense anxiety-evoking potential is brought down to zero.

**ii. *Flooding:***

Whilst systematic desensitisation was making important breakthroughs in the treatment of anxiety, an alternative procedure known as "flooding" was also becoming increasingly popular (Marshall, 1981). Systematic desensitisation aimed at reducing fear of various stimuli to a minimum during treatment with the use of gradual and brief exposure. Conversely, flooding encouraged entirely the opposite. During the first treatment session, this technique exposed the patient to the situation in which the most intense anxiety-evoking stimulus was present. The patient was then required to remain in this situation for as long as possible. This process was regarded as highly distressful for both patient and therapist, but was effective. However, the rate of patients being frightened away by this form of treatment was also high (Marshall, 1981).

**iii. *Behavioural self-control:***

Paul (1966) made one of the most profound contributions to SP treatment literature in particular, with the use of desensitisation for treatment of people with a phobia for public speaking. Paul's (1966) study "revealed that targeting the anxiety associated with speaking leads to reductions in the targeted response, but little improvement in the skilled appearance of the subjects" (Marshall, 1981). This treatment study led to the realization that people have various types of phobias. In addition this research proved that simply changing behavioural patterns of individuals was not enough. When additional training skills that were necessary for example, skills in speech delivery were added to the treatment, it was revealed that participants appeared highly competent.

Paul's study was one of many that began a revolution in the treatment of phobias. It became clear that there were many different phobias, each requiring other specific components for successful treatment in addition to desensitisation. Individuals with phobia of public speaking intrinsically required at least two skills, behavioural competence and anxiety control. Desensitisation had only been addressing one of these skills. With this finding a movement

towards training clients about how to control their own behaviour began (Mahoney & Thoresen, 1974).

With treatments such as desensitisation and flooding, the patient was a passive participant in the process of their own behaviour modification. 'Behavioural self-control' required that the patient became an active participant, thus transforming passive learning processes into active coping strategies (Mahoney & Thoresen, 1974). Clients were taught to apply the skill of deep muscle relaxation in the everyday situation in which anxiety occurred.

Behavioural self-control is described as "a set of procedures that the individual can learn to use in directing and managing his [sic] own internal and external actions" (Mahoney & Thoresen, 1974; p. 21). Having the client actively involved in therapy allowed the inclusion of "cognitions" (Section 1.3.3) to be accepted as variables that influenced the outcome of treatment (Marshall, 1981). Behavioural self-control includes three basic elements namely, self-observation, environmental planning, and behavioural programming. In the treatment of phobias, self-observation and behavioural programming are most relevant, and are described as follows.

Self-observation "requires that the person not only attend to his [sic] own actions but also record their occurrence for purposes of feedback and evaluation" (Mahoney & Thoresen, 1974; p. 22). The client is instructed by the therapist to keep charts or a diary where significant information such as the rate of a specific behaviour can be recorded. This is also called self-monitoring. The more clients are encouraged to keep accounts of activities that they engage in whilst monitoring themselves, the more aware they become of themselves and their behavioural patterns. This element is explained further in (iv) below under 'modelling'.

Behavioural programming "involves altering the consequences of a behaviour instead of changing its eliciting cues" (Mahoney & Thoresen, 1974; p. 24). Self-administered therapeutic techniques such as, self-reinforcement and self-punishment are examples of this element. Behavioural planning is further explained as part of 'modelling', below.

#### **iv. *Modelling:***

Much in line with behavioural self-control, Bandura (1977) constructed a process of treatment by modelling. Modelling (Section 1.3.3) requires the client to observe a model that behaves

effectively in a feared situation, in other words, a coping model. It is considered that the coping model's precise form of behaviour and specific characteristics (that the client can identify with) are to be seen as variables that impact on the power of the modelling process thereby inducing behaviour changes for the client.

However, other variables are involved as well. Clients' level of self-efficacy (Section 1.3.3) contributes to the extent of their belief that they will be able to act in a similar fashion to the coping model when in a feared situation. The therapist needs to identify whether clients have a high or low level of self-efficacy. If clients have a low level of self-efficacy, this needs to be addressed first. With the use of behavioural planning, clients engage in self-reinforcement or self-punishment in order to increase their levels of self-efficacy. Mahoney and Thoresen (1974) explain this process as follows.

Upon viewing a coping model in a given situation, clients firstly attempt to match the model's behaviour during therapy sessions. If clients are able to attain or exceed the self-imposed standard that their choice of coping model exhibit, they reward themselves with something special for example, candy. In addition they engage in self-praise and express positive self-evaluations. If however, they do not meet the standard of the coping model they deny themselves the reward and engage in self-criticism. The greater the number of times they reward themselves, the more their increase in self-efficacy.

Once clients feel confident enough to try and match their coping models' behaviours in real-life situations, they keep a self observation record of the numbers of successes and failures they experienced whilst experimenting. Clients evaluate their own performance. They observe their own behaviours and coping methods, record them, and discuss them with the therapist during therapy. In this manner, they learn to cope with the feared situation, increase their level of self-efficacy in their own time, and either reward or punish themselves for their successes and failures.

#### **1.4.2 Development of Cognitive Behaviour Therapy (CBT) strategies:**

Research concerning the treatment of SP began in a heated manner when SP was included as an independent disorder in the DSM-III (APA, 1980). By 1989, 17 studies had been conducted towards finding a treatment for SP, and by 2000; nearly 30 additional studies had

been conducted towards finding the most effective treatment for SP. The literature around these studies reveals that cognitive-behaviour therapy (CBT) is regarded as the most effective treatment method for SP (Butler & Wells, 1995; Albano, 2000).

CBT forms an umbrella for several, separate methods of treatment that are integrated in varying combinations to form treatment packages. 'Social skills training', 'exposure', 'anxiety management' and 'cognitive restructuring' are four of the treatment methods that fall under this umbrella. The efficacy of the combinations of these treatments as treatment packages is reviewed in Section 1.5, under outcome studies. The above-mentioned treatment methods are explained individually with the following.

**i. *Social Skills Training (SST):***

Referring to Paul's (1966) research and other similar research studies such as, Marzillier, Lambert, and Kellet (1976), that were conducted before the publication of the DSM-III (APA, 1980), researchers became curious about the actual effectiveness of SST in the treatment of SP. It was presumed that individuals suffering from social phobias (e.g., public speaking phobia) lacked verbal (e.g., appropriate speech content) and nonverbal (e.g., eye-contact, posture, gestures) social skills (Heimberg & Juster, 1995). The aim of SST interventions was to increase the required behavioural skills for socially anxious individuals in an attempt to remove the cause of their anxiety. Subsequently, it was expected that the acquired social skills would aid individuals to experience successful social outcomes.

SST has various components including, behavioural rehearsal, corrective feedback, modelling, and social reinforcement to teach effective behaviour. (Heimberg & Juster, 1995). Behavioural rehearsal is a procedure whereby more desirable responses to interpersonal conflict situations are practiced under supervision of the therapist (Heimberg & Juster, 1995). Clients role-play the particular feared situation whilst in therapy, and the therapist helps make the situation as realistic as possible.

Using corrective feedback, the therapist points out the specific skills that are noticed to be deficient for the client. For example, if clients avoid eye-contact, the therapist draws this to their attention. Corrective feedback can be done more effectively if the role-play is audio taped or videotaped, and clients can hear or see for themselves where they are lacking in social skills. By incorporating modelling into SST treatment, clients role-play the feared

situation and try to meet the standards of their coping model whilst in therapy. The therapist then provides social reinforcement for clients by praising them when they exhibit adequate social skills during the role-play (Craighead, Kadzin & Mahoney, 1976).

**ii. Exposure:**

"Exposure-based strategies involve repeatedly encountering a feared situation until it no longer arouses fear" (Antony, 1997; p. 831). In spite of the fact that the term 'exposure' was only coined in the mid- 1980s, it has been increasingly realized that old-school behavioural treatments including desensitisation and flooding used 'continued exposure' to the stimulus that evokes anxiety until anxiety subsides (Nortje, unpublished manuscript). In treatment studies conducted over the last two decades (e.g., Fava et al., 1989), researchers started to concentrate more on just the exposure component of therapy and exclude other components such as relaxation.

As is done in the desensitisation process, the therapist and the client construct a hierarchy of situations that the client fears. The client is then exposed to each situation starting with the least feared situation. This procedure is known as 'graded exposure', as the exposure is conducted in stages instead of being conducted with the most intense anxiety-evoking situation the first time, as is conducted in flooding.

Exposure is conducted through '*exposure in fantasy*' (in the imagination), exposure simulation (role-playing during therapy), and *in vivo exposure* (in real-life situations). Exposure in fantasy, and exposure simulation are normally used as stepping-stones that work towards strengthening patients' belief that they will be able to cope with exposure *in vivo*; that is, when faced with the real- life situation. Similar to other phobias, exposure in SP is most successful when it is prolonged (thus allowing enough time for the fear to decrease), predictable, conducted as often as possible, and without the use of alcohol or any other substance that would help reduce anxiety (Antony, 1997). Usually, patients practice exposure in fantasy, and exposure with the use of role-played situations during therapy, and when ready, conduct *in vivo* exposure in the real situations.

**iii. Anxiety Management:**

Anxiety management is simply any process that helps to keep anxiety at a minimal level (Butler & Wells, 1995). Characteristic components of anxiety management include, relaxation,

distraction, self-instructional training (SIT), and self-monitoring. These components are explained briefly with the following. "The application of relaxation techniques to social phobia is based on the straightforward notion that they should provide the person with a means of coping with the physiological manifestations of anxiety" (Heimberg & Juster, 1995; p. 279). Patients are taught *progressive relaxation* that follows standard instruction for tensing and relaxing different muscle groups, or *focused relaxation* that involves instructions similar to transcendental meditation (Suinn, 1990). Patients are encouraged to practice progressive relaxation before confronting a feared situation (Andrews et al., 1997). Relaxation is known to make exposure easier because physiological symptoms are kept under control (Öst et al., 1981; Al-Kubaisy et al., 1992).

Normally when individuals experience anxiety, they tend to concentrate on these feelings of anxiety, and the anxiety only becomes worse. *Distraction* is a method of reducing anxiety for patients by instructing them to divert their attention to something else other than their feelings of anxiety (Salkovskis, 1996). For example, students who start to feel anxious when they are next in line to present a speech in a huge lecture theatre can practice distraction by counting the number of empty seats in the lecture theatre. This way they distract themselves from their feelings of anxiety, thereby reducing the feelings of anxiety.

*Self-monitoring* has been discussed in some detail in Section 1.4.1, iii/iv under 'behavioural self-control' and 'modelling'. It is important to note that a method for monitoring one's anxiety level is with the use of the 'Subjective Units of Discomfort Scale' (SUDS). "SUDS is a 0-100 scale with greater numbers indicating greater distress" (Hope & Heimberg, 1993; p. 111). Point 25 on the scale denotes mild anxiety; 50 denotes moderate anxiety, with beginning to have difficulty concentrating; 75 denotes high anxiety, with thoughts of escaping; and 100 denotes worst possible anxiety that can be imaginable. Patients can rate themselves on the SUDS and make a note of their ratings. In the process of being able to rate their anxiety with the use of the SUDS, they are able to keep their anxiety under control as well. For example, if they realize that their feelings of anxiety can be rated at 75 on the scale when in a feared situation; with the use of relaxation, distraction or SIT, they should be able to bring their rating down to 25 or less. In this manner they effectively control or monitor their own anxiety level. In addition, the therapist is able to gauge patients' progress based on changes in the ratings.

#### ***iv. Cognitive Restructuring:***

Cognitive restructuring is a method of modifying cognitive factors such as, dysfunctional thoughts, perceptions, assumptions, and beliefs; by questioning and testing their faulty logic (Heimberg & Juster, 1995). Clark and Wells (1995) view cognitive factors as central to the development and maintenance of SP. "At its very base, fear of scrutiny or negative evaluation by others is a problem of the perception of other peoples' motives and behaviours" (Heimberg & Juster, 1995). Interventions that deal with the modification of cognitive factors have been used as means of achieving cognitive change. Following is an explanation of two cognitive interventions that use cognitive restructuring in treatment.

Ellis' rational emotive therapy (RET) is based on the premise that psychological disorders are a direct result of faulty or irrational patterns in thinking (Andrews et al., 1997). RET focuses on modifying clients' faulty thinking and beliefs that are replaced during the course of therapy with more rational patterns. This process is aimed at alleviating the disorder and is conducted with the A-B-C-D-E paradigm. "A" refers to the event to which the individual is exposed. "B" refers to the chain of thoughts, beliefs or self-verbalizations that the individual engages in as a response to "A". "C" is the emotional and behavioural responses that are a consequence of "B". "D" refers to the therapist's attempts at modification of the self-verbalizations and beliefs that occur in "B". "E" stands for the modified and beneficial emotional and behavioural consequences (Andrews et al., 1997; p.20).

In Beck's (1985) therapy (Section 1.3.4) the ultimate goal of treatment is the development of rational, adaptive patterns in thinking. Patients are made aware of their thoughts, by making them identify their inaccurate or distorted thinking patterns. The inaccurate thoughts are then replaced with more objective and accurate cognitions. This is done with therapist feedback and with the use of behavioural experiments that are aimed at testing the illogical thoughts. Finally, the underlying assumptions that give rise to the maladaptive cognitions are dealt with as well, in order to avoid relapses.

#### **1.4.3 Individual versus group treatment for SP**

Joseph Hershey Pratt, who is acknowledged as the father of contemporary group therapy, undertook group treatment for patients with tuberculosis in 1905 (Yalom, 1995). Pratt discovered that the support, warmth and caring amongst group members was the main reason

why members did not experience feelings of depression and/or isolation. This finding inspired several therapists over the years to use group therapy, as it serves for a treatment purpose in itself.

Yalom states that, "the best available research has established that group therapy is effective... [and is] as robust as individual therapy" (p. 511). However, it is plausible to question how this could possibly work in the case of treatment for SP, as SP is chiefly defined by fear of social interaction with others. This query is discussed with the following. Scholing and Emmelkamp (1993b) compare the results and discussions of individually formatted treatment studies of Butler et al. (1984), with group formatted treatment studies of, Emmelkamp et al. (1985), Mattick and Peters (1988) and Mattick et al. (1989).

Scholing and Emmelkamp (1993) write that, "Especially for social phobia, group treatment may have clear advantages" (p. 668). They explain these advantages as follows. Firstly, "group treatment requires continuous participation and exposure to a group, for many social phobics one of the most anxiety provoking and avoided situations" (p. 668). Andrews et al. (1997) explain that, if socially anxious individuals persist in the anxiety-evoking situation, which would be the group situation, and then their anxiety will eventually diminish. Yalom (1995) explains that "group therapy provides an arena for patients to interact freely with others, then helps them to identify and understand what goes wrong in their interactions, and ultimately enables them to change those maladaptive patterns" (p. xiv).

Secondly, Scholing and Emmelkamp (1993) explain that "because social phobics are generally reluctant to talk about their fears they are often convinced that their complaints are rare and strange" (p. 668). However, when they realize that all the others in the group have similar or worse complaints, this is a form of relief for them. Thirdly, "treatment effects can be enhanced by calling in assistance of other group members, for example to arrange difficult social situations for exposure and to challenge irrational thoughts" (p. 668). In this way, other members in the group not only challenge each other's thoughts, but also their own thoughts that may be similar. In addition, through conducting role-played exposure exercises, patients realize that, if the target patient does not appear so bad in the role-play, most probably neither would they, in a similar situation. Finally, "group therapy requires less therapists' time than individual therapy" (p.668).

There are, however, serious disadvantages in group therapy for SP as well. Scholing and Emmelkamp (1993) explain these as follows. Firstly, it becomes impossible to spend much time on each individual's problems. "Challenging cognitions requires intensive individual therapist-patient contact" (p. 668). Secondly, some patients become highly anxious just by being part of the group and do not benefit at all. Heimberg, Dodge and Becker (1987) explain this, "... intense anxiety will prevent social phobics from concentrating on (and understanding) the treatment rationale and concepts necessary for the conduct of exposure simulations or cognitive restructuring" (p. 303). In the process they will not be able to inhibit or monitor their automatic negative thoughts and will eventually dropout of the group. Such individuals either need to remain in an individualized treatment format, or at least begin with individual therapy before entering a group.

Thirdly, Scholing and Emmelkamp (1993) explain that "some patients may get the impression that even among people with similar fears they are the most anxious or silent ones" with no chance of being able to cope or get better. Patients tend to compare their progress in treatment with others in the group. Some patients may feel that they are still struggling with problems that others have overcome. In order not to let the others see this, they either shy away from speaking and sharing their problems, or they act as though they are completely cured and dropout of the group. Finally, another reason why patients' dropout is because group therapy is more time-consuming than is individual therapy.

Two treatment studies have compared the relative effectiveness of individual versus group therapy for social phobia. Wlazlo, Schroeder-Hartwig, Hand, Kaiser and Münchau (1990) compared group and individual exposure *in vivo* for two groups of Ss. One group of patients had social skills deficits and the others were diagnosed with social phobia (DSM-III-R, APA, 1987). Amongst the social phobics, there was no difference between individual and group treatment. Amongst the individuals with skills deficits, group treatment yielded better results than individual treatment.

The other comparative individual and group treatment study was conducted by Scholing and Emmelkamp (1993) on DSM-III-R diagnosed social phobics. Effects of (i) exposure *in vivo* alone, (ii) cognitive therapy followed by exposure *in vivo*, and (iii) a treatment package in which exposure and cognitive therapy were integrated from the start, were compared. Individual and group formats were set up for all three treatments. Individual treatment was

found to be more effective than group treatment in decreasing somatic complaints. Apart from this difference, "hardly any significant difference between group and individual therapy was found" (Scholing & Emmelkamp, 1993; p. 680).

#### 1.4.4 Examples of CBT packages for individual and group treatment formats

There is a broad spectrum of CBT treatments that use a mixture of various strategies and techniques as explained in Section 1.4.2 above. It is important to note that combinations of these strategies and techniques have been described as most effective for the treatment of SP. Following is an example of a cognitive behaviour group therapy (CBGT) programme for SP, and an example of an individualized CBT programme for SP. Brief accounts of these treatment programmes are given as follows.

##### i. Example of a CBGT programme:

This CBGT programme's rationale follows from the conceptualisation of the Heimberg model (Section 1.3.5). The Heimberg manual (1991) explicates the treatment procedure for this CBGT programme as follows. The group consists of two therapists and 5- 7 participants, and is 12 sessions in length. The programme revolves around graduated role-played exposures to feared situations within group sessions. Based on Beck's model (1985) cognitive restructuring is integrated into the exposure exercises. This is, however, only conducted after specific training in the identification, analysis, and disputation of irrational thoughts has been conducted. In taking this sequence, social phobics challenge their irrational thoughts with the use of behavioural experiments (role-played exposure exercises, and *in vivo* exposure experiments). The integration of cognitive and behavioural interventions maximizes access to central cognitions that are dysfunctionally evoked in threatening situations. Homework assignments consist of *in vivo* exposure experiments based on group activities.

##### Stages of treatment (Heimberg et al., 1987; p. 5/6):

*Session 1:* Therapists present a cognitive-behavioural model of SP with emphasis on the learned nature of social anxiety and the reciprocal influence of cognitive, behavioural, and physiological components of anxiety.

*Sessions 2 & 3:* A didactic approach to the teaching of cognitive-behavioural concepts is adopted. Exercises adapted from Burns, 1980; Moorey and Burns, 1983; and Sank and

Shaffer, 1984, are utilized to teach patients to identify, analyse, and dispute problematic cognitions ("automatic thoughts").

*Sessions 4-12:* Are devoted to simulated exposures, cognitive restructuring, and homework assignments. Patients choose a target situation that they find threatening, and the group for role-played exposure purposes simulates each patient's situation. Immediately after each role-play, therapists and group members assist the target patient to identify, analyse, and dispute automatic thoughts associated with the exposure situation. Patients rate their level of anxiety from 0-100 on the Subjective Units of Discomfort Scale (SUDS). These ratings are later used for cognitive restructuring exercises. Homework exercises from the previous week are discussed at the beginning of each session.

*Session 12 (final session):* Time is devoted to reviewing of homework and the conduct of simulated exposures. The remainder of the session is devoted to discussion of what the patients learned and how this learning might be applied in the future.

#### Conclusion:

This programme involves various techniques including, exposure simulations and cognitive restructuring. The main aim of this treatment programme is to effectively integrate exposure simulation with cognitive restructuring. Even if the patients do not "see something he/she needs to see in discussion, he/she might very well see it in exposure" (Heimberg, 1991; p. 175). The effective integration of these two techniques is implicitly capable of reducing patients' social anxiety.

#### **ii. Example of an Individualized CBT programme:**

This individualized CBT programme's rationale follows from the conceptualisation of the Clark and Wells model (Section 1.3.6). A full description of this treatment programme is given in Appendix 2. According to Clark and Wells (1995), the main implication for treatment as derived from the model is that, cases need to be formulated "in terms of the maintenance processes outlined in the model" (p. 86). In treatment, patients need to be made aware of the specific processes that help maintain the problem they have, and they need to be taught how to overcome these processes.

These processes include, (1) the use of safety behaviours in a threatening situation, (2) keeping the entire attentional focus in a threatening situation on one's self, thereby constructing negative self images of how one appears and performs, (3) processing of

threatening situations in a dysfunctional manner, thereby anticipating negative evaluation, (4) engaging in 'mind reading', thereby assuming what others are thinking and seeing regarding one's performance, (5) avoiding/delaying/putting off doing something social, (6) engaging in a post-mortem of the threatening situation after leaving the situation.

Psychoeducation forms a very important part of the treatment programme. In order for patients to understand the rationale behind the various treatment interventions that are involved, time needs to be devoted to introducing patients to CBT, the cognitive model, and the various interventions that will be utilized in treatment. Another important aspect in treatment is the explanation about, and use of safety behaviours (Section 1.3.6). The rationale behind the importance of the 'Safety behaviours experiment' (explained below), then becomes clear to patients.

#### Stages of treatment (Clark, 1997):

Treatment is normally 12 sessions in length.

*Session 1:* Construction of a cross-sectional model linking *negative automatic thoughts, safety behaviours, anxiety symptoms, and the contents of self-focused attention* (Refer to Appendix 2). Once the model has been constructed, the second aim is to modify the dysfunctional processes outlined in the model (listed above).

*Session 2:* Conducting the 'safety behaviours experiment' (the special feature to this treatment programme). Safety behaviours that are commonly used by patients are identified. With the help of stooges, two role-plays of the same threatening social situation are conducted. In the first role-play, clients are instructed to use all their safety behaviours. In the second role-play, patients are instructed to drop all their identified safety behaviours. Patients and stooges rate patients' performance. Both role-plays are videotaped.

*Session 3:* Video feedback of the safety behaviours experiment. Patients watch their performance in both role-plays. The therapist asks guided questions in order to enlighten patients about the comparison in their performance. Patients will usually realize that their performance was better when safety behaviours were dropped. In addition, stooge' rating of performance is compared with patients' own ratings. Patients realize that they anticipate far more negative evaluation than they should, because the stooges' ratings are much higher than their own.

*Session 4 onwards:* (i) Patients discuss and learn strategies for shifting their attentional focus to what is actually happening in the social situation, instead of keeping their attentional focus on themselves.

(ii) Patients conduct exposure *in vivo* with threatening situations, without the use of their safety behaviours.

(iii) Patients interrogate the environment by testing predictions about worst possible outcomes, for example, patients stutter on purpose when in conversation with someone in order to gauge whether this is a criterion for social rejection.

(iv) Patients discuss and learn strategies to deal with their anticipatory anxiety and post-mortem.

(v) Patients challenge their self-constructed negative social image and replace it with a veridical social image.

(vi) Patients challenge their negative self-schemas, which include, negative thoughts, assumptions, and beliefs.

(vii) Patients are required to complete homework record sheets and exposure *in vivo* experiments. Previous session's homework is discussed at the beginning of each session. The homework record sheets include the 'Record Sheet for Noting Behavioural Experiments' and the 'Daily Dysfunctional Thought Record' (Appendix 1, part of Group Treatment Manual). When patients review their record sheets with the therapist, they can discuss why they thought their various behavioural experiments might have gone badly, alternative interpretations of the outcome of the experiment, and planning of what to do the next time.

#### Conclusion:

This programme involves various techniques including, exposure, behavioural experiments, cognitive therapy techniques, and a video-feedback exercise. All aspects of the negativity and anxiety involved in social interactions are interrogated and dealt with. The ultimate aim of this treatment programme is to change patients' faulty thinking processes that help maintain their social anxiety. In doing this, the chances of relapses are avoided.

#### **1.4.5 Pharmacological treatments:**

Pharmacological treatments have made important breakthroughs in the treatment of SP. Two of the most recent studies are explained in this section. These two studies were conducted with the use of selective serotonin re-uptake inhibitors (SSRIs). Stein (1998) explains that SSRIs reduce anxiety, and serve as an antidepressant as well; Prozac, being one of the most

commonly know SSRIs. Stein (1998) explicates that for some individuals, coping with social anxiety and the perceived rejection or humiliation that follows, inadvertently leads the individual into depression. SSRIs help to cure anxiety and depression.

Stein (1998) conducted an investigation to check whether Paroxetine (a SSRI) is effective in the treatment of generalized social phobics. Over the course of 11 weeks, 187 generalized social phobics (diagnosed as per DSM-IV criteria) were treated. 91 patients (adults, with no age or gender discrimination) were treated with Paroxetine, whilst 92 received placebo. Paroxetine dosage started at a daily dosage of 10 mg and was gradually increased up to 50 mg. The Leibowitz Social Anxiety Scale (LSAS), and Clinical Global Impression (CGI) Improvement rating scales were administered at regular intervals. At the end of 11 weeks, 55% (50 of 91) of the patients on Paroxetine were considered "much improved" or "very much improved" on the CGI rating scale (Stein, 1998, p. 2). In comparison, 23.9% (22 of 92) of the placebo patients had improved. Average scores on the LSAS were reduced by 39.1% for patients on Paroxetine, as opposed to a 17.4% reduction for the placebo patients.

In response to this, a study was conducted once again by Stein (1999) with the use of Fluvoxamine (another SSRI). Over the course of 12 weeks, 90 social phobics (diagnosed as per DSM-IV criteria) participated. 44 patients were treated with a mean daily dosage of 202 mg of Fluvoxamine, whilst 46 received placebo. At the end of 12 weeks, 18 of the 44 patients' symptoms improved that were treated with Fluvoxamine, whilst only 10 of the 46 receiving placebo improved significantly. Stein (1999) claims that this is proof enough for her that SSRIS can be useful in the treatment of social phobia.

Stein (1999) also explicates that it would be interesting to see how much more improvement would be achieved with a combination of psychotherapy and SSRIS. Research has been conducted using other pharmacological treatments in combination with CBT, and other treatment procedures, such as exposure alone. These are reviewed for their efficacy in Section 1.5, under outcome studies.

An important query that arises with regard to pharmacological treatment of SP is, whether, or not, patients maintain treatment gains once treatment is terminated. It is plausible to question whether patients immediately regress, and experience anxiety in social situations, once again. Important to note is that, treatment is not terminated abruptly. Normally treatment is



continued for at least 18 months. Patients are reviewed every two or three months whilst in treatment in order to check whether dosage of the specific drug should be increased or decreased. Normally, dosage of the drug is tapered down to minimal dosage, and stopped completely towards the end of 18 months. This pattern ensures that patients transition out of treatment gradually, and maintain treatment gains even once treatment is terminated (Katzung, 1994).

The reason why studies can show whether medication is effective, or not, within the span of 12 weeks (as is described in the studies referred to above) is because, by the end of the third week of treatment, the patients' plasma concentration, with the given medication, is at an optimum level. Therefore, results are expected by the third week, as the medication has begun to work at its optimal level, from this stage (Katzung, 1994).

## **1.5 OUTCOME STUDIES**

Over the last two decades various treatment protocols have been experimented with, for the treatment of SP. Following is a review of some of the individual and group format treatment outcome studies. Heimberg and Juster's (1995) research on treatment outcomes for SP is drawn on for the purposes of this section. All individuals included in the following studies were diagnosed with social phobia (except where specified), as per the DSM-III (APA, 1980), DSM-III-R (APA, 1987) or DSM-IV (APA, 1994). Outcome studies in the treatment of SP are classed under relaxation strategies, social skills training approaches, exposure-based treatments, cognitive restructuring strategies, combined cognitive-behavioural treatments, and pharmacological intervention-based treatments.

### **1.5.1 Relaxation strategies:**

Systematic desensitisation (SD) was a popularly used treatment method before the publication of the DSM-III (APA, 1980), in which the diagnosis for SP as a separate disorder is specifically outlined. Studies conducted by Marzillier, Lambert, and Kellet (1976); Trower et al. (1978); and Shaw (1979), though conducted before the publication of the DSM-III, were aimed at treating patients with social anxieties under the broad category of 'phobias' as per the DSM-II (1968). In these studies, some treatment successes are reported with the use of SD.

These successes have not been examined further, and have not been replicated. The reason for this can be explicated with the following. SD's treatment format implicitly implies learning to cope with distressing social stimuli in a graded hierarchy by thinking about the stimuli. This procedure is better known as 'imaginal exposure' in more recent literature. Imaginal exposure is considered to be a treatment method in itself, and has been utilized, for example, by Heimberg et al., 1985 (Section 1.5.4); and Emmelkamp et al., 1985 (Section 1.5.3). In addition, Taylor and Woody (1997) explicate that imaginal exposure is considered to be an implicit component of cognitive restructuring (explained further in Section 1.5.3), which is considered to be one of the most effective treatment methods for SP in more recent literature.

The relaxation component of SD is also used independently in more recent treatment methods, for example, through the protocol used in 'Applied Relaxation' (AR, below). In other words, SD appears to have been separated into two more widely used treatment components, that is, imaginal exposure and relaxation, that are used independently in more recent treatment protocols for SP. This can be considered the reason why no further efforts have been made in testing SD's treatment efficacy for SP after the late 1970s (Heimberg and Juster, 1995).

Based on studies conducted by Öst et al. (1981); and Jerremalm et al. (1986), where Applied Relaxation (AR) was used in treatment for social phobics, Heimberg and Juster (1995) explicate the following. They suggest that the efficacy of relaxation strategies for curative purposes of SP is most useful "...if the person is given the opportunity to practice relaxation skills when he or she experiences anxiety in problematic situations, that is, in combination with exposure techniques" (p. 279). AR may help individuals feel less anxious or 'more relaxed' in socially threatening situations; however, individuals' behaviours are not changed with relaxation as a treatment method alone.

### **1.5.2 Social Skills training (SST):**

Marzillier, Lambert, and Kellet (1976) were amongst the first to test treatment efficacy for SP with the use of SST for diagnosed socially anxious patients. Patients were included in this study if their primary complaints included interpersonal difficulties, anxiety in various social situations, and deficits in social skills (Heimberg & Juster, 1995). Patients were assigned to SST, SD, or a no treatment control group. Patients in the SST group, and the SD group

showed improvements, but these improvements were not significantly greater than those shown by the no treatment control group.

Trower, Yardley, Byrant, and Shaw (1978) conducted a study to compare the relative effectiveness of SST with SD. Patients were classified as 'socially phobic' with a predominant problem of anxiety, or 'socially inadequate' with a predominant problem of lack of social skills (Wells and Clark, 1997). Patients in both classes were treated with SST and SD. Socially inadequate patients showed vast improvement with SST. Social phobic patients reported reduced anxiety, however their social behaviours remained mostly unchanged.

Wlazlo, Schroeder-Hartwig, Hand, Kaiser, and Münchau (1990) intended to compare exposure-based treatments with SST. Patients were classified as having "primary social phobia" or "primary social skills deficits" (Heimberg & Juster, 1995; p. 278). The hypothesis constructed for this study was that individuals with social skills deficits would benefit from SST interventions, and those with SP would benefit from exposure-based interventions. The aim was to randomly assign patients from both classes to both treatment groups. However, patients were not randomly assigned to the two treatment groups. This created a serious methodological problem, as comparison between the two treatment interventions became impossible. However, results drawn from this study are as follows: "improvements were noted in self-reported social skills, social anxiety, avoidance, inference of symptoms in daily life activities" (Heimberg & Juster, 1995; p. 278). Whether patients benefited more from SST or exposure-based interventions was not conclusively established.

Stravynski, Marks, and Yule (1982) compared treatments of SST alone, with SST plus cognitive restructuring (CR, using Ellis' RET) in the treatment of 22 social phobics. Treatment consisted of 12, 1.5 hour weekly sessions. All patients reported significant improvement in social interaction. Patients treated with CR as well reported reduced irrational beliefs regarding social situations. However, no significant differences in improvement were noted between patients assigned to treatment with SST alone, compared with those assigned to SST plus CR. Therefore, it was concluded that SST alone was as beneficial as SST in combination with CR.

### 1.5.3 More Focused Interventions: Exposure-based and Cognitive Restructuring (CR) Interventions:

Existing literature explicates that exposure is considered to be highly effective in the treatment of SP. However, exposure is most effective when used in combination with other interventions, such as, cognitive restructuring (Heimberg & Juster, 1995). Exposure-based interventions and CR based interventions are firstly described independently, and then described in combination or in comparison with each other.

Several studies have examined exposure-based interventions in the treatment of SP. However, each study differs in the amount of therapist-directed exposure, time spent on exposure simulation during therapy, and inclusion of imaginal or *in vivo* exposure. Results and conclusions drawn from a couple of the exposure-based treatment studies are reviewed below.

Fava et al., (1989) conducted treatment through self-directed exposure in an uncontrolled study for 10 social phobics. Seven of the 10 patients who remained in treatment for the entire length (12, 1.5 hours sessions) of the study showed significant reductions in social anxiety. Similarly, Al-Kubaisy et al. (1992) conducted a study to compare treatment efficacy of relaxation and exposure for 28 social phobics (treatment was conducted for agoraphobics and specific phobics in this study as well). Patients were allocated to relaxation training, intense therapist-directed exposure, or instructions for self-directed exposure groups. Exposure-based (self-directed and therapist-directed) treatments were more effective than relaxation training. Patients in both types of exposure-based treatment groups showed higher rates of reduced anxiety, and increased approach behaviours. Patients receiving therapist-directed exposure fared better in assessment measures than the patients receiving instructions for self-directed exposure, thus establishing therapist-directed exposure as the best treatment method in this study.

Alström et al. (1984) compared treatment efficacy of exposure (therapist-directed and imaginal), dynamically oriented supportive therapy, relaxation therapy, and 'basal therapy' (anxiolytic medication plus self-directed exposure). Forty-two social phobics were randomly assigned to the four treatment groups. Patients in the first three treatment groups received basal therapy as well. Several aspects of this study remain unclear, for example, interventions used in supportive therapy are not explained, instructions for self-directed exposure are not

elaborated on, the anxiolytic drug used is not specified and treatment dosages are not given, exclusion criteria used in selection of participants is unclear, and administration of treatment within and across groups is not systematically outlined. The results and conclusion drawn from this study are as follows. Patients in the exposure treatment group showed most reductions in anticipatory anxiety and anxiety in feared situations. These patients avoided less when faced with difficult situations as compared with patients in the other treatment groups. Therefore, it was concluded that exposure is most effective in treatment of SP.

Efficacy of CR interventions has been studied in great detail as well. Cognitive factors are most central to the acquisition and maintenance of SP (Clark & Wells, 1995). Butler (1985) asserts that, "social phobia might be resistant to treatment... which does not include a cognitive element" (in Heimberg & Juster, 1995; p. 283). Following is a review of some of the leading studies that used CR interventions for comparison of treatment efficacy with other treatment interventions (apart from exposure-based interventions).

Kanter and Goldfried (1979) were the first to research the effects of cognitive treatments for DSM-II (APA, 1968) diagnosed socially anxious individuals. A variation of RET (Section 1.4.2, iv) was compared with self-control desensitisation. The RET used in this study was 'systematic rational restructuring' (SRR) in which patients utilized imagery of anxiety-evoking situations in order to identify irrational thoughts, challenge these thoughts, and replace them with more realistic thoughts. 'Self-control desensitisation' (SCD) used progressive relaxation in response to anxiety evoked by imagery of threatening situations. Sixty-eight patients were randomly assigned to SRR treatment, SCD treatment, combination of SRR and SCD treatment, or a wait-list control group. Patients were treated in groups of 8-10, for seven weeks, with sessions 1.5 hours in length.

Patients in active treatment groups improved far more significantly than did the wait-list patients. Patients in the SRR group, and combined treatment (SRR plus SCD) group improved on 16 of the 19 measures of assessment. The SCD patients only improved on 10 of the 19 measures. SRR and combined treatment groups reported maintenance of treatment gains at the 9-week follow-up assessment. For the SCD patients anxiety reduced significantly, however, negative thoughts persisted. Patients in the SRR group and combined treatment group also experienced reduced anxiety. Kanter and Goldfried (1979) concluded that cognitive interventions were indeed of significant use in the treatment of social anxiety.

Jerremalm et al. (1986) assigned 38 social phobics to applied relaxation (AR), self-instructional training (SIT), or wait-list condition treatment groups. The patients in the SIT treatment group benefited most as reported on several assessment measures, as they no longer had irrational thoughts. The patients in AR treatment experienced reduced anxiety, but continued to have distorted thinking patterns. The most significant difference in post-treatment gains was between the wait-list condition group and the SIT treatment group. This study confirmed the necessity for cognitive intervention in treatment of SP, thus supporting the findings of Kanter and Goldfried (1979) above.

Emmelkamp et al. (1985) conducted a study to compare RET, SIT, and exposure. RET followed the treatment protocol outlined in Section 1.4.2, (iv). Exposure consisted of role-playing within the group, and *in vivo* exposure homework exercises. SIT did not include relaxation. It was instead, modified to enable patients to identify negative thoughts and feelings in threatening situations (through imaginal rehearsal), and cope with these thoughts by developing and practicing realistic thoughts. Patients were assigned to one of the three treatment groups, that is, RET, SIT, or exposure.

The RET treatment group and SIT treatment group improved considerably more than patients in exposure treatment. The RET treatment group and SIT treatment group reported fewer irrational thoughts, and reduced social anxiety. Patients in exposure treatment fared better on the pulse rate measure at post-test. However, patients in RET and SIT treatments continued to report less social anxiety, and irrational beliefs than did the patients in exposure treatment at post-test. The main conclusion derived from this study was that, patients need to reformat their mind-set about threatening social situations, and for this, cognitive interventions were necessary.

Heimberg and Juster (1995) explicate that advocates of cognitive techniques attribute treatment success in studies combining cognitive techniques with behavioural treatments to the cognitive nature of the treatment. In order to evaluate which treatment intervention is of greater value for SP, Taylor and Woody (1997) conducted an enterprising study as follows. The effects of CR followed by exposure (involving role-playing of threatening situations in therapy), were compared with a control intervention known as Associative Therapy (AT, explained below) followed by exposure.

Taylor and Woody (1997) explicate that CR implicitly entails two forms of therapeutic exposure. Firstly, with CR, participants are required to think about distressing social situations, which can be regarded as a form of imaginal exposure. Secondly, participants are required to "share private events (thoughts, beliefs, memories, feelings) with his or her therapist and so entails *in vivo* exposure to social scrutiny" (p. 489). AT requires participants to simply free-associate to memories and thoughts about past and recent social encounters. When compared with CR, AT inherently contains a similar amount of exposure. According to Taylor and Woody (1997), Beck and Emery's (1985) cognitive model predicts that, CR is a superior means of curing SP, when compared with AT. "CR contains belief-changing methods that are not present in AT, methods that include the systematic review and evaluation of the person's assumptions and appraisals of social stimuli" (p. 489).

Fifty-five social phobics participated in Taylor and Woody's (1997) study, and were randomly assigned to the CR treatment group, or the AT treatment group. For the first 8 weeks in treatment, patients were treated with individualized, 1.5 hour, weekly sessions of either CR, or AT. For the second 8 weeks, all patients were treated with 2 hour, weekly sessions of group exposure. Taylor and Woody (1997) had hypothesized that patients who attended CR followed by exposure would enjoy more treatment successes than patients treated with AT followed by exposure.

However, at post treatment assessments, it was established that there was no difference in post-treatment gains whether patients were treated with CR followed by exposure, or AT followed by exposure. Taylor and Woody (1997) explain that the reason for this might have been because participants stopped challenging negative automatic thoughts, and stopped using coping statements (which were encouraged during the CR phase of therapy) once they entered the exposure phase of therapy. Taylor and Woody (1997) conclude that, "It may be that CR facilitates exposure only when participants are prompted to use CR exercises throughout the course of EXP (exposure), as is integrated in cognitive-behaviour therapy" (p. 496).

#### 1.5.4 Broad Spectrum Interventions: Cognitive-Behavioural Therapy (CBT) and Cognitive-Behavioural Group Therapy (CBGT) Interventions

Exposure and CR are seen as the most useful components in the treatment of different aspects of SP. Exposure and CR have different ways of incorporating corrective information that leads to remission from SP. For this reason, a combined treatment package that involves CR and exposure amongst other treatment interventions would be most effective in the treatment of SP. This in other words is described as a Cognitive-Behavioural Therapy (CBT) treatment programme. Following are treatment outcome studies of such programmes.

Heimberg, Becker, Goldfinger, and Vermilyea (1985) started a revolution in the treatment of SP with their CBT treatment package for SP. Several studies (as explicated below) have utilized this treatment package for SP. The latest version (Heimberg, 1991) of this treatment is outlined in Section 1.4.4, *i*. The treatment package used in the 1985 study included a combination of imaginal exposure, exposure simulation, *in vivo* exposure, cognitive restructuring, and homework assignments. At post treatment, and 6-month follow-up, all patients, except for one, reported and showed significant reductions in social anxiety, general anxiety, and fear of negative evaluation.

Heimberg et al. (1990) re-evaluated the efficacy of the Heimberg et al. (1985) CBT treatment package. Slight changes were made to the treatment package that included, increasing the range of cognitive restructuring activities and removing imaginal exposure. In addition, they modified this treatment to a Cognitive-Behavioural Group Therapy format (CBGT). Heimberg et al. (1990) compared their CBGT package to Educational-Supportive therapy (ES) in a group format. ES involved psychoeducational presentations, and sharing of thoughts, ideas, insights and advice in a caring environment.

Bruch, Heimberg, and Hope (1991) re-evaluated a subset of the data from the study described above, in order to compare the relationship between CBGT outcome and cognitive change. Schwartz and Garamoni (1986) explicate that "the ratio of positive thoughts to the sum of positive plus negative thoughts ( $P/[P+N]$ ), termed the 'states of mind ratio' is linked to varying levels of psychopathology" (in Heimberg & Juster, 1995; p. 286). States of mind ratios are rated as follows: .00 to .31 are termed *negative monologue* (severe psychopathology), 0,32 to 0,44 are termed *negative dialogue* (moderate psychopathology), 0,45 to 0,55 are termed

*internal dialogue of conflict* (mild psychopathology), and 0,56 to 0,68 are termed *positive dialogue*. Schwartz and Garamoni (1986) suggest that, a shift from any of the states of mind ratios to the *positive dialogue* state of mind ratio is indicative of change produced by cognitive treatments. Ratios higher than 0,68 are associated with dysfunction as well, as they represent insufficient attention to threat.

Bruch et al. (1991) analysed 14 CBGT patients, and 16 ES patients' complete data sets from the Heimberg et al. (1990) study, that included assessments at pre-treatment, post treatment, and 6-month follow-up. At pre-treatment, all patients' states of mind ratios were 0,29 (within the range of *negative monologue*). At post treatment, all patients' states of mind ratios fell within the *internal dialogue of conflict* range. However, at 6-month follow-up, all CBGT patients' ratios fell within the theoretically ideal range (0,67) whilst ES patients returned to baseline ratios.

Lucas and Telch (1993b) re-examined the efficacy of the Heimberg et al.'s (1990) CBGT and ES comparison. In addition to the CBGT format, and the ES therapy format, they administered an individualized treatment format (for several patients) that remained in line with the CBGT treatment format of the Heimberg et al. (1990) approach. CBGT patients (61%) were more improved than ES patients (24%), thus maintaining the Heimberg et al.'s (1990) results. Treatment outcomes between CBGT (61%) and individualized CBT (50%) did not differ significantly.

Heimberg (1991) constructed a treatment manual that outlines the final modification of this CBGT package treatment. Heimberg's (1991) treatment package has been used extensively in several studies and has proved to be one of the most successful treatment methods that exist for SP (Hope & Heimberg, 1993a, 1993b; Hope, Herbert, White, 1995; Hope, Heimberg, Bruch, 1995; Safren, Heimberg, Juster, 1997). In addition, Heimberg, Salzman, Holt, and Blendell (1993) establish that treatment gains appear to be maintained over long-term follow-up with the use of this treatment package. All therapists (apart from Heimberg) that have been mentioned above were trained by Heimberg, thus, promoting the validity and reliability of these outcomes.

Albano, Marten, Holt, Heimberg, and Barlow (1995) tailored the Heimberg (1991) treatment package to a Cognitive-Behavioural Group Treatment for Adolescents (CBGT-A) suffering

from social phobia. An extra component of skill building (e.g., social, problem solving, assertiveness) was included in treatment. Parents of the adolescents were also involved in some stages of treatment, and proved to be useful change agents (through assigned practice and feedback). Five adolescents (2 females, 3 males) took part in the Albano et al. (1995) programme and confirmed remission from SP at several follow-up assessments. Hayward (1999) replicated these results with a girls-only application of the protocol (Albano, 2000).

The Clark and Wells (1995) individualized CBT treatment package for SP (refer to Appendix 2) has also made groundbreaking outcomes in the treatment of SP. The first administration of this treatment package was conducted by Clark and Wells (1995) for 12 social phobics. This programme is mainly aimed at addressing the maintenance cycles in social phobia. If these cycles are undone, treatment successes and maintenance of treatment successes are high. The programme involves various techniques including, exposure, behavioural experiments, homework assignments and experiments, cognitive therapy techniques, and a video-feedback exercise. All patients experienced a high level, or complete remission from SP. Bates and Clark (1998) examined treatment efficacy of the Clark and Wells (1995) treatment on a 30-year old, female social phobic, and established complete treatment success. McManus, Clark, and Hackmann (2000) treated 10 social phobics with the Clark and Wells (1995) treatment. All patients experienced complete remission from SP. To date, there is no published material that evaluates a group format of this treatment package. Clark (personal contact, 2000) believes that the Clark and Wells (1995) model is better than the Heimberg model at this stage.

### **1.5.5 Comparison of Pharmacological Treatments for SP**

Apart from the studies outlined in Section 1.4.5 above, five other studies have been conducted in order to establish pharmacological treatment efficacy for SP. Falloon, Lloyd, and Harpin (1981) compared treatments of SST plus propranolol (Inderal, a beta blocker), with SST plus placebo, over a span of 8 weeks in treatment, with a 6-month follow-up. Sixteen social phobic patients took part and were randomly assigned to either treatment group. All patients showed "reductions in social anxiety and increases in positive self-image" (Heimberg & Juster, 1995; p. 279). At post-treatment analysis, and the 6-month follow-up, it was established that inclusion of propranolol to treatment, did not enhance the effects of SST. Patients in the

placebo control group with SST experienced as much treatment gains as those in treatment with SST and propranolol.

Turner, Beidel and Jacob (1994) compared exposure (imaginal and *in vivo*) with atenolol (a cardioselective beta blocker), and placebo. Treatment was conducted on 72 social phobics who were randomly assigned to one of the three treatment groups. Atenolol and placebo were administered double blind, from 25mg per day in the first week, to 100mg a day in the fourth week, of a 3-month treatment programme. Exposure-based treatment was conducted for 20 sessions over the 3 months (twice weekly for two months, and once weekly for the last month). Nine sessions were devoted, to imaginal exposure; 7 sessions were devoted to a combination of imaginal and *in vivo* exposure; and 4 sessions were devoted to self-directed *in vivo* exposure. At post treatment assessment, exposure-based treated patients had improved considerably more than patients treated with atenolol or placebo. On the improvement index, 55.6% of exposure patients, 13.3% of the atenolol patients, and 6.3% of the placebo patients, had greatly improved. Few patients took part in the 6-month follow-up assessment, thus making results inconclusive.

Gelernter et al. (1991) compared the Heimberg (1990) CBGT treatment to treatment with alprazolam, phenelzine, or pill placebo, plus self-exposure. Patients treated with medication (or placebo tablets) took four, daily, fixed dosages for 12 weeks. Patients treated with alprazolam began at a dosage of 0.7mg per day and dosage was increased to a highest dosage of 6.3mg per day. Patients treated with phenelzine began at a dosage of 10mg per day and dosage increased to a highest dosage of 90mg per day. CBGT groups consisted of 10 patients per group, and were treated with the Heimberg (1990) protocol for treatment.

On all assessment measures at post treatment, all patients appeared to be equally improved. However, patients treated with phenelzine and CBGT maintained treatment gains at 2-month follow-up, as compared with patients that received pill placebo and alprazolam, who did not. These findings are difficult to interpret. However, reasons for, and conclusions drawn from these incomprehensible results are explicated by Gelernter et al. (1991) as follows. Firstly, it is suggested that patients may have experienced a higher level of self-efficacy owing to the medication they received, and therefore all patients were equally improved at post treatment measures. Secondly, assessment was heavily dependent on self-report measures that might have created biases. Thirdly, it could be concluded that phenelzine is more effective for long-

term treatment outcome maintenance than is alprazolam. Finally, pill placebo yielding equivalent results to other treatments could be disregarded as an unlikely rival treatment for SP. It can also be hypothesized that the self-exposure played an important role in treatment.

Heimberg et al. (1994) compared treatment efficacy of the Heimberg (1991) CBGT protocol, ES therapy, phenelzine, and pill placebo for 133 patients. All patients (apart from drop-outs) received 12 weeks of treatment. Thereafter, patients who failed to respond to CBGT and phenelzine treatment were excluded along with all ES therapy and pill placebo patients. Remaining CBGT and phenelzine treated patients received 6 additional months of maintenance treatment. These patients were repeatedly assessed over a further 6-month period with no treatment. Results are outlined as follows. Firstly, phenelzine produced more positive effects for patients than did CBGT after 6 weeks in treatment. Secondly, phenelzine and CBGT produced equal results after 12 weeks in treatment, both being superior to ES and pill placebo treatment. Thirdly, during the 6-month untreated follow-up, CBGT patients maintained treatment successes as opposed to several patients treated with phenelzine, who suffered serious relapses.

Clark and Agras (1991) examined the effects of treatment through a combination of a brief cognitive-behavioural intervention plus a pharmacological treatment. Thirty-four musicians with DSM-III-R diagnosed SP were randomly assigned to one of four treatment conditions as follows: CBT plus buspirone, CBT plus placebo, buspirone alone, placebo alone. Dosages of buspirone were given 3 times on a daily basis, beginning with 5mg and increased to 60 mg. CBT consisted of identifying maladaptive self-statements, and replacing them with realistic self-statements, modelling, applied relaxation training, and *in vivo* exposure.

At post treatment, no difference in improvement was established between buspirone alone and pill placebo alone treated patients. CBT treated patients (with or without buspirone) were equally improved to a great extent in reduction of performance anxiety. At 1-month follow-up, CBT patients treated with pill placebo were further improved and had maintained treatment gains experienced at post treatment assessment. These patients surpassed improvement of the patients treated with CBT and buspirone, thus proving that CBT alone was sufficient for maintenance of treatment success.

The most important conclusion that can be drawn from this section is that pharmacological treatment for SP is by and large not a leading treatment method at this stage in research literature for treatment of SP. However, Stein (1998, 1999; refer to Section 1.4.6) suggests that selective serotonin re-uptake inhibitors (SSRIs) such as fluoxetine, fluvoxemine and paroxetine appear to be useful in the treatment of SP. Stein (1999) suggests that a combination of CBT with any SSRI would make profound advances in the treatment of SP. There is no published material as yet that examines this suggestion.

### **1.5.6 Conclusions**

Different treatment methods and outcome studies have been outlined above. It can be deduced from this literature that treatment methods such as, relaxation strategies, SST, exposure, and CR are most effective when used in combination, rather than independently. The rationale for this deduction is that, each treatment method addresses and provides corrective information for a particular aspect in the multi-dimensional problem posed by SP. No treatment method on its own is capable of curing SP. This fact is observable with the treatment successes of CBT programmes that involve more than one treatment method for effective remission from SP. Following are brief conclusions drawn from each set of outcome studies reviewed under the various sub-headings above.

Relaxation strategies provide treatment gains for patients through reduced anxiety. However, patients' social behaviours remain unchanged (Öst et al., 1981). The reason for this finding is that patients do not experiment with threatening situations once anxiety is inhibited to some extent. Anxiety might be alleviated during the therapy session, but upon entering a threatening social situation, anxiety is re-experienced. Methods of coping with this anxiety whilst in the threatening situation become feeble as the reality of the situation becomes far too overwhelming. Without the addition of for example, role-playing of threatening situations whilst receiving corrective feedback for distorted cognitions, during therapy, relaxation strategies become ineffectual.

Stravynski, Marks, and Yule (1982) and Wlazlo et al. (1990), conclude that SST is useful in the treatment of SP. Some individuals become social phobics as a result of social skills deficits. Individuals such as these may have experienced humiliation in certain social situations owing to their social skills deficits, and therefore find these situations, threatening. SST is

most beneficial for these social phobics because, their social phobia is alleviated once they no longer feel socially inadequate.

Referring to Trower et al.'s (1978) study (Section 1.5.2), it can be concluded that anxiety experienced by social phobic individuals is not a result of social skills deficits. It is the existing anxiety before entering and whilst in a social situation (may be due to previous unsuccessful social encounters) that evokes the inability to effectively utilize known social skills. However, it is possible for individuals such as these to experience marginal reductions in anxiety merely by practicing social skills through SST even though they are not learning anything new (Trower et al., 1978). For these individuals, however, SST needs to be conducted in combination with other treatment interventions that address the roots of this anxiety, because social skills deficits are not the cause of the anxiety.

Exposure-based treatments are highly effective for treatment of SP, as patients are encouraged to enter the threatening social situation, whether imaginably, through a role-play, or in reality, and face the consequences of the situation. This practice enables experimentation with the feared situations until an adequate method of overcoming the anxiety experienced is formulated. In addition, individuals can modify their behavioural patterns through the behavioural experiments. However, exposure on its own as a treatment method is not effective. Whilst the behavioural aspect of SP is addressed, the cognitive and somatic aspects of SP are not addressed. Negative irrational thoughts and feelings need to be challenged in order to decrease the chance of relapse upon conclusion of treatment. Irrational thoughts and feelings are most effectively challenged through CR. Several studies vouch for the combined efficacy of exposure and CR, for example, Mattick and Peters (1988); and Mattick, Peters, and Clark (1989) found CR plus exposure more effective than exposure alone. Taylor and Woody (1997) explicate that a combination of CR with exposure, is better than CR alone followed by exposure alone.

When varying degrees of each of these treatment methods are combined to form CBT programmes, such as those outlined under Section 1.5.4, all the different dimensions of the problem faced by social phobics would be addressed. CBT is regarded as the most effective and leading treatment method for SP. The difference between CBT and other methods of treatment is that CBT shows the most substantial benefits at follow-up investigations (Heimberg & Juster, 1995). This is simply because, by providing corrective information for all

aspects of SP, there is minimal chance of relapsing. Each method that is constituted in an ideal treatment package will inevitably compliment the other methods used in treatment. In this manner, social phobic individuals enjoy treatment gains in more than one aspect of the problem posed by social phobia, thus improving as a whole.

However, it must be noted that all CBT programmes are not necessarily considered equally effective. Invariably, the more sophisticated (carefully formulated) the programme, the greater the treatment successes. The Clark and Wells (1995) CBT programme has been described as being even more effective than the Heimberg (1991) CBT programme for treatment of SP (personal contact with Clark, 2000). This is mainly because, the Clark and Wells (1995) CBT programme is primarily aimed at conceptualising and modifying the maintenance cycles in SP. Treatment techniques are geared towards "generating a more realistic and stable sense of the self as a social object... [which is achieved through] ...extensive exposure to situations in conjunction with carefully selected manipulations that augment disconfirmatory processing and produce changes in self-appraisals, assumptions, and beliefs" (Wells and Clark, 1997; p. 23). Clark and Wells (1995) disclaim the necessity for SST, as they believe that social phobics already have the necessary social skills.

With reference to pharmacological treatments for SP, there is conclusive evidence to suggest that medication does alleviate social phobic symptoms and assists social phobic individuals to experience higher levels of self-efficacy. However, the treatment gains are not maintained in the long run.

Taking into consideration that CBT programmes are most effective in the treatment of SP, and that the Clark and Wells (1995) CBT programme is superior in quality to the extensively researched Heimberg (1991) CBT programme; the Clark and Wells (1995) CBT programme becomes a heightened area of interest in research around treatment of SP. Material has not been published to date, explicating how the Clark and Wells (1995) CBT individualized treatment programme can be adapted to a group format. The purposes of this study, is to adapt the Clark and Wells (1995) CBT treatment programme to a group format. This is made possible with the use of the Clark (1997) treatment manual that explains the Clark and Wells (1995) CBT individualized treatment programme in great detail. Successful treatment outcomes with this study would prove to be an important breakthrough in the literature around SP.

# CHAPTER 2

## METHODOLOGY

## **2. METHODOLOGY**

### **2.1 RESEARCH AIMS:**

- 1) To adapt the Clark (1997) manualized treatment for social phobia (SP) so that it can be used for group therapy of SP,
- 2) To construct individual case studies of participants in the group in order to evaluate whether the group process is as effective as individualized treatment, and
- 3) To evaluate the practicality of the adaptation, and to refine it accordingly for future use, by constructing a supplementary group treatment manual to the Clark (1997) manual.

### **2.2 ADAPTATION OF THE CLARK (1997) TREATMENT PROGRAMME**

This study was aimed at implementing and adapting the Clark and Wells model of SP to a group context. The Clark (1997) manual for individual treatment of SP was drawn on as a basis for the course of therapy within the programme and used as a guideline for designing each of the sessions. A research team consisting of a psychology honours student (for purposes of her mini-thesis research), Professor David Edwards, who is an accredited cognitive therapist, and myself met before each session and planned the session to follow. The research team decided at the start of the programme to plan one session at a time in order to reflect on what was achieved in the previous session and to make sure that all participants were having their individual needs met whilst in the group. In doing this, we maintained the structure of the Clark and Wells model whilst being flexible enough to accommodate techniques that contributed to a smooth running of the group process.

Based on various other studies (e.g. Brown et al., 1995; Heimberg et al., 1990; Heimberg, et al., 1993; Heimberg et al., 1994; Hope et al., 1990, 1995; and Lucas and Telch, 1993) that have been conducted for group treatment of social phobics, the research team ascertained that the programme should ideally consist of between 12 to 16 sessions, and each session should be

± 2 hours in length. At the start of the programme, the research team did not firmly decide on the exact number of sessions (i.e. 12, 13, 14, 15 or 16) so as not to be rushed because of any firm deadlines. According to the Clark (1997) manual, 12 sessions is ideal for an individualized treatment programme. The research team realized that a group programme would probably be longer than 12 sessions, as there are extra processes that need to be catered for, for example, establishing adequate group cohesion, whilst making sure that sufficient time is spent on individual needs of members in the group. The research team would allow 16 sessions, which is the most number of sessions used in similar group therapy programmes.

The research team decided that apart from the group sessions, one individual session with each of the participants was required. This session would be for the safety behaviours experiment (SBE) and feedback. The reason for conducting this session individually is because the SBE and video feedback of the SBE takes approximately 2 hours per participant. This process would have become too lengthy for all the participants if they all attended each other's experiments. Therefore, in order to economize on the time spent in therapy for the participants, it was decided that the SBE be conducted individually.

At the start of the programme sessions were held twice a week with three-day breaks between sessions. This provided participants with enough time to conduct and reflect on homework assignments/experiments before the next session. From session 9 onwards, sessions were held once a week in order to have greater amounts of time away from the group when the participants could conduct several homework experiments and have more time to start learning to cope without the group. Owing to time constraints of the university terms, the first five sessions were held during term two of the academic year, and, following a 7-week vacation, sessions 6 to 13 were held during the third academic term. During the vacation between sessions 5 and 6, participants were required to do several homework assignments and exercises. The homework assignments and exercises are explained further in Section 2.4.2 (also refer to Appendix 1). The individual sessions for each participant, involving the SBEs were held between sessions 6 and 7.

The aim was to incorporate all that was dictated in the Clark (1997) manual, along with effective ways of bringing a group together harmoniously (Section 3.1.2, and Appendix 1). With the help of pointers from Free (1999) about techniques on how to conduct group

therapy, and Edwards' (1998) techniques in co-counselling, the research team predicted that warmth and harmony would be brought into the group. Free (1999) provided meaningful exercises for introducing participants to one another at the start of the group, and methods for closure of the group. Edwards (1998) provided methods of bringing a level of intimacy and trust amongst group members by pairing members of the group for various in-session exercises during sessions 1, 2, 3 and 4. For every different exercise that participants were paired in this manner, each participant had to find a new partner. Therefore, by the end of the various in-session exercises, between sessions 1 to 4, every participant had worked with every other participant individually. For further descriptions of the sessions, and a complete description of the adapted group treatment manual, refer to Appendix 1: Group Treatment Manual.

**Table 2: Research and treatment programme format**

Term 2	Initial Screening Interviews (Pre-group interview) Sessions 1 to 5
Seven-week vacation: Homework assignments and exercises	
Term 3	Session 6 Safety Behaviours Experiments: Individual sessions Sessions 7 to 13
Two-week vacation	
Term 4	Debriefing Interviews* 6-week follow-up assessment interviews*
* For research purposes only; not part of treatment programme	

The additional interviews referred to in Table 2 above that were conducted for research purposes only, are further described in Section 2.4.2, below. The initial screening interviews (including the pre-group interview) are described in Section 2.4.3 below.

### **2.3 PARTICIPANTS**

The research team decided that participants would be chosen from students attending Rhodes University in Grahamstown, South Africa. It was certain that all students at this university would be able to converse in English, and would have a common background of being

students. However, before a request was made to students to participate in the programme, the research team had to decide what the specific inclusion and exclusion criteria for participation in the group would be. Suitability as per these criteria is outlined below.

Inclusion criteria:

Participants had to meet the DSM-IV (APA, 1994) criteria for Social Phobia (Table 1.3).

Exclusion criteria:

As per the DSM-IV (APA, 1994; p. 668) several disorders, as mentioned below, can be confused with SP. The differences between these disorders and SP are explicated in Section 1.2.2 'Differential Diagnosis'. These are Avoidant Personality Disorder (APD), Panic attacks, Depression, Separation Anxiety, Dysmorphic Disorder, Pervasive Developmental Disorder, Schizoid Personality Disorder, Agoraphobia, Adjustment Disorder, Parkinson's Disease, Eating Disorders, and Substance Abuse Disorders. The research team needed to decide which of these disorders, if not all of these disorders, would be considered part of the exclusion criteria when selecting participants. It was decided that apart from APD, which is considered an implicitly similar disorder to SP (Heimberg, 1996), and mild depression (scored with the BDI-II; Section 2.4.1) all other disorders would be part of the exclusion criteria. The Clark and Wells model is specifically designed for the treatment of SP, alone. The research team decided that, if any of the above mentioned disorders (apart from APD) were identified amongst individuals who wanted to take part in the group, the individuals would be excluded. Several posters inviting participation in the programme were put up on notice boards around Rhodes University campus and in student residence buildings (Appendix 7).

## **2.4 INSTRUMENTS FOR SCREENING, ASSESSMENT AND DATA COLLECTION**

### **2.4.1 Structured self-rating scales**

i) *Beck Depression Inventory (BDI-II):*

The BDI-II (Beck & Steer, 1996) is an assessment scale for levels of depression. The BDI-II is a 21-item questionnaire wherein each item is rated on a 4-point rating scale ranging from 0-3. The questionnaire pertains to the individual's state of depression, and includes questions referring to; for example, post failure, self-dislike, crying, and guilty feelings. Each question is

then scored accordingly with the responses (Appendix 4[i]). Depression levels in this inventory range from 0 to 63; 0-9 indicates minimal level of depression, 10-16 indicates mild depression, 17-29 indicates moderate depression, and 30-63 indicates severe depression.

ii) *Beck Anxiety Inventory (BAI)*:

The BAI (Beck, 1987) is an assessment scale for anxiety constructed. The BAI is a 21-item inventory. 21 different symptoms of anxiety wherein each symptom is rated on a 4-point rating scale ranging from 0-3. Respondents indicate whether they have experienced the anxiety symptom or not during the last week. The symptoms included in the list are for example, feeling hot, heart pounding or racing, hands trembling, and difficulty breathing (Appendix 4[ii]). Anxiety levels in this inventory range from 0 to 63; 0-7 indicates minimal level of anxiety, 8-15 indicates mild anxiety, 16-25 indicates moderate anxiety, and 26-63 indicates severe anxiety.

iii. *Social Cognitions Questionnaire (SCQ)*:

The SCQ (Clark & Wells, 1995) is a 22-item inventory that lists cognitions that are commonly activated in social phobics in threatening social interactions. Each item in the inventory is rated by the respondent on two separate dimensions; (1) on a scale of 0 to 4, respondents rate how frequently the thought occurred in the past week, (2) on a scale of 0 to 100% respondents rate the extent to which they believed in the thought (Appendix 4[iii]).

iv. *Social Behaviour Questionnaire (SBQ)*:

The SBQ (Clark & Wells, 1995) is a 28-item inventory of the various safety behaviours that social phobics employ in social interactions. On a scale of 0 to 3, respondents rate how frequently they use the respective safety behaviours, for example, staying on the edge of crowds, gripping glasses tightly, and avoiding eye-contact (Appendix 4[iv]).

v. *Social Summary Rating Questionnaire (SSR)*:

The SSR (Clark & Wells, 1995) is 5-item inventory. In this inventory, ability to function socially is asked about which includes, level of anticipatory anxiety prior to a social encounter; degree of self focused attention whilst in the social encounter; and degree to which the respondent engages in post-mortem criticism following the social encounter. The items are rated on a 9-point (0 to 8) rating scale by the respondent (Appendix 4[v]).

vi. *Social Attitudes Questionnaire (SAQ)*:

The SAQ (Clark & Wells, 1995) is 50-item inventory. The respondent's attitudes, beliefs, underlying assumptions, and automatic thoughts are asked about in this questionnaire. Each item is rated by the respondent on a 7-point rating scale from 'totally agree' to 'totally disagree' (Appendix 4[vi]).

vii. *Fear of Negative Evaluation (FNE)*:

The FNE (Watson & Friend, 1969) consists of 30 true or false questions. Each question angles a different aspect of the respondent's moods, attitudes, feelings, and participation in social situations that are being measured over a specific period of time (Appendix 4[vii]).

viii. *Social Phobia Rating Scale (SPRS)*:

The SPRS (Wells, 1997) is an assessment scale for levels of social anxiety. It has 5 broad question categories. The first 4 questions are marked by respondents on a 9-point rating scale (0-8). These 4 questions pertain to the level of social anxiety they experienced during the past week. The fifth question is about beliefs and thoughts that one might have in a social situation. Various thoughts are listed in this question and the belief that one has in these thoughts are rated from anywhere between 0 [no belief] to 100 [completely believe] (Appendix 4 [viii]).

## 2.4.2 Written Self-Report Materials:

i. *Self Report Questionnaire*:

Participants were given this questionnaire at the pre-group interview (Section 2.5.2). Each participant had to complete this questionnaire before the first session. This questionnaire was adapted by the research team (to suit the purposes of this programme) from a questionnaire constructed by Sank and Shaffer (1984). The two main aims of this questionnaire are to, (1) provide detailed case histories, and (2) conceptualise the presenting problems of the participants. These two aspects form an integral part of the case studies constructed for each participant. The questionnaire also includes other important aspects such as, biographical data, parental relationships, and education (refer to Appendix 5[i]).

ii. *Records of in-session exercises:*

Identification of feared situations, negative thoughts, safety behaviours, automatic anxiety symptoms, and increased self-awareness, were conducted through co-counselling exercises (explained in Section 2.2). These exercises form part of the Group Treatment Manual (Appendix 1). The notes and records made during the exercises were photocopied, and the originals were returned to the participants. By keeping a copy of these exercises, the research team was able to keep track of participants' needs and concerns as explicated through the exercises. In addition, the research team was able to use these exercises as additional information for tracking progress of the participants that formed part of the case studies.

iii. *Homework record sheets:*

Usually, the homework that is given at the end of each session pertains to what has been discussed and explored during the session. For example, after the sessions pertaining to recognition of *automatic thoughts and negative beliefs*, and importance of conducting behavioural experiments (involving in vivo exposure), the 'Dysfunctional Thoughts Record' and the 'Record Sheet for Noting Behavioural Experiments' were given to participants as part of homework for the remainder of the programme after every session. These homework record sheets are used by Clark and Wells (1995), and can be found in the Clark (1997) manual (pp. 76-77) and in Appendix 1.

Whilst participants completed the routine questionnaires at the beginning of each session (as explained above), the group facilitator would collect homework record sheets in order to review what experiments participants had carried out (whatever was collected was photocopied and kept on file as well, for research purposes). Thereafter, at the beginning of each session, the homework records were returned to participants, and time was devoted to a discussion of the previous session's homework. This discussion would sometimes even last up to an hour depending on participants' needs. Towards the end of each session, the group facilitator would explain the next homework assignment. All the additional homework exercises that are not part of the Clark (1997) manual (that is, apart from the 'Dysfunctional Thoughts Record', and the 'Behavioural Experiment Noting Sheet') are outlined in the Group Treatment Manual (Appendix 1).

*iv. Weekly session evaluation questionnaire:*

Each participant had to complete this questionnaire after each session. This questionnaire was adapted by the research team (for the purposes of this programme) from a questionnaire constructed by Freeman, Pretzer, Fleming, and Simon (1990). The questionnaire consists of five parts measuring the following: perceptions and feelings regarding the level of progress made by the respondent, and group cohesion during the session; level of understanding and adequacy of discussion about the previous session's homework assignments and exercises; adequacy of facilitators' participation, understanding and empathy; level of mastery of various skills by the respondent; and general feedback about anything that is of concern to the respondent. These questionnaires were reviewed after each session by the research team, and used in planning future sessions (Appendix 5[iii]).

*v. Debriefing and feedback questionnaire:*

The research team constructed this questionnaire for the purposes of debriefing the participants after completion of the entire treatment programme. The questionnaire consists of 40 questions that are each rated by the respondent on a 7-point ordinal rating scale. Starting with session 1, through to session 13 (including the Safety Behaviours Experiment), the respondent basically reviewed the entire treatment programme in this questionnaire. Brief summaries were used in order to remind participants of the aim(s) of each session. Each milestone achieved during the course of the programme is questioned for the level of insight and understanding experienced. In addition, further comments from participants are encouraged regarding what they consider to be ways in which to improve the treatment programme (Appendix 5[iv]).

*vi. Group member's self-rating for SBE*

After both role-plays in the SBE, group members had to complete the same self-rating questionnaire consisting of 6 questions. Five questions were rated on a 10-point (1-10) rating scale regarding their performance during the role-play. The sixth question was a descriptive question regarding the anxiety symptoms they feared the volunteer would notice about them during the role-play. Group members used this questionnaire to compare their performances in the two role-plays, that is, with and without safety behaviours (Appendix 5[iv]).

vii. *Volunteer's rating of the group member in the SBE*

Volunteers completed a questionnaire to rate the group member's performance after both role-plays in the SBE. This questionnaire consists of 5 questions, 4 of which are rated on a 10-point (1-10) rating scale, and one descriptive question regarding noticeable anxiety symptoms. Group members used the volunteer's responses in this questionnaire to gather evidence about the way in which others view their social performance/adequacy (Appendix 5[v]).

### 2.4.3 Semi-structured Interviews:

i. *Initial Screening Interview:*

Using the exclusion criteria outlined above in Section 2.3, the research team constructed a '*screening interview questionnaire*' that contains questions that help identify the exclusion criteria disorders. The questionnaire consisted of 12 semi-structured questions pertaining to interviewee's experience of panic attacks, separation anxiety, Dysmorphic disorder, pervasive developmental disorder, schizoid personality disorder, substance abuse, agoraphobia, adjustment disorder, Parkinson's disease, and abnormal eating disorders. The volunteers were not given the questionnaire to answer by themselves in a written format. They answered the questionnaire verbally. This method was utilized in order to ensure that they explained each answer to the interviewer with the help of additional questions (not outlined in the questionnaire) if necessary. The research team considered this to be a better method of looking for the relevant exclusion criteria. In addition, the questionnaire consists of a checklist of observations/non-verbal behaviours that the interviewer looked for in the interviewee (Appendix 5[ii]).

ii. *Debriefing interview:*

The interview was conducted with the use of the 'Feedback Questionnaire for Debriefing' (Appendix 5[vi]). The questionnaire consisted of 40 structured questions that participants rated on a 7-point rating scale (1-7). The questions required participants to reflect on the entire treatment programme that included the structure of sessions, homework assignments, psychoeducational presentations, the SBE and video-feedback of the SBE, and in-session exercises. Participants were also invited to give a qualitative account of criticisms as to how the various components of the treatment programme could have been made more effective. In

addition, as part of this qualitative account, participants assessed their own opinion of how well they had progressed over the course of programme, and methods by which they would maintain their progress. Essentially, this interview would enable the research team to identify further modifications to the adapted programme for future use.

iii. *Six-week follow-up interview:*

The six-week follow-up interview was a semi-structured interview with three broad enquiry areas as follows. Firstly, participants were required to report on how well they had maintained their progress after the completion of the programme, that is, whether they had experienced relapses or not. Secondly, participants were invited to voice any final concerns regarding their social phobias that they might have recognized after completion of the group programme. Thirdly, participants were required to give detailed feedback about the behavioural experiments they had conducted after the completion of the programme, and whether these experiments had been successful in disconfirming any negative cognitions that continued to persist for them.

#### 2.4.4 Tape Recordings:

i. *Video tape recordings:*

As stipulated in the Clark (1997) manual, "all sessions [were] video and audio taped" (p. 12). A 180-minute videotape was used for recording each session. The video camera was situated in a position that would focus on the entire group at all times thereby capturing all facial expressions, postures and behavioural gestures of the participants. These tapings were important as they form a complete record of the programme and enabled a detailed review of the programme for purposes of session-by-session evaluation, evaluation of group cohesion, and for use in the construction of each participant's case narrative. The only video tapings that participants were allowed to view were their own individual safety behaviours experiments (explained in iii, below).

ii. *Audio tape recordings:*

Two-60 minute tapes were used for audio taping of each session. Small floor microphones were placed in front of each participant's chair in the circle in order to record all conversations, presentations, and discussions that took place during the course of each session. Apart from audio taping of the sessions, the video-feedback session, debriefing

interview and six-week follow-up interviews were audio taped as well. These audiotapes provided a word-by-word account of all the participants' experiences during the programme. The audiotapes of the video-feedback session captured whether the participants had experienced their critical turning point in treatment at this stage. The audiotapes of the debriefing and six-week follow-up interviews captured the extent to which participants had progressed or relapsed since the end of the treatment programme. These tapes were extensively used in the construction of case narratives of the participants.

ii. *Videotape records of the SBE:*

Both role-plays of each participant's SBE were video taped for use in the video-feedback session. Instead of focusing the video camera in one fixed position as was done for video taping of sessions, in the SBE, the video camera was manipulated to focus on all the behaviours, expressions and gestures of the participant and the volunteer at all times. By video taping the SBEs in this manner, participants were given the opportunity to collect evidence that would either confirm or negate their mental representations about themselves, and confirm or negate their assumptions about how others viewed them by closely observing the volunteer's behaviour. For research purposes the videotaped recording of the SBEs assisted in the construction of case narratives of the participants.

## **2.5 SCREENING, SELECTION AND DATA COLLECTION PROCEDURES**

### ***2.5.1 Initial Screening Interview:***

Individuals that responded to the posters requesting participation were invited to the initial screening interview. Individuals were interviewed individually in order to assess their suitability for the programme. Individuals were first asked a series of unstructured questions. The general aim of these questions was to determine their reasons for responding to the posters, and their concerns regarding their social adequacy. The responses of the volunteers summarized whether their descriptions of their problems and concerns fitted with the diagnostic criteria for SP as per the DSM-IV (APA, 1994).

Thereafter, if the individuals met the diagnostic criteria for SP they answered the screening interview questionnaire verbally. At the end of the interview, the individuals were asked to complete the Social Phobia Rating Scale (SPRS; Section 2.4.1), the Beck Depression Inventory (BDI; Section 2.4.1), and two Beck Anxiety Inventories (BAI; refer to Section

2.4.1). One BAI referred to the volunteer's anxiety levels whilst in an anxiety-evoking situation, and the other referred to the volunteer's anxiety levels in general. Upon leaving, they were informed that their interviews would be discussed with the other members of the research team. If they received emails inviting them to a second interview (the pre-group interview, below), they would know that they were suitable for the programme.

### ***2.5.2 Pre-group Interview:***

Once again, these interviews were conducted individually. At the pre-group interview, the selected participants were told that they would be involved in a group. Being social phobic individuals, this realization was highly anxiety evoking. Therefore, additional time was spent helping the participants understand that each of them was one of many others with similar problems. Therefore, nobody in the group would be in judgment of them. It was important at this stage not to divulge any information about the Clark and Wells model or about SP. The research team decided that the participants needed to understand the model and the specific characteristics of SP when in the group setting so that all participants were informed in the exact same way. In addition, for psycho-educational purposes as described in the Clark (1997) manual, it is important that the descriptions of the model and SP are conducted during the therapy sessions. Thus, only a brief explanation of the aims of the programme was given to the participants at this stage.

Participants were given a *'self report questionnaire'* (explained in Section 2.4.2) at this interview. Participants were asked to complete this questionnaire in detail and bring it to the first session. Before leaving, the participants were once again asked to complete the SPRS, the BDI-II, two BAIs, and in addition, the Social Behaviour Questionnaire (SBQ; Section 2.4.1), and the Social Cognitions Questionnaire (SCQ; Section 2.4.1). The SBQ and SCQ are specifically used in pre-treatment assessment, as they are clinically useful questionnaires (Clark, 1997). From these questionnaires, it was already possible to deduce the participant's feared situations, avoided situations, negative thoughts, worst fears, and safety behaviours.

### ***2.5.3 Consent Forms***

The research team decided that the 'Consent forms' (Appendix 6) to participate in the programme would be signed at the beginning of the first session when it was sure that all participants who agreed to be involved in the programme, actually attended the first session.

#### **2.5.4 Repeated measures of various assessment instruments:**

##### **i. Instruments completed at first and final group sessions:**

The Social Attitudes Questionnaire (SCQ; Section 2.4.1) and Fear of Negative Evaluation questionnaire (FNE; Section 2.4.1) were completed by participants only at the first and final group sessions. This was because both these are fairly lengthy and complex questionnaires. In order to avoid wasting times during each session, the research team agreed that there would be a sufficient amount of data collected if these questionnaires were only completed twice during the course of the programme.

##### **ii. Instruments completed at the start of each session:**

Upon arrival at each session, participants completed the following questionnaires: BDI-II, BAI, SSR, SBQ, and SCQ. Regular administration of these scales aided in monitoring the participants' progress in the various cognitive, behavioural, and emotional spheres. All records of the scores from these questionnaires were discussed with participants at the debriefing interview in order for participants to explain and discuss the variations in their questionnaires' scores. The quantitative data gathered through the questionnaire scores was necessary as a means of comparison and progress that participants made through the course of the programme.

#### **2.5.5 Additional material collected at each group session:**

At every session, participants' homework, which included the 'Daily Dysfunctional thought Record', 'Record Sheet for Noting Behavioural Experiments', and other assigned homework (refer to appendix 1 for details of homework assignments) would be collected and photocopied. In addition, all exercises conducted during the sessions would be collected and photocopied as well. All original copies would be returned to participants. Collection of this self-report material was essential in the formulation of case studies.

#### **2.5.6 Debriefing interview:**

This interview was conducted after the completion of the programme. Participants were interviewed individually in order for unbiased opinions about the participants' views about the therapy programme. Participants reflected on the entire course of the programme with the use of the debriefing questionnaire and were able to give constructive criticisms as to how the

various sessions could have been made more effective. Essentially, this interview would enable the research team to gather qualitative data pertaining to further modifications of the adapted programme for future use.

#### ***2.5.7 Six-week follow-up interview:***

As described above in Section 2.4.3, this interview was conducted in order to assess whether participants had maintained the progress they made during the treatment programme. This interview was essential to the research that was conducted in this study. It enabled the research team to understand and recognize the final strengths and weaknesses of the adapted programme through participants' self reports about successes and failures regarding the programme and their personal development after the completion of the programme. Qualitative information was gathered in this interview regarding the final evaluation of the programme. If participants were suffering with relapses of SP, it would be evident that the adapted group treatment format was unsuccessful.

## **2.6 DATA PROCESSING**

### **2.6.1 Structured and self-rating scales:**

The self-report scales were processed by employing the standard scoring methods used by Bates and Clark (1998). Quantitative data gathered from the scores of the questionnaires are displayed graphically in order to provide a visual representation of the participants' progress. Qualitative information gathered in the semi-structured interviews; from the self-report questionnaire, homework assignment records, and material gathered during sessions (completed handouts, video-tapings, audio tapings) have been used to construct an extended case narrative for each participant.

The case narratives have been juxtaposed with the graphical representations of participants in order to evaluate the participants' progress in treatment and to make a comparison of participants' social phobic status before, during and after the completion of the treatment programme. In addition, through this evaluation, comparisons are made possible amongst group members. Information that presents the finding that certain participants made faster progress than others have been investigated. In addition, this information is evaluated in order to conceptualise whether participants' failure to make progress was due to the treatment

programme or participants' inability to make a change in their ways of processing threatening situations.

### **2.6.2 Case narratives:**

Case narratives have been constructed for all the participants in the programme with the use of the screening interview questionnaire that gives a historical overview of the participants' lives and characteristics; homework records that present a qualitative measure of participants progress in treatment; in session exercise records that were used to construct the participants' cognitive models; structured self-rating scales that provide a quantitative account of the participants' progress in treatment; the video taped recordings that provide a session-by-session review of the participants' behavioural and emotional changes that are visibly noticeable; the audio taped recordings that provide word-for-word analysis of participants' progress and personal growth during the course of the programme; and finally, the debriefing and six-week follow-up interviews that provide evidence of how well participants fared after the completion of the treatment programme.

Case narratives were constructed primarily to evaluate participants' progress throughout the programme, and to compare their social phobic status at the start of the programme, at the end of the programme and at the 6-week follow-up after the programme. Focus therefore follows how the interventions, homework and group processes effected changes (if any) in the participants' levels of anxiety. This would enable an understanding of how, if at all, the participants experienced change.

Most importantly, the case narratives have been used to draw out the salient aspects of the treatment programme wherein participants experienced critical turning points in treatment. Cross-case comparisons have been made in order to understand why each participant might have experienced this critical turning point at different stages in treatment. In addition, the cross-case comparisons highlight how each treatment intervention may or may not have had a different impact on different individuals. Through a conceptualisation of these points it is possible to gather evidence about how, for example, the intensity of a participant's core beliefs can change the way in which the participant experiences the safety behaviours experiment when compared with others in the group.

As discussed below in 2.6.3, the case narratives also assisted in the evaluation of the practicality and success of the actual adapted treatment programme.

### **2.6.3 Formative evaluation of the adapted group programme:**

Through evaluation of the information gathered from participants feedback about the programme in their session feedback questionnaires and the debriefing interview questionnaires, the practicality and success of the adapted group treatment format can be investigated. Comparisons between the treatment success of the individualized treatment programme and the adapted group treatment programme can be made. In addition, an evaluation of the specific components that were changed to suit the group treatment format can be made. Graphical representations of participants' scores in the session feedback questionnaires and debriefing questionnaires have been juxtaposed with their verbal feedback at the debriefing interview. With the use of this information the practicality of the adapted treatment programme has been investigated.

Discussions regarding why some participants benefited from certain treatment interventions more than others have been examined with the use of the case narratives. In addition, discussions regarding why all participants found certain treatment interventions totally agreeable or disagreeable have been examined. With the use of participants' case narratives that describe participants' progress in treatment, the success of the adapted treatment programme has been evaluated. In addition, with the use of participants' feedback about the various treatment interventions and their progress in treatment with these interventions, suggestions to improve the treatment programme for future use have been made, and additionally are presented are part of the 'Group Treatment Manual' (Appendix 1) that has been constructed as part of this study's research.

# CHAPTER 3

## THE GROUP THERAPY PROGRAMME AND CASE REPORTS

### 3. THE GROUP THERAPY PROGRAMME AND CASE REPORTS

#### 3.1 THE GROUP THERAPY PROGRAMME

##### 3.1.1 The Participants:

Seven volunteers, who all responded via e-mail to the posters inviting participants (Appendix 7), participated in the programme. Each of these volunteers were screened individually (in the initial screening interview), and all volunteers met the inclusion criteria (Section 2.3) for the programme. The group consisted of 7 participants whose particulars are outlined in Table 3.1, below. Two participants dropped-out of the programme after the 7-week vacation (after session 5, Table 2).

**Table 3.1: Particulars of participants that took part in the programme**

Section	Gender	Age	Race	Country of Origin	Year of Study at University
3.2.1	Male	21	Caucasian	Botswana	First
3.2.2	Male	19	Black	South Africa	Second
Appendix 3a	Female	20	Black	South Africa	Second
Appendix 3b	Female	22	Black	Cameroon	Third
3.2.3/4	Female	22	Black	South Africa	Third
3.2.3/4	Male	20	Black	South Africa	Second
Appendix 3c	Male	19	Black	South Africa	Second

Black: native Africans who are not Coloured (mixture of races) or Indian

##### 3.1.2 The group therapy programme:

The programme consisted of thirteen group sessions, excluding the individualized session for each participant, in which the safety behaviours experiments were conducted. The group sessions were held once or twice weekly in the evenings (when all participants and facilitators

had no other pending commitments), and each session was  $\pm 2$  hours in length. A brief summary of the general procedure for all the group sessions is outlined below. The detailed session-by-session outline of the programme can be found in the 'Group Treatment Manual' (Appendix 1).

Upon entering each session, participants were required to complete the routine set of quantitative assessment questionnaires (Section 2.4.1). Once these were completed, group members described what they did for homework, and the group leaders worked with this. This discussion would sometimes last up to an hour, as each participant was given ample time to discuss his or her findings, problems, and experiences with the homework assignment(s). These discussions also allowed time for consolidation of concepts that were discussed or learned in the previous session.

At times, through the experiences participants had with their homework assignments, especially with the behavioural experiments, important developmental milestones in the programme were reached. At stages such as these, participants needed individualized attention from the facilitators and other group members, and in-depth discussions that focused solely on themselves, so that they could share their feelings, thoughts and anxieties. It was predicted that, these discussions would be useful to all members in the group, as a lot of insight and understanding would be achieved from each other's experiences. In addition, through the discussion of each participant's findings and experiences with the homework, irrespective of whether they were brief or in-depth discussions, the facilitators would be able to obtain qualitative accounts of each participant's progress since the previous session. Dysfunctional cognitions and behaviours would be identified and addressed immediately through this process.

Following these discussions, time would be devoted to psycho-educational presentations. In this part of the session, new concepts, interventions or theoretical knowledge pertaining to the programme agenda would be introduced. Participants were encouraged to question any aspect of the material that they did not understand. Participants would then either discuss the new concepts within the group, or form pairs and conduct in-session exercises so as to refine their understanding of the concepts whilst applying them to their own problems.

The next part of the session involved an explanation of the homework assignments to be completed by the following session. Usually the homework involved exercises that related to the concepts or theory introduced during the session. The session would be concluded by inviting participants to sort out any queries they had regarding the homework. Participants were required to complete the session feedback questionnaire before leaving each session.

### **3.1.3 Structure of the therapy programme:**

During the first five sessions of the programme, the main aim was to help participants construct their idiosyncratic cognitive models with respect to their problems. Their models followed the outline given in the Clark and Wells cognitive model for SP (Section 1.3.6, Figure 1.6). The group was guided through the process of monitoring their thoughts, feelings and behaviours so as to increase their self-awareness. This was achieved through several psycho-educational presentations, structured in-session exercises, and homework exercises that consolidated the specific content of the preceding session. Participants identified situations they feared in the first session of the programme. In the next three sessions, negative thoughts, automatic anxiety responses and safety behaviours used in the feared situations were systematically and progressively identified. Thereafter, participants were able to identify their shifts in attentional focus, and discuss their feelings and thoughts regarding increased self-awareness whilst in the feared situations.

Having discussed and identified all these components, participants had gained sufficient insight into their problem and began to construct their idiosyncratic cognitive models (as part of their homework after the fourth session). The constructed cognitive models were discussed in session 5. Participants were able, at this stage, to conceptualise how their social phobia was maintained by realizing how their feelings, thoughts and behaviours in feared situations, interacted and reinforced one another.

Following this, the aim of the remaining eight sessions was to assist participants in applying practical methods of overcoming the problems conceptualized in their models. This was achieved by carrying out the safety behaviours experiment (individualized session), conducting role-plays in the group when necessary, and assigning homework in every session that required participants to conduct regular behavioural experiments (*in vivo* exposure with their

feared situations). In addition, participants were guided through the process of cognitive restructuring in which they learnt to test, analyse, and challenge their thoughts and predictions, before, during and after their experiences in their behavioural experiments.

The safety behaviours experiment (SBE) mainly served to help participants decide whether safety behaviours were useful or self-defeating. It was conducted between sessions 6 and 7. Participants were required to identify the safety behaviours that they use in the threatening situation that they chose to role-play. The role-play was set up with the help of stooges who interacted with the participants in the role-play. Exactly the same role-play was conducted twice, with each role-play lasting approximately 8-10 minutes. In the first role-play, participants were required to utilize all the safety behaviours that they identified. In the second role-play, participants were required to drop all their safety behaviours. After each role-play, participants and stooges completed rating scales to rate the participant's performance during each role-play. In this experiment, stooges invariably rate participants' performance much higher than participants rate themselves. In addition, participants realize that their social interaction in the second role-play, without their safety behaviours, is far more rewarding. Participants viewed their SBE as part of the video-feedback session.

Behavioural experiments were the main focus once the safety behaviours experiments were conducted. Participants were required to conduct behavioural experiments with situations they feared. Participants, who struggled to go out and conduct behavioural experiments, found it easier to begin by conducting experiments within the group. In session 7, 'post-mortem' was explained to participants as, a process that social phobic people engage in immediately after encountering a threatening situation, as a means of analysing the situation (Appendix 2). The post-mortem usually highlights all the negative aspects of the social encounter, owing to negative cognitions that social phobic individuals use when analysing themselves and others.

In addition, behavioural experiments enabled participants to test and challenge their thoughts and predictions about feared situations. With the use of a psychoeducational presentation, participants were introduced to the concept of cognitive restructuring. In session 8, participants were issued a manual (Appendix 1) entitled 'Cognitive restructuring- a guide to working with negative, dysfunctional and self-defeating thoughts' (Edwards, 2000). This manual was discussed in detail as part of the psychoeducational presentation in session 8. The process of identifying negative, dysfunctional and self-defeating thoughts was explained. In

addition, ways of challenging and testing these thoughts. As per the manual, one of the methods of challenging and testing thoughts and predictions is by conducting behavioural experiments. The psychoeducational presentation in session 9 focused on the different kinds of cognitions. Underlying assumptions, core beliefs (about oneself and others), and automatic thoughts were explained.

Participants described their experiences and outcomes of their behavioural experiments as part of the homework discussion at the beginning of each session. At times, the outcomes of these experiments seemed unsatisfactory to the participants. In such cases, one of the facilitators would guide participants through a logical analysis and discussion of their behavioural experiments. This process helped participants to challenge their dysfunctional thoughts and assumptions about the outcomes of the experiment and to realize their misinterpretations. Ultimately, with experimentation and use of cognitive restructuring, participants gained more accurate feedback from their behavioural experiments as they were able to analyse their thoughts and assumptions in a more logical, rational way without the facilitator's assistance. In addition, through repeated experimentation, and analysis of experimental outcomes, they were able to start building more positive and veridical self-images, as they realized that their thoughts and predictions about their appearances were largely inaccurate. At session 13, the group was closed with a closing exercise that is described in the Group Treatment Manual (Appendix 1). Participants had made their maintenance plans at this session and the group programme was brought to a close.

### **3.2 CASE REPORTS**

Following are individual case reports for each of the participants in the programme. The first two participants' case reports have been constructed in detail and include case narratives that are juxtaposed with graphical representations of quantitative assessment measures (Sections 3.2.1 and 3.2.2). The second two participants' case reports have been briefly summarized with the use of graphical representations of assessment measures that provide sufficient information to deduce how effective the programme was for them (Appendices 3a, 3b). The final two case reports are those of the participants who dropped out of the programme (Sections 3.2.3 and 3.2.4). Henwood (2000) who was part of the research team constructed one participant's case report in detail, with the case narrative and graphical representations of assessment measures (Appendix 3c).

### 3.2.1 The Case Report of Sam<sup>1</sup>

"Sam", aged 21, is a Caucasian, male student. He was in his first year of study at Rhodes University (RU) when he participated in the programme. He was the only generalized social phobic in the group. In addition, he was one of the participants who benefited the most from the therapy programme. Sam involved himself completely in the programme, and gained ample insight into his problems. He was one of the first members of the group to understand, assimilate and integrate the cognitive-behavioural interventions.

#### A) Case narrative

Sam was born two months prematurely in Pretoria, in 1979. His father was a geological foreman at the diamond mine in Botswana until 1992, when he was retrenched. Thereafter, and to date, his father is a car sales representative for a firm in Botswana. His mother started teaching French for primary school students in 1988. Prior to this, she was a housewife. At present, she no longer teaches, and is constructing a 'Setswana (language spoken in Botswana) to English to French, Children's Illustrated Dictionary', at her home in Botswana. Both Sam's parents were in their second marriages with each other. They divorced in 1997. Sam has one brother, aged 29. He has three other half-siblings, one born to his mother (from her previous marriage), and two born to his father (from his previous marriage). However, he has never met them and knows nothing about them. He and his brother are mutually fond of one another. Sam explains that they have only come to "really know" one another recently, since their large age difference of 8 years is no longer a barrier between them.

Sam has had a traumatic childhood and teenage life. His parents fought a lot when he was a child, and "the fights were quite bad at times". However, his father never physically abused his mother. His father had numerous covert affairs (since 1988), some of which, his father failed to hide successfully from the family. Invariably, his father's affairs were with women of a lower social class. His parents argued a lot about his father's indiscriminate affairs. Sam would cry himself to sleep every night with the fear that his parents would get divorced. When they finally divorced in 1997, Sam tried to commit suicide.

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<sup>1</sup> The name of the participant has been changed in order to protect his identity.

Sam had lived with his parents until he was 11 years old, when he was sent to the first of three boarding schools. After his father was retrenched, Sam had to leave this school in Botswana, and move to another boarding school in South Africa that was more affordable. Due to his shy nature, Sam struggled to make friends at this school. He was bullied, and labelled anti-social by his teachers and peers. Therefore, he occupied himself doing other things, for example, growing cannabis in his dorm at boarding school, and smoking the cannabis on the school's premises. He was expelled from this school in 1994 because of these illegal activities. Since he was only 15 years old at the time, the police could not arrest him.

In 1995, his parents placed him at a school in their hometown, and he lived at home with them. He stayed away from trouble during this time. Due to his parents' growing marital problems, that were causing serious physiological and psychological strain on Sam, he was once again sent away to a boarding school in Zimbabwe in 1997. He completed his secondary education at this school. He had managed to make a few friends at this school, and still keeps in touch with two of them who also study at RU. Sam was suspended for 10 days at this school for being involved in a prank that was played on the librarian. Sam confesses that he would purposely get himself into trouble, in order to get his parents' attention, which he had never had.

Sam's father was "never there for me... he never showed fatherly support or concern for me". In front of the public eye, his father would put on a show, and lead people to believe that Sam was his "daddy's boy". However, in the privacy of their home, his father was distant. Sam mentions that his father never even made an effort to discipline him. Sam only remembers being beaten once by his father, when he was 16 years old. This happened whilst his mother had gone to Europe to visit her family after 21 years of absence from them. On this occasion, his father had brought his mistress home. Whilst his father was cooking supper, Sam had told his father that it was a bad idea to fry pork in oil. Later that night, when his father's mistress had left, his father beat him severely. Sam explains that, it was possibly the humiliation of being told what to do, by his son, in front of his mistress, that outraged him.

Sam mentioned that he had, and still has a very strong emotional attachment towards his mother, although she has never hugged him or shown affection towards him. In addition, she has never gone out of her way to tell him that she loves him. Sam mentioned that they "fought like cats and dogs". Their fights were usually because she was "far too domineering" and

never allowed Sam to have his own opinions about anything. However, Sam respected his mother, and believed that she only wanted what was best for him. Sam was told by his brother that their mother was an alcoholic until around 1987. Sam was not old enough, at the time, to gather this for himself.

After completing his schooling in 1998, Sam went to live with his mother for one year, and helped her with the compilation of her dictionary (mentioned earlier). In this time, she never allowed Sam to socialize with anyone, in case he was an embarrassment to her and himself. She was highly condescending towards him and often made him feel worthless, as she had always done in the past as well. He mentioned that she had always given him the impression that he was a social outcast. "In spite of all her very real weaknesses and problems", Sam dotes on his mother, and has "always valued her opinion of me, and thought it to be a true reflection of who I am".

***(a) Life situation at the start of the programme***

At the start of the programme, Sam mentioned that his daily routine was "satisfying, yet uneventful". Sam had a clearly planned daily routine. He avoided doing anything that was not a part of the routine. He would go straight to the destinations where he had to be, and straight back home when he had finished whatever he had to do for the day. He was not involved in any sporting activities or any other form of extra-curricular activities within the university. During the day, he attended all his lectures. During the evenings, he cooked his supper, and watched television or studied. He normally tried to be in bed by 10.30 pm, every night. Between lectures, he worked at the 'Library for the blind' where he made audio taped books that the blind people could listen to. He said that he found this "enjoyable and satisfying, because I'm fulfilling my humanitarian duties".

At the time, he was not dating anyone, and did not seem worried with this. He seemed most comfortable with the idea of being single. He had three close, male friends, one of whom was living with him, and the other two were friends he had since his school days. He met his two school friends, once a week, preferably at his home. He never went out with them to socialize at public places. It bothered him that he was unable to socialize freely at social gatherings or nightclubs, for example. He realized that he was an anti-social person, but feared being social, in case he was rejected or humiliated. He managed to have good superficial relationships with people "mostly greeting them, and asking about lectures". However, he was entirely unable to

engage in meaningful conversation with these people, and therefore, he had never managed to gather a wide circle of friends for himself. This caused him serious concern, because he could not imagine being a "loner" his whole life.

***(b) Presenting problem***

In the initial interviews, although Sam had a constant nervous expression on his face, he spoke freely about his problems. He seemed to confide in the interviewer with ease, and gave meaningful, insightful answers to all the questions asked. It was clear that Sam was motivated to change. Sam already had a relatively high level of insight into his problems as he had often spent time analysing himself and his life. Referring to his relationship with his mother, Sam entirely blamed his mother for his social phobias. He mentioned that, had she not oppressed him so much, and allowed him to socialize instead, without reminding him constantly that he was an embarrassment, "I would not be in this position today". He also mentioned that this was the first time in his life that he had expressed these sentiments.

Sam envied people that could approach other people (strangers and acquaintances), and make conversation with them, with ease. He admired people who showed self-confidence and control over their behaviour, irrespective of how challenging the social encounter they were in, may have been. He knew that several people considered him to be anti-social. He also knew that he created this impression because he never made the effort to seem more social. However, he had felt extremely self-conscious and anxious when speaking with anybody he did not know, or anybody that he had met only a few times before. Sam seemed distraught with his life. His social anxiety frustrated him and he was looking for some meaningful change.

Sam's goals for treatment, therefore, were related to his difficulties with socializing in all aspects of his life. He wanted to overcome the fears that he experienced every morning, when he "realized that it was time to interact with the world again". He wanted to "become confident enough to even stand up to my mother and show her that I do belong in this world".

***(c) Constructing a cognitive model of Sam's problem***

Through several exercises, homework assignments, and discussions during the first five sessions of the programme, it became possible to conceptualise Sam's problem based on the Clark and Wells model. The most common themes that came through in Sam's accounts of his anxiety involved certain core-beliefs he had about himself. Firstly, he believed that he was

socially unacceptable. He had never even entered several social encounters because his belief in his social unacceptability caused him to avoid socializing where possible. Secondly, he believed that he was socially inadequate, thereby believing that he lacked social skills. Thirdly, he felt certain that other people thought of him as socially unacceptable and inadequate. He believed that he did not know "the first thing about being social" and feared rejection because of this. He admitted that he was anti-social, but did not know how to be any other way. Being anti-social had always been his means of protecting himself from rejection.

In addition, he had other problems that caused him to feel self-conscious about his appearance. Therefore, he had a negative self-image. Firstly, the size of his ears was a constant source of embarrassment for him. He was sure that people made comments about his "unnaturally large ears". At school, he was often referred to as "Dumbo, the flying elephant". His two close friends, who had been at school with him, often called him "Dumbo" in order to joke with him, and would not mean any harm by this. Although Sam would laugh with them, he would feel very hurt and more conscious about his ears. Without even realizing, he would look upset, and they would make further comments, for example, "that's why people don't know how to be around you... you need to lighten up". This would only make things worse, because Sam would feel self-conscious and socially unacceptable in their company, as well.

Secondly, Sam had often been referred to as "queer (homosexual) looking by people who teased me". Even his mother had suggested that he was homosexual, for example, when he had asked her if he could learn ballet, and when he had told her about his passion for cooking. Sam mentioned that he had "no homosexual tendencies, whatsoever", and could not understand why people had referred to him in this way. Nevertheless, this added to his negative self-image. He feared being mocked or teased by passers-by for something he was not. He loved music, and enjoyed dancing in the privacy of his room, but feared looking queer and/or eccentric if and when he danced at a nightclub or party. Therefore, he completely avoided such situations "in case I make a fool of myself".

He mentioned that he feared the simplest social encounters in life. For example, even before walking past a crowd of people, his anxiety levels would heighten, and he was sure that he would be laughed at, or people would say nasty things about him as he walked past. Therefore, he would either wait for the crowd to disperse, or find another route to his destination. He feared arriving late for his lectures, as this would mean entering the lecture

theatre when everyone was already seated. He feared being looked at, laughed at, or tripping and falling while attempting to find a seat. Therefore, he would always be amongst the first to enter the lecture theatre, and would find a seat in such a position that he would be amongst the first to exit the lecture, as well. He would miss lectures if he knew that he was going to be late for them.

Sam feared approaching and having a conversation with anyone. His anxiety would heighten, even at the prospect of speaking with anyone. He was not sure of what to speak about with people he did not know, and feared appearing uninteresting. Even before entering any social situation, Sam would experience heightened anxiety that he could not bear. He imagined that people would mock him, tease him, laugh at him, think he was queer, and find him uninteresting. Therefore, he entirely avoided social encounters when he could.

As a result of his existing insight into his social anxiety, Sam had already established the basic foundation upon which he could construct his idiosyncratic cognitive model. He had already identified the situations that he feared, the negative beliefs that he had about himself, and the marked level of avoidance that he had used as his main safety behaviour. During therapy, he went on to identify the automatic anxiety responses he experienced before entering, and whilst in the situations he feared. In addition, he identified the safety behaviours he used in threatening social situations that he was unable to avoid. He noted, that whilst in the situations which stimulated the highest levels of anxiety, he experienced nausea, difficulty breathing, abdominal cramping, lack of concentration, restlessness, inability to speak, and sometimes even felt as though he was beyond the point of panic.

When he had no other choice but to engage in a feared social situation, he used specific safety behaviours to minimize his anxiety and possible humiliation or embarrassment. For example, Sam had feared attending lectures for two main reasons. He feared that a lecturer would call upon him to answer a question in front of the entire lecture theatre. He had also feared that, one or more of his "superficial" acquaintances would spot him at a lecture, would want to sit next to him, and speak with him. Therefore, since lectures themselves were unavoidable, Sam engaged in specific safety behaviours that he used at every lecture. Upon arriving as early as possible for a lecture, Sam would find a seat in the lecture theatre that positioned him in a way that he would not be noticed easily by the lecturer or by anybody else that he knew. Thereafter, he would keep as still as possible, so as not to attract attention to himself. By

keeping still, he avoided the possibility of dropping things or making creaking noises with his chair.

Another example of an unavoidable feared situation, involved the possibility of meeting and speaking with people he knew, for example, whilst walking from one destination to the next. He feared making conversation with people. Therefore, he would always try to avoid eye contact or slip away conveniently. If this did not succeed, he would have to stop and make conversation. He rehearsed all that he was going to say (in his mind) whilst approaching the person. He preferred to ask a lot of questions, so as to avoid being asked questions. He feared that if he would be asked questions, he would not be able to construct coherent answers in his highly anxious state. However, due to his heightened anxiety, and his preoccupation with planning the next question, he would not even hear the person's answers to his questions.

Sam used another safety behaviour on a daily basis. This involved making sure that he was coming across well, by dressing smartly. He reasoned that, by dressing smartly, he avoided attracting the attention of certain people who normally paid attention to, and commented on, other people who were dressed shabbily. At this stage, he did not realize or admit that, by dressing smartly to attend lectures, he in fact drew more attention to himself.

As part of homework, from session 2 onwards, Sam began to monitor his automatic thoughts and emotions more closely in social interactions. He did this with the use of the first three columns of the 'Daily Record of Dysfunctional thoughts'. Sam had to keep an account of the emotions, and negative thoughts that came to mind, before entering, and during these social encounters. Sam managed, with great difficulty, to engage in three situations in which he monitored his thoughts and emotions.

The first situation (between sessions 2 and 3) involved going to Church on Sunday. He found that he felt anxious and rated this emotion as 90/100. He found himself thinking, "I won't enjoy it, I'll feel humiliated, I won't know anyone, the people will look at me, they will laugh/comment, I might do something wrong". He rated his beliefs in all these thoughts as 80/100. Sam experienced similar negative thoughts and emotions before going to Church, as he did before entering a lecture theatre. He wanted to be the first person to arrive at Church, and wanted to find himself a seat where he would not be noticed. Being a religious person, it

was part of his Sunday routine to go to Church, but he mentioned that he had always suffered with his anxiety.

The second situation (between sessions 3 and 4) involved walking from one lecture to the next. He found that he felt anxious, fearful of rejection, and self-conscious. He rated all these emotions as 80/100. He found himself thinking "I may trip and make a fool of myself while walking, people will look at me and talk about me". He rated his belief in these thoughts as 50/100. He then felt light-headed (60/100), and his body shaking (90/100), with the following thought; " if I see someone I know, I might offend them with my anti-social nature". He rated his belief in this thought as 100/100.

Sure enough, as part of his third situation, someone that he knew, happened to be walking in his direction. His first thoughts were, "avoid eye-contact, she won't notice me". He rated his belief in these thoughts as 40/100. He then thought, "oh no, she's seen me, I have to speak with her. My face is turning red (100/100). I don't know what to say (70/100). I'll just ask the usual, about her lectures, and say that I'm in a rush". As she came closer, Sam felt hot in his face (100/100) at the thought that his face was turning red, and numbness in his feet (80/100).

As part of the homework for session 4, Sam started to construct his cognitive model. Sam had to engage in a situation he feared in order to construct this model. The model that Sam constructed is outlined in Figure 3.1, below.

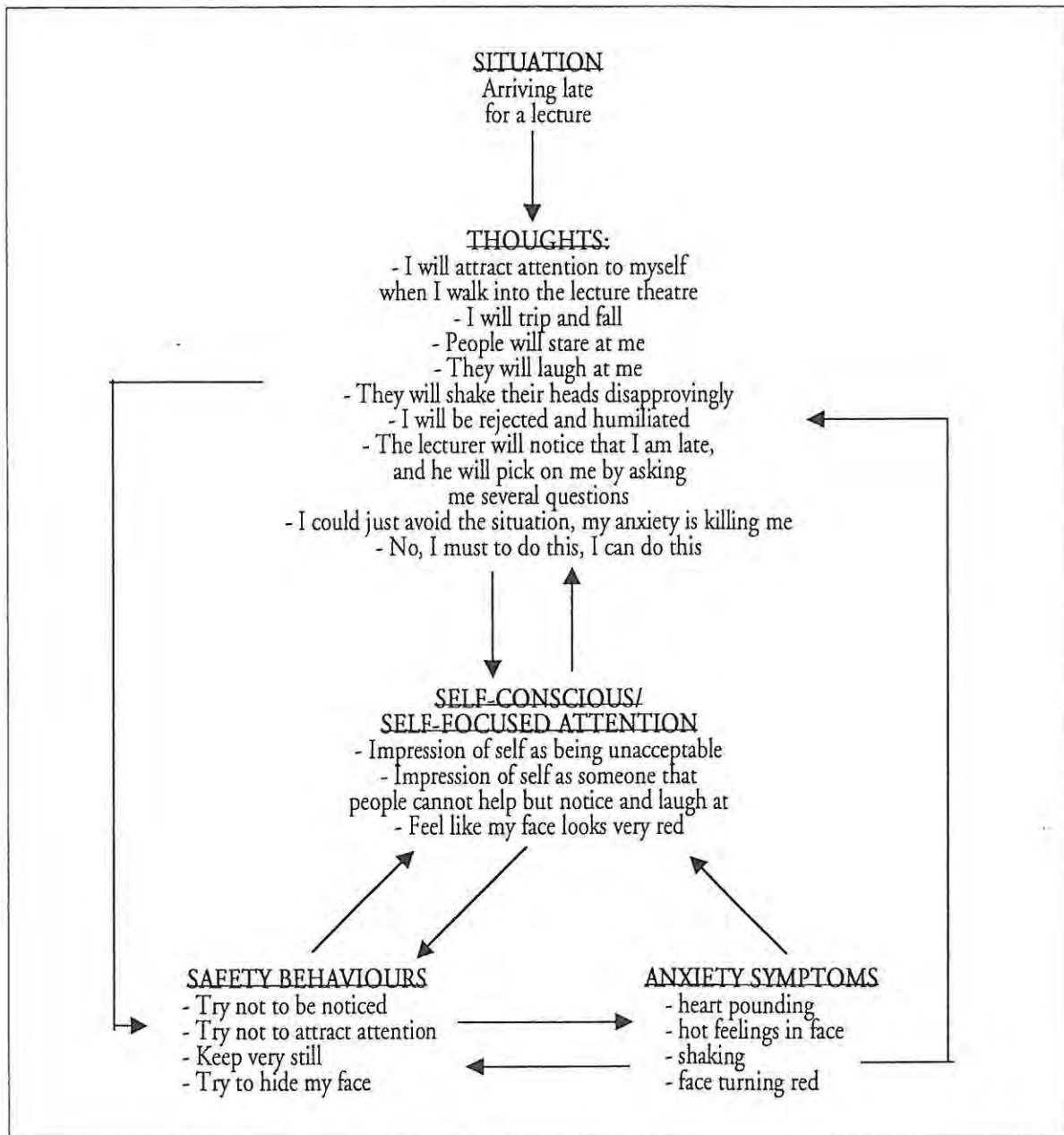
**(d) *An idiosyncratic cognitive model outlining one anxiety-provoking situation for Sam***

The model in Figure 3.1 (overleaf) illustrates the structure of Sam's anxiety response to a typically socially threatening situation that he constructed by himself. As part of the model outlined in Figure 3.1, it is interesting to note that one of Sam's final automatic thoughts involved his desire to avoid the situation, as he had always done in the past. However, in spite of his heightened anxiety, Sam was able to follow this thought with a consciously generated self-instruction "I must do this". This was proof that Sam had taken the first, very important step in the curative process of the programme. By entering the situation, he had allowed himself the opportunity to experience a situation he had normally avoided.

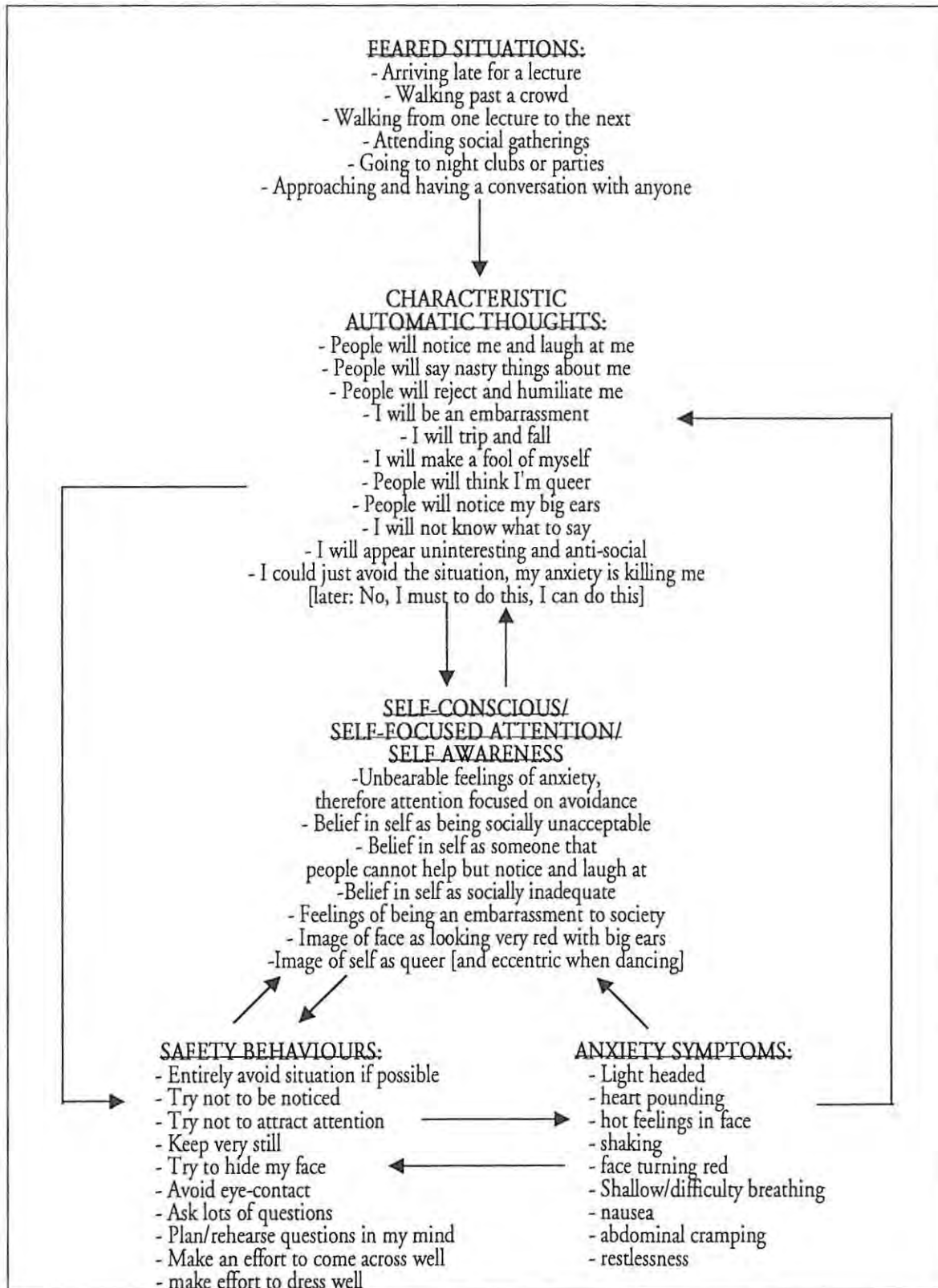
In session 5, through the discussion about his experience outlined in the model (Figure 3.1, below), and analysis of his session evaluation questionnaire, the following became clear.

Formulating his model benefited him greatly, as this process had given him the opportunity to further analyse and understand all that he already knew about himself even before the start of the therapy programme.

**Figure 3.1: Sam's personal cognitive model**



**Figure 3.2: Researcher's comprehensive cognitive model, of all Sam's anxiety responses in all his feared situations**



In addition, Sam felt positive about the deeper insight into, and understanding about his problem that he had gained through the programme, thus far. Through monitoring himself, and identifying the specific cognitive content (automatic/negative thoughts) about his feared social encounters, Sam had enabled himself to deconstruct his core-beliefs to some extent. At this point, the programme temporarily stopped for the 7-week vacation. Outlined above, in Figure 3.2, is a comprehensive cognitive model that takes into account all Sam's thoughts, anxiety symptoms, self-focused attention and safety behaviours, in all the situations that he feared based on information obtained up to the end of session 5.

When the programme commenced in session 6, at the beginning of the third term, Sam shared all the experiences he had had during the vacation. He had gone home to his mother, and had tried hard not to allow her to make him feel like, and believe that he was a social outcast. He achieved this by going against her will, and venturing out of the house on several occasions. He collected more information about his feared situations by monitoring his social interactions. On two occasions, he accompanied his brother and attended social gatherings. However, he was still concerned about the way in which he handled difficult situations. This problem was addressed with the implementation of the SBE (below, in Part e).

During session 6, Sam expressed his pending need to find a job. He had been volunteering at the 'Library for the Blind'. But, he wanted to find another job where he would earn his own pocket money whilst studying. Sam explained that he feared approaching, and conversing with the manager at whichever place he might go to, to look for work. He also feared that, due to his social inadequacy, he would not make a good impression at an interview with the manager. Therefore, he asked that this situation be used for his safety behaviours experiment.

**(e) *Safety Behaviours Experiment (SBE)***

For Sam's SBE, a role-play was set up which involved a male volunteer who would role-play the role of a manager of whichever company, restaurant, etc., that Sam had gone to, looking for a job. Sam was requested to arrive 20 minutes before the volunteer arrived, so as to complete a few routine procedures before the role-plays were conducted. Sam seemed quite overcome with anxiety, and struggled to construct coherent sentences, even with the facilitators. He mentioned that he had seriously thought about not attending the SBE. However, his need to find a job had motivated him to come and experiment with the situation. Sam mentioned that, "if I can't ask for a job in a role-play, how will do this in reality?"

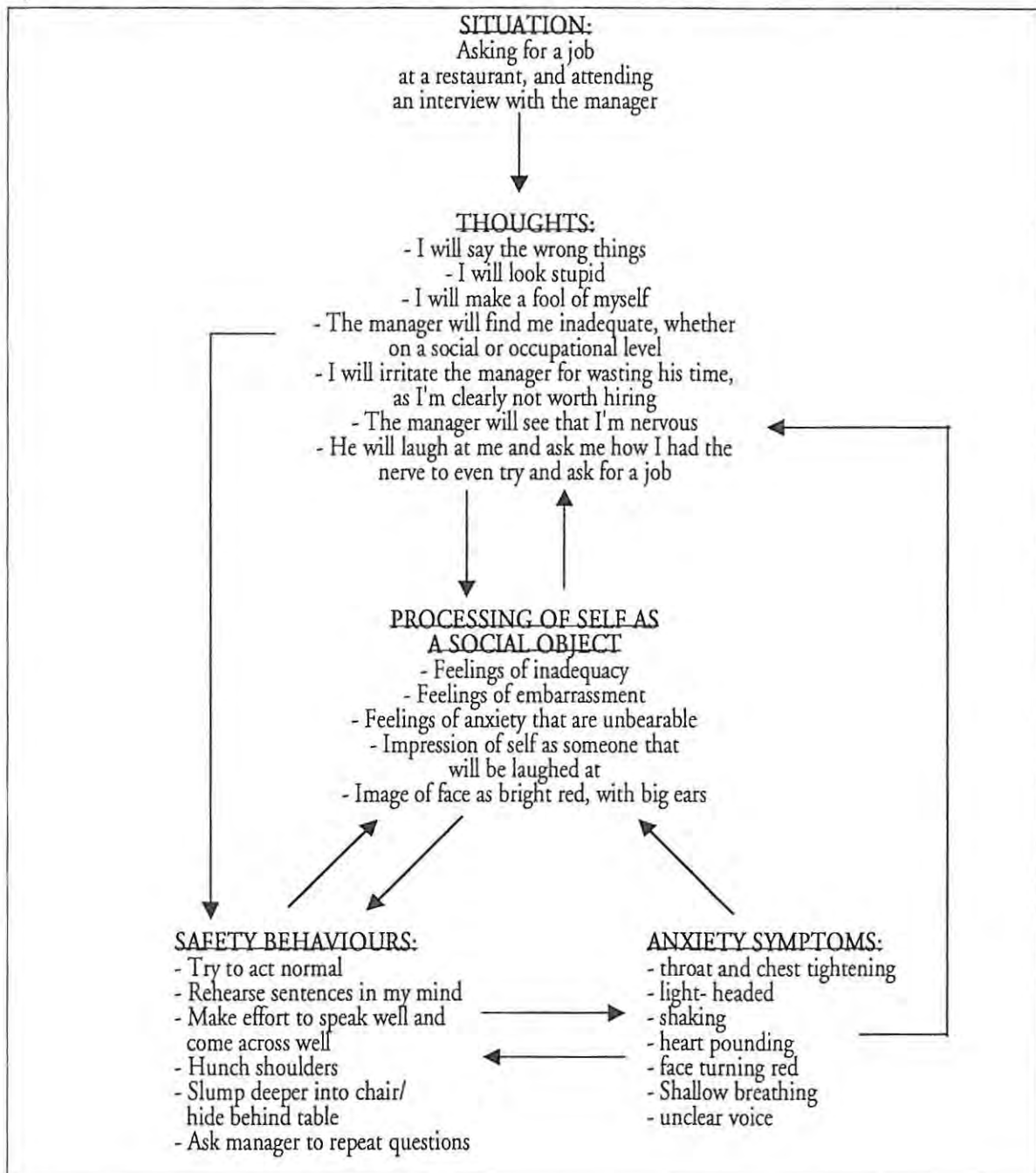
Sam had started to construct a cognitive model of the situation he had requested to role-play. He had only filled the 'thoughts' sections on the model, and brought this model to the SBE with him. He completed the model after the first role-play. The complete model is outlined in Figure 3.3 (below). Before the role-plays took place, a short briefing was held with Sam. Sam was asked about his expectations regarding the social interaction involved in the role-plays. Sam believed that he would "perform badly, and be seen as inadequate for any job". His specific beliefs and train of thoughts regarding this situation are outlined in the model, below (Figure 3.3), under 'thoughts'.

It was decided that Sam would approach the waitress (one of the facilitators) of a restaurant, and enquire about job vacancies. The waitress would then escort Sam to the manager's office, where the manager (the volunteer) would be sitting behind his table. The manager would invite Sam to take a seat, and interview him.

Sam was then asked to recall all his safety behaviours that he would normally use in such a situation. He listed them as follows: plan and rehearse sentences in my mind in order to speak well and come across well, hunch shoulders (to feel less self-conscious), and try to act normal (confident). Sam was then told about the exact procedure of both role-plays. In the first role-play he would adopt all his safety-behaviours, and in the second, he would drop all his safety behaviours. Each role-play would last approximately 8 minutes, but after 4 minutes the facilitators would give him a signal, which meant that he could feel free to leave the situation if he wanted to. The volunteer was then briefed about the role-plays in a different room, so that Sam would meet him for the first time, in the first role-play. The volunteer was told that the role-plays were being conducted as part of social skills research. Therefore, he was entirely unaware of Sam's problems. This would ensure that he would not be looking for signs of a social phobic in Sam's behaviour. After this, the first role-play took place.

Sam adopted all the safety behaviours he had mentioned earlier. He stayed in the situation for the entire 8 minutes. However, he never asked any questions. He only answered questions that he was asked. Even when the manager asked him whether he had any queries, Sam bluntly said "no". The volunteer ended the role-play by saying to Sam; "I will get back to you about the success of your interview, later this week". After the first role-play, Sam and the volunteer completed the rating forms (Appendix 5[iv/v]).

**Figure 3.3: Sam's cognitive model regarding the first role-play of his SBE**



A brief feedback interview was then carried out with Sam whilst the volunteer waited in a separate room. In the feedback interview, Sam expressed that his belief in his inadequacy was confirmed, "why else would he only want to get back to me later this week?". One of the facilitators explained to Sam that, employers never hire prospective employees at the end of an interview. Anybody would have to wait a few days for a response. This explanation comforted

Sam, but he still believed that he was unsuccessful in this encounter. Sam felt as though his "voice sounded very unclear" because he struggled to speak when his throat and chest tightened. However, he also mentioned that this had been the first time that he had had a "full-blown conversation with a perfect stranger". Therefore, he had not anticipated some of the anxiety symptoms that he had experienced, and this heightened his anxiety further.

Sam was concerned about the number of times that he had asked the volunteer to repeat questions that the volunteer had asked. Sam explained that, "I was trying to construct coherent answers in my mind, during the time that the manager repeated his question". Sam also explained that, he had used this strategy as a safety behaviour that he had not identified earlier. Sam was sure that he had irritated the manager by wasting his time. Sam identified another safety behaviour that he had not mentioned earlier. He realized that he had been slumping deeper into his chair whilst trying to hide behind the table, in an attempt to conceal his nervousness and self-consciousness. He mentioned that, had this been a real interview, he would "most certainly be denied the job". He was convinced that the manager (the volunteer) had found him inadequate. Sam's ratings regarding his experience with role-play 1 are given in Table 3.2, below.

**Table 3.2: Sam's ratings after each role-play of the SBE**

	After role-play 1	After role-play 2
1. How anxious did you feel?	8	7
2a. How self-conscious did you feel?	9	6
2b. What were you self-conscious about?	- creating a bad impression - looking stupid - not being able to answer unexpected questions	- creating a bad impression
3. How anxious did you think you appeared?	10	8
4. How good was your performance overall?	3	5
5. What individualized things did you fear would be noticed, and to what extent?	- exaggerated hand movements (8) - unclear voice (10)	- unclear voice (9)

A brief feedback interview was then held with the volunteer. He mentioned that Sam seemed "quite nervous and self-conscious". He assumed that any person would be nervous whilst in an interview, however, he could not understand what Sam had been self-conscious about. The volunteer had noticed that Sam was "not sure about his capabilities". He had arrived at this conclusion due to Sam's choice and willingness to wash dishes in the kitchen, although Sam had also been offered the job of a waiter. The volunteer mentioned that, had Sam "appeared less self-conscious, and slightly more self-confident, he would have been guaranteed the job". The volunteer mentioned that he had not minded repeating his questions, but he was not sure about how a real manager might have handled this. It was then explained to the volunteer that, exactly the same role-play would be conducted again. The volunteer's ratings regarding Sam's performance in role-play 1 are given in Table 3.3, below.

**Table 3.3: Volunteer's ratings regarding Sam's performance after each role-play of the SBE**

	After role-play 1	After role-play 2
1. How anxious do you think Sam looked?	6.9	4
2a. How self-conscious do you think Sam looked?	7	3
2b. What were you self-conscious about?	- not sure	-
3. How good so you think Sam's social interaction skills were?	6	9
4. What individualized things did you notice about Sam, and to what extent?	- hands clasped firmly (8) - he did not sit upright (10) - he sank further into his chair (9)	- hands folded throughout the interview (6)

The second role-play was then carried out. Sam managed to drop most of his safety behaviours. Most notably, he sat upright in his chair, and answered questions more spontaneously, even though the questions were somewhat different in this interview. Sam even managed to ask a few questions about his expected salary, working hours, and the popularity of the restaurant. Once again, the rating forms were completed, and feedback interviews were carried out.

In Sam's feedback interview, he mentioned that he felt as though his performance was slightly better. He still felt conscious about creating a bad impression. However, since he had managed

to focus more of his attention on the volunteer than on his anxiety symptoms, he might have created a better impression in this role-play. Sam mentioned that, "at least I never asked him to repeat his questions, so I might not have irritated him as much". By focusing more of his attention on the volunteer, Sam felt as though he was "being interviewed by a new person". Sam had not even noticed that the volunteer had worn spectacles in the first role-play, as well. Sam's ratings regarding his experience with role-play 2 are given in Table 3.2, above.

The volunteer mentioned that Sam appeared "far less nervous or self-conscious" in this role-play. He appreciated the fact that Sam had made an effort to ask a few questions in this role-play. He mentioned that Sam appeared "a lot more confident" than he had appeared in the first role-play. The volunteer also explained that, "by seeing him sitting upright in his chair, I felt as though I was dealing with a competent person". The volunteer mentioned that he would have given Sam the job based on his performance in the second role-play. The volunteer's ratings regarding Sam's performance in role-play 2 are given in Table 3.3, above.

**(f) *Video-feedback***

Before watching the video footage, Sam was asked to make some predictions about what he expected to see. Sam expected to see "visual evidence that I lack social skills, I'm socially unacceptable, and need to forget about trying to find a job... I also expect to feel further humiliated by how red my face becomes when I am anxious". However, he also expressed that "I'm hoping to disconfirm these beliefs and thoughts". Whilst watching the role-plays, Sam appeared to be very thoughtful about what he was seeing. At various points, the facilitator would pause the video and ask Sam about his impressions so far. Sam was also reminded about certain concerns he had had in the feedback interviews after the role-plays, and was asked whether his concerns were warranted.

Whilst watching the first role-play, Sam had very few comments to make. He mentioned that, "I look worse than I felt". Watching the first role-play, initially distressed Sam even further than he had felt during the feedback interview after the role-play. He realized that he looked "strange" because of the way he sat in his chair. He also felt as though he had humiliated himself by asking the volunteer to repeat all the questions twice, if not thrice. However, his concern about the exaggerated use of his hands, was disconfirmed. Sam realized that, although he looked uncomfortable because of how tightly he was clasping his hands, he at least felt

aware of the fact that, he was most probably arriving at several other wrong conclusions about his appearance.

He then began to notice other positive aspects about his appearance. He noticed that his face did not appear as red as he had expected it to look. In addition, he realized that he had felt and appeared highly self-conscious for no apparent reason. He realized that he looked like any other person. There was "nothing socially unacceptable about me even though I was still using my safety behaviours". Sam also realized that although he had asked the volunteer to repeat questions, "all my answers are well expressed". He was not sure, at this stage, however, as to whether his answers sounded well expressed because he had planned them in his mind. Finally, and most importantly, Sam realized that his voice sounded perfectly normal. He had "entirely imagined that my voice sounded unclear".

The volunteer's feedback from the first role-play was then shared with Sam, and he was shown the scores that the volunteer had given him. He agreed with the scores that the volunteer had given him. He also accepted the volunteer's feedback to be a true reflection of himself, as the feedback matched with what he had seen on the videotaping.

Whilst viewing the second role-play, the video was paused, once again, in certain places. Sam was asked whether he was noticing any differences. Sam noticed that he appeared "perfectly normal" in the second role-play. He realized that, by sitting upright and spontaneously answering questions, he did not appear as anxious or self-conscious as he had appeared in the first role-play. He had therefore made a good impression on the manager. Sam mentioned that, "I saw in myself the person that I had longed to be". This role-play convinced Sam that he did not require his safety behaviours. In addition, the impression he created on himself whilst watching the videotaping, convinced him that it was "about time to start questioning my beliefs about my social-self".

When Sam realized that he was capable of looking as impressive as he had appeared on the videotaping, he was eager to hear the volunteer's feedback. He appreciated the volunteer's feedback as it confirmed all Sam's own conclusions. The fact that the volunteer would have given him the job made him feel motivated to actively start looking for a job. In the session feedback questionnaire (Appendix 5[iii]), for the first time, Sam had circled the option 1 (much progress, very satisfied, etc.) for 20/29 questions. He made an additional comment at the end of

the questionnaire that read, "video-feedback was great!". Sam reported his successes with the SBE to the group during session 7. He expressed that he felt ready to conduct behavioural experiments in real-life in order to gain more positive feedback that would help him completely overcome his social anxiety.

**(g) Behavioural experiments**

During session 8, Sam mentioned that he had been feeling depressed about two burglaries that had taken place at his house over the last week. Many things had been stolen from his house and he also felt very angry at the thought that thieves had chosen the same house, twice. Nevertheless, Sam shared a behavioural experiment that he had conducted. He had noted all the information regarding this experiment on the 'Record Sheet for Noting Behavioural Experiments'. Sam purposely decided to arrive late for a lecture. This had been a feared situation that he had tried to experiment with earlier in the programme (Figure 3.1). Sam's predictions were similar this time as well, "I thought that everyone would stare and shake their heads disapprovingly. They may comment on my clothes, the way I walk, and the noise I make". He rated his belief in these thoughts as 60%. He tested his predictions by "coming through the front door of the lecture theatre in order to get a good look at all those present".

Sam mentioned that he almost turned around and "concluded that I would never be able to walk through those doors". In spite of these thoughts, he decided that it was "now or never, I should just drop my safety behaviours and do this". The outcome of this experiment was highly rewarding for Sam. Although his heart was pounding and he felt light-headed as he entered the lecture theatre, he noticed the following. "The majority of the people looked up". This gave Sam the worst fright of his life. Just as he was about to turn around and leave, "they all looked back down at their note-pads, and continued to take notes. No-one started talking". Sam learned from this experiment that, "of course everyone looks up at late-comers. I've done it too". In addition, he learned that "I am not as special or noticeable as I had thought I was". He rated his belief in this view as 80%. He also realized that everyone has "important and pressing things to do. Therefore, everyone arrives late for lectures at some point in their lives. We all get delayed". He rated his belief in this view as 60%.

During session 9, Sam had been very quiet, and did not share much with the group. He mentioned that he had not conducted any experiments between sessions 8 and 9. Other group members asked Sam about his job-hunting experiences. Sam confessed that he had not yet tried

to find a job, and appeared to be highly distressed by this. Sam was absent in session 10. When one of the facilitators checked up on him out of concern, Sam mentioned that he had simply forgotten about the session. However, he attended session 11. At this session, Sam narrated all the happenings in his life over the previous week. He had conducted numerous behavioural experiments aimed at finding a job. He had decided at the end of session 9 that he would not return to the group until he had found a job. His reasoning for this had been, "since I was not actively looking for a job, I had clearly wasted the time of the facilitators and the volunteer who had helped me conduct my SBE with so much patience. This was bothering my conscience".

Sam had found himself a job, but had struggled through the process. He narrated his experiences as follows. On the Friday afternoon of the previous week, Sam had gone to look for a job. "I stood outside a shop in a state of shock caused by my anxiety, inability to breathe, and anger with myself". He had rated all these emotions as 10/10. "I could not bring myself to enter the shop and ask for a job as I believed that everyone in the shop would stare at me disapprovingly. I also believed that the shop owners would either be angry with me for wasting their time, or laugh at me for expecting to get a job". He rated his belief in these thoughts as 80%. "I felt extremely dizzy, and walked back home feeling like a failure".

On Saturday morning, Sam managed to walk into one place and ask for a job. He had felt very nervous as he had walked into the place, and did not speak clearly. He did not ask any questions, or manage to concentrate on anything that was said to him. However, he had noticed that, "the lady was unexpectedly and surprisingly friendly. She never showed any signs of irritation". However, Sam "ran home after this". Sam ventured out of his home again, on the same morning, and went to yet another place. This time, he had decided to remember all that had happened during his SBE, and dropped all his safety behaviours. He focused on the manager of the place, and ignored his anxiety symptoms. However, he was sure that he did not speak clearly, "I may have mumbled, and I did not show any confidence". Sam walked home, feeling like a failure, yet again.

Finally, on the Monday morning, Sam "decided that I had nothing to lose and confidently asked the manager of the nearest business that I could find, for a job". Although they "turned me down, they did not throw me down, and were supportive and sympathetic". This experience made Sam even more determined to find a job. "I decided that the next place I walk into, I'll act confident, be clear about what I'm going to say, and will not be concerned about what others

think. I have to drop my safety behaviours". Sam walked into a BP filling station. He approached the counter at the BP 'Quick-shop' and confidently asked for a job. He was able to ask questions, told the manager about certain skills he had, and managed to do all this front of some customers. The manager took Sam's contact details, and telephoned Sam on Tuesday morning with a job offer. With this, Sam expressed to the group that, "I've conquered the worst. Those of you that have not, believe me, it's easier than you think, just try".

Sam was absent from session 12 as he was ill. In session 13, Sam narrated another rewarding experience he had had. He was invited to a residence party, and decided to "challenge himself". Whilst walking to the party venue, Sam felt anxious, "stupid and awkward" (5/10). His automatic thoughts were, "I will look stupid (80%), people will laugh at me if something embarrassing happens (100%), if someone speaks with me- they may not understand me (90%)". Sam reasoned with himself and had the following train of thoughts, "everyone is in the same situation (100%), the possibility of me embarrassing myself, is equal for everyone present tonight (100%), I must not pay attention to my voice, but speak clearly when I do speak with anyone". Sam arrived at the party alone, and met two people that he knew. Sam had predicted that, he would be able to speak with these two people, but nobody else would approach him. Sam's prediction was proved wrong, as two strangers came and introduced themselves to him. He made "good conversation with these people, and I knew that I had made new friends". Sam learned from this experiment that, "people are social and want to interact. If I give them half a chance and perhaps go out of my way to do so, then I will be a lot more approachable". He rated his belief in this view as 100%.

#### **(h) Debriefing Session**

At the individualized debriefing session, which took place three weeks after the final group session, Sam explicated that he was satisfied with his "eventful life". He had maintained all treatment gains thus far. He narrated one experience that had a "tremendous impact on me". On the Friday that had recently passed, Sam had been invited to a party by people that he had met that afternoon. As he mentioned, "I have become a regular party animal". Sam attended this party and had a "great time". During the morning of the day on which Sam's debriefing took place, one of the people who had invited Sam to the party on the previous Friday happened to be buying something at the BP 'Quick shop' where Sam still worked. This person went out of his way to tell Sam that, "should he have a party, he would be sure to invite me". The following was the highlight for Sam, and Sam had to use the person's words, otherwise, he joked by

saying that the interviewer would not believe him, “he actually said that *I was the life of the party*... Wow, what a boost for my morale”.

As part of the content in the debriefing questionnaire (Appendix 5[vi]), Sam mentioned that the three sessions he enjoyed the most had been, firstly, session 4, in which he had started to construct his first idiosyncratic cognitive model, and started to integrate all the information he had already gathered about his social anxieties, and anxiety responses. Secondly, he learnt the most about himself in the SBE session. In this session he had realized that, “all my core-beliefs were self-defeating, and none of them were in fact a true reflection of me... watching myself on the video tape was one of the most life-changing experiences that I have ever had”. Thirdly, he enjoyed session 11 “for vain reasons... I revelled in the amount of hero-worshipping I had received from the rest of the group”. This had been the session in which Sam had narrated his painstaking process of finding a job.

Regarding the actual content of the programme, he mentioned that, he would have appreciated the group process more, “had the first few sessions (1 to 4) been less laborious”. Sam had greater insight into his problems than the other members in the group. For this reason, he must have found the in-session exercises that were carried out during these sessions, to be unnecessary for him. Apart from this, Sam was entirely satisfied with the programme, and mentioned that he was sure that future implementations of this programme would be successful in treating other people like himself.

**(i) *Six-week follow-up interview***

At this interview, Sam had continued to maintain treatment gains. He mentioned that he missed the group and the group leaders “but I think of the evenings we all spent together, and that is my eternal inspiration”. Sam had no worries about ever experiencing a relapse, as he was convinced that “I have made too much of meaning of my life, and refuse to feel lonely again”. Sam mentioned that he continued to attend parties, and had a wide circle of friends, and sat in the “most conspicuous seats at all my lectures”. His old school friends sometimes “feel envious about the popularity I enjoy”. Sam also mentioned that he was moving to a larger university in the following academic year. He requested that his email address and telephone numbers be distributed to all the other group members, “so they can reach me whenever they feel lonely, or feel as though they are falling into old ways”. Sam left the interview standing tall, and looking confident.

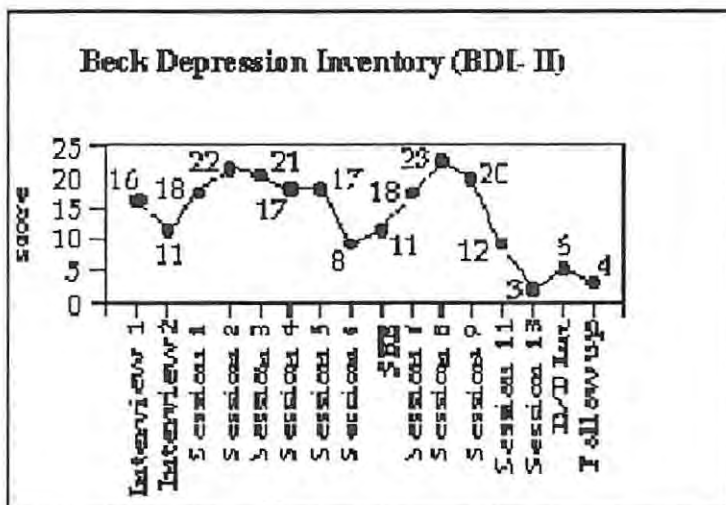
## B) Presentation of Quantitative Data:

In order to evaluate the effectiveness of the programme with respect to Sam's problems, all the questionnaires that Sam completed, were scored, and are presented as graphical representations of his progress in treatment. Refer to Section 2.4.1 for descriptions about each of the measurement scales and inventories used. Sam did not attend sessions 10 and 12, and it must be noted that no scores are presented for these sessions in the graphs. Sam was questioned about the fluctuations of each questionnaire's scores at the debriefing interview. All explanations for these fluctuations, as described below, are Sam's own experiences.

### i. Beck Depression Inventory (BDI-II)

The BDI-II measured Sam's levels of depression. At the first interview, Sam's BDI-II score was 16, indicating that he was mildly depressed. In session 2, his BDI-II score indicated mild depression, as well. However, from session 3 to 5, Sam's BDI-II scores indicated moderate depression, and after the vacation, in session 6, his score indicates minimal depression. Sam could not explain this fluctuation. He suggested that the moderate depression between sessions 3 and 5 might have been as a result of the upcoming exams. Sam had always disliked exams.

Graph 3.1

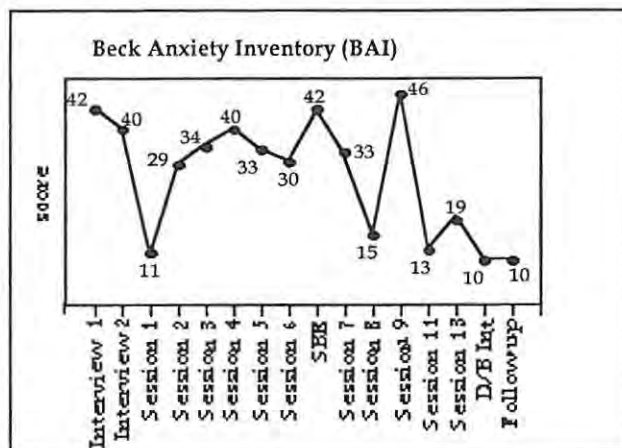


At the time of session 8, Sam's BDI-II score was the highest, at 23, indicating moderate depression. This had been the time that Sam's house had be burgled twice. He attributed his depression to this. The steady decline in his BDI-II scores, thereafter, was as a result of the "constructive effort I had been making to find a job, and my happiness with my life". During the debriefing interview and the follow-up interview, his BDI-II scores indicated minimal depression. Upon realizing that he had overcome his core-beliefs, Sam no longer experienced depression. When reviewing his actual questionnaire at the debriefing interview, his BDI-II score of 6 was due to his past failures, indecisiveness, and guilty feelings/self-criticalness about why he had not taken action regarding his problems at an earlier stage of his life. Sam realized that it was incorrect to feel guilty or self-critical. At least he had managed to make the change.

## ii. Beck Anxiety Inventory (BAI)

The BAI measured Sam's levels of anxiety. Sam's BAI score in the first interview was 42, indicating severe anxiety. Sam explained that he was highly anxious about meeting the interviewer and did not know what to expect. In the second interview his BAI score in a feared situation indicated severe anxiety (40), and his BAI score in general indicated moderate anxiety (18). The anxiety symptom that he rated as severe and could barely stand, in general, was his fear of the worst happening.

**Graph 3.2**



In the first group session, Sam's BAI score was 11, indicating mild anxiety. He attributed this drop in anxiety to the fact that he felt comfortable around other people who were experiencing

the same problems that he had. Sam's BAI scores from sessions 2 to 7 indicate severe anxiety. Sam explained that this had been the time when Sam was monitoring his thoughts and anxiety symptoms (sessions 2 to 5) whilst engaging in situations he had always avoided; and conducting behavioural experiments (sessions 6, SBE and 7). For session 8, Sam could not explain his BAI score. In session 9, however, he had been experiencing severe anxiety that he attributed to his preoccupation with finding a job. In session 11, his anxiety was mild again whilst he enjoyed his success of having found a job. In session 13, Sam was experiencing moderate anxiety at the prospect of not having the group support any longer.

Sam's BAI score of 10 at the debriefing interview included 10 anxiety symptoms that were all rated as 'mild and did not bother him much', although he continued to experience these symptoms. These included numbness and tingling, wobbliness in legs, dizzy and light-headed, heart pounding or racing, unsteady, nervous, hands trembling, difficulty breathing, abdominal cramping, and face flushed. All these symptoms are anxiety responses that Sam had complained about throughout the programme. However, it was a relief for him that, in spite of the fact that he still experienced these symptoms, they no longer bothered him.

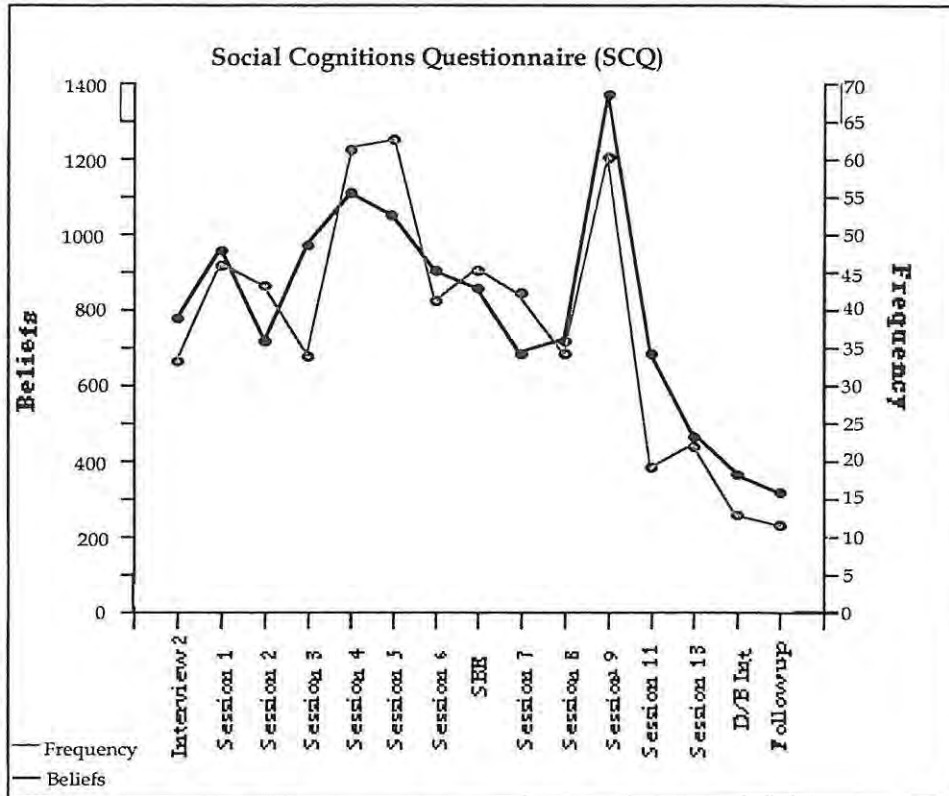
### **iii. Social Cognitions Questionnaire (SCQ)**

Sam had to identify the cognitions he was preoccupied with in social situations, and rate his belief (0-100) in these cognitions, as well as the frequency (1-5) with which these cognitions occurred to him. In the second interview, Sam's SCQ scores (790/2200- belief, 33/84- frequency) indicated that he had several, frequent cognitions that preoccupied him, and he believed quite strongly in these cognitions. For example, he rated the frequency of thoughts such as, "I am unlikeable; I am going to tremble and shake uncontrollably; People will stare at me; I am inferior; People are not interested in me; and People won't like me" as thoughts that usually (4/5) or always (5/5) occurred when he was nervous. In addition, his beliefs in all these thoughts were either rated as 90/100 or 100/100.

Sam's two highest scores in his beliefs and frequencies of cognitions are presented in sessions 4 and 9. In session 4, Sam explicated that he had been constructing his cognitive model and "at some moments in that time, I believed in more strongly in my core-beliefs". For this reason, his score had been high at this point. The cognitions that he believed most strongly, included, "People will stare at me; I am foolish; People are not interested in me; I am vulnerable; I am weird/different; and people will see I am nervous". Sam rated all these

cognitions between 70/100 and 100/100 (I am completely convinced this thought is true), and between 4/5 and 5/5 (thought usually occurs/always occurs when I am nervous).

**Graph 3.3**



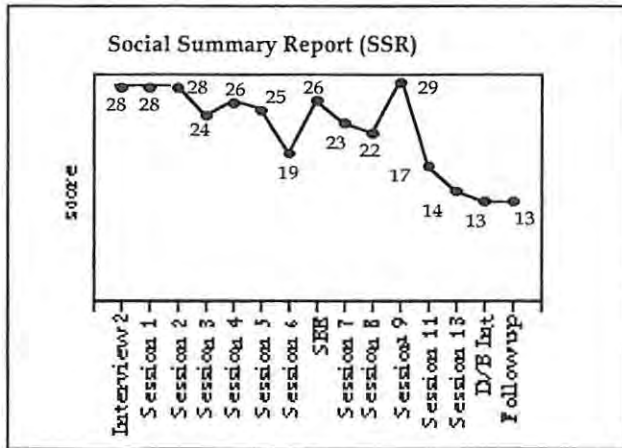
In session 9, Sam explicated that, this had been the time that he was most seriously looking for a job. Referring to his traumatic experiences in this time (3.2.1, A [g]) Sam's beliefs in his cognitions had obviously heightened. The cognitions that he believed most strongly, included, "I will be unable to speak; People will stare at me; People will reject me; I will be paralysed with fear; I will babble or talk funny; I am inferior; I am foolish; People are not interested in me; I am vulnerable; and People will see I am nervous". Sam rated all these cognitions between 90/100 and 100/100 (I am completely convinced this thought is true), and between 4/5 and 5/5 (thought usually occurs/always occurs when I am nervous).

#### **iv. Social Summary Rating (SSR)**

The SSR measured Sam's level of anticipatory anxiety prior to social interactions, the degree of self-focused attention in social interactions, and the degree to which he engaged in post-mortem self-critiques. In the second interview, Sam's SSR score was 28/40, which indicated

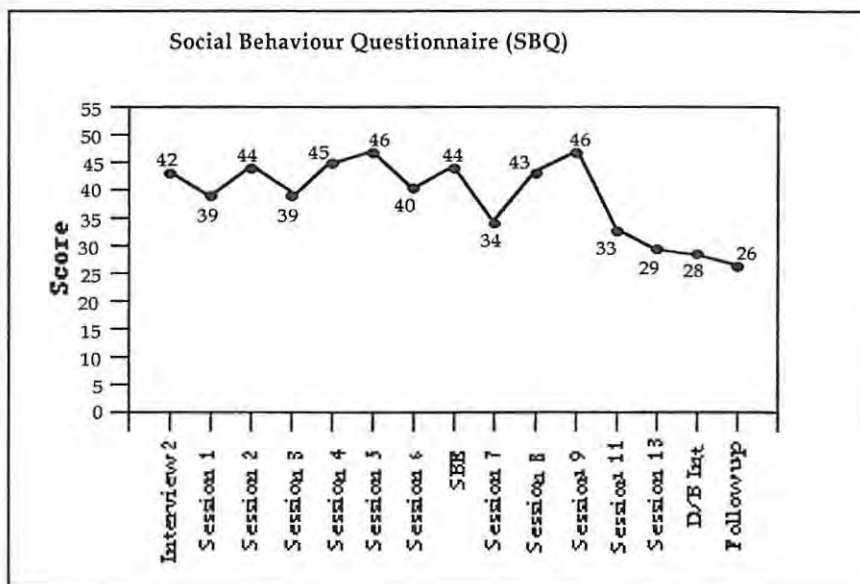
marked social anxiety in the week before he answered the questionnaire. Sam's SSR score remains in the twenties, apart from his score in session 6, and from session 11 onwards. Sam mentioned that in session 6, he had just returned from the vacation and had not engaged in any of his feared situations during the previous week. From session 11 onwards, Sam experienced mild or no social anxiety as he had managed to overcome most of his core-beliefs.

**Graph 3.4**



v. Social Behaviour Questionnaire (SBQ)

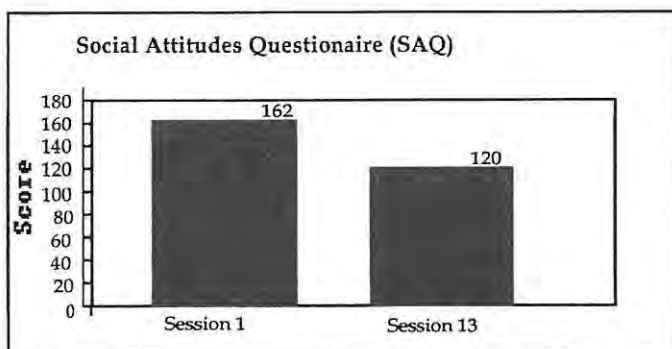
**Graph 3.5**



The SBQ assessed the degree to which Sam employed safety behaviours. In the second interview, Sam's SBQ score was 42/84. Sam had responded that he *always* used the following safety behaviours when he was anxious. He had tried to picture how he appeared to others, stayed on the edge of groups, made an effort to get his words right, positioned himself so as not to be noticed, and checked that he was coming across well. Had there been an option that referred to avoiding situations completely, Sam would have circled 'always', here as well. During the video feedback in the SBE, Sam mentioned that he had realized that he did not require his safety behaviours. According to Sam, this explains the drop in his SBQ score in session 7. However, in sessions 8 and 9, whilst trying to find a job, he had once again been using his safety behaviours; therefore the increase in SBQ scores. From session 11 onwards, Sam's SBQ scores decline. Sam attributed this to his self-instructive cognition, "I must drop all my safety behaviours", before he entered the BP 'Quick-shop" where he finally got his job. This experience reminded him that his safety behaviours were unnecessary.

#### vi. Social Attitudes Questionnaire (SAQ)

The SAQ was used to measure Sam's attitudes and beliefs. His SAQ score during session 1 was 162/300, indicating some important attitudes and beliefs he had regarding social situations. Sam responded 'totally agree' to various significant attitudes. These included: "If I make a mistake in a social situation, then people will reject me; Everyone will stare at me and think I'm strange if I don't act normally; Other people are better at getting it right socially than me; People think I'm uninteresting; and If people see I'm anxious, they will humiliate, ridicule and discount me". It is important to note that several of the above mentioned statements include the cognitive distortions with which he had constructed his core-beliefs. When comparing his session 1 score, with his session 13 score (120/300), it can be seen that he had managed to overcome most of his cognitive distortions, and all his core-beliefs.



**Graph 3.6**

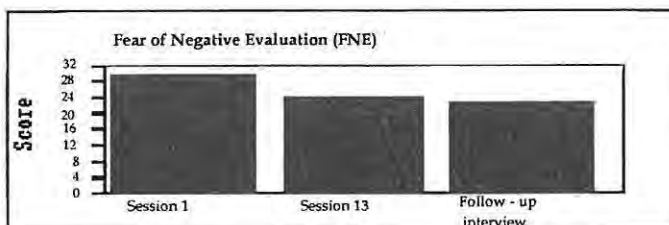
However, the difference in his scores between sessions 1 and 13 is not a remarkable change. When questioned about this, Sam explained that, when answering his questionnaire in session 13, he was reminded of the ways in which he had thought and felt at the start of the programme. In spite of all the progress he knew he had made, Sam explained that, "I did not feel as though it would be appropriate for me to circle the *totally disagree* category for several questions until I really felt confident about my present state-of-mind". At the 6-week follow-up session, it was discernable that Sam felt confident about his progress, and he managed to maintain progress.

#### vii. Fear of Negative Evaluation (FNE)

The FNE questionnaire was used to measure Sam's mood and his general assumptions pertinent to his social phobia. In the first session, Sam's score was 29/30. His responses indicated that he feared negative evaluation under all circumstances and from all people. As mentioned earlier, Sam was a generalized social phobic. In session 13, however, his FNE score dropped to 24/30, and further dropped to 23/30 at the follow-up interview. Although

Sam had explicated that he no longer had problems socializing; it is possible to understand that he still feared the possibility of losing the social approval that he had worked so hard to gain. For example, Sam continued to circle the 'true' options for questions such as, "I often worry about what my superiors think of me". Sam explained that he did not think that he necessarily needed to answer with the 'false' option for certain questions in order to justify that he no longer suffered with fear of negative evaluation. Sam felt that it is important to continue to worry about the impression that he makes on lecturers and friends who he values.

#### Graph 3.7



### **C) Conclusions around Sam's Case Report**

Sam's progress in therapy can be attributed to the Clark and Wells (1995) treatment that worked successfully for him. Although Sam had a considerable amount of insight into and understanding of his problems even before the start of programme, he only began to put this insight and understanding into perspective through the various exercises that were conducted during the sessions, and whilst constructing his idiosyncratic cognitive model. Through monitoring himself, and identifying the specific cognitive content (automatic/negative thoughts) about his feared social encounters, Sam had enabled himself to gradually deconstruct his core-beliefs, which included his beliefs that he was socially unacceptable, socially inadequate and belief that everyone thought this of him.

The video-feedback of Sam's SBE preceded a major turning point for him in treatment. Sam realized how detrimental his safety behaviours had been to his social interactions whilst comparing his performance in role-play 1 with role-play 2. In role-play 2, Sam saw in himself "the person that I had longed to be". However, instead of dropping these safety behaviours in future interactions, he used them even more because his anxiety heightened whilst struggling to drop them in real-life encounters. For this reason, his SBQ scores increased between the SBE and session 9.

Sam struggled considerably with understanding how to correct the situation. However, he experienced the major turning point in treatment when he suddenly realized that in order to turn this problem into a benefit he needed to do what he managed to do in the SBE. He consciously made the effort to follow the same self-instruction during his behavioural experiments (as part of homework) as he had followed during role-play 2 of the SBE. His self-instructive cognition, "I must drop all my safety behaviours", which he continuously repeated to himself, before entering the BP 'Quick-shop' where he got the job, was proof enough for him that he was able to do two very important things. Firstly, he was able to challenge and change his negative cognitions by repeatedly giving himself a self-instruction that diverted his attentional focus from these negative cognitions. Secondly, he was able to drop his safety behaviours and perform better in his social interaction without them, even in a real-life encounter, without the supportive presence of the facilitators.

This turning point for Sam can also be linked with the following. All the graphs that depict Sam's progress in treatment have a similar trend. His questionnaire scores are all notably

lower at the end of the treatment programme. However, instead of gradually decreasing, all his questionnaires' scores reach a peak in the graphs at session 9. The peak scores were (as he explained in the debriefing session) due to his increased use of his safety behaviours that made him even more socially anxious and "vulnerable". Thereafter (he missed session 10 and) his scores plummet downwards in session 11. Sam had found a job between sessions 9 and 11. However, it was not the fact that he had found a job (between sessions 9 and 11) that made his social anxiety, and therefore, his questionnaire scores decrease. As is mentioned above, Sam had finally discovered how to drop his safety behaviours and be free of them. In addition, he had finally collected "very real evidence" that he would be "able to make it socially if I tried". For Sam, getting a job was his greatest achievement. He had effectively learned how to cope with his social anxiety in future encounters with the use of self-instructional cognitions that replaced his previous negative cognitions. In light of the qualitative data, this is the most likely explanation of the gradual decrease in all his questionnaires' scores from session 11.

It is interesting to note that Sam was one of the members in the group who had been giving himself self-instructive cognitions from the early stages in treatment. For example, during one of his very first behavioural experiments (Figure 8), his train of thoughts was as follows, "I could just avoid the situation, my anxiety is killing me... No, I must do this, I can do this". By instructing himself to enter the situation, he made his first step in the curative process. However, Sam did not even realize the value of his self-instructive cognitions until much later in treatment. Through this experience, Sam had overcome both kinds of avoidance, that is, behavioural avoidances, as he was willing to enter the situation, and cognitive avoidances, by dropping his safety behaviours and processing his negative cognitions in a new way.

Sam responded very well to the group process. From the beginning of the therapy programme, Sam was keen to "make the change" in his life. Therefore, even though he was one of the most severely affected social phobics in the group, it was clear that he was motivated and he had made the decision that he would use the group setting to learn to overcome his fears. Thereafter, he was positive about the manner in which he would adapt his experiences and findings to the real world. He effectively did this by interacting with other group members and contributing to the group process from the very first session. In

addition, he always made the effort to engage himself with no reservations with the homework assignments and behavioural experiments.

Sam was a vital member to the group as he had motivated others to engage in constructive behavioural experiments, due to his own innumerable success stories with behavioural experiments. Sam was a lively source of encouragement to the other members in the group. His most inspiring contribution was during session 11 when he mentioned, "I've conquered the worst. Those of you who have not, believe me, it's easier than you think, just try." The members of the group, especially Nick, (next case study) who were suffering to engage in behavioural experiments, started to see Sam as his coping role model.

### **3.2.2 The Case Report of Nick<sup>2</sup>**

"Nick", aged 19, is a black, male student. He was in his second year of study at Rhodes University (RU) when he participated in the programme. Although Nick participated enthusiastically in the programme, he struggled with certain core beliefs that he was unable to efface until the final stages in the programme, if at all. Nick's case has been outlined in detail because he was the only member of the group who did not show progressive improvement whilst in the programme. He was the last member in the group to achieve any form of treatment gains.

#### **A) Case narrative**

Nick was born and brought up in Bloemfontein. His father is a teacher and his mother is a nurse. They live with his two younger brothers in Bloemfontein. Nick's parents have fought with one another since Nick can remember. Some mornings, as a child, he would wake up and find chairs broken and holes punched into the doors of the house from fist fights his parents had had the previous night. He gathered in his early teens that, the fights had something to do with his father's extra-marital affairs.

Both parents have beaten Nick severely on several occasions with a belt, and metal objects, such as chains and the buckle of a belt, until he bled. Most of the times he was not quite sure

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<sup>2</sup> The name of the participant has been changed in order to protect his identity.

why he was being beaten. However, he does remember one occasion when he was beaten by his father for losing 50 cents. Nick expressed that he never had received any love or emotional support from either parent. He blames them for whatever problems he has. His relationship with his father is similar to one between a boss (his father) and his slave (Nick). He has no relationship to speak of with his mother. She had always ignored him unless she was saying cruel things to him, for example, she once told him that he was evil and useless. He has no special bonds with his brothers either. As a child, Nick was convinced in his own mind that he was adopted. He remembers being forced to go to church every Sunday as a child. At present, however, he believes that the Lord's mercy is what carried him through his life at home. He does not visit home unless he has absolutely no other option. He never mentioned who is paying for his education at RU.

**(a) *Life situation at the start of the programme***

At the start of the programme, Nick explained that his life was "miserable" for a boy his age, living in a spirited university town. His typical day included attending all his lectures, attending tennis practice in the early part of the evenings, and watching television on most nights if he did not have a test to study for, or pending assignments to be completed. He did not have many friends. Those he did call his friends criticized and bullied him mercilessly about his way of life. He explained that people must have found it difficult to hear what he was saying because they would always respond to him with a "huh?". For this reason, he did not talk very much to anybody. Nick confessed that he could count the number of times he had been out to socialize, over the past year, on one hand. He wanted very much to have a girlfriend but always hesitated before he approached a girl, whether he felt attracted to her or not. In turn, he had never dated a girl his entire life. This bothered him a lot.

**(b) *Presenting problem***

In the initial individual interviews, Nick seemed very afraid to answer any questions. He wanted very much to participate in the programme because he could identify with all the symptoms outlined in the posters requesting participation (Appendix 7). However, he was convinced that he would never be able to change. When asked to expand on his conviction, he expressed that he always worried about what others thought of him, and therefore, had difficulties expressing his problems. In addition, he was never able to trust anyone. After serious deliberation, he said, "I need help making real friends and trusting people. I want to go out and have fun without worrying about what others are thinking about me. I'm alone, I

really want to know how to go about approaching a girl I like without freezing up and saying something stupid because I'm so nervous. Others guys do all these things so easily, so what's wrong with me?". He expressed that his worst problem was that people could always see his nervousness. In his attempts to conceal his nervousness by avoidance (e.g. avoiding eye-contact), he would be labelled 'anti-social'.

Nick's goals for treatment, therefore, were mainly related to his lacking confidence, worries about what others were thinking about him, his visible nervousness at social gatherings, and his difficulties in approaching and having a fruitful conversation with an other person, especially someone of the opposite sex. He wanted to discover how to become an interesting, and "more fun" person to be with. He wanted most of all, in his own words, "to feel adequate because this would help me have faith in my dreams" (Nick's self-report questionnaire).

***(c) Constructing a cognitive model of Nick's problem***

Through several exercises, homework assignments, and discussions during the first five sessions of the programme, it became possible to conceptualise Nick's problem based on the Clark and Wells model. The most common themes that came through in Nick's accounts of his anxiety in social situations involved his negative impression about his appearance, and his strange sounding voice. He considered himself to be small, puny, and visibly shaking with nervousness (most of the time). He considered his voice to be inaudible. He expressed that the only reason why he thought that anyone would notice him, since he hardly ever spoke and tried hard not to attract attention to himself by standing on the edge of groups, was because they must have thought, "Look, he's so small and nervous".

He was not sure whether the people who noticed him, pitied him, or whether they were using him as a source of free comedy. Either way, his anxiety levels would heighten because the fact that people had noticed him convinced him that he appeared as ridiculous as he had imagined he did. His anxiety would heighten even more when he was approached and spoken to because he would have to reply to the person(s) with his inaudible, strange sounding voice. He experienced anxiety when walking past a crowd of people, attending social gatherings, going to pubs or clubs, or even when walking into a restaurant or library, and when approaching or speaking with someone of the opposite sex. Being in these situations was anxiety provoking for Nick, as he feared that others would form an impression of him as being uninteresting, boring, nervous, "small", anti-social and inadequate.

In session 1, once Nick identified the situations he feared, or in which he experienced anxiety, Nick was able to examine these situations in order to construct his idiosyncratic cognitive model. In session 2, Nick identified a series of negative thoughts and beliefs he had regarding, and whilst in, situations in which he experienced anxiety. In addition he identified the automatic anxiety responses he experienced in these situations. It seemed that Nick mostly had negative thoughts even before entering a threatening situation, and for this reason, had avoided some of them. For example, he had never mustered enough courage to approach a girl. He had negative thoughts about his appearance, saying something nonsensical, or sounding foolish because of his strange voice. However, girls had approached him on several occasions. He experienced high levels of anxiety, at the thought that a girl had noticed him and was walking towards him. The whole dilemma about whether she pitied him or found him funny to look at would enter his mind. He believed that more often than not, girls approached him because they thought, "Ah shame, poor thing, he's so small and nervous".

Whilst waiting for the girl to approach him, he would feel aware of his inadequate appearance and this would make his heart pound, he would feel hot, and would feel himself shaking. He would also be entirely confused about what to say to her. This would make him freeze up with fear. Whilst speaking with the girl, he would not be able to concentrate on the content of the conversation as he feared that she noticed how nervous, and self-conscious he felt about his appearance and his voice. He thought that, by asking a lot of questions, he would keep her attention. However, he never knew what the answers were to any of his questions as he would be planning and phrasing the next question in his mind. He feared that if he did not keep on talking, she would tell him "you're such a loser, and so boring". He also feared that at any moment she would respond to him with the "huh?" that he was so accustomed to hearing. He had thoughts that if either of these things happened, this would mean that his worst fears about his strange voice, and the negative impression he created on people, would be confirmed, once more. Nick expressed that if he could change the possibility of these things happening, he would be a "more fun" person to be around, and he would be able to have the respect and attention from other people that he often dreamed about.

In session 3, Nick began to focus on the safety behaviours he adopted, in an attempt to prevent the things he feared, from happening. In the first place, he would try not to attract attention to himself, in any situation involving many people, by positioning himself so as not to

be noticed (e.g., in the corner of a room). Referring to the above mentioned, Nick would attempt to conceal his nervousness by avoiding eye contact with the girl who was approaching him, and by trying to act normal, that is, like every other confident person in that situation. He realized that asking many questions, talking more, and censoring whatever he said, were safety behaviours he used whilst having a conversation. He was so conscious about his voice that he made an effort to come across well, by speaking louder and trying to be clearer. At this stage however, he did not realise that these safety behaviours only drew more attention to the anxiety he was trying so hard to conceal.

As part of homework, from session 2 onwards, Nick began to monitor his automatic thoughts and emotions more closely in social interactions. He did this with the use of the first three columns of the 'Daily Record of Dysfunctional thoughts'. Nick encountered four situations in which he monitored his thoughts and emotions. The first situation (that took place between sessions 2 and 3) involved playing tennis in front of his coach and members of the RU tennis team. Due to his anxiety, he did not perform as well as he would have liked to, on that particular day. The emotions he experienced were anger, sadness and anxiety. He rated all three emotions as 99/100. He found himself thinking, "Maybe this wasn't meant to be", and continued in his downward spiral of negative thoughts by saying to himself, "I'm useless, what am I trying to prove". He rated his belief in these thoughts as 90/100.

The second situation involved making a pre-planned speech in front of his class (that took place between sessions 3 and 4). This was a compulsory exercise for every student in his class. He experienced anxiety, which he rated as 80/100. He could feel his heart pounding, was sweating, and shaking. He had especially worn clothes to conceal his sweating on that day. His automatic thoughts were, "I am going to make a fool of myself, I'll get my words mixed up", and rated his belief in these thoughts with 50/100. After his speech, he received a hearty round of applause, and was complemented for his speech. However, when narrating this experience to the group during the following therapy session, he ended his experience with the following. "I know that the only reason why they applauded and complemented me was because they saw how nervous I was and felt bad for me". Nick was convinced that his speech was terrible, and cringed at the thought that people pitied him.

The third situation (that took place between sessions 3 and 4) involved approaching a girl in the computer laboratories. Nick experienced severe anxiety, which he rated as 100/100. His

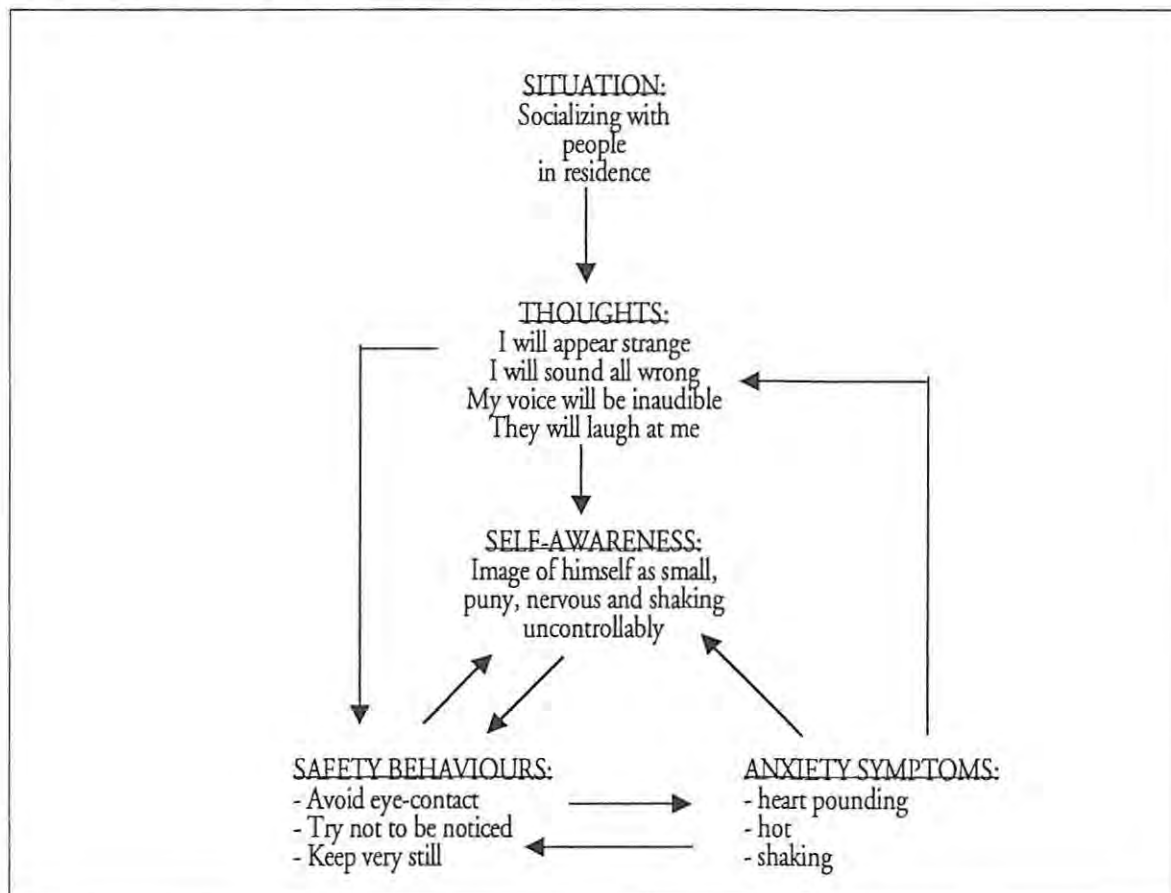
automatic negative thoughts were, "I might sound stupid, what am I going to say?" and he rated his belief in these thoughts as 100/100. Nick hesitated as he stood up to walk over to her, felt very faint, and sat down again and thought, "Not today, you will not succeed". He did not approach the girl.

The fourth situation (that took place between sessions 4 and 5) involved a social situation with friends living in his residence building. This situation will be described in detail, as Nick used this situation to construct his idiosyncratic cognitive model (Figure 3.4), that was also part of the homework assigned to participants in session 4.

**(d) An idiosyncratic cognitive model outlining one anxiety-provoking situation for Nick**

The model below was constructed by Nick, and illustrates the structure of his anxiety response to a socially threatening situation. This model involves his experience in the fourth situation (from previous section) where Nick monitored his thoughts and feelings closely.

**Figure 3.4: Nick's personal cognitive model**



Nick narrated this situation to the group as part of the homework discussion at the beginning of Session 5. It was a Saturday evening and some of Nick's friends and acquaintances were sitting in the common room in his residence. They were all in a social mood and making plans for the evening ahead. Nick expressed that he could hear the noise they were making and wanted very much to be a part of the fun. He mostly had negative thoughts even before entering the situation. His thoughts were, "I will appear strange (60/100), I might say something that will sound all wrong (60/100), my voice will be inaudible (90/100), it's a room full of people and they're all going to laugh at me (70/100)". All these thoughts made him feel "butterflies" in his stomach, as his anxiety (70/100) had begun. Nevertheless, he also thought, "I hope to make a good impression, for once" (20/100).

As he entered the situation, his thoughts revolved around hiding his anxiety. He thought, "keep looking at the floor, and avoid eye-contact so as to avoid noticing who is laughing at me". He could feel his heart pounding, felt hot, and could feel himself shaking uncontrollably with anxiety. In an attempt to conceal these anxiety symptoms, he leaned against a wall in the corner of the common room, and tried to stand very still. At this stage, he had "even more negative thoughts" which included "I'm not making a good impression, others must think I'm so anti-social, I won't be invited to join the others". He also thought, "I must join the conversation in order to rectify the damage". This was the only thought that Nick had had, which might have helped him take the risk that was involved in actively engaging in this situation. However, Nick feared that when he would speak, "his voice would sound wrong", people would ignore what he was saying, and make comments and laugh at him instead. He concluded his narration with, "I know I'm anti-social. Had they noticed me and included me that night, they're aim would have been to laugh at me and torture me further".

At this stage in the programme (session 5), other members in the group had already begun to make their own attempts at replacing their automatic negative thoughts with positive ones. Monitoring of thoughts and behaviours helped other members of the group to identify their negative thoughts and challenge them. However, Nick had difficulty in distancing himself from his negative thoughts. For example, the automatic negative thought "others must think I'm anti-social" became a self-fulfilling belief, "I am anti-social", owing to the fact that he did not attempt to join in the conversation or make himself heard or noticed.

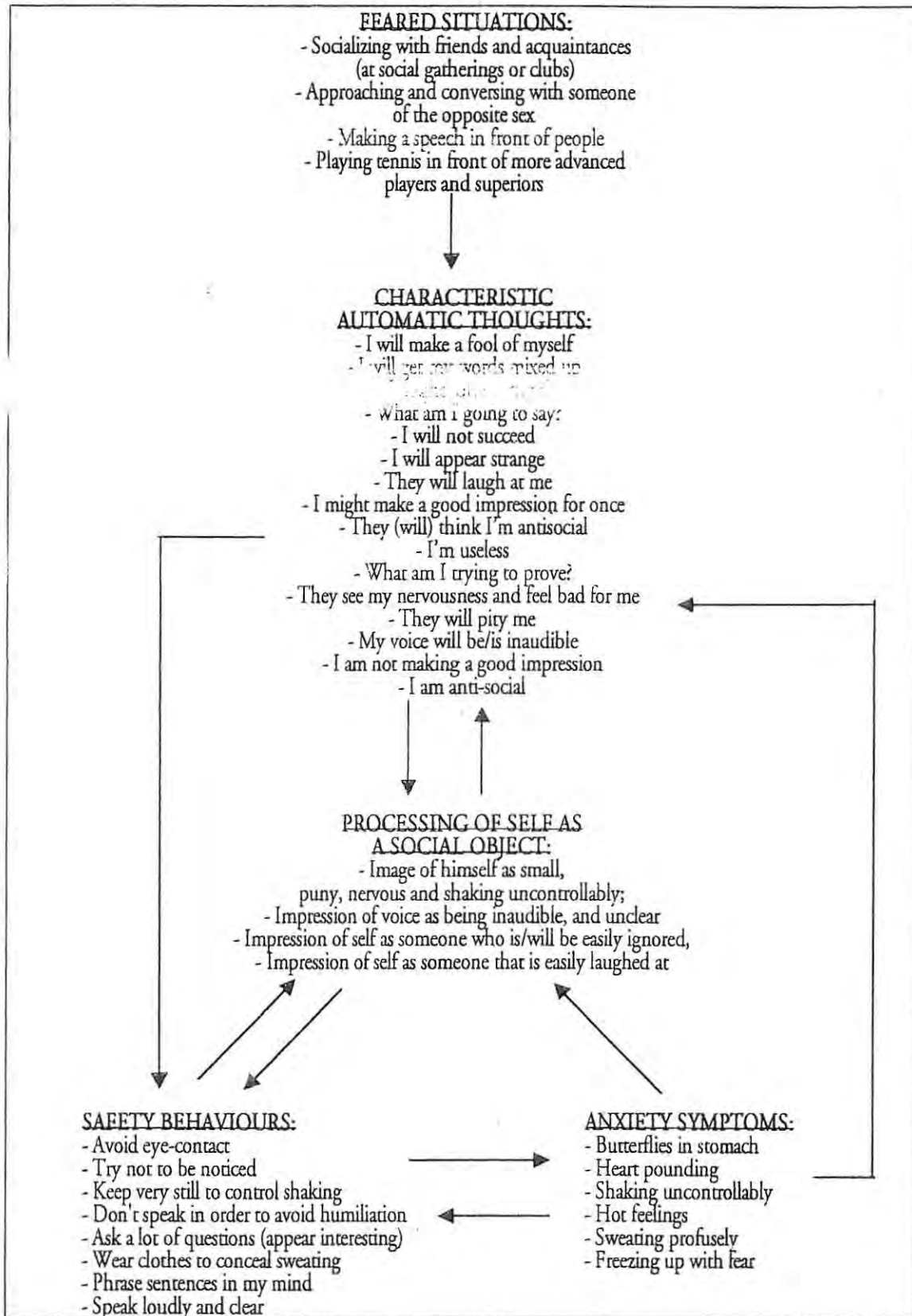
Through his feedback in the discussion, Nick admitted that he might have been too hard on himself. It was explained to Nick by the facilitators that, these negative thoughts and beliefs of his, would not be changed unless he experimented with his feared situations by risking the possibility of being humiliated. The only way he would overcome these thoughts and beliefs of his, was by challenging them and actively involving himself in situations that he feared. Nick realized that he needed to start taking risks and testing his cognitions and predictions. He was feeling helpless about changing although he had at least started to have some insight into his problem through constructing the model.

The model that Nick constructed by himself is outlined in Figure 3.4, above. Following is a researched cognitive model (Figure 3.5, overleaf) that takes into account all Nick's thoughts, anxiety symptoms, and safety behaviours in the situation described above. This model illustrates the aspects that Nick failed to identify about himself.

At this point, the programme was stopped temporarily for the 7-week vacation. The facilitators were quite concerned that Nick would dropout from the programme. However, the facilitators and other group members made efforts to convince him to try and experiment further with situations he feared. In addition, he was asked about which situation he would like to experiment with, in his safety behaviours experiment, upon commencement of the programme in the following academic term. He expressed his desire to experiment with approaching and having a conversation with a girl. Nick was encouraged to experiment with this situation, in particular, during the vacation.

When the programme commenced in the following academic term, not only did Nick return to the group for session 6, he was also only too eager to share his experiences during the vacation. He had attended several social gatherings with friends at home, had been to a nightclub in Bloemfontein, and two girls who were friends of his cousins, had approached him. However, Nick's beliefs about his inadequacy, inability to socialize, and definite need for the use of safety behaviours had remained unchanged. He attributed any successes he had experienced, to the kindness of other people who felt pity for him.

**Figure 3.5: Researcher's comprehensive cognitive model, of all Nick's anxiety responses in all his feared situations**



Nick was asked by the facilitators to expand on his conviction that others felt pity for him. He was asked whether he had evidence for this conviction. Nick responded with, "even when I avoid interaction with people because of my nervousness, they still approach me, therefore, they must feel pity for me". Nick was encouraged to make an effort to interact with people and then deduce for himself, whether they pitied him or not. An ideal opportunity to test his convictions would be in the safety behaviours experiment. In his session feedback questionnaire, after session 6, Nick seemed positive about the remainder of the programme, and did not feel discouraged by the fact that two members of the group had dropped-out.

From session 7 onwards, the group was guided through a process of collecting new, more valid information and evidence about the way they appeared, perceived themselves, and others' perceptions of them, in social situations. This involved carrying out the safety behaviours experiment, and several behavioural experiments in real life contexts.

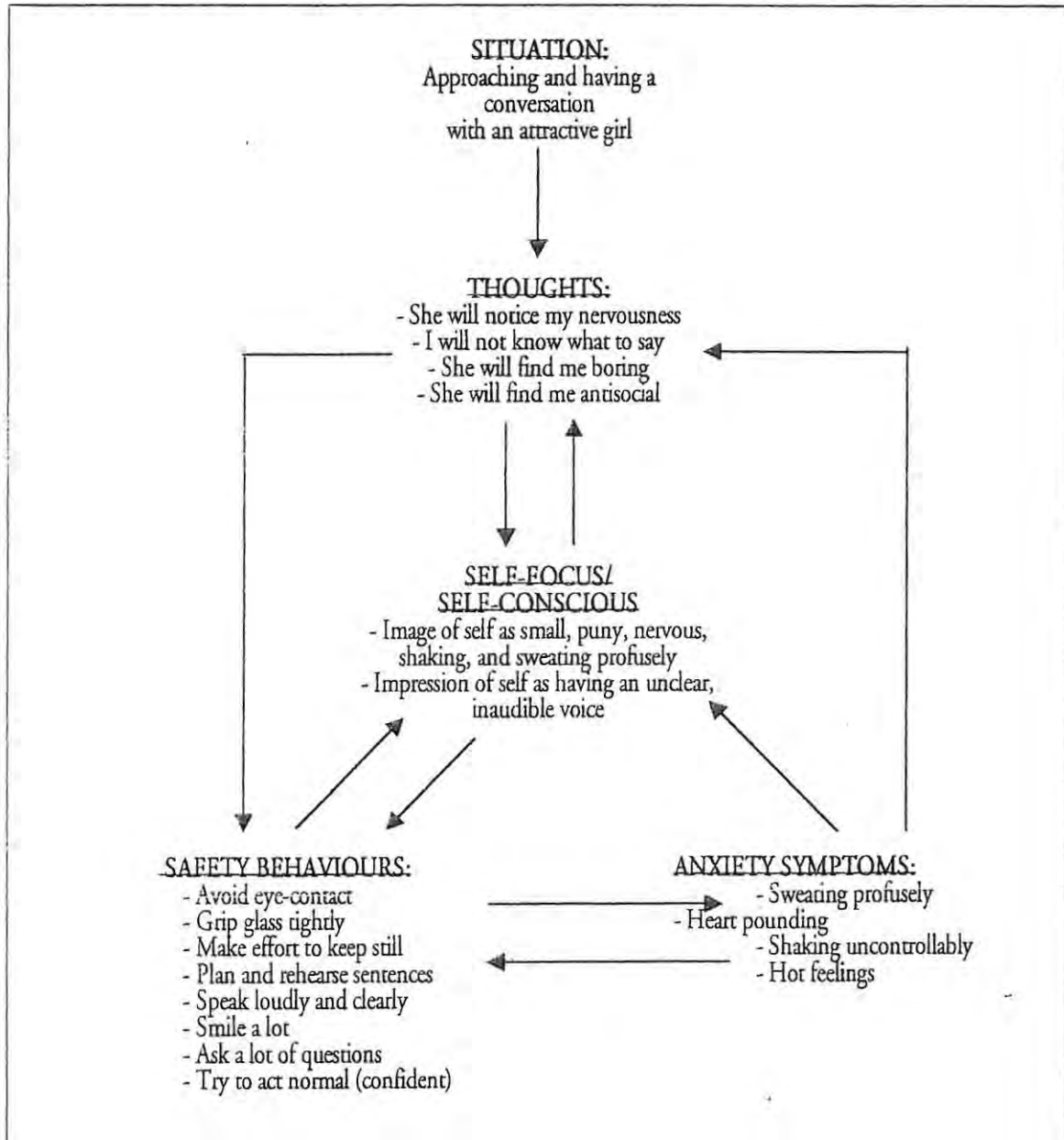
#### ***(e) Safety Behaviours Experiment***

Nick carried out his safety behaviours experiment between sessions 6 and 7. For the experiment, as Nick had requested, a role-play was set up which involved a female volunteer who came closest to Nick's description of a girl who he would be attracted towards. Nick was requested to arrive 20 minutes before the volunteer arrived, so as to complete a few routine procedures before the role-plays were conducted. Nick seemed quite overcome with anxiety, and struggled to construct coherent sentences, even with the facilitators. However, after completing his routine set of questionnaires that he had been filling in at the beginning of each session, Nick seemed more comfortable.

Nick had started to construct a cognitive model of the situation he had requested to role-play. He had only filled the 'thoughts' sections on the model, and brought this model to the SBE with him. He completed the model after the first role-play. The complete model is outlined in Figure 3.6 (below). Before the role-plays took place, a short briefing was held with Nick. He believed that the volunteer would notice his nervousness. He also believed that because he would not know what to say, she would find him uninteresting and anti-social. It was decided that Nick would approach the volunteer, who he would be meeting in a party situation, begin a conversation with her by offering her a drink, and take a seat with her where they would continue their conversation. Nick was then asked to recall all his safety behaviours that he normally used in such a situation. He listed them as follows: avoid eye-contact, grip glass

tightly, make effort to keep still (so as to control shaking), plan and rehearse sentences in my mind, make sure she hears what I'm saying (by speaking more loudly and clearly), keep smiling at whatever she says (so as to make her believe that I'm listening to her), ask a lot of questions, and try to act normal (confident).

**Figure 3.6: Nick's cognitive model regarding the first role-play of his SBE**



Nick mentioned a few new safety behaviours here that he had not mentioned before. Nick was then told about the exact procedure of both role-plays. In the first role-play he would adopt all his safety-behaviours, and in the second, he would drop all his safety behaviours. Each role-

play would last approximately 8 minutes, but after 4 minutes the facilitators would give him a signal, which meant that he could feel free to leave the situation if he wanted to. The volunteer was then briefed about the role-plays in a different room, so that Nick would see her for the first time, in the first role-play. The volunteer was told that the role-plays were being conducted as part of social skills research. Therefore, she was entirely unaware of Nick's problems. This would ensure that she would not be looking for signs of a social phobic in Nick's behaviours. After this, the first role-play took place.

**Table 3.4: Nick's ratings after each role-play**

	After role-play 1	After role-play 2
1. How anxious did you feel?	9	5
2a. How self-conscious did you feel?	9	3
2b. What were you self-conscious about?	- Avoiding eye-contact - Visibly sweating, shaking	-
3. How anxious did you think you appeared?	8	5
4. How good was your performance overall?	3	6
5. What individualized things did you fear would be noticed, and to what extent?	- Running out of things to say (8) - Being boring (6) - Sweaty palms when shaking hands (7)	- not being interesting enough (6)

Nick adopted all the safety behaviours he had mentioned earlier. He stayed in the situation for the entire 8 minutes. After the first role-play, Nick and the volunteer completed rating forms (Appendix 5[iv/v]). Nick rated his own performance, whilst the volunteer rated Nick's performance. A brief feedback interview was then carried out with Nick whilst the volunteer waited in a separate room. Nick mentioned the following in the feedback interview. He was mainly distressed and concerned with the fact that he had no more questions to ask the volunteer in the second role-play. He felt that his performance was terrible, as she noticed his uneasiness, anxiety, and must have found him boring. Nick had especially worn clothes to conceal his sweating, but did not think that he was successful in hiding this. He had not heard any of the volunteer's responses to his questions, and therefore realized that she must have noticed how incoherent his questions sounded. When there was a brief pause in the conversation, he had felt as though this pause lasted for a few minutes, and Nick had

experienced increased anxiety because he thought that the volunteer found him uninteresting. Although he faced the volunteer through the entire role-play, he avoided eye contact with her by looking straight past her. He made a considerable effort to keep his hands very still so as to conceal any signs of visible shaking from anxiety. He also made a considerable effort to make his voice loud and clear. Nick's ratings regarding his experience with role-play 1 are given in Table 3.4, above.

A brief feedback interview was then held with the volunteer. She mentioned that Nick seemed friendly. She had enjoyed her conversation with him, but wanted to have asked him more about himself. She had noticed that he was uncomfortable in the clothes he wore, and was uncomfortable in his seating position. It was then explained to her that exactly the same role-play would be conducted again. The ratings that the volunteer gave Nick regarding his performance in role-play 1 are given in Table 3.5, below.

The second role-play was then carried out. Nick managed to drop most of his safety behaviours. Most notably, he actively involved himself in the conversation, and asked fewer questions. He gave her a chance to ask him questions, which he answered, which obviously meant that he heard what she was saying. The conversation was a lot more spontaneous. Once again, the rating forms were completed, and feedback interviews were carried out.

**Table 3.5: Volunteer's ratings regarding Nick's performance after each role-play**

	After role-play 1	After role-play 2
1. How anxious do you think Nick looked?	5	2
2a. How self-conscious do you think Nick looked?	6	3
2b. What were you self-conscious about?	- his appearance, seemed uncomfortable in his clothes	
3. How good so you think Nick's social interaction skills were?	7	9
4. What individualized things did you notice about Nick and to what extent?	- seemed uncomfortable in his seating position (6)	- slightly shy (3)

In Nick's feedback interview, he mentioned that he had enjoyed the conversation a lot more in the second role-play. He enjoyed speaking about himself, but felt vulnerable to ridicule

without his safety behaviours. He was concerned that she might have left with a bad impression of him. This was because, after about 6 minutes of the role-play, there was a pause in the conversation. Since Nick had not been rehearsing what to say in his mind, he did not know what to say in order to end the pause. He ended up asking inchoate questions, and the volunteer responded with a laugh and said, "huh?". This made Nick "feel like a fool" and undid whatever feelings of success he had experienced thus far. The ratings that Nick gave himself regarding his experience with role-play 2 are given in Table 3.4, above.

The volunteer expressed that Nick was a lot more comfortable in the second role-play, but seemed self-conscious when he asked "silly, trivial" questions at the end of the role-play. She mentioned that, she herself had decided to be a little less friendly in the second role-play, but noticed that Nick handled this pressure with ease. She noticed that he sat comfortably in his chair, and moved his hands more "which made him look less like a statue". She also mentioned that she would not mind meeting him again under less formal circumstances. The ratings that the volunteer gave Nick regarding his performance in role-play 2 are given in Table 3.5, above.

**(f) *Video-feedback***

Before watching the video footage, Nick was asked to make some predictions about what he expected to see. Nick looked as though he would start crying if he had the chance. However, he composed himself and expressed that he had never seen himself on videotape and therefore could not make any predictions. When asked to describe himself based on his mental image of himself, because that was probably what he could expect to see, he expressed concerns about his size, the way his voice sounded, and visible shaking with nervousness. At various points, the facilitator would pause the video and ask Nick about his impressions so far. Nick was reminded about certain concerns he had had in the feedback after each role-play, and was asked whether his concerns were warranted.

Whilst watching the first role-play, Nick was already experiencing much relief. He noticed that he was much bigger in size than the volunteer. This made him feel much happier as he did not feel so small and puny, anymore. He also noticed that the shaking feeling he had experienced, was not visible at all. However, he was not sure as yet, whether this was as a result of his safety behaviours. He did notice though, that he looked quite silly in his efforts to keep still. He realized himself, that he looked uncomfortable.

Nick noticed that the questions he was asking did not relate to the volunteer's answers to his previous questions. The volunteer appeared perplexed a couple of times, and Nick's constant smile did not help the situation. Nick actually laughed at this and said, "no wonder people would laugh at me, I look ridiculous". The brief pause that Nick had experienced as lasting for a few minutes, came and went, and Nick did not even notice it. He was reminded of it later, and the tape was rewound to look for it. Nick could not find or remember where the pause was. The volunteer's feedback from the role-play was then shared with him, and he was shown the scores she had given him. He agreed with the scores she gave him, as he noticed that he did not appear as badly as he had imagined.

Whilst viewing the second role-play, the video was paused, once again, in certain places. Nick was asked whether he was noticing any differences. He noticed that his voice sounded very normal until he got flustered when there was the final pause in the conversation. He realized that the "huh?" she expressed to his questions was well warranted at that stage. It became evident that when he did not use the safety behaviour of making an effort to come across well, his voice sounded better. He enjoyed watching himself interact with so much ease. He also enjoyed watching the volunteer respond so well to him. He could not believe that he had been able to make such spontaneous conversation with a girl. He expressed that he had been enjoying the conversation so much, that he had forgotten that he was not using his safety behaviours anymore. However, when the conversation paused, he remembered that he was making an effort to drop his safety behaviours, because he had not pre-planned the next sentence. As a result, he felt vulnerable to ridicule and panicked.

Apart from this, Nick noticed that maintaining eye contact with the volunteer, and relaxing his body (not straining to keep still) made him look like "a real stud". He felt proud that he was able to make that sort of impact on a girl. Dropping his safety behaviours in this aspect made him feel confident. He was impressed with what he saw in the second role-play, and believed the feedback that the volunteer had given him regarding this role-play. He felt even more impressed when he heard that she had deliberately been less friendly in the second role-play, but mentioned that he had handled the situation with ease. In the session feedback questionnaire, for the first time, Nick had circled the option 1 (much progress, very satisfied, etc.) for 17/29 questions. The feedback questionnaire showed that he felt more positively about this session than any others.

However, there was cause for concern when Nick narrated his experience with the safety behaviours experiment to the group, in the following group session. Nick appeared to have regressed once again. He expressed to the group that he believed that he did not require his safety behaviours, but also expressed that he believed that this was a "once in a lifetime experience". He said that, "had we been at a real party, with other guys around, she would never have sat with me, or given me the time of day". The facilitators suggested that, the only way of testing this belief would be, by conducting a behavioural experiment in which Nick would approach a girl in a real-life situation where other males were present. Another participant in the group decided to help Nick challenge his belief, and decided for Nick, that they would go to a nightclub together that weekend, where Nick could conduct the suggested behavioural experiment. This participant, "Ben" (Appendix 3c) had also requested a safety behaviours experiment in which he would approach and speak with a girl. Ben too, was successful with his second role-play. However, Ben believed that he could have an equally impressive impact on any other girl, in a real-life situation, if he made an effort to drop his safety behaviours. Ben believed the same for Nick. This challenge marked the beginning of Nick's behavioural experiments.

**(g) Behavioural experiments**

During session 8, Nick shared with the group that he and Ben had been to a nightclub, together, the previous weekend. However, when Nick wanted to approach a girl he had never spoken with before, he was stopped by his automatic negative thought. He thought, "what am I going to say to her?". Nick never approached the girl, in spite of Ben's encouragement. Instead, Nick stood in a corner of the club for the rest of the night feeling sad and depressed. He noticed how "other guys would simply call out to girls they did not even know, and the girls would come rushing to them". He once again wondered what it was that "other guys have that I don't have". In order to help Nick challenge his negative thoughts, the group agreed to participate in an exposure simulation exercise, whilst in therapy that evening.

A party situation was role-played. Both the female participants and facilitators stood at one end of the room. The male participants and facilitator stood at the other end. Firstly, the male facilitator role-played the action of calling out to one of the girls and engaging in conversation with her. After watching how this was done, Nick was encouraged to drop all his safety behaviours and call out to any of the girls in a confident way. Nick had to repeat this action

fours times before he finally managed to drop all his safety behaviours and attain a positive response from the female role-players.

The female role-players did not respond to Nick the first three times and told him that he did not look confident enough as yet. In this way, they were being realistic with Nick and allowed him the chance to understand that they were not going to pity him. In his fourth attempt, the female role-players expressed that; Nick appeared natural and confident about himself. He tried hard to convince the role-players that they were "still feeling pity for him, and being too kind" towards him. The facilitators reminded Nick that it had taken him four attempts to achieve a desired response from the female role-players. Therefore, they were definitely being honest with him, and not pitying him when he finally received a response. However, Nick still did not look convinced. One of the facilitators finally suggested that Nick should try and experiment with this situation in real-life and see whether any girl would respond to his call.

During the remaining sessions that Nick attended, he shared various behavioural experiments he had been conducting. The two experiments that had the most impact on him were as follows. In session 10, Nick narrated his experience when two girls approached him in the computer laboratories, asking for help. Nick saw this as an ideal opportunity to conduct a behavioural experiment. In spite of his high level of anxiety, Nick agreed to help the girls. After about an hour, he had finished helping them, and mentioned that he was heading back to his residence now. One of the girls said, "wait for just two minutes and we'll go together. I live in the girls' residence next door to you. Don't you remember me from the dining hall? I know you!". Nick could not believe that she had noticed him. This made his anxiety levels heighten.

Once again, he caught himself thinking about what he would talk about on the way home, and whether she would find him boring. This time, however, he thought to himself "don't think about what to say, Nick. Just let the conversation flow. Forget you ever owned safety behaviours. Just go with the flow". Nick said that, "the girl laughed her little head off the whole way home. She actually found me funny, which meant that she enjoyed my company". She asked whether she and Nick could meet again sometime. Nick agreed with pleasure. Nick expressed that he felt as though she was being genuine with him. In such a situation, she would not have asked for his help out of pity for him. He also expressed that he had not experienced any anxiety while they walked home. He knew that he was creating a good

impression on her. Nick also expressed that this was the first time that he realized that he had the ability to succeed in his social interactions with females.

In session 13, the final group session, Nick narrated his experience of going to a nightclub by himself. He decided that this was his ultimate behavioural experiment, in order to leave the therapy group with "a bang". In his 'Record Sheet for noting Behavioural Experiments', Nick predicted that, if he went alone to the nightclub, he "would look like a lost sheep, with nobody to talk to, and would not belong". He rated these predictions with 60% belief in them. Nevertheless, he went alone, knowing that his friends would not be there. The outcome of his experiment was that "Everybody treated me like a regular. People were greeting me, some came over to talk to me, some wanted me to join in and dance with them". He rated the likelihood of these outcomes happening again, in the future as 99%. Nick learned from this experiment that; "The thought of not being like everybody else is the most wrong thought I have ever had".

In the final three sessions, it became clear that, at last, Nick was making an effort to take the risk and conduct behavioural experiments. He was a slow starter in this process when compared with the other participants. It was only at this stage that Nick began to display a concerted effort towards challenging his cognitive distortions. Other participants had already been displaying this effort as from session 6. However, in spite of all the evidence that Nick had collected through his behavioural experiments; in the final session, Nick still held onto one particular belief. This belief was that, girls only approached him because "they pity me". Nick remained convinced that girls thought "Ah shame, poor thing" when they noticed him. In addition, he was yet to experiment with a situation in which he approached a girl, instead of the girl approaching him.

Nick did not seem to have the conviction about his ability to succeed in his social interactions with girls that he had had after his experiment with the girl from the computer laboratories (above). When reminded of this behavioural experiment, he mentioned that she had never contacted him again, and therefore, he was convinced that she had felt pity for him when she asked whether they could meet again. The facilitators asked Nick about why he had never tried to contact her. Perhaps she had been waiting for him to contact her. Nick had no response to this suggestion. He mentioned that he would try to make an effort to contact her, and thereby challenge his assumption about her feeling pity for him.

During the final session, another member in the group, "Lindiwe" (Appendix 3a) told Nick that many people had asked her if she had noticed the wonderful change in attitude that Nick displayed. Lindiwe ate at the same dining hall as Nick, and attended several lectures with Nick. She even confessed that Nick had a few secret admirers. None of this information made any sense to Nick. He simply said, "well, then why is it that girls continue to look at me in the same way they did before?". The facilitators questioned whether Nick had collected any proof to support this statement. Nick was asked whether he had actually been looking at the girls and noticing how they looked at him, or whether he was assuming that they looked at him in a particular way. Nick confessed that he had not constructively searched for evidence to challenge this assumption, as yet. The facilitators suggested that Nick should conduct behavioural experiments to test this assumption of his.

#### ***(h) Debriefing Session***

At the individualized debriefing session, which took place three weeks after the final group session, Nick appeared to be more positive than he had been in the final group session. He had collected sufficient evidence through new behavioural experiments that he had been wrong in his assumptions about the way in which girls looked at him. Nick mentioned that, he had never really looked to see the expressions on girls' faces in the past. For this reason he had never really noticed whether they looked at him in a peculiar manner. Instead, he had just assumed this, whilst avoiding eye contact and looking at the ground.

During the three weeks that elapsed between the final group session, and the debriefing session, Nick had conducted regular behavioural experiments that he had integrated into his daily routine. These experiments involved, making sure to look at girls' facial expressions and observe the way in which they looked at him. He carried these experiments out whilst walking into the dining hall or lecture theatres, and whilst walking down a street or past a crowd of girls. Initially, Nick had found this process highly anxiety provoking as he anticipated that he would see only negative expressions. He had expected to see girls laughing at him, or girls looking at him with a questioning expression of "how dare you look at me, you strange person". When Nick tried to observe a girl's facial expression, he would feel hot and feel his heart pounding, and "would not feel brave enough to look up at the girl".

However, within the first two days of his routine, he decided that he would "just have to look up and face the consequences if I ever intended to question my beliefs". He kept reminding

himself about what Lindiwe had said to him in the final group session about his secret admirers, and this gave him incentive to carry out his experiments. He found that, to begin with, it was easier to observe girls in the dining hall or at lecture theatres. These were large venues, and he was able to act as though he was not looking directly at any particular girl. With time, he began to look at girls who walked past him in the street, and the girls who sat in crowds when he walked past them. He also started to observe individual girls' expressions in the dining hall and at lecture theatres.

In addition, Nick observed the way in which girls looked at other males in similar situations, as a means of comparison with the way in which they looked at him. He was surprised with what he had found, and had formed new beliefs about himself, and girls in general. He expressed these beliefs and findings with the following. He believed that, either the girls had never noticed his anxiety in the past and had always admired him, or he was definitely exuding confidence that he had never had before. He found that girls, who did happen to look at him, were doing so with genuine feelings of attraction or admiration. He found that some girls were "literally calling him with their eyes", whilst some other girls noticed him looking at them and "looked away with a shy expression". In addition, he noticed how girls were always friendly and smiled at males who looked at them, and who maintained eye contact with them. He observed that in many situations, girls made comments and laughed at the males who avoided noticing them.

However, through his extensive observations, he was sure that, most girls humiliated such males because these girls felt embarrassed when they were ignored. It had nothing to do with whether the males appeared comical, nervous or simply over-confident. This finding made him feel a lot better about the way in which he must have appeared in the past, when he had avoided noticing girls that were around him, or in his presence. He found that most girls looked at him in the same way that they had looked at any other male who cared to look at them. Therefore, he also believed that there was nothing peculiar about himself.

As part of the content in the debriefing questionnaire (Appendix 5[vi]), Nick admitted that he had not been asserting himself enough during the first 10 sessions of the programme. He mentioned that he had expected things to happen to him. He did not realize that he had to make an effort to overcome the problems he had. When he realized the amount of progress the others were making, he felt ashamed and upset that he had not tried as hard to make

progress in any aspect of his problems. He then decided that he would have to "make a start somewhere", and began conducting behavioural experiments that posed serious challenges to his cognitive distortions. He also mentioned that he had never gained so much insight into his personal problems as he had managed to achieve through participating in this programme. Regarding the actual content of the programme, he mentioned that, there was nothing he would have liked to see changed, or conducted differently. From a participant's point of view, everything was perfect for him.

Finally Nick was questioned about what he planned to do next in order to maintain his treatment gains, and in order to make continual progress regarding his problems. Nick mentioned that he was conducting his behavioural experiments, one step at a time. With the evidence he had collected about the way in which girls looked at him, he felt ready to try and approach girls and speak with them. He had decided that he would conduct sufficient behavioural experiments where he would interact with girls, out of his own free will. He agreed that he would report his findings at the six-week follow-up interview, and "who knows, I may even have a girlfriend by then".

*(i) Six-week follow-up interview*

Nick had made further progress by this interview. All the scores in these questionnaires had dropped since the debriefing interview, and he mentioned that he had continued to conduct behavioural experiments and engage in the process of cognitive restructuring. Nick had challenged his worst fears by conducting behavioural experiments that involved approaching and interacting with girls (outlined below). In addition, Nick had continued to frequent nightclubs and social gatherings, and never experienced anxiety or negative thoughts and predications in these situations. He had even managed to join the people in his residence and socialize with them. This in particular was regarded as a great achievement for him. Five months previously, socializing with the people in his residence, had been used as the feared situation with which he had constructed his first cognitive model (d, above). At the time, he had begun to believe that he was "anti-social" as a result of his failure with this situation. At this interview he no longer believed that he was anti-social.

The behavioural experiments that Nick described in detail at this interview were those in which he had approached and interacted with different girls, in two different situations. In his first behavioural experiment, Nick approached a girl that he was not in anyway attracted

towards. He reasoned that if he could have a successful conversation with her, this would give him incentive to approach another specific girl he "had in mind". The girl he approached in the first experiment was sitting by herself at the day-kaif (the students canteen on campus). His automatic thoughts before approaching her were, "what will I say? How do I speak with someone I don't even know?". He then decided that he would start a conversation with her by asking her for change for his R10 note. From there onwards he would just allow the conversation to flow.

Upon reaching the girl and asking for change, he could feel his heart pounding and felt himself shaking, but nevertheless, "showed her the ten Rand note, and asked for change". She was pleased to assist him, and asked him whether he was looking for change to make a phone call. Nick saw this as an opportunity to start a conversation, and directed his attentional focus onto the actual content of the conversation rather than on his anxiety symptoms. They had a "pleasant" conversation about their degrees of study, the residences they stayed in, and how awful they had found that day's lunch in the dining hall. This was Nick's first successful encounter. He had achieved his goals in this experiment that included, dropping his safety behaviours, diverting his attentional focus from himself, and making meaningful conversation with someone of the opposite sex.

Nick's second behavioural experiment entailed approaching and speaking with a specific girl that he was very attracted towards. Nick had seen this particular girl in his dining hall, and she was doing several subjects with him. He had noticed her in many of his lectures. From his previous experiment, Nick had found that, the strategy of thinking of a reason to speak with the girl was the best way to start a conversation. He decided that he would approach her by asking her if she had a copy of the assignment topic that was handed out in the previous lecture. Before approaching the girl, Nick reminded himself that he must, "drop all safety behaviours, keep attentional focus on the conversation, and let the conversation flow. If it doesn't flow, walk away confidently, and try again some other time". Nick approached the girl outside the lecture theatre, where she was standing alone, and asked her his question. Her response caught him entirely by surprise. She smiled and said that she had seen him in the previous day's lecture, and therefore, she was sure that he had his own copy. Nick's anxiety heightened instantly because he realized that she had noticed him previously, and she had "caught me out, in my attempt to find a reason to speak with her". He also had negative

thoughts about the impression he had already created on her since she had noticed him in the past.

He felt himself shaking again, and felt very hot. Nick "was thinking of how to hide his face and run away" when she continued by saying that, she did not know how to go about answering the question in their assignment. She asked whether they could work on their assignments together. Nick felt his anxiety disappear immediately, and agreed by saying, "of course, but only if you promise not to make me feel like an idiot again!". She found this very funny and looked shy. They agreed that they would meet at the dining hall and decide when and where they would meet, in order to discuss the assignment.

When they met at the dining hall, they sat together for supper, and had a wonderful conversation. Nick expressed that, that day had been the best day of his life. It had been two weeks since they had handed in their assignment, and they were still friends. She often sought him out at the dining hall and at lectures, and sat with him. Nick looked pensive when he mentioned that his ultimate challenge would involve asking her out on a date. He mentioned that he "loved" her company and "she would make the ideal girlfriend". He knew that she was attracted to him too, and could sense that she was waiting for him to propose a relationship between them. He feared that he would approach the situation wrongly. Whilst in the interview, he decided that he would take her out on a date to a restaurant, and ask her to be his girlfriend.

Nick concluded this interview by saying that he was very happy with his life. Whatever he had dreamt about at the beginning of the programme had become a reality for him. He was convinced that he would never regress or suffer a relapse because he "would just need to conduct a behavioural experiment, challenge my thoughts and predictions, and collect the appropriate evidence". Nick was proud of the progress he had made. He mentioned that he often missed the facilitators and the group, and would never forget them, since they had helped him discover his ability to socialize. Nick concluded by saying, "Every situation in life can be taken as an experiment, and lately, I'm always winning!".

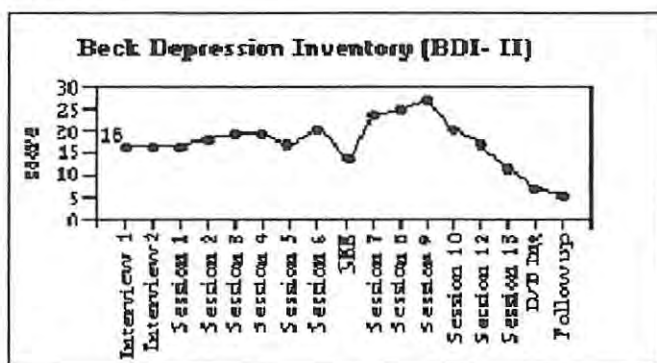
## **B) Presentation of Quantitative Data:**

In order to evaluate the effectiveness of the programme with respect to Nick's problems, all the questionnaires that Nick completed were scored, and are presented as graphical representations of his progress. Refer to Section 2.4.1 for descriptions about each of the measurement scales and inventories used. Nick did not attend session 11, and it must be noted that no scores are presented for this session in the graphs. Nick was questioned about the fluctuations of each questionnaire's scores at the debriefing interview. All explanations for these fluctuations, as described below, are Nick's own explanations.

### **i. Beck Depression Inventory (BDI-II)**

The BDI-II measured Nick's levels of depression. At the first interview, Nick's BDI-II score was 16, indicating that he was mildly depressed. From session 2 to 6, his BDI-II scores indicated moderate depression. Nick expressed that his depression had increased between sessions 2 and 6 because he began to feel convinced that there was no way that he would be able to change. Monitoring his automatic thoughts and constructing his cognitive model only highlighted all that was negative in his life.

**Graph 3.8**



At the session involving the SBE his BDI-II score returned to the range of mild depression. The SBE gave Nick a ray of hope, and he felt less depressed when he attended this session. However, his BDI-II scores steadily increased again within the range of moderate depression from session 7 to 9. Between sessions 7 and 9, he noticed the amount of progress that everyone else in the group had been making, and he felt depressed at the thought that he was failing to do the same. From session 10 onwards, his BDI-II scores steadily decreased within the range of mild depression, as he had decided to conduct experiments that posed serious

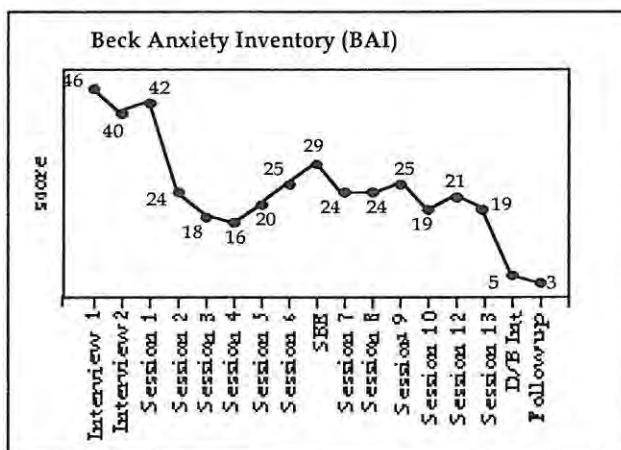
challenges to his cognitive distortions, and he began to collect evidence that his cognitions were inaccurate. This caused his level of depression to steadily drop.

During the debriefing interview and the follow-up interview, his BDI-II scores indicated minimal depression. After recognizing that his ability to socialize, Nick no longer experienced depression and had in fact become happier than he had been in a very long time. When reviewing his actual questionnaire at the debriefing interview, his BDI-II score of 6 was due to indecisiveness, decreased appetite, and difficulty concentrating. Nick entirely attributed these symptoms to his nervousness about his upcoming end of year examinations. These symptoms had nothing to do with depression.

## ii. Beck Anxiety Inventory (BAI)

The BAI measured Nick's levels of anxiety. Nick's BAI score in the first interview was 46, indicating severe anxiety. Nick explained that he was highly anxious about meeting the interviewer and did not know what to expect. In the second interview his BAI score in a feared situation indicated severe anxiety (40), and his BAI score in general indicated moderate anxiety (18). In the first group session, Nick's BAI score was 42, indicating severe anxiety that he attributed to his nervousness about meeting and getting involved with a group of strangers. The anxiety symptom he rated as severe and could barely stand was his fear of the worst happening.

**Graph 3.9**



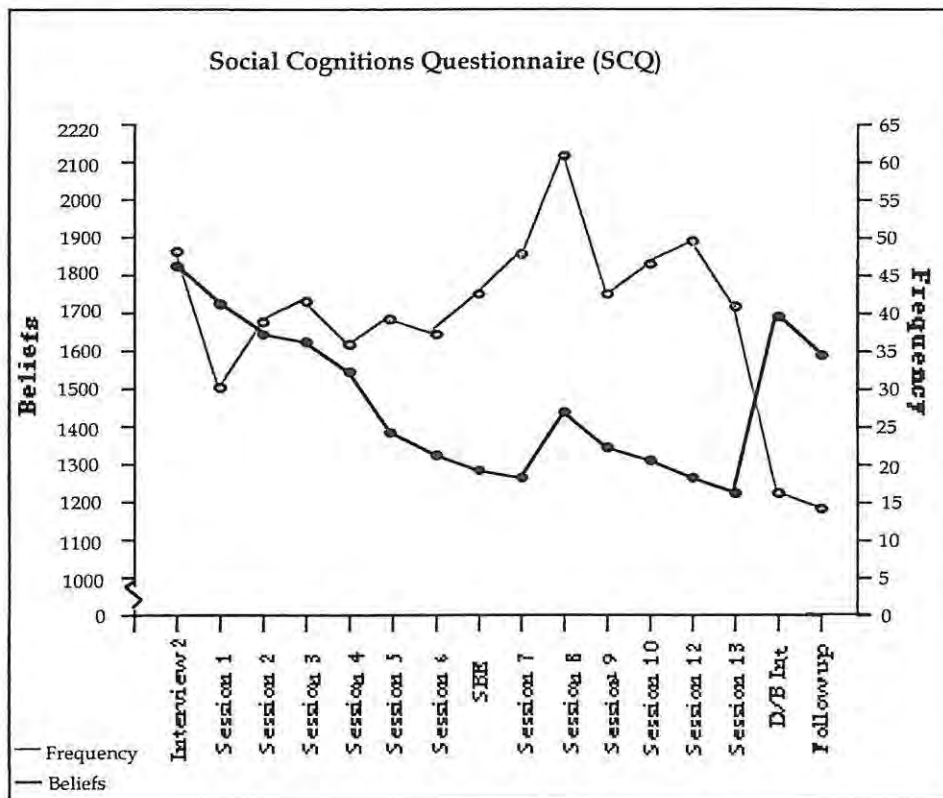
Nick mentioned that he could never differentiate between whether he felt depressed or anxious. He explained that, "when things went right, my depression and anxiety would decrease. When things went wrong, my depression and anxiety would increase". For this reason Nick mentioned that he sometimes struggled to answer the BAI accurately.

Nick's BAI score of 5 at the debriefing interview included 5 anxiety symptoms that were all rated as mild and did not bother him much, although he continued to experience these symptoms. These included inability to relax, fear of the worst happening, nervousness, fear of losing control, and sweating (not due to heat).

**iii. Social Cognitions Questionnaire (SCQ)**

Nick had to identify the cognitions he was preoccupied with in social situations, and rate his belief (0-100) in these cognitions, as well as the frequency (1-5) with which these cognitions occurred to him.

**Graph 3.10**



In the second interview, Nick's SCQ scores (1810/2200- belief, 48/88- frequency) indicated that he had numerous, frequent cognitions that preoccupied him, and he believed very strongly in these cognitions. For example, he rated the frequency of thoughts such as, "I will be unable to speak; I will be paralysed with fear; I will babble or talk funny; People will stare at me; People will reject me; People are not interested in me; I am inadequate, vulnerable, weird, different; and People think I am boring" as thoughts that usually (4/5) or always (5/5) occurred when he was nervous. In addition, his belief in all these thoughts was either rated as 90/100 or 100/100.

Nick's beliefs in and frequency of his negative cognitions remained higher than all the other participants throughout the programme. When asked about his belief in the thought score, which had increased considerably between session 13 and the debriefing session, in spite of the decrease in frequency of these thoughts, Nick said, "I still believe very strongly in my thoughts. Although I experience them a lot less, they are still believable. The behavioural experiments helped me to realize that the thoughts in this questionnaire were not constructive thoughts if I wanted to socialize; however, they are still believable".

At the follow-up interview, his final SCQ scores (1600/2200- belief, 6/88- frequency) indicated that Nick did not have frequent cognitions that preoccupied him. However, his belief in several negative cognitions, for example, "I will drop and spill things, I will babble and talk funny; and I will be unable to concentrate" were rated as 90/100.

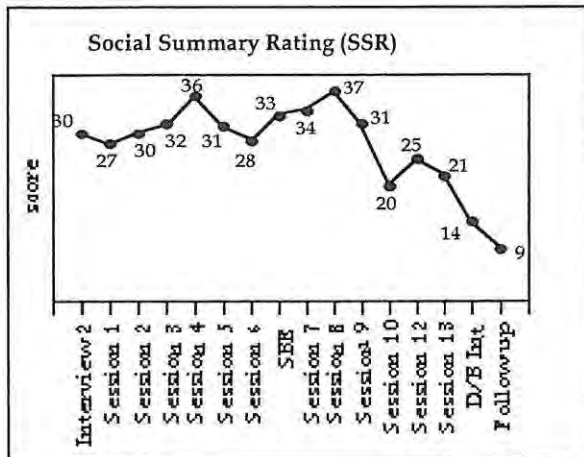
#### **iv. Social Summary Rating (SSR)**

The SSR measured Nick's level of anticipatory anxiety prior to social interactions, the degree of self-focused attention in social interactions, and the degree to which he engaged in post-mortem self-critiques. In the second interview, Nick's SSR score was 30/40, which indicated marked social anxiety in the week before he answered the questionnaire. In session 4, his SSR score was 36/40 being one of his highest scores of social anxiety. He attributed this to his attempts at monitoring his automatic thoughts during that week that caused him severe social anxiety.

In session 8, his SSR score was 37/40 being his highest score of social anxiety. He attributed this to his failed attempts at conducting meaningful behavioural experiments. In that week, he had nearly always avoided social situations, had entirely focused his attention on his anxiety

symptoms whilst in unavoidable social encounters, had always gone over things that would go wrong in his social encounters, and had always conducted a post-mortem of social situations he had encountered.

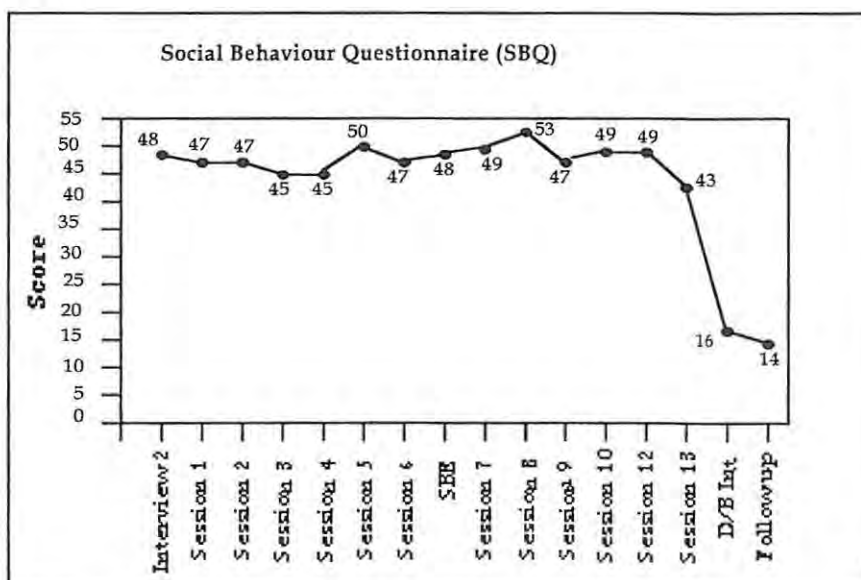
**Graph 3.11**



However, from session 8 onwards, his SSR scores gradually decreased. He attributed this to his concerted efforts in conducting behavioural experiments and avoiding negative anticipatory thoughts, or conducting a post-mortem. His final SSR score was 9/40. This score encompassed his continual efforts regarding externally focusing his attention, trying to avoid anticipatory anxiety prior to encountering a social situation, and trying to avoid conducting a post-mortem after encountering the social situation.

#### **v. Social Behaviour Questionnaire (SBQ)**

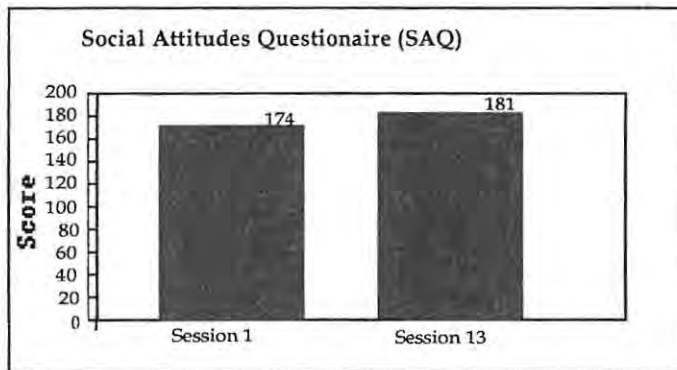
The SBQ assessed the degree to which Nick employed safety behaviours. In the second interview, Nick's SBQ score was 48/84. Nick had responded that he *always* used the following safety behaviours when he was anxious. He tried not to attract attention, made an effort to get his words right, talked less, tried to control his shaking, censored what he was going to say, tried to act normal, and made an effort to come across well. Once again, as with the SSR scores, Nick's SBQ scores were at their highest in session 8. He gave the same reasons as those explicated above in the SSR analysis.

**Graph 3.12**

Even after conducting the SBE, Nick struggled to drop his safety behaviours. He mentioned that his efforts directed at dropping his safety behaviours, in fact made him use them even more. This can be seen in his increased SBQ scores after the SBE. In the SBQ that Nick completed at the follow-up interview (14/84), he had not responded with *always* for any of the questions apart from 'thinking positively'. Nick's SBQ scores had only sufficiently dropped after the completion of the programme. He attributed this to his new findings about the way in which girls looked at him. Until he had discovered these findings, he explained that he had always used his safety behaviours as a means of protecting himself from being vulnerable to ridicule by others.

#### **vi. Social Attitudes Questionnaire (SAQ)**

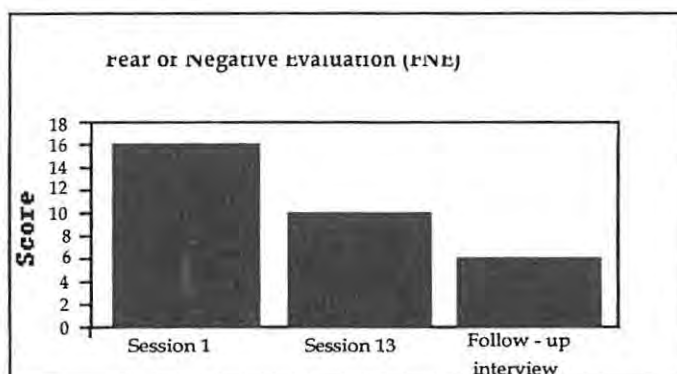
The SAQ was used to measure some of Nick's attitudes and beliefs. His SAQ final score had increased (181/300) from his SAQ first score (174/300) in the programme. Nick simply expressed that, just because he had overcome most of his situational social phobias by session 13, this did not mean that, for example, he was not allowed to continue being concerned about the impression he created on the public. He expressed that he continued to try very hard to make a good impression on others. However, he was not trying to make a good impression in order to attain approval from others. He was merely living up to high standards he wanted to set for himself. If he failed to live up to these standards, this would not make him feel sad or inadequate anymore.

**Graph 3.13**

Through his behavioural experiments, he had deduced that he would be accepted anyway. In effect, Nick's beliefs and attitudes had changed for the better. However, this questionnaire did not manage to highlight the kind of change involved. For several questions, Nick had circled the same category on the ordinal scales provided in the SCQs in the first and thirteenth sessions. For example, he continued to "totally agree" that, he's vulnerable, he must not show signs of weakness to others, and he must not let anyone see that he is anxious. Conversely, he also continued to "totally agree" that; to be worthwhile, he did not need everyone's approval.

#### vii. Fear of Negative Evaluation (FNE)

The FNE questionnaire was used to measure Nick's mood and his general assumptions pertinent to his social phobia. In the first session, Nick's score was 16/30. His responses indicated that he was worried about other peoples' perception of him, and felt distressed at the thought of being negatively evaluated.

**Graph 3.14**

Most of all, it was evident from his responses in this questionnaire that he feared his loss of social approval. In session 13, however, his FNE score dropped to 10/30, and further dropped to 6/30 at the follow-up interview. This score reflected on what he had mentioned regarding his SAQ. Although he remained concerned about what people thought of him, he no longer feared the prospect of negative evaluation.

### **C) Conclusions around Nick's case**

When reviewing the graphs that represent Nick's questionnaire scores, it is justifiable to say that Nick did not experience much progress during the course of the treatment itself. However, his scores are visibly lower at the de-briefing session and the 6-week follow-up session. This corresponds with Nick's case narrative wherein his progress is described as having taken place towards the end and after the completion of the formal programme. It was only at this stage that Nick made a concerted effort to tackle and test his negative cognitions and core-beliefs. For example, only after session 11 did he make the effort to actually look at girls' faces to investigate their expressions to see whether they were expressions of pity and disdain, as he had predicted.

Nick responded to the therapy programme in the way in which Clark and Wells would have predicted, although the important changes did not happen during the treatment itself. One of the main therapeutic components of the treatment is participants' use of behavioural experiments to test their negative cognitions and core-beliefs. Nick failed to do this during the large part of the treatment programme. Whilst making his idiosyncratic cognitive model during sessions four and five, instead of identifying his negative cognitions and starting the process of testing these cognitions, Nick found it difficult to distance himself from these negative cognitions and core-beliefs. For example, his negative thought, "others must think I am anti-social", became a self-fulfilling belief that "I am anti-social". However, when he decided to try and test this same negative thought between the final two sessions, he found that girls found him not only social, but highly humorous as well.

Another factor was that Nick was not easily convinced by the evidence that was presented to him. For example, in the safety behaviours experiment, although he managed to drop all his safety behaviours during the second role-play, he was not yet ready to 'drop' his negative cognitions as well. He convinced himself that the safety-behaviours experiment was a set-up!

He continued to believe that girls pitied him and thought him to be boring. He never believed that it was possible for him to experience similar success with girls in “real-life situations”. There was no way of convincing him of this unless he made the effort to conduct his own meaningful behavioural experiments. Even the role-play conducted for Nick during session 8 with two female participants in the group had limited impact. In spite of the convincing evidence that he collected that he was not pitiable or unattractive, he maintained that the girls were just trying to encourage him to feel less anxious and more self-confident, and he did not like being ‘patronized’ in this way.

Nick only managed to change these negative beliefs when he conducted behavioural experiments with girls who were unaware of the fact that he was attending therapy to improve his ability to socialize with them. He was not able to discount evidence obtained from situations outside of the therapy setting in the same way. This increased his self-confidence and considerably reduced his social anxiety. Subsequently he dared to conduct more behavioural experiments and test his negative beliefs and experience considerable relief from his social anxiety. This is reflected in his much reduced questionnaire scores at the debriefing and follow-up sessions.

Nick could have contributed more in the group had he begun the process of disconfirming his negative cognitions and core-beliefs at an earlier stage in treatment. His experiences (as described above in the debriefing and the 6-week follow-up sessions) are success stories that he could have shared with the group. Instead he just listened to everyone else’s success stories and could not share any of his own. Due to this, Nick might not have experienced the group’s understanding of one another in the way that other members experienced it. The other members in the group were all able to relate to one another as they were progressing together.

On two occasions when another member in the group, Ben (who had similar social anxieties to Nick, and had overcome them by this stage), offered to help Nick conduct his behavioural experiments, Nick did not make use these opportunities, although he got as far as entering the social situations with Ben. However, Nick managed to experiment with the very same social situations towards the end of the programme by himself and experience success with these situations.

He never compared himself to the others in the group and felt inferior, and he never accepted support or feedback from the other members in the group, as this made him feel somewhat inferior. This point has already been expressed above, as well, in his inability to accept the female participants' feedback from the role-play conducted during the session. He always felt that his problems were unique and his own to challenge. However, once he did embark on the behavioural experiments, he went about disconfirming his negative beliefs and cognitions in the most intelligent way. For example, he watched how girls looked at other boys to see whether it was similar or different to the way in which they looked at him. He was very proactive in this aspect of the treatment once he made up his mind to go ahead with it.

In conclusion, therefore, Nick's case shows how appropriate behavioural experiments designed to systematically investigate the accuracy of specific self-defeating cognitions play a major role in overcoming social phobia. But this is not a mechanical process. The participant needs to have some minimum level of motivation to conduct the experiments, and has to be able to process the new information in an objective manner.

### **3.2.3 CASE REPORTS OF DROP-OUTS**

#### **The Case Report of Tumi**<sup>3</sup>

"Tumi", aged 22, is a black, female student. She was in her third year of study at Rhodes University (RU) when she participated in the programme. Although Tumi made considerable efforts with her homework and participated enthusiastically in the group, she dropped-out of the treatment after session 5 (before the 7-week vacation).

#### **A) Case narrative**

Tumi was born in Johannesburg, in South Africa, in 1978. When Tumi was born, her mother stopped working. Her father is a print setter. She has one sister, aged 40, and three brothers, aged 35, 33 and 32. She is the youngest. Tumi mentioned that she and her father did not share "any kind of relationship". Her father was merely the person who provided money for her education and clothing, if and when he felt like being helpful. They never did anything together, and were never at the same place at the same time. Therefore, she had never shown any emotions towards him. Her mother and her shared a very strong relationship. Although

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<sup>3</sup> The name of the participant has been changed in order to protect her identity

her mother was very strict with her and “beat me up” when she was deviant, Tumi could always speak to her mother about anything, and ask her mother for whatever she needed.

Tumi mentioned that her parents argued a lot, and were only seen together when her mother needed to buy things for the house. Her parents argued about money matters in particular. Tumi hated her brothers, as she did her father, as she felt that her brothers were just like her father, that is, “stingy and lied about the amount of money they had”. She never mentioned her sister’s relationship with her.

Tumi’s grades at school fluctuated a lot. They were excellent at times and terrible at other times. She had one very close friend during her primary school years. At high school, however, she would sit with people at break-times, but be by herself after school. She mentioned that, “due to the constant fighting at home amongst everyone, I did not find it easy to be around people... it frightened me”. Tumi completed high school in 1995, and university at the University of South Africa for one year before she moved to RU. Tumi has had one steady relationship with someone of the opposite sex. The relationship ended because she felt as though “he did not have time for me”. She mentioned that she has no difficulty conversing with people of the opposite sex.

**(a) *Life situation at the start of the programme***

Tumi described a day in her life as follows. She wakes up at 4:30 am and studies until 6 am, and then takes her shower. At 7:10 am, after the morning news, she leaves her room for lectures. She eats all her meals at her residence-dining hall. During the day, if she is not attending lectures or studying at the library, she watches television in her room as she has her own television. Tumi mentioned that she talks to people at lectures and at the dining hall, simply because she sitting next to the person she is talking with. She has no close relationships with anybody at university. She mentioned that people have described her as “quiet, serious, selfish, and reserved”. Tumi explained that in spite of passing judgement on her, which only close friends should do, none of these people have made the effort to know her as a friend. Tumi was mainly distressed about the fact that, at home she always knew that her mother was there for her. At university, however, she has been forced to meet new people who are quick to judge her personality, and she does not like this.

**(b) Presenting problem**

Tumi initially came across as a sensitive and fragile person. Gradually, she allowed herself to expose her feelings and thoughts, whilst trying to share her problems. She did not seem afraid of sharing her problems with the interviewer and was very bothered by her problems. She mentioned that she found it difficult to people, especially people she did not know. By this she meant that she able to approach people and converse with the, but did not know what to talk about. She feared that people found her boring because of this. In addition, she felt extremely nervous when she did not know what to say to people, and her nervousness would be visible to others. She also mentioned a few times that, "people talk too much" and this makes her feel nervous as well. For this reason she is happy that she has her own television and does not need to socialize in the common room of her residence.

Tumi's goals for treatment were mainly geared at her inability to converse with people with ease. She wanted "to talk with people without boring them". In addition, she wanted to, "feel comfortable when talking to people". Her main concern and therefore goal for treatment involved her desire to, "stop thinking that something bad will happen when I go and talk to people. I don't worry about what they think of me. I just want to be myself".

**(c) Constructing a cognitive model of Tumi's problems**

Through several exercises, homework assignments, and discussions during the first five sessions of the programme, it became possible to conceptualise Tumi's problems based on the Clark and Wells model. The most common themes that came through in Tumi's accounts of her anxiety in social situations involved her inability to converse with people, especially the talkative people. Due to this, she never went to social gatherings, nightclubs, parties or any other social events. She made sure to be the first to arrive at a lecture theatre so as to position herself in such a way that she would not have company sitting with her. At the dining hall, if she noticed that anybody was approaching her to sit with her, she would eat quickly and leave.

In session 1, once Tumi identified the situations she feared, or in which she experienced anxiety, she was able to investigate these situations in order to construct her idiosyncratic cognitive model. In session 2, Tumi identified a series of negative thoughts and beliefs she had regarding, and whilst in, situations in which she experienced anxiety. In addition, she identified the automatic anxiety responses she experienced in these situations. In session 3, Tumi began

to focus on the safety behaviours she adopted in an attempt to prevent the things she feared from happening.

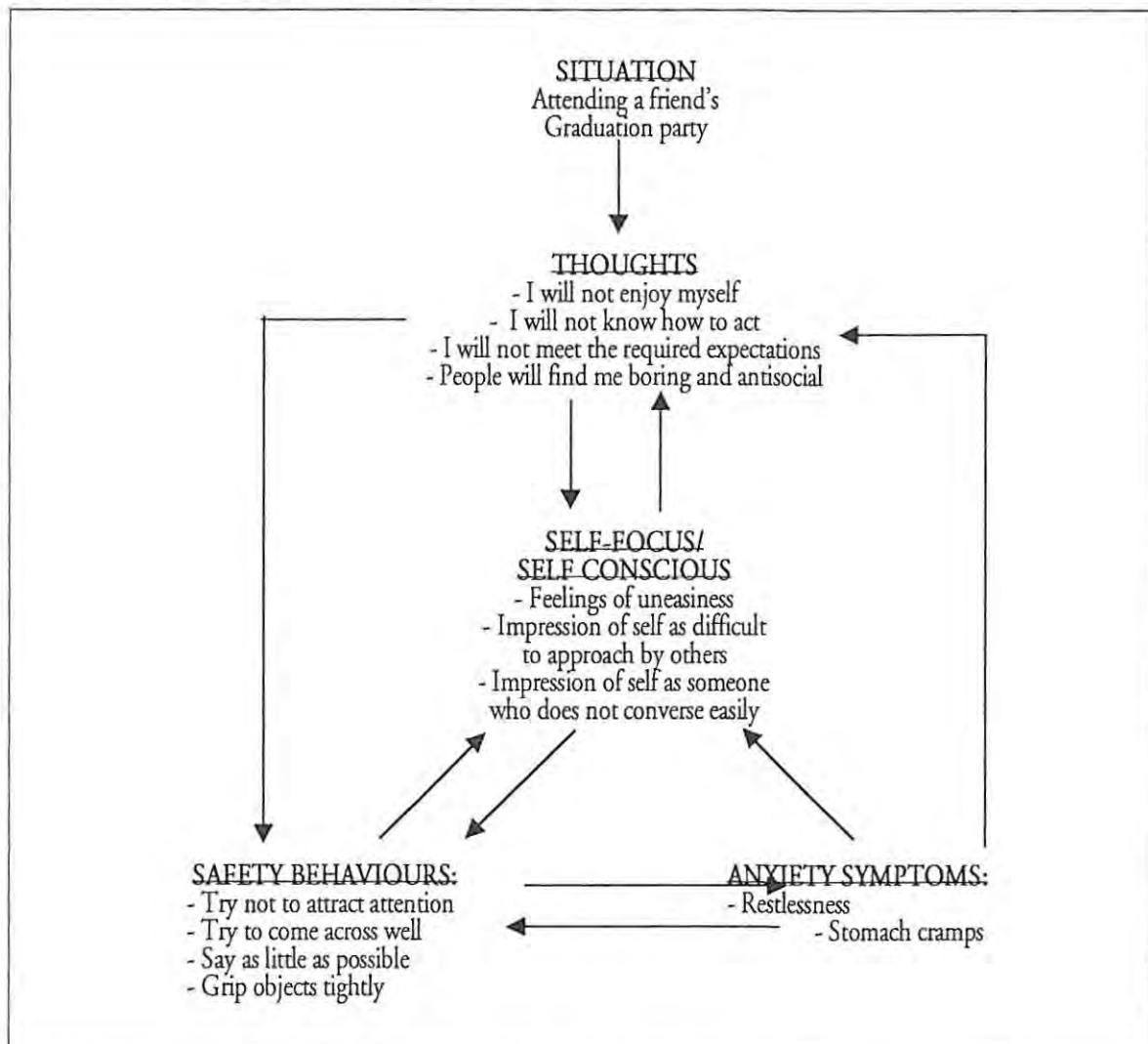
As part of the homework from session 2 onwards, Tumi began to monitor her automatic thoughts and emotions more closely in social interactions. She did this with the use of the first three columns of the 'Daily Dysfunctional Thought Record'. Tumi had to keep an account of the emotions, and negative thoughts that came to her mind in social interactions in everyday life. Tumi encountered two situations in which she monitored her thoughts and emotions. The first situation (that took place between sessions 2 and 3) involved sitting and conversing with others in the dining hall. Tumi experienced anxiety, which she rated as 70/100. She could feel her stomach cramping and started to feel restless. Her automatic thoughts were, "I will be unable to speak (100/100), "I will not make sense when I do speak" (100/100), "I need to avoid the situation so that my anxiety does not increase" (100/100). Before she could even say anything, Tumi got up and put her lunch tray away and left.

The second situation involved attending a graduation party of a friend (that took place between sessions 3 and 4). Tumi did not particularly want to attend this party but the homework assigned involved engaging in feared social situations. She experienced tremendous anxiety that she rated (100/100). She felt her stomach cramping, and felt restless. Her automatic thoughts were, "I will make a fool of myself" (90/100), "I will not know how to act" (80/100), "I will not meet the required social expectations" (90/100), "I will not enjoy myself" (90/100), "People will find me boring and antisocial" (100/100). At the party she tried not to attract attention to herself by staying on the edge of the group, and sitting alone in a corner. When approached by someone, she tried to across well, but said as little as possible so that they would leave her alone.

Tumi constructed her idiosyncratic cognitive model with the use of her second situation above. This model is depicted in Figure 3.7, below.

***(d) An idiosyncratic cognitive model outlining one anxiety-provoking situation for Tumi***

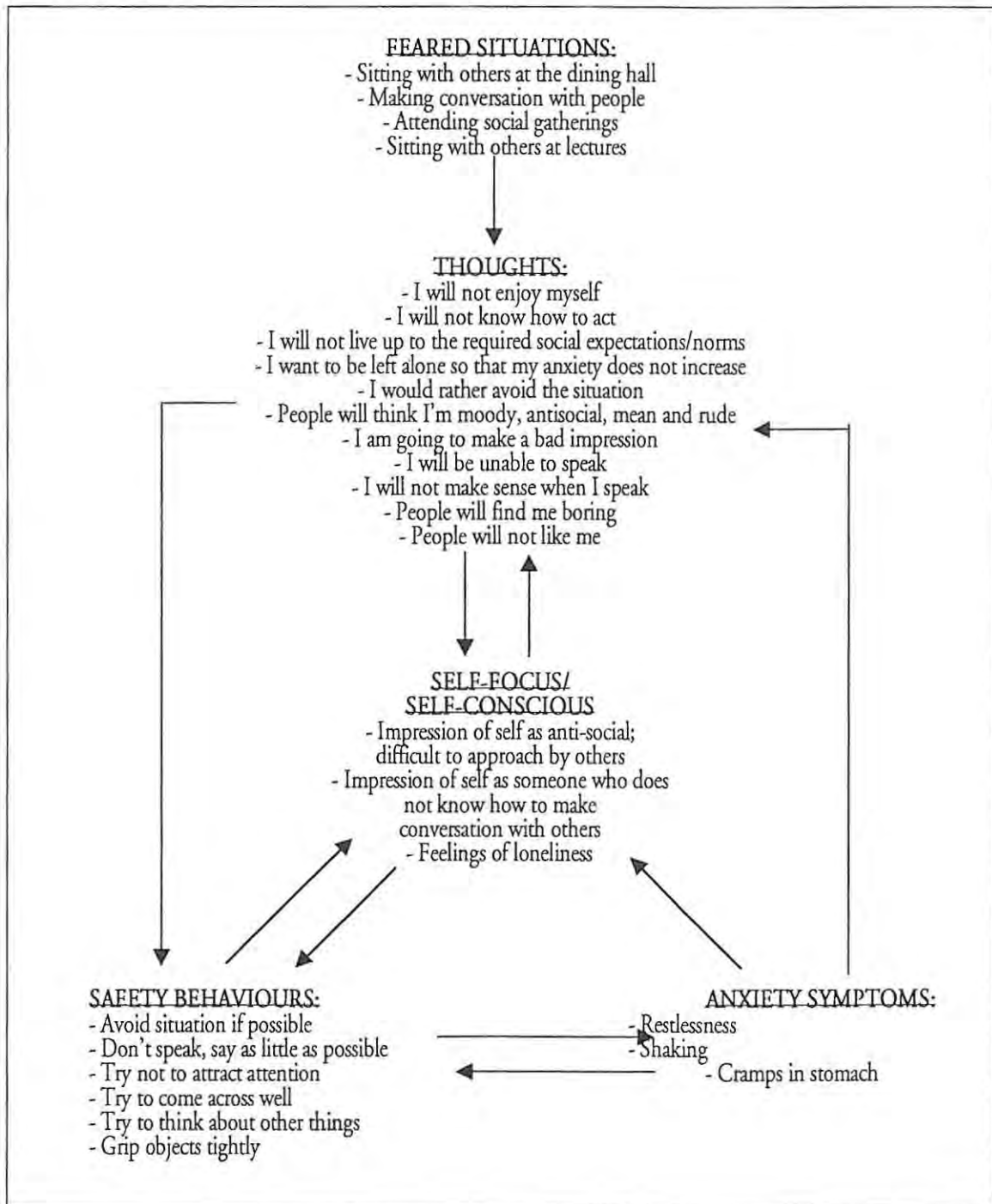
The model outlined overleaf (Figure 3.7) was constructed by Tumi, and illustrates the structure of her anxiety response to a socially threatening situation.

**Figure 3.7: Tumi's personal cognitive model**

Tumi constructed the above model as part of her homework after session 4. Her model was discussed in session 5 along with all the other participant's models. Tumi then decided that she would like to role-play conversing with someone for her SBE. However, she never returned to the therapy programme in session 6 after the 7-week vacation.

Depicted in Figure 3.8 below, is the structure of Tumi's anxiety responses to all the socially threatening situations in which she had monitored her thoughts and emotions, with the use of the first three columns of the 'Daily Record of Dysfunctional Thoughts'. This comprehensive cognitive model was constructed by the researcher, using information gathered during the first five sessions of the therapy programme (before the 7-week vacation).

**Figure 3.8: Comprehensive cognitive model of all Tumi's anxiety responses in all her feared situations**

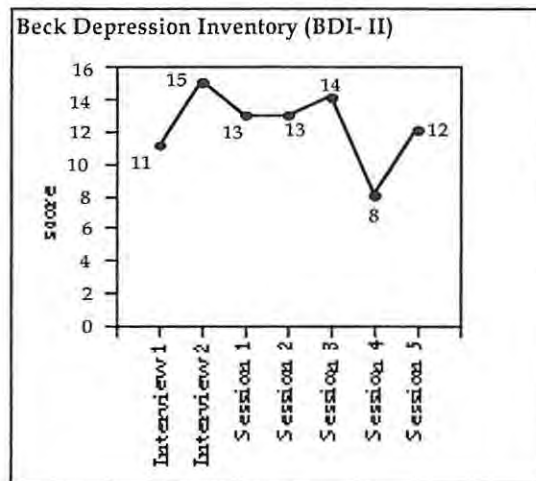


## B) Presentation of Quantitative Data:

In spite of the fact that Tumi left the group at the end of session 5, graphical representations of her scores from her questionnaires have been depicted below. Tumi sent an email to one of the facilitators expressing that she had too much academic work to worry about, and the group was taking up too much of her time. Tumi refused to meet with any of the facilitators of the group once she decided that she was leaving the group. Therefore, she could not explain any the scores that are represented below. She received no form of debriefing either. These graphical representations show to some extent that Tumi still had a lot of work to do in therapy before she would experience any remission from her social anxieties.

### i. Beck Depression Inventory (BDI-II)

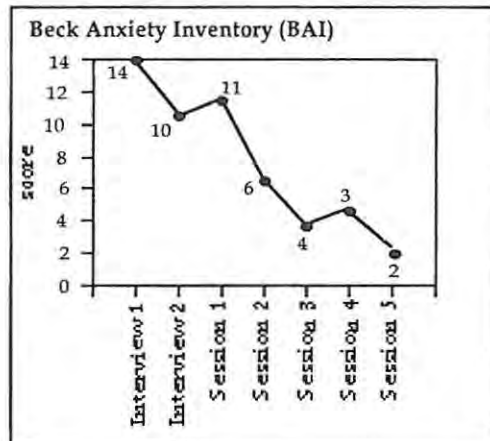
Graph 3.15



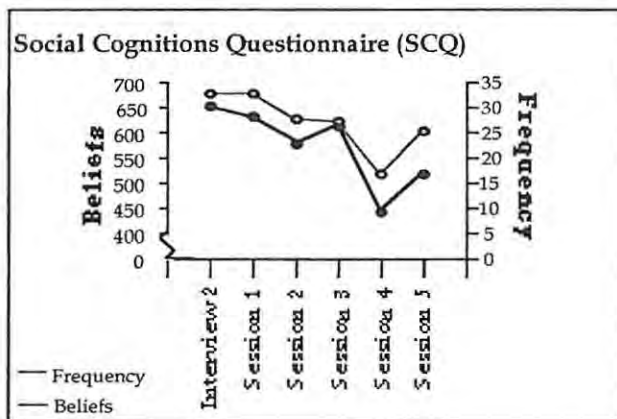
The BDI-II measured Lindiwe's levels of depression. Tumi's BDI-II scores fluctuate in the range of mild depression (10-16), apart from her session 4's score, which indicates minimal depression.

### ii. Beck Anxiety Inventory (BAI)

The BAI measured Tumi's levels of anxiety. Her initial score of 14 indicates mild anxiety, and her level of anxiety gradually decreases to 2, indicating minimal anxiety.

**Graph 3.16**

### iii. Social Cognitions Questionnaire

**Graph 3.17**

Tumi had to identify the cognitions she was preoccupied with in social situations, and rate her belief (0-100) in these cognitions, as well as the frequency (1-5) with which these cognitions occurred to her. Her initial score of 650/2200 (belief) and 32/88 (frequency), being a relatively low score, indicates that she had specific negative cognitions and core-beliefs. According to her questionnaires, these cognitions included, “I will be unable to speak (70/100), People will

reject me (70/100), People think I'm boring (90/100), I will babble and talk funny (80/100)". All these cognitions occurred 4/5 or 5/5 times by way of frequency.

#### iv. Social Summary Rating (SSR)

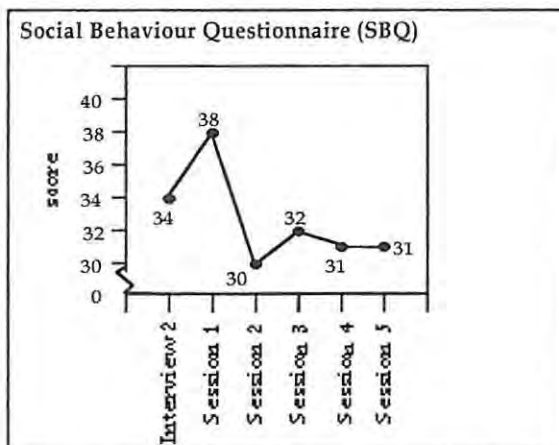
**Graph 3.18**



The SSR measured Tumi's level of anticipatory anxiety prior to social interactions, the degree of self-focused attention in social interactions, and the degree to which she engaged in post-mortem self-critiques. The marked increase between sessions 2 and 4 directly relates to the experiments that Tumi carried out whilst monitoring her thoughts and emotions.

#### v. Social Behaviour Questionnaire (SBQ)

**Graph 3.19**



The SBQ assessed the degree to which Tumi employed safety behaviours. This graph does not really have much bearing before the SBE is conducted, as participants are not even entirely aware of the way in which safety behaviours affect their social behaviour.

Conclusions around Tumi's case follow under Section 3.2.4, after the "The case report of Keketso" below.

### **The Case Report of Keketso<sup>4</sup>**

"Keketso", aged 20, is a black, male student. He was in his second year of study at Rhodes University (RU) when he participated in the programme. He dropped out of the programme after session 5. He seemed to be benefitting from the treatment group and it was quite a surprise to the facilitators when he decided that he was dropping out of therapy.

#### **A) Case narrative**

Keketso was born in South Africa, in 1980. Keketso has never met his real father, but has had a stepfather who worked in the mines. His mother is a schoolteacher. His stepfather and he don't have much of a relationship. His mother and he have a strong relationship. He has two brothers, aged 23 and 14, and a sister, aged 6. Keketso and his siblings are very emotionally attached to one another. Keketso was always a top student at school, and did not fear examinations, as he knew that he would "come out tops".

##### ***(a) Life situation at the start of the programme***

Keketso described a day in his life as follows. He wakes up, goes to lectures, comes back to his residence and either studies or watches television, and chats with his close friends until at least 1 am. He mentioned that he had very many friends. He has had one very steady relationship for three years with a girl, who broke up with him when he decided to move to RU to study, "this broke my heart". He mentioned that he felt very lonely and he missed having a girlfriend. Nevertheless, his problems were not related to his ability or inability to socialize.

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<sup>4</sup> The name of the participant has been changed in order to protect his identity

**(b) *Presenting problem***

In the initial interview, Keketso came across as being extremely nervous and on edge. He had a slight problem when trying to communicate his problems. Nevertheless, after telling the interviewer a bit about his hobbies, he finally managed to feel relaxed and speak freely. He mentioned that his problems were mainly related to his choice of career. Being a journalism student, he was expected to make speeches, interview people and ask questions at press conferences. However, his anxiety inhibited him from doing any of the above. In addition, he had severe anxiety when eating at public places. He imagined that he appeared “ugly and gluttonous whilst chewing my food”.

Keketso’s goals for treatment were therefore related to his public-speaking phobias, and his desire to eat at a restaurant. He wished to be able to take girls out on dates but was unable to do this for fear of being laughed at by the girls. His greatest dream was “to work for the South Africa Broadcasting Corporation” some day.

**(c) *Constructing a cognitive model of Keketso's problem***

Through several exercises, homework assignments, and discussions during the first five sessions of the programme, it became possible to conceptualise Keketso's problem based on the Clark and Wells model. The most common themes that came through in Keketso's accounts of his anxiety in social situations involved his inability to make public presentations, and eat in public. Due to this, he never attended “Cheese and Wine” parties at university, was unable to eat properly at the dining hall, and his grades were dropping academically.

In session 1, once Keketso identified the situations he feared, or in which he experienced anxiety, he was able to deconstruct these situations in order to construct his idiosyncratic cognitive model. In session 2, Keketso identified a series of negative thoughts and beliefs he had regarding, and whilst in, situations in which he experienced anxiety. In addition he identified the automatic anxiety responses he experienced in these situations. In session 3, Keketso began to focus on the safety behaviours he adopted, in an attempt to prevent the things he feared from happening.

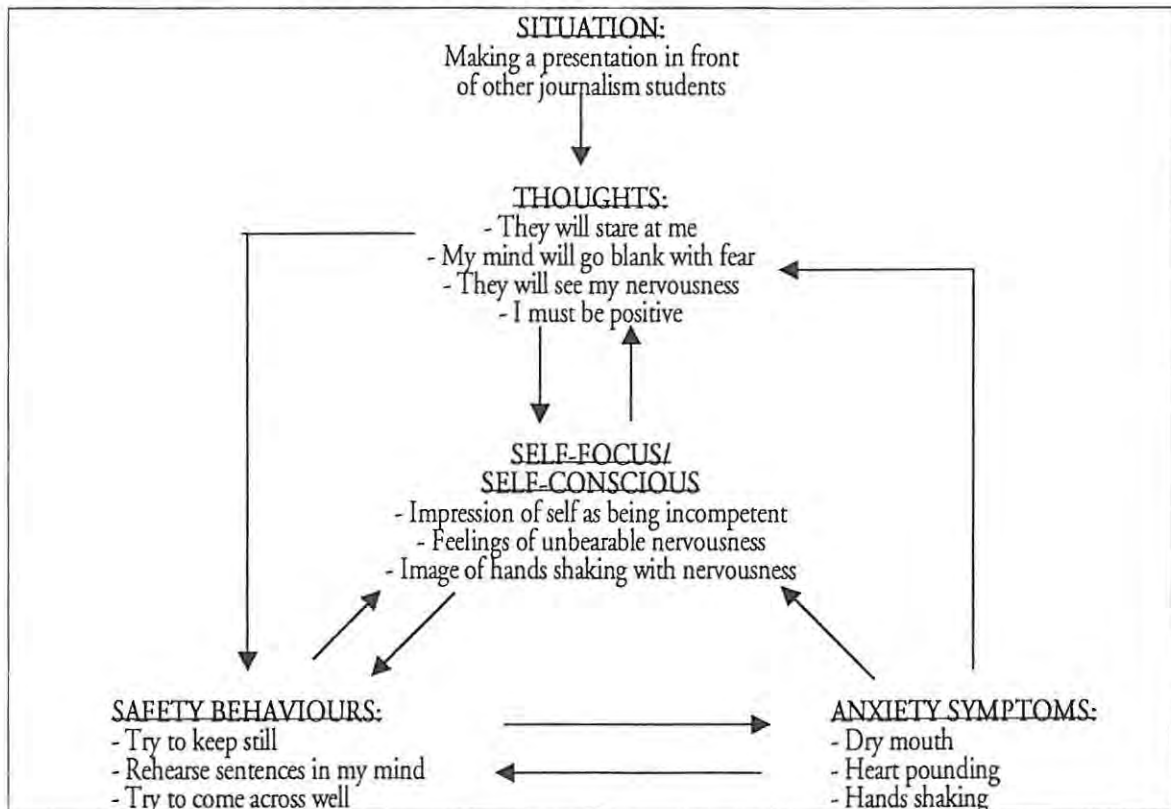
As part of homework, from session 2 onwards, Keketso began to monitor his automatic thoughts and emotions more closely in social interactions. He did this with the use of the first three columns of the ‘Daily Record of Dysfunctional thoughts’. Keketso had to keep an

account of the emotions, and negative thoughts that came to mind, in social interactions in his everyday life. Keketso encountered two situations in which he monitored his thoughts and emotions. The first situation (that took place between sessions 2 and 3) involved eating at the dining hall during “peak rush hour”. Keketso experienced anxiety, which he rated as 90/100. He could feel his heart pounding, hands shaking, and felt as though he was choking. His automatic thoughts were, “I will look gluttonous (100/100); I will choke on my food (60/100); I will make a bad impression (80/100); The people at my table will leave with disgust (100/200)”.

The second situation involved making a presentation in front of other journalism students (that took place between sessions 3 and 4). Keketso felt his mouth go dry, his heart was pounding, his hands were shaking and he had hot feelings. His automatic thoughts were, “They will stare at me and make comments (90/100); I will go blank with fear (100/100); People will see my nervousness (80/100); I must be positive (10/100)”. Keketso constructed his idiosyncratic cognitive model with the use of his second situation above.

(d) *An idiosyncratic cognitive model outlining one anxiety-provoking situation for Keketso*

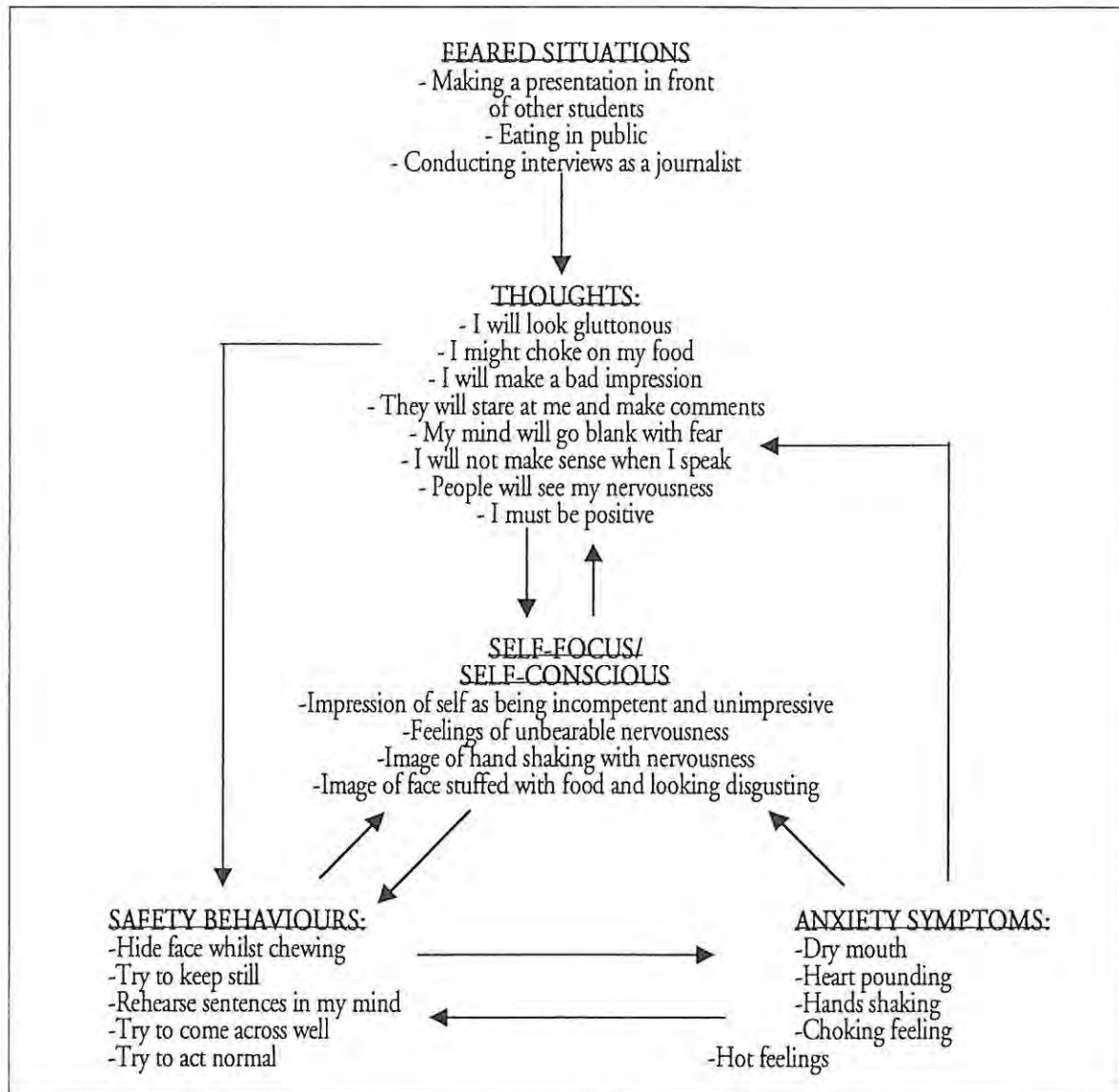
**Figure 3.9: Keketso's personal cognitive model**



The model outlined above (Figure 3.9), was constructed by Keketso, and illustrates the structure of his anxiety response to a socially threatening situation.

Keketso constructed the above model as part of his homework after session 4. His model was discussed in session 5 along with all the other participant's models. Keketso then decided that he would like to role-play interviewing someone important for his SBE. However, he never returned to the therapy programme in session 6 after the 7-week vacation.

**Figure 3.10: Comprehensive cognitive model of all Keketso's anxiety responses in all his feared situations**

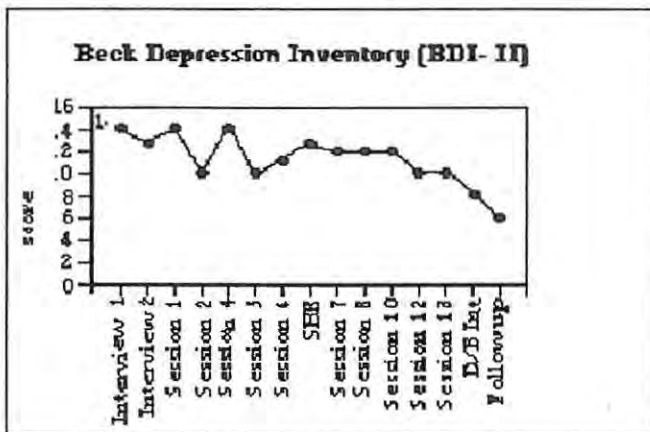


In spite of the fact that Keketso did not return, depicted in Figure 3.10 above, is the structure of Keketso's anxiety responses to all the socially threatening situations in which she had monitored her thoughts and emotions, with the use of the first three columns of the 'Daily Record of Dysfunctional Thoughts'. This comprehensive cognitive model was constructed by the researcher, using information gathered during the first five sessions of the therapy programme (before the 7-week vacation).

### **B) Presentation of Quantitative Data:**

In spite of the fact that Keketso left the group at the end of session 5, graphical representations of his scores from his questionnaires have been depicted below. Keketso sent an email to one of the facilitators expressing that he had too much academic work to worry about, and the group was taking up too much of her time. Keketso refused to meet with any of the facilitators of the group once he decided that he was leaving the group. Therefore, he could not explain any the scores that are represented below. He received no form of debriefing either. These graphical representations show to some extent that Keketso still had a lot of work to do in therapy before he would experience any remission from his social anxieties.

#### **i. Beck Depression Inventory (BDI-II)**



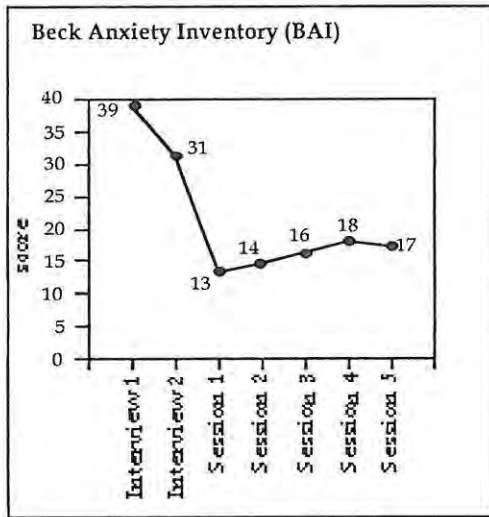
**Graph 3.20**

The BDI-II measured Keketso's levels of depression. Keketso's BDI-II scores are all in the minimal range (0-9) indicating that he had no depression.

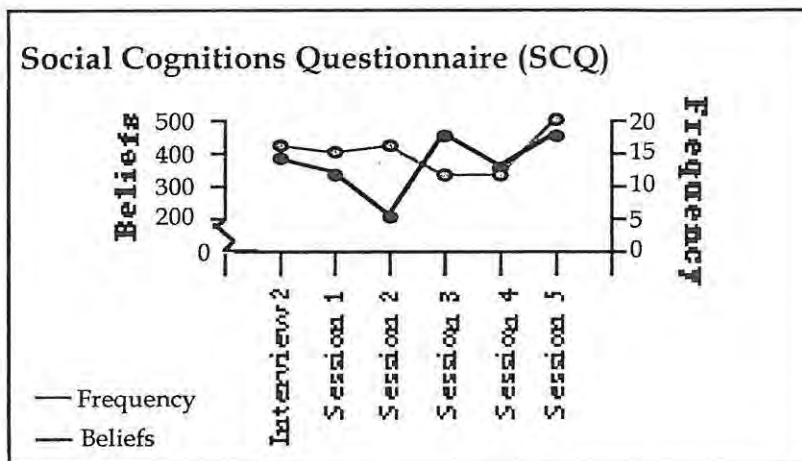
**ii. Beck Anxiety Inventory (BAI)**

The BAI measured Keketso's levels of anxiety. His initial score of 39 indicates severe anxiety, and his level of anxiety gradually decreases to 13, indicating mild anxiety. Thereafter, the increase is most probably due to the experiments he conducted whilst monitoring his thoughts and emotions.

**Graph 3.21**



**iii. Social Cognitions Questionnaire**

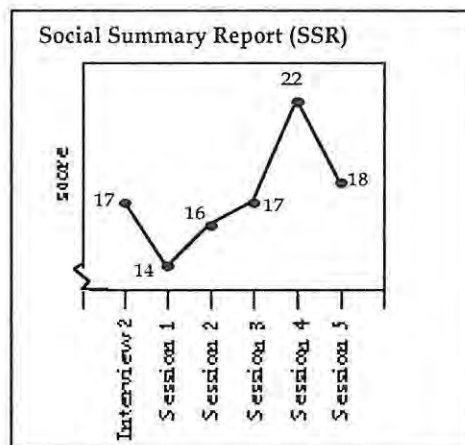


**Graph 3.22**

Keketso had to identify the cognitions he was preoccupied with in social situations, and rate his belief (0-100) in these cognitions, as well as the frequency (1-5) with which these cognitions occurred to him. His initial score of 390/2200 (belief) and 16/88 (frequency), being a relatively low score, indicates that he had specific negative cognitions and core-beliefs. According to his questionnaires, these cognitions included, "People will stare at me (100/100); People are not interested in me (70/100); People will see I am nervous (100/100)". All these cognitions occurred 5/5 times by way of frequency.

#### iv. Social Summary Rating (SSR)

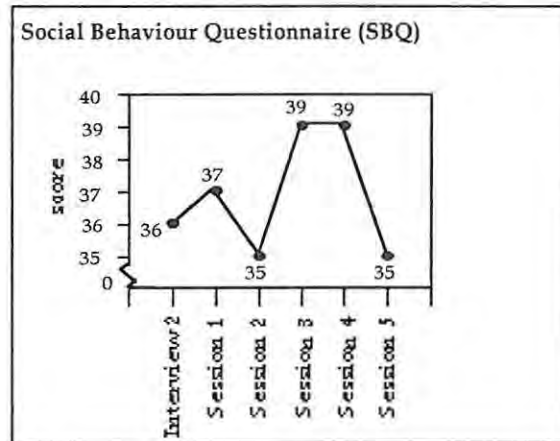
**Graph 3.23**



The SSR measured Keketso's level of anticipatory anxiety prior to social interactions, the degree of self-focused attention in social interactions, and the degree to which he engaged in post-mortem self-critiques. The marked increase between sessions 1 and 4 directly relates to the experiments that Keketso carried out whilst monitoring his thoughts and emotions. He possibly found the experience of challenging his cognitions and fears too anxiety provoking.

#### v. Social Behaviour Questionnaire (SBQ)

The SBQ assessed the degree to which Keketso employed safety behaviours. This graph does not really have much bearing before the SBE is conducted, as participants are not even entirely aware of the way in which safety behaviours affect their social behaviour.

**Graph 3.24**

### 3.2.4 Conclusions around the Drop-Out Cases

Tumi and Keketso never showed any signs that they would dropout during the time that they were attending the treatment programme. When reviewing their scores for sessions 1 to 5, their progress was comparable to other members in the group. Most members in the group have higher BAI; SCQ and SSR scores at sessions 2, 3 and 4. This was because, as part of homework, they were entering socially threatening situations in order to monitor their thoughts and behaviours whilst anxious. Where participants' scores do not increase during this phase, this is because they failed to effectively engage in their threatening situations, either due to avoidance or lack of understanding about how to go about doing the homework.

Tumi's scores are not especially high in these sessions because although she entered her socially threatening situations, she would avoid interacting with people in the situation. Tumi's social anxieties were not attributed to her fear of entering a threatening situation, but interacting with people in the situation. Unfortunately, she never stayed long enough in the treatment programme to explore the possibility of engaging with other people in her threatening situations. Conversely, Keketso entered and interacted in his socially threatening situations and correspondingly, his scores reach their peak between sessions 3 and 4. In these respects, they were not markedly different from other members in the group. Tumi was more like Nick, who entered the socially threatening situation but avoided interaction, and Keketso was more like Ben, who made every effort to experience anxiety so as to monitor his thoughts

and behaviours. Both Nick and Ben, in their different ways, went on to make substantial progress in changing their phobic behaviour.

Tumi and Keketso both participated actively in the construction of their idiosyncratic cognitive models based on their homework assignments and were involved in the group discussions whilst discussing homework assigned to the group. Tumi would only give her opinions and feedback when requested to do so, but she would always make the effort to give constructive feedback to others and try to understand her social anxieties through the exercises. Keketso, being a media studies student, had a clear goal that he wanted to work for South African Broadcasting Cooperation and viewed this treatment programme as his key to achieving this goal. He made the effort to work towards this goal by enthusiastically engaging in the homework assignments, group discussions and exercises that were conducted during the sessions.

During session 5 (before the break in the programme) both of them identified the situations that they wanted to role-play as part of the safety behaviours experiment, which would take place after the vacation. Tumi wanted to role-play a party situation where people that wanted to socialize with her would approach her. Keketso wanted to role-play either having a meal with friends, or a situation where he would interview an important figure at the university. In these aspects, yet again, both of them were actively involved in the activities of the programme, and neither showed any sign that they were considering dropping-out.

Neither Tumi nor Keketso made the effort to formally inform the facilitators or other members that they were leaving the group. Both gave similar reasons for dropping out of the group when contacted. They responded to an email that was sent to them when they did not attend session 6, saying that they were not paying enough attention to their academic work, as the programme was too time-consuming. The facilitators made an effort to ask how the session times could be re-scheduled in order to be less time-consuming and to accommodate them, but neither responded to these emails. Both of them refused to attend a de-briefing session in spite of several requests.

Four hypotheses can be advanced that could account for their dropping out. The first is that they did, as they said, find the programme time-consuming. Second, it could be that they feared the level of exposure they would experience in the safety behaviours experiment and

other behavioural experiments to follow, and this led them to avoid reconnecting with the programme. Third, in the case of Tumi, it may be that she did not feel she was making any progress and she might have found the programme “boring”. In the session feedback questionnaire at the end of session 3, she mentioned as a final comment that she did not understand why they were being made to do so many exercises during the sessions, and she did not feel as though she was making much progress at all. Her lack of progress, however, directly related to the fact that she was not conducting her homework assignments as required for her progress. She avoided interacting in her threatening situations, and therefore never had a chance to experience and monitor thoughts or behaviours whilst anxious. For this reason she might not have experienced the progress that other members of the group were making. This aspect could have even led her to feel somewhat left out of the group experience. Most other members of the group might have been relating to each other, and she did not experience this closeness due to her lack of progress.

A fourth reason that might be considered is that participants felt that they had already gained enough from the programme and could continue on their own. This clearly does not apply to Tumi, but it is possible that Keketso did feel that he was better able to tackle his problems in the future. The only way these hypotheses could have been evaluated thoroughly would have been to interview the dropouts. Unfortunately this was not possible, and so it is not possible to come to a firm conclusion as to the full nature of their motivation for not continuing.

# CHAPTER 4

## DISCUSSION AND CONCLUSIONS

## 4. DISCUSSION AND CONCLUSIONS

### 4.1 Applicability of the Clark and Wells model:

Referring to the processes outlined in the case studies (Section 3.2, Appendix 3), evidence has been provided for the accuracy of the Clark and Wells model. The model outlines how vicious cycles are responsible for the maintenance of SP. In all the case narratives these maintenance cycles are present, and are visually represented in the idiosyncratic cognitive models of each of the participants. The components that form the maintenance cycles that are in the model include, intrusive negative thoughts, use of self-defeating safety behaviours, inaccurate self-processing as a social object, and attentional focus on anxiety symptoms. With the use of examples from the case narratives (Section 3.2), the existence of each component that forms part of the maintenance cycle will be discussed.

#### 4.1.1) **Intrusive Negative Thoughts:**

As predicted in the Clark and Wells (1995) model, all the participants in the group experienced intrusive negative thoughts before entering, whilst in, and after exiting the anxiety-evoking situation. Characteristic examples of negative thoughts that were experienced by the participants before entering the situation are, Sam's thought "I will make a fool of myself", Keketso's thought "They will stare at me and make comments", and Lindiwe's thought "he will think I'm a loser". Characteristic examples of negative thoughts experienced by the participants whilst in the situation are, Mary's thought "They think I make bad tasting tea and want to humiliate me", Tumi's thought "they are ignoring me because they think I am uninteresting", and Nick's thought "I am a loser and they can see that".

The characteristic negative thoughts that participants experienced during the post mortem of the situation only served to heighten their social anxiety with regard to future encounters of a similar given situation. Examples of these thoughts are, Nick's thought "They could see my nervousness and think I am such a loser... I will never be accepted", and Mary's thought "Next Sunday they will ask who made the bad tea and will refuse to let me make tea again". For all the participants, these negative thoughts were essentially predictions and anticipations of negative evaluation, humiliation and rejection by others.

In addition, as predicted by Clark and Wells (1995), the participants' core-beliefs manifested themselves in the negative thoughts that they experienced; for example, Sam (Case 3.2.1) believed that, "I am a social outcast". This core-belief manifested itself in the negative thoughts he experienced, which were for example, "They will laugh at me; They will think I'm queer; I will be an embarrassment". Nick's negative thought, "others must think I am anti-social", became a self-fulfilling belief that "I am anti-social", and this was part of the reason why he found socializing so threatening, even during the large part of the treatment programme.

#### **4.1.2) Safety Behaviours:**

Clark and Wells (1995) outline the self-defeating nature of safety behaviours and the way in which the use of safety behaviours can often result in social phobics' appearing antisocial, unfriendly, inconsiderate or unfeeling towards others. As predicted by Clark and Wells (1995), each of the participants used several safety behaviours in the situations that they found threatening. For example, Nick (case 3.2.2) avoided eye contact and stayed on the edge of groups by standing in the corner of the room when he attended a social gathering. He used these safety behaviours, as he felt socially inadequate. In spite of using these safety behaviours, if and when he was approached by anyone of the opposite sex, he used other safety behaviours in order to conceal his nervousness. These safety behaviours included, planning and rehearsing sentences in his mind and asking a lot of questions, in order to keep the attention of the person he was conversing with; making an effort to speak loudly and clearly, for fear that his voice was inaudible and strange; and smiling a lot, so as to appear interested.

As Clark and Wells predict, and various outcome studies have already confirmed, safety behaviours are self-defeating (Bates and Clark, 1998; Clark and Wells, 1993). This prediction is reconfirmed in this study. Nick did not realize that the safety behaviours he used when attending social gatherings made him appear anti-social. He thought that he was not even being noticed. Secondly, the safety behaviours Nick used whilst conversing with someone of the opposite sex, made conversing with him quite a difficult task. Instead of listening to the answers he was being given for his questions, Nick would be planning and rehearsing his next question. As a result of this safety behaviour, his conversations with others were largely incoherent, and he asked several questions more than once. The persons he conversed with might have found him uninterested in their answers, unfeeling or inconsiderate for continuing

to smile even when they might have said something that saddened them, and strange for talking unnecessarily loudly.

Mary also used safety behaviours that were self-defeating in nature. She thought that by keeping very still and not saying anything whilst at a social gathering (which were her safety behaviours), she would not attract attention to her English accent that was not like the others' accents. However, what she did not realize was that she was eliminating her few chances of making any friends. Her inability to make friends would make her feel depressed and lonely. As Mary discovered during the course of the treatment programme, this safety behaviour of hers was entirely self-defeating as people were in fact attracted to her because of her different accent, and wanted very much to make friends with her.

Similarly, Tumi used specific safety behaviours whilst eating at the dining hall. She would firstly make sure that she was one of the first to enter the dining hall so that she could chose a safe place far away from the others, preferably in a corner somewhere. If people happened to join her at her chosen table, she would try and think of other things whilst eating as quickly as possible, and only answer questions she was asked. Secondly, she would not make conversation for fear of saying something out of place. These safety behaviours were entirely self-defeating as she would get stomach cramps and appear antisocial. She too never managed to make friends due to her safety behaviours.

#### **4.1.3) Self-Processing:**

Clark and Wells (1995) also emphasize the role of self-processing as a means by which individuals guide their behaviour. As Clark and Wells (1995) predict, all the participants in this programme constructed mental representations of the way in which they assumed they appeared to others, and gained perceptions of themselves in social situations based on their biased internal information. These perceptions were invariably inaccurate, unfavourable and unrealistic mental representations. In addition, due to these inaccurate perceptions, their behaviour in threatening social situations was aimed at diverting the attention from their seemingly visible flaws.

For example, Nick assumed that others viewed him as a "small, nervous, visibly shaking", pitiable and a socially unacceptable person. He therefore tried to avoid being noticed and avoided eye contact with anyone. Lindiwe assumed that others viewed her as "overweight and unattractive", and therefore, covered her face and tried not to be noticed, as well. Sam believed that others had an impression of him as being "entirely unfit for society, with big

ears". He left his home with great difficulty every morning and avoided social interaction, in order to avoid being ridiculed. Keketso imagined that others saw his face as "looking stuffed with food and disgusting" while he ate in front of others, and therefore never accepted social invitations to lunches and dinners, and never attended the university 'cheese and wine' parties. However, the participants that remained in treatment until the end of the programme discovered that none of these perceptions were accurate representations of themselves, or the way in which they appeared to others. It is reasonable to conclude, in agreement with Clark and Wells (1995) that the participants' behaviour might in fact have made them more vulnerable to public interest and ridicule. In addition, this kind of behaviour reconfirms the view that social phobics can be seen as antisocial and unfriendly.

#### **4.1.4) Attentional Focus on Anxiety Symptoms:**

Clark and Wells (1995) also suggest that social phobics keep their entire attentional focus on their own emotions and cognitions instead of diverting their attentional focus to the actual social interaction or situation. In this process, social phobic individuals' emotions and cognitions are intensified as they focus solely on themselves. Confirming this suggestion, all the participants found that they had been keeping their entire attentional focus on themselves. They would keep their entire attentional focus on the anxiety symptoms and negative cognitions that they experienced and this would further hamper their social interactions, as they were unable to focus on the actual social interaction. In addition, through this process, their inaccurate mental representations of the way in which they thought others saw them, became further distorted.

For example, Mary (Appendix 3b) experienced uncontrollable shaking in threatening situations, such as when conversing with another person. Her attentional focus would remain on this feeling of uncontrollable shaking throughout the conversation. In addition, she would construct a mental impression of herself as visibly shaking. Part of her attentional focus would then move to her intrusive thoughts about the other person noticing this visible shaking and ridiculing her for this. Mary had assumed that by moving a lot, she would divert the other person's attention from her visible shaking. However, in the process of moving a lot, and focusing on her feelings of shaking, and focusing on her self-image as seen by others as uncontrollably shaking, she would have no more attentional resources to engage in the actual conversation.

Lindiwe would experience a similar process (to that of Mary) each time she tried to dance at a nightclub. She would experience a series of intrusive negative thoughts about her weight. Her attentional focus would remain on these thoughts and her mental impression of herself as being “obese, unattractive and ugly”. Her attentional focus would also revolve around her anxiety symptoms that would be triggered due to her fear of being ridiculed and rejected by others because of her imagined unacceptable appearance. She would feel her stomach cramping, sweat and experience a racing heartbeat. She would imagine that she appeared to others as an obese, unattractive person with rivers of sweat running down her face, and looking flushed due to her racing heartbeat. Owing to the fact that her attentional focus would remain on the experience of these anxiety symptoms and mental impression of herself, she would have no more attentional resources to focus on just enjoying the music and dancing. She would sit in an inconspicuous place in the nightclub and feel miserable about her appearance and uncontrollable anxiety symptoms.

#### **4.1.5) The Clark and Wells Model is Culturally Transportable:**

In addition to the confirmation of the existence of the components of the Clark and Wells model as explained above, there is yet another very interesting finding regarding the applicability of the Clark and Wells model. This is that the Clark and Wells model can be viewed as culturally transportable. With reference to Section 1.5 ‘Outcome Studies’, examples of experimentations with this model by Clark in Oxford, Bates in Canada (Bates and Clark, 1998), Wells in Australia, and with the inclusion of this study in South Africa, there is conclusive evidence that all these studies have yielded similar results.

Within this adapted group programme, apart from the South African participants there was also one participant from Botswana and one from Cameroon. In addition, participants in this programme were raised in urban and rural settings, and were raised with African and European cultures. However, one aspect that does remain constant in all the individualized treatment programmes and this adapted group treatment programme is that therapy has been conducted in English. A hypothesis that requires further research pertains to the possibility that treatment outcomes may differ if the Clark and Wells (1995) treatment is translated into another language. Therefore, at present, the Clark and Wells model can be viewed as culturally transportable with the pre-requisite that participants are fluent in the English language.

## **4.2 An In-Depth Evaluation of the Adapted Clark and Wells Group Therapy Programme**

In this section, *firstly*, the efficacy of the curative process of the group treatment programme will be compared with the Clark and Wells (1995) individualized treatment programme. The ongoing feedback that has been gathered through the session-feedback questionnaires is imperative to this conceptualisation. *Secondly*, the actual adaptation of the individualized treatment programme to the group format will be discussed. The main aim of this section is to evaluate the credibility and acceptability of the adapted group treatment format. For the purposes of this discussion, Individualized Treatment Programme will be abbreviated to ITP and Group Treatment Programme to GTP.

### **4.2.1 Evaluation of the curative process of the adapted GTP when compared with the ITP**

Clark (1997) establishes that in order for the change process in SP to be beneficial, clients have to start processing the social situations that they find threatening in a new way. In order for this to occur, clients have to systematically experience a series of cognitive and behavioural interventions that address the key variables that maintain the social phobia. These key variables include clients' negative thoughts, automatic anxiety symptoms, safety behaviours, and the processing of the self as social object before entering, whilst in and after exiting an anxiety evoking situation. According to Clark (1997), the interaction of the safety behaviours and self-focused attention results in individuals becoming trapped in a vicious cycle in which the evidence they have for their fears is self-generated and any evidence that opposes this self-generated evidence is ignored. In addition Clark (1997) explicates that social phobics selectively retrieve and dwell on negative information that confirms their fears of being socially inadequate.

Clark (1997) suggests that this vicious cycle of social phobia can be broken with the use of behavioural experiments that assist in the process of collecting realistic evidence about social phobics' appearance and social adequacy; and through the process of cognitive restructuring wherein the social phobics challenge their negative cognitions and beliefs whilst constructing positive and more realistic cognitions and beliefs about themselves. This section aims to evaluate and discuss whether the adapted group treatment format developed and used in this study was adequate in achieving successful treatment outcomes. It is imperative to this study

to establish whether the adapted group treatment format was transposed accurately from the Clark and Wells (1995) individualized treatment format, thus producing similar treatment benefits as other individualized format outcomes studies, for example, Bates and Clark (1998) and Clark and Wells (1995).

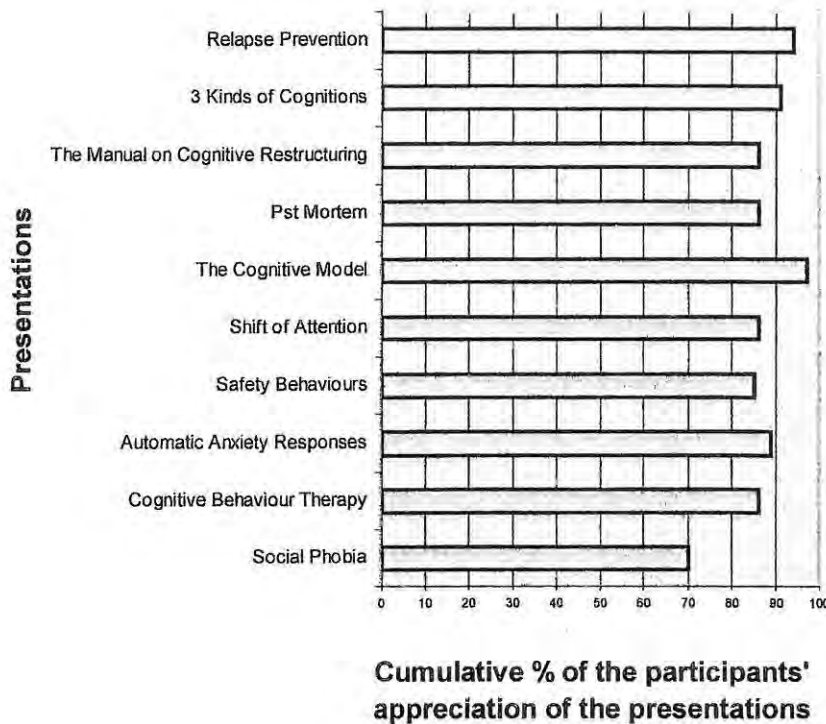
In order to establish the above-mentioned, participants' evaluation of various interventions in treatment as reported in their session-feedback questionnaires (Appendix 5[iii]) and debriefing interview questionnaires (Appendix 5[vi]) are represented graphically. The graphical representations are accompanied by a brief discussion regarding the various interventions. Thereafter it can be established as to whether the programme was an overall success.

The treatment interventions that are evaluated and discussed are, psychoeducational presentations, the awareness exercises conducted during the sessions at the beginning of the programme, the homework assigned throughout the programme, the discussion of homework at the beginning of every session, the SBE and video-feedback of the SBE, on-going use of cognitive restructuring interventions, and usefulness of behavioural (in-vivo exposure) experiments. *All the interventions are graded on a scale of 0 to 6, the highest, most valuable being 6; neutral being 3; and the lowest being 0 on this scale.*

#### **i) Psychoeducational Presentations:**

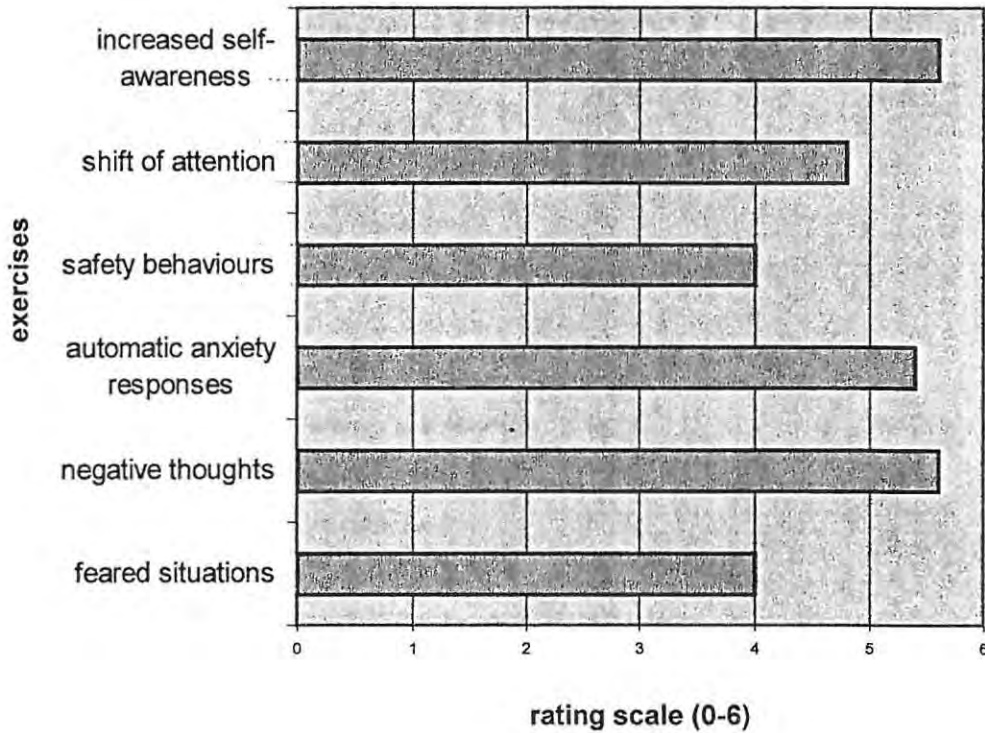
The psychoeducational presentations enabled participants to understand the rationale behind the various treatment interventions, and to understand and identify the various components of the cognitive model that they each idiosyncratically derived for themselves. Depicted in Figure 4.1 below, is a graphical representation of how valuable and understandable the participants found each psychoeducational presentation in the programme. The statistics for this graph were collected from the session feedback questionnaires. Figure 4.1 shows that psychoeducational presentations are of valuable use in the Clark and Wells treatment as each presentation has a success rate of 70% or higher. This confirms the Clark and Wells (1995) prediction that psychoeducational presentations are a necessary part of the treatment programme as they introduce participants to the components and interventions used in treatment.

**Figure 4.1: How valuable and understandable the psychoeducational presentations were for the participants**

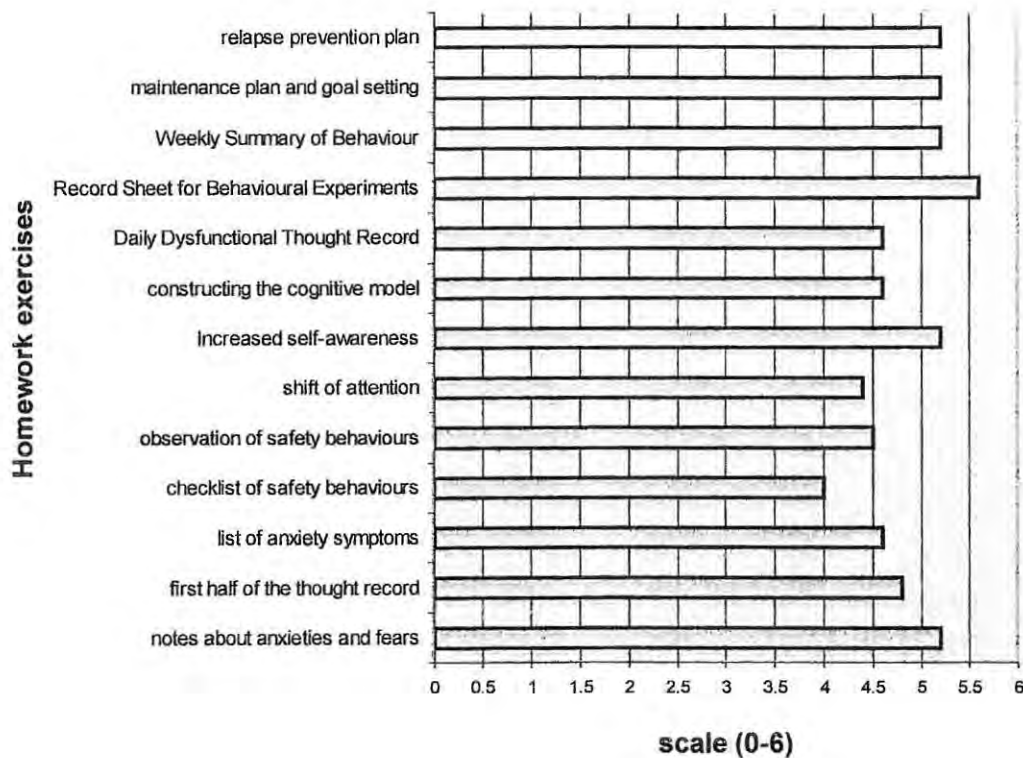


**ii) Awareness Exercises during first four sessions of programme:**

Depicted below in Figure 4.2 are the participants' evaluations of the various exercises that were conducted during the first four sessions of the programme. Sam mentioned at the debriefing interview that, these exercises were valuable for the participants as they "got to know one another and gain confidence in one another" whilst learning more about their cognitions and emotions in anxiety-evoking situations. The other participants gave similar feedback as well. These exercises had reported benefits from the participants as they managed to construct their idiosyncratic cognitive models based on information gathered through these exercises. Therefore, there is conclusive evidence that the exercises were beneficial in achieving one of the treatment aims in the programme, that is, the construction of the participants' cognitive models.

**Figure 4.2: Participants' cumulative evaluation of awareness exercises****iii) Homework assigned throughout the programme:**

As is depicted in Figure 4.3, below, here again participants have evaluated the usefulness and value of the homework assignments on the higher side of the grading scale. Lindiwe mentioned at the debriefing interview that the homework assignments gave invaluable amount of support to the knowledge and insight she gathered for herself during the sessions. Sam mentioned that the homework assignments were useful for him as they consolidated the discussions around the previous sessions' homework. He also mentioned that through the homework assignments, he always learnt something new about himself. [Apart from the record sheets for thoughts and behavioural experiments that are part of the Clark (1997) manual for therapy, the remaining homework assignments were developed by the facilitators of this adapted group study.]

**Figure 4.3: Participants' cumulative evaluation of homework exercises**

#### iv) Discussion of Homework assignments:

The discussions around the homework exercises and assignments have predominantly been evaluated by the participants with a '6', which is the highest mark on the grading scale in the various feedback questionnaires. For this reason it seemed unnecessary to present a graphical representation of this intervention. Participants benefited greatly from the homework discussions as these discussions proved to be the most dynamic part of the sessions. Participants mentioned at the debriefing interview, and wrote on many occasions as final comments in the session-feedback questionnaires that they appreciated the manner in which the cognitive restructuring process was integrated into the homework discussions.

Mary mentioned that, "I felt as though we were targeting our biggest problems that were in our minds in the homework discussions". This statement implied that she felt as though the "biggest problems" were the negative cognitions and beliefs that participants had about themselves, and these "biggest problems" were being dealt with during the homework discussions. Nick mentioned at the six-week follow-up interview that, "it was somewhere in those homework discussions that I began to realize that I don't look so bad to others after

all". This comment is a tremendous credit to the manner in which the homework discussions were conducted, as Nick was one participant who took a very long time to change the impression he had about himself. If even he had realized during these discussions that his impression about himself was inaccurate, the discussions must have been beneficial to all the participants in constructing veridical social images of themselves.

**v) Safety Behaviours Experiment and Video Feedback of the SBE:**

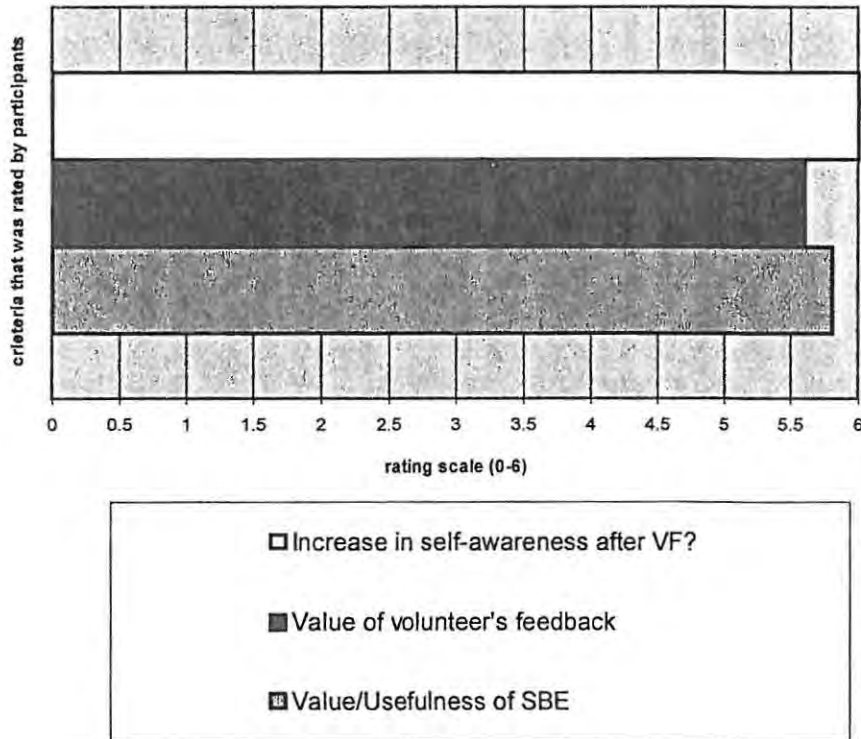
The use of self-defeating safety behaviours were mainly targeted through the safety behaviours experiment (SBE). As predicted by Clark (1997), this aspect of treatment was a critical turning point for most of the participants. Through the participants' experience with the SBE, all the participants realized that many of the safety behaviours they used were dysfunctional and self-defeating, and dropping these safety behaviours was an important feature in reducing their social anxiety. Participants discovered that without their safety behaviours, their social interactions in the second role-play of their SBEs were far more rewarding. They realized that, keeping their attentional focus on the social interaction instead of on themselves enabled them to really engage with the volunteer(s).

In addition, when participants viewed the visual evidence of their improved performance in the second role-play as part of the video-feedback session, it was evident that the SBE was of great value to all the participants. Figure 4.4 (below) is a depiction of the participants' evaluation of the SBE and video-feedback. The data for this graph was collected from the debriefing interview questionnaire (Appendix 5[vi]) wherein participants were required to evaluate the usefulness of the SBE and video-feedback (VF) in their overall treatment benefits.

As is discussed below with examples from the case studies, participants enjoyed three very important reported benefits in treatment as a result of the SBE and video-feedback of the SBE. Firstly, they realized that the mental representations that they had constructed of themselves were inaccurate. Upon viewing their appearance on the television, they realized that they appeared very differently to what they had expected. Secondly, they discovered that the volunteers appreciated their company and presence in social interactions even in the first role-play where they used their safety behaviours and kept the attentional focus on themselves. Therefore, they realized that they were not social outcasts, which was an assumption that most of them had had about themselves. Thirdly, they realized that they appeared far more sociable in the second role-play as a result of dropping their safety behaviours and diverting their

attentional focus to the social interaction. Apart from appearing more social, they had also felt far more at ease with the social interaction when they dropped their safety behaviours.

**Figure 4.4: Participants' cumulative evaluation of their treatment gains: the SBE/Video-feedback**



For example, Mary had constructed a mental representation of herself as “uncontrollably shaking, appearing socially inadequate and speaking in English that is not understandable for others”. During the first role-play, Mary used her safety behaviours which included, moving a lot so as to divert the volunteers’ attention from her shaking, avoiding eye-contact so as to avoid being asked questions where she would be required to answer in her “bad English accent”, and rehearsing/planning questions that she would ask the volunteers, with a proper accent. During the second role-play, Mary dropped all these safety behaviours and diverted her attentional focus to the actual conversation. She answered all the questions that she was asked and in fact made the volunteers laugh several times as she managed to use her good sense of humour with her spontaneous responses and comments.

Whilst viewing her performance in the first role-play as part of the video-feedback, Mary discovered that firstly, her mental representation of herself was largely inaccurate. Her imagined uncontrollable and visible shaking was in fact not visible at all. However, her safety behaviour of moving a lot made her appear nervous and restless. She realized that this safety behaviour had made her appear worse rather than better. She also noticed that by avoiding eye contact and rehearsing questions and answers in her mind, she appeared uninterested in the conversation. She realized that these safety behaviours were in fact creating "a wall around myself from any communication". In the second role-play, where she stood still and only used arm movements as gestures to explain things, she appeared far more confident and in control of her disposition. She also noticed that by looking at the volunteers' faces and being spontaneous, she had made a lasting impression on them.

As predicted by Clark and Wells with regard to clients' experiences in the SBE, Mary had reached her critical turning point in treatment. The visual evidence supported her decision to always keep her attentional focus on the actual social interaction and to make every effort to never use her safety behaviours again. She also realized that merely by doing these two things, she would be able to keep her anxiety levels under control.

Sam, Ben and Lindiwe achieved similar treatment gains from the SBE and video feedback sessions to that of Mary. They too experienced the SBE and video-feedback as their critical turning point in treatment. Nick also reacted to the SBE and video feedback in a similar manner, but did not achieve similar treatment gains. He in fact regressed after the SBE, which was a negative turning point for him. Nick had constructed a mental representation of himself as being "small, puny, visibly shaking, sweating profusely and speaking with an inaudible voice". The safety behaviours he used in the first role-play included speaking loudly in order to be heard clearly, making an effort to keep still so as to control his visible shaking, smiling a lot so as to appear interested, and planning/rehearsing questions in his mind so as to come across well. In the second role-play he dropped all these safety behaviours and managed to have a very sociable and spontaneous conversation with the volunteer.

Whilst watching the video-feedback of the first role-play, Nick realized that his mental representation of himself had been entirely inaccurate. He was not small or puny, he was not visibly shaking, and he did not have rivers of sweat running down his face or wetting his clothes. However, he did notice that with his effort to keep entirely still he appeared uptight

and nervous. By speaking loudly he appeared awkward, by smiling a lot “I appear ridiculous”, and by rehearsing questions and answers in his mind, it was clear that he was not paying attention to the conversation. He asked the volunteer several questions twice. Nick understood that his safety behaviours were more self-defeating than helpful. He was highly impressed by his performance in the second role-play and mentioned several times that he could not believe that “this is me and I am capable of making such an impression on a girl”. He felt at ease in the second role-play and managed to successfully keep his attention on the conversation rather than on his anxiety symptoms.

However, after the SBE, at the following group session, Nick was convinced that he would never be able to perform as well (as he had in the second role-play) in a real-life social interaction. Nick felt as though the SBE had set a false precedent in his life and he was very upset about this. His depression levels had worsened and he experienced more frequent negative cognitions. He felt as though he had all the more reason to believe in these negative cognitions, as the SBE had been a set-up to try and cheat him into believing that he was capable of socializing. This example of Nick’s is evidence that the SBE can have a negative outcome as well. Hereafter Nick took his own time to conduct behavioural experiments where he believed that he was capable of socializing, independent of assistance from the facilitators and other group members.

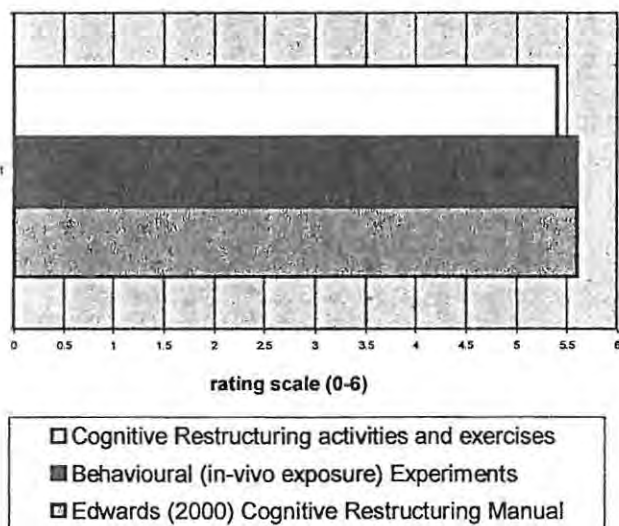
Apart from Nick’s experience, since four other group members experienced a critical turning point after the SBE and video-feedback, there is conclusive evidence that this treatment intervention was of valuable use to the curative process from social phobia.

**vi) Behavioural Experiments (*in vivo* exposure)/ Cognitive Restructuring:**

The behavioural experiments were of utmost importance for all the participants. Clark and Wells suggest that exposure is only useful if the participants process the social situation in a new way. As is clear in the aim of behavioural experiments, which is to “help patients test and disconfirm their negative expectations and beliefs” (Clark, 1997; p. 34), participants learn to process social situations in a new way. The participants who remained in the group until the end of the programme succeeded in processing social situations differently through carrying out regular behavioural experiments and completing their record sheets. Participants found that, the more behavioural experiments they conducted, the more evidence they collected that

helped disconfirm their negative expectations and beliefs; and helped enhance the self-defeating nature of safety behaviours.

**Figure 4.5: Participants' cumulative evaluation of the cognitive and behavioural treatment interventions**



The continuous process of cognitive restructuring was conducted whilst frequenting social situations that participants found threatening. Participants had to engage in behavioural experiments in order to experience negative cognitions and negative beliefs about themselves that they would challenge and test. The evidence they collected in these behavioural experiments assisted them in disconfirming their negative thoughts, predictions and beliefs about the situations that previously threatened them. Through conducting several behavioural experiments, they had created a sufficient number of opportunities to practice replacing negative cognitions with more realistic, positive and self-enriching cognitions. The cognitive restructuring process required the participants to construct veridical social images of themselves, to stop engaging in mind reading of others' impressions about them, to deal with post-mortem, and to deal with unconditional assumptions. With the use of the thought record, the participants were also able to keep track of their improvement.

Nick, for example, realized that he was not going to succeed in treatment unless he started conducting behavioural experiments wherein he would disconfirm his negative beliefs and cognitions. Nick struggled to disconfirm several of his negative beliefs such as, "girls pity me and that's why they approach me and make conversation". In spite of the evidence he collected in the SBE and in the role-play conducted during session 8, Nick insisted that his

belief was true. Nick only managed to begin to disconfirm this belief when girls that recognized him from their dining hall approached him at the computer laboratories. When he realized that these girls had approached him out of their own free will and enjoyed his company, he realized that there might have been some truth in the evidence that had been volunteered to him previously.

Although Nick only managed to conduct constructive, regular experiments after the completion of the programme, his feedback at the debriefing and 6-week follow-up sessions was rewarding for the facilitators and for himself. Nick managed to drop his safety behaviours and have fruitful conversations with girls without feeling pitied. In addition, he managed to collect enough evidence to support his desire to become extremely extroverted, and attend as many social gatherings as possible, without feeling threatened. Conversely, although Mary collected enough evidence to disconfirm her beliefs about being boring and unwanted at social gatherings, she did not feel the need to become an extreme extrovert. Her evidence merely served to make her feel better about herself and to feel confident about herself.

Sam was quick to understand the concept involved in dropping his safety behaviours. He kept reminding himself before each behavioural experiment, that if he managed to drop his safety behaviours, he would be able to cope (better) with the situation that might have otherwise been highly anxiety provoking for him. Lindiwe managed to conduct several behavioural experiments and disconfirmed her beliefs that she was "overweight, unattractive and boring". She eventually managed to dance at a nightclub and actually become the centre of attention due to that fact that she was such a talented dancer. Ben managed to clinch a place in the Rhodes University basketball team after he overcame his beliefs about being "too tall and socially inept".

All the participants realized at some stage in treatment that, by dropping their safety behaviours they were able to encourage the kind of interaction with others that they had always desired. Other people responded and reacted favourably towards them. They also realized that the more behavioural experiments they conducted, the more frequently they were able to practice dropping their safety behaviours. Through the evidence the participants collected in their behavioural experiments, they managed to process the same socially threatening situations in a new way that was more favourable for them. In other words, through these experiments the participants had practiced living their daily lives without their

safety behaviours and had managed to divert their attentional focus onto the actual social interaction, which in turn diverted their attention away from their anxiety symptoms.

All the participants struggled to realize that they had been creating distorted social images of themselves. They also struggled to realize that their inaccurate mental representations only helped to maintain their cycle of social anxiety in specific situations. However, once the participants managed to correlate their successes in their social interactions with their other treatment gains, such as, dropping their safety behaviours, shifting their attentional focus to the actual social interaction, and continually disconfirming their negative thoughts and predictions; they also realized and started to believe that the social images that they had had of themselves had been largely incorrectly constructed. The participants managed to reconsider and reconstruct the social-images they had created of themselves as seen by others; and inevitably, they no longer experienced the anxiety symptoms that they used to experience in the given situations.

All the participants managed to begin the process of disconfirming their inaccurate mental representations of themselves after they viewed themselves in the video-feedback of the SBE. Thereafter, by the end of the treatment programme, participants had constructed veridical social images of themselves that are described as follows. Sam's inaccurate mental representation of himself was of "a socially unacceptable person with big ears". Sam challenged his belief that he was socially unacceptable by engaging in various social situations that would test his social acceptability. He attended several parties and even became termed the "life" of one party. A person who had attended this party mentioned that he would invite Sam to "any party I ever have so that there would be life at my party too" (part of an email from Sam after the completion of the programme). Evidence such as this helped Sam to construct his veridical social image as being "great company, socially competent, still with big ears... but that doesn't bother me anymore".

Lindiwe's inaccurate mental representation of herself was of an "obese, unattractive, ugly, boring person". She too challenged her beliefs about being boring, obese and ugly. She conducted several behavioural experiments that involved meeting and conversing with people of the opposite sex. She would look for evidence in these experiments to see whether the boys/men she spoke with found her boring or unattractive. She also conducted several experiments wherein she would directly ask friends of hers whether she appeared obese. In one of these experiments she tried on clothes of a friend that looked "great in my opinion" and

found that she fitted into her friend's clothes. This was evidence that she was not obese. However, she still considered herself to be slightly overweight and decided to go on a diet to rectify this problem. At the end of the programme Lindiwe had constructed a veridical social image of herself as "good looking, friendly, interesting and attractive enough".

To summarize the above mentioned; the participants had managed to break the cycles that helped maintain their social anxiety. As concluded by Clark and Wells (1995), by breaking the maintenance cycles, the main aim of the treatment programme would be met. In the process of breaking these maintenance cycles, participants had effectively dealt with their anticipatory and post-mortem anxiety as well. The combination of exposure through behavioural experiments, cognitive restructuring, and psychoeducational presentations, proved to be a successful combination in treatment for the participants in the group.

**Edwards (2000) *Cognitive Restructuring Manual*:**

As is depicted in Figure 4.5 above, the Cognitive Restructuring Manual proved to be valuable amongst the participants. This manual primarily served to assist participants in understanding the manner in which cognitive restructuring could be done by themselves. As compared with the ITP wherein clients have the singular attention of the therapist who concentrates on the client's maladaptive cognitions and tackles them at great length with the client, in the GTP each participant had to conduct their cognitive restructuring activities relatively independently. Therefore, this manual "became my best friend" as Ben mentioned. He also mentioned that, "through the use of this manual, I was able to ask about and challenge specific issues about my thoughts during the homework discussions instead of wasting time... the manual gives you the basics... it's up to you what you do with it".

**vii) Final Remarks about the Curative Process in the Adapted Group Treatment Programme:**

Through the graphical representations and the discussion above in this section, there is conclusive evidence that the adaptation of the individualized treatment programme to a group format was successful. All the participants who remained in therapy until the end of the programme achieved complete remission from SP. In addition, each treatment intervention whether adapted for the group setting or conducted in a similar manner to that in the ITP proved to be beneficial in its usage by the participants. The participants have evaluated treatment interventions that were adapted and altered slightly for usage in the GTP and these

evaluations are displayed in the graphical representations above. Upon reviewing these graphical representations, there is no evidence to show that any of these interventions failed to produce the desired outcomes in treatment success. Through the various treatment interventions, participants managed to break their vicious maintenance cycles of SP. Participants managed to successfully learn to process their social interaction in a new way that would abate their social anxieties, thereby making the adapted treatment programme credible.

#### **4.2.2 Formative Evaluation of the Group Process:**

When comparing the Clark (1997) ITP and adapted GTP it is self-evident that the goal of both treatment programmes is the same; the goal being to break the maintenance cycles of SP for the social phobics. The GTP was lengthier (+ 3 sessions) when compared to the ITP. This is however inevitable as the focus of the facilitators is not solely on one person in the GTP.

The main area that needed adaptation from the ITP to the GTP were in the first few sessions wherein exercises were carried out during the sessions to familiarize participants with the various components of the model. At this stage, the group cohesion needed to be formed as well. In the ITP, Clark (1997) suggests that clients construct their idiosyncratic cognitive model in the first session. This would have been impossible to achieve in a group setting with five or more participants as it would have required that all participants familiarize themselves with one another, build trust spontaneously in one another, and almost immediately plunge into the treatment programme on the very first sitting. Therefore, the programme was adapted in such a manner that participants could familiarize themselves with one another whilst familiarizing themselves with the components of the cognitive model.

The exercises were conducted with the co-counselling techniques (Edwards, 1998) wherein participants interviewed one another about their feared situations, negative thoughts, automatic anxiety symptoms, safety behaviours and self-processing/increased self-awareness as a social object. In this way, participants managed to spend personal time with one another and build trust in one another whilst discovering their cognitions and emotions surrounding their social anxieties. Through this process, participants became more confident about sharing their anxieties and fears with one another as they realized that their experiences with their social phobia were similar.

These exercises were conducted over the first four sessions. The cognitive model was then introduced to the participants and they were ready to construct their idiosyncratic cognitive

models as part of the homework assigned at the end of session four. Thereafter, the SBE and video-feedback (VF) of the SBE were introduced to the participants in session 5. A further adaptation had to be made in the way in which the SBE and VF sessions were conducted. Clark (1997) suggests that the SBE be conducted in session 2 and the VF of the SBE be conducted in session 3. Due to the initial delays in the programme wherein the expected outcomes in the ITP for session 1 were only achieved by session 5 in the GTP, the SBE could only be conducted after session 6. The VF sessions were conducted immediately after the SBE instead of in the following session in order to economize on time since the SBE and VF of the SBE were being conducted individually for each participant. Although this was an extremely time consuming process for the facilitators, it was the only realistic way in which participants could conduct their experiments with minimal use of their time. It would have been ideal to have all the participants watching each other's SBEs. However, this would have required an extra 10 (2 hours per participant) hours in therapy for each participant.

Another important adaptation that was necessary for the GTP to be a success was the way in which homework was discussed at the beginning of each session throughout the programme. In the ITP, Clark (1997) suggests that homework be discussed with clients for  $\pm 20$  minutes at the beginning of each session. In a different section, Clark (1997) outlines the separate treatment activities involved in the cognitive restructuring process that includes constructing veridical social images, stopping clients from engaging in mind reading of others' impressions about them, dealing with post-mortem, and dealing with unconditional assumptions. Homework discussions lasted up to an hour or more in the adapted GTP. This was primarily because all the participants had to share their homework experiences. Therefore, for the purposes of time leverage, homework discussions and cognitive restructuring activities were combined in this adapted GTP.

In order to facilitate the adequate understanding of the various cognitive restructuring concepts, psychoeducational presentations were presented to participants wherein core-beliefs, automatic thoughts and underlying assumptions were explained. In addition, the Edwards (2000) manual on *Cognitive Restructuring* was handed out to participants for their use with homework assignments (This manual can be found in Appendix 1 as part of the *Group Treatment Manual*). Through combining homework discussions and cognitive restructuring activities, a considerable amount of cognitive restructuring was achieved through the homework. While participants described their homework record sheets, a group leader used Socratic questioning in order to really challenge participants' thoughts about their threatening

situations. In addition to this, the other participants were invited by the group leaders to participate and help each other identify and reconstruct everyone's negative cognitions. In this manner, participants gained further insight into their own negative beliefs and cognitions merely by deconstructing each other's negative cognitions and beliefs.

Another important reason for targeting the cognitive restructuring process through the homework discussions was that the facilitators would not have had adequate time to spend on each participant's maladaptive cognitions and tackle them in great detail. Therefore, by combining these two treatment interventions, participants were able to practice their own cognitive restructuring process through other participant's experiences. In addition, with the use of the Edwards (2000) Cognitive Restructuring Manual, participants would have been able to conduct a large part of their cognitive restructuring activities independently. Ultimately, owing to the combining of homework discussions with cognitive restructuring activities, the final separate tasks of constructing veridical social images and dealing with post mortem became an ongoing process through the latter half of the programme.

Appendix 1 "Group Treatment Manual" outlines the session-by-session structure of the adapted GTP. This manual must be used as an ancillary manual to the Clark (1997) manual. Suggested alterations that need to be made to the adapted group treatment are discussed below in Section 4.4 under the third aim of this study.

#### **4.3. Advantages and Disadvantages of the Group Treatment Format:**

Referring to the study conducted by Scholing and Emmelkamp (1993b) that has been outlined in Section 1.4.3, the advantages and disadvantages of the group format will be discussed. A brief summary of the advantages and disadvantages that they outline are as follows. The advantages include; the benefit for participants to continually participate and be exposed to a group; participants realization that their problems are similar to everyone else's' in the group; participants made faster progress through vicarious learning from one another's experiences; and participants can help one another to make progress in treatment, for example, by conducting role-plays within the therapy setting. The disadvantages include; the inability for therapists to spend sufficient individualized time with participants in the group setting; some participants become highly anxious merely by being part of the group (this exposure alone is over-bearing); some participants may feel that they are not making sufficient progress when

comparing themselves to the others who have similar problems to theirs; and participants tend to drop-out because group therapy is far more time consuming when compared with individualized therapy.

**i) Advantages of the group treatment format:**

Firstly, participants benefited from the continuous participation and exposure to the group. Nick, for example, had difficulty interacting in the group during the first two sessions. He was visibly anxious about being in a room full of strangers. However, by the third session, he began to participate and it was evident that the mere exposure to the group had helped him make a start in his curative process. At the debriefing interview, Lindiwe mentioned that she always looked forward to coming to the group because she felt as though she had friends again. She mentioned that she enjoyed the participation, mutual understanding, and the unspoken rule that required everyone to share and be involved.

Secondly, when the participants realized that all the members of the group had similar if not worse complaints than themselves, there was visible relief on the faces of the participants. In the first session, after the exercise was conducted on identifying feared situations, participants realized that many of them had similar social concerns and fears. In the initial screening interviews, Sam had mentioned that he was disconcerted at the prospect of sharing his fears with strangers. He mentioned that he knew he would have the worst fears. In addition, he mentioned that the group would reject him. However, immediately after all the members of the group had shared the feared situations that they each had identified, Sam was able to communicate freely and did not appear to be pensive any longer.

Thirdly, all the participants appreciated and benefited from the discussions around participants' irrational thoughts, where the irrational thoughts were challenged by other group members and by the facilitators. These discussions were highly beneficial to the group as participants were exposed to challenging various irrational thoughts, apart from their own. Through this, participants already had an idea of how to replace certain irrational thoughts with more realistic thoughts even though they might not have personally experienced the situation in which the specific irrational thoughts occurred.

In addition, through discussing and challenging all participants' irrational thoughts in the group, which consisted of five participants in the later stages of treatment, each participant enjoyed five times as much practice in cognitive restructuring as opposed to individualized

therapy. In the session feedback questionnaires, participants always acknowledged the invaluable amount of insight they had achieved merely by hearing other members' opinions about their individual experiences, and by listening to what others had experienced. Participants began to serve as models for one another in this process. Through vicarious learning from each other's experiences participants were able to make faster progress.

Fourthly, participants who were frightened of conducting behavioural experiments in real-life situations had the advantage of at least role-playing a situation within the group in order to feel more confident. For example, Nick required an exposure simulation exercise in order to help him feel brave enough to start conducting his own real-life behavioural experiments. This experiment that was conducted within the group was advantageous to the entire group, as all the members were taken step-by-step through the entire process involved in conducting a behavioural experiment. This included challenging negative cognitions, dropping safety behaviours and diverting attentional focus to the actual social interaction. After this role-play was conducted, Nick felt more confident about conducting behavioural experiments and he would not have managed this without the assistance of the other members in the group.

The group cohesion and rapport that each member had with the others was one of the best benefits to all the participants. Especially worth mentioning was the encouragement and assistance that Ben and Lindiwe offered Nick. Ben volunteered to take Nick to a nightclub and help him conduct his behavioural experiment. Lindiwe did special research for Nick and told him about his secret admirers, and about the change that everyone had seen in him, even though he refused to see it in himself. Sam also provided a sizeable amount of support and encouragement to all the group members with his words after his successful behavioural experiment, "I have conquered the worst. Those of you that have not, believe me, it's easier than you think, just try" (Session 11). At the follow-up interview, Sam requested to have his email address distributed to the other group members so that they could contact him if they ever felt as though they were relapsing. These examples are evidence that the group worked as a unit that cared for, and supported one another.

#### **ii) Disadvantages of the group treatment format:**

Firstly, less individualized attention is afforded to each participant, by the therapist, in a group format. In a programme such as the Clark and Wells therapy programme, in which challenging irrational cognitions are an important component in treatment, individualized attention may be

required for certain individuals. However, the psychoeducational presentations that clearly explained all the important processes, discussion of homework which as mentioned earlier involved five times as much practice for each participant with the CR process, feedback from other members in group, and the use of daily homework records, all appeared to compensate for the lack of individualized attention. In addition, the cognitive restructuring activities were facilitated to a large extent with the use of the Edwards (2000) *Cognitive Restructuring Manual*.

All the participants, apart from Nick, were quick to grasp the process by which cognitive restructuring takes place. Nick might not have taken so long to start collecting evidence, conducting behavioural experiments, and challenging cognitions, had he been in individualized therapy. His guided discovery in this programme might have been more beneficial to him with slightly more personalized guidance.

Secondly, a disadvantage that this study's group suffered with, involved the two participants that dropped out after session 5. As mentioned earlier in Section 1.4.3, Heimberg, Dodge & Becker (1987) suggest that some participants become more socially anxious merely by being part of a group. This is a directly opposing argument to the first advantage discussed above. Some people benefit from exposure to a group, whilst others feel more anxious. Keketso (Case 3.2.4) always appeared visibly nervous and had great difficulty when sharing with the group. Although there may be alternative explanations, this may have been the reason why Keketso ultimately dropped-out of the group. During sessions 4 and 5, Keketso mentioned in the group that he had no negative cognitions anymore, and he felt confident to enter the situations he had previously feared. This could have been Keketso's way of trying to convince the facilitators that he was cured and was ready to dropout.

A third disadvantage to a group format is that even amongst people with similar fears, some participants assume that they have no chance of coping with their fears. Such participants assume that they will remain struggling with problems and there is no hope for them. Tumi (who also refused to meet for debriefing) was one of the quieter members of the group although she initially appeared to be enthusiastic about challenging her fears. Her difficulty seemed to lie in her growing conviction (during her stay in the group) to the fact that she was a dislikeable person who was considered nasty and mean by others, and therefore she would never be able to make friends. Nick and Tumi were similar to each other in that, Nick too felt as though he was never going to overcome his social anxiety. However, Nick chose to stay in

the group and catch up with the other participants' successes in treatment. Tumi chose to dropout.

The final disadvantage of group therapy is that, it is far more time-consuming for the participants in the group. Sometimes participants can be discouraged to stay in a group if they are spending considerable time in therapy but not achieving any real treatment gains. Tumi and Keketso mentioned that their reason for not returning to the group was because the group therapy was too time consuming for them. They mentioned that they were neglecting their academic work by attending therapy and by being required to do homework assignments for the therapy.

#### **4.4 Confirmation of the Research Aims:**

The research aims of this study are given in Section 2.1. Following is a discussion regarding the outcomes of these three research aims.

In terms of the **first aim** of this research which involved the adaptation of the Clark (1997) manualized treatment to a group therapy format for SP, the adaptation was successful. This has been explicated in some detail in Section 4.2. The group programme that was carried out was both practical and effective for application to a group context. The evaluation of the practicality of this adaptation is further discussed under the third research aim, below. The effectiveness of the treatment is implied in the successes outlined in the case studies in Section 3.2 above, and under the In-Depth Evaluation of the Adapted Clark and Wells Group Therapy Programme in Section 4.2, above.

In terms of the **second aim** of this research, individual case studies have been constructed (Section 3.2, Appendix 3) and evidence can be drawn from these case studies to conclude that the group process was as effective as individualized treatment. As is discussed above in Section 4.2, the five participants who remained in treatment until the end of the programme managed to break their maintenance cycles of social anxiety which is the principal aim of treatment, as per the Clark (1997) individualized treatment. In addition other treatment aims as per the Clark (1997) criteria that are also discussed under Section 4.2, were effectively met as well. The fact that at the six-week follow-up interview none of the participants had

experienced a relapse; this was evidence that the group process was effective in the long run as well.

In terms of the **third aim** of this research, the practicality of the adaptation of the model was evaluated with the use of the session evaluation forms, by monitoring the participants' progress throughout treatment, and with the use of the debriefing interviews. The discussion of this research aim is complemented with graphical representations, which are used as a means of evaluation of how valuable the participants found each of the components of the group process. These graphical representations and discussions can be found under Section 4.2 and 4.3.2 above.

At the start of the programme (sessions 1 to 4) it was possible to carry out all the planned exercises in the sessions. All the exercises were well received and understood by the participants, and the participants managed to create their idiosyncratic cognitive models with the use of the information they collected from these exercises. In spite of the fact that in the individualized treatment, the patient's idiosyncratic cognitive model is constructed during the very first session, it was necessary to spend four sessions on this process with the group. Participants understood each of the components in the model through the extensively drawn-out exercises. This compensated for the lack of individualized attention and explanation that would have been given to each participant in individual therapy.

Between group sessions 6 and 7, the SBEs and video feedback of the SBEs were carried out individually for all the participants. This aspect of the programme has been examined in some detail under Section 4.2. As from session 7, the main focus of the programme involved the behavioural experiments that the participants conducted, and the CR involved in constructing a veridical self-image, dealing with post-mortem, anticipatory anxiety and dealing with remaining assumptions. Participants conducted behavioural experiments and completed the thought and behaviour records as part of homework. These records and the behavioural experiments were then discussed intensively at the beginning of each session. Through vicarious learning, participants learned a lot from one another's experiences and helped each other challenge thoughts, assumptions and emotions. In this process the treatment component of CR effectively took place. The group actively got involved in each other's feared situations and avoided making the same mistakes made by someone else in the group. Therefore, the learning process involved in breaking the maintenance cycles was hastened.

#### **4.5 Final conclusion**

An adapted cognitive behaviour group treatment programme was applied to the treatment of seven social phobic university students (2 of whom dropped out) who all experienced debilitating social anxiety in a various threatening social situations. This experience of social anxiety had severely restricted their capacity to socialize with others. In addition, some participants experienced secondary problems that included mild depression, demoralization, low self-esteem and helplessness about their social inadequacy. The success of this treatment programme's approach has been attributed by participants to one or more of the following. The realization that their mental representations of themselves was severely distorted; their core-beliefs about social rejection had been too strong and refused reality testing until they joined the programme; realizing that letting go of safety behaviours was pivotal to making social interactions comfortable and spontaneous; and realizing that focusing their attention on the social interaction reduced their automatic anxiety symptoms, and made the interaction more meaningful. Through the regular completion of homework assignments and exercises, participants constructed new mental representations of themselves that were more meaningful and positive. In addition, they disconfirmed several negative beliefs and assumptions they had had about themselves.

This study represents encouraging preliminary research with the adapted Clark (1997) treatment programme to a group format. The detailed 'Group treatment Manual' that should be used as an ancillary document to the Clark (1997) manual is given in Appendix 1. In terms of future implementation of this programme and recommendations for subsequent group therapy, the researcher suggests that the group manual (Appendix 1) and the agenda adopted by the research team can be applied to group therapy for SP with no revision. The researcher further suggests that the next phase in similar research around group therapy for SP should involve a control group in conjunction with the adapted Clark CBGT applied in this study. A group treatment comparison between the Heimberg et al. CBGT and the adapted Clark CBGT would be valuable to the knowledge around CBGT for SP.

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**VOLUME  
TWO**

# APPENDICES

## Appendix 1

### The Group Treatment Manual

#### ADAPTATION OF THE CLARK (1997) MANUAL FOR THE GROUP TREATMENT OF SOCIAL PHOBIA

In order to conduct group therapy with the Clark (1997) manual for individualized treatment of Social Phobia (SP), certain areas of the manual needed to be adapted to a group format. Following is a manual that outlines the way in which the areas in the Clark (1997) manual were adapted to the group format for the purposes of research at Rhodes University, SA. The following manual must be used as a supplementary document to the Clark (1997) manual for the purposes of further research or application.

Each session is described in detail. After the description of each session, copies of the exercises, homework assignments, and handouts issued to participants during the session, are attached. In addition, the overheads used for didactic purposes are included as well.

## SESSION 1

### Agenda:

1. Complete questionnaires: BDI-II, BAI, FNE, SCQ, SAQ, SBQ, SSR
  2. Introduction of participants and facilitators to one another
  3. Sign Contracts
  4. Introduce Social Phobia
  5. Introduce Cognitive Therapy
  6. Awareness exercise 1: "Identifying feared situations"
  7. Group discussion about feared situations
  8. Explain homework exercise
  9. Complete session feedback questionnaire
- 

### 1. Questionnaires

As standard procedure, the following questionnaires are to be completed by participants at the beginning of each session; the Beck Depression Inventory (BDI-II), Beck Anxiety Inventory (BAI), Social Summary Rating (SSR), Social Behaviour Questionnaire (SBQ) and the Social Cognitions Questionnaire (SCQ). In addition, at the beginning of the first and final sessions of the programme, the Social Attitudes Questionnaire (SAQ) and the Fear of Negative Evaluation (FNE) Questionnaires are completed as well. Copies of the questionnaires can be found in the Clark (1997) manual.

### 2. Introduction

Introductory exercise:

Any exercise that is conventionally used to introduce participants of a group to one another can be used. The exercise that was used in the Edwards, Kannan and

Henwood (2000) programme is described with the following. The participants and facilitators must sit in a circle. A ball of string is passed (tossed) at random from one individual to the next. Each time the ball of string is passed on, the last person to have caught the ball of string should hold onto a piece of the string in order to form a web in the centre of the circle. Before passing the ball of string to the next person, each person has to introduce oneself with one's name and any two facts about oneself that one would like to share with the group.

The aims of this exercise are to introduce everyone to one another, and to show that the group is connected through the web that has been formed. Through demonstration it is shown that even if one person lets go of their string in the web, the web is destroyed. The web signifies the group's oneness and harmony that binds everyone together. All the members of the group know one another now, and the pact has been made to honour the group in order to try and avoid the chance of people dropping out of the group.

### 3. Contract signing

Now that the pact is created, and everyone is comfortable with being a part of the group, the contracts can be signed. The contract used in the Edwards, Kannan and Henwood (2000) programme can be found after this description of session 1.

### 4. Introduce Social Phobia

Using the overhead entitled "Social Phobia", social phobia is explained to the participants. A handout entitled, "An introduction to social phobia", is handed out to participants for their perusal.

### 5. Introduce Cognitive Therapy

Using the overhead entitled "What is cognitive therapy", cognitive therapy is explained to the participants. A handout entitled "An introduction to Cognitive

Therapy", is handed out to participants for their perusal.

#### Co-counselling for the exercises conducted during the sessions

With reference to Edwards' (2000) co-counselling techniques, members of the group are paired off for the various exercises that participants carry out during the sessions. Pairing participants provides a chance for each participant to learn more about another participant on a one-to-one basis. For every different exercise that participants are paired in this manner, each participant has to find a new partner. Therefore, by the end of the 6 different exercises (one or two per session), at the start of the programme, every participant knows one another through their individualized interaction with each other.

The six different exercises that are carried out during the first four sessions of the programme will help participants gather information that they will use to construct their idiosyncratic cognitive models. A copy of a blank cognitive model follows after the description of session 1.

#### 6. Awareness exercise 1: "Identifying feared situations"

Participants pair off in order to carry out an exercise that involves gathering of information about their feared and avoided situations (i.e. block 1: situation in the cognitive model). Participants are given a sheet of questions as a guide to carry out structured interviews with each other. Each participant has their turn to be the interviewer and interviewee, respectively. A copy of the list of questions used for this exercise follow as "exercise 1". Participants write down the answers of their partners.

#### 7. Group discussion about feared situations

After the exercise, which should last + 20 minutes (10 minutes per person in the pair), participants rejoin the group and each member of the group has the opportunity to discuss the situations they have identified as feared situations. Facilitators have a

chance at this stage to make participants aware of the fact that these are the situations in which the participants are experiencing SP. The same procedure of discussing the exercises is followed for the remaining five exercises that will be carried out over the course of the following three sessions. Depending on the various aspects that each exercise is highlighting, the facilitators have a chance to explain how this aspect also fits into the model of social phobia for each participant.

#### 8. Explain homework exercise

The homework exercises are explained to participants at the end of each session. "Homework Exercise 1" follows at the end of this session's description. As part of the homework for session 1, participants are required to imagine what their lives would be like if they did not have any anxieties or fears. This involves making a list of what they would do in the situations that they have identified as feared situations, if they did not experience fear or anxiety. In particular, what would they do differently? Apart from this, participants have to make a list of all the goals that they had failed to achieve in their lives because of the fears and anxieties they experience. In addition, they have to make a list of their goals that they would like to achieve in this programme. The importance of goals for the programme is highlighted as this may give the participants a sense of purpose and motivation that is aimed at a worthwhile goal as a result of the group therapy.

#### 9. Session Feedback Questionnaire

As standard procedure, at the end of each session, the session feedback questionnaire (SFQ) needs to be completed. A copy of this questionnaire follows. This questionnaire gives appropriate information to the facilitators about where participants are still facing difficulties, and what the participants would like to see changed about the programme. Facilitators need to review the session feedback questionnaires after each session in order to make the necessary changes that have been requested or implied in the SFQ by participants.

## Resources used in Session 1 (that follow):

- Example of a contract
- Overhead: "Social Phobia"
- Handout: "Introduction to Social Phobia"
- Overhead: "What is Cognitive Therapy"
- Handout: "An Introduction to Cognitive Therapy"
- Blank model for reference in relation to exercises 1-6
- Exercise 1: "Identifying feared situations"
- Homework exercise 1
- Motivational quotes for participants (to be handed out to participants, if desired)
- Session feedback questionnaire

Rhodes University Department of Psychology  
Psychology Masters Research Project

**CONSENT FORM**

I, ....., agree to participate fully in the Psychology Masters Research Project entitled,

**"An Evaluation of the effectiveness of a group therapy programme for social phobia among a group of students at Rhodes University."**

Requirements:

- 1) I agree to attend each weekly session, for one-and-a-half hours, or as decided upon by the group, until the programme is completed.
- 2) I agree to complete all the assessment forms throughout the duration of the programme.
- 3) I agree to complete the required assessment interview at the start of the programme.
- 4) I agree to complete the required homework assignments after each session.
- 5) I agree to participate in the debriefing interviews at the end of the programme.
- 6) I agree to allow the assessment and debriefing interviews to be tape- recorded and videotaped.
- 7) I understand that I will be expected to attend the one and two month follow-up sessions that will follow upon completion of the therapy.
- 8) I understand that the project will include case narratives or case vignettes. However, names of the participants will be altered.
- 9) I agree to maintain complete confidentiality concerning all information disclosed about the group members.
- 10) I understand that, should I for any reason need to withdraw form the programme, I am able to do so. However, I must discuss this with the group facilitator.

Signed by  
Research participant: .....

Date: .....

Signed by  
Researcher: .....

Date: .....

# Social phobia

## What is it?

Feeling **anxious** or **uncomfortable** in certain social situations.

## What are these situations?

- Making conversation in a group
- eating in public
- writing in public
- fear of showing signs of anxiety

## Where does this leave you?

shaking, sweating, blushing, crying, dizzy

## End result?!

Fear of being **rejected**, **humiliated**, or just **performing badly**

## What happens then?

**Avoidance** of the situation

**Endurance** of the situation with **great difficulty**

## AN INTRODUCTION TO SOCIAL PHOBIA

### What is social phobia?

It is common to feel anxious or uncomfortable in certain social situations. Many people for example, become nervous when asked to speak in front of an audience. Even seasoned actors and teachers experience anxiety in social situations. This type of situation is uncommon for many people, but anxiety can still occur in more usual day to day situations which involve you and one or more other people. For instance you may feel anxious making conversation in a group, you may feel conscious eating or writing in public, or you may fear showing signs of anxiety such as shaking, sweating or blushing. These are all examples of social phobia, in which a person fears being conspicuous, making a fool of themselves or performing badly in social situations.

Different people have different worries when in social situations and different combinations of anxiety symptoms. Some symptoms are physical and include: shaking, sweating, blushing, crying, dizziness, speeded heart rate, voice tremor, dry mouth. Other symptoms include difficulty concentrating, getting words wrong, difficulty thinking, mind going blank and so on.

Avoidance is a common feature of social phobia. You may have found that you avoid certain social situations, or you may find that you usually go into situations but you usually feel uncomfortable in them. It may be very specific circumstances that trigger your anxiety, or it may be that you feel anxious in a range of situations.

# What is cognitive therapy?

- A structured process
  - Based on tested models of specific problems
  - Approach to social phobia developed at Oxford University for individuals
  
- The programme
  - Personalized programme for each participant
  - Detailed analysis of the problem through questioning and self-monitoring exercises
  - Detailed checking of what happens using video feedback
  - Learning new ways of thinking and behaving
  - Experimenting with new ways of behaving and thinking in role play
  - Graded exposure to anxiety provoking situations
  - Regular feedback, review of progress and adjustment of programme to suit individual

## AN INTRODUCTION TO COGNITIVE THERAPY

### What is Cognitive Therapy?

Cognitive Therapy is a well respected psychological treatment for emotional disorders such as anxiety disorders, depression and inappropriate anger. Cognitive Therapy is based on the idea that emotional disorders can be treated by identifying the false, illogical, and negative thinking that causes and maintains our negative emotions, and by changing it. This is often accomplished by carefully monitoring your thoughts during periods of distress. Very often individuals with these thoughts are not aware of their inappropriate and negative thinking since the thoughts can be very automatic or "unconscious". Therapy is therefore directed at clarifying these thoughts and working to develop a different set of attitudes and attributions. In this programme you will work within the group and alone to identify key thoughts and behaviours which help to maintain your problem. Special techniques are used to help you determine how realistic your thoughts are, to find out what to do to change the way you feel in social situations, and to try to improve the way you see yourself.

Our group represents a group Cognitive Therapy programme. This means that you have the opportunity to learn the skills to help you to identify and change your negative thinking in a classroom-like setting. It does not mean sitting around with a group of strangers discussing your private life, but instead a being involved in a series of discussions and exercises together as a means of learning together and guiding one another.

Situation ①

Thoughts ②

Self-focus ⑤

Safety Behaviours ④

Anxiety Symptoms ③

## Exercise 1

### Feared or Avoided Situations

1. What types of situations do you fear?
2. Which of these situations are avoided?
3. What are the main things you are afraid may happen in these situations?
4. What are you afraid people will think about you?

"Courage is the capacity to confront what can be imagined..."

## Homework Exercise 1

Try to imagine some of the things you may have done without your anxiety or fears.

Make a list with these questions in mind.

1. What might I have done in situations if I did not experience fear or anxiety?
2. What specific activities would I be engaging in which I am now avoiding?
3. What goals have I failed to achieve because of my problem?

Also think about some of your goals for this programme. What are you hoping to achieve or gain. This is important as it can give you a sense of purpose and motivation aimed toward a worthwhile goal.

"Don't ever stop trying to get where you always wanted you be.

The moment you stop trying,

Is the moment your dreams stop coming true..."

Rebekah Shing

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*"Change is the end result of all true learning. Change involves three things: First, a dissatisfaction with self - a felt void or need; second, a decision to change - to fill the void or need; and third, a conscious dedication to the process of growth and change - the willful act of making the change ...Doing Something."*

Leo Buscaglia

"The greatest challenges of your lifetime,  
And thus the greatest rewards,  
Should be the ones you create,  
Because you are the only one  
That can look deep inside your inner self  
To determine what fears must be conquered."

Gary Harrington

"To dream anything that you want to dream -  
that is the beauty of the human mind.  
To do anything you want to do -  
that is the strength of the human will.  
To trust yourself to test your limits -  
that is the courage to succeed."

Author Unknown

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## REPORT ON THERAPY SESSION

Name: \_\_\_\_\_

Date of session: \_\_\_\_\_

Main goal(s) of session: \_\_\_\_\_

**PART I. Please circle your response on the scales given to each of the following:**

1. Before you came in today, how much progress did you expect to make in dealing with your problems **in today's session?**

1    2    3    4    5    6    7  
MUCH                      SOME                      NO  
PROGRESS                      PROGRESS                      PROGRESS

2. **In today's session**, how much progress do you feel you actually made?

1    2    3    4    5    6    7  
MUCH                      SOME                      NO                      THINGS  
PROGRESS                      PROGRESS                      PROGRESS                      GOT WORSE

3. **In future sessions**, how much progress do you think you will be able to make in dealing with your problems?

1    2    3    4    5    6    7  
MUCH                      SOME                      NO  
PROGRESS                      PROGRESS                      PROGRESS

4. How satisfied are you with **today's session?**

1    2    3    4    5    6    7  
VERY                      SATISFIED                      INDIFFERENT                      DISSATISFIED  
SATISFIED

5. **In today's session**, how well do you think the facilitators understood your problem?

1    2    3    4    5    6    7  
VERY                      FAIRLY                      POORLY  
WELL                      WELL

6. How well were you able to convey your problems or concerns **in this session?**

1    2    3    4    5    6    7  
VERY                      FAIRLY                      POORLY  
WELL                      WELL

7. **In today's session**, did you find that everyone in the group had an equal opportunity to speak about their problems, or did certain people dominate the discussions?

1    2    3    4    5    6    7  
VERY                      FAIR                      DISCUSSIONS                      DISCUSSIONS WERE  
FAIR                      OPPORTUNITY                      WERE DOMINATED                      VERY DOMINATED  
OPPORTUNITY                      BY SAME PEOPLE                      BY SAME PEOPLE



**PART IV. Rate the extent to which you gained the following skills in today's group session. Please refer only to this session. Keep in mind that not all of these skills can be gained in any one session.**

		VERY MUCH	SOME	NONE
1.	Better insight into and understanding of my psychological problems.	1	4	7
2.	Methods or techniques for better ways of dealing with people (i.e. asserting myself).	1	4	7
3.	Techniques in defining and solving my everyday problems.	1	4	7
4.	Confidence in undertaking an activity to help myself.	1	4	7
5.	Greater ability to cope with my anxiety.	1	4	7
6.	Better control over my actions.	1	4	7
7.	Greater ability to <b>recognize</b> my unreasonable <b>thoughts</b> .	1	4	7
8.	Greater ability to <b>correct</b> my unreasonable <b>thoughts</b> .	1	4	7
9.	Greater ability to <b>recognize</b> my self-defeating or erroneous <b>assumptions</b> .	1	4	7
10.	Greater ability to <b>evaluate</b> my self-defeating or erroneous <b>assumptions</b> .	1	4	7

**PART V. (i) Please describe the most outstanding aspect of today's session, (ii) any interests or concerns you would like to share. (Please write on the other side of the page if this space is inadequate).**

## SESSION 2

### Agenda:

1. Complete questionnaires: BDI-II, BAI, SCQ, SBQ, SSR
  2. Review/Discussion of homework
  3. Explanation of negative thoughts
  4. Awareness Exercise 2: "Identifying negative thoughts"
  5. Group discussion about negative thoughts
  6. Presentation on "Automatic Anxiety Responses"
  7. Awareness Exercise 3: "Automatic Anxiety Responses"
  8. Group discussion about automatic anxiety responses
  9. Explain homework exercises
  10. Complete session feedback questionnaires
- 

### 2. Review/Discussion of homework

As standard procedure, at the beginning of each session from session 2 onwards, participants are invited to share their homework with the group. This involves explanation of the behavioural exercises they conducted (from session 3 onwards), description of their findings about themselves, lists of goals or safety behaviours, anxiety symptoms and unnatural self images they have made for/ recognized in themselves, experience of post mortem etc. Whatever homework was assigned is discussed at the beginning of each session.

Whilst discussing homework participants will invariably also mention their

achievements whilst conducting the homework assignments/experiments. This is positive feedback for all members in the group as each member then realizes what he or she is capable of achieving as well.

Homework discussions normally take up at least half the session. Participants are conducting behavioural experiments wherein they are monitoring their thoughts, anxiety symptoms, safety behaviours and imagined self-representations of themselves. Therefore, they each require at least 10 minutes of individualized attention from the facilitators, whilst they challenge their negative thoughts and beliefs.

### 3. Explanation of negative thoughts

Involves a quick explanation about negative thoughts and how they are intrusive in the situations that are feared or anxiety provoking. The exercise that participants carry out in order to identify their negative thoughts will help them to fill block 2 in their cognitive model: thoughts.

### 6. Presentation on "Automatic Anxiety Responses"

Using the overhead entitled "Automatic Anxiety Responses", anxiety symptoms are explained to the participants. A handout entitled, "Automatic Anxiety Responses", is given to participants for their perusal. The exercise that follows this explanation, that is, exercise 3: Automatic Anxiety Responses is used to help participants fill block 3 of their cognitive models: anxiety symptoms.

### 9. Explain homework exercises

Now that participants are aware of the specific negative thoughts and anxiety symptoms they experience when they engage in feared situations, the next step is for them to monitor these thoughts and symptoms whilst in situations that they fear. For this purpose, participants are given the first three columns of the "Daily Record of

Dysfunctional Thoughts". The reason for giving only the first three columns is so that participants can start to familiarize themselves with the use of the record. In addition, the remaining columns of the record will only make sense to them once they have conducted their safety behaviours experiment and are ready to conduct similar behavioural experiments on their own. It is explained to participants that they need to complete the three columns of the daily record of dysfunctional thoughts as part of homework for the remainder of the programme. Therefore, each time they experiment with an anxiety provoking or feared situation, they need to note down the negative thoughts they had in that situation. Two copies of this record are handed out to participants at the end of every session.

In addition to the record, participants are given an assignment wherein they are required to list their anxiety symptoms. They are required to imagine anxiety provoking situations that vary in the intensity of anxiety they feel. For each anxiety-provoking situation, they should try to remember the automatic anxiety symptoms they experienced, and note this down.

### **Resources used in Session 2 (that follow):**

- Exercise 2: "Identifying negative thoughts"
- Overhead: "Automatic Anxiety Responses"
- Handout: "Automatic Anxiety Responses"
- Exercise 3: "Automatic Anxiety Responses"
- Daily Record of Dysfunctional Thoughts (first three columns only)
- Homework exercise: Making a list of anxiety symptoms



## AUTOMATIC ANXIETY RESPONSES

### \* **DEFINING ANXIETY:**

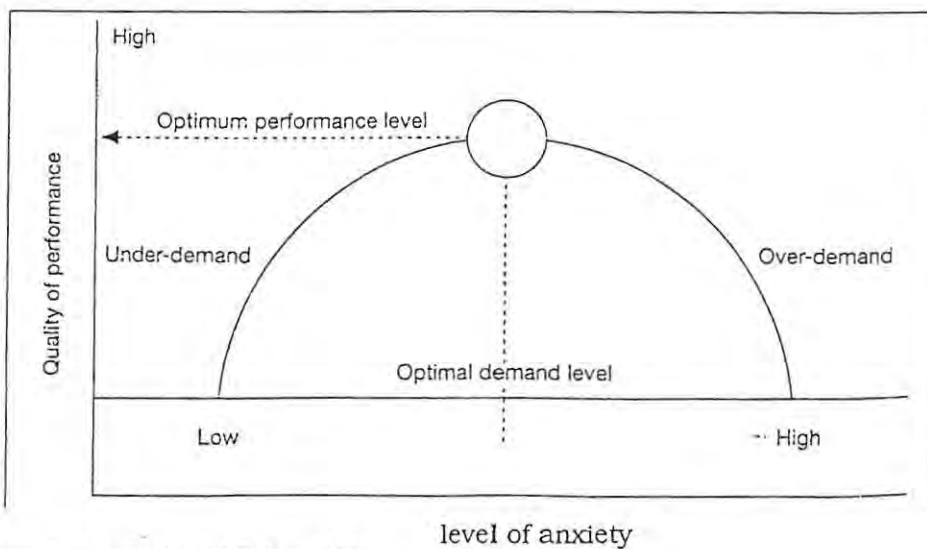
Anxiety, most generally, is a vague, unpleasant emotional state. When anxious, you experience feelings such as apprehension, dread, distress, and uneasiness. You will feel anxious when you are faced by a threatening situation.

### \* **AUTONOMIC NERVOUS SYSTEM**

### \* **SYMPATHETIC NERVOUS SYSTEM**

- \* **perspiration:** you sweat in order to cool your body, as many of us feel unnecessarily hot.
- \* the **bronchioles in the lungs dilate** (or expand) to allow a greater flow of oxygen.
- \* **breathing becomes more rapid** so that extra oxygen is available.
- \* **heart rate and blood pressure increase.**
- \* **pupils dilate** to allow more light to enter the eyes.
- \* digestion and other intestinal activities are inhibited or slowed down to allow blood, which otherwise would be needed there, to be used for more important functions: **butterflies in your stomach.**

### \* Symptoms of anxiety can be 'enabling' and disabling'



(Low & Edwards, 1997. p. 610)

## AUTOMATIC ANXIETY RESPONSES

### Defining anxiety

Anxiety, most generally, is a vague, unpleasant emotional state. When anxious, you experience feelings such as apprehension, dread, distress, and uneasiness. You will feel anxious when you are faced by a threatening situation.

### What happens to our bodies when we are in a threatening situation?

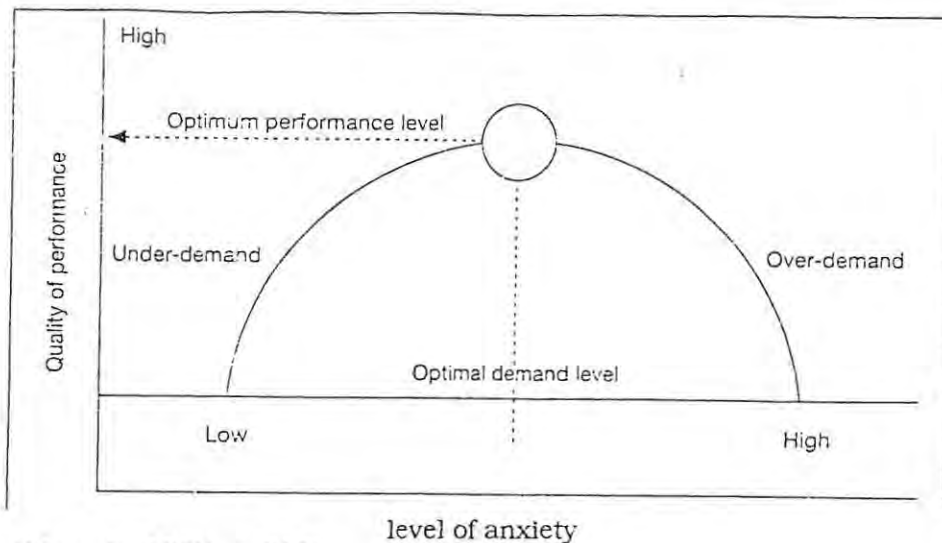
This is something you might have already discovered when answering some of the questionnaires. You are asked whether you experience feelings, such as, numbness, tingling, dizzy, lightheaded, your heart beats faster, shaky, face is flushed, faint, and other symptoms. These are the things that happen to your body when you are anxious. However, is it not amazing that your body reacts when in actual fact, it is your mind that realizes that you are in a threatening situation. This is explained as follows: Our bodies have a system called the "**autonomic nervous system**". This system functions without any conscious control over it. In other words, it works automatically. This autonomic nervous system has two parts, namely, the "sympathetic nervous system" and the "parasympathetic system". We are interested in particular with the sympathetic nervous system.

### The sympathetic nervous system

The sympathetic nervous system is responsible for 'sympathetic' functioning between the internal organs and the central nervous system. This system mobilizes the body's resources for physical and/ or psychological arousal in emergency situations. This is why, when you are in a threatening situation and start experiencing anxiety, the sympathetic nervous system starts to have effects that are visible as physical responses that you can actually feel. Arousal of the sympathetic nervous system (SNS) is called the "fight or flight" response. Some of the symptoms or effects of the SNS as you would feel them are as follows:

- \* perspiration: you sweat in order to cool your body, as many of us feel unnecessarily hot.
- \* the bronchioles in the lungs dilate (or expand) to allow a greater flow of oxygen.
- \* breathing becomes more rapid so that extra oxygen is available.
- \* heart rate and blood pressure increase.
- \* pupils dilate to allow more light to enter the eyes.
- \* digestion and other intestinal activities are inhibited or slowed down to allow blood, which otherwise would be needed there, to be used for more important functions: butterflies in your stomach.

Symptoms of anxiety can be 'enabling' and disabling'



(Louw & Edwards, 1997. p. 610)

The picture above expresses that, it is good to have a certain level of anxiety as you perform optimally when anxiety is there. In other words, the symptoms of anxiety that you are experiencing are "enabling" better performance. However, when the anxiety becomes too much, your performance starts to deteriorate. In other words, the symptoms of anxiety that you are experiencing are "disabling" better performance.

[This and more information about this topic can be found in:  
Louw, D. A. & Edwards, D. J. A. (1997). Psychology. An introduction for students in South Africa. (pp. 98- 99, 610) Johannesburg: Heinemann.]



DAILY RECORD OF DYSFUNCTIONAL THOUGHTS

DATE	SITUATION 1. Actual event leading to unpleasant emotion or 2. Stream of thoughts, daydream, or recollection, leading to unpleasant emotion	EMOTION(S) 1. Specify sad/anxious/angry, etc. 2. Rate degree of emotion 1-100	AUTOMATIC THOUGHT(S) 1. Write automatic thought(s) that preceded emotion(s). 2. Rate belief in rational response, 0-100%

EXPLANATION: When you experience an unpleasant emotion, note the situation that seemed to stimulate the emotion. (If the emotion occurred while you were thinking, daydreaming, etc., please note this.) Then note the automatic thought associated with the emotion. Record the degree to which you believe this thought: 0% = not at all; 100% = completely. In rating degree of emotion: 1 = a trace; 100 = the most intense possible.

Homework assignment: session 2

Name: \_\_\_\_\_

### List of anxiety symptoms

Write down the symptoms you experience in situations that create anxiety for you. Use the following order to establish for yourself the symptoms you experience depending on the intensity of the anxiety provoking situation.

5. most anxiety ever

4. very anxious

3. Anxious

2. Mildly anxious

1. No symptoms

## SESSION 3

### Agenda:

1. Complete questionnaires: BDI-II, BAI, SCQ, SBQ, SSR
  2. Review/Discussion of homework
  3. Explanation about safety behaviours with case studies and the safety behaviours checklist
  4. Awareness Exercise 4: "Safety Behaviours" (to fill block 4 in the model)
  5. Group discussion about safety behaviours
  6. Presentation on "Shift of Attention and Increased Self Awareness"
  7. Awareness Exercise 5: "Identifying the shift of attention and increased self awareness" (to fill block 5 in the model: Self-focus)
  8. Group discussion about shift of attention and increased self awareness
  9. Explain homework exercises
  10. Complete session feedback questionnaires
- 

### 3. Explanation/Presentation about Safety Behaviours with case studies and the safety behaviours checklist

The way in which safety behaviours are used by socially anxious individuals is explained with the use of the overhead entitled: "Safety Behaviours". In addition, the case studies entitled, "Understanding safety behaviours through factual case studies" is handed out to participants. Participants volunteer to read from the handout a case study of their choice to the group. After each narrative, the case study is discussed and participants volunteer to enact the safety behaviours used in the case study. Finally, the checklist of safety behaviours is handed out to the participants and each safety behaviour is discussed whilst participants try and identify whether they use that particular safety behaviour, and under what circumstances they use that safety

behaviour.

#### 6. Presentation on Shift of Attention and Increased Self Awareness

The overhead entitled "Shift of attention and increased self awareness", is explained to the participants. A copy of this overhead is also handed out to them.

#### 9. Explain homework exercises

As part of homework, participants are required to continue entering anxiety provoking or feared situations. In addition to completing the daily record of dysfunctional thoughts, they are also required as part of homework for this session, to tick off the safety behaviours they used. This is done on the "Homework: Checklist of Safety Behaviours". They are also given a blank sheet with just a heading "Observation of Safety Behaviours". On this sheet they write out their own case narrative, similar to the case studies discussed in the group, regarding the way in which they used their safety behaviours.

The "homework exercise on shift of attention and increased self awareness" is also handed out to participants. They are required to complete this exercise in addition to their thoughts record and safety behaviours checklist once they have encountered a situation that was anxiety provoking.

#### Resources used in Session 3 (that follow):

- Overhead: "Safety Behaviours"
- Handout: "Understanding Safety Behaviours through factual case studies"
- Handout: "Safety Behaviours"
- Handout: "Checklist of safety behaviours"
- Exercise 4: "Safety Behaviours"
- Overhead/ Handout: "Shift of attention and increased self awareness"

- **Exercise 5: “Identifying the shift of attention and increased self-awareness”**
- **Homework: Checklist of safety behaviours**
- **Homework exercise: Observation of safety behaviours**
- **Homework exercise on shift of attention and increased self-awareness**

# Safety Behaviours

- strategies that are intended to avert feared catastrophes e.g. Keep quiet to avoid saying something stupid
- things that you do to conceal and prevent negative things from happening
- most complete form of safety behaviour = avoidance of difficult situations e.g. avoid talking to people from opposite sex that you are attracted to
  - this eliminates risk of failed performance and its believed consequences e.g. Prevents chance that may appear a fool
- BUT:
- avoidance leads to fewer opportunities to disconfirm negative beliefs and therefore fear is maintained e.g. Do not go into situations and therefore cannot take note of the times that you did do well in these situations and then continue to have beliefs of what would happen (without any evidence !!!)
- if avoidance is not possible - the situation is endured with difficulty
- here - the person practices safety behaviours aimed at reducing the risk of social failure and humiliation
- SB - vary in form but are directly related to **NEGATIVE BELIEFS**

## EXAMPLES:

### Negative Belief

"I'll get my words wrong and be unable to speak"

"I'll shake and spill my drink"

### Safety Behaviour

Rehearse sentences mentally before saying them. Try to speak clearly, quickly. Ask questions but do not talk about self

Grip cups with both hands.  
Drink when no one is watching.  
Hold arms rigid

## Understanding safety behaviours through factual case studies

### Michael's case:

Michael finds that having tea with his wife's family is a threatening situation. They sit formally around a table and this creates anxiety for him. The negative thoughts that enters his mind in this threatening situation are as follows. "If I hold the cup, I'll SHAKE, they'll NOTICE, I'll feel EMBARRASSED, they'll think its not normal, it's strange. Maybe they'll think I'm a nervous person". The automatic anxiety responses that Michael then suffers from are sweating, hot flushes and trembling. In order to conceal his anxiety, Michael employs one or more of the following safety behaviours. He avoids the possible humiliation by getting his wife to hold the cup for him. He tries to take control of himself. He attempts to take deep breathes before hand and say, "Relax, Relax..." to himself. He attempts to hold the cup in one hand, and the saucer in the other, and grips them very tightly. He also avoids eye contact.

### Rita's case:

Rita finds making a telephone call to be anxiety provoking. The negative thoughts that enter her mind in this threatening situation are, "I won't be able to speak, I'll stutter. The other person will be confused. I'll be upset with myself". The automatic anxiety responses that Rita then suffers from are feeling tense, having sweaty hands, shoulders tensed up, shaky hands, and heart racing. In order to conceal her anxiety, Rita employs the following safety behaviours. Before the situation, she rehearses what she has to say. She thinks about how she is feeling and depending on this, she delays the call if necessary. She also thinks about what she might be asked. During the call, she focuses on her body and tries to relax. She monitors her voice and how it sounds, and checks whether she is stuttering or not. She thinks about changing sentences. She avoids using words, such as, what, why, only. If she feels that she is beginning to stutter, she puts her hand on her chest.

### Alex's case:

Alex finds that trying to join in the conversation whilst sitting in the staff room during a coffee break is a threatening situation. He thinks of asking a question, but then starts to feel anxious. The negative thought that enters his mind in this threatening situation is, "I'll sound stupid". The automatic anxiety responses that Alex then suffers from are feeling uncomfortable, tense, having sweaty palms, stiff muscles, and his mind going blank. In order to conceal his anxiety, Alex employs one or more of the following safety behaviours. He delays asking the question. He takes deep breaths to try and relax. He speaks quickly or mumbles with his hand over his mouth. He rehearses what he has to say and checks it against his memory of what he has just said.

### John's case:

John finds that meeting a member of the opposite sex where there is a potential for sexual attraction on either side, to be highly anxiety provoking. The negative thoughts that enter his mind in this threatening situation are, "If I appear to be sexually interested in any way, I will be ridiculed. Oh my God this is awful. This girl will see that I am attracted to her. I will panic. She'll think I'm a total nutcase". The automatic anxiety responses that John then suffers from are, his heart races, he experiences shortness of breath, has panic feelings, and feel extremely hot. In order to conceal his anxiety, John employs one or more of the following safety behaviours. He leans away from the other person, and partially covers his face. He hides his hands between his knees in case they shake. He hunches his shoulders, drops his gaze, and wraps his legs around each other. He curls up and makes himself as insignificant as possible, and smiles a lot.

## SAFETY BEHAVIOURS

One of the things that keeps social phobia going is the way you behave when you feel anxious in social situations. When socially anxious, people often do things to conceal their anxiety and prevent negative things from happening in the situation. For example, if you shake whilst signing your name in a public place and you think that everyone will notice, you may attempt to control the shaking by tensing your muscles or writing very slowly. You may try to conceal your symptoms in other ways as well. These behaviours are called safety behaviours because they are used to prevent feared events from taking place. They are intended to keep you safe from drawing attention to yourself, making a fool of yourself and so on. The following examples illustrate the use of safety behaviours.

Sally was nervous in formal group situations, especially if she had to make a presentation at work. In the situation she would become hot and flustered and her negative thought was that she would "freeze" and be unable to get her words out. She was concerned that her colleagues would notice her anxiety and difficulty communicating, and that they would think she was inadequate. She could not entirely avoid these situations at work, and in order to cope with them and reduce the danger of "freezing" and her colleagues thinking negatively of her, she would say little in meetings, or would rehearse sentences in her mind before saying them. In order to make talking easier she would distract herself by looking away from her colleagues, or by trying to blank-out her mind.

Allan was anxious in many social situations, both at work and outside of work. He was concerned that he would become anxious and people would notice him sweating. If people noticed this he was convinced that they would think he was abnormal and weird. In order to prevent this from happening, Allan concealed his sweating by wearing light coloured clothing, wearing a jacket most of the time, and keeping his arms close to his sides so as not to reveal his armpits.

In both these cases the use of safety behaviours contributed to the problems experienced by Sally and Allan. They contributed in three ways:

1) Some of the safety behaviours actually made the feared events more likely to happen. In Sally's case, not looking at her colleagues and blanking-out made concentration more difficult and made her appear uncomfortable. The behaviours made her more noticeable and made it harder for her to think of what to say. In Allan's case, keeping his arms close by his sides and wearing a jacket made him sweat more.

2) The safety behaviours prevented Sally and Allan from discovering what really happens as a result of anxiety. Only by stopping safety behaviours in situations were they able to discover that "freezing" did not occur and that people hardly notice sweating and, even if they do, they do not react in the way that was feared.

3) Safety behaviours increased the degree of self-consciousness experienced in social situations. Both Sally and Allan often found themselves in the situation of monitoring themselves and trying to present a favourable impression. The heightened self-consciousness made them feel more conspicuous and diverted their attention away from assessing what was really happening in the situation.

During the course of this programme, you will be working within the group as a means of exploring your safety behaviours and how they maintain your social anxiety. In order to overcome your fears and feel more comfortable in social situations, you will be experimenting with changing your safety behaviours in a way that enables you to challenge your negative thoughts.

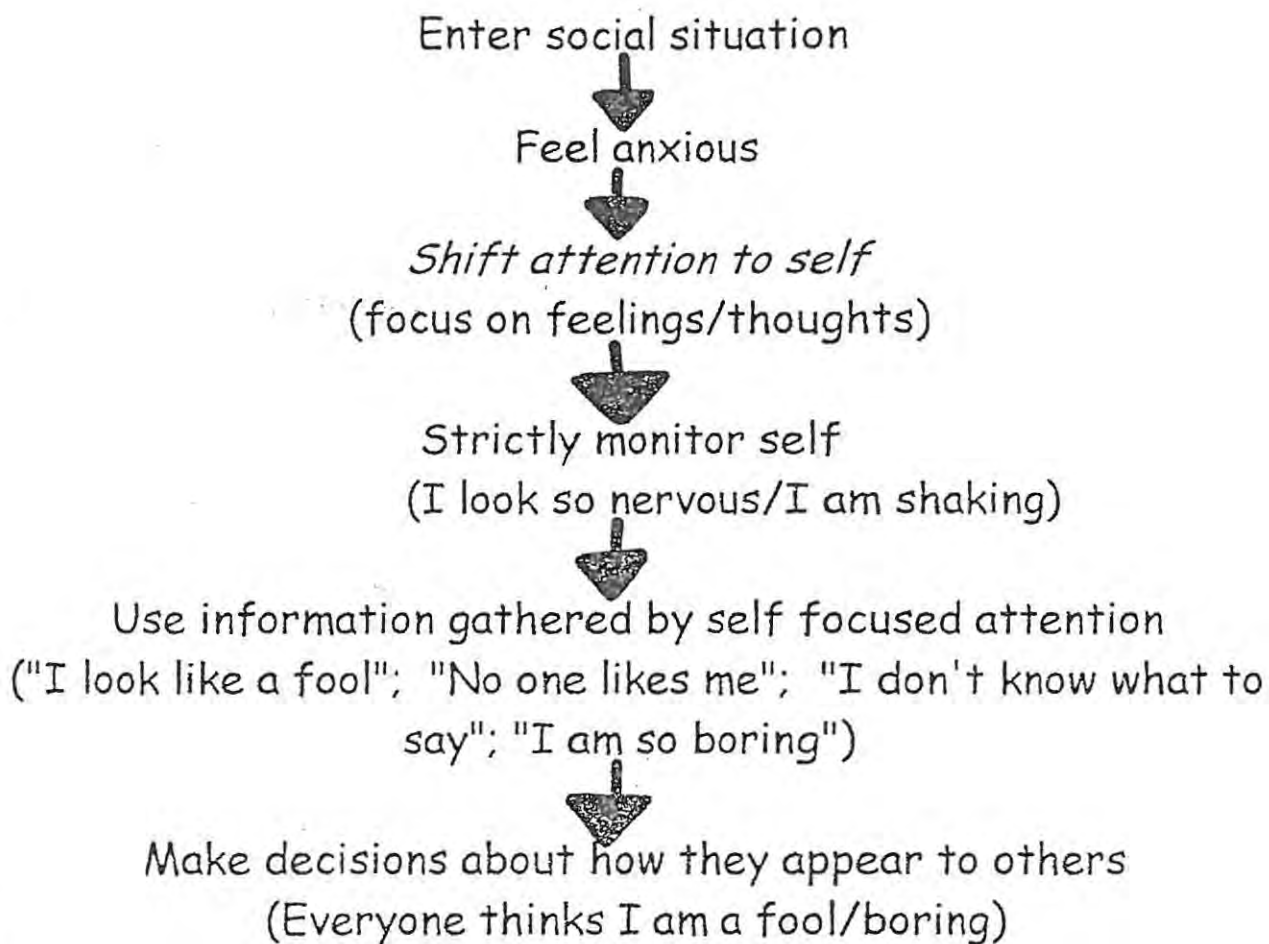
## CHECKLIST OF SAFETY BEHAVIOURS

Use alcohol to manage anxiety  
Try not to attract attention  
Make an effort to get your words right  
Check that you are coming across well  
Avoid eye contact  
Talk less  
Avoid asking questions  
Try to picture how you appear to others  
Curl up and make yourself not easily noticeable  
Grip cups or glasses tightly  
Position yourself so as not to be noticed  
Try to control shaking (put your hands between your knees)  
Choose clothes that will prevent or control sweating  
Wear clothes or make up to hide blushing  
Rehearse sentences in your mind  
Censor what you are going to say  
Blank out or switch off mentally  
Avoid talking about yourself  
Keep still  
Ask lots of questions  
Think positive  
Stay on the edge of groups  
Avoid pauses in speech  
Focus on your hands  
Hide your face  
Try to think about other things  
Talk more  
Try to act normal  
Try to keep tight control of your behaviour  
Make an effort to come across well  
Smile a lot  
Cover your mouth while talking  
Mumble/ Stutter  
Use distraction (e.g. play with your hair)  
Focus on your voice

Exercise 4  
Safety Behaviours

1. When you thought (feared event) might/was happening, did you do anything to try to prevent it from happening?  
Did you try to do anything to try to prevent people from noticing?
  
  
  
  
  
  
  
  
  
  
2. Is there anything you do to try to ensure that you come across well?
  
  
  
  
  
  
  
  
  
  
3. Do you do anything to try to control the symptoms?
  
  
  
  
  
  
  
  
  
  
4. Do you do anything to avoid drawing attention to yourself?
  
  
  
  
  
  
  
  
  
  
5. Do you monitor how you are coming across? Do you try to work out how you are coming across?

## SHIFT OF ATTENTION AND INCREASED SELF AWARENESS



# socially anxious people therefore pay more attention ~~to~~ to their own thoughts and negative feelings (interoceptive information)

# little or no attention to cues from others when constructing an image of how they think they appear

Exercise 5

Identifying the shift of attention and increased self awareness

1. When you are afraid that something will happen, what happens to your attention?
  
  
  
  
  
  
  
  
  
  
2. Do you become self conscious?
  
  
  
  
  
  
  
  
  
  
3. Do you start focusing your attention on yourself and how you think you might appear?
  
  
  
  
  
  
  
  
  
  
4. Are you more or less aware of what other people are doing at that moment?

## HOMEWORK: CHECKLIST OF SAFETY BEHAVIOURS

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Experiment with a situation where you experience anxiety. Tick the safety behaviours you used in the situation.

- Use alcohol to manage anxiety
- Try not to attract attention
- Make an effort to get your words right
- Check that you are coming across well
- Avoid eye contact
- Talk less
- Avoid asking questions
- Try to picture how you appear to others
- Curl up and make yourself not easily noticeable
- Grip cups or glasses tightly
- Position yourself so as not to be noticed
- Try to control shaking (put your hands between your knees)
- Choose clothes that will prevent or control sweating
- Wear clothes or make up to hide blushing
- Rehearse sentences in your mind
- Blank out or switch off mentally
- Avoid talking about yourself
- Keep still
- Ask lots of questions
- Think positive
- Stay on the edge of groups
- Avoid pauses in speech
- Focus on your hands
- Hide your face
- Try to think about other things
- Talk more
- Try to act normal
- Try to keep tight control of your behaviour
- Make an effort to come across well
- Smile a lot
- Cover your mouth while speaking
- Mumble/ Stutter
- Use distraction (e.g. play with your hair)
- Focus on your voice

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- HOMEWORK EXERCISE -

OBSERVATION OF SAFETY BEHAVIOURS

DATE



## SESSION 4

### Agenda:

1. Complete questionnaires: BDI-II, BAI, SCQ, SBQ, SSR
  2. Review/Discussion of homework
  3. Awareness Exercise 6: "Contents of self awareness"
  4. Group discussion about contents of self-awareness
  5. Presentation of the cognitive model and how to use it
  6. Participants complete a model with the use of the material gathered from feared situations they experimented with for homework
  7. Discussion of each participant's model
  8. Explain homework exercises
  9. Complete session feedback questionnaires
- 

### 3. Awareness Exercise 6: "Contents of self awareness"

In this exercise the questions that are asked will help participants identify what they notice as they focus their attention on themselves. What images they hold of themselves, how they think they appear to others, impressions about how they think they come across to others, and how they think they will look if they do not use their safety behaviours. This exercise does not assist in filling any of the blocks in the model. However, it helps participants to see how the different components in the model are all interlinked to create that final impression that they have of the feared or avoided situation.

### 5. Presentation of the cognitive model and how to use it

A copy of the blank model is used as an overhead. Any participant can volunteer to assist the facilitator by giving personal examples that can be used to fill the model.

The participants can now understand the exact use of all the exercises that they have been carrying out. The facilitator then shows the participants how all the blocks in the model are interlinked and how arrows can be drawn between the boxes in order to form the vicious cycle of social phobia that each participant is suffering with.

6. Participants complete a model with the use of the material gathered from feared situations they experimented with for homework

After the model is explained to participants, they are each handed a blank copy of the cognitive model, and they construct their idiosyncratic cognitive models with the use of any feared situation they experimented with for homework. Some participants may still not be entirely clear about how to construct their models, and facilitators go around helping the participants.

7. Discussion of each participant's model

Each participant now has a turn to hold their model up to the group and explain how they constructed their model and explain their social phobia to the group. This exercise ensures that participants are aware of how their social phobia is maintained with their explanation of their use of safety behaviours, feelings of anxiety symptoms, intrusive negative thoughts etc.

8. Explain homework exercises

As part of homework, participants are handed two copies of each of the following; the first three columns of the thought record, the safety behaviours checklist and the blank model. It is explained to participants that they are required to experiment with at least two situations that they fear or avoid. Thereafter, they are required to write down the negative thoughts they had before, whilst in, and after the situation, tick off the safety behaviours they used, and construct a further two idiosyncratic cognitive models for themselves. In addition, participants are handed another copy of exercise 6, that they complete whilst reflecting on the feared and avoided situations that they

experimented with as part of homework. The aim is for participants to understand that due to their heightened self-awareness, they experience increased anxiety in feared or avoided situations.

**Resources used in Session 4 (that follow):**

- Exercise 6: "Contents of Self-awareness"
- Homework exercise (6)





## SESSION 5

### Agenda:

1. Complete questionnaires: BDI-II, BAI, SCQ, SBQ, SSR
  2. Review/Discussion of homework (from this session onwards, at least half the session is used to discuss homework so as to explore every group members' social phobia)
  3. Explanation of the practical methods of assisting participants overcome their problem (with respect to each section of the cognitive model) as a means.
  4. Explain the Safety Behaviours Experiment (SBE) and its use in therapy
  5. Explain homework exercises
  6. Session Feedback Questionnaires
- 

### 3. Explanation of the practical methods of assisting participants overcome their problem (with respect to each section of the cognitive model)

With the use of a series of overheads, practical methods of how to address each component of the cognitive model, are explained to participants. The series of overheads follow at the end of this description of session 5. Copies of these overheads were handed out to participants as well.

### 4. Explain the Safety Behaviours Experiment (SBE) and its use in therapy

The procedure of the SBE is explained to participants. It is also explained to participants that the SBE will be conducted individually (individualized sessions) so that each participant has their own experience of what it feels like to drop all their

safety behaviours whilst experimenting with a feared situation. If participants were to watch one another's experiments, there may be a tendency for participants to be biased if they have watched others before experiencing the experiment for themselves. The novelty of the SBE would be lost as a result. After explaining the above to participants, each participant is asked to think about a potential role-play situation that they would like to use in their SBE. Participants are told that they need to decide their role-play situation before the following session.

#### 5. Explain homework exercises

The homework assigned in session 4 is assigned once again so that participants can reinforce what they have learnt from the homework discussion at the beginning of this session (5), and also so that they increase their understanding of themselves in social interactions. At this stage in the Edwards, Kannan and Henwood (2000) programme, the programme was temporarily stopped for the vacation (7-week break). Therefore, before letting the participants go, they were reminded of the importance of experimenting with situations and keeping a close monitor on their thoughts, feelings and behaviours. The participants were also reminded that the individual sessions with SBEs would take place after the vacation, so participants had something to look forward to when they returned. For future reference, if this programme is conducted on university students, the facilitators should try to time the vacation elsewhere in the programme. If possible, the programme should not have any breaks. At this stage (end of session 5) participants are at the climax of the therapy programme. The vacation made several participants lose the momentum of the programme. It took some effort to get participants back on track after the vacation! Two students dropped-out after the vacation.

#### Resources used in Session 5 (that follow)

- Series of overheads used to explain what happens next...

**Now you have worked out  
the model of your social  
anxiety, what next ... ???**

In the next sessions we will be working with tried and tested practical methods in each of the sections of the model which will assist you in overcoming your problem...

## **1 Anxiety responses:**

- Learning to accept them
- Learning not to focus on them.

## **2 Negative thoughts:**

- Learning to challenge them with questions like "Is this accurate?" "Is this helpful?"
- Doing experiments to see if they are valid.

### **3 Self-focused attention:**

- Learning to keep focus on the other person
- Learning to get involved in what the conversation is about.

### **4 Negative self image:**

- Building a positive self-image

## 5 Safety behaviours:

- Examining whether they really help... Or are they self-defeating?
- Experimenting with dropping them.
- Learning to do without them.

## **Applying these methods will involve...**

- ▶ Role plays with the group
- ▶ Experiments in real situations
- ▶ Logical analysis and discussion to help you to get accurate feedback and to reality test dysfunctional thoughts and assumptions.

## SESSION 6

### Agenda:

1. Complete questionnaires: BDI-II, BAI, SCQ, SBQ, SSR
  2. Review/Discussion of homework
  3. Discussion about the role-plays that each participant would like to use for the SBE
  4. Explain homework exercises
  5. Session feedback questionnaire
- 

This session is relatively the shortest session in this programme. This is because between this session and session 7, participants have to conduct their individualized SBEs. This additional individual session is time consuming for participants. Therefore, it is in the best interest of participants to keep this session short so that the focus remains on the SBE.

### The Safety Behaviours Experiment

Role-plays are set up individually for each participant to meet with the facilitators for the SBE. The procedure of the SBE can be found in the Clark (1997) manual. (After each role-play, participant and volunteer (stooge) were given a record to complete regarding the participant's performance in the role-play. These records can be found overleaf.)

### Resources used in the SBE (that follow)

- Participant's record of performance in the role-plays
- Volunteer's (stooge's) record of participant's performance in the role-play

## PARTICIPANT'S RECORD

Enter on a scale of 1 to 10 the rating you would give as an answer to each question.  
(You are allowed to use .1 to .9 between numbers to be precise)

Questions:	Ratings:	
	After role-play 1	After role-play 2
1. How anxious did you look?		
2. How self-conscious did you feel?		
3. What were you self-conscious of? (Please list briefly in the columns)		
4. How anxious did you think you appeared?		
5. How good was your performance overall?		
6. What other individualized things did you fear would be noticed, and to what extent (Rate these as well) e.g. blushing, stuttering, being bored, being boring, shaking lip, looking frustrated etc.		

## VOLUNTEER'S RECORD

Enter on a scale of 1 to 10 the rating you would give as an answer to each question.  
(You are allowed to use .1 to .9 between numbers to be precise)

Questions:	Ratings:	
	After role-play 1	After role-play 2
1. How anxious did you think X looked?		
2. How self-conscious did you think X felt?		
3. What might X have been self-conscious of? (Please list briefly in the columns)		
4. How good do you think X's social interaction skills were?		
5. What other individualized things did you notice about X, and to what extent (Rate these as well) e.g. blushing, stuttering, being bored, being boring, shaking lip, looking frustrated etc.		

## SESSION 7

### Agenda:

1. Complete questionnaires: BDI-II, BAI, SCQ, SBQ, SSR
  2. Review/Discussion of homework
  3. Group feedback discussion about the Safety Behaviours Experiments each participant's experience/ Discussion about whether there is a need for safety behaviours in any social interaction
  4. Explanation about the how to use the entire "Daily Record of Dysfunctional Thoughts", explanation about how to use the "Record Sheet for Noting Behavioural Experiments"
  5. Explain homework exercises (behavioural experiments)
  6. Session Feedback questionnaires
- 

4. Explanation about the how to use the entire "Daily Record of Dysfunctional Thoughts", explanation about how to use the "Record Sheet for Noting Behavioural Experiments"

Explanations of how to use these records can be found in the Clark (1997) manual.

5. Explain homework exercises (behavioural experiments)

Participants are required from this session onwards to conduct behavioural experiments as part of homework. The importance of these behavioural experiments is explained to participants as a means of continually practicing the act of dropping safety behaviours, monitoring negative thoughts, monitoring feelings and anxiety symptoms, and monitoring their self focused attention and increased self-awareness whilst in feared or avoided situations. Through continuously entering feared and avoided situations and experimenting with them, participants will eventually master

the art of engaging in social interactions with no anxiety. In order to assist in this process, at the beginning of each session, from session 8 onwards, facilitators help participants to challenge their irrational cognitions and question their behaviour patterns whilst in feared or avoided situations that they experimented with as part of homework. This is explained further under session 8, No. 2.

Participants are given two copies of the Daily Dysfunctional Thoughts Record and Record Sheet for Noting Behavioural Experiments at the end of each session from session 7 onwards. In addition, in the Edwards, Kannan and Henwood (2000) programme, participants were given an additional "Weekly Summary of Behaviour" with a few points that the participants had to note down each week.

### **Resources used in Session 7 (that follow)**

- Daily record of Dysfunctional Thoughts
- Record Sheet for Noting Behavioural Experiments
- Weekly Summary of Behaviour

Rhodes University

**Cognitive Behavioural Group Therapy for Social Phobia**

Weekly Summary of Behaviour

NAME:.....

DATE:.....

---

Either in the space provided or on separate sheets of paper, summarise your self-observations from one or more situations in which you felt anxious. You should try to include as many of the following aspects in your summary as possible:

- Details of the specific situation
  - Specific emotions you felt (rate them on a 10 point scale)
  - Specific automatic thoughts/beliefs/fears about the situation
  - Use of safety behaviours (where you able to drop them/what did you do/not do?)
  - Evidence for beliefs surrounding the outcome (what was the result of the situation?)
  - Positive characteristics you noticed in yourself
  - Negative characteristics you noticed in yourself
  - Possibilities for change
- 

SUMMARY

## **SESSION 8**

### Agenda:

1. Complete questionnaires: BDI-II, BAI, SCQ, SBQ, SSR
  2. Review/Discussion of homework
  3. Presentation on Post-Mortem
  4. Explain homework exercises
  5. Session Feedback Questionnaires
- 

### 2. Review/Discussion of homework

While participants complete the series of questionnaires at the beginning of the session, the facilitator gathers the homework sheets so as to determine each participant's achievements since the previous session. When the participants return to the group, each member is guided through a process of understanding their behaviour, thoughts and feelings in difficult situations by identifying their dysfunctional negative thoughts/beliefs and by challenging these by looking for evidence and alternative explanations to their thoughts and beliefs. This procedure is followed at the beginning of each session from this session onwards.

### 3. Presentation on Post-Mortem

With the use of a series of overheads, post-mortem is explained to the participants. These overheads can be found overleaf. Hereafter, as part of homework, participants are required to assess whether they conduct a post-mortem of the feared or avoided situation that they experiment with. In addition, they follow the steps that are explained in the presentation to try and stop conducting the post-mortem. This is discussed in detail as well as part of the discussion of homework at the beginning of each session (session 9 onwards).

## **Resources used in Session 8 (that follow)**

- **Overheads used to explain Post-Mortem**

# 1 - After the event, do you do a post-mortem?

- ❑ After being in a social situation in which you have been anxious, do you
  - ▶ think about it?
  - ▶ review what you said?
  - ▶ review what you might have said?
  - ▶ think about the impression you made and what others thought of you?

*This is the "post-mortem"*

## 2 - What happens in the post-mortem?

- When we ask people what they think about in the post-mortem we typically find:
  - ▶ they focus on their negative self-image
  - ▶ they jump to biased conclusions about how they appeared to others
  - ▶ they draw inaccurate conclusions about what others think about them
  - ▶ they use their biased and distorted interpretations to provide evidence of failure.

### 3 - Is the post-mortem helpful?

- ❑ Many people find that, as a result of the post-mortem, they
  - ▶ feel more anxious
  - ▶ feel worse about themselves (lower self-esteem)
  - ▶ feel more motivated to avoid similar situations in future

*What kind of thoughts, images and feelings do you have when you do a post-mortem?*

## 4 - What can I do about the post-mortem?

- Research has shown that the following are helpful:
  - ▶ Find ways to obtain valid evidence about you appear and what people thought about you and what you said or did. Behavioural experiments can help to achieve this.
  - ▶ Pay attention to positive information and feedback.
  - ▶ Ban the most-mortem.

## SESSION 9

### Agenda:

1. Complete questionnaires: BDI-II, BAI, SCQ, SBQ, SSR
  2. Review/Discussion of homework
  3. Review the manual: "Cognitive Restructuring- a guide to working with negative, dysfunctional and self-defeating thoughts" (David Edwards, 2000)
  4. Explain homework exercises
  5. Session Feedback Questionnaires
- 

3. Review the manual: "Cognitive Restructuring- a guide to working with negative, dysfunctional and self-defeating thoughts" (David Edwards, 2000)

A manual designed by Professor David Edwards was issued to participants in order to assist them in their process of cognitive restructuring. This manual can be found overleaf. It addresses all the essential components in treatment of SP including, how to use the Daily Record of Dysfunctional Thoughts, a series of questions aimed at examining thoughts whilst trying to correct cognitive distortions, and the process involved in conducting behavioural experiments.

### Resources used in Session 9 (that follow)

- "Cognitive Restructuring- a guide to working with negative, dysfunctional and self-defeating thoughts" (David Edwards, 2000)

**Cognitive restructuring**  
-  
**a guide to working with  
negative, dysfunctional  
and self-defeating  
thoughts**



***David Edwards***

*Department of Psychology  
Rhodes University  
Grahamstown*

August 2000

# Cognitive restructuring: a guide to working with negative, dysfunctional and self-defeating thoughts

1. Cognitive restructuring	1
2. Using the <i>Daily Record of Dysfunctional Thoughts</i>	3
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4. Questions to help you examine negative thoughts and correct cognitive distortions	11
5. Conducting behavioural experiments	13
6. For further reading	16

## 1 - Cognitive restructuring

Back in the 1700's the philosopher Immanuel Kant believed that mental disorders resulted from people substituting private meanings for public ones (Emery, 1981). He argued that public meanings are continually checked out against reality. Private meanings are not - they stay untested and this may keep a person in a state of emotional distress.

To overcome depression and anxiety and other psychological problems we may have to change some of the basic meanings we give to events. Many depressed and anxious people latch on to one idea or meaning and don't look for other ways of thinking about the situation.

The fact is that any one situation can be looked at in a variety of different ways. Some of those ways will lead to strong and painful negative feelings while others will not. We can not only learn to see alternative ways of viewing situations but can discover we have the power to choose. No thinking pattern is absolute. We can elect to think in ways that are neutral or positive rather than destructive and negative.

"Cognitive restructuring" is the term psychologists use for the process of examining and changing our habitual thinking patterns.

## 2 - Using the *Daily Record of Dysfunctional Thoughts*

Cognitive therapists have shown how automatic thoughts contribute to the generation and maintenance of painful and sometimes disabling emotions such as anxiety, depression, hopelessness, guilt and resentment. They have also shown how working with automatic thoughts can be a major step in improving self-awareness and providing a means of dealing effectively with emotional problems.

Below are nine steps which you can train yourself to use to work with

## 2

your automatic thoughts on a systematic and regular basis. The *Daily Record of Dysfunctional Thoughts* form is designed to help you to follow each of the steps. Using it regularly will help you to become aware of *your* private meanings and to engage in effective cognitive restructuring.

### ***Step 1: Identify the times when you feel unhappy or distressed***

There may be several types of situation where you feel distressed in some way. If a person feels distressed all the time they will usually notice that there are significant variations in mood if they monitor it from hour to hour. To increase awareness of how emotions change you may need to monitor them during the day. If you monitor the types of situation where you feel bad you will most likely find that the same types of situation recur. For the purpose of this analysis choose a particular everyday incident which results in your feeling distressed or upset.

### ***Step 2: Identify and quantify (0-100) the specific emotions you experience when you feel distressed***

People are not always accurate in labelling their emotions. They sometimes use vague words like 'upset', or 'bad' or 'stressed'. However at these times people are usually feeling one or more specific emotions such as sadness, anxiety, guilt, disappointment, anger etc. So pay attention to the particular emotions you feel at the time. (Some people require training in this, and most people improve with practice).

Quantification does not have to be very accurate. Use your own subjective scale where 0% is a time you did not feel the emotion at all, and 100% is the strongest you have ever felt it or could imagine feeling it in a very difficult situation.

## 3

### *Step 3: Thought collection*

The aim is to collect thoughts that you have at the same time as you feel bad in some way. There are several ways of doing this, and here are the main ones:

- Retrospectively you can recall the event and then become aware of specific automatic thoughts you had at the time. Write them down.
- Retrospectively reconstruct the event in imagination. Visualise what happened as clearly as possible. Try to enter again into the whole feeling of being there. Now pay attention to automatic thoughts provoked by this exercise and write them down (or work with a partner and have him/her write them down for you).
- Carry a notebook with you and monitor thoughts as they occur in the day. Pay attention at times when you notice you are experiencing unpleasant emotions (anxiety, depression, guilt, shame, sadness etc.). Record them in the notebook.

Note: some thoughts are very clear strings of words that you can easily identify. Others are much more subtle and sink into the background. These are not easy to identify, but this improves with practice.

▼ *These next steps should then be* ▼  
▼ *carried out for each thought:* ▼

### *Step 4: Rate how much you believe it*

Rate how much you believe the automatic thought. Use a scale of 1-100%. If your belief level is very low (<30%) you may not need to bother with further the remaining steps.

### *Step 5: Critically evaluate the thought*

The next step is to examine the meaning of the thoughts to see if they are logical, accurate or helpful. Three useful ways of doing this are described later in this booklet.

## 4

- Check for and identify cognitive distortions. Does the thought represent one of the distortions described below on pages 5-10?
- Ask questions to help you look for alternative interpretations and perspectives. 24 useful questions are listed on pages 10- 13.
- Conduct behavioural experiments to investigate whether the thoughts are accurate. Examples of how to do this are given on pages 13-15.

### ***Step 6: Write the conclusion to your re-evaluation***

Summarize the conclusion you have come to following the re-evaluation process. Write it into the *Rational Response* column of the *Daily record of dysfunctional thoughts*.

### ***Step 7: Rate your belief in your re-evaluation***

Rate how much you believe your rational response (use a scale of 1-100%). This is important. If you don't believe your rational response, then it will not be effective in changing what you feel. This means that you have either done the analysis superficially, or there are other automatic thoughts and beliefs that have not yet been dealt with and which you will need to identify.

### ***Step 8: Re-rate your belief in the original automatic thought***

If you have correctly identified and corrected the cognitive distortion in the thought and achieved a rational perspective on it, you can expect that your belief in the irrational thought will have been reduced

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considerably. If not, then most likely you do not believe your re-evaluation, and you need to take a deeper look.

### *Step 9: Specify and quantify (0-100) the emotions you now feel*

If your belief in the original thought has changed, then the emotion will probably have changed too. If it has not, you have missed something important.

## 3 - Cognitive distortions

A cognitive distortion is an error in the manner in which people represent the world to themselves in their automatic thoughts, their beliefs, expectations or basic assumptions .

Cognitive distortions can be grouped into five major types, each of which contains further subtypes. This is set out below. However in many cases there is a great deal of overlap between types and subtypes so that individual thoughts may be seen as instances of more than one.

### *Type 1 Distortion: Global or overinclusive judgements*

In this case you judge events in a manner which fails to make important discriminations or which oversimplifies the information available. There are several types:

Dichotomous or all-or-none thinking: You see things in exclusive polar categories instead of along a continuum. For example, if you make a mistake in some work the work is 'bad' (polar opposite of good). If you take a coffee break you become 'lazy' (polar opposite of hard-working). This type of thinking is often

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associated with extreme mood swings as the individual's emotions change dramatically depending on which of the two categories is currently being applied.

Overgeneralisation: On the basis of the data you overgeneralise to reach your conclusion. For example, he angrily criticises your political belief. You conclude that he doesn't approve of your other attitudes or tastes either.

Inappropriate labelling: Here, you apply an overinclusive negative label to someone or something on the basis of a single instance. One slip and you are 'stupid', you are let down once (without knowing the reason) and the person is 'untrustworthy'. You fail at a project and you become 'a loser'.

Personalisation: You overgeneralise and assume that something that applies only to a small aspect of your beliefs, or behaviour applies to the whole of you. For example, you are unable to separate criticism of your behaviour from criticism of yourself as a person so that when someone disagrees with you you experience it as a personal attack. Another example is the maxim 'your work is your worth'.

### *Type 2 distortion: Arbitrary inference*

These errors involve reaching a conclusion that something is the case on the basis of *inadequate evidence*. This includes:

Mindreading : You jump to conclusions about what something thinks or believes ('he thinks I'm too fat', 'she is bored with what I'm saying')

Fortune telling : You predict what is going to happen in the future on the basis of poor evidence (if I say that he'll be hurt... offended... enraged...)

Catastrophising: You predict catastrophic consequences,

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believing them to have a high probability when in fact the true probability is very low. E.g. a family member is late coming home and you respond as if they have been run-over, raped, murdered etc.

Magnification: You overestimate the seriousness of an outcome (e.g. you assume that to fail the course would be the end of your academic career, or that no one would respect you any more). Or you underestimate your resources for coping with an unpleasant outcome (e.g. you assume that the shame, embarrassment or criticism will be unbearable)

Emotional reasoning: You use your emotions as evidence for the way things are. E.g. you use your feeling of rejection or isolation as evidence that people reject you or that you are unable to relate to people.

### *Type 3 distortion : Selection of negative evidence*

In this case you support a negative conclusion that you have already reached by selecting evidence that accords with it.

Mental filter (selective abstraction): You focus on only a part of the situation and ignore the rest. For example, you notice a frown but not a smile. You remind yourself of what you didn't say at the interview but wanted to, but you ignore the good things you did say. You fail to attend to information that does not fit your global judgement.

Discounting evidence: A negative belief is often maintained by discounting evidence that contradicts it. Thus if I believe she dislikes me, and then she talks to me in a friendly way, I say to myself "She doesn't really mean it" or "She's just using me to keep herself from getting bored as her friends are busy".

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*Type 4 distortion: Misattribution - Drawing conclusions based on a mistaken inference*

In this case you have data of some sort on which you base your judgement, but you use it within an inappropriate or distorted meaning framework.

- Misattribution of causes: You incorrectly attribute an event to a cause which is not the real cause. Examples:

*Self-conscious misattribution*: Someone looks at you and you believe this is because they are inappropriately interested in what you are thinking and feeling.

*Paranoid misattribution*: You are inappropriately suspicious because you believe that people are deliberately trying to hurt you or take advantage.

*Misattribution of symptoms*: "These heart palpitations are symptoms of an impending heart attack... These feelings of faintness or dizziness are a sign that I am going insane."

*Misattribution of responsibility*: You inappropriately take responsibility for bad things that happen to other people. For example, you introduce a friend to someone and they quarrel and you blame yourself for causing the friend pain... Another example, you decide to break off a relationship that is not working out and you blame yourself for the feelings of disappointment and rejection experienced by the other.

*Magical thinking*: You believe that your thoughts can cause things to happen. For example, you believe that, if you think of harming someone, harm will actually befall them.

- Misattribution of rights: You attribute rights to another person which you would not claim for yourself (non-assertiveness) or you claim rights for yourself which you would not accord to others (aggressiveness). Examples:

You lend your tape cassettes willingly to a friend but would not ask your friend to lend you hers because you believe she would feel imposed upon.

You are angry with others in front of you in a queue while expecting others behind you not to be angry with you.

*Inappropriate shoulds:* Related to this are implicit demands that people, institutions or events should be different to what they are. These can usually be translated into should statements so that their appropriateness can be evaluated. Very often these 'shoulds' imply that people or events should comply with your personal viewpoint as to how the things should be.

### *Type 5 distortion: Defensive cognitive avoidance*

You present reality to yourself in a distorted way in order to avoid the negative emotional impact of the true state of affairs. The classical defense mechanisms are examples of this, although the process in many of them (e.g. repression, projection, reaction formation) is too complex to be interpreted from an analysis of automatic thoughts alone.

Denial of reality: You think or fantasise as if some event that really took place did not. For example, you stole some money or cheated on a test and you fantasise that it didn't happen and tell yourself that it didn't.

Denial of concern: Your response enables you to deny that you feel lonely, disappointed, hurt etc. E.g. (after girl-friend has broken off with you) 'I didn't like her much anyway. I'm best rid of her.' A classic example of this is: Sour grapes: You tell yourself that something you wanted and can't have would not have pleased you anyway. E.g. after failing to get job, bursary. 'Well it was not the sort of thing I wanted anyway.' Or, 'The people there are terrible.'

Rationalisation: You offer morally acceptable reasons for actions not consistent with your values. For example you bully someone, and say, "I'm doing this for your own good." You consistently skip classes and tell yourself that the lectures are not of good quality.

False optimism: You maintain a positive perspective without regard to the actual realities of the situation. E.g. After a disappointment: "Don't worry, Things are bound to work out fine in the end, they always have." Or before tackling something anxiety provoking: 'Go on you'll do fine. There's nothing to worry about. I feel lucky today.'

## 4 - Questions to help you examine negative thoughts and correct cognitive distortions

You are probably used to believing your automatic thoughts uncritically. It can be difficult at first to discover alternative ways of thinking. Sometimes it helps to talk them over with a friend, counsellor or therapist. However you can learn to question your own thoughts effectively with practice. Here are 24 questions which people find helpful in this process.

### *For overinclusive judgements*

1. Am I putting experience into two rigid categories? Do I think in all or none terms, for example - 'If I'm not a perfect success I'm a failure', or 'If I'm not very thin, then I'm fat', or 'If I'm not highly intelligent I'm stupid'?
2. Am I overgeneralising?
3. Am I taking this too personally?

*For arbitrary inference*

4. Is there another explanation? Are there other interpretations compatible with the evidence? For example, if she walked past me without greeting me, could she have not recognised me because I just had my hair cut? Might she have been in a hurry or preoccupied with her own personal problems?
5. What evidence do I have for this conclusion? Be rigorous in checking whether you have any hard data which supports the thought. For example, if the thought is "She doesn't like me", review the data you have to support this. Then review the quality of the evidence. Lack of evidence that she does like you does not constitute evidence that she doesn't, for example. If she walked past you without saying hello, ask whether this is good evidence for your belief that she doesn't like you. You can also extend this approach by making two lists: one with all the evidence for your thought and one with all the evidence against it.
6. Am I confusing a feeling with a fact? Because I feel unwanted it does not mean that I am unwanted. Because I feel anxious, it does not mean that there is actually something dangerous.

*For selection of negative evidence*

7. Am I ignoring facts which do not fit into my interpretation? Review the positive aspects of the situation as accurately as possible.
8. Do I discount evidence without good reason? Do I say things like - "He's only talking to me because he's sorry for me".
9. Am I putting too much focus on irrelevant factors?

*For misattributions*

10. Am I making a mistake about what causes what?

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11. Am I over-responsible? ... Do I take responsibility for causing events that I am not responsible for? ... Or for which I am only responsible for in a small way?
12. Do I believe that because I think of doing something it's the same as actually doing it?
13. Am I recognising my personal rights in this situation?... Do I give another person more rights than I accord to myself?

### *For rationalisations*

14. Am I deceiving myself or rationalising?
15. Am I relying on superficial self-statements based on positive thinking that is not related to reality? Replace them with genuine reality-based coping statements.

### *For catastrophic thinking - decatastrophising questions*

16. What is the worst that could happen?
17. What is the probability (measure it out of 100) that this catastrophic thing would happen? When anxious, people often grossly overestimate how probable an unpleasant outcome is.
18. What if this happened? Could I deal with it? It might be unpleasant and demanding to have to deal with the feared outcome, but you may have resources to do so, or could get the needed resources.

### *General*

19. Am I overlooking my own strengths and resources?
20. Does it serve a useful function for me to think like this? Does

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thinking this only make the situation worse?

21. What difference will this make in a week, a year, ten years from now?
22. Am I asking questions which have no answers?
23. Am I focusing on unpleasant feelings rather than on identifying and solving the problem?
24. Am I making the problem worse by using absolute or exaggerated words like *always*, *forever*, *should*, *must*, *need*, *can't*?

## 5 - Conducting behavioural experiments

Sometimes a negative thought remains convincing even though we have examined it for cognitive distortions or looked for alternative perspectives. In some cases there is not enough hard evidence for us to be sure whether the thought is accurate or not. In these cases you can generate evidence by conducting behavioural experiments. Use the following steps:

1. Identify the everyday situation where the negative thought gets activated.
2. Plan experiment which will enable you to obtain evidence with regard to the accuracy of the thought.
3. Predict what will happen if the thought is true.
4. Conduct the experiment and collect relevant information by observing closely what happens.
5. Examine whether the information you have collected supports

your prediction or not.

Here are examples of situations where people have found this approach helpful.

- Simon was feeling depressed. He thought, "My friends won't like to speak to me or be with me when I'm like this". He tested this thought by calling one or two friends and suggesting they go out somewhere together. He predicted that (1) the friends would not want to talk to him and would cut the conversation short, (2) they would not want to go out with him, (3) if they did go out together the friends would not enjoy his company.

The result was that he became involved in a conversation with the first friend he called that lasted over half an hour. The friend welcomed the idea that they go out for tea in town. When they went out for tea, the two conversed comfortably and when they parted the friend spontaneously said how much he had enjoyed seeing Simon again.

Simon concluded that his original thought had been an example of mind-reading and fortune-telling and had been coloured by his depressed mood. He accepted that the evidence had contradicted all his negative predictions.

- Samantha believed that when she went out for a drink her hand would shake while she was holding the glass; that people would notice this, think she was odd and laugh at her. As an experiment, Samantha went to a bar with two other people, Freda and David. Freda ordered some mineral water, poured it into a glass and held it, with her hand shaking visibly, for ten minutes. During this time Samantha and David observed the people around them to see if Samantha's predictions were true. They found that although some people did look in their direction, this appeared to be part of their normal looking around, not because they noticed the shaking hand. No one stared, commented or laughed (example from Clark<sup>1</sup>).

<sup>1</sup> Clark, D. M. (1997). *Cognitive therapy for social phobia: Some notes for therapists*. Oxford University Department of Psychiatry.

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- Mandy went away for a weekend with friends and found herself eating much more than she wanted to. She had the thought that this eating had caused her to put on weight and that everybody would notice.

Mandy's simple experiment was to weigh herself. Her prediction was that she would be two kilograms heavier than the last time she weighed herself. To her surprise she was actually half a kilogram lighter than that. Her prediction was disconfirmed.

## 6 - For further reading

Burns, D. (1980). *Feeling good*. New York: William Morrow.

Burns, D. (1989). *The feeling good handbook*. New York: Plume.

Butler, G., & Hope, T. (1995). *Manage your mind: The mental fitness guide*. Oxford: Oxford University Press.

Emery, G. (1982). *Own your own life*. New York: New American Library.

Emery, G. (1981). *A new beginning*. New York: Simon & Schuster.  
Written largely for women who have problems with depression, it is an excellent general introduction to skills of identifying and changing dysfunctional beliefs.

Emery, G. (1987). *Getting undepressed*. New York: Simon & Schuster.  
This is a reissue of *A new beginning*, and is practically identical to it.

Emery, G. & Campbell, J. (1986). *Rapid relief from emotional distress*. New York: Rawson.

Greenberger, D. & Padesky, C. A. (1995). *Mind over mood: Change how you feel by changing the way you think*. New York: Guilford.

Martorano, J. T. (1989). *Beyond negative thinking: Breaking the cycle of depressing and anxious thoughts*. New York: Plenum.

## SESSION 10

### Agenda:

1. Complete questionnaires: BDI-II, BAI, SCQ, SBQ, SSR
  2. Review/Discussion of homework
  3. Presentation on the 3 kinds of cognitions: Automatic thoughts, Underlying Assumptions and Core beliefs
  4. Presentation on Low Self-Esteem
  5. Explain homework exercises
  6. Session Feedback Questionnaires
- 

### 3. Presentation on the 3 kinds of cognitions: Automatic thoughts, Underlying Assumptions and Core beliefs

With the use of a series of overheads, the three kinds of cognitions are explained to participants. These overheads can be found overleaf. A copy of these overheads are handed out to participants as well. Thereafter an intense discussion on each participants' core beliefs, underlying assumptions and automatic thoughts should take place.

### 4. Presentation on Low Self-Esteem

A handout entitled "Low self-esteem" is handed to participants and a discussion follows on how low self-esteem is very often a characteristic of social phobic people. This handout can be found overleaf.

### Resources used in Session 10 (that follow)

- Overheads on the "3 kinds of cognitions"
- Handout on Low Self-Esteem

# 3 KINDS OF COGNITION: AUTOMATIC THOUGHTS, UNDERLYING ASSUMPTIONS AND CORE BELIEFS

---

## 1. Automatic thoughts

### What are they?

Thoughts which run through our minds automatically in response to everyday events and situations.

They control our feelings and behaviour.

We usually don't stop to question or reality test them.

### What can I do?

Become aware of them.

Record them on the daily record of dysfunctional thoughts.

Question them, look for cognitive distortions, develop rational responses.

Conduct experiments to test them.

## 2. Underlying assumptions

### What are they?

Ideas which may be hidden in the automatic thoughts.

One kind is *should* or *must* or *have to* statements - implicit rules that we live by.

Another kind is *If...., then....* statements, such as :

"If they don't like me then I am no good",

"If I make a mistake, then I am a failure",

"If they get angry, then I must be wrong".

### What can I do about "should", "must" and "have to" statements?

Ask yourself...

What is the rule that I feel I must follow?

Where did the rule come from? If I learned it years ago, is it still appropriate for my life now?

Did the person who taught me the rule know what they were talking about?

Is there an alternative rule that I could live by?

List the advantages and disadvantages of living by this rule and by the alternative rule.

## What can I do about "if ... then..." statements?

You can use all the strategies already described for working with automatic thoughts. I.e.:

- ▶ Become aware of them.
- ▶ Record them on the *daily record of dysfunctional thoughts*.
- ▶ Question them, look for cognitive distortions, develop rational responses.
- ▶ Conduct experiments to test them.

## 5. Core beliefs

### What are they?

Unconditional ideas about myself such as:

- ▶ "I am inadequate..."
- ▶ "I'm useless ..."
- ▶ "I'm insignificant ..."
- ▶ "I'm worthless ..."
- ▶ "I'm unlovable ..."
- ▶ "I can't cope on my own."

Unconditional ideas about other people such as:

- ▶ "They can't be trusted ..."
- ▶ "They want to humiliate me ..."
- ▶ "They will hurt me ..."
- ▶ "They will abandon me..."

### What can I do about core beliefs?

- Become aware of them.*
- Desert island:* What this be true of me if I was marooned on a desert island?
- Operationalize the idea:* What are the characteristics of a worthless and a worthwhile person? What are the characteristics of a lovable and an unlovable person? Using these characteristics, how would I classify people that I know?
- Origins:* When I was a child did adults around me give me this message either directly or indirectly?  
e.g. by not being loving towards me ("I'm unlovable")... being critical towards me ("I'm useless, I'm worthless")... ignoring my feelings and wants ("I'm unimportant").

## Coping with social phobia

### Low self-esteem

#### The problem

Quite understandably, many people with social phobia are lacking in self-confidence and self-esteem. They doubt the ability to impress or to achieve respect, and find it hard to believe that they will be liked or accepted by others. They believe their performance in social situations leaves much to be desired (they feel they are awkward, boring or abnormally anxious), and consequently they may see themselves as in some way inferior, inadequate, unlikeable or weird.

This negative self-image may be present only in social situations, when people feel themselves to be under scrutiny or being judged by others. Or it may be present in a more general sense, even when the person is alone. Similarly, low self-esteem may arise because social anxiety has only recently developed and dented self-confidence. Or the socially anxious person may never have felt certain of their own worth.

#### Negative thinking and low self-esteem

Three kinds of negative thinking contribute to low self-esteem:

- a) a bias in how you perceive yourself (biased perception);
- b) a bias in how you make sense of what you see (biased interpretation); and
- c) high standards for social performance.

a) Biased perception When your self-esteem is low, you are swift to notice anything about yourself that you are unhappy about or do not like. This may mean aspects of your physical appearance (e.g. your eyes are too small), your character (e.g. you are not outgoing enough), or simply mistakes that you make (e.g. how could you say something so stupid?) or ways in which you fall short of some ideal (e.g. how come everyone else is so much more confident than you?). In social situations, you focus on what you did wrong and ignore what you did right.

All your shortcomings, flaws and weaknesses jump out at you. In direct contrast, your strengths, assets and qualities are hard to spot. Worse still, if you are socially anxious, you assume that others must perceive you in the same way.

b) Biased interpretation. Low self-esteem not only biases your perception of yourself, but also distorts how you interpret what you see. If, for example, you make a mistake, you may take this to mean you are useless as a person. Anything undesirable in you is seen as a reflection of your worth. In contrast, anything good about you (for example, someone compliments you or shows they like you) is brushed aside, discounted or distorted (it was an exception, they were only being

kind, etc.). One consequence of this is that your thinking is biased towards self-criticism (e.g. "I'm useless", "I'm stupid", "Nobody likes me"). This makes you unhappy, increases your social anxiety, and keeps your low self-esteem going.

c) High standards People with low self-esteem often feel that they are failing to meet some standard they have set for themselves. They should be socially at ease, they should be able to deal calmly with life's problems, they should always be the life and soul of the party, they should never be seen to be anxious, they should always be liked and approved of by everyone they meet.

The real problem is not failing to meet these standards, but rather that the standards are unrealistically high. It is simply not humanly possible always to be socially relaxed, calm, in control, vivacious, liked and approved of. Attempting to be so results in pressure, anxiety, self-criticism and demoralisation.

### Cognitive therapy and low self-esteem

Biased perception, biased interpretation and unrealistically high standards make it hard for you to achieve a balanced, kindly view of yourself. Your therapist will work with you to help you to notice and value positive aspects of yourself (correcting biased perception), to counter self-critical thoughts (correcting biased interpretation) and to develop more helpful and realistic standards. The result will be a more balanced, appreciative, accepting perspective on yourself.

## SESSION 11

### Agenda:

1. Complete questionnaires: BDI-II, BAI, SCQ, SBQ, SSR
  2. Review/Discussion of homework
  3. Presentation on "Carrying out a development plan/ Relapse Prevention"
  4. Explain homework exercises
  5. Session Feedback Questionnaires
- 

### 3. Presentation on "Carrying out a development plan/ Relapse Prevention"

As the programme is nearing its end at this stage, relapse prevention and continued development needs to be discussed with participants. This can be done with the use of the overhead, overleaf. A copy of this overhead is handed out to participants as well.

### 4. Explain homework exercises

In addition to the homework that participants are conducting for each session, participants are required to construct their maintenance plans, and set goals for themselves in order to avoid a relapse. This is discussed at the beginning of session 12. Participants are also given a list of further suggested readings around "Cognitive Therapy for Social Phobia". The suggested readings contain practical suggestions and exercises that the participants might like to use once the therapy programme is over.

### Resources used in Session 11 (that follow)

- Overhead on "Make a development and maintenance plan/ Relapse Prevention"

□ *Make a development and maintenance plan:*

- a) Make a graded hierarchy of situations that are problematic now and in the future.
- b) Plan regular exercises in exposure, giving up self-focus and safety behaviours, behavioural experiments and cognitive restructuring work.
- c) Is there anything we have not covered here that you would like help with?

□ *Relapse prevention:*

- a) Make a list of possible difficulties and setbacks.
- b) Make a list of new problematic situations that could occur in the future.
- c) Make a plan to deal with setbacks and new problematic situations.

## **Cognitive therapy for social phobia: Books for further reading with practical suggestions and exercises**

Garner, A. (1980). *Con conversationally speaking*. New York: McGraw-Hill.

Holland, S. & Ward, C. (1991). *Assertiveness: a practical approach*. Bicester: Winslow Press.

Hutchings, S., Comins, J., & Offiler, J. (1991). *The social skills handbook: practical activities for social communication*. Bicester: Winslow Press.

Nelson-Jones, R. (1986). *Human relationship skills: Training and self-help*. Eastbourne: Cassell.

Simmons, M. & Daw, P. (1994). *Stress, anxiety, depression: a practical workbook*. Bicester: Winslow Press.

## SESSION 12

### Agenda:

1. Complete questionnaires: BDI-II, BAI, SCQ, SBQ, SSR
  2. Review/Discussion of homework
  3. Discussion on relapse prevention and developments plans
  4. Discussion about how far every participant has reached with treating their Social Phobia; what would the participants like to discuss most importantly in session 13 (final session)
  5. Discuss what each participant would like to specifically focus on as part of homework, so that this can be reviewed at the beginning of the final session (13)
  6. Session feedback questionnaires
- 

## SESSION 13

### Agenda:

1. Complete questionnaires: BDI-II, BAI, FNE, SCQ, SAQ, SBQ, SSR
2. Review/Discussion of homework
3. Discussion of each participant's outstanding concerns
4. Discussion about the importance of continuing with behavioural experiments and cognitive restructuring exercises
5. Closing exercise
6. Session feedback questionnaire

## 5. Closing exercise

Any exercise that is conventionally used to end a group programme can be used. The exercise that was used in the Edwards, Kannan and Henwood (2000) programme is described with the following. All the participants and facilitators stood up and held hands in the circle. Each participant made a closing comment which described how they felt, what they have learnt, what they take with them from the group etc. Each facilitator also made a closing comment that involved giving words of encouragement to the participants. Thereafter, on the count of three, everybody let go of each others' hands simultaneously, and there ended the group programme.

## Appendix 2

### The Clark and Wells (1995) individualized treatment programme for Social Phobia

The Clark and Wells treatment programme for SP involves a combination of several interventions. The rationale for treatment follows the conceptualisation of the Clark and Wells (1995) model outlined in Section 1.3.6. According to Clark and Wells (1995), the main implication for treatment as derived from the model is that, cases need to be formulated "in terms of the maintenance processes outlined in the model" (p. 86). In treatment, patients need to be made aware of the specific processes that help maintain the problem they have, and they need to be taught how to overcome these processes.

With regard to other treatment methods, this model assumes that it is not lack of social skills that inhibits adequate social interaction. In addition, exposure is only curative if individuals learn to process the interaction differently. Anxiety management strategies invariably take the role of safety behaviours that lessen anxiety, yet prove to be self-defeating. The model provides a clear synthesis of interacting variables from which components for treatment are derived. It is imperative for therapists to follow the strict guideline of this synthesis in order to obtain optimum results. Clark (1997) explains the various techniques that are used in treatment as means for alleviating social anxiety, as follows.

#### a) Psychoeducation:

Psychoeducation forms a very important part of the treatment programme. In order for patients to understand the rationale behind the various treatment interventions that are involved, time needs to be devoted to introducing patients to CBT, the cognitive model, and the various interventions that will be utilized in treatment (explanations of each intervention follows). In the Clark (1997) manual for treatment, there are a series of handouts that are helpful in treatment. These include an explanation of the outline of the model, an explanation of several of the concepts in CT, and aspects that are common to social phobics such as patterns in negative thinking, use of safety

behaviours, self consciousness, low self-esteem, and blushing.

h) Gathering of information for the cognitive model:

The first aim of the treatment programme is to gather information in order to construct a cross-sectional model linking negative automatic thoughts, safety behaviours, anxiety symptoms, and the contents of self-focused attention. Refer to Figure 1.6: Cognitive Model of Social Phobia. Once the model has been constructed, the second aim is to modify the dysfunctional processes outlined in the model. The first and most important process that is dealt with is patients' use of safety behaviours.

c) The Safety Behaviours experiment:

Patients should be given a brief explanation as to what safety behaviours (Refer to Section 1.3.6, C (ii); p. 40) are, and how they might be using them without even being aware of this. Patients identify the safety behaviours that they use with the help of the list of safety behaviours in the 'Safety Behaviours Questionnaire' (Appendix 4[iv]). Once these are identified, patients chose a threatening situation that they would like to role-play. The role-play is then set up with the help of stooges who interact with the patients in the role-play. Stooges are not to be informed that the patients are social phobic. Patients and stooges should give consent to videotaping the role-plays. Exactly the same role-play is conducted twice, with each role-play lasting approximately 8 to 10 minutes.

In the first event, patients are required to utilize all the safety behaviours that they would normally use. In the second event, patients are required to drop all safety behaviours, as difficult and anxiety evoking as this may be. After each role-play, patients complete a rating scale (0- 10) regarding how anxious they felt; how self-conscious they felt, what they were self-conscious about; how anxious they think they appeared; how good their performance was overall; and the extent to which other aspects about themselves that they normally fear will be noticed, were in fact noticeable (e.g., blushing, sweating). At the same time, stooges also complete a similar questionnaire that rates the patients' performance. Invariably, stooges rate the patients much higher than the patients' rate themselves.

#### d) Video-Feedback:

Once the role-plays have been carried out, a video-feedback session is conducted. Patients view their own performance in each of the role-plays. Through a series of guiding questions that the therapist asks, patients compare their performance in the two role-plays. This enables patients to shift their attention to what is actually happening in the situation, rather than what they assume is happening, because they are so preoccupied with their feelings and thoughts. Observing themselves on the television allows patients to view the situation more objectively than subjectively.

Invariably, patients will notice that they draw attention to the very things that they are trying to conceal by using safety behaviours in the first role-play. They also notice that they appear reasonably confident and competent in the second role-play where all safety behaviours are dropped. In addition they compare their rating scale with that of the stooge and realize that they anticipate far more negative evaluation from others than is actually given to them.

#### e) Behavioural/ in-vivo exposure experiments:

There is a very big difference between dropping safety-behaviours in the confinement of the therapy situation, and dropping them in real-life situations. The next aim is for patients to "collect new, more valid information about how they appear and how other people view their behaviour [in order to construct a]... more accurate image of their social selves" (Clark, 1997; p. 33). Patients are encouraged to conduct as many behavioural experiments in situations that they have most frequently avoided thus far. In other words, they are required to conduct in-vivo exposure experiments.

Before conducting these experiments, therapists need to help patients realize how they should process the threatening situations differently. This is explained with the following. "...patients are encouraged to drop all of their safety behaviours and to shift their attention away from themselves and on to observing other people and the conversation; in other words, to reduce their self-awareness and increase involvement in the interaction" (Clark, 1997; p. 33). This enables two very important findings for patients. In the first instance, they realize that they do not need their safety behaviours as they come across reasonably well. Secondly, their shift of attention reduces their anxiety tremendously. The ultimate aim of the exposure exercises is for patients to go out and disconfirm their negative assumptions and beliefs.

To carry out these experiments more effectively, patients are given a 'Record Sheet for Noting Behavioural Experiments' (refer to Appendix 1). With this sheet, patients can plan their behavioural experiments, record their experiments' outcomes, and discuss the outcomes with the therapist in the next therapy session. In addition, patients are also given the 'Daily Record of Dysfunctional Thoughts' (refer to Appendix 1). This is an even more useful sheet than the 'Record Sheet for Noting Behavioural Experiments', as patients record their thoughts and interpretations about the situation with which they experimented. When reviewing their thought record with the therapist, they can discuss why they thought the experiment might have gone badly, alternative interpretations of the outcome of the experiment, and planning of what to do the next time.

Normally, questions that help identify alternative interpretations of an experiment's outcome will enable patients to realize that they are engaging in "mind reading" (Clark, 1997; p. 37). In other words, patients interpret the outcome of the experiment wrongly because they tend to make assumptions about what the other person(s) in the interaction were thinking. Once patients have engaged in a number of different behavioural experiments over the course of several weeks, they are encouraged to engage in a "zero avoidance week" (Clark, 1997; p. 37). Patients are instructed by the therapist to make "a point of not avoiding any aspect of social interaction using as one's cue whenever you feel like avoiding/delaying/putting off doing something social, don't. Do it straight away"(Clark, 1997; p. 37). With this technique, patients realize that do not need to remain socially 'on-guard'. They become more spontaneous.

#### f) Interrogating the environment:

Dropping of safety behaviours and shifting attention to others and the interaction enables patients to realize that they come across better than they think. However, this process is not always smooth. The excessively high standards (Section 1.3.6, A) that patients set for themselves invariably hamper this process. "A good way of helping patients to challenge their beliefs involves encouraging them intentionally to perform behaviours which they falsely believe will lead to negative evaluation" (Clark, 1997; p. 39). In other words, patients are required to go and do what they think is the worst possible experiment and test it. These experiments are termed 'interrogating the environment' because they allow patients to test how others think and respond even when the worst happens (e.g. the patient stuttered, spilt his drink, or disagreed with others).

g) Dealing with the Post-Morrem:

First and foremost, patients need to be made aware that they are engaging in post-mortem (Section 1.3.6, C). Patients need to understand that the process of post-mortem undermines their confidence in future social interactions, and effaces the success experiences and insights they may have achieved in treatment thus far. Achieving a 'ban' normally stops the process of post-mortem. This involves therapist and patient to review the content of the post-mortem and agree that it consists of biased, misleading or ambiguous information. If however, a ban is not achieved, patients are "instructed to focus in what actually happened, rather than their feelings and pay attention to positive information" which is otherwise ignored (Clark, 1997; p. 44).

h) Constructing a veridical social image:

Patients construct a veridical social image by disconfirming their belief in impressions of themselves (refer to Section 1.3.6, C) that they assume, reflects, what others are seeing. In most cases, the techniques already outlined produce a marked decline in the frequency of such images. However, some patients continue to experience distorted images in spite of the fact that they know that these images are incorrect.

A useful technique for replacing the distorted image with an equally vivid but accurate image, is through 'image restructuring'. This should not be treated as an intellectual exercise. Instead, patients should "dwell on their negative images long enough for an emotional reaction to be elicited before they attempt to switch to a more realistic image" (Clark, 1997; p. 46). Patients are then reminded about successful social encounters, and their impression in the second role-play of the video-feedback exercise.

i) Dealing with unconditional assumptions/beliefs:

Normally, in the final stages of therapy, unconditional assumptions and beliefs (refer to Section 1.3.6, A) are dealt with. Most patients deal with these assumptions and beliefs during the course of therapy. However, some patients tend to hold on to beliefs such as, "I am worthless" or "I am unlikeable". Techniques such as those used in CT can be used, as these are techniques that deal with faulty cognitions.

Before using these techniques however, the therapist may find it helpful to ask the 'desert island' question. "This involves asking patients whether they would continue to think of themselves as unlikeable, worthless etc. if they were shipwrecked on a desert island" (Clark, 1997; p. 47). Most social phobics say "no"; because their negative self-schema is situationally constructed. If they are away from social situations they have a more positive view of themselves. Therapists use this knowledge to teach patients how to utilize their positive self-schema in social situations as well. With the use of a "positive data log" patients conduct further behavioural experiments that involve looking for, and recording signs of being liked, and being seen as worthy by others (Clark, 1997; p.50). This helps patients disconfirm their negative self-schema.

#### Conclusion:

This programme involves various techniques including, exposure, behavioural experiments, CT techniques, and a video-feedback exercise. All aspects of the negativity and anxiety involved in social interactions are interrogated and dealt with. The ultimate aim of this treatment programme is to change patients' faulty thinking processes that help maintain their social anxiety. In doing this, the chances of relapses are avoided.

## Appendix 3 (a)

### The Case Report of Lindiwe<sup>5</sup>

#### A) Brief Case Narrative:

"Lindiwe", aged 19, is a black, female student. She was born in Natal (Umzinto), in South Africa. She was in her second year at university when she participated in the therapy programme. Her mother is a teacher and her father is a prison warden. Lindiwe mentioned that her father was a very quiet man. He never responded to her feelings, and she was never emotionally attached to him. Lindiwe said that her mother had always been exceptionally fond of her, and "spoilt me rotten" as a child. Lindiwe's parents argued a lot when she was a child, and still do. She often wishes that "they would stop fighting and start getting along". Lindiwe has a brother, aged 21, and her sister is 16. She mentioned that, "as children, my brother, sister and I were very close". For the last two years, she and her siblings have not lived in the same city, and therefore, she has lost the emotional attachment with them that she used to have, when she was younger. Lindiwe does not ever remember having had close friends. However, she always had several acquaintances.

#### *(a) Life situation at the start of the programme*

Lindiwe described a typical day in her life as, attending all her lectures during the day, and watching television or studying during the evenings. She mentioned that this daily pattern does not change and, "my problems with socializing began a long time ago". She also mentioned that she likes to think that she is a person that people would like. However, she has never been able to socialize freely. Through her observations, she feels that people have only made an effort to associate with her when they are in need of her help. Whenever anybody knocks on her room door in her residence, she is sure that the person is in need of a favour. Nobody has paid her a social visit. Lindiwe mentioned that her performance in her academic career, at university, has been slightly affected by her problems.

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<sup>5</sup> The name of the participant has been changed in order to protect her identity.

### ***(b) Presenting problem***

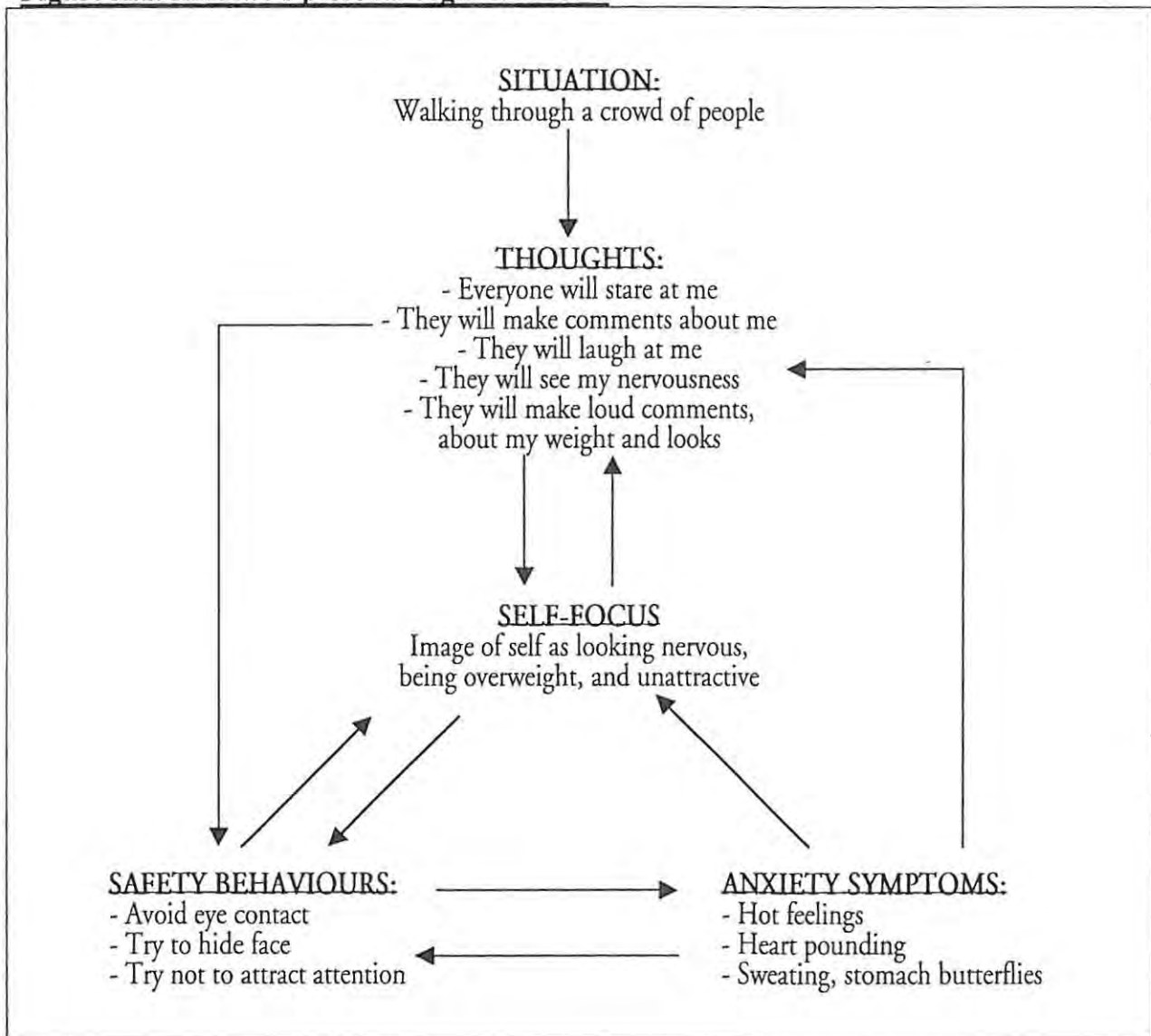
In the initial interviews, Lindiwe appeared very shy and nervous. She did not say very much, and had difficulty making eye contact with the interviewer. Her main difficulties involved making presentations, where she would find herself unable to speak; and she mentioned that, "generally, I am a very nervous and self-conscious person in any social situation". Therefore, she had never been to parties, social gatherings or nightclubs, due to her fears of being boring and uninteresting in the eyes of others. Lindiwe also had low self-esteem because she had a core-belief about herself, as being, overweight and unattractive. For this reason, she feared that people would laugh at her, and make comments about her. She believed that people of the opposite sex avoided her because "they would not want to be around a fat, unattractive person, like myself". The main reason why she had responded to the posters requesting participation was because, "I want to know how to find out what is going on in my life, take control of it, and deal with it". She was concerned about the fact that she had no close friends, and did not know how to make friends or socialize, in general.

Lindiwe's goals for treatment, therefore, were related to her core-beliefs about being overweight, unattractive, and undesirable to people of the opposite sex, because of this. In addition, her inability to socialize, and her inability to make a presentation without feeling anxious, needed to be addressed. She wanted to believe in herself, and to be able to "communicate freely, without my fears, or discomfort, when I interact with people".

### ***(c) Idiosyncratic cognitive models outlining anxiety provoking situations for Lindiwe***

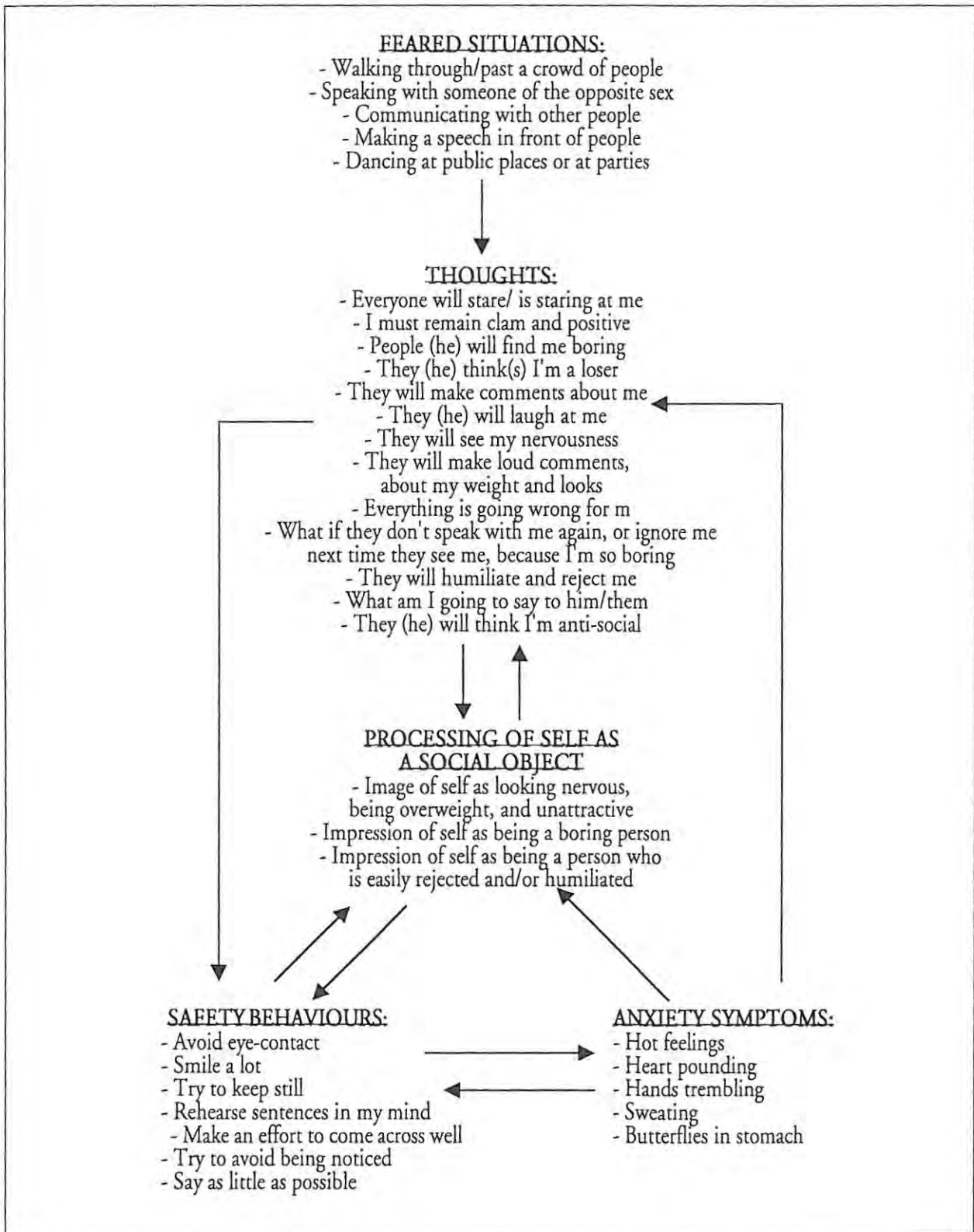
i) Figure A.1, below, illustrates the structure of one of Lindiwe's anxiety responses to a socially threatening situation. Lindiwe constructed this model after the first four sessions of the group therapy programme.

**Figure A.1: Lindiwe's personal cognitive model**



ii) Figure A.2, below, illustrates the structure of Lindiwe's anxiety responses to all the socially threatening situations in which she had monitored her thoughts and emotions, with the use of the first three columns of the 'Daily Record of Dysfunctional Thoughts'.

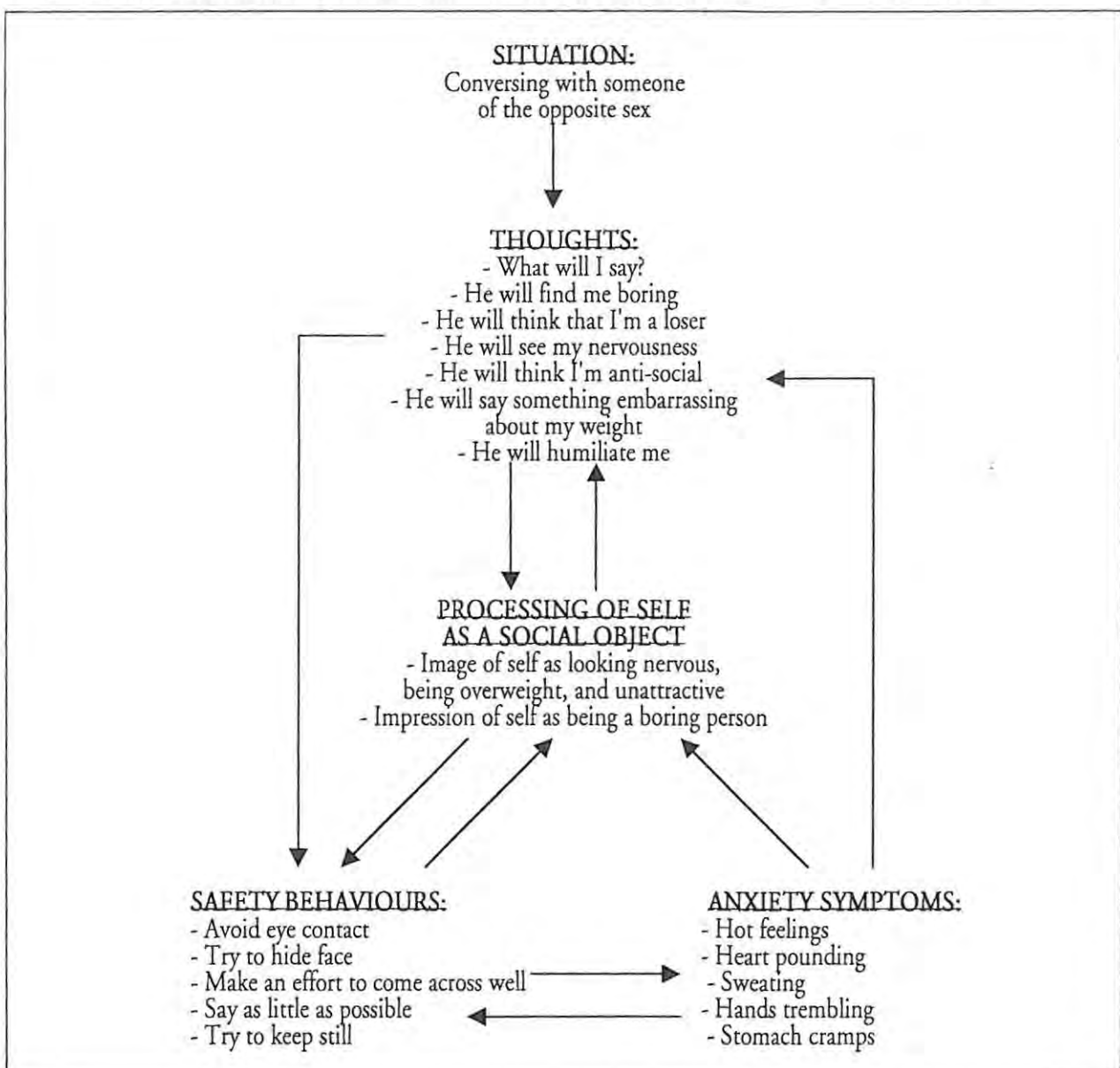
**Figure A.2: Comprehensive cognitive model of all Lindiwe's anxiety responses in all her feared situations**



This comprehensive cognitive model was constructed by the researcher, using information gathered during the first five sessions of the therapy programme (before the 7-week vacation). As part of homework, Lindiwe had experimented with monitoring her thoughts and emotions in three situations that form part of the model outlined in Figure A.2, above.

iii) Figure A.3, below, depicts the cognitive model that Lindiwe constructed during the session in which her SBE took place (between sessions 6 and 7).

**Figure A.3: Lindiwe's cognitive model regarding the first role-play of her SBE**



These were, walking through a crowd of people whilst entering a lecture theatre (also used by herself to construct Figure A.1), speaking with someone of the opposite sex whilst queuing for lunch in the dining hall, and communicating with other people in the common room at her residence. Although Lindiwe suffered with serious anticipatory anxiety, she would try to remain calm and positive whilst engaging in one of her feared social situations. In the process, she managed to collect constructive information that helped her to start disconfirming her core-beliefs. The feared situation that she had chosen for her SBE, involved a conversation with someone of the opposite sex. Only the 'thoughts' and 'safety behaviours' sections of the model were filled out before the SBE, Lindiwe completed the rest, after the first role-play.

***(d) A brief summary of Lindiwe's progress during and after the therapy programme***

Lindiwe benefited greatly from her SBE and managed to disconfirm several of her negative cognitions as a result of her video-feedback. She realized that she did not appear as overweight or unattractive as she had imagined herself to appear. In addition, after her experience in, and video-feedback of her second role-play, she realized that she was an interesting person to speak with. She managed to keep the attention of the male volunteer, and made him laugh several times. The volunteer had asked her, during the second role-play, whether she would like to meet him again. He also mentioned that he had enjoyed her company. This was the highlight of her SBE. Lindiwe's ratings regarding her experience with each role-play, and the volunteer's ratings regarding Lindiwe's performance during each role-play are given in Tables A.1 and A.2, below.

From session 7 onwards, Lindiwe conducted several behavioural experiments as part of her homework. These experiments included, making conversation with people at every given opportunity, making the effort to speak to people of the opposite sex, volunteering to lead groups and make presentations as part of her academic work, and attending social gatherings. Through her experiences with these behavioural experiments, Lindiwe had discovered that none of her beliefs about herself were correct. By the end of the programme, she had already managed to make several new friends (males and females) who included her in their outings and parties. She had even managed to dance in the presence of people she knew, at a nightclub,

without feeling conscious about her weight or appearance. In addition to her own treatment successes, Lindiwe was a positive influence on other group members, especially Nick (3.2.3).

**Table A.1: Lindiwe's ratings after each role-play**

	After role-play 1	After role-play 2
1. How anxious did you feel?	8	3
2a. How self-conscious did you feel?	9	1
2b. What were you self-conscious about?	- Not knowing what to say - My weight and looks - Appearing boring	- Nothing really
3. How anxious did you think you appeared?	6	2
4. How good was your performance overall?	4	2
5. What individualized things did you fear would be noticed, and to what extent?	- Mumbling (6) - being boring (8) - my weight (10) - my looks (6)	- my weight (3)

At the de-briefing session, Lindiwe mentioned that she had had several other interesting social encounters, in the three weeks that had passed, since the programme had ended. Her most exciting encounter involved approaching and conversing with a person of the opposite sex whom she had "had a crush on for at least a month". She had maintained all treatment gains. She mentioned that there was nothing about the programme that she would have liked to have changed, or conducted differently. She mentioned that she missed the group and the facilitators.

At the 6-week follow-up interview, Lindiwe mentioned that she was "enjoying my new, social life". She had continued to maintain treatment gains and appeared to be definite that she would not suffer from a relapse of social phobia. She had continued to do her behavioural experiments and had a healthy social life.

**Table A.2: Volunteer's ratings after each role-play**

	After role-play 1	After rule-play 2
1. How anxious do you think Lindiwe looked?	5	1
2a. How self-conscious do you think Lindiwe looked?	4	0
2b. What were you self-conscious about?	- She did not know what to say - Afraid of the stranger - Difficulties making Eye contact	- Nothing
3. How good so you think Lindiwe's social interaction skills were?	5	8
4. What individualized things did you notice about Lindiwe, and to what extent?	- free (4) - communication (4) - lively (4) - shaking (2)	- free (8) - spoke a lot (8) - lively (9) - interesting (8)

**B) Presentation of Quantitative Data:**

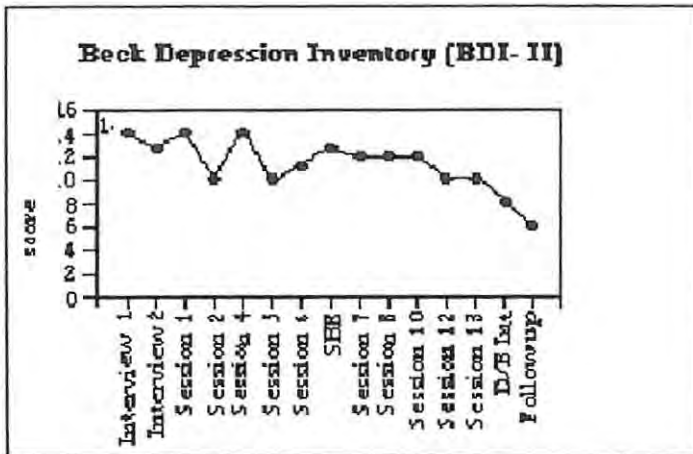
In order to evaluate the effectiveness of the programme with respect to Lindiwe's problems, all the questionnaires that Lindiwe completed were scored, and are presented as graphical representations of her progress. Lindiwe did not attend sessions 3, 9 and 11. It must be noted that no scores are presented for these sessions in the graphs. Lindiwe was questioned about the fluctuations of each questionnaire's scores at the debriefing interview. All explanations for these fluctuations, as described below, are Lindiwe's own explanations.

**i. Beck Depression Inventory (BDI-II)**

The BDI-II measured Lindiwe's levels of depression. During the entire length of the treatment programme, Lindiwe's depression scores had fluctuated between mild depression and minimal depression. Lindiwe was unable to explain any of the fluctuations in her depression scores, as she had never seen herself as a depressed person, "no matter how difficult or bad things may seem". She mentioned that these scores did not make much sense to her because, "for example, you wake up one morning and don't feel hungry... or you don't sleep so well because you have

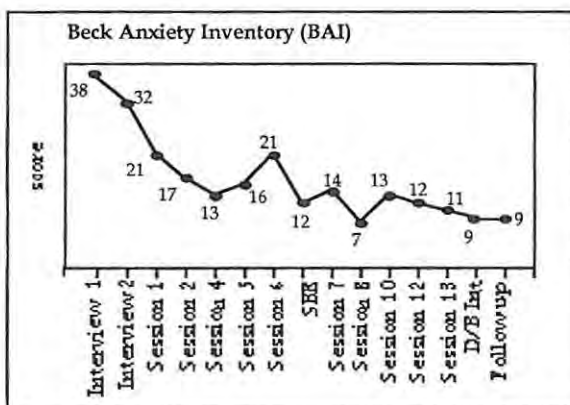
bad dreams... that does not reflect on how depressed you are, although you circle the appropriate options in the questionnaire”.

**Graph A.1**



**ii. Beck Anxiety Inventory (BAI)**

The BAI measured Lindiwe's levels of anxiety. Lindiwe's BAI score in the first interview was 38, indicating severe anxiety. Lindiwe explained that she was highly anxious about meeting the interviewer and speaking about her problems. Her score remained in the severe anxiety range in interview 2 as well. However, her scores steadily decrease during the course of the programme, indicating that she was feeling some respite from her anxiety.

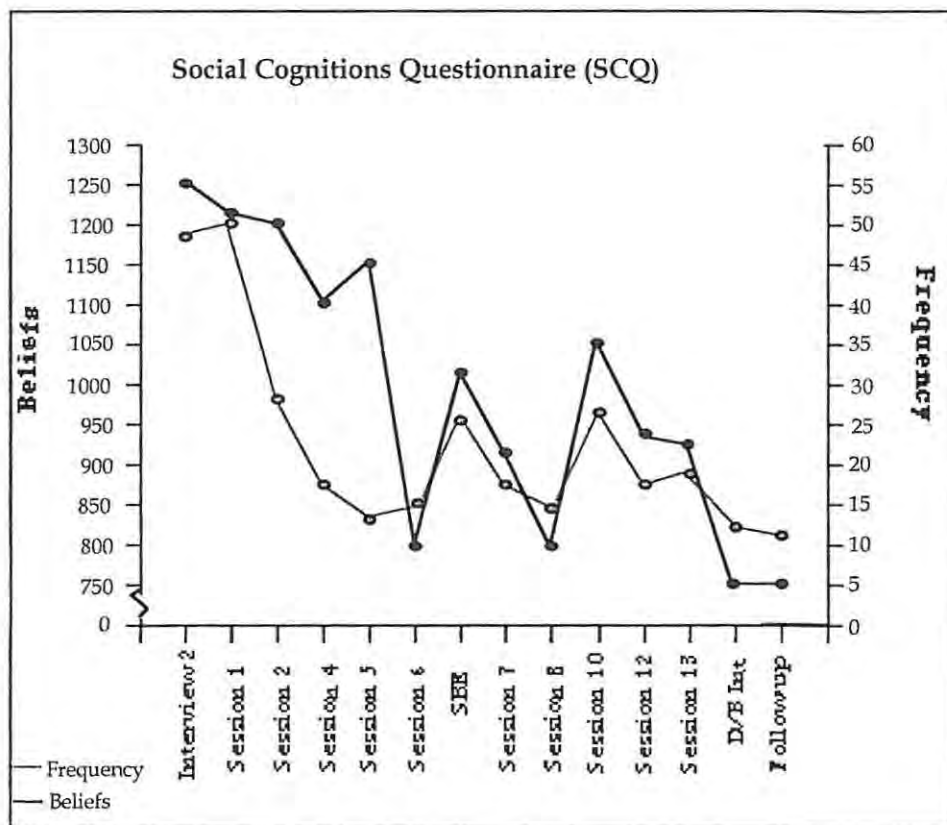


**Graph A.2**

Lindiwe mentioned that her scores increase at sessions 5 and 6 because she was anxious about her upcoming examinations (before the vacation). After the vacation, in session 6, her score increased once more because of her high level of anxiety before meeting the group again. Lindiwe missed session 9, and between sessions 8 and 10, her score changes from 7 to 13. She mentioned that she had been studying for several tests at that stage, and had been doing several behavioural experiments. She mentioned that she was feeling “restless” during that time, and this increased her anxiety.

iii. Social Cognitions Questionnaire

Graph A.3



In the second interview, Lindiwe's SCQ scores (1250/2200- belief, 48/88- frequency) indicated that she had numerous, frequent cognitions that preoccupied her, and she believed very

strongly in these cognitions. For example, she rated the frequency of thoughts such as, "I will be unable to speak; People will stare at me; People will reject me; People are not interested in me; I am inadequate; and People think I am boring" as thoughts that usually (4/5) or always (5/5) occurred when she was nervous. In addition, her beliefs in all these thoughts were rated between 80/100 and 100/100.

Lindiwe's SCQ scores progressively decreased. However, there is a noticeable increase at the SBE, and between sessions 8 and 10. Lindiwe was one of the most anxious participants at the SBE. She mentioned this as well, at the debriefing interview when questioned about her increase in scores. She mentioned that she was not able to focus or concentrate when she first arrived at her SBE. She had several negative cognitions that were racing through her mind, and she felt as though she believed each one of them. Some of these negative thoughts form part of her model at the SBE (Figure A.3).

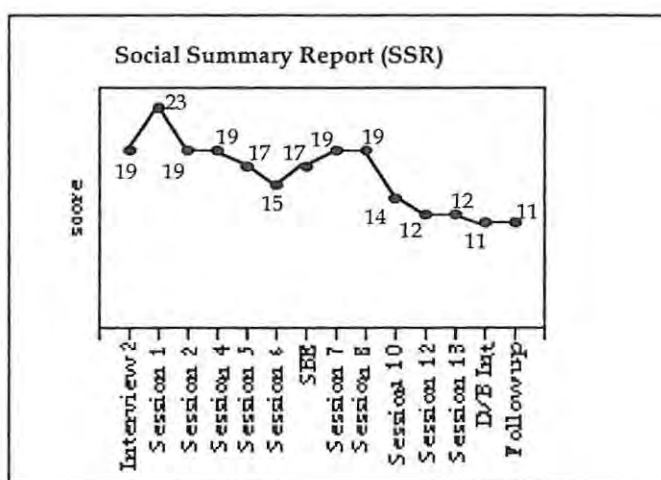
As explicated above in Lindiwe's BAI section, her scores increased between sessions 8 and 10 because she was "extremely restless and on edge" at this time. She mentioned that, "since I was doing so many behavioural experiments, sometimes the experiments were not so rewarding as well". This caused her negative cognitions to increase, and similarly, her beliefs in these cognitions increased as well. However, this trend is changed immediately at session 11, and as she explained, "it's always nice to come to the group, share your concerns, and get feedback from everyone that makes you see things differently... you realize that you were worrying about nothing". Lindiwe's final scores were 750/2200 (belief) and 11/88 (frequency), which indicate remarkable improvement. Lindiwe managed to overcome most of her negative cognitions.

#### **iv. Social Summary Rating (SSR)**

The SSR measured Lindiwe's level of anticipatory anxiety prior to social interactions, the degree of self-focused attention in social interactions, and the degree to which she engaged in post-mortem self-critiques. In the first session, Lindiwe's SSR score was 23/40, which indicated a high level of social anxiety in the week before she answered the questionnaire. However, similar to most of the other graphical representations of scores for various

questionnaires, her scores gradually become less, and increase at the SBE. Lindiwe had been experiencing social anxiety in the week before her SBE. However, her scores decrease once again, as from session 8 onwards, indicating that, even though she was under exams stress at this stage, at least she was ready to engage in social interactions without experiencing high levels of social anxiety. She attributed this reduced level of social anxiety to her successes with her SBE and experiments that she had conducted following her SBE, that were rewarding.

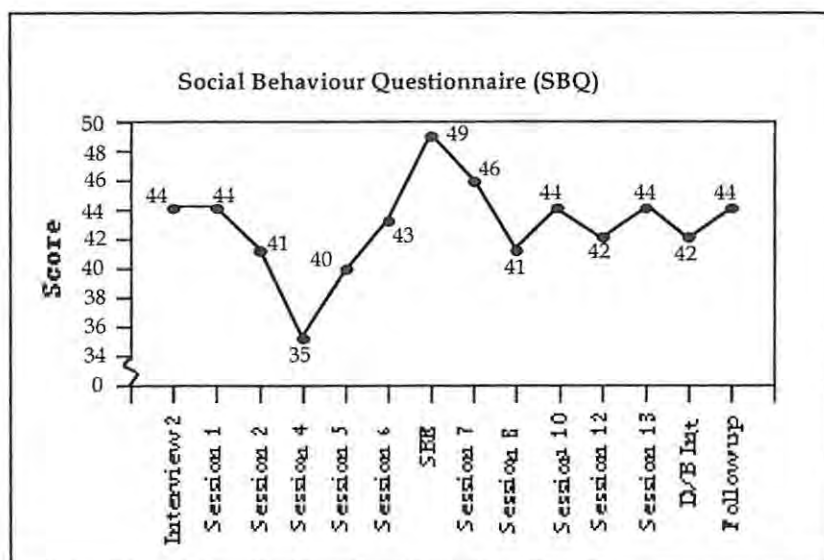
**Graph A.4**



**Social Behaviour Questionnaire (SBQ)**

The SBQ assessed the degree to which Lindiwe employed safety behaviours. Lindiwe appeared to be less successful than the other participants in this area. Between sessions 1 and 4, her use of safety behaviours markedly decreases. Lindiwe had not identified her safety behaviours by this stage in the programme and therefore she had not been monitoring them. There is evidence from her feedback in session 4, that when safety behaviours were discussed in detail, and the participants had to construct their cognitive models, Lindiwe realized and understood properly what safety behaviours were, and started to recognize how and where she used them.

**Graph A.5**

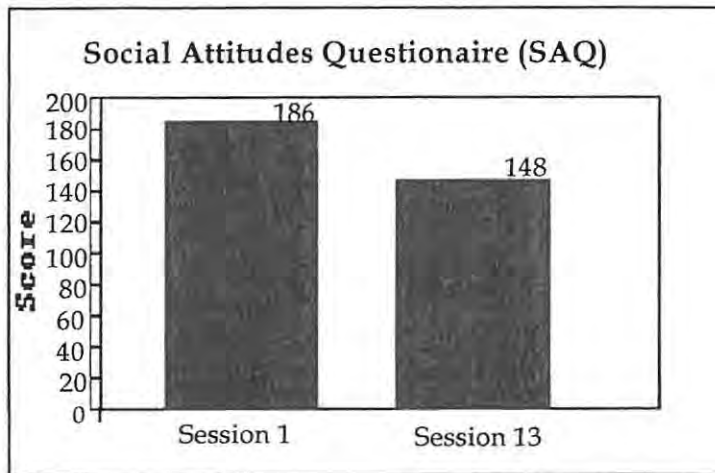


As is meant to happen with this treatment, Lindiwe's SBQ score decreases after the SBE, when she realized (with the video-feedback, and her experience with the SBE) that her safety behaviours were more harmful than useful. Lindiwe explains that her scores still remained relatively high even towards the end of the programme because, even though her emotions and thoughts had changed, and she was able to actively engage in social interactions, she continued to use certain safety behaviours. She could not explain her use of safety behaviours and mentioned that she might have been completing the form wrongly.

#### **vi. Social Attitudes Questionnaire (SAQ)**

The SAQ was used to measure some of Lindiwe's attitudes and beliefs. Her SAQ score in session 1 (186/300) is not remarkably higher than her score in session 13 (148/300). Some of the statements to which Lindiwe circled the "totally agree" options included: "Everyone will stare at me and think I'm strange if I don't act normally; Other people are better at getting it right socially than me; People think I'm uninteresting; and If people see I'm anxious, they will humiliate, ridicule and discount me". Lindiwe mentioned that she had experienced remarkable changes in her thinking patterns and emotions by the end of the treatment programme.

**Graph A.6**



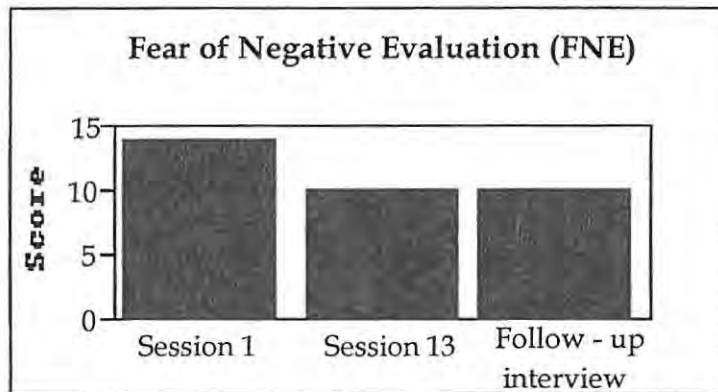
Several of her attitudes and beliefs were similar to those explicated by Sam (3.2.1, Graph 3.6), and in addition, similar to Sam, Lindiwe also felt that, in spite of all the progress she knew she had made, she did not feel confident enough to circle the *totally disagree* option for several questions. She still felt as though she had attitudes and beliefs that she needed to work on. At the 6-week follow-up session, Lindiwe had maintained her progress, and it was clear that she appeared more confident.

**vii. Fear of Negative Evaluation (FNE)**

The FNE questionnaire was used to measure Lindiwe's mood and her general assumptions pertinent to her social phobia. In the first session, Lindiwe's score was 14/30. In the follow-up interview her score was 10/30. Lindiwe mentioned that she never quite understood this questionnaire or its purpose because most of the statements are true to anybody whether they are social phobic or not. Therefore, even though her specific fears of negative evaluation had been effaced by the end of the programme, she still felt as though there were certain fears she maintained, and these were healthy. For example, she mentioned that, "it is necessary to be concerned about taking care of your friendships. I will worry about negative evaluation from

the people who I care for, and who care for me. As for the rest of the people, this therapy programme has helped me see that I should not worry about them”.

**Graph A.7**



**C) Conclusions around Lindiwe’s case**

Lindiwe’s questionnaire scores had decreased by the end of the programme, and she had experienced considerable changes in her emotional, behavioural and cognitive patterns. At the follow-up interview she mentioned that she had experienced complete treatment success. She was able to engage in social interactions that she never had known she was capable of, prior to treatment. She also mentioned that she was on the verge of entering into a relationship with the boy she had had a crush on (mentioned earlier). During the course of the programme, Lindiwe had tried to lose weight, but was unsuccessful. Nevertheless, her weight no longer bothered her. She mentioned that, “I looked around and noticed other girls who are much bigger than I am, and they don’t care”. She realized that “it does not matter how fat or thin a person may be. You need to be confident about who you are”. This point refers to Bandura’s self-efficacy, and ability to learn from and imitate a coping role model. Lindiwe had managed to deconstruct and efface all her core beliefs that had previously stopped her from taking the risks involved in enjoying her life.

Mention needs to be made, however, about her continued use of safety behaviours in spite of the fact that she had managed to experience remission from SP. Lindiwe mentioned at the debriefing interview that she might have been completing the questionnaires wrongly. This is a possibility, as she was also the last member in the group (at the beginning of the programme) to understand safety behaviours and identify them in her behaviour. Therefore, in spite of her treatment gains from the SBE and video-feedback sessions wherein her safety behaviours were targeted and she understood how they could be self-defeating, it can be hypothesized that Lindiwe never really paid attention to monitoring her safety behaviours in her behavioural experiments. Instead, she paid greater attention to her cognitive restructuring activities and diverting her attentional focus to the actual social interaction. Subsequently, by positively changing her thought processes and changing her self-appraisal, she automatically ceased to use her safety behaviours. However, she did not even realise that she was not using them anymore, as she had not been monitoring them, and continued to complete the SBQ in a misleading manner.

Lindiwe was one of the vital members to the group because she actively engaged in correcting her negative assumptions and beliefs, and this not only aided herself, it also aided other members to constructively learn from her experiences. She always had feedback for others in the group that helped them highlight the positive in their unsuccessful encounters. This feedback encouraged them to try again with their behavioural experiments without giving up hope. When she had experienced several unsuccessful encounters between sessions 8 and 10, her statement in session 12, "I tried again and again, and got it right", shed new light on the purpose of behavioural experiments for all participants in the group.

Apart from collecting her own constructive evidence about her social interactions, she made the effort to collect evidence for Nick as well, which she shared in session 13. In the debriefing interview, she explained that, "I realized that he was struggling with his negative beliefs and made the effort for him in order to give him a boost since I move in the same circles as he does". As mentioned above, under Lindiwe's SCQ (Graph A.3), Lindiwe highlighted the advantages of being in a group, and experiencing success as a unit. She always appreciated others' feedback, and made sure to actively give her feedback to others as well.

## Appendix 3 (b)

### The Case Report of Mary<sup>6</sup>

#### **A) Brief Case Narrative:**

“Mary”, aged 22, is a black, female student. She was born in Nkar Village, in Cameroon, West Africa. She was in her third year at university. Her mother died when she was 4 years old, and Mary does not remember her. Mary’s father is a lecturer in Cameroon. Her father never remarried after her mother died. Instead, he devoted his life to taking care of Mary, her two brothers (28 and 26 years), and her sister (24 years). Mary is the youngest child in her family, aged 22. Mary mentioned that her siblings are her closest friends, and living away from them (as they are in Cameroon) has been very difficult for her. She also mentioned that she has always shared a very emotionally attached relationship with her father, who stressed the importance of education and religion. She was brought up to be a good Christian, and for this reason, she has never committed any “devious acts” that could bring shame to her family. She has always been amongst the top 10% of her class at school and university, and is proud of this.

#### **(a) *Life situation at the start of the programme***

Mary described a typical day in her life as waking up at 6:30 am, attending all her lectures during the day, eating her meals in the residence dining hall, watching television or studying during the evenings, and sleeping by 10 pm at the latest. She never missed Church on Sundays, and occasionally went to Church during the week if she felt depressed or anxious. She mentioned that her life was satisfying, yet she wished to have the sort of excitement in her life that other people have, as part of university life. Mary did not have a desire to attend “wild parties and drink alcohol”, but she at least wanted to attend some social gatherings. She had no friends, and two acquaintances in her residence. She mentioned that she had made an effort to make these acquaintances, and had “in fact expected them to be members of this therapy group

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<sup>6</sup> The name of the participant has been changed in order to protect her identity

as well!". Mary had never had a boyfriend, and was never in a steady relationship with any man.

**(b) *Presenting problem***

In the initial interviews, Mary appeared to be a friendly person who other people would want to know, if only she could efface her social anxieties. She made intelligent, interesting conversation even after the interviews were completed. She had well good social manners, and had no trouble making eye contact with the interviewer. Her main difficulties involved attending social gatherings, speaking with strangers, making friends, joining in a conversation with people that she knew (for example, from her residence building), and meeting people that she knew at a public place. Her difficulties were related to her core-beliefs that she was boring and uninteresting in the eyes of others.

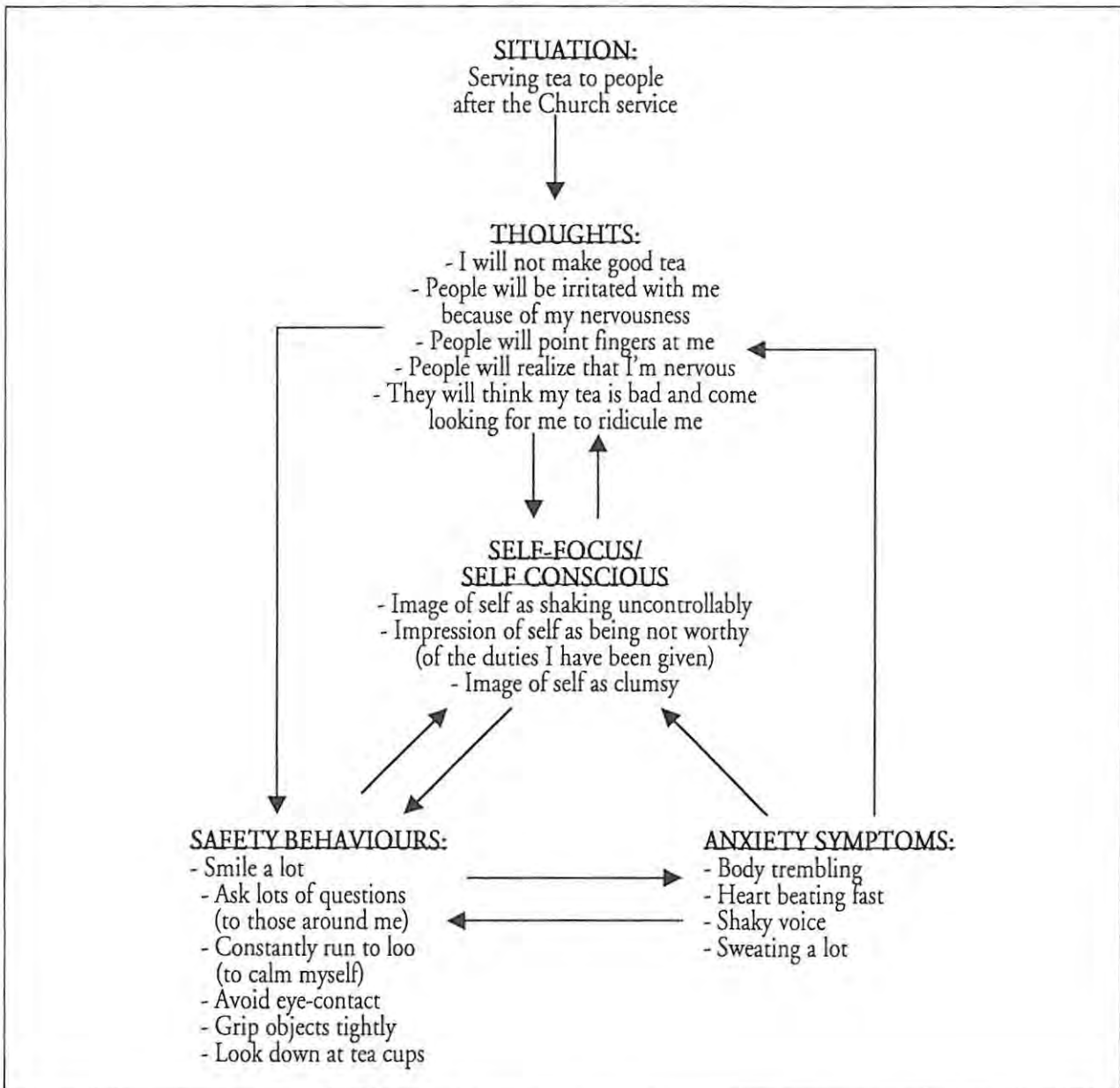
Another one of her negative beliefs involved her negative impression about her spoken English and accent that she assumed would be laughed at or mocked by others. Despite the fact that Mary spoke good English, she believed that her accent was not understandable. She preferred to believe that "merely by conversing, I make myself less socially acceptable". Mary had another social fear that caused her great concern. She was involved in the group of people that made tea for the elders who attended Church on Sundays. She feared that her tea tasted terrible and that somebody would ridicule or humiliate her for this. Therefore, attending Church had become a "social nightmare" for her. "Being a good Christian, I had never had a boyfriend"; however, she wanted very much to be involved with someone who "shares my Christian values". She mentioned that she had met such men at her Church but was never able to speak with them or get to know them because of her social anxieties.

Mary's goals for treatment, therefore, were related to her negative beliefs about her inability to make an impression on people when she conversed with them, and her impression that she would be laughed at because of her spoken English. In addition, her fear of making tea at Church needed to be addressed. Mary wanted most of all, "to be liked by others, and to have friends who visit me and laugh with me, rather than at me".

**(c) Idiosyncratic cognitive models outlining anxiety provoking situations for Mary**

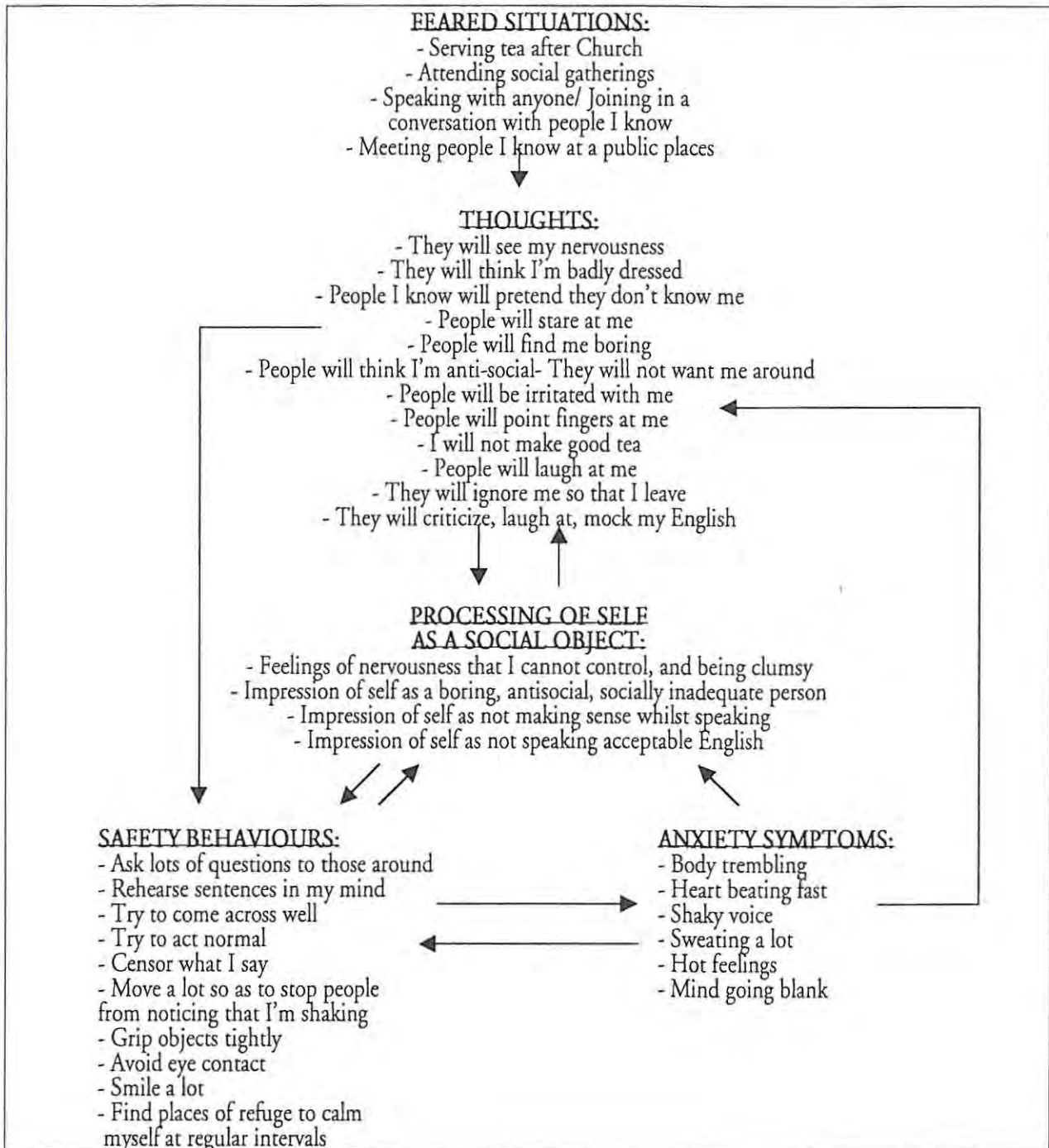
i) Figure A.4, below, illustrates the structure of one of Mary's anxiety responses to a socially threatening situation. Mary constructed this model after the first four sessions of the group therapy programme.

**Figure A.4: Mary's personal cognitive model**



ii) Figure A.5, below, illustrates the structure of Mary's anxiety responses to all the socially threatening situations in which she had monitored her thoughts and emotions, with the use of the first three columns of the 'Daily Record of Dysfunctional Thoughts'.

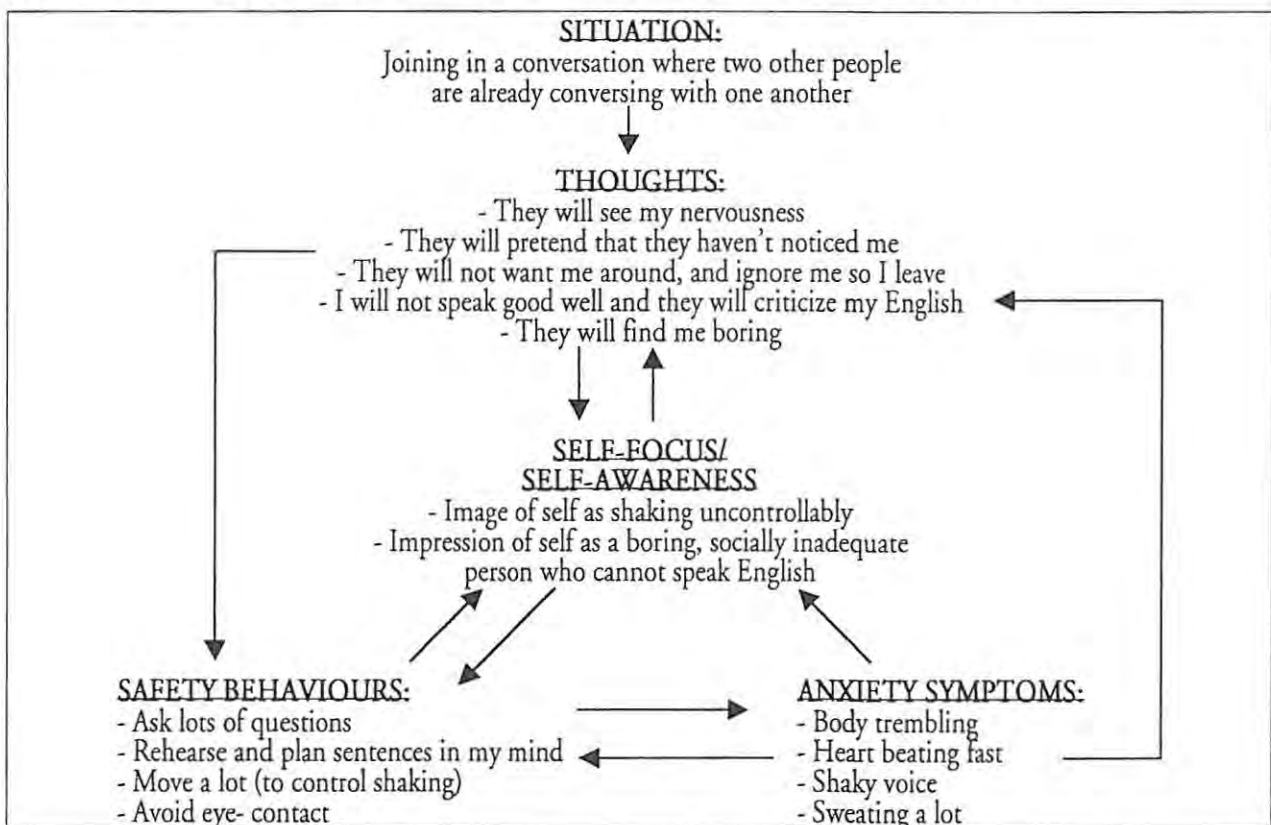
**Figure A.5: Comprehensive cognitive model of all Mary's anxiety responses in all her feared situations**



This comprehensive cognitive model was constructed by the researcher, using information gathered during the first five sessions of the therapy programme (before the 7-week vacation). As part of homework, Mary had experimented with monitoring her thoughts and emotions in three situations that form part of the model outlined in Figure A.5, above. These were, serving tea after Church (described in Figure A.4), attending her residence hall's garden party, and conversing with some people in the common room whilst watching television. Mary experienced severe anxiety in all three situations, but nevertheless tried very hard to monitor her thoughts and emotions. At the garden party, however, she completely blanked out when other people approached her. This encounter was highly unsuccessful for her, and she chose to experiment with conversing with people for her SBE.

iii) Figure A.6, below, depicts the cognitive model that Mary constructed during the session in which her SBE took place (between sessions 7 and 8).

**Figure A.6: Mary's cognitive model regarding the first role-play of her SBE**



Only the 'thoughts' and 'safety behaviours' sections of the model were filled out before the SBE. Mary completed the rest after the first role-play.

**(d) A brief summary of Mary's progress during and after the therapy programme**

Mary benefited to a great extent from the SBE. She realized that her safety behaviours did more harm to her appearance and behaviour, than good. In addition, she realized most importantly, that by moving a lot in order to control her shaking, she looked even more nervous. Mary was able to join the conversation of the other two people with a lot more ease in the second role-play. She made them laugh several times and had their constant attention. Both volunteers mentioned that they had no trouble understanding her English. In fact, they mentioned that she could use her accent to her benefit, "as it makes people curious about where she's from". Mary's ratings regarding her experience with each role-play, and the volunteers' ratings regarding Mary's performance during each role-play are given in Tables A.3 and A.4, below.

**Table A.3: Mary's ratings after each role-play**

	After role-play 1	After role-play 2
1. How anxious did you feel?	8	5
2a. How self-conscious did you feel?	9	1
2b. What were you self-conscious about?	- My voice trembling - I'm not interesting - I have to think of a story to tell - My body shaking	- My voice - eye contact
3. How anxious did you think you appeared?	8	6
4. How good was your performance overall?	1	4
5. What individualized things did you fear would be noticed, and to what extent?	- looking - uninteresting (7) - trembling (8) - shaking knees (6)	- trembling (7)

From session 7 onwards, Mary conducted several behavioural experiments as part of her homework. These experiments included, attending social gatherings (where she had some interest in the nature of the gathering), speaking to people, trying to have conversations with the boys at her Church, and offering to take on other responsibilities at Church apart from making tea. Through her experiences with these behavioural experiments, Mary had discovered that none of her beliefs about herself were correct. She had managed to make a few new friends, converse with the people she made tea for at Church without hiding from them, and attended social gatherings where she had made some progress when trying to converse with people. However, she felt that she still had a long way to go before she would feel completely happy about her social life.

**Table A.4: Volunteer's ratings after each role-play**

	After role-play 1		After role-play 2	
	Volunteer 1	Volunteer 2	Volunteer 1	Volunteer 2
1. How anxious did you think Mary looked?	4	6	2	3
2a. How self-conscious did you think Mary looked?	2	7	0	3
2b. What might Mary have been self-conscious of?	- not being able to fit into the conversation	- was not participating in the conversation	-	-
3. How good do you think Mary's social interaction skills were?	7	6	9	8
4. What other individualized things did you notice about Mary and to what extent?	-	Blushing (7) Stuttering (6) shaking lip (6)	-	-

At the de-briefing session, Mary mentioned that she had made an effort to maintain treatment successes that she had gained by the end of the programme. However, she had not had much of an opportunity to conduct more behavioural experiments. When asked to explain this further, Mary mentioned that, "I did not feel the need the test my social skills over the last three

weeks... I've been happy in my own company". The interviewer encouraged Mary to interact with people and to continue to do behavioural experiments.

At the six-week follow-up interview, Mary mentioned that she had conducted several behavioural experiments and was very happy with the progress she was making. She mentioned that she had been spending a lot of time with a particular boy in her Church and was happy with this. She also mentioned that she did not really feel the need to attend several social gatherings as she was happy to be with the few friends she had made, who came to visit her on a regular basis. Mary appeared to be confident in what she was saying, and there appeared to be no concern about her suffering a relapse.

## **B) Presentation of Quantitative Data:**

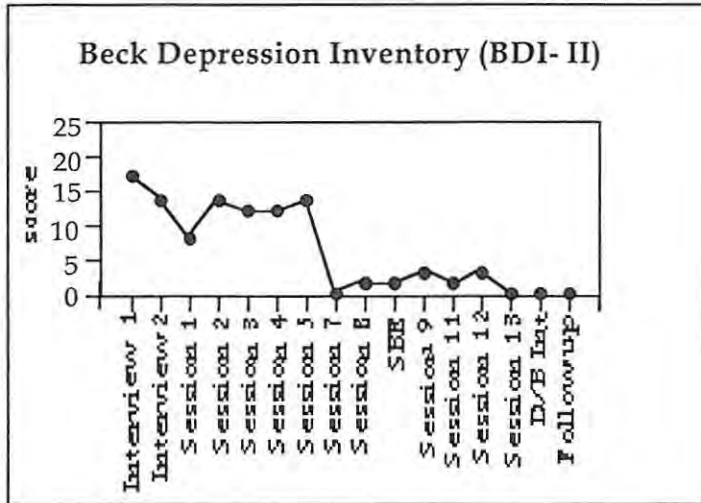
In order to evaluate the effectiveness of the programme with respect to Mary's problems, all the questionnaires that Mary completed were scored, and are presented as graphical representations of her progress. Mary did not attend sessions 6 and 10. It must be noted that no scores are presented for these sessions in the graphs. Mary was questioned about the fluctuations of each questionnaire's scores at the debriefing interview. All explanations for these fluctuations, as described below, are Mary's own explanations.

### **i. Beck Depression Inventory (BDI-II)**

The BDI-II measured Mary's levels of depression. Mary's score at the beginning of the programme is 17, indicating moderate depression. Her depression gradually became minimal (8) by session 1, as Mary was very hopeful about her life situation improving with the therapy programme. However, her depression increased to mild depression (13), once again in session 2, as she was concerned with her inability to risk conducting experiments in which she had to monitor her thoughts and emotions. However, she made the effort. After the mid-year vacation of 7 weeks (between sessions 5 and 6), Mary's depression scores remain in the minimal range (0, 1, 2) for the remainder of the programme and after completion of the programme. Mary mentioned that she was inspired by her visit to Cameroon during the vacation, when she met

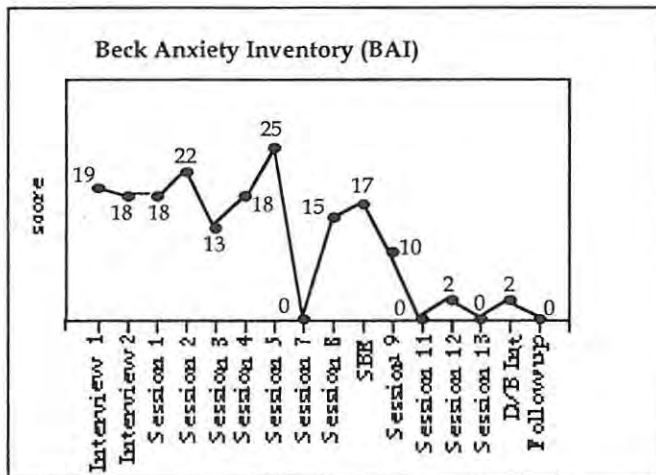
her family and conducted several behavioural experiments in her home environment. She also mentioned that she had just needed, “cheering up which only my family could do for me”.

**Graph A.8**



**ii. Beck Anxiety Inventory (BAI)**

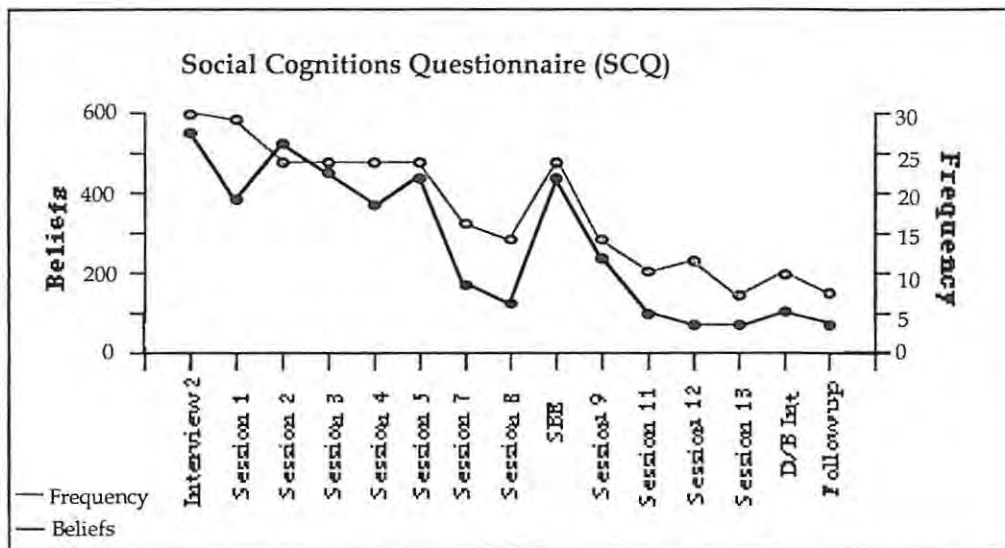
**Graph A.9**



The BAI measured Mary's levels of anxiety. Mary's initial BAI score of 19 indicates moderate levels of anxiety. Mary's BAI scores were the lowest throughout the programme, when compared with the others. Her BAI scores increased to 25 by session 5, as she had been experiencing severe anxiety whilst monitoring her thoughts and emotions, that required risking feared situations. However, just as with her BDI scores, her BAI scores are minimal, at '0', during session 7 after she had visited her family. The gradual increase thereafter, Mary attributed to her anxiety "just at the thought of the SBE". However, thereafter, her scores once again gradually drop to '0' as "I had learned to overcome my anxiety and challenge the situations that I feared".

### iii. Social Cognitions Questionnaire

**Graph A.10**



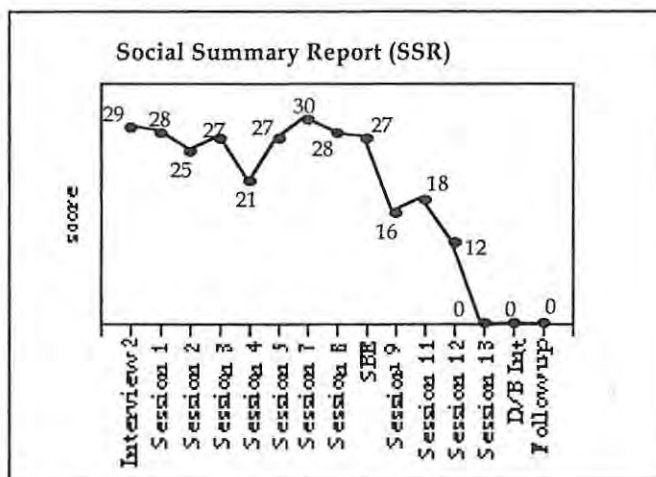
Mary had to identify the cognitions she was preoccupied with in social situations, and rate her belief (0-100) in these cognitions, as well as the frequency (1-5) with which these cognitions occurred to her. In the second interview, Mary's SCQ scores (560/2200- belief, 30/88- frequency) indicated that she had a few very specific cognitions that she was struggling with, and believed. These included, "I am going to tremble or shake uncontrollably; I will drop or

spill things; People are not interested in me; People will I'm nervous; People think I'm boring; I will babble or talk funny". She rated the first five thoughts as 100/100 (belief), and frequencies with 5/5 for all six thoughts. She rated the fifth thought with 60/100 (belief).

These six thoughts were the only thoughts according to her inventories, which she was struggling with. As is clearly visible however, in the graph (34) above, Mary's scores gradually drop during the entire programme, and after the programme. The only negative fluctuation was during the SBE session. Mary explained that on that particular day, she was unable to control her thoughts or rationally discount all the negative thoughts she was having. At the six-week follow-up, Mary's scores were, 80/2200(belief) and 9/88 (frequency). Her scores were the lowest amongst all the participants in the group.

#### iv. Social Summary Rating (SSR)

**Graph A.11**

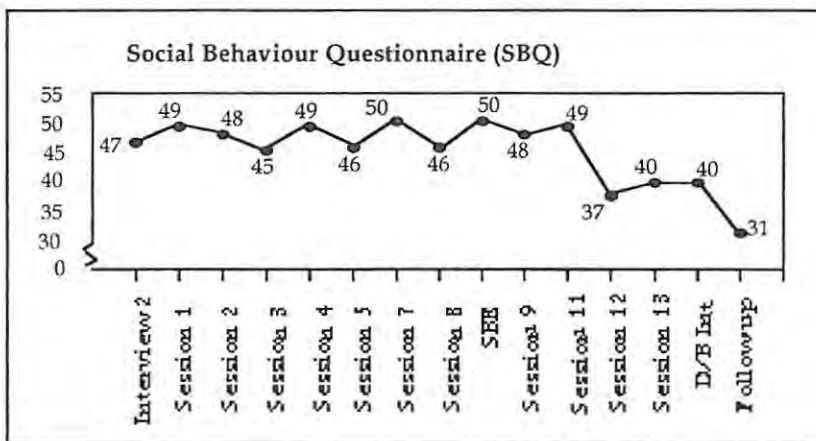


The SSR measured Mary's level of anticipatory anxiety prior to social interactions, the degree of self-focused attention in social interactions, and the degree to which she engaged in post-mortem self-critiques. In the first session, Mary's SSR score was 29/40 indicating that she had had some serious difficulties with socializing freely over the previous week. By session 5, her score had remained in the same range (27/40). Mary mentioned that, "the more I made an

effort to conduct experiments in which I monitored my thoughts, the more socially anxious I had felt". After her vacation, her score was 30/40 at session 7. Mary mentioned that, "it was awful trying to fit back into Rhodes life again". However, from session 7 onwards, her scores gradually decrease, indicating that she had been suffering less and less social anxiety when trying to socialize. Her maintained score of zero from session 13 onward indicates that she had overcome whatever social fears she had had.

**v. Social Behaviour Questionnaire (SBQ)**

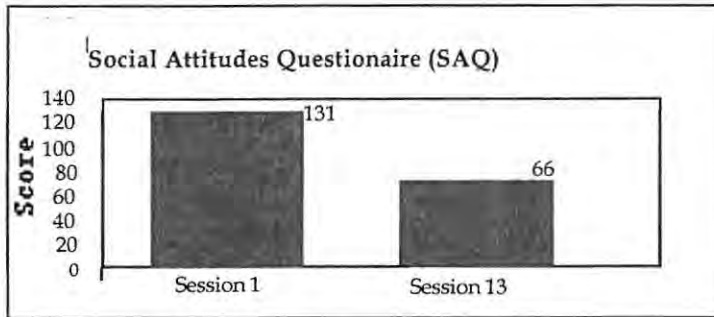
**Graph A.12**



The SBQ assessed the degree to which Mary employed safety behaviours. Mary's scores range between 47/84 to 50/84 between the beginning of the programme and session 11, in spite of the SBE. Mary herself could not explain these scores when questioned about them. She mentioned that she knew that she had not been using her safety behaviours after she had conducted her SBE. She also mentioned however, that, "I possibly still circled certain safety behaviours because I felt as though I was not over with them as yet". Her scores decrease to 31/84 by the six-week follow-up interview, which is not such a tremendous decline from her initial score. Nevertheless, Mary mentioned that she no longer used her safety behaviours, and she convinced the interviewer that she knew that her safety behaviours only did her harm

vi. Social Attitudes Questionnaire (SAQ)

Graph A.13



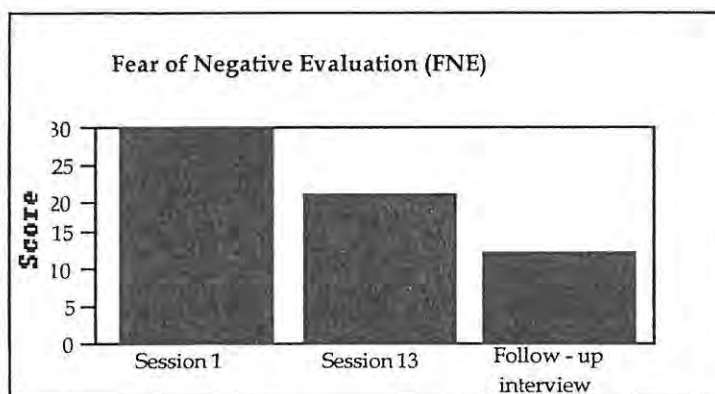
The SAQ was used to measure some of Mary's attitudes and beliefs. The difference between Mary's initial score of 131/300 and her final score of 66/300 was the greatest change in scores amongst all the participants' SAQs, apart from Ben (Appendix 3c). This change in score is convincing evidence that Mary had managed to efface several of her negative beliefs, and less than complementing attitudes about her social acceptability. Mary's responses to certain statements changed from "totally agree/agree very much" in the first session's questionnaire to "disagree slightly/ disagree very much" in the final session's questionnaire. A few of these statements are as follows, "If I make a mistake in a social situation, people will reject me; I must appear intelligent and witty; Other people are better at getting it right socially than me". The change in response to these statements indicates that Mary had nearly managed, if not successfully managed to efface all her negative attitudes and beliefs.

vii. Fear of Negative Evaluation (FNE)

The FNE questionnaire was used to measure Mary's mood and her general assumptions pertinent to her social phobia. In the first session, Mary's score was 30/30. In the follow-up interview her score was 12/30. The difference between her first and final scores in this questionnaire is also a considerable change. Mary explained her reasons for continuing to

circle the 'True' option for certain questions in a similar manner to that of the other participants. She too mentioned that it is impossible to “deny your closest friends, relatives, lecturers and other such superiors, the right to evaluate you negatively if there is a need for this”. In addition, she mentioned that, “it is my duty to worry about their opinion of me, and therefore I cannot understand the meaning of a lot of these questions”.

**Graph A.14**



**C) Conclusions around Mary's case**

When reviewing the graphs that depict Mary's questionnaire scores it is clear that the safety behaviours experiment was her critical turning point in the treatment programme. From the SBE onwards, all her scores gradually decrease. This pattern in her scores corresponds with the narration of her experiences in the programme. At the debriefing session, Mary mentioned that she had struggled to conduct her behavioural experiments and monitor her thoughts and behaviours prior to the safety behaviours experiment. She explained further that she had been unable to effectively divert her attentional focus from herself and drop her safety behaviours, and she just needed concrete support and guidance to go about doing this, which the safety behaviours experiment offered.

She mentioned that the video-feedback of her safety behaviours experiment showed her that her safety behaviours were her “worst enemy”. In addition, she realized that when she diverted her attentional focus to the social interaction she was in, she experienced a greater level of acceptance and accommodation from the other members of the social interaction. It is noteworthy, however, that Mary’s SBQ scores do not decrease as dramatically and rapidly as her other questionnaires’ scores. Mary could not explain this finding at the debriefing session, but she mentioned that she might have continued to circle the safety behaviours she had been using (prior to the SBE) without realizing that she was not using them anymore. Having experienced success in her safety behaviours experiment, Mary mentioned that she was able to conduct further behavioural experiments and actively disconfirm her negative cognitions and beliefs and make steady progress in treatment. Correspondingly, her scores decreased.

The processes at work in Mary’s case are exactly those, which would be expected from Clark and Wells treatment model. Her anxiety level, according to the BAI, gradually increases during the first few sessions, is at its peak at the SBE, and gradually decreases thereafter. The gradual increase in her BAI score reflects an increase in her level of exposure as she entered socially threatening situations in order to monitor her thoughts and behaviours. It is normal that her anxiety was at its peak at the SBE. However, upon receiving concrete feedback through the video-feedback at the SBE about her appearance in her social interactions, with and without her safety behaviours, she disconfirmed several of her negative cognitions, and saw the way in which she actually appeared to others instead of relying on her mental image of herself. In this way, her anxiety gradually decreased after the SBE even though she continued to engage in socially threatening situations (in her behavioural experiments). Now, she was engaging in them differently without her safety behaviours, focussing her attention to the social interactional process rather than keeping her attentional resources on herself, and she was actively in the process of creating a veridical self-image.

Mary was one of the quieter members of the group who only participated when asked for her opinions or feedback. However, she was always receptive to other members’ and the facilitators’ feedback regarding her situations and experiences. She valued this feedback as the most important and useful aspect of the programme. A crucial factor for Mary that allowed her

to progress in the treatment programme was that she had an open-minded and trusting attitude towards any evidence that was presented to her that might serve to disconfirm her negative cognitions. In addition, she was motivated to actively engage in several behavioural experiments that provided further evidence of the distortions in her former self-image and negative beliefs.

## **Appendix 3c**

(Case report written by Jennifer Henwood: Member of the Research team)

### **The Case Report of Ben Mabuza\***

“Ben Mabuza”, aged 19, presently studying his second year Bachelor of Commerce at Rhodes University was chosen, to illustrate the process of participating in the cognitive-behavioural group therapy programme for social phobia. Ben participated fully in the programme and gained a great deal of insight into his problem as well as showing high levels of progress into adapting cognitive behavioural therapy into his daily ways of thinking and behaving. His case therefore allowed a detailed documentation of the process.

#### **Case narrative:**

Ben was born in Nelspruit in 1981. His father was a schoolteacher. He died of internal bleeding, when Ben was eight years old. His mother is a schoolteacher. He said that his parents got along well when his father was alive. His youngest brother died when

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\* The name of the participant has been changed to protect his identity.

Ben was very young. He said that he was too young to remember him and has never known the reason for his death. His older brother died last year in a car accident, at the age of 20. At present he lives with his mother and his younger brother, who is 17 years old. Ben said that his mother always wanted the best for him. He said that she brought him up very well and that she is his reason and drive for succeeding in life. Ben shared that he had a very close relationship with his mother. He said that she was his best friend. Religion plays a very important role in his life.

***(a) Life situation at the start of the programme***

At the start of the programme Ben explained that his activities on a typical weekday were very predictable. He played basketball a lot and spent most of his time sitting in front of the computer. He said that he also watched a lot of television. He explained how he prays when he wakes in the morning and always "looks forward to a brighter day". He said that he complained about his life a lot and he hated doing that. He said that before he went to sleep at night, he would always look back at the events that happened during the day and analyse them. He said he tried hard to get along with people, although he considered himself a "very anti-social person". He had friends, but said that he would rather call them acquaintances because he was not very close to anybody. He explained that he was more of a one-man person. At the time he was not dating anyone but shared that he would like to be involved with more girls. He said that he was scared, although he was not sure what caused him this fear. He explained how he was trying to go out with someone at the time, but lacked the courage to tell her how he felt about her.

***(b) Presenting problem***

In the initial interviews, Ben had no difficulty answering questions surrounding his problem. He provided meaningful answers showing that he had a lot of insight into his problem. It was obvious that Ben was powerfully motivated to change. He said that often he watched other people in inter-personal relationships and wished that he could be more like them. He had recently grown very fond of a girl and had wanted a girlfriend for a long time but was too nervous and afraid. He said that one of his weakest points was that he had a lot of difficulty communicating with the opposite sex. He explained

that he was extremely nervous of saying the wrong thing and this usually led him to say nothing. He said that he was extremely self-conscious and that this tended to restrict his flow of thought, which hindered his ability to communicate. He said that he had read a lot of books about self-confidence in the hope that they would help him to change his ways but he had realised that he needed support.

Ben's goals for treatment, therefore, were related to his difficulties regarding interacting with members of the opposite sex, especially those he is attracted to. He also wanted to understand himself better. He wanted to understand why he finds it so hard to relax and feel comfortable in social situations. He said that he has always wanted to have a positive state of mind. He said, "I just want to be happy".

### *(c) Constructing a Cognitive Model of Ben's problem*

In the beginning stages of the programme, a conceptualisation of Ben's problem, based closely on the Clark & Wells model was drawn out through several group exercises, homework assignments and discussions. As briefly discussed above, there were specific situations, in which Ben feared the most. The most common themes in Ben's accounts of his anxiety in social situations surrounded his extreme insecurity with his height. People would often make comments about how tall he is and he said that he found this very intimidating and often avoided situations in which this was likely to happen. Based on this, basketball matches posed a great deal of pressure for Ben. He would get extremely nervous before a match, and felt that everyone made comments about his performance and his height during the game. This would often interfere with his game. The other situations which led to high levels of anxiety were those which involved a member of the opposite sex, especially approaching or conversing with somebody he was attracted to. Other situations he feared were, walking into a crowd of people, being the centre of attention, and going out to clubs. He went to church every Sunday evening and would leave straight afterwards because he was afraid of interacting with people and not knowing what to say. Being in these situations was difficult and anxiety provoking for Ben as he was afraid that people would think he was boring; tease him; make fun of him; think he was weird, antisocial and uninteresting.

Once these specific situations had been clearly identified in session 1, Ben, through a process of guided discovery, his homework exercises and monitoring his behaviour, was able to carefully deconstruct the situations in which he feared. In session 2, Ben began to think about and identify many of his negative thoughts and beliefs, regarding the social interactions, which caused him to feel anxious. It seemed that Ben was usually positive and optimistic before entering a situation, although he wanted to be sure that he would not fumble. On entering a situation with a girl he was attracted to he would always try to monitor the first impression she had of him. He said that he would usually become self-conscious in middle of conversation. He would often blank out and be unable to think properly. He felt she would notice that he was shy and would see him “blushing” (when asked what he meant by ‘blushing’, Ben said that he did not mean that he would change colour, as the English word in fact suggests, but that he would look flustered and shy). He said he always tried to fight the symptoms that he experienced as they “affect my confidence”. He thought if he spoke to a girl she would easily lose interest and give an excuse to leave because he was uninteresting. He also felt afraid that she would tell him he was boring. He had thoughts that if this did happen, it would mean that he had failed. He said that he wanted to change these feelings because he often felt guilty about the things he should have done but lacked the courage.

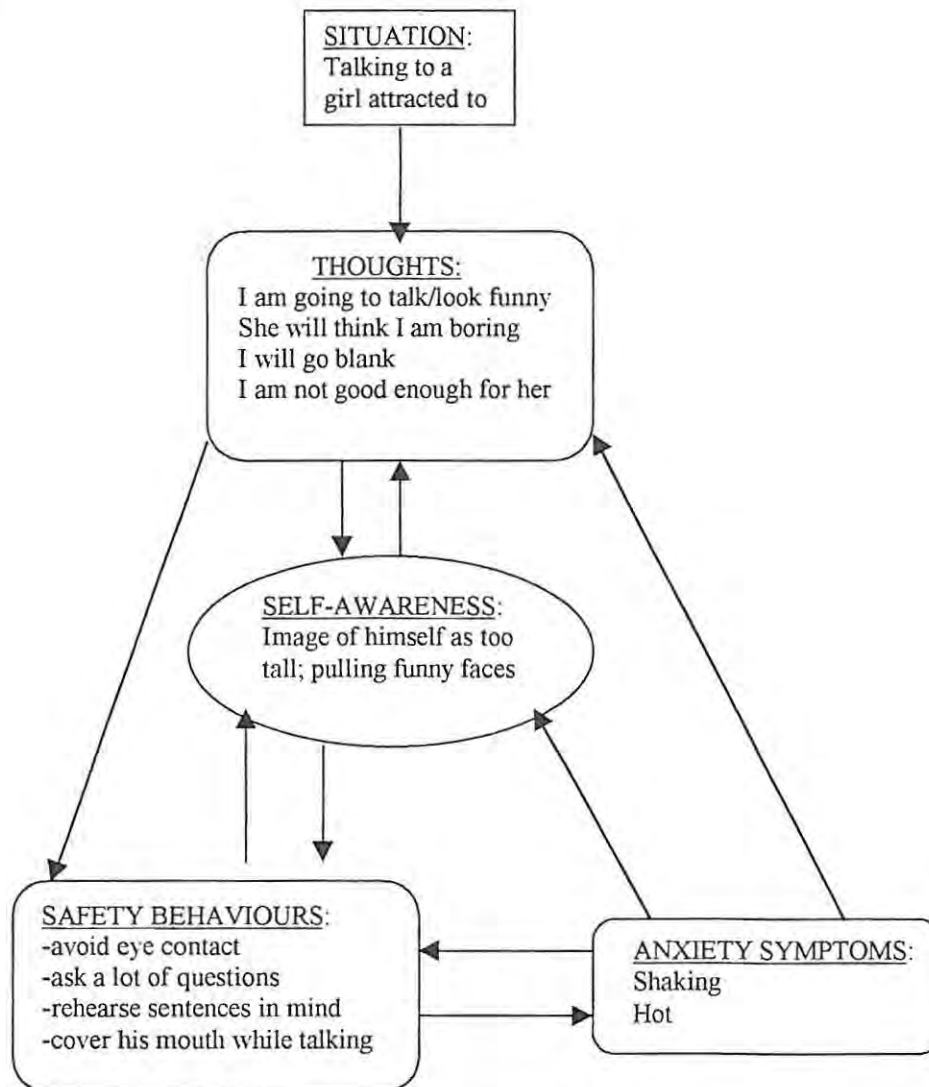
In session 3, once these aspects of his problem had been outlined, Ben, along with the group began to focus on the safety behaviours he adopts as a means of trying to prevent feared aspects of the event from happening. He said that often, instead of going to talk to a girl he looks at her from a distance. He said that in many interactions he tries to act normal but he did suggest at this time that he felt that this only drew more attention to his anxiety. In order to come across well he would focus on his voice and his language. He would always “try to be perfect”. He also tended to avoid eye contact, continually check that he was coming across well, censor what he was going to say, cover his mouth while talking, rehearse sentences in his mind and smile a lot. He would also often try to make people laugh as a way of monitoring how he was coming across.

After session 3, Ben started to monitor his negative automatic thoughts more closely in social interactions. Through his homework exercise, which involved filling in the first three columns of the Daily Record of Dysfunctional Thoughts (as far as 'Automatic Thoughts'), he was able to look deeper into many of the thoughts that came into his mind as he entered a social interaction. Ben encountered three important situations in which he monitored his thoughts and emotions closely. The first situation involved passing in front of a crowd of residence acquaintances. He found that he felt very anxious. He rated the degree of his anxiety as 60/100. He found himself thinking "Come on Ben just walk fast so they don't notice you" and then his thoughts changed a great deal and he said to himself "What the heck, go and talk to them, you've got nothing to lose" and "Come on Ben you can do it". From this, it seems that his initial automatic thought was related to what he normally would have done and the second two were consciously generated self-instructions, and were related to his desire to take the risk to involve himself in social situations which had the potential to trigger anxiety. The second situation involved unexpectedly meeting a girl he was interested in on campus. He felt as though he was going to faint and his heart was pounding. He rated the degree of anxiety as 90/100. His automatic thought was "I am not good enough for her" and then he said to himself "Just greet her and go". The third situation was a basketball match. He felt very anxious and rated this feeling as 80/100. He noted that the thoughts, which preceded his anxiety, were "You have to perform well", "Do not embarrass yourself" and "You cannot afford to screw up". During this time he also noted some of the anxiety symptoms that he experienced in anxiety causing situations. He noted, that in situations, which stimulated the highest levels of anxiety, he appeared flustered, felt very hot and could not speak properly.

In session 4, Ben started to construct his cognitive model. Through his feedback in the discussion and his session evaluation it was clear that at this stage Ben felt positive about what he had learned about his problem through the formulation of his model.

*(d) An idiosyncratic cognitive model outlining one anxiety provoking situation for Ben*

The model below illustrates the structure of Ben's anxiety response to a typical socially threatening situation. His fear of approaching and talking to a girl he is attracted to has been outlined.



By the end of session 5, Ben had come to see how his adoption of safety behaviours, in particular, was often self-defeating. However, he was still concerned about many of the ways he handled difficult situations (this aspect of his concerns was then dealt with during the implementation of the safety behaviours experiment later on in the programme). Through monitoring himself closely in several anxiety provoking situations, he had come to realise a great deal about the way in which he handled difficult

interactions and was aware of many of his dysfunctional negative thoughts. It was at this point, that the programme stopped temporarily for the vacation.

When the programme commenced at the start of the new semester, Ben shared in session 6, his experiences from the vacation. He had played in many basketball tournaments in the vacation and shared how he had felt that he had gained a lot of confidence. He said however that he still felt a lot of pressure from the crowd. He had realised that in fact he was not very tall in comparison to many of the other basketball players but he continued to place a lot of pressure on himself to perform well and was still intimidated and consumed by what he believed the crowd was thinking of him.

From session 7, the group was guided through a process of collecting new, more valid information and evidence regarding how they appear and how other people perceive their behaviour. Ben therefore, along with the rest of the group, carried out a series of behavioural experiments in real life contexts.

#### *(e) Safety Behaviours Experiment*

Ben carried out his safety behaviours experiment between session 7 and 8. For this experiment, a role-play was set up which involved an attractive female volunteer. Before the role-plays took place, a short briefing was carried out with Ben. He said that he was in some ways excited, because he had heard from the other group members how revealing and beneficial it had been, but at the same time he said that he was very anxious and nervous. He believed that the volunteer would notice that he was shy and that he would not know what to say to her. He said that he was afraid that she would think that he was uninteresting. It was then agreed that the role-play would involve Ben approaching the volunteer, as if on the way to a lecture, and begin a conversation with her. He was then asked to recall what particular safety behaviours he would normally use in this situation. During this time some additional safety behaviours, not previously mentioned, were identified. The following safety behaviours were listed: avoids eye contact; hides mouth; plans and rehearses sentences in his mind; asks lots of questions (tries to dominate conversation); wrings his hands; tries to control shaking by tapping his foot. Ben was then told about the exact procedure of the role-plays. It was explained that

he must adopt all of his safety behaviours in the first role-play and then drop them in the second. He was also told that each role-play would last approximately 7 minutes, and for the first three minutes he must not leave the situation, but after that he could if he wanted to. The volunteer was then briefed about the role-play situation, after which the first role-play was carried out.

Ben engaged in all of his specified safety behaviours. He did not leave the situation early. After the first role-play, Ben and the volunteer completed rating forms. A feedback discussion was then carried out. Ben said that he had felt very aware of the time; he felt that his behaviour was 'the usual' and that he was very afraid of 'screwing up' and that he tried to just flow with the conversation but ended up asking the same thing, he also said that he wasn't really listening to what she was saying because he was so focused on coming across well and keeping the conversation interesting. Ben said that the girl had noticed he was very shy and anxious and that it seemed like she kept trying to force him to make eye contact because he felt that she had kept focusing on his hands moving/fidgeting. After feedback, the volunteer said that in the first role-play, Ben came across as very shy. She said that he looked very self-conscious (8.5/10) but said that she did not know what he might have been anxious of. She did say however that his social interaction skills were above average (6/10).

The second role-play was then carried out. Ben managed to drop most of his safety behaviours. Most notably, it was interesting to observe that he maintained eye contact for most of the conversation and the conversation flowed a lot more freely. Once again the rating forms were completed. Feedback discussions were then carried out individually with Ben and the volunteer. Ben said that in the second role-play he was not aware of the time because the conversation was flowing easier. Ben felt that he had managed to drop most of his safety behaviours. He said that he allowed the conversation to move more freely without rehearsing what he should say. He felt that this meant that he appeared more interested in what the girl was saying. He said he was very conscious of making an effort to listen and to make eye contact. Ben said however that she could still see he was very nervous. The volunteer said that in the second role-play Ben still seemed to have

quite a low self-confidence. She said however that he definitely came across as more relaxed as he spoke more openly and maintained eye contact. She said that he still seemed a bit anxious but not unnaturally for meeting someone for the first time. She rated his self-consciousness as (5/10). She noticed that he spoke about himself a lot and that he generally seemed good at interacting. She said that he seemed to be the type of person who could talk to people easily and open up. She rated his social interaction skills as (7.5/10).

***(f) Video-Feedback***

Prior to watching the video footage of the experiment, Ben was asked to make some comments regarding his predictions about how what he would see when he watched himself on video. He said that he felt anxious to watch the video, as it was likely to reinforce his beliefs about how he appeared to others in social situations. He said that he did not really want to watch himself because he would not like what he saw. When probed to explain his feelings further he said that his concerns surrounded: his voice (he thought that it sounded 'funny' and was slow); his facial expressions (thought that he would see himself making ridiculous and funny faces); and he also expected to look very shy. At various points in the feedback, the facilitator would stop the video and ask Ben for his impressions so far. In the first role-play Ben said that he felt very shocked seeing himself. He said that he looked a lot more shy than he had expected. As he was watching he said that he kept telling himself "look it's true – I do look ridiculous and my voice is slow and comical". He said that he had seen his "funny facial expressions" and his "funny smile" and he had said to himself "Of course people will laugh at me with that look". At this point he said that he felt embarrassed and humiliated because the video had confirmed many of his beliefs about himself. The volunteer's feedback from the role-play was then shared with Ben. It became clear that there was a mismatch between his perception of himself and the volunteer's perception of him.

In viewing the second role-play, the video was once again paused in certain places. At one point, Ben was asked what he was noticing in his behaviour and whether he noticed any difference. He said that he noticed that he was more into the conversation and was

making more eye contact. He said that he had to admit that although he was looking hard, he did not see any funny looks. An important realisation for Ben was that he said he had noticed that when he did not make eye contact his face looked funny but that this was not the case when he made eye contact. He said that he preferred how he looked when he made eye contact. He therefore found that this safety behaviour was counterproductive and was having the opposite effect to what he had wanted. He noticed too that by making eye contact he was less slouched in his chair because he was not trying to hide his face by looking at the ground. He also saw that a pause in the conversation did not come across as badly or for as long as he had thought it had been. This pause had felt abnormal for him in the situation but in watching it, he said that it looked no different to conversations, which looked completely natural. Ben said that he could not find any evidence to support many of the thoughts he had. He was not noticing that he was abnormally shy in the second role-play. He attributed this to the fact that he was not as focused on himself and due to this he appeared more natural and he said that he liked what he saw. He noticed that the interaction was flowing more easily and said that he thought this was because he was focusing more on the conversation than thinking of questions to ask. He saw that by looking away and continually putting forward questions, it was difficult for her to have a natural conversation, and then because the conversation was not going well, Ben told himself that there was something wrong with him. Through discussion of the video however, he found that in fact it was not something wrong with him, but instead it was his safety behaviours creating the problem. He said that he usually asks questions to prevent pauses in conversation but saw that this ultimately made the conversation more uncomfortable. Also he had thought that he should not keep eye contact to make himself feel better and to protect himself but saw how this served only to confirm his negative beliefs because it in fact made him look funny. He said that he had always thought that he was unable to make girls laugh but in watching himself he thought that he looked comfortable and noticed that she was laughing at his comical comments. He therefore came to realise that his belief about not being able to make girls laugh was not true. Finally, he said that, "most of the beliefs I had do not hold any truth in watching the video". He said that he had had these thoughts for "so long that I had believed them and from them I had created images regarding how I

appeared to others and therefore in many ways my beliefs had caused me to behave in ways which caused my beliefs to come true". He then commented that after watching the second video he did believe the volunteer's feedback.

Therefore, after watching the video of himself Ben realised that he came across much better than he had thought, and that dropping his safety behaviours in fact made him appear more confident and relaxed. By this stage in the programme, Ben was realising more and more, that many of his beliefs regarding how he appeared in social situations were based largely on what he was feeling and his negative self-image. He had said that he had learned that this information is misleading.

### *g) Behavioural Experiments*

During session 8, Ben shared that he had asked the girl he was attracted to at the start of the programme, to the movies. He said that he had found it much easier to act naturally and found her to be a lot more receptive. He said that he had also gone to her residence and there had been a lot of girls around. He said that he was slightly anxious but was pleased with how well he had handled the situation. He had never imagined that he could have managed talking to so many girls but was able to keep a conversation flowing and made them laugh a lot. The facilitator commented that he too had noticed that Ben was making more eye contact and that he liked this as it made him seem more relaxed and approachable.

During the next session five sessions Ben shared with the group, several different behavioural experiments that he had carried out. For example, in session 9, he explained how he had dressed up in a suit to attend a beauty pageant. He said that he had predicted that people would look at him funny because they would not be used to seeing him smart. He felt a bit anxious about how he would appear to others but decide to take the challenge and go out and see what would happen. He found that people complimented him and that no one noticed that he looked different because everybody else looked smart too. He said that in the past he would not have attended a function like this because he was too concerned about people laughing at him. His prediction was therefore incorrect

and he concluded that he felt very confident in himself for going out. In another experiment, some friend's of Ben's introduced him to a group of girls. He predicted that they would find him boring. The outcome in fact turned out very differently. He said that he was dominating the conversation. He found that they enjoyed his company and complimented his charming personality. He had a really good time and that "his perception of people had totally changed", they seemed much friendlier and accepting than he had imagined.

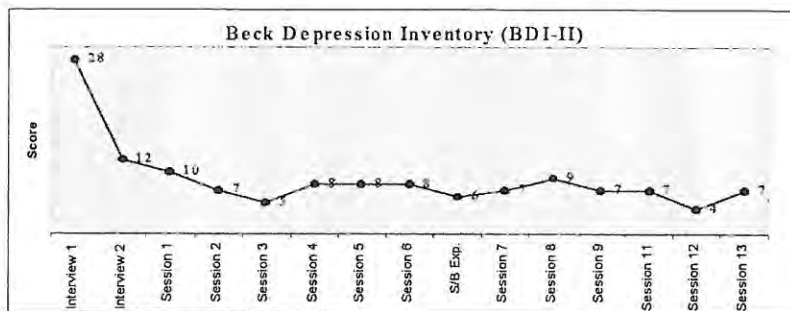
In the final three sessions, it was evident that Ben had constructed a less negative image of his social self. He provided many of the other group members with valuable feedback, which reflected a great deal of insight and understanding. For example, he suggested to one of the other members that they treat their negative thoughts as weeds and as they see them they need to pull them out. In the final session he shared that in the previous weekend he had decided to phone a girl and ask her to go out with him somewhere. He said that he was slightly anxious but once he was asking her he felt okay. They arranged to meet at a restaurant later that evening. Ben arrived slightly early and waited. He said that at one point he felt anxious, especially when she had not arrived by the arranged time. He waited a bit longer however and she did arrive. The beginning of the conversation was slightly awkward but this did not feel unnatural to Ben. He said that they spent two-and-a-half hours talking before they realised the time. He had never experienced this before. He then went with her to her house and they spent a further two hours in conversation. He said that he had felt so good about taking the challenge to phone her and although he had felt anxious about it, it had served to disconfirm many of his negative beliefs.

During the final feedback at the end of session thirteen, Ben said some very motivating words to the group, encouraging them to keep on trying, to use all that they have learnt and to never give up. He said that he had gained so much from the programme as well as from the other group members and looked forward to his new life in the social world.

### 3.4.2 Presentation of quantitative data:

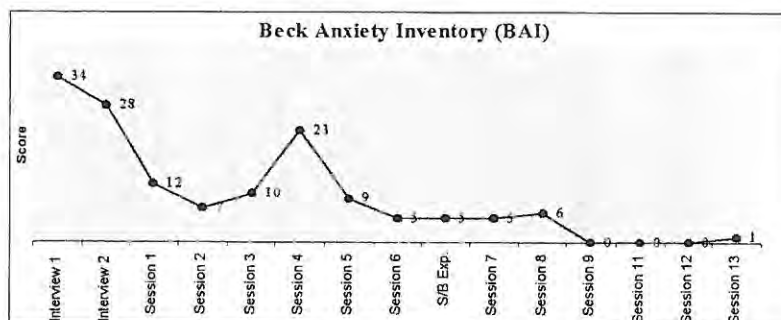
In order to evaluate the effectiveness of the group programme for Ben's problem, the scores from all of the questionnaires he completed were recorded and presented in graphic form. It should be noted that Ben was absent for session ten and therefore no score is reflected in the graphical representations.

Graph 1: Beck Depression Inventory (BDI-II)



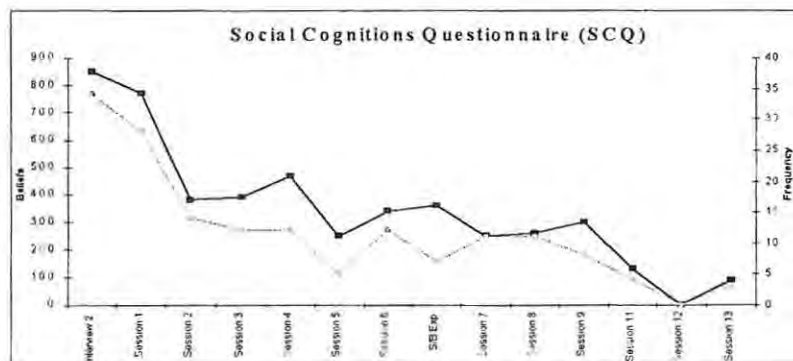
The BDI-II measured Ben's levels of depression [refer to 2.4]. At the first interview Ben's BDI-II score was 28, indicating that he was moderately depressed. His BDI-II score however dropped to 12, indicating mild depression by the second interview. During the feedback session, Ben was asked whether he could explain this decrease in his score. He accredited it to the fact that the programme had given him a sense of hope. He was finally doing something to change his pattern of behaviour and was gaining a more positive outlook to life. His level of depression then dropped to 10 in the third session and remained between 8 and 10 for the entire programme.

Graph 2: Beck Anxiety Inventory (BAI)



The BAI served to measure Ben’s weekly levels of anxiety [refer to 2.4]. Ben’s BAI score in the first interview was 34, which indicated that he was experiencing severe anxiety. In the second interview his BAI scores both indicated that he was experiencing severe anxiety: 28 (in situation) and 26 (in general). The symptoms he rated as severe and could barely stand were the same in the second interview as the first. These were: unable to relax; fear of the worst happening; heart pounding or racing; unsteady; nervous; shaky; scared; discomfort in abdomen and face flushed. Ben accredited his higher levels of anxiety in session 4 to the way in which his negative thoughts had seemed to drown him at that time. He said that he had been “failing to rise above the challenges in my life”. Another important aspect to note is that Ben’s homework prior to session 4, shows that he had faced some difficult challenges in his social interactions in the past week. These are explained in detail later, however they may explain the increase in his score. It can be seen that after session 6, Ben’s scores indicated that his anxiety levels had dropped considerably and remained constant after session 9.

**Graph 3: Social Cognitions Questionnaire (SCQ)**



The SCQ measured Ben’s common cognitions which often preoccupied him in social interactions as well as his belief (0-100) in these cognitions and their frequency (1-5). In the first interview Ben’s SCQ ( 850/2200 - belief / 34/88 - frequency) indicated that he had some very strong cognitions and beliefs surrounding these thoughts. For example, he indicated that he thought “I will be unable to speak” all of the time when he was nervous and rated this belief 90/100. He also thought “I am unlikeable” a lot of the times when he

was nervous and rated this thought 60/100. Other thoughts which usually occurred when he was nervous were: “People will stare at me” (80/100); “I am inferior” (70/100); “People will see I am nervous” (70/100) and people will think I am boring” (80/100). These all indicate that he had many cognitions that were negative regarding his interaction in social situations and his beliefs around this thoughts were high, indicating that he believed strongly that his thoughts were true.

His SCQ scores progressively dropped throughout the programme and by the final session it can be seen that he no longer thought all of the negative thoughts that had previously come into his mind when he was anxious ( 0/2200 – belief / 3/88 – frequency).

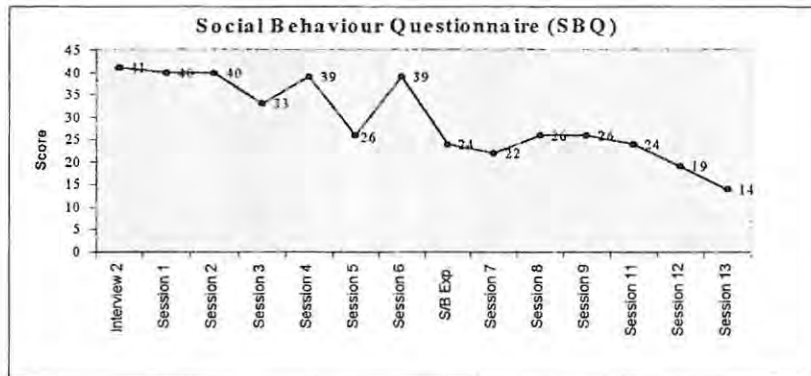
**Graph 4: Social Summary Questionnaire (SSQ)**



The SSQ measured Ben’s level of anticipatory anxiety prior to social encounters, the degree of self-focused attention in social interactions, and the degree to which he engaged in post-mortem self-critiques. In the first session, Ben’s Social Summary Rating Questionnaire (SSQ) score (34/40) reflected that, in the last week his social anxiety had been markedly disturbing and/or disabling. He often avoided difficult situations or aspects of those situations and his attention was almost entirely focused on himself. He always went over things in his mind that he thought might go wrong before entering the situation and always went over social interactions after they were finished. It can be seen that after session 4 Ben’s score drops from 29 to 13. His feedback showed that he was gaining a great deal of faith in the programme at this time. He said that he was

feeling more positive about being effective in his social interactions and that he was “glad to be getting into the meat of the programme”. This suggests that the programme was gaining more and more credibility for Ben. After session 4, his scores remained constant for the next three sessions, until after session 8 when they gradually got lower and lower and in session 13 his score was just 2/40.

**Graph 5: Social Behaviour Questionnaire (SBQ)**

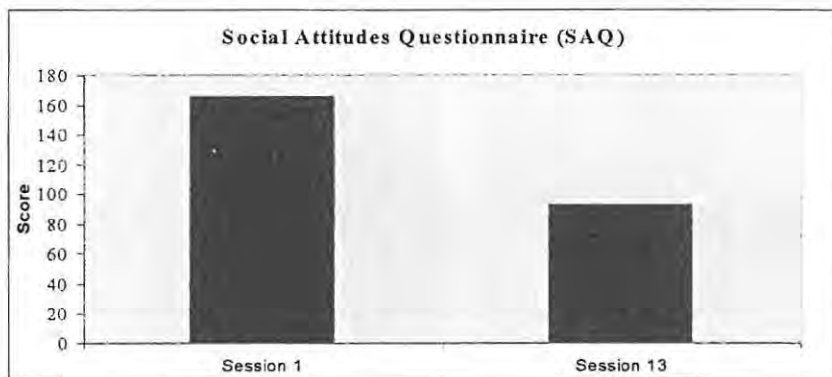


The SBQ assessed the degree to which Ben employed safety behaviours. In the first interview, Ben’s SBQ score was 41/84. He responded that he always checked that he was coming across well; tried to act normal; rehearsed sentences in his mind and censored what he was going to say. He said that he often avoided eye contact; tried to picture how he appeared to others and tried to keep tight control of behaviour. He responded very similarly in the first session. Ben’s score can once again be seen to drop progressively as the programme moved on. His score in session 5, just prior to the vacation was 26/84. This reflects that Ben was already beginning to drop many of his safety behaviours. In session 6, the session after the vacation, however, it had increased again to 39/84. However, after he had carried out the safety behaviours experiment, his scores dropped constantly, reflecting that he had dropped many of his safety behaviours through his realisation that they were self-defeating. By session thirteen his score had dropped to 13/84. In this questionnaire he only responded “always” to thinking positive.

**Graph 6: Social Attitudes Questionnaire (SAQ) (refer overleaf)**

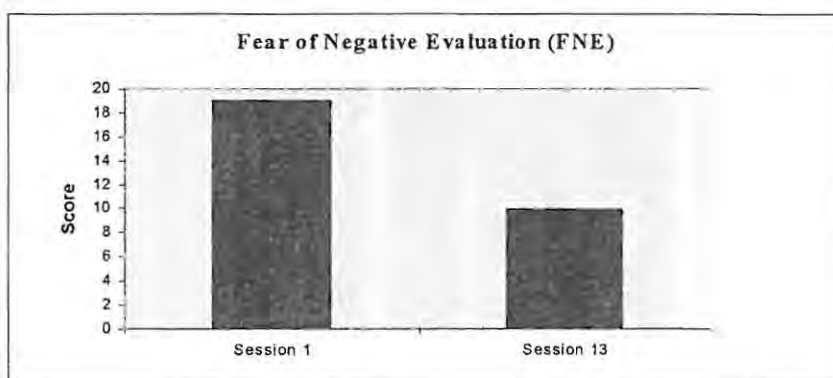
The SAQ was used to measure some of Ben’s attitudes and beliefs. Ben’s Social Attitudes Questionnaire (SAQ) score (166) in session 1, reflected some important

attitudes he had regarding social interactions. Ben responded “totally agree” to various significant attitudes. These included: “Other people are better at getting it right socially than me”; “My anxiety is obvious to other people”; and “If I am quiet people will think I am boring”. He responded “agree very much” to the following attitudes: “I must not show signs of weakness to others”; “If I make a mistake in social situations people will reject me”; “Everyone will stare at me and think I am strange if I don't act normally”; “I'm different”; “Others are more acceptable and likeable than I am ”; “If someone does not like me it is my fault”; “If others get to know me they will not like me”; and “When people see that I am anxious, they see the real, inferior me”. It was important to note these, as they highlight many of his core assumptions that were made obvious during the programme. By comparing this score to the score for his SAQ at the completion of the programme (93) it can be seen that most his strong beliefs changed over the course of treatment.



**Graph 7: Fear of Negative Evaluation (FNE) (refer overleaf)**

The Fear of Negative Evaluation questionnaire (FNE) was used to measure Ben’s mood and his general assumptions pertinent to his social phobia. In the first session Ben’s score was 19/30. His responses indicated that he was apprehensive about others’ evaluations and that he felt distress over negative evaluations. There was also evidence that he tried to avoid potential evaluative situations and he had high expectations that others would evaluate him negatively. It was clear therefore, that Ben had high levels of fear for his loss of social approval. By session 13 however, Ben’s score had dropped to 10/30. This was perhaps because Ben was processing his operations in socially evaluative situations differently and more positively.



### **3.4.3 Conclusion:**

Prior to treatment, Ben's questionnaire scores were significantly higher on all accounts than at the completion of the programme. His scores indicate that at the start of treatment he was highly distressed in several situations. By the final session however, Ben's scores indicate, that he was not disabled at all, in social situations. Ben himself reported at the completion of treatment that his social fears had decreased considerably over the course of treatment. For example, he reported feeling more comfortable inviting girls out and was able to attend social functions alone. The critical turning point in treatment for Ben was the safety behaviours experiment. All of his scores reflect a decrease from this point onward in treatment. This treatment intervention was very important for Ben as it made him aware of the way in which his safety behaviours were often dysfunctional. He realised that by dropping his safety behaviours he appeared more confident and relaxed. This was important as he was then motivated to experiment without his safety behaviours, which in turn led him to realise further that many of his beliefs regarding how he appeared in social situations was based largely on what he was feeling and his negative self image. In the feedback interview, Ben reported that he had been continually aware of making eye contact and had found that people seemed more interested in what he was saying, and that he also felt more comfortable as he could see people's responses to him. Many of Ben's core beliefs surrounded his fear of not performing well, being uninteresting, appearing shy, and not knowing what to say. Through the behavioural experiments, conducted for homework, Ben carried out several experiments in real life contexts, in order to test his predictions. He recorded these situations and found that many outcomes were contrary to his fears. Ben therefore began to process social interactions differently.

## Appendix 4 [ii]

### Beck Anxiety Inventory

Name \_\_\_\_\_ Date \_\_\_\_\_

Below is a list of common symptoms of anxiety. Please read each item in the list carefully. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY by placing an X in the corresponding space in the column next to each symptom.

		Not at all	Mildly It did not bother me much	Moderately It was very un- pleasant but I could stand it	Severely I could barely stand it
1	Numbness or tingling.				
2	Feeling hot.				
3	Wobbliness in legs.				
	Unable to relax.				
5	Fear of the worst happening				
6	Dizzy or lightheaded.				
7	Heart pounding or racing.				
8	Unsteady.				
9	Terrified.				
10	Nervous.				
11	Feelings of choking.				
12	Hands trembling.				
13	Shaky.				
	Fear of losing control.				
15	Difficulty breathing.				
16	Fear of dying.				
17	Scared.				
18	Indigestion or discomfort in abdomen.				
19	Faint.				
20	Face flushed.				
21	Sweating (not due to heat).				

SOCIAL COGNITIONS QUESTIONNAIRE

Appendix 4 [iii]

Name.....Date.....

Listed below are some thoughts that go through peoples' 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.

0    10    20    30    40    50    60    70    80    90    100

I do not believe this thought \_\_\_\_\_ I am completely convinced this thought is true

Name: .....

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

Appendix 4 [v]Social Summary Rating

Name..... Date.....

- 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) 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 social situations that you found difficult in the last week.

0	1	2	3	4	5	6	7	8
Entirely Externally focused			Both Equally			Entirely Self focused		

- d) 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
Never		Rarely		Sometimes		Often		Always

- e) 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
Never		Rarely		Sometimes		Often		Always

SOCIAL ATTITUDES QUESTIONNAIRE (REVISED)

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

**I must not show signs of weakness to others**

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

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

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

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

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

**I'm unlikeable**

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

**Other people are more anxious than I am**

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

**I'm different**

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

**Other people are better at getting it right socially than me**

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

**I must appear intelligent and witty**

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

**I look as anxious as I feel**

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

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

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

**I'm unacceptable**

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

**Anxiety is not a sign of weakness**

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

**Other people are more competent than I am**

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

**Others are more acceptable or likeable than me**

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

**My anxiety is obvious to other people**

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

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

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

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

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

**I must not let anyone see I am anxious**

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

**People think I am uninteresting**

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

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

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

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

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

**I'm inferior**

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

**I'm vulnerable**

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

**Other people are less anxious than I am**

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

People can see right through me, and see my weakness

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

I don't need to be liked by everyone

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

I'm a weird person

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

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

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

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

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

I'm odd/peculiar

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

I'm important to other people

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

People see anxiety as a sign of weakness

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

I have to do things right to be accepted

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

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

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

If I keep up appearances, I might scrape by

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

My opinions mean nothing

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

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

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

I'm attractive

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

If people notice I am anxious they will think I am odd  
 TOTALLY AGREE AGREE DISAGREE DISAGREE TOTALLY  
 AGREE VERY MUCH SLIGHTLY NEUTRAL SLIGHTLY VERY MUCH DISAGREE

People are intolerant of signs of weakness  
 TOTALLY AGREE AGREE DISAGREE DISAGREE TOTALLY  
 AGREE VERY MUCH SLIGHTLY NEUTRAL SLIGHTLY VERY MUCH DISAGREE

If someone thought that I was inferior to them, I couldn't stand it  
 TOTALLY AGREE AGREE DISAGREE DISAGREE TOTALLY  
 AGREE VERY MUCH SLIGHTLY NEUTRAL SLIGHTLY VERY MUCH DISAGREE

If I am quiet, people will think I'm boring  
 TOTALLY AGREE AGREE DISAGREE DISAGREE TOTALLY  
 AGREE VERY MUCH SLIGHTLY NEUTRAL SLIGHTLY VERY MUCH DISAGREE

I'm inadequate  
 TOTALLY AGREE AGREE DISAGREE DISAGREE TOTALLY  
 AGREE VERY MUCH SLIGHTLY NEUTRAL SLIGHTLY VERY MUCH DISAGREE

If people see that I'm anxious, they will think I am weak or inferior  
 TOTALLY AGREE AGREE DISAGREE DISAGREE TOTALLY  
 AGREE VERY MUCH SLIGHTLY NEUTRAL SLIGHTLY VERY MUCH DISAGREE

I'm interesting  
 TOTALLY AGREE AGREE DISAGREE DISAGREE TOTALLY  
 AGREE VERY MUCH SLIGHTLY NEUTRAL SLIGHTLY VERY MUCH DISAGREE

If people look at me, it means they are thinking negative things about me  
 TOTALLY AGREE AGREE DISAGREE DISAGREE TOTALLY  
 AGREE VERY MUCH SLIGHTLY NEUTRAL SLIGHTLY VERY MUCH DISAGREE

I'm a boring person  
 TOTALLY AGREE AGREE DISAGREE DISAGREE TOTALLY  
 AGREE VERY MUCH SLIGHTLY NEUTRAL SLIGHTLY VERY MUCH DISAGREE

Even if people see my anxiety, it doesn't mean that I am inferior to them  
 TOTALLY AGREE AGREE DISAGREE DISAGREE TOTALLY  
 AGREE VERY MUCH SLIGHTLY NEUTRAL SLIGHTLY VERY MUCH DISAGREE

I must always live up to other people's expectations  
 TOTALLY AGREE AGREE DISAGREE DISAGREE TOTALLY  
 AGREE VERY MUCH SLIGHTLY NEUTRAL SLIGHTLY VERY MUCH DISAGREE

**FEAR OF NEGATIVE EVALUATION**

Please circle either 'TRUE' or 'FALSE' to the following statements.

1. I rarely worry about seeming foolish to others. (T) (F)
2. I worry about what people will think of me even when I know it doesn't make any difference. (T) (F)
3. I become tense and jittery if I know someone is sizing me up. (T) (F)
4. I am unconcerned even if I know people are forming an unfavourable impression of me. (T) (F)
5. I feel very upset when I commit some social error. (T) (F)
6. The opinions that important people have of me cause me little concern. (T) (F)
7. I am often afraid that I may look ridiculous or make a fool of myself. (T) (F)
8. I react very little when other people criticise me. (T) (F)
9. I am frequently afraid of other people noticing my shortcomings. (T) (F)
10. The disapproval of others would have little effect on me. (T) (F)
11. If someone is evaluating me I tend to expect the worst. (T) (F)
12. I rarely worry about what kind of impression I am making on someone. (T) (F)
13. I am afraid that others will not approve of me. (T) (F)
14. I am afraid that others will find fault with me. (T) (F)
15. Other people's opinions of me do not bother me. (T) (F)
16. I am not necessarily upset if I do not please someone. (T) (F)
17. When I am talking to someone, I worry about what they may be thinking about me. (T) (F)
18. I feel that you can't help making social errors sometimes, so why worry about it. (T) (F)
19. I am usually worried about what kind of impression I make. (T) (F)
20. I worry a lot about what my superiors think of me. (T) (F)
21. If I know someone is judging me, it has little effect on me. (T) (F)
22. I worry that others will think I am not worthwhile. (T) (F)
23. I worry very little about what others will think of me. (T) (F)
24. Sometimes I think I am too concerned with what other people think of me. (T) (F)
25. I often worry that I will say or do the wrong things. (T) (F)
26. I am often indifferent to the opinions others have of me. (T) (F)
27. I am usually confident that others will have a favourable impression of me. (T) (F)
28. I often worry that people who are important to me won't think very much of me. (T) (F)
29. I brood about the opinions my friends have about me. (T) (F)
30. I become tense and jittery if I know I am being judged by my superiors. (T) (F)

**SOCIAL PHOBIA RATING SCALE (SPRS)**

1. How distressing has your social anxiety been in the last week?

0	1	2	3	4	5	6	7	8
<i>Not at all</i>				<i>Moderately</i>				<i>Extremely—The worst I have ever been</i>

2. How much have you avoided social situations because of your anxiety in the past week?

0	1	2	3	4	5	6	7	8
<i>Not at all</i>				<i>Half of the time</i>				<i>All of the time</i>

3. How self-conscious have you felt in difficult social situations in the past week?

0	1	2	3	4	5	6	7	8
<i>Not at all</i>				<i>Moderately</i>				<i>Extremely self-conscious. The most I have ever felt</i>

4. People cope with their social anxiety in different ways. Place a number from the scale below next to each item listed to show how often you do the following when you are socially anxious.

0	1	2	3	4	5	6	7	8	
<i>Not at all</i>				<i>Half of the time</i>				<i>All of the time</i>	
<i>Say little</i>	_____			<i>Control my thoughts</i>	_____			<i>Hold my arms still</i>	_____
<i>Take slow breaths</i>	_____			<i>Try to relax</i>	_____			<i>Focus on my voice</i>	_____
<i>Grip objects tightly</i>	_____			<i>Sit down</i>	_____			<i>Avoid eye contact</i>	_____
<i>Move slowly</i>	_____			<i>Cover my face</i>	_____			<i>Speak quickly</i>	_____
<i>Use distraction</i>	_____			<i>Wear certain clothes</i>	_____			<i>Focus on my hands</i>	_____

5. Below are a number of thoughts that people have when they are socially anxious. Indicate how much you believe each thought when you are socially anxious by placing a number next to each one from the scale below.

0	10	20	30	40	50	60	70	80	90	100	
<i>Do not believe the thought</i>										<i>Completely convinced the thought is true</i>	
<i>look bad</i>	_____									<i>They'll notice I'm anxious</i>	_____
<i>everyone is looking at me</i>	_____									<i>I'll drop and spill things</i>	_____
<i>I'm losing control</i>	_____									<i>I'm boring</i>	_____
<i>I'll be unable to speak</i>	_____									<i>I'm inadequate</i>	_____
<i>I'll babble and talk funny</i>	_____									<i>They think I'm stupid</i>	_____
<i>I look abnormal</i>	_____									<i>They don't like me</i>	_____
<i>They won't respect me</i>	_____									<i>I'll look foolish</i>	_____
<i>Other thoughts not listed</i>										<i>Rating</i>	_____

Self-Report Questionnaire

Where possible answer on this sheet. For questions which require more detailed answers please answer on separate sheet. Thank you for taking time to answer this questionnaire.

Name..... Date.....

A. Current Life Situation

1. Please briefly describe what you do on a typical weekday, starting with the time that you wake up in the morning, and ending with the time that you go to sleep at night.  
Did this pattern change when your present difficulties began?
2. How are you getting along with people? How do people seem to feel about you?  
Do you have friends? Any close friends? How often do you see them?  
Have your relationships with others changed as a result of your current difficulties?
3. Are you dating anyone at the present moment?  
If so, how would you characterise your relationship with this person?  
If not, are you happy with this situation?
4. How would you describe your present relationship with your family of origin?  
How often do you visit them?
5. Has your performance at university been affected by your problem?
6. Have you ever used drugs or alcohol on a regular basis? If so, how often and in what amounts?  
Has this ever been a problem for you?  
Is this currently a problem for you?  
Do you think this is a problem?

## B. Developmental History

1. When and where were you born?  
Did you experience any significant moves as a child? If so, when did these occur and what were the reasons that your family moved?  
Were you ever separated from one or both parents for a period of time during your childhood?
2. What were your parents occupations when you were growing up?
3. Do you have any brothers or sisters?  
What are their current ages?  
Where do you fit in, in terms of birth order?
4. How would you describe your father, especially during your childhood?  
How did your father respond to you when you were upset (angry, depressed, anxious) about something? When you were happy about something?  
How did he discipline you when you misbehaved?  
How would you characterise your relationship with your father during your childhood?
5. How would you describe your mother, when you were a child?  
How did your mother respond to you when you were upset (angry, depressed, anxious) about something? When you were happy about something?  
How did she discipline you when you misbehaved?  
How would you characterise your relationship with your mother during your childhood?
6. How would you describe your parents' relationship during your childhood?  
Did your parents ever argue? If so, what kinds of things did they argue about? How did their fights make you feel?
7. How would you characterise your relationship with your sibling(s) as a child?
8. Was religion an important part of your upbringing? Is so, in what way was it important?
9. Did you have any particular fears as a child (objects, situations)/  
Do you still have any of these?
10. How were your marks/grades at school?  
Primary school:  
  
High school:  
  
How did you feel about examinations while you were at school?  
Primary school:  
  
High school:

Did you make many friends at school? Any close ones?

Primary school:

High school:

11. Were you ever in trouble with the police or school authorities? If so, when did this occur?  
Can you describe the incident(s)?

### C. Social History

1. At what age did you begin dating?
2. Do you have difficulty communicating with the opposite sex? If so, what creates these difficulties?
3. Have you had any serious (long-term, exclusive) relationships? can you describe the most significant one(s)? How did it (they) begin and why did it (they) end?  
Is there any common pattern that seems to take place in many of your romantic involvements?
4. How is (are) your sexual relationship(s) with your partner(s)?  
Are you satisfied with the quality of this relationship?

### D. School/Occupational History

1. What year did you graduate from high school?  
What is the highest degree you have obtained? In what field is this degree?  
Did you take any time off from school during your education? If so, why?
2. What have you done since leaving school?

### E. Medical History

1. When was your last medical check-up?  
What were the results?
2. Are you currently in treatment for any medical condition?  
Are you taking any medication at the present time? If so, what type(s) and at what dosage?  
Do you have any medication or food allergies?
3. Have you ever had or do you presently have an eating disorder of any kind? If so, which eating disorder and to what extent?  
What have you done about this eating disorder?

4. Have you ever been for any kind of psychological therapy/treatment? Explain the nature of this.

F. General

1. What are some of your goals for this treatment programme?

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Panic attacks

- 1.1. Do you suffer from panic attacks?
  - Never
  - Have had one such attack?
  - Have more than once
  - Had a panic attack last week
  - Suffer severely: more than once a week
- 1.2. Are you constantly worried about having another panic attack, or when the next attack will be?

Separation Anxiety

- 2.1. Do you feel excessive distress when anticipating or experiencing separation from home/parents?
- 2.2. Have you experienced refusal or reluctance to go somewhere (such as, returning to university) due to separation fears?
- 2.3. Have these symptoms then lasted for more than four weeks?
- 2.4. Did these symptoms interfere with your performance at university?
- 2.5. Have you experienced such fear even before the age of 18?

Dysmorphic disorder

- 3.1. Have you ever been preoccupied by what might seem to be a defect in your appearance?
- 3.2. What is this defect?
- 3.3. Do you think that your concern with this defect affects your work, social or personal functioning?

Pervasive developmental disorder

4. Would you describe your peers as being at the same developmental level as yourself, mostly older, or mostly younger?

Schizoid Personality disorder

- 5.1. Do you prefer not to have close relationships, including with family members?
- 5.2. Do you prefer solitary activities rather than group activities?

### Substance abuse

- 6.1. Do you use drugs of any form, apart from what has been prescribed by a doctor?
- 6.2. Are you more a social user, or do you enjoy using drugs even whilst alone?
- 6.3. Do you feel that the use of alcohol helps you become more sociable?

### Agoraphobia

- 7.1. Do you avoid leaving your home or room on campus, unless it is very necessary?
- 7.2. Have you had fear of open spaces, e.g. shops, shopping malls?

### Adjustment disorder

- 8.1. Do you find it difficult to adapt to changes?
- 8.2. Do you normally overcome this difficulty, or do you neverendingly struggle to adapt?
- 8.3. Does this affect your occupational and social functioning?

### Parkinson's Disease

9. Have you ever been diagnosed with it?

### Abnormal eating disorders

- 10.1. Do you find that your weight and shape are of greatest importance to you in self evaluation?
- 10.2. Do you ever binge eat and then use laxatives or induce vomiting?
- 10.3. Is your weight a problematic issue to you?
11. Observe non verbal behaviour, e.g. eye contact, facial expressions, body posture and gestures.
12. Check for: squint, facial scarring, or stuttering. If any are present, observe if this is problematic to the individual in any way. Could this be the reason for being social phobic?

## Appendix 5 [iii]

### Note to reader:

In order to graphically represent the data collected from these questionnaires in a user-friendlier manner, the scales 1 to 7 as depicted in the questionnaire were reversed and subtracted by 1, thereby making them 0 to 6 in the graphical representations in the main text. In the questionnaires, 1 is the highest score on the scale. In the graphs, 6 is the highest score on the scale.

## REPORT ON THERAPY SESSION

Name: \_\_\_\_\_

Date of session: \_\_\_\_\_

Main goal(s) of session: \_\_\_\_\_

**PART I.** Please circle your response on the scales given to each of the following:

1. Before you came in today, how much progress did you expect to make in dealing with your problems **in today's session?**

1	2	3	4	5	6	7
MUCH PROGRESS			SOME PROGRESS			NO PROGRESS

2. **In today's session**, how much progress do you feel you actually made?

1	2	3	4	5	6	7
MUCH PROGRESS		SOME PROGRESS		NO PROGRESS		THINGS GOT WORSE

3. **In future sessions**, how much progress do you think you will be able to make in dealing with your problems?

1	2	3	4	5	6	7
MUCH PROGRESS			SOME PROGRESS			NO PROGRESS

4. How satisfied are you with **today's session?**

1	2	3	4	5	6	7
VERY SATISFIED		SATISFIED		INDIFFERENT		DISSATISFIED

5. **In today's session**, how well do you think the facilitators understood your problem?

1	2	3	4	5	6	7
VERY WELL			FAIRLY WELL			POORLY

6. How well were you able to convey your problems or concerns **in this session?**

1	2	3	4	5	6	7
VERY WELL			FAIRLY WELL			POORLY

7. **In today's session**, did you find that everyone in the group had an equal opportunity to speak about their problems, or did certain people dominate the discussions?

1	2	3	4	5	6	7
VERY FAIR OPPORTUNITY		FAIR OPPORTUNITY		DISCUSSIONS WERE DOMINATED BY SAME PEOPLE		DISCUSSIONS WERE VERY DOMINATED BY SAME PEOPLE



**PART IV.** Rate the extent to which you gained the following skills in today's group session. Please refer only to this session. Keep in mind that not all of these skills can be gained in any one session.

		VERY MUCH	SOME	NONE
1.	Better insight into and understanding of my psychological problems.	1	4	7
2.	Methods or techniques for better ways of dealing with people (i.e. asserting myself).	1	4	7
3.	Techniques in defining and solving my everyday problems.	1	4	7
4.	Confidence in undertaking an activity to help myself.	1	4	7
5.	Greater ability to cope with my anxiety.	1	4	7
6.	Better control over my actions.	1	4	7
7.	Greater ability to <b>recognize</b> my unreasonable <b>thoughts</b> .	1	4	7
8.	Greater ability to <b>correct</b> my unreasonable <b>thoughts</b> .	1	4	7
9.	Greater ability to <b>recognize</b> my self-defeating or erroneous <b>assumptions</b> .	1	4	7
10.	Greater ability to <b>evaluate</b> my self-defeating or erroneous <b>assumptions</b> .	1	4	7

**PART IV.** (i) Please describe the most outstanding aspect of today's session, (ii) any interests or concerns you would like to share. (Please write on the other side of the page if this space is inadequate).

PARTICIPANT'S RECORD

Enter on a scale of 1 to 10 the rating you would give as an answer to each question.  
(You are allowed to use .1 to .9 between numbers to be precise)

Questions:	Ratings:	
	After role-play 1	After role-play 2
1. How anxious did you look?		
2. How self-conscious did you feel?		
3. What were you self-conscious of? (Please list briefly in the columns)		
4. How anxious did you think you appeared?		
5. How good was your performance overall?		
6. What other individualized things did you fear would be noticed, and to what extent (Rate these as well) e.g. blushing, stuttering, being bored, being boring, shaking lip, looking frustrated etc.		

## Appendix 5 [v]

### VOLUNTEER'S RECORD

Enter on a scale of 1 to 10 the rating you would give as an answer to each question.  
(You are allowed to use .1 to .9 between numbers to be precise)

Questions:	Ratings:	
	After role-play 1	After role-play 2
1. How anxious did you think X looked?		
2. How self-conscious did you think X felt?		
3. What might X have been self-conscious of? (Please list briefly in the columns)		
4. How good do you think X's social interaction skills were?		
5. What other individualized things did you notice about X, and to what extent (Rate these as well) e.g. blushing, stuttering, being bored, being boring, shaking lip, looking frustrated etc.		

## Appendix 5 [vi]

### Note to reader:

In order to graphically represent the data collected from these questionnaires in a user-friendlier manner, the scales 1 to 7 as depicted in the questionnaire were reversed and subtracted by 1, thereby making them 0 to 6 in the graphical representations in the main text. In the questionnaires, 1 is the highest score on the scale. In the graphs, 6 is the highest score on the scale.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**FEEDBACK ON SESSIONS 1 TO 10,**  
**& SAFETY BEHAVIOURS EXPERIMENT**

Please provide feedback for the following using the scale as given below:

1	2	3	4	5	6	7
-Very valuable		neutral				- completely valueless
- Made complete sense						- made no sense
- very effective						- not effective
- very useful						- no use at all
- well understood						- no understanding
- learnt much						- learnt nothing

---

**Session 1:**

In this session, we introduced ourselves to one another, and then went on to introducing various other things. You were introduced to social phobia, social anxiety, cognitive behaviour therapy, and a basic idea of what the therapy to follow will entail. We began by trying to identify situations that each of you feared.

1. How much understanding did you gain from the first session's introduction to social phobia and cognitive behaviour therapy? \_\_\_\_\_
2. How useful were the notes on these topics provided to you to take home? \_\_\_\_\_
3. How much did you learn about yourself regarding the "feared and avoided situations" exercise (ex.1)? \_\_\_\_\_

Further comments:

---

**Session 2:**

In this session, we started working with the identified feared situations. We identified what "negative thoughts" and "automatic anxiety symptoms" each of you experienced in the feared situations. You were presented with a brief explanation on automatic anxiety symptoms, and we discussed them. You were given an extensive homework exercise on identification of negative thoughts and automatic anxiety responses.

4. How much did you learn about yourself regarding the "identifying negative thoughts" exercise (ex.2)? \_\_\_\_\_
5. How much did you learn and understand about automatic anxiety symptoms based on the presentation and the notes given to you to take home? \_\_\_\_\_
6. How much did you learn about yourself regarding the "automatic anxiety symptoms" exercise (ex.3)? \_\_\_\_\_
7. How much use was the homework record sheet provided to you on identifying negative thoughts? \_\_\_\_\_
8. How useful was the homework exercise where you had to list your anxiety symptoms on a scale of 1 to 5? \_\_\_\_\_

Further comments:

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### Session 3:

In this session, we went a bit further to identify which "safety behaviours" each of you used in your feared situations. You were presented with the reasoning behind why safety behaviours are used by people. What role do they play in making a person feel safer about a situation. You were also provided case studies of people that used safety behaviours in their given feared situations. Later you went on to understand the "shift of attention" that takes place for you in a feared situation. Your homework required for you to identify your safety behaviours using the checklist, and to figure out better, how your attention shifts in the feared situation.

9. How much did you learn about safety behaviours from the presentation on it? \_\_\_\_\_
10. How useful did you find the checklist of safety behaviours and the case studies about the way people used their safety behaviours? \_\_\_\_\_
11. How much did you learn about yourself regarding the "safety behaviours" exercise- ex. 4 (not the experiment)? \_\_\_\_\_
12. How much did you learn from the presentation on shift of attention and increased self awareness? \_\_\_\_\_
13. How much did you learn about yourself regarding the "shift of attention" exercise (ex. 5)? \_\_\_\_\_
14. How much use was the homework sheet on identifying safety behaviours using the list? \_\_\_\_\_

Further comments:

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**Session 4:**

In this session, we used the information we had already collected to learn more about how "increased self awareness" plays a role in our functioning in a feared situation. Now having found this out, we went ahead to put all the pieces of the puzzle together and construct models of what exactly was done in the feared situation. An idea of how this should be done was presented to you, and you had to construct your models as part of homework.

15. How much did you learn about yourself regarding the "increased self awareness" exercise (ex. 6)? \_\_\_\_\_
16. How well did you understand the presentation on how to use the model? (where you basically put everything together and finally see how all the exercises done so far work together.) \_\_\_\_\_
17. How effectively did you manage to construct this model as part of the homework? \_\_\_\_\_

Further comments:

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**Session 5:**

In this session, we basically reviewed the models that you constructed for homework, and we discussed what you would do over the vacation.

18. How much did you understand about the presentation regarding what happens next, once you have constructed your model? \_\_\_\_\_
19. How well did the vac. go in respect to effectively conducting experiments with feared situations, whereby you can construct new models? \_\_\_\_\_

Further comments:

## Session 6:

In this session, we reviewed what you did over the vacation and re-evaluated the models each of you had constructed. We went further to discuss the "safety behaviours experiment" and each of you identified situations you considered highly anxiety provoking to use as part of the role plays. We briefly discussed what was meant by "dropping the safety behaviours" which would be an important part of your role playing in the experiments.

20. How much did you understand and realize the need for the safety behaviours experiment? \_\_\_\_\_
21. How valuable was the discussion about the homework you did during the vac.? \_\_\_\_\_
22. Even if it wasn't entirely your homework discussed, to what extent could you relate to, and understand more about yourself with the discussion of other people's homework? \_\_\_\_\_

Further comments:

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## SAFETY BEHAVIOURS EXPERIMENT

Each of you were involved in role playing the same situation twice. Once with your safety behaviours and once without them. You were then given feedback by your volunteer role player(s) who you were interacting with in the role plays. Both role plays were video taped and you viewed these video tapes in order to establish for yourself, in which role play you saw yourself as interacting better. You and your volunteer role player(s) filled out assessment forms in order for comparison of your self evaluation and the observer evaluation of you.

23. Did you find that overall the experiment made sense and was of value to you? \_\_\_\_\_
24. Did you find the volunteer role players' feedback valuable? \_\_\_\_\_
25. Did the video feedback have much value or make much sense to you regarding your self awareness? \_\_\_\_\_
26. Was the way in which the role plays were conducted and the debriefing provided to you effective? \_\_\_\_\_

27. Was the records sheet provided to you after each role play effective to your understanding of how you felt you conducted and experienced the situation? \_\_\_\_\_

Further comments:

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### Sessions 7/8/9/10

In these sessions, you have basically been reviewing the safety behaviours experiments, and homework where you had to go out and conduct experiments of your own. Your experiences and findings have been central to the discussions. Even though your homework is discussed along with everyone else's, the idea is to see how much you can identify with, and learn from other people's experiences as well. You have in addition been introduced to "post mortem" and how it works, the presence of "assumptions and beliefs" and how they work, and you have been presented with a manual on "Cognitive Restructuring" for your own use. This manual should enhance your understanding of your feared situations whilst helping you do therapy on yourself where this is possible. You have also been introduced to the concept of "low self-esteem" and how this may be playing a role in your interaction with others, and with your "self concept".

28. Were the discussions about the safety behaviours experiments of any value to you? (this is including discussions of other people's experiences; did the discussions provide more understanding and make more sense of how you experienced your own experiment) \_\_\_\_\_
29. How useful were the records given to you as part of homework; the daily dysfunctional thought record, and the record for noting behavioural experiments. \_\_\_\_\_
30. Were the discussions regarding these record sheets useful to you? This is including the discussions of other people's records- did it make more sense to your own understanding of experiments you conducted as part of homework. \_\_\_\_\_
31. How much did you learn and understand from the presentation on post mortem? \_\_\_\_\_
32. Did you manage to effectively understand and identify your use of post mortem as part of your homework experiments? \_\_\_\_\_
33. How well did you understand the presentation on the cognitive restructuring manual? \_\_\_\_\_

34. Did you manage to effectively use it to make more sense of your homework experiments? \_\_\_\_\_
35. How much did you understand and learn from the presentation on the presence of "assumptions and beliefs"? \_\_\_\_\_
36. How effectively did you manage to identify and work with you existing assumptions and beliefs as part of the homework? \_\_\_\_\_
37. How much sense and effectiveness did you receive from the handout on "low self- esteem"? \_\_\_\_\_
38. Did the handout on low self- esteem enable you to carry out experiments as part of homework with a better understanding of yourself? \_\_\_\_\_
39. How useful did you find the explanation on the development and maintenance plan, i.e. what you have to do for yourself once the group is over? \_\_\_\_\_
40. How effectively have you been able to put this plan into use thus far? \_\_\_\_\_

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Apart from comments you have given on each session, is there anything else you would like to add? If so, please explain yourself clearly, and give ideas of what you think might make our last sessions most worthwhile. Have you got any unfinished business that needs to be paid special attention to; that is, were you left behind in any of the sessions and are still left wondering what exactly happened there?

**Appendix 6**

Rhodes University Department of Psychology  
Psychology Honours Research Project

**CONSENT FORM**

I,....., agree to participate fully in the Psychology  
Honours Research Project, titled:

**"An Evaluation of the effectiveness of a group therapy programme for  
social phobia among a group of students at Rhodes University."**

**Requirements:**

- 1) I agree to attend each weekly session, for two hours, or as decided upon by the group, until the programme is completed.
- 2) I agree to complete all the assessment forms throughout the duration of the programme.
- 3) I agree to allow the sessions to be audiotaped and videotaped. I understand that these will remain confidential and will only be viewed by the group facilitators. I understand that this is an important aspect of the programme so as to assess progress.
- 4) I agree to complete the required homework assignments after each session.
- 5) I agree to participate in the debriefing interviews at the end of the programme.
- 6) I agree to allow the assessment and debriefing interviews to be tape-recorded.
- 7) I understand that the project will include case narratives or case vignettes. However names will be changed.
- 8) I agree to maintain complete confidentiality concerning all information disclosed about the group members.
- 9) I understand that, should I for any reason need to withdraw from the programme, I am able to do so. However, I must discuss this with the group facilitator.

**Signed by**

Research participant:.....

Date:.....

**Signed by**

Researcher:.....

Date:.....

## Appendix 7

**Hallo !!**

Thank you for taking the time to read this message. We hope that it will serve to act as an important guide in some of your lives.

**DO YOU FEAR...and spend your life avoiding any of the following social situations:**

- \* speaking/presenting to small or large groups?
- \* talking to authority figures?
- \* being the centre of attention?
- \* making small talk at parties?
- \* eating, drinking or writing in front of others?
- \* taking part in group activities?

When in such situations do you experience blushing, breathlessness, shaking, trembling, fear of vomiting, butterflies in the stomach, a sudden need to go to the toilet or sheer panic? Do you feel the need to escape from such a situation in order to cope?

IF SO - you could be suffering from **SOCIAL PHOBIA** - the most common anxiety disorder.

The **GOOD NEWS** is that **HELP IS AVAILABLE !!!** Social phobia is a treatable condition and with support and guidance you could be freed from this debilitating experience.

*SO - how can you go about getting help?*

Help is close at hand. We are appealing to you to accept this chance to receive guidance and treatment. As a part of a psychology research project, we are conducting a treatment programme for social phobics. The programme will involve a series of treatment sessions. Complete confidentiality is guaranteed.

What have you got to lose? With help you could be living the life you want to - without having to be overcome by fear and regular distress. We ask you to find the courage to accept this opportunity. We realise it may be difficult for you to take this step - but you will be doing yourself a favour. We want to help you. **TAKE THAT VERY IMPORTANT STEP.**

Thank you for your time. Please feel free to phone us or e-mail - at any time.

