

Treatment of Social Anxiety Disorder: A Case Study of a 31-Year-Old

An Empirically Supported Treatment Case Study  
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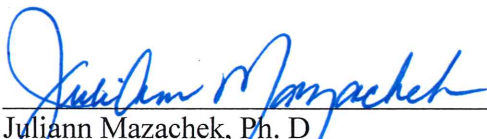
TREATMENT OF SOCIAL ANXIETY DISORDER: A CASE STUDY OF A 31-YEAR-OLD

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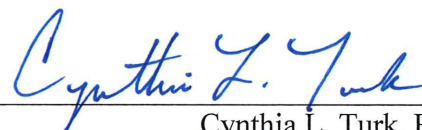
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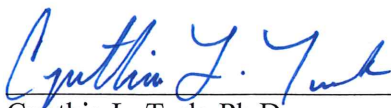


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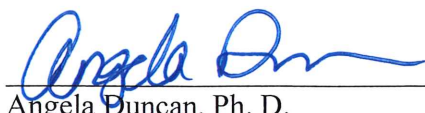


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### **Abstract**

The following is a de-identified case study that presents the assessment, diagnosis, and treatment of Social Anxiety Disorder (SAD) utilizing Cognitive Behavioral Therapy (CBT). Names and other identifying information have been changed to protect the client's privacy with the name "Lilly" used in lieu of the client's real name. At the time of treatment, this 31-year-old African American woman was struggling with building and maintaining friendships, maintaining conversation, assertiveness, and a fear of public speaking. In addition, Lilly noted difficulty being herself in social situations due to her social anxiety. Lilly was administered the Anxiety Disorders Interview Schedule (ADIS-5) and various self-report measures to aid in diagnosis and track treatment progress. A combination of a primary diagnosis of SAD with a secondary diagnosis of Generalized Anxiety Disorder (GAD) was determined to most accurately capture the client's presenting symptoms. The client attended 20 treatment sessions involving assessment, psychoeducation, self-monitoring, in-vivo exposures, grief and loss strategies, and termination. Pre-to-post as well as ongoing assessment suggests Lilly experienced meaningful reductions in symptom severity following treatment of SAD with CBT. Importantly, Lilly noted living a life more consistent with her values (e.g., family and being herself) due to the reduction of SAD symptoms and avoidance.

### **Treatment of Social Anxiety Disorder: A Case Study of a 31-Year-Old**

Social Anxiety Disorder (SAD) is characterized by The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association [APA], 2013) as marked fear or anxiety about social situation(s) in which the individual is exposed to possible scrutiny by others. Individuals with SAD fear they will act in a way or show anxiety symptoms that will lead to negative evaluation by others. Social situations almost always provoke fear or anxiety in the individual. Individuals with SAD often avoid social situations or endure the situations with intense fear and/or anxiety. The fear and anxiety are out of proportion to the actual threat posed by the social situation. To assign the diagnosis of SAD, the individual must experience persistent anxiety symptoms for at least six months, experience clinically significant distress and/or impairment in social or occupational functioning, and the symptoms cannot be attributed to another mental or medical condition.

In the United States, the estimated 12-month prevalence of SAD is approximately 7% (DSM-5; APA, 2013). In the general population, higher rates of social anxiety disorder are found in females compared to in males (APA, 2013; Asher et al., 2017). In response to the National Epidemiological Survey on Alcohol and Related Conditions, a sample of 43,093 adult participants; the survey revealed slightly more females (5.67%) experience a lifetime prevalence of SAD compared to males (4.20%; Xu et al., 2012). About 75% of individuals have an age of onset between 8 and 15 years old (APA, 2013). In contrast to mood and substance use disorders, the median age at onset of SAD occurs at a much earlier age (13 years; Kessler et al., 2005). Lilly reported first experiencing symptoms of SAD at age 14.

To assess race and ethnic prevalence among anxiety disorders, Asnaani et al. (2010) examined data from the Collaborative Psychiatric Epidemiology Studies. The sample included

6,870 White Americans, 4,598 African Americans, 3,615 Hispanic Americans, and 1,628 Asian Americans (Asnaani et al., 2010). White Americans endorsed SAD symptoms (12.6%) more frequently than African Americans (8.6%), Hispanic Americans (8.2%), and Asian Americans (5.3%). Furthermore, research suggests social anxiety in African American adults has a more chronic course than in White Americans (Sibrava et al., 2013). Ward et al. (2013) revealed, in a sample of 272 African American individuals located in a Midwestern city, both male and female participants endorsed low psychological openness (i.e., extent to which individuals are open to acknowledging mental health problems) and fears about stigma. Consistent with these findings, Lilly frequently described having experienced low psychological openness and concerns of stigma within her immediate and extended family.

According to the DSM-5 (APA, 2013), females diagnosed with social anxiety disorder report a greater number of social fears and comorbid depressive and anxiety disorders, while males are more likely to fear dating, use alcohol to relieve symptoms, and have oppositional defiant disorder (ODD) or conduct disorder (CD). Most individuals diagnosed with social anxiety disorder had a diagnosis of at least one other mental health disorder during the past 12-month period (Fehm et al., 2007). The most common comorbid mental health disorders are other anxiety disorders, such as generalized anxiety disorder and specific phobia (Canals et al., 2019). These patterns are consistent with Lilly's presentation as she met criteria for GAD, but did not report dating-specific fears, substance use, ODD or CD.

When compared to other mental health disorders (e.g., major depressive disorder, panic disorder, specific phobia, etc.), SAD ranked in the top five mental health disorders with the greatest impairment in quality of life (Alonso et al., 2004). More specifically, compared to those without SAD, those with SAD experience educational impairment (e.g., fail a grade or drop out

of school), financial dependence on parents or others well into adulthood, underemployment, and impairment in close relationships (Aderka et al., 2012; Dryman et al., 2016) Lilly's experience fit this pattern as she acknowledged concerns in continuing her education (e.g., postgraduate certification degree), living with her parents into her late twenties, and lacking close relationships.

### **Theoretical Model of Social Anxiety Disorder**

#### **Cognitive Models**

Rapee and Heimberg's (1997) cognitive model describes how individuals with SAD process information when faced with a social situation. The cognitive model suggests individuals with SAD create a mental representation of self when in the presence of an audience (Rapee & Heimberg, 1997). The presence of an "audience" enhances the feeling of being "on stage" that socially anxious individuals have while in the presence of others (Barlow, 2014, Chapter 3). In the presence of an audience, socially anxious individuals form an internal mental representation of how they are perceived by the audience (Heimberg et al., 2010). This mental representation of self is a picture formed from various sources. The mental representation of the self is negatively biased in part based on previous negative learning experiences. For instance, early learning experiences taught Lilly that her anxiety was unacceptable; accordingly, Lilly noted her mental representation of herself in social situations was as extremely visibly anxious. Socially anxious individuals adjust their mental representation of self as seen by the audience moment by moment based on perceived internal cues (e.g., increased heart rate), external cues such as observation of self (e.g., standing alone), and audience behavior (e.g., yawning; Barlow, 2014, Chapter 3). For Lilly, perceived internal cues included nausea and an increased heart rate, which would lead her to picture herself as even more visibly anxious to others. She was particularly cognizant of and

sensitive to others' behavior such as pausing in conversation which she interpreted to mean "I am boring to talk to." This bias toward social threat further biased her image of how she was coming across to others in a negative direction.

Given that socially anxious individuals are often critical of their own social behaviors, it is easy to assume that they have deficits in their social skills. However, research suggests socially anxious individuals are typically within normal range of social skills (Schneider & Turk, 2014). Rather, anxiety may interfere with demonstrating skilled social behavior. In a social situation, socially anxious individuals are allocating attentional resources toward detecting social threats (i.e., attention bias), monitoring and adjusting their mental representation, and trying to pay attention to the social task at hand. Unfortunately, this division of attentional resources may result in performance deficits, potentially leading to real—not imagined— negative social evaluation (Heimberg et al., 2010). That said, research shows that successful treatment of social anxiety improves social performance (Schneider & Turk, 2014).

One update to the model indicates socially anxious individuals fear evaluation of any kind—not only negative evaluation (Weeks et al., 2010). Additionally, anxious individuals predict the audience holds extremely high standards that are inherently critical (Leary et al., 1988). This produces a high likelihood that socially anxious individuals will determine they have fallen short of the audience's expectations almost by default. Said differently, SAD individuals focus on the incongruence of their own mental representation of self as seen by the audience and their perception of the audience's impossible performance standards (Heimberg et al., 2010).

Socially anxious individuals make predictions about the audience's expectation of their performance, their ability to meet expectations, and the probability and consequences of negative evaluation. Inevitably, negative evaluation is judged to be likely and costly, producing the

cognitive, behavioral, and physiological symptoms of anxiety which then feed back into the individuals' mental representation of self, thus perpetuating the cycle of anxiety. Lilly reported common beliefs of "I'm not interesting" and "They'll think I'm incompetent," which continued her cycle of anxiety.

Another theory contributing to the understanding of social anxiety disorder is the cognitive behavioral model developed by Clark and Wells (1995). While there is sizable overlap with Rapee and Heimberg's (1997) model (e.g., being acutely self-focused), Clark and Wells (1995) propose the use of "safety behaviors." Safety behaviors are actions employed to prevent or decrease the consequences of feared outcomes (Leigh & Clark, 2018). For example, a socially anxious individual may prepare conversation topics in advance to reduce the chances of being embarrassed by "not knowing what to say" or avoiding eye contact to minimize their awareness of social cues they would perceive as unfavorable during social interactions. Safety behaviors may provide short-term relief but, being grounded in avoidance, ultimately serve to perpetuate the cycle of anxiety because they prevent the individual from learning that the feared outcome is unlikely to occur. For instance, Lilly frequently avoided making eye contact with the clinician throughout treatment. Outside of treatment, Lilly noted using her phone to "look busy" to avoid potential social interactions.

Cognitive models suggest social anxiety persists due to the inability to accurately process information in the environment because of interference from safety behaviors, negative beliefs, division of attentional resources, and attention bias to social threat. Hope et al. (2019) coined the term "amber-colored glasses" to describe how socially anxious individuals view the world through a cautious lens. Treatment interventions based on this model utilize cognitive restructuring to identify, label, and dispute negative automatic thoughts and beliefs. Cognitive

restructuring encourages the individual to develop thoughts that portray the individual's experience more accurately. The new thoughts are referred to as a rational response. Rational responses are utilized during exposures to help the individual overcome avoidance, correct a negative mental representation of the self, and test predictions about negative thoughts and beliefs (Clark & Wells, 1995). Thereby, distortions in beliefs, attentional bias, and safety and avoidance behaviors are first identified and then modified and "corrected" to enhance the individual's ability to derive satisfaction from relationships and improve overall quality of life. Treatment interventions derived from this model also use exposure to feared social situations as an opportunity to correct negative beliefs about the self and others.

### **Behavioral Models**

Avoidant behavior contributes to the maintenance of social anxiety (Foa & Kozak, 1986). Individuals often avoid situations or objects entirely (e.g., not going to an event) or use subtle behavioral changes to reduce anxiety and/or worry in the situation (e.g., not making eye contact). The use of avoidance does not allow for corrective learning. The decrease in anxiety caused by avoidance ultimately negatively reinforces avoidance behaviors. Exposure therapy (ET) can be used to reduce avoidance and permit corrective learning.

Research suggests ET is an effective method for treating anxiety disorders (Craske et al., 2014). In ET, the individual is "exposed" to a feared situation or object. There are various forms of exposures: imaginal, interoceptive, and in vivo (Barlow, 2014, Chapter 3). Imaginal exposures are utilized to confront a feared situation or thoughts when a situation cannot be re-created in real time (e.g., giving a speech and being severely criticized in front of a large audience). Interoceptive exposures intentionally produce feared internal stimuli (e.g., drinking caffeine to elicit an increased heart rate). In vivo (real-life) exposures involve individuals encountering

actual anxiety provoking situations. For instance, Lilly engaged in an in vivo exposure involving “small-talk.” Treatment of SAD primarily relies on in vivo exposures compared to interoceptive and imaginal exposures (Kaczurkin & Foa 2015), which is consistent with the interventions employed in Lilly’s treatment.

During an exposure, the objective is to stay psychologically engaged so the natural processes involved in fear reduction (extinction) can occur (Heimberg, 2002). Following repeated prolonged exposure to the feared situation or object, in the absence of the associated aversive event, the client comes to associate the feared stimulus with relative safety (Hofmann, 2008). The mechanism through which the formation and extinction of associations occurs is best conceptualized by the inhibitory model, which is derived from a classical conditional approach.

Within the classical conditioning approach, the conditioned stimulus (CS) is the stimulus that predicts the presence of another stimulus (Clark, 2004). The stimulus that is predicted is deemed the unconditioned stimulus (US). The US will produce an unconditioned response (UR), indicating the response is instinctive and automatic. Through repeated pairing of the CS and US, the CS elicits a conditioned response (CR) similar to the UR, indicating a learned response.

The inhibitory learning model states the original fear association (CS – US) learned during fear conditioning is not erased during extinction trials (Craske et al., 2012). Rather, the original learning remains and secondary inhibitory learning about the CS – US relationship is established. Specifically, after exposure, the CS possesses two meanings: its original CS – US excitatory association and a new inhibitory meaning (CS – no US). For example, Lilly noted entering treatment with the learned association that disagreeing during a conversation is dangerous (e.g., “I will be disliked if I disagree with someone”). Exposures designed to violate associated feared outcomes do not remove the existing association. Rather, exposure allows for

the development of a secondary non-threatening association (e.g., “If I disagree with someone, it’s unlikely they will dislike me”). Therefore, the original association is inhibited but not unlearned. The inhibitory learning model has the potential to explain spontaneous recovery and reacquisition, which may lead to reappearance of fear and anxiety post treatment.

After treatment has ended, some individuals experience a return of the fear response and the resurrection of the avoidance-based cycle of anxiety. The spontaneous recovery or reacquisition of fear after treatment may be due to a deficit in anxious individuals inhibitory learning (Craske et al., 2012). Therefore, to enhance long-term effectiveness, exposure should be designed to maximize saliency and generalizability. There are various methods for maximizing the effectiveness of exposures (Craske et al., 2014) such as: 1) designing exposures that maximally violate expectancies for inhibitory learning; 2) removing safety behaviors; 3) intermittently reinforcing extinction; and 4) varying duration, stimuli, context, and intensity of exposure. The various techniques to maximize exposure effectiveness may be utilized with each of the three types of exposure.

### **Empirical Support for Intervention**

Cognitive Behavioral Therapy (CBT) is the most researched form of psychosocial intervention for social anxiety disorder (Rodebaugh et al., 2004). Cognitive Behavioral Therapy (CBT) for SAD is a combination of Cognitive Therapy (CT) and ET. Multiple randomized controlled trials have found both treatments individually effective (Taylor, 1996; Acarturk et al., 2009). However, meta-analyses indicated mixed findings regarding whether exposure is improved by the addition of CT (Ougrin, 2011). This case study will utilize a manualized treatment approach that combines CT and ET to treat SAD. Recent studies representative of this literature are examined below.

### **Cognitive Behavioral Therapy**

Ougrin (2011) conducted a meta-analysis examining the efficacy of CBT treatment for SAD and other psychological disorders. The analysis focused on randomized controlled trials that aimed to compare the efficacy of CT and ET. 20 studies were included in the meta-analysis with a total of 1,308 participants. Specific to SAD, CT was found to be superior in both short and long-term outcomes versus ET ( $g = 0.28 - 1.01$ ).

Barkowski et al. (2016) conducted a meta-analysis examining the efficacy of cognitive-behavioral group therapies (CBGT) for individuals diagnosed with SAD compared to waitlist control groups or active treatment. Active treatment groups included common factor control group (e.g., supportive group treatments or relaxation groups), individual treatment or pharmacotherapy. The analysis identified 36 randomized controlled trials with a total of 2,171 participants. In comparison to waitlist control groups, CBGT resulted in a large effect size ( $g = .84, p < .001$ ) specific to SAD symptoms. In the eight studies that obtained follow-up data up to six months after treatment completion, the effect was maintained with  $g = 1.09, p = .009$ . In comparison to active treatment groups, CBGT resulted in a non-significant effect size ( $g = .06, p = .656$ ) which suggest CBGT for treatment of SAD may not be superior to other forms of treatment commonly employed to treat SAD.

A network meta-analysis conducted by Mayo-Wilson et al. (2014) compared the treatment efficacy of 41 interventions and control conditions in individuals diagnosed with SAD. The analysis included 101 randomized controlled trials with a total of 13,164 participants. The 41 interventions were grouped into 17 classes, and further reduced to three categories (i.e., controls, pharmacological interventions, and psychological and behavioral interventions). The psychological and behavioral interventions included CBT (individual and group settings) and

exposures without CT. Compared to waitlist groups, individual CBT (SMD = 1.19) and CBGT (SMD = .92) produced large effect sizes. Specific to manualized CBT, the approach espoused by Hope et al. (2019) produced an effect size of SMD = 1.02. In comparison to waitlist groups, selective serotonin reuptake inhibitors (SSRI) and serotonin and norepinephrine reuptake inhibitors (SNRI) produced an effect size of SMD = .91.

Leichsenring et al. (2013) conducted a randomized control trial (N = 495) examining the efficacy of manualized CBT, manualized psychodynamic therapy, and a waitlist group in the treatment of SAD. Both the CBT and psychodynamic approach were found superior to the waitlist. When comparing manualized CBT and psychodynamic therapy, significant differences in remission were found favoring the CBT group ( $p = .034$ , 95% CI=1.04 – 2.92). For self-report measures, analysis revealed significant differences in favor of CBT for scores on the Liebowitz Social Anxiety Scale ( $p = .01$ ,  $d = .25$ ; Heimberg et al., 1999), Social Phobia and Anxiety Inventory ( $p = .0009$ ,  $d = .33$ ; Turner et al., 1989), and Inventory of Interpersonal Problems ( $p = .003$ ,  $d = .29$ ; Horowitz et al., 1988). These findings support the authors' conclusion that manualized CBT is effective in reducing intensity of symptoms and has a lasting effect post treatment.

A randomized control trial (N=38) was conducted by Ledley (2009) that compared a manualized individual therapy group and a control group. The manualized individual therapy group utilized *Managing Social Anxiety: A Cognitive-Behavioral Therapy Approach*, designed by Hope et al. (2019). The treatment condition led to significant improvement on SAD self-report measures (effect sizes ranged from 1.03 to 5.22). Additional support for the effectiveness of CBT was provided by the finding that among the 35% of clients that completed a three-month

follow up assessment, significant improvements from pre-treatment to follow up ( $p < .001$ ) were obtained.

RCT's and meta-analytic findings support CBT as an effective treatment for SAD. Efficacious treatment of social anxiety disorder would emphasize exposure treatment, psychoeducation, and the utilization of cognitive restructuring. Additionally, findings suggest manualized CBT is an effective approach and may improve the maintenance of skills acquisition post-treatment (Ledley, 2009). The intervention should be individualized including identification of client specific cognitions, physiological responses, and safety and avoidance behaviors. Exposures should be graduated in difficulty, vary in content, and designed to violate client feared outcomes.

Based on review of the scholarly research literature, the decision was made to utilize CBT including the employment of ET in the treatment of SAD in the present case study. The interventions described in the *Managing Social Anxiety: A Cognitive-Behavioral Therapy Approach*, designed by Hope et al., (2019) provided the structure for treatment. This protocol is a 16-session manualized approach conducted in a 20-week period utilizing cognitive-behavioral therapy, exposure training, and skills practice with adults in an individual setting. Initially, clients learn to recognize thoughts, behaviors, and physiological responses associated with anxiety. Next, cognitive restructuring is employed to identify and challenge anxious self-talk, followed by education, development and practice of specific coping skills. Following mastery of skills training, the protocol shifts primarily to gradual exposure of imaginary, interoceptive, and/or in vivo situations specific to client's fear and avoidance hierarchy of anxiety-provoking situations. Each chapter is coupled with therapeutic homework supporting skills practice between session.

Socially anxious individuals have an attention bias toward social threat and perceived threatening social contexts. Individuals with SAD too frequently perceive social situations as dangerous and view the world through a cautious lens. This can become difficult when an individual has experienced social situations that are genuinely dangerous—not merely imagined to be dangerous. Many experiences of African American women are different from White American women, in that an African American woman often experiences double discrimination based on race and gender identity (Banks & Kohn-Wood, 2002; Seng et al., 2012). Experiencing oppression as the result of being a member of two or more marginalized groups has been labeled intersectionality (Crenshaw, 1989). Additionally, Kline et al. (2021) identified a statistically significant relationship ( $r = .15, p = .038$ ) between social anxiety and internalized racism in African American young adults.

Social anxiety may weaken pride in an individual's racial group, which could limit resilience to racial discrimination and/or other stressors (Kline et al., 2021). Kline et al. (2021) emphasized how clinicians need to remain aware of the possibility members of marginalized groups may frequently experience social contexts that are truly threatening. Therefore, thoughts and behaviors that parallel the symptoms of SAD may be the appropriate and psychologically healthy response in some situations. In the development of SAD, these types of experiences may become generalized to situations that do not possess the same degree of rational threat or danger.

The “me-not me” technique coined by Hope et al. (2019) maintains that awareness and the therapeutic response to threatening social contexts should be different from typical cognitive behavioral procedures (e.g., challenging the validity of the individual's perceived fear in a situation). The clinician and client would focus on how the client could respond and cope in a potentially threatening social situation. The clinician should be careful to not dismiss or

minimize the ways in which an experience may be challenging for a client. Lilly is an African American woman that stated concern for taking off her “amber-colored glasses” out of fear for dangerous situations. For example, Lilly noted she would not go for walks at night because of her gender identity. The clinician and Lilly discussed her fear as appropriate to context and the unfortunate importance of fear and/or anxiety in certain situations (e.g., living in a dangerous neighborhood; see Appendix I).

### **Presenting Problem and Relevant History**

#### **Identifying Information**

To protect the client’s anonymity, identifying details have been changed and the name “Lilly” will be used in lieu of the client’s real name. Lilly is a 31-year-old female who lives with her husband, Andy, in a midsized city in the Midwestern United States. Lilly noted she and her husband have been married for 1 year. At the time of treatment, Lilly and Andy were expecting their first child together. Lilly identifies as Christian, although she avoids attending church due to social anxiety. Lilly reported the family income places her in the socioeconomic status category of middle class. Lilly reported holding a job in the education field, while Andy serves in the military. She described being raised by her biological parents in a household that included two siblings. Lilly is the middle child with a half-sister that is 2 years older, and a brother that is 2 years younger. Lilly noted her parents have been married for over 30 years. Lilly reported her mother works seven days a week in home health care. Lilly noted speaking with both parents frequently, although she does not frequently speak with her siblings. At the start of treatment, Lilly noted a close relationship with her parents but distant relationship with her two siblings.

**Presenting Problem**

Lilly evidenced a high level of insight and psychological sophistication as she specifically requested ET. Her self-reported concerns included significant difficulty building and maintaining friendships, difficulty maintaining conversation, a lack of assertiveness, and a fear of public speaking. Lilly described becoming aware of experiencing fear and anxiety in more than one social situation as a freshman in high school. She acknowledged that social anxiety has interfered significantly with her work, home, and social life. For example, she described difficulty maintaining close relationships with family members. Lilly reported “codependency issues” in reference to relying heavily on her husband to complete required social tasks (e.g., grocery shopping, calling doctor offices). Lilly noted inability to pursue her desired career as a teacher because of the social and public speaking requirements of that profession. Most notably, Lilly described social anxiety as a constant barrier regarding closeness with family members and offered examples of actively avoiding family holidays and gatherings over the last few years which has created a sense of guilt. Lilly described being tired of “hiding anxiety from others” and expressed a sincere desire to manage her symptoms more effectively.

**Psychiatric/Medical History**

Lilly was self-referred and presented to a University-based psychological services clinic with social anxiety symptoms. She reported that she had been receiving services at a different outpatient clinic but was seeking additional resources out of an awareness that she might benefit from ET. Lilly reported her mother likely had Generalized Anxiety Disorder but never received a formal diagnosis or treatment. Also, Lilly wondered how her father’s chronic alcohol use may have impacted her own mental health. Lilly reported a medical history of Sjogren’s Syndrome and lupus which contributed to her general fatigue and ongoing worry regarding her health. Lilly

noted her pregnancy was considered a “high risk pregnancy” due to her diagnosis of lupus.

Additionally, Lilly reported frequent and excessive worry about the “damage” lupus could cause to her health. Lilly noted taking specific medication to help alleviate and manage symptoms of both medical diagnoses.

### **Education and Work**

Lilly holds a bachelor’s degree from a mid-sized private university. For the past year, she has worked in the education field. At the time she presented for treatment, she noted difficulty building relationships with co-workers. Lilly’s job position allows for assignments in different locations and time periods within the organization. She noted how she does not stay in one position for long for fear of perceived incompetence and concern others will notice her anxiety symptoms. Lilly noted a desire to advance her career by pursuing postgraduate certification in education; however, the fear of being required to make oral presentations has precluded furthering her education.

### **Social**

Lilly reported having a small number of friends, including one best friend of over 20 years. In the middle of treatment, Lilly noted this best friend passed away, which created a sense of guilt because of her avoidance. She added she did not have many friends in childhood. Lilly specifically referenced having trouble building and maintaining friendships since her freshman year of high school. Her relationship skills may have been influenced by her interactions with her siblings as a child. Lilly noted she was not close with her two siblings growing up and that her siblings would “bully” her for being the “good child,” which caused her to avoid interacting with her siblings. Her two siblings also shared the same friend group, which she was not invited to join because Lilly was too “shy and sensitive.” Lilly did not share her experiences in past

romantic relationships. Although her relationship with her current partner may suggest an ability to be more herself once she has built a long-standing close relationship.

### **Ethical Considerations**

At the start of treatment, Lilly noted she was already receiving therapy through the local community mental health center outpatient clinic. Due to her interest in specifically seeking ET, which was not offered by her initial therapist, she sought out additional services from the author of this document. The *Ethical Principles of Psychologists and Code of Conduct* (APA, 2017) states that, in situations like this, both clinicians and client should discuss and consult with each other to minimize the risk of confusion and conflict. The clinician and Lilly discussed ethical implications of receiving therapy from two different providers simultaneously, and Lilly signed a release of information that allowed the two clinicians to consult and discuss treatment options to avoid conflict and confusion that could be detrimental to Lilly. The product of those conversations was an agreement to focus on the use of exposure-based CBT to treat social anxiety in her work with this therapist, while the other provider cover topics regarding religion and boundary issues. The other provider was collaborative and professional during consultation as the provider was aware of and support of the client seeking ET.

Some authors have raised concerns about the application of ET during pregnancy, as exposures, by design, induce anxiety (Arch et al., 2012; Arch, 2014). With the lack of research on ET for anxiety disorders during pregnancy, it is unclear the degree to which clinicians can generalize the safety of ET from non-pregnant to pregnant clients (Arch et al., 2012). Early studies focusing on the safety of ET reported a moderate elevated heart rate (80-130 beats per minute) and skin conductance during the first 4 – 20 minutes of exposure in non-pregnant participants (e.g., Beckham et al., 1990; Grey et al., 1981). Thus, Arch et al. (2012) predicted

physiological reactivity to exposure may remain within the mild to moderate range. Conversely, untreated anxiety disorders are characterized by sustained elevated anxiety and have shown to carry some risks during pregnancy (Arch et al., 2012; Arch, 2014). In comparison, the use of pharmacotherapy to treat anxiety disorders also carries potential risks during pregnancy (e.g., acute withdrawal at birth; Lattimore et al., 2005). A study found pregnant women preferred psychotherapy (74.27%) over medication compared to non-pregnant women (46.62%; Arch, 2014). Therefore, ET for anxiety disorders during pregnancy is likely to pose less risk than untreated anxiety disorders and is preferred over pharmacotherapy. That said, to better understand safety concerns of exposure-based treatment of anxiety disorders during pregnancy, more research is necessary.

### **Assessment**

In addition to a clinical screening interview, Lilly was administered the Anxiety Disorders Interview Schedule (ADIS-5; Brown & Barlow, 2014). Following the diagnostic interview, Lilly received the clinic's standard set of self-report measures, which she completed prior to beginning treatment.

### **Diagnostic Interview**

**Anxiety Disorders Interview Schedule.** The Anxiety Disorders Interview Schedule (ADIS-5; Brown & Barlow, 2014) is a structured interview designed to aid in the process of differential diagnosis across the mood, anxiety, obsessive-compulsive, trauma, and related disorders. The ADIS-5 is comprised of demographic information, description of presenting problem, medical/treatment history, and 16 diagnostic sections. The ADIS-5 was developed based on the publication of the DSM-5 and addressed concerns about poor psychometric properties reported for existing scales (i.e., Hamilton Rating Scale for Anxiety and Depression).

Improvements were accomplished by expanding the number and depth of diagnostic sections, and other changes such as revision of wording of items to improve administration.

Administration of the ADIS-5 requires familiarity with the DSM-5 symptom criteria to inform clinical judgments that determine if further inquiry is necessary and/or for further elaboration of client responses. In some diagnostic sections, the ADIS-5 provides a dimensional assessment of key and associated features of a disorder. In addition, the ADIS-5 provides inquiry to understand different features (e.g., avoidance) of various disorders.

Excluding a few sections, each diagnostic section includes questions regarding an initial inquiry, symptoms (current and past episodes), and both symptom and situation-based ratings of functional impairment and distress. The “current episode” section contains inquiries to establish a current diagnosis and aid in differential diagnosis. Through inquiry, each “current episode” is assigned a clinical severity rating (CSR; Brown & Barlow, 2014) on a scale of 0 (none) to 8 (very severe) on both interference and distress. The *Anxiety and related disorders interview schedule for DSM-5 (ADIS-5) adult and lifetime version: Clinician manual* (Brown & Barlow, 2014) recommends CSRs of 4 (moderate) or greater warrant assignment of a diagnosis.

The ADIS-5 is closely modeled on the ADIS-IV, so, in the absence of published psychometric data on the ADIS-5, and consistent with recommendations drawn from the current scholarly literature (Grisham et al., 2004), psychometric properties from the ADIS-IV are reported here. For most diagnostic sections, previous editions of the ADIS have revealed good reliability (e.g., Di Nardo et al., 1999). Brown et al. (2001) examined inter-rater reliability for DSM-IV disorders (DSM-IV; American Psychiatric Association, 1994) across a two-week period with a sample of 362 participants from various outpatient settings and found a good-to-excellent coefficient range of  $r = .67$  to  $.86$ , apart from persistent depressive disorder ( $r = .31$ ). The ADIS-

5 is copyrighted and cannot be viewed without prior purchase, therefore refer to Appendix A for purchasing information regarding the ADIS-5.

Lilly reported on 16 social situations listed in the SAD diagnostic section and overall interference and distress of symptoms. Utilizing the CSR, Lilly's ratings exceeded the suggested cut-off of a rating of "4" or above in 11 areas. More specifically, she assigned a rating of "8" in two areas (giving a speech or presentation and talking to a person in authority); ratings of "7" in two areas (refusing requests and asking others to change their behaviors); ratings of "6" in two areas (maintaining a conversation and talking on the phone); ratings of "5" in three areas (speaking with unfamiliar people, introducing yourself to a group, and participating in meetings); and a rating of "4" in two areas (initiating conversation and attending parties). Ratings below "4" were assigned to four areas, with performing in front of others rated a "2," and all other areas rated as "0" (writing in public, eating in public, using public restrooms, and dating situations). Lilly rated her overall interference as a "6" and her overall distress as a "7."

Lilly endorsed four of the eight potential areas of worry above the diagnosable threshold of a "4" rating in regard to excessiveness, excessiveness of her worry with ratings of "6" assigned to work/school, health of self, health of others, and family). The four remaining areas of worry were rated below the clinical threshold, with a rating of "3" assigned to two areas (minor matters and community/world affairs), and the two remaining areas rated "0" (interpersonal relationships and finances). Regarding the uncontrollability of her worry, only two areas reached the rating of "4" threshold (work/school and health of self). Sub-clinical ratings of "3" were assigned in three areas (health of others, family, and minor matters), with a rating of "0" assigned to all other areas. Lilly reported overall her interference as a "6" and her distress as a "7." Additionally, utilizing the CSR, Lilly provided clinical-level ratings to four physiological

symptoms of GAD, with a rating of “5” assigned to feeling keyed up, being easily fatigued, difficulty concentrating or mind going blank, and muscle tension. Sub-clinical ratings were assigned in two areas as she provided a rating of “3” to difficulty falling/staying asleep, and a rating of “1” to irritability.

It is important to note Lilly’s responses to the Major Depressive Disorder (MDD; DSM-5; APA, 2013) diagnostic section, as her score on the BDI-II indicated moderate depression. Utilizing the CRS, Lilly reported on severity of MDD symptoms for a current episode (i.e., two-week period). Lilly endorsed one of nine potential MDD symptoms above the diagnosable threshold of a “4” rating, with a rating of “5” assigned to feeling worthless, or excessive, inappropriate guilt. Sub-clinical ratings were assigned in the other eight areas as she provided a rating of “3” to psychomotor agitation, and also to impaired concentration, slowed thinking, or indecisiveness, a rating of “2” to sleep disturbance, and all other areas were assigned a rating of “0.” Lilly endorsed weight gain but contributed it to her pregnancy and assigned a rating of “0.” Regarding a past episode (two years prior), Lilly endorsed three areas above diagnosable threshold of a “4” rating, with a rating of “5” assigned to loss of interest and pleasure in usual activity; ratings of “4” assigned to depressed mood and to fatigue or loss of energy. Sub-clinical ratings were assigned in all other areas as she provided a rating of “2” to impaired concentration, slowed thinking, or indecisiveness, with a rating of “0” assigned to all other areas. Therefore, based on her self-reported CSR ratings, Lilly did not endorse the minimum of five symptoms required to meet the required criteria to assign a diagnosis of MDD.

### **Self-Report Measures**

Lilly completed self-report measures prior to the diagnostic interview to aid in differential diagnosis and to provide baseline scores of symptom severity. She completed the

same set of measures prior to the termination session to assist in evaluating treatment progress. A complete list of pre- and post-treatment scores on the set of self-report measures can be found in Table 1 in the Appendices. Pre- and post-treatment fear and avoidance hierarchy ratings can be found in Table 2 in the Appendices.

### **Adult General Measures**

**Sheehan Disability Scale.** The Sheehan Disability Scale (SDS; Sheehan, 1983) is a five-item self-report measure designed to assess current functional impairment in the previous week across three domains: work/school, social life, and family/home life. The SDS is comprised of three items, one for each domain, with each item rated on a 10-point scale from 0 (not at all disrupted) to 10 (extremely disrupted). Responses to the three items are summed to produce a global functional impairment score. Possible scores range from 0 to 30 with higher scores indicating increased functional impairment. Two additional items inquire about the number of days work/school was missed, and impaired productivity due to symptoms, in the previous week. Responses to these two items are not included on the final score. There is no recommended cutoff score to delineate problematic levels of impairment; however, change-over-time in scores can be of value in monitoring response to treatment. In addition, it is recommended clinicians pay attention to clients who score 5 or greater on any of the three scales, since higher scores are associated with significant functional impairment. In a sample of outpatients assessed for mental health disorders, the SDS demonstrated high internal reliability ( $\alpha = .89$ ; Leon et. al., 1997). Refer to Appendix B to view the SDS self-report questionnaire.

The SDS is designed to assess functional impairment, therefore it is plausible Lilly's SDS scores may not be solely attributed to mental health concerns, but likely also reflect impairment due to her medical disorders. The research finding that SAD is typically associated with higher

impairment in the social domain than in the home or work domains (Druss et al., 2009; Stein et al., 2017) is consistent with Lily's pre- and post-treatment scores on the SDS. At pre-test, Lily's total score of 21 indicated significant functional impairment, and her post-test score of 8 indicates a decrease in functional impairment.

**Beck Depression Inventory-II.** The Beck Depression Inventory-II (BDI-II; Beck et al., 1996) is a 21-item self-report measure designed to assess severity of symptoms of depression over the previous two-week period. The BDI-II was developed based on the publication of the DSM-IV, which changed diagnostic criteria for Major Depressive Disorder. Furthermore, the original BDI relied on the theory of negative cognitive distortions as central to depression, while the BDI-II also includes items that assess mood and behavioral symptoms (Kendall et al., 1987). The 21 items reflect a variety of symptoms and attitudes commonly found among clinically depressed individuals (Beck et al., 1961). The severity of each item is rated on a four-point scale from 0 (symptoms absent) to 3 (severe symptoms; Beck et al., 1996). Several of the nine DSM-5 symptoms of Major Depressive Disorder are represented by multiple items on the BDI-II. The responses to all 21 items are summed to produce a total scale score for the BDI-II. Possible scores range from 0 to 63, and interpretative ranges of scores have been established with scores of 0 to 13 indicating minimal depression, scores of 14 to 19 indicating mild depression, scores of 20 to 28 indicating moderate depression, and scores of 29 to 63 indicating severe depression (Beck et al., 1996).

Extensive psychometric properties of the BDI-II have been reported. Beck et al. (1996) examined test-retest reliability across a one-week period with a sample of 500 outpatients from various clinics and hospitals and found a strong coefficient of .93. These same authors also demonstrated strong internal consistency ( $\alpha = .92$ ). In a subsequent study employing a sample of

205 boys and 203 girls with a mean age of 15.09 years, Osman et al. (2004) examined internal consistency and reported Cronbach's alpha of .93. The BDI-II showed moderate convergent validity with the Beck Anxiety Inventory ( $r = .61$ ; Osman et al., 2004). Evidence for high convergent validity was supported when the BDI-II was compared with the Reynolds Adolescent Depression Scale ( $r = .84$ ; Krefetz et al., 2002). The BDI-II is copyrighted and cannot be viewed without prior purchase, therefore, refer to Appendix C for purchasing information regarding the BDI-II self-report questionnaire. Lilly's total score of 22 at pre-test indicates moderate depression, and her post-test score of 8 suggests minimal depression.

**Penn State Worry Questionnaire.** The Penn State Worry Questionnaire (PSWQ; Meyer et al., 1990) is a 16 item self-report measure designed to assess the presence of problematic worry. The PSWQ was designed to measure the excessiveness, generality, and uncontrollable dimensions of worry. The severity of each item is rated on a five-point Likert scale ranging from 1 (not at all typical of me) to 5 (very typical of me). After reverse scoring items 1, 3, 8, 10, and 11, each item is summed to give a single score for the PSWQ. Possible scores range from 16 to 80, with scores of 16 to 39 indicating low worry, 40 to 59 indicating moderate worry, and 60 to 80 indicating high worry. A cut-off score of 50 or higher appropriately identified Generalized Anxiety Disorder (GAD; DSM-5; APA, 2013) in a primarily anxiety sample with 99.9% specificity and 71.7% sensitivity (Wuthrich et al., 2014). In a clinical sample of primarily GAD based on a cut off score of 50, the PSWQ accurately identified clinical status with 94.3% specificity and 72.2% sensitivity (Wuthrich et al., 2014). These findings suggest the PSWQ is very adept at ruling-out "true negatives." In other words, it is unlikely to produce a high score for someone who does not experience anxiety-related worry at a problematic level. It is also quite

effective in capturing “true positives” in that it is very unlikely to produce a low score for someone who is experiencing clinical levels of anxiety-related worry.

Additional psychometrics supporting the use of the PSWQ include Meyer et al.’s (1990) examination of test-retest reliability across an 8-to-10-week period with a sample of 45 participants which produced a strong correlation coefficient of  $r = .92$ . Strong internal consistency ( $\alpha = .95$ ) was also documented in a sample of 73 students enrolled at a university (Meyer et al., 1990). The PSWQ showed good discriminant validity with the BDI-II ( $r = .36$ ; Meyer et al., 1990). In a sample of 161 individuals randomly selected from a telephone book, van Rijsoort et al. (1999) examined construct validity and found a moderate coefficient ( $r = .61$ ) when the PSWQ was compared to the Worry Domains Questionnaire (WDQ; Tallis et al., 1992). Refer to Appendix D to view the specific items of the PSWQ self-report questionnaire. Lilly’s total score of 67 at pre-test is consistent with a diagnosis of GAD; and her post-test score of 58 suggests she continues to experience moderate worry. Lilly may benefit from continuing treatment specifically targeting her GAD symptoms.

### **Social Anxiety Measures**

**Social Interaction Anxiety Scale.** The Social Interaction Anxiety Scale (SIAS; Mattick & Clark, 1998) is a 20 item self-report measure designed to assess current fear in social interaction situations. The severity of each item is rated on a five-point Likert scale ranging from 0 (not at all characteristic or true of me) to 4 (extremely characteristic or true of me). After reverse scoring items 5, 9, and 11, each item is summed to give a single score for the SIAS. Possible scores range from 0 to 80, with higher scores indicating more severe social interaction anxiety. A cut off score of 34 or higher has been found to suggest social anxiety disorder, as that

score appropriately classified 82% of individuals with social anxiety disorder (Heimberg et al., 1992).

Other psychometrics supporting the use of the SIAS include Mattick and Clarke's (1998) examination of test-retest reliability over a four-week period with a sample of 36 participants which produced a strong coefficient of .92. The SIAS has also demonstrated strong internal consistency ( $\alpha = .92$ ) in a sample of 1,069 individuals (Mattick & Clarke, 1998). In a subsequent study with a sample of 317 university students, Carleton et al. (2009) examined internal consistency using Cronbach's alpha and found a coefficient range of .86 to .93. The SIAS showed good discriminative validity between persons diagnosed with social anxiety disorder producing a mean score of 34.6 and unselected (normal) sample a mean of 18.8, with the difference being statistically significant ( $F_{1,1064} = 296.84, P < 0.001$ ; Mattick & Clark, 1998). In addition, when compared to the Beck Depression Inventory – Short Form (Beck & Beamesderfer, 1974) a medium correlation ( $r = .47$ ) was found, indicating good discriminant validity (Mattick & Clark, 1998). Evidence for good convergent validity was provided when the SIAS was compared with the Social Phobia Scale (SPS; Mattick & Clark, 1998) and produced an  $r = .79$ . Refer to Appendix E to view the SIAS self-report questionnaire. Lilly's total score of 69 at pre-test indicated clinically significant social interaction anxiety and is well above the established cut-off of 34 determined to be sufficient for a diagnosis of social anxiety disorder. Her post-test score of 50 documents a 19-point decrease in her self-reported social interaction anxiety, although this score remained consistent with a diagnosis of social anxiety disorder.

**Social Phobia Inventory.** The Social Phobia Inventory (SPIN; Connor et al., 2000) is a 17 item self-report scale designed to evaluate symptoms consistent with social anxiety disorder over the previous week. Items on the SPIN reflect the symptoms domains of fear (e.g., of people

in authority, parties, talking to stranger, social events), avoidance (e.g., speaking to people, being criticized, center of attention), and physiological discomfort (e.g., blushing, sweating, shaking, and trembling). The severity of each item is rated on a five-point scale from 0 (not at all) to 4 (extremely). A total score for the SPIN is calculated by summing responses to all items. Possible scores range from 0 to 68, with scores of 0 to 20 indicating none/very mild symptoms, 21 to 30 mild symptoms, 31 to 40 moderate symptoms, 41 to 50 severe symptoms, and 51 or more very severe symptoms of social anxiety (Connor et al., 2000). The authors of the SPIN have identified that a cut-off score of 19 or higher indicates a diagnosis of social anxiety disorder with a diagnostic accuracy of 79%.

Connor et al. (2000) also examined test-retest reliability across a two-week period with two groups of individuals diagnosed with social anxiety disorder and found high coefficients of .89 (N = 64) and .75 (N = 54). In a subsequent study, the SPIN demonstrated strong internal consistency ( $\alpha = .82 - .94$ ) in a sample of 353 individuals. In a sample of 5,252 adolescents (12 – 16 years old), Ranta et al. (2007) obtained Cronbach's alpha of .89, demonstrating the appropriateness of using the SPIN within different age groups. Refer to Appendix F to view the SPIN self-report questionnaire. At pre-test, Lilly's total score of 51 suggested very severe symptoms and was consistent with a diagnosis of social anxiety disorder. Her score of 39 at post-test suggesting notable improvement, but is still considered to suggest a moderate severity of social anxiety symptoms.

**Social Anxiety Session Change Index.** The Social Anxiety Session Change Index (SASCI; Hayes et al., 2008) is a 4-item self-report measure designed to be administered prior to each session to evaluate progress the client believes they have made since the beginning of treatment. The SASCI measures the level of anxiety experienced in the four specific areas of:

anticipation of/engagement in social/performance situations, avoidance of social/performance situations, interference with social activities, and concern about embarrassment or humiliating themselves. The change in severity on each item is rated on a 7-point Likert-type scale from 1 (much less than the start of treatment) to 7 (much more than the start of treatment). A total score of perceived change in severity of social anxious symptoms is calculated by summing responses to all items. Possible scores range from 4 to 28, with scores of 4 to 15 indicating improvement, scores of 17 to 28 indicating a worsening of symptom severity, and a score of 16 indicating no change since the beginning of treatment (Hayes et al., 2008).

Initial reliability testing of the SASCI was evaluated with a sample of 42 adult clients seeking treatment for social anxiety disorder at two separate university-based clinics. Participants were selected for participation if they had a primary diagnosis of social anxiety disorder and had received manualized treatment based on the *Managing Social Anxiety: A Cognitive-behavioral Approach* by Hope et al. (2019). Subsequent examination of the psychometric properties of the SASCI have demonstrated good internal consistency ranging from .84 to .94 (Hayes et al., 2008). The SASCI demonstrated potential as a measure of treatment progress in a study that obtained pre- and post-treatment scores across a 16-week course of Cognitive Behavioral Therapy (Hayes et al., 2008). In this treatment outcome study, the decrease from pre-treatment ( $M = 16.33$ ,  $SD = 2.80$ ) to post-treatment ( $M = 9.68$ ,  $SD = 3.10$ ) of SASCI scores for the treatment completion group was statistically significant ( $z = -11.68$ ,  $p < .01$ ). These results support the SASCI's ability to capture treatment progress (Hayes et al., 2008). In addition, the SASCI's session-by-session change score produced a correlation of  $r = .75$ , which was significant at  $p < .01$  when compared to the Brief Fear of Negative Evaluation Scale (BFNE-II; Carleton et al., 2011) which

also utilizes a session-by-session change score and ending score (Hayes et al., 2008). Refer to Appendix G to view the SASCI self-report questionnaire.

A comparison of Lilly's SASCI total scores from first administration in Session #5 to final administration in Session #20 reveals a 13-point decrease. This reflects a sizeable decrease in her self-rated social anxiety since starting treatment. Refer to Appendix H to view the complete series of Lilly's session-by-session SASCI scores.

**Fear and Avoidance Hierarchy.** An important element of the manualized treatment protocol is the development of a Fear and Avoidance Hierarchy, which is a list of situations in which the client experiences distress related to social anxiety. When identifying anxiety-provoking situations, it is important for situations to be specific (i.e., giving a presentation) and to directly represent what the client wants to work on in treatment. To create the hierarchy, the client and clinician collaboratively generate a list of potential situations and then assign an anxiety and avoidance rating to each situation. Next, items are ordered based on level anxiety to complete the hierarchy. The client and clinician may consider variations of each situation to aid in the development of the hierarchy. For example, "giving a presentation in front of an authority figure" and "giving a presentation in front of a friend."

The Subjective Units of Discomfort Scale (SUDS; Wolpe & Lazarus, 1967) is utilized by the client and clinician to assist in assigning anxiety ratings. The SUDS is a 0-to-100-point scale, with higher numbers indicating greater anxiety. The following descriptive labels are used to aid clients in assigning anxiety; 0 = no anxiety, 25 = mild anxiety, alert, able to cope, 50 = severe anxiety, some trouble concentrating, 75 = severe anxiety, 100 = very severe anxiety, worst ever experienced (Hope et al., 2019).

In addition to SUDS, avoidance ratings are assigned to each situation on a 0-to-100 scale, with higher numbers indicating greater avoidant behaviors. The following descriptive labels are used to aid clients in assigning avoidance ratings; 0 = no avoidance, 25 = avoid once in awhile, might engage in some avoidance behaviors, 50 = avoid sometimes, engage in subtle avoidance behaviors, 75 = usually avoid, obvious avoidance, 100 = always avoid (Hope et al., 2019). Avoidance ratings are not limited to either entering a situation or not (e.g., going to the store or not going completely), but also include subtle avoidance behaviors. For instance, an individual may not completely avoid a conversation, but could avoid making eye contact throughout that conversation or engage in a safety behavior such as overpreparing for a speech. Lilly noted after entering a social situation she would find the exits in case she wanted to avoid potential interactions.

In addition to facilitating the creation of the hierarchy, SUDS ratings are used throughout exposures, with the clinician asking the client to provide their SUDS ratings before, during, and after each exposure to gauge the client's anxiety. The clinician and Lilly spent one session generating a fear and avoidance hierarchy. Throughout treatment, additional areas for exposures were identified and modified. Refer to Table 2 in the Appendices to view Lilly's fear and avoidance hierarchy with pre-and post-treatment SUDS and avoidance ratings.

### **Diagnosis**

The following diagnoses were determined through assessment and clinical interview based on criteria listed in the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (APA, 2013).

**300.23 (F40.11) Social Anxiety Disorder**

Lilly endorsed symptoms consistent with Social Anxiety Disorder (SAD) and met required criteria for the diagnosis. Lilly endorsed fear and anxiety in multiple social situations in which she is exposed to possible evaluation by others. For instance, Lilly endorsed fear and anxiety in conversations with others, meeting unfamiliar and familiar people, being observed by an authority figure, and public speaking. Lilly feared she would act in a way that showed anxiety symptoms and be negatively evaluated (e.g., will be embarrassed, seen as incompetent). Lilly described social situations almost always provoke anxiety and fear of evaluation. Lilly noted avoiding social situations such as, conversations with family and friends, presentations, and attending parties. Lilly reported social situations that could not be avoided (e.g., speaking with her boss, introducing herself to others) are endured with intense anxiety. Lilly's fear is out of proportion to the actual threat posed by the social situation, for example the fear of being fired after speaking to an authority figure. Lilly reported persistent fear, anxiety, and avoidance since freshman year of high school. Lilly's fear, anxiety, and avoidance cause clinically significant distress and impairment in important areas of her life. For example, Lilly reported impairment in the home setting due to avoidance of required social task that inevitably fall on her husband to complete.

The presentation of Lilly's anxiety symptoms meets the DSM-V rule-outs for SAD. First, Lilly made no connections between her symptoms and the physiological effects of a substance. Second, the disturbance is not better explained by GAD because Lilly's fear, anxiety, and avoidance are produced at the thought of or being in social situations. Third, and most salient for Lilly, she did not attribute experiencing fear or anxiety in social situations as a product of the noticeable symptoms of Sjogren's Syndrome or lupus (e.g., dry eyes or dry mouth). Rather, her

concerns centered around being perceived as incompetent out of fear of displaying anxiety symptoms and the fear of being perceived as “boring.” Therefore, it is surmised that Lilly’s fear and anxiety surrounding social situations is unrelated to her medical conditions.

### ***300.02 (F41.1) Generalized Anxiety Disorder***

Lilly endorsed symptoms consistent with Generalized Anxiety Disorder (GAD) and met required criteria for the diagnosis. Lilly reported excessive anxiety and worry, occurring more days than not for longer than six months. Lilly noted areas of worry include interpersonal relationships, the health of significant others, her own health, and family members. For example, Lilly reported constant worry about the health of her mother even though her mother does not have any reported health concerns. Lilly reported worry regarding the safety of most family members and her ability to take care of them. Although Lilly reported worry related to lupus that was excessive and uncontrollable, her worry was not limited to her medical conditions only. Also, Lilly noted excessive anxiety surrounding day-to-day tasks, even after tasks have been completed. Lilly endorsed four of the six required symptoms that are associated with her anxiety and worry. Lilly reported feeling “keyed up,” difficulty falling and staying asleep, fatigue, muscle tension, and her mind going blank. Lilly reported anxiety, worry, and physical symptoms cause clinically significant distress and impairment in important areas of functioning. Lilly noted sleep disturbance cause fatigue throughout the following day, making it difficult to complete task. In addition, Lilly noted she cannot go to new areas (e.g., a park) due to worry about her and her husband’s safety, which causes distress within their relationship. Lilly’s disturbance is not attributed to the physiological effect of a substance. Lilly’s disturbance is not better explained by Sjogren’s Syndrome or lupus because the areas of worry are not solely focused on her health

conditions. The disturbance is not better explained by SAD because Lilly's worries do not only convey worry of social situations and consequences of social situations.

### **Differential Diagnosis**

**300.01 (F41.0) Panic Disorder/ Panic Attack Specifier.** Lilly used the phrase "panic attacks" when self-reporting her experiences; however, she only endorsed experiencing three symptoms during a "panic attack." To assign a diagnosis of Panic Disorder or Panic Attack specifier the individual must experience four of the 12 required symptoms during a panic attack. Therefore, Lilly's panic attacks do not meet criteria A for panic disorder because the panic attacks described are limited symptom panic attacks, have direct trigger (e.g., social situations), and are expected. In addition, the symptoms do not reach peak within minutes. Lilly also does not meet criteria B for panic disorder as she did not experience persistent concern or worry about additional panic attacks or their consequences. These attacks are better explained by Lilly's social anxiety disorder, as her self-described "panic attacks" do not meet DSM-5 criteria and only occur in response to feared social situations.

### **Case conceptualization**

#### **Etiology**

The triple vulnerability model (Barlow, 2000, 2002) suggests three factors pertinent to the development of anxiety disorders. The triple vulnerability model states anxiety disorders develop due to an interaction between a generalized biological vulnerability, generalized psychological vulnerability, and a specific psychological vulnerability.

A generalized biological vulnerability must be present, usually in the form of a genetically inherited tendency to respond anxiously. Then a generalized psychological vulnerability, which is the perception that environmental events are uncontrollable and

unpredictable, must be present. Finally, a specific psychological vulnerability must be present and interact with existing generalized biological and psychological vulnerabilities to develop a specific anxiety disorder, such as SAD (Barlow, 2000). Specific psychological vulnerability is formed by learning through early life experiences or observation that a specific object, internal sensation (e.g., heart racing), or situation (e.g., social interaction) is dangerous. These three vulnerabilities interact with life stress to produce an anxiety or related disorder.

Lilly presented at treatment with various contributing factors that led to the development of her social anxiety. Lilly reported that her mother struggles with an undiagnosed anxiety disorder. In addition, Lilly noted her father struggles with an undiagnosed alcohol use disorder. One national epidemiologic survey examined individuals ( $N = 7,785$ ) with a prior-to-past-year alcohol use disorder and discovered half of respondents reportedly experienced a mood or anxiety disorder (Fan et al., 2019). Lilly may have inherited a genetic predisposition from either side of the family.

Environmental factors and early life experiences play significant roles in the development of SAD (Bitran & Barlow, 2004). Lilly noted her father's drinking patterns early on in treatment. Lilly reported feeling on guard and the desire to "always be good" while her father was drinking because of his unpredictable mood. Additionally, Lilly noted taking on caregiver responsibilities at an early age. To control her environment, Lilly learned to constantly strive for an unfeasible standard of perfection, which may have put her in a continuous state of inadequacy.

The most notable contributions to Lilly's symptoms are her early life experiences. Lilly noted that she was raised in a rough neighborhood and spent most of her childhood being afraid that her personal safety was at risk. She also noted she was bullied most of her high school career. Lilly initially noticed worries about being evaluated beginning in high school when

classmates relentlessly bullied her for her physical appearance and shyness. For example, Lilly reported being called “ugly” multiple times. In those moments, she learned people were dangerous and that she needed to avoid other people to survive. Research suggests individuals with SAD were subjected to early experiences in which the potential danger of social evaluation was conveyed by family members and/or peers (Bruch, 1989). Also consistent with Barlow’s specific psychological vulnerability, Lilly noted worries about social interactions after her parents discussed social interactions with other people and described others as untrustworthy and judgmental. Lilly learned through these experiences that other people are dangerous and judgmental; therefore, they should be feared and avoided.

### **Maintenance**

Socially anxious individuals attempt to regulate anxiety through avoidance, reassurance seeking, and safety behaviors. Lilly presented for treatment with several factors maintaining her SAD symptoms. Avoidance of social interactions reduced Lilly’s anxiety in the short-term, which negatively reinforced avoidance and increased the probability she would avoid social situations in the future, ultimately maintaining her symptoms. For example, Lilly noted avoidance in speaking with others over the phone, which reduced uncomfortable negative thoughts and physiological sensations, therefore increasing the likelihood of avoiding phone calls in the future. In addition, Lilly noted avoiding family functions, purposefully ending conversations early, and not leaving her house on most weekends due to fear of potentially running into co-workers. Lilly reported she had not been to a grocery store in almost a year because of how many other shoppers would be there and the fear she might have to ask an employee a question. Lilly also reported engaging in several safety behaviors such as looking for exits after entering a social situation, minimizing participation in conversation, and utilizing her

phone to “look busy” in the hope that people will not interact with her. Notably, Lilly’s husband inadvertently reinforces her avoidance by fulfilling tasks she avoids (e.g., shopping, taking out the trash). These avoidance behaviors prevent new learning that these social situations are not dangerous.

Consistent with the cognitive model (Clark & Wells, 1995; Rapee & Heimberg 1997), a biased mental representation of self, hypervigilance toward external evaluation cues, avoidance, and safety behaviors aid in maintaining symptoms. Because of avoidant behaviors, individuals with SAD may receive verbal and/or nonverbal feedback from the audience that their performance is inferior, which may maintain negative cognitions about the self (Rapee & Heimberg 1997). Prior to seeking treatment, Lilly’s symptoms were maintained by frequently avoiding social situations, using safety behaviors during her rare social interactions (e.g., looking for exits, avoiding eye contact), and negative assumptions and beliefs about social situations (e.g., “Others are dangerous”). Additionally, Lilly frequently dismissed most successful performances (e.g., making eye contact) in social interactions which continued to perpetuate her cycle of anxiety. Through her avoidance, Lilly did not have the opportunity to experience new learning (people are not always dangerous) and develop a secondary non-threatening association regarding social interactions.

Lilly’s parents also modeled that a person with a mental health concern or diagnosis would be labeled as “crazy.” Mental health was not openly discussed during her childhood. If it was, the discussion was negative. Lilly learned that it was important to be seen as “normal.” She could not display symptoms of anxiety, or she would be labeled “crazy.” Lilly’s constant state of alertness regarding her anxiety symptoms contributed to her negative mental representation of

self and negative thoughts. Moreover, a core belief for Lilly is that “anxiety equals incompetence.”

### **Treatment Goals and Plan**

#### Assessment

- Diagnostic evaluation
- Continue to monitor progress on a weekly basis using the SASCI

#### Psychoeducation

- Psychoeducation on SAD, treatment overview, maintenance of anxiety symptoms, and components of anxiety.
- Psychoeducation on “amber-colored glasses” and cognitive restructuring.

#### Cognitive Restructuring

- Develop ability to identify and reframe dysfunctional thoughts and core beliefs

#### Exposure

- Facing fears and avoided activities using a gradual approach
- Reduce distress/life interfering behaviors

#### Booster sessions

- Monitor ongoing application of coping strategies, lend additional therapeutic direction as needed

### **Course of Treatment**

Lilly was seen over the course of six months and attended a total of 20 CBT sessions. Three sessions were conducted via telehealth due to COVID-19 and weather restrictions; the remainder of sessions were conducted in-person. Treatment consisted of a diagnostic interview and subjective assessments, self-monitoring, psychoeducation, cognitive restructuring,

exposures, identifying opportunities for independent exposures outside of session, and identifying and challenging core beliefs.

### **Assessment & Psychoeducation**

The first and second session was focused on diagnostic assessment, which included administration of the ADIS-IV and other diagnostic questionnaires previously discussed. After assessment, Lilly received psychoeducation about SAD, maintenance of SAD, and CBT. Lilly was familiar with the symptoms of SAD and the exposure aspect of treatment, as she stated researching this approach on her own before intentionally requesting ET.

Lilly received psychoeducation on the three components of anxiety (i.e., cognitive, physiological, and behavioral) and how these components of anxiety would be addressed in treatment through cognitive restructuring, exposure, and homework. After psychoeducation and treatment rationale, Lilly was asked to self-monitor the three components of anxiety, which included the situation in which she experienced anxiety, her thoughts, physiological symptoms (e.g., heart rate), and observable behavior (e.g., safety behaviors). Self-monitoring allowed the clinician and Lilly to establish common thoughts, physiological symptoms, avoidance, and safety behaviors the client experiences. Once common symptoms and maintenance behaviors were established, Lilly and the clinician worked together to design a hierarchy of exposures that would gradually challenge her anxiety and avoidance (see Table 2). Next, the clinician provided education on cognitive restructuring and “amber-colored glasses” (Hope et al., 2019).

### **Cognitive Restructuring**

Throughout treatment Lilly frequently had negative thoughts and assumptions about her external appearance and behaviors. Consistent with Rapee and Heimberg’s (1997) cognitive model, cognitive restructuring allowed Lilly to challenge her mental representation of self and

develop a more accurate representation through rational responses. Prior to each exposure Lilly collaborated with the clinician to engage in cognitive restructuring to challenge negative thoughts and develop a rational response. Lilly's rational responses had a variety of themes focused on more surface level (e.g., "Pausing is a normal part of conversation") and value oriented (e.g., "Connecting with others is important to me" and "Small talk equals connection") beliefs. Throughout exposures the clinician would prompt Lilly to say her rational response out loud. Following exposures, Lilly and the clinician would revisit Lilly's negative thoughts to further challenge her mental representation of self. Additionally, cognitive restructuring was utilized prior to completing independent exposures.

Throughout treatment Lilly reported a set of recurring and frequent automatic thoughts such as "I won't know what to say," "I'm not interesting," or "I'll disappoint them". These thoughts are directly related to her core belief of "I'm not good enough." Core beliefs are fundamental beliefs an individual holds about the self, others, or the world (Wenzel et al., 2016). One session was devoted to utilizing cognitive restructuring to test the validity of "I'm not good enough." As follow-up, Lilly and the clinician designed an exposure to test this core belief outside of session. The exposure consisted of Lilly being more of herself in conversation, such as talking about her own interests with another person. The exposure was effective, in that Lilly reported feeling like herself after completing the exposure. If time had allowed, an additional session focused on the core belief of "Anxiety equals incompetence" could have been beneficial to Lilly.

### **In-Vivo Exposures**

Based on the inhibitory learning model, exposures were designed to vary in intensity, content, duration, and involved the removal of safety and avoidant behaviors. Exposures

completed in treatment consisted of *in-vivo* exposures. Lilly completed in-session exposures and independent exposures as her treatment homework. Consistent with Lilly's treatment goal of becoming closer with family and friends, many of the exposures assigned as homework were completed with those family members or friends. In-session exposures focused on increasing distress tolerance of social interactions and reducing safety behaviors and avoidance associated with social situations. For example, initiating and maintaining a conversation with a stranger in which "small-talk" was required. During the first exposure, Lilly presented as hesitant and broke role in the middle of exposure. Fortunately, Lilly increasingly presented as engaged and cooperative as exposures continued in treatment.

Following the first three exposures Lilly appeared to "disqualify the positives" when debriefing after the exposure. Eventually, Lilly not only began to give herself recognition on her successes when debriefing after the exposure, but also stated her belief that her success was genuine. Outside of session, Lilly independently engaged in the exposure practiced within session that week. Exposures were designed to emulate a core social fear for Lilly, such as initiating and maintaining conversation. The clinician focused on conversational exposures to enhance and maintain Lilly's ability to communicate to her family and friends.

Consistent with the established fear hierarchy, exposures to face conversational fears and negative assumptions included: disagreeing in conversation, "small-talk" conversation, intentionally pausing during conversation, calling a business and asking questions, and a conversation while an "authority" figure watched. During a later exposure, Lilly noted a resurgence of anxiety when she provided positive feedback to an "authority" figure. During this specific exposure there was an unintentional pause lasting one minute. The clinician helped Lilly process surviving her fear of long pauses during a conversation. Throughout treatment, Lilly

displayed adherence to completing all assigned exposures, although she would occasionally not complete the supporting worksheet. Lilly displayed devotion to completing treatment to live a life more consistent with her own values and goals.

### **Grief and Loss**

Prior to shifting focus on completing in-session exposures, one and a half sessions were devoted to providing support for the loss of her grandmother and close friend. The clinician suggested pausing SAD treatment to focus on Lilly's grief and loss of loved ones. During these sessions, the clinician utilized different techniques to aid Lilly in processing her losses. For example, Lilly was encouraged to tell stories and/or share favorite memories of both individuals. Additionally, the clinician and Lilly focused on processing feelings of guilt surrounding her avoidance of the two individuals while they were still alive in response to her social anxiety.

### **Termination**

By the sixth month of treatment (Session 20), Lilly demonstrated the ability to frequently challenge her cognitive distortions, evidenced better insight into her symptoms, and had reduced or modified her maintenance behaviors. Prior to termination, the clinician and client agreed to terminate a week before the client was set to give birth to her daughter. During the termination session, the clinician and Lilly developed a plan to continue and maintain progress, while reflecting on progress throughout treatment. Lilly noted she might want to meet for additional sessions a month after giving birth, allowing her time to settle into being a new mother.

### **Evaluation of Treatment Outcomes and Disposition**

As Lilly continued through treatment, she reported reaching out to relatives she had not spoken to in years, a decrease in avoidance of family visits, and experiencing less guilt for

avoiding family members. By the end of treatment, Lilly reported feeling closer to her family than previous years and less anxiety when interacting with her husband's family and friends.

Lilly's self-report on the SDS is consistent with treatment progress as she experienced improvement across all three domains, with a 5-point decrease in the work and social domain and a 3-point decrease in the home domain. Lilly's SPIN score decreased by 12 points, and her SIAS score decreased 19 points, which is a decrease of over one standard deviation (Heimberg et al., 1992; Connor et al., 2000) and suggestive of meaningful change. That said, her post-treatment score on the SPIN and SIAS indicate continued elevated social anxiety which may benefit from additional treatment.

Lilly's PSWQ score decreased by 9 points, which is a change of over half a standard deviation which according to Wuthrich et al. (2014) is suggestive of moderate change. Her PSWQ scores may have continued to decrease through targeting automatic thoughts in worry areas outside of social interactions. Most notably, Lilly's final BDI-II score decreased 16-points, indicating a change from moderate depression to minimal depression. This decrease may be attributed to Lilly's increase in contact with family members since starting treatment. Refer to Table 1 in the Appendices to view pre-and post-treatment scores.

Hayes et al. (2008) reported on post-treatment scores ( $M = 9.68$ ,  $SD = 3.10$ ) of participants receiving treatment based on *Managing Social Anxiety: A Cognitive-Behavioral Therapy Approach* (Hope et al., 2019), so Lilly's final score of 10 on the SASCI indicates a typical end-of-treatment score. Although, based on Lilly's SIAS and SPIN post-treatment scores which remain above established cut-off scores for diagnosing SAD, she may benefit from additional treatment. Refer to Appendix G to view Lilly's SASCI session by session change scores.

In addition to self-report measures, utilizing SUDS and avoidance ratings Lilly re-rated her fear and avoidance hierarchy items at post-treatment. These ratings showed significant improvement in areas where treatment focused, except for making a phone call in front of her husband. This apparent inconsistency may be due to Lilly underreporting how anxiety provoking this behavior was at the start of treatment. Lilly continued to report higher avoidance ratings in areas that were not addressed in session (e.g., presenting a PowerPoint) that could be addressed with additional treatment. Refer to Table 2 in the Appendices to view fear and avoidance hierarchy items with pre- and post-treatment ratings.

### **Transcript: Self Evaluation**

This case study includes a transcript of the eighth session. The transcript includes additional comments highlighting areas of clinical strength, reflecting on areas for improvement, and specifically noting when clinician statements consistent with CBT were applied (See appendix I). This session involved psychoeducation on amber-colored glasses and thinking errors. Additionally, part of session focused on the loss of Lilly's family member.

### **What I Did Well**

Reflecting on the transcribed session, I was able to determine areas where I demonstrated effective clinical and therapeutic skills. For example, when discussing the "amber-colored glasses," Lilly appeared hesitant to endorse this concept and asked challenging questions. In the moment, I was able to provide thoughtful answers to her questions that reflected my understanding of the maintenance of social anxiety. In session, I was aware of how long the amber-colored glasses discussion took. Instead of moving on to complete the session's agenda, I provided Lilly multiple opportunities to ask questions and allowed time for understanding the concept. Additionally, I validated Lilly's feelings regarding her previous negative life

experiences without validating behaviors maintaining her social anxiety and continually referenced how continued therapy would be useful in helping her learn to manage her symptoms more effectively. Throughout the transcribed session, I demonstrated the ability to implement motivational interviewing techniques.

As for overall areas of success, I was able to maintain a therapeutic relationship with Lilly even during more challenging sessions. This case provided me the opportunity to demonstrate my ability to be flexible with my therapeutic skills. For example, I displayed effective therapeutic skills by offering Lilly an opportunity to discuss the recent loss of a family member instead of remaining exclusively focused on the manualized protocol; but then returning to the protocol later in that same session. Additionally, I recognized the ethical concern regarding a client receiving services from multiple providers and initiated contact with the other provider to clarify our separate roles.

### **Needs Improvement**

Reviewing the transcribed session also allowed me the opportunity to reflect on areas of continued growth. I noticed the tendency to use filler words more than necessary, such as “yeah” and “so.” I realized I had not always followed the treatment manual protocol. At the beginning of session, I decided to discuss Lilly’s homework from the previous week when providing psychoeducation on cognitive restructuring. However, time did not allow for us to review cognitive restructuring and the homework should have been discussed at the beginning of session. Additionally, I did not review the “amber-colored glasses” worksheet in session with Lilly, this could have served as an opportunity to reinforce Lilly’s understanding of “amber-colored glasses.” During the transcribing process, I realized I could have provided more validation and support to the client because of the recent loss of a family member and used this

discussion to provide a “corrective emotional experience” that was in direct opposition to the lessons she had learned from her family regarding expression of emotions, how seeking therapy is a sign of “weakness” and being “crazy.” After self-reflecting on this session, the lack of further validation and support may have been due to my awareness that this session would be my transcript and I wanted to provide an intervention. In that moment, I failed to recognize that helping the client resolve grief and loss by using the therapeutic relationship was an intervention too. Throughout the case, I struggled with time-management and ending session after the prototypical 50 minutes. I could have been more intentional in starting exposures sooner in session.

Upon further reflection, it became apparent that I may have neglected two important elements of Lilly’s past and current life experiences. First, being an African-American female places Lilly in two potentially influential marginalized populations. Said another way, her concerns about being “judged” and evaluated by others, the constant dread over not being “perfect” along with the need to “prove herself” to others that was closely paralleled by doubt over whether that was achievable, and her belief that she had “no choice” but to fill the role of “middle child,” may all be the product of—or at least exacerbated by—being raised female in an African-American household in the U.S. Second, the fact that she was pregnant throughout treatment and maintained consistent attendance literally right up to her delivery date may provide additional insights into her motivation for seeking treatment at this time. Addressing the impact of Lilly’s race on her life experiences and SAD symptoms would have provided a better understanding of Lilly.

### References

- Acarturk, C., Cuijpers, P., van Straten, A., & de Graaf, R. (2009). Psychological treatment of social anxiety disorder: A meta-analysis. *Psychological Medicine, 39*(2), 241-254.  
<https://doi.org/10.1017/S0033291708003590>
- Aderka, I. M., Hofmann, S. G., Nickerson, A., Hermesh, H., Gilboa-Schechtman, E., & Marom, S. (2012). Functional impairment in social anxiety disorder. *Journal of Anxiety Disorders, 26*(3), 393-400. <https://doi.org/10.1016/j.janxdis.2012.01.003>
- Alonso, J., Angermeyer, M. C., & Lepine, J. P. (2004). The European Study of the Epidemiology of Mental Disorders (eseмед) project: An epidemiological basis for informing mental health policies in Europe. *Acta Psychiatrica Scandinavica, 109*(420), 5-7.  
<https://doi.org/10.1111/j.1600-0047.2004.00325.x>
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>
- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.)
- American Psychological Association. (2017). *Ethical Principles of Psychologists and Code of Conduct* (2002, amended effective June 1, 2010, and January 1, 2017).  
<https://www.apa.org/ethics/code>
- Arch, J. J. (2014). Cognitive behavioral therapy and pharmacotherapy for anxiety: treatment preferences and credibility among pregnant and non-pregnant women. *Behaviour Research and Therapy, 52*, 53-60.
- Arch, J. J., Dimidjian, S., & Chessick, C. (2012). Are exposure-based cognitive behavioral therapies safe during pregnancy? *Archives of Women's Mental Health, 15*(6), 445-457.

- Asher, M., Asnaani, A., & Aderka, I. M. (2017). Gender differences in social anxiety disorder: A review. *Clinical Psychology Review, 56*, 1-12. <https://doi.org/10.1016/j.cpr.2017.05.004>
- Asnaani, A., Richey, J. A., Dimaite, R., Hinton, D. E., & Hofmann, S. G. (2010). A cross-ethnic comparison of lifetime prevalence rates of anxiety disorders. *The Journal of Nervous and Mental Disease, 198*(8), 551-555. <https://doi.org/10.1097/NMD.0b013e3181ea169f>
- Banks, K. H., & Kohn-Wood, L. P. (2002). Gender, ethnicity and depression: Intersectionality in mental health research with African American women. *African American Research Perspectives, 174*. [https://digitalcommons.iwu.edu/psych\\_scholarship/6](https://digitalcommons.iwu.edu/psych_scholarship/6)
- Barkowski, S., Schwartz, D., Strauss, B., Burlingame, G. M., Barth, J., & Rosendahl, J. (2016). Efficacy of group psychotherapy for social anxiety disorder: A meta-analysis of randomized-controlled trials. *Journal of Anxiety Disorders, 39*, 44-64. <https://doi.org/10.1016/j.janxdis.2016.02.005>
- Barlow, D. H. (2000). Unraveling the mysteries of anxiety and its disorders from the perspective of emotion theory. *American Psychologist, 55*(11), 1247–1263. <https://doi.org/10.1037/0003-066X.55.11.1247>
- Barlow, D. H. (2002). *Anxiety and it's disorders: The Nature and Treatment of Anxiety and Panic*. Guilford Press.
- Beck, A. T. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*(6), 561. <https://doi.org/10.1001/archpsyc.1961.01710120031004>
- Beck, A. T., & Beamesderfer, A. (1974). Assessment of depression: the Depression Inventory. *Modern Problems of Pharmacopsychiatry, 7*, 151–169. <https://doi.org/10.1159/000395074>
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory: BDI-II*. Pearson.

- Beckham, J. C., Vrana, S. R., May, J. G., Gustafson, D. J., & Smith, G. R. (1990). Emotional processing and fear measurement synchrony as indicators of treatment outcome in fear of flying. *Journal of Behavior Therapy and Experimental Psychiatry*, *21*(3), 153–162. [https://doi.org/10.1016/0005-7916\(90\)90002-3](https://doi.org/10.1016/0005-7916(90)90002-3)
- Bitran, S., & Barlow, D. H. (2004). Etiology and treatment of social anxiety: A commentary. *Journal of Clinical Psychology*, *60*(8), 881–886. <https://doi.org/10.1002/jclp.20045>
- Brown, T. A., & Barlow, D. H. (2014). *Anxiety and related disorders interview schedule for DSM-5 (ADIS-5)-adult and lifetime version: Clinician manual*. Oxford University Press.
- Brown, T. A., Di Nardo, P. A., Lehman, C. L., & Campbell, L. A. (2001). Reliability of DSM-IV anxiety and mood disorders: Implications for the classification of emotional disorders. *Journal of Abnormal Psychology*, *110*(1), 49–58. <https://doi.org/10.1037/0021-843x.110.1.49>
- Bruch, M. A. (1989). Familial and developmental antecedents of social phobia: Issues and findings. *Clinical Psychology Review*, *9*(1), 37-47. [https://doi.org/10.1016/0272-7358\(89\)90045-7](https://doi.org/10.1016/0272-7358(89)90045-7)
- Canals, J., Voltas, N., Hernández-Martínez, C., Cosi, S., & Arija, V. (2019). Prevalence of DSM-5 anxiety disorders, comorbidity, and persistence of symptoms in Spanish early adolescents. *European Child & Adolescent Psychiatry*, *28*(1), 131–143. <https://doi.org/10.1007/s00787-018-1207-z>
- Carleton, R. N., Collimore, K. C., Asmundson, G. J. G., McCabe, R. E., Rowa, K., & Antony, M. M. (2009). Refining and validating the Social Interaction Anxiety Scale and the Social Phobia Scale. *Depression and Anxiety*, *26*(2). <https://doi.org/10.1002/da.20480>

- Carleton, R. N., Collimore, K. C., McCabe, R. E., & Antony, M. M. (2011). Addressing revisions to the brief fear of negative evaluation scale: Measuring fear of negative evaluation across anxiety and mood disorders. *Journal of Anxiety Disorders, 25*(6), 822–828.  
<https://doi.org/10.1016/j.janxdis.2011.04.002>
- Clark, R. E. (2004). The classical origins of Pavlov's conditioning. *Integrative Physiological & Behavioral Science, 39*(4), 279-294.
- Clark, D. M. & Wells, A. (1995). A cognitive model of social phobia. In R. Heimberg, M. Liebowitz, D. A. Hope, & F. R. Schneier (Eds.), *Social phobia: Diagnosis, assessment and treatment* (pp. 69–93). The Guilford Press.
- Connor, K. M., Davidson, J. R., Churchill, L. E., Sherwood, A., Weisler, R. H., & Foa, E. (2000). Psychometric properties of the Social Phobia Inventory (SPIN). *British Journal of Psychiatry, 176*(4), 379–386. <https://doi.org/10.1192/bjp.176.4.379>
- Craske, M. G., Liao, B., Brown, L., & Vervliet, B. (2012). Role of inhibition in exposure therapy. *Journal of Experimental Psychopathology, 3*(3), 322–345.  
<https://doi.org/10.5127/jep.026511>
- Craske, M. G., Treanor, M., Conway, C. C., Zbozinek, T., & Vervliet, B. (2014). Maximizing exposure therapy: An inhibitory learning approach. *Behaviour Research and Therapy, 58*, 10–23. <https://doi.org/10.1016/j.brat.2014.04.006>
- Crenshaw, D. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum, 1989*(1), Article 8.  
<http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8>

- Di Nardo, P. A., Moras, K., Barlow, D. H., Rapee, R. M., & Brown, T. A. (1993). Reliability of DSM-III-R anxiety disorder categories: Using the Anxiety Disorders Interview Schedule—Revised (ADIS-R). *Archives of General Psychiatry*, *50*(4), 251-256.
- Druss, B. G., Hwang, I., Petukhova, M., Sampson, N. A., Wang, P. S., & Kessler, R. C. (2009). Impairment in role functioning in mental and chronic medical disorders in the United States: results from the National Comorbidity Survey Replication. *Molecular Psychiatry*, *14*(7), 728-737. <https://doi.org/10.1038/mp.2008.13>
- Dryman, M. T., Gardner, S., Weeks, J. W., & Heimberg, R. G. (2016). Social anxiety disorder and quality of life: How fears of negative and positive evaluation relate to specific domains of life satisfaction. *Journal of Anxiety Disorders*, *38*, 1-8. <https://doi.org/10.1016/j.janxdis.2015.12.003>
- Fan, A. Z., Chou, S. P., Zhang, H., Jung, J., & Grant, B. F. (2019). Prevalence and correlates of past-year recovery from DSM-5 alcohol use disorder: Results from National Epidemiologic Survey on alcohol and related conditions-iii. *Alcoholism: Clinical and Experimental Research*, *43*(11), 2406–2420. <https://doi.org/10.1111/acer.14192>
- Fehm, L., Beesdo, K., Jacobi, F., & Fiedler, A. (2007). Social anxiety disorder above and below the diagnostic threshold: Prevalence, comorbidity and impairment in the general population. *Social Psychiatry and Psychiatric Epidemiology*, *43*(4), 257–265. <https://doi.org/10.1007/s00127-007-0299-4>
- Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, *99*(1), 20–35. <https://doi.org/10.1037/0033-2909.99.1.20>

- Grey, S. J., Rachman, S., & Sartory, G. (1981). Return of fear: The role of inhibition. *Behaviour Research and Therapy*, *19*(2), 135–143. [https://doi.org/10.1016/0005-7967\(81\)90037-1](https://doi.org/10.1016/0005-7967(81)90037-1)
- Grisham, J. R., Brown, T. A., & Campbell, L. A. (2004). The Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV).
- Hayes, S. A., Miller, N. A., Hope, D. A., Heimberg, R. G., & Juster, H. R. (2008). Assessing client progress session by session in the treatment of social anxiety disorder: The Social Anxiety Session Change Index. *Cognitive and Behavioral Practice*, *15*(2), 203-211. <https://doi.org/10.1016/j.cbpra.2007.02.010>
- Heimberg, R. G. (2002). Cognitive-behavioral therapy for social anxiety disorder: Current status and future directions. *Biological Psychiatry*, *51*(1), 101-108. [https://doi.org/10.1016/s0006-3223\(01\)01183-0](https://doi.org/10.1016/s0006-3223(01)01183-0)
- Heimberg, R. G., Brozovich, F. A., & Rapee, R. M. (2010). A cognitive behavioral model of Social Anxiety Disorder. *Social Anxiety*, 395–422. <https://doi.org/10.1016/b978-0-12-375096-9.00015-8>
- Heimberg, R. G., Horner, K. J., Juster, H. R., Safren, S. A., Brown, E. J., Schneier, F. R., & Liebowitz, M. R. (1999). Psychometric properties of the Liebowitz Social Anxiety Scale. *Psychological Medicine*, *29*(1), 199-212. <https://doi.org/10.1017/s0033291798007879>
- Heimberg, R. G., & Magee L. (2014). Social Anxiety Disorder. In D. H. Barlow (Eds.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (5th ed., pp. 114-154). The Guilford Press.
- Heimberg, R. G., Mueller, G. P., Holt, C. S., Hope, D. A., & Liebowitz, M. R. (1992). Assessment of anxiety in social interaction and being observed by others: The Social

- Interaction Anxiety Scale and the social phobia scale. *Behavior Therapy*, 23(1), 53–73.  
[https://doi.org/10.1016/s0005-7894\(05\)80308-9](https://doi.org/10.1016/s0005-7894(05)80308-9)
- Hofmann, S. G. (2008). Cognitive processes during fear acquisition and extinction in animals and humans: Implications for exposure therapy of anxiety disorders. *Clinical Psychology Review*, 28(2), 199-210. <https://doi.org/10.1016/j.cpr.2007.04.009>
- Hope, D. A., Heimberg, R. G., & Turk, C. L. (2019). *Managing social anxiety: A cognitive-behavioral therapy approach: Workbook*. Oxford University Press.
- Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureño, G., & Villaseñor, V. S. (1988). Inventory of interpersonal problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology*, 56(6), 885–892. <https://doi.org/10.1037/0022-006x.56.6.885>
- Kaczurkin, A. N., & Foa, E. B. (2015). Cognitive-behavioral therapy for anxiety disorders: an update on the empirical evidence. *Dialogues in Clinical Neuroscience*, 17(3), 337-346.  
<https://doi.org/10.31887/DCNS.2015.17.3/akaczurkin>.
- Kendall, P. C., Hollon, S. D., Beck, A. T., Hammen, C. L., & Ingram, R. E. (1987). Issues and recommendations regarding use of the Beck Depression Inventory. *Cognitive Therapy and Research*, 11(3), 289-299. <https://doi.org/10.1007/BF01186280>
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593-602.  
[10.1001/archpsyc.62.6.593](https://doi.org/10.1001/archpsyc.62.6.593)
- Kline, E. A., Warner, C. M., Grapin, S. L., Reyes-Portillo, J. A., Bixter, M. T., Cunningham, D. V. J., Mahmud, F., Singh, T., & Weeks, C. (2021). The relationship between social

- anxiety and internalized racism in black young adults. *Journal of Cognitive Psychotherapy*, 35(1), 53–63. <https://doi.org/10.1891/jcpsy-d-20-00030>
- Krefetz, D. G., Steer, R. A., Gulab, N. A., & Beck, A. T. (2002). Convergent validity of the Beck Depression Inventory-II with the Reynolds Adolescent Depression Scale in psychiatric inpatients. *Journal of Personality Assessment*, 78(3), 451–460. [https://doi.org/10.1207/s15327752jpa7803\\_05](https://doi.org/10.1207/s15327752jpa7803_05)
- Lattimore, K. A., Donn, S. M., Kaciroti, N., Kemper, A. R., Neal, C. R., & Vazquez, D. M. (2005). Selective serotonin reuptake inhibitor (SSRI) use during pregnancy and effects on the fetus and newborn: A meta-analysis. *Journal of Perinatology*, 25(9), 595–604. <https://doi.org/10.1038/sj.jp.7211352>
- Leichsenring, F., Salzer, S., Beutel, M. E., Herpertz, S., Hiller, W., Hoyer, J., ... & Leibing, E. (2013). Psychodynamic therapy and cognitive-behavioral therapy in social anxiety disorder: A multicenter randomized controlled trial. *American Journal of Psychiatry*, 170(7), 759–767. <https://doi.org/10.1176/appi.ajp.2013.12081125>
- Leigh, E., & Clark, D. M. (2018). Understanding social anxiety disorder in adolescents and improving treatment outcomes: Applying the cognitive model of Clark and Wells (1995). *Clinical Child and Family Psychology Review*, 21(3), 388–414. <https://doi.org/10.1007/s10567-018-0258-5>
- Leary, M. R., Kowalski, R. M., & Campbell, C. D. (1988). Self-presentational concerns and social anxiety: The role of generalized impression expectancies. *Journal of Research in Personality*, 22(3), 308–321. [https://doi.org/10.1016/0092-6566\(88\)90032-3](https://doi.org/10.1016/0092-6566(88)90032-3)
- Ledley, D. R., Heimberg, R. G., Hope, D. A., Hayes, S. A., Zaider, T. I., Van Dyke, M., ... & Fresco, D. M. (2009). Efficacy of a manualized and workbook-driven individual

- treatment for social anxiety disorder. *Behavior Therapy*, 40(4), 414-424.  
<https://doi.org/10.1016/j.beth.2008.12.001>
- Leon, A. C., Olfson, M., Portera, L., Farber, L., & Sheehan, D. V. (1997). Assessing psychiatric impairment in primary care with the Sheehan Disability Scale. *The International Journal of Psychiatry in Medicine*, 27(2), 93–105. <https://doi.org/10.2190/T8EM-C8YH-373N-1UWD>
- Mattick, R. P., & Clarke, J. C. (1998). Development and validation of measures of social phobia scrutiny fear and social interaction anxiety. *Behaviour Research and Therapy*, 36(4), 455–470. [https://doi.org/10.1016/s0005-7967\(97\)10031-6](https://doi.org/10.1016/s0005-7967(97)10031-6)
- Mayo-Wilson, E., Dias, S., Mavranzouli, I., Kew, K., Clark, D. M., Ades, A. E., & Pilling, S. (2014). Psychological and pharmacological interventions for social anxiety disorder in adults: A systematic review and network meta-analysis. *The Lancet Psychiatry*, 1(5), 368–376. [https://doi.org/10.1016/s2215-0366\(14\)70329-3](https://doi.org/10.1016/s2215-0366(14)70329-3)
- Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990). Development and validation of the Penn State Worry Questionnaire. *Behaviour Research and Therapy*, 28(6), 487–495. [https://doi.org/10.1016/0005-7967\(90\)90135-6](https://doi.org/10.1016/0005-7967(90)90135-6)
- Osman, A., Kopper, B. A., Barrios, F., Gutierrez, P. M., & Bagge, C. L. (2004). Reliability and validity of the Beck Depression Inventory--II with adolescent psychiatric inpatients. *Psychological Assessment*, 16(2), 120–132. <https://doi.org/10.1037/1040-3590.16.2.120>
- Ougrin, D. (2011). Efficacy of exposure versus cognitive therapy in anxiety disorders: Systematic review and meta-analysis. *BioMed Central Psychiatry*, 11(1), 1-13.  
<https://doi.org/10.1186/1471-244X-11-200>

- Ranta, K., Kaltiala-Heino, R., Koivisto, A.-M., Tuomisto, M. T., Pelkonen, M., & Marttunen, M. (2007). Age and gender differences in social anxiety symptoms during adolescence: The Social Phobia Inventory (SPIN) as a measure. *Psychiatry Research, 153*(3), 261–270. <https://doi.org/10.1016/j.psychres.2006.12.006>
- Rapee, R. M., & Heimberg, R. G. (1997). A cognitive-behavioral model of anxiety in social phobia. *Behaviour Research and Therapy, 35*(8), 741–756. [https://doi.org/10.1016/s0005-7967\(97\)00022-3](https://doi.org/10.1016/s0005-7967(97)00022-3)
- Rodebaugh, T. L., Holaway, R. M., & Heimberg, R. G. (2004). The treatment of social anxiety disorder. *Clinical Psychology Review, 24*(7), 883–908. <https://doi.org/10.1016/j.cpr.2004.07.007>
- Schneider, B. W., & Turk, C. L. (2014). Examining the controversy surrounding social skills in social anxiety disorder: The state of the literature. In J. W. Weeks (Ed.), *The Wiley-Blackwell handbook of social anxiety disorder* (pp. 366 - 388). Wiley-Blackwell.
- Seng, J. S., Lopez, W. D., Sperlich, M., Hamama, L., & Meldrum, C. D. R. (2012). Marginalized identities, discrimination burden, and mental health: Empirical exploration of an interpersonal-level approach to modeling intersectionality. *Social Science & Medicine, 75*(12), 2437-2445. <https://doi.org/10.1016/j.socscimed.2012.09.023>
- Sheehan D.V. (1983). The Sheehan disability scales. *The Anxiety Disease and How to Overcome It* (p. 151). Charles Scribner & Sons.
- Sibrava, N. J., Beard, C., Bjornsson, A. S., Moitra, E., Weisberg, R. B., & Keller, M. B. (2013). Two-year course of generalized anxiety disorder, social anxiety disorder, and panic disorder in a longitudinal sample of African American adults. *Journal of Consulting and Clinical Psychology, 81*(6), 1052-1062. <https://doi.org/10.1037/a0034382>

- Stein, D. J., Lim, C. C., Roest, A. M., De Jonge, P., Aguilar-Gaxiola, S., Al-Hamzawi, A., ... & Scott, K. M. (2017). The cross-national epidemiology of social anxiety disorder: Data from the World Mental Health Survey Initiative. *BioMed Central Medicine*, *15*(1), 1-21. <https://doi.org/10.1186/s12916-017-0889-2>
- Tallis, F., Eysenck, M., & Mathews, A. (1992). A questionnaire for the measurement of nonpathological worry. *Personality and Individual Differences*, *13*(2), 161-168.
- Taylor, S. (1996). Meta-analysis of cognitive-behavioral treatments for social phobia. *Journal of Behavior Therapy and Experimental Psychiatry*, *27*(1), 1-9. [https://doi.org/10.1016/0005-7916\(95\)00058-5](https://doi.org/10.1016/0005-7916(95)00058-5)
- Turner, S. M., Stanley, M. A., Beidel, D. C., & Bond, L. (1989). The social phobia and anxiety inventory: construct validity. *Journal of Psychopathology and Behavioral Assessment*, *11*(3), 221-234.
- van Rijsoort, S., Emmelkamp, P., & Vervaeke, G. (1999). The Penn State Worry Questionnaire and the Worry Domains Questionnaire: Structure, reliability and validity. *Clinical Psychology & Psychotherapy*, *6*(4), 297-307. [https://doi.org/10.1002/\(sici\)1099-0879\(199910\)6:4<297::aid-cpp206>3.0.co;2-e](https://doi.org/10.1002/(sici)1099-0879(199910)6:4<297::aid-cpp206>3.0.co;2-e)
- Ward, E., Wiltshire, J. C., Detry, M. A., & Brown, R. L. (2013). African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. *Nursing Research*, *62*(3), 185-194. <https://doi.org/10.1097/NNR.0b013e31827bf533>
- Weeks, J. W., Jakatdar, T. A., & Heimberg, R. G. (2010). Comparing and contrasting fears of positive and negative evaluation as facets of social anxiety. *Journal of Social and Clinical Psychology*, *29*(1), 68-94. <https://doi.org/10.1521/jscp.2010.29.1.68>

Wenzel, A., Dobson, K. S., & Hays, P. A. (2016). Cognitive restructuring of underlying beliefs.

In A. Wenzel, K. S. Dobson, & P. A. Hays, *Cognitive Behavioral Therapy Techniques and Strategies* (pp. 109–131). American Psychological Association.

<https://doi.org/10.1037/14936-006>

Wolpe, J., & Lazarus, A. A. (1967). Behavior therapy techniques. *The British Journal of Psychiatry*, *113*(495), 239-239.

Wuthrich, V. M., Johnco, C., & Knight, A. (2014). Comparison of the Penn State Worry Questionnaire (PSWQ) and abbreviated version (PSWQ-A) in a clinical and non-clinical population of older adults. *Journal of Anxiety Disorders*, *28*(7), 657–663.

<https://doi.org/10.1016/j.janxdis.2014.07.005>

Xu, Y., Schneier, F., Heimberg, R. G., Princisvalle, K., Liebowitz, M. R., Wang, S., & Blanco, C. (2012). Gender differences in social anxiety disorder: Results from the national epidemiologic sample on alcohol and related conditions. *Journal of Anxiety Disorders*, *26*(1), 12–19. <https://doi.org/10.1016/j.janxdis.2011.08.006>

**Table 1***Self-Report Measures*

Self-Report Measures	Pre-Treatment	Post-Treatment
<b>SDS</b>		
Work	8, Markedly	3, Mildly
Social	10, Extremely	5, Moderately
Home	3, Mildly	0, None
Total	21	8
<b>PSWQ</b>	67, High Worry	58, Moderate Worry
<b>BDI-II</b>	22, Moderate	6, Minimal
<b>SPIN</b>	51, Very Severe	39, Moderate
<b>SIAS</b>	69	50

*Note.* SDS = Sheehan Disability Scale. PSWQ = Penn State Worry Questionnaire. SPIN = Social Phobia Inventory. SIAS = Social Interaction Anxiety Scale.

**Table 2***Fear and Avoidance Hierarchy*

Situation	Pre-Treatment		Post-Treatment	
	SUDS	Avoidance	SUDS	Avoidance
Presenting a PowerPoint	100	100	90	90
Being watched by an authority figure with a silent background	100	100	60	60
Leading a conversation	100	100	15	15
Presenting a PowerPoint with an interactive audience	90	90	60	50
Small talk conversation	75	90	20	10
Being watched by an authority figure with noisy background	90	50	20	20
Disagree with familiar person	80	40	20	40
Going to the grocery store	75	90	10	5
Disagree with unfamiliar person	70	70	40	60
Conversation with a specific topic	50	80	20	10
Comment on an Instagram post (friend)	40	30	60	70
Phone call in front of husband	10	35	20	30

*Note.* SUDS = Subjective Units of Distress Scale.

## **Appendix A**

### Anxiety Disorders Interview Schedule (ADIS-5)

To purchase the ADIS-5 view <https://global.oup.com/academic/product/anxiety-and-related-disorders-interview-schedule-for-dsm-5-adis-5---adult-version-9780199325160?lang=en&cc=us>

or contact (800) 445-9714.

**Appendix B**

**Sheehan Disability Scale (SDS)**

Please mark ONE circle for each scale.

**WORK\* / SCHOOL**

**The symptoms have disrupted your work / school work:**

Not at all                      Mildly                      Moderately                      Markedly                      Extremely

I have not worked / studied at all during the past week for reasons unrelated to the disorder.  
 \* Work includes paid, unpaid volunteer work or training

**SOCIAL LIFE**

**The symptoms have disrupted your social life / leisure activities:**

Not at all                      Mildly                      Moderately                      Markedly                      Extremely

**FAMILY LIFE / HOME RESPONSIBILITIES**

**The symptoms have disrupted your family life / home responsibilities:**

Not at all                      Mildly                      Moderately                      Markedly                      Extremely

**Days Lost**

On how many days in the last week did your symptoms cause you to miss school or work or leave you unable to carry out your normal daily responsibilities? \_\_\_\_\_

**Days Unproductive**

On how many days in the last week did you feel so impaired by your symptoms, that even though you went to school or work, your productivity was reduced? \_\_\_\_\_

**Appendix C**

Beck Depression Inventory – II (BDI-II)

To purchase the BDI-II self-report questionnaire and/or manual view

<https://www.pearsonassessments.com/> or contact (800) 627-7271.

**Appendix D**

**Penn State Worry Questionnaire (PSWQ)**

Initials \_\_\_\_\_

**PSWQ**

Please rate your answer according to how typical or characteristic each statement is of you.

	<b>Not at all Typical</b>				<b>Very Typical</b>
1. If I don't have enough time to do everything, I don't worry about it.	①	□	□	□	□
2. My worries overwhelm me.	①	□	□	□	□
3. I don't tend to worry about things.	①	□	□	□	□
4. Many situations make me worry.	①	□	□	□	□
5. I know I shouldn't worry about things, but I just can't help it.	①	□	□	□	□
6. When I am under pressure I worry a lot.	①	□	□	□	□
7. I am always worrying about something.	①	□	□	□	□
8. I find it easy to dismiss worrisome thoughts.	①	□	□	□	□
9. As soon as I finish one task I start to worry about everything else I have to do.	①	□	□	□	□
10. I never worry about anything.	①	□	□	□	□
11. When there is nothing more I can do about a concern, I don't worry about it any more.	①	□	□	□	□
12. I've been a worrier all my life.	①	□	□	□	□
13. I notice that I have been worrying about things.	①	□	□	□	□
14. Once I start worrying, I can't stop.	①	□	□	□	□
15. I worry all the time.	①	□	□	□	□
16. I worry about projects until they are all done.	①	□	□	□	□

## Appendix E

### Social Interaction Anxiety Scale (SIAS)

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructions:** For each item, please circle the number to indicate the degree to which you feel the statement is characteristic or true for you. The rating scale is as follows:

- 0 = **Not at all** characteristic or true of me.
- 1 = **Slightly** characteristic or true of me.
- 2 = **Moderately** characteristic or true of me.
- 3 = **Very** characteristic or true of me.
- 4 = **Extremely** characteristic or true of me.

CHARACTERISTIC	NOT AT ALL	SLIGHTLY	MODERATELY	VERY	EXTREMELY
1. I get nervous if I have to speak with someone in authority (teacher, boss, etc.).	0	1	2	3	4
2. I have difficulty making eye contact with others.	0	1	2	3	4
3. I become tense if I have to talk about myself or my feelings.	0	1	2	3	4
4. I find it difficult to mix comfortably with the people I work with.	0	1	2	3	4
5. I find it easy to make friends my own age.	0	1	2	3	4
6. I tense up if I meet an acquaintance in the street.	0	1	2	3	4
7. When mixing socially, I am uncomfortable.	0	1	2	3	4
8. I feel tense if I am alone with just one other person.	0	1	2	3	4
9. I am at ease meeting people at parties, etc.	0	1	2	3	4
10. I have difficulty talking with other people.	0	1	2	3	4
11. I find it easy to think of things to talk about.	0	1	2	3	4
12. I worry about expressing myself in case I appear awkward.	0	1	2	3	4
13. I find it difficult to disagree with another's point of view.	0	1	2	3	4
14. I have difficulty talking to attractive persons of the opposite sex.	0	1	2	3	4
15. I find myself worrying that I won't know what to say in social situations.	0	1	2	3	4
16. I am nervous mixing with people I don't know well.	0	1	2	3	4
17. I feel I'll say something embarrassing when talking.	0	1	2	3	4
18. When mixing in a group, I find myself worrying I will be ignored.	0	1	2	3	4
19. I am tense mixing in a group.	0	1	2	3	4
20. I am unsure whether to greet someone I know only slightly.	0	1	2	3	4

## Appendix F

### Social Phobia Inventory (SPIN)

The Social Phobia Inventory (abbreviated as SPIN) is a 17-item questionnaire developed by the Psychiatry and Behavioral Sciences Department at Duke University. It is effective in screening for, and measuring the severity of social anxiety disorder.

Please read each statement and click in the column that indicates how much the statement applied to you **over the past week**.

	Not At All	A Little Bit	Somewhat	Very Much	Extremely
1. I am afraid of people in authority.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I am bothered by blushing in front of people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Parties and social events scare me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I avoid talking to people I don't know.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Being criticized scares me a lot.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I avoid doing things or speaking to people for fear of embarrassment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Sweating in front of people causes me distress.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I avoid going to parties.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I avoid activities in which I am the center of attention.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Talking to strangers scares me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I avoid having to give speeches.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I would do anything to avoid being criticized.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Heart palpitations bother me when I am around people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. I am afraid of doing things when people might be watching.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Being embarrassed or looking stupid are among my worst fears.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. I avoid speaking to anyone in authority.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Trembling or shaking in front of others is distressing to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## Appendix G

### Social Anxiety Session Change Index (SASCI)

#### Worksheet 3.3

#### Social Anxiety Session Change Index

SASCI

Name \_\_\_\_\_ Date \_\_\_\_\_

Please answer the following questions concerning how you are doing today, compared to how you were doing **BEFORE YOU BEGAN TREATMENT**.

Compared with how you felt **before the beginning of treatment...**

How anxious do you currently become in anticipation of or when in social/performance situations (situations where you interact with or do something in front of people)?

- 7 Much more
- 6 Moderately more
- 5 Slightly more
- 4 Not different
- 3 Slightly less
- 2 Moderately less
- 1 Much less

Compared with how you felt **before the beginning of treatment...**

How much do you currently avoid social/performance situations, being the center of attention, or talking with people?

- 7 Much more
- 6 Moderately more
- 5 Slightly more
- 4 Not different
- 3 Slightly less
- 2 Moderately less
- 1 Much less

Compared with how you felt **before the beginning of treatment...**

How concerned are you, currently, about doing/saying something embarrassing or humiliating in front of others, or that others might think badly of you for what you do or say?

- 7 Much more
- 6 Moderately more
- 5 Slightly more
- 4 Not different
- 3 Slightly less
- 2 Moderately less
- 1 Much less

Compared with how you felt **before the beginning of treatment...**

Currently, how much does your anxiety about social/performance situations interfere with your ability to participate in work/school or in social activities?

- 7 Much more
- 6 Moderately more
- 5 Slightly more
- 4 Not different
- 3 Slightly less
- 2 Moderately less
- 1 Much less

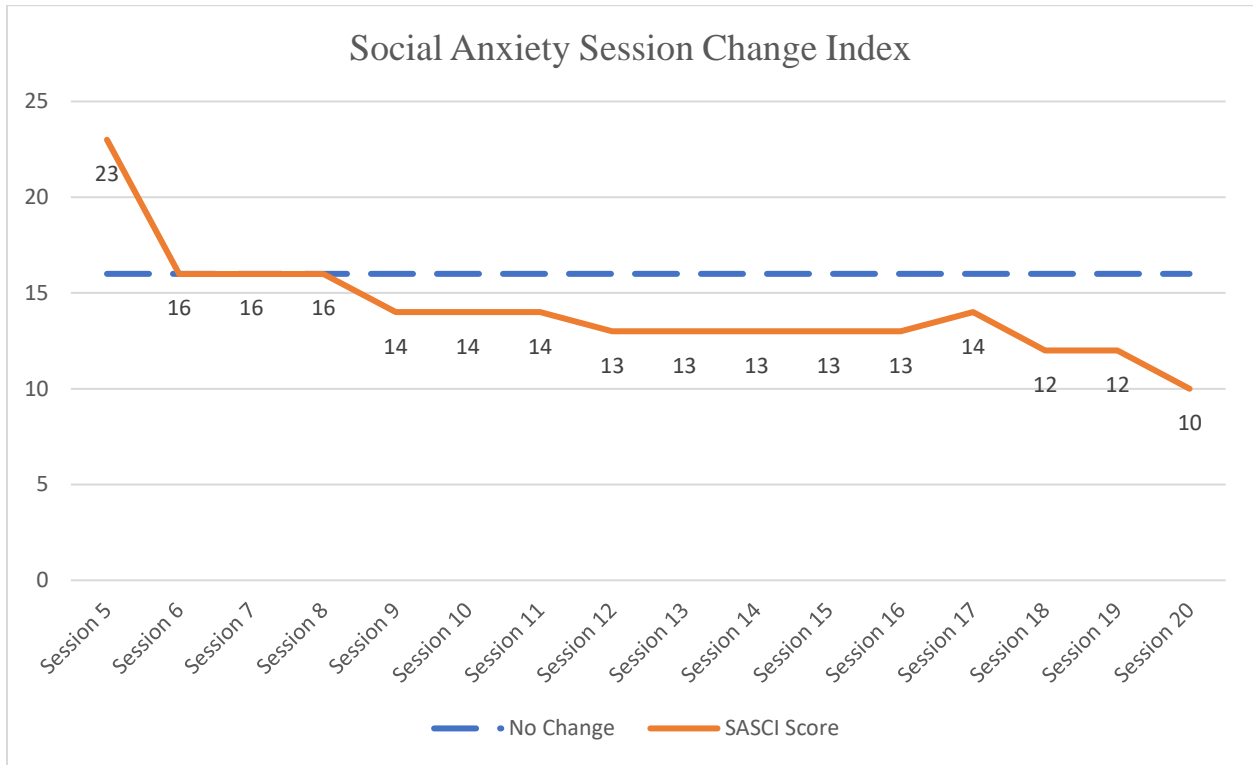
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**Appendix H**

Social Anxiety Session Change Index (SASCI) Graph



*Note.* Client filled out the Social Anxiety Session Change Index starting session 5 through session 19. The “dashed” line represents the score of 16, which indicates “No Change” since starting treatment.

**Appendix I**  
Session Eight Transcript:

T: I know a lot happened since I last saw you. So how are you doing?

C: I'm doing alright.

T: Yeah.

C: It's been a crappy two weeks but I'm doing my best.

T: What's that look like?

C: Hmm, well I went to visit my grandma in the hospital as you know, and it was uncomfortable, and I was sitting in the parking lot for a while, and I was just about to go home I was so scared to go in. My husband talked to me, he's like "it's important that you go." I'm glad I did.

T: I am too.

*\*\*Reinforces approach behavior rather than avoidance behavior, consistent with the inhibitory learning model.*

C: She passed, and I would've regretted that.

T: I'm sorry for your loss.

C: But um when I did go in, I didn't expect it to be so bad. I expected her to be talking and she really wasn't, she was in and out.

T: Yeah, I remember you saying that last session.

C: I did my best to just talk to her, but it was awkward and uncomfortable. I knew she couldn't respond. It's just like "I'm running out of things to say" I'm still glad I did it.

T: Yeah, I'm glad that your husband was there to give you that push you needed. I'm glad that you got to see her and spend time with her.

C: And then umm yeah, she died and ugh I don't know my family felt like ...umm when they're planning the funeral they'll asked me "do you want to read a poem?" or something like that and I'm just like no and I feel horrible and it's just like of course I want to and the thought of it is just... you would think her dying would kick me into action.

T: Hmm.

*\*\*I could have validated the client's loss in this moment. Alternatively, I could have reflected the struggle between what her anxiety wants her to do and her desire to honor her grandmother. Such a contrast can motivate change, consistent with motivational interviewing approaches.*

C: The terror of public speaking is still really bad.

T: Yeah, your top one on your hierarchy is public speak and it's something you'll have to gradually work on. I am sorry that you won't experience that at your grandma's funeral. Is that something you wanted to do?

C: Yeah, I wanted to.

*\*\*Another opportunity to point out the desire to avoid on the one hand and the desire to honor her grandmother on the other hand.*

T: Is that something you guys shared together?

C: \*cough\*

T: Sorry I know I said I wouldn't make you talk a lot.

*\*\*Referring to client losing her voice recently*

C: No, it's okay, trust me I couldn't talk at all. I had to call the office and I was just like struggling to tell the guy. I was struggling so bad, but it's gotten better.

T: Yeah.

C: Yeah, it's not something we shared but it would've been nice to do for her. When I was there, I don't know, her not being able to talk scared me because I'm just like you know she doesn't want me to be here. I can't communicate so like leave, and I tried to stay as long as I could without freaking out and leaving. I think I stayed at least an hour at the hospital. I wanted to make it a point not to like popping in and out because of course I want to run.

T: Yeah, and you didn't, be proud of yourself for that too. It can feel easier to avoid in the moment.

*\*\*Reinforcing the client for not avoiding and treatment-consistent behaviors.*

C: Hmm yeah. So, at the funeral of course I'm going to see everybody that I don't normally see, my extended family and must talk to them a lot. And that's scary too. I just don't know what to say and on top of it crying in front of people so much and I can't avoid not crying.

T: Hmm.

*\*\*Attempting to not reinforce automatic thoughts by agreeing with client, while also providing space to grieve.*

C: So, I'm just like this is going to be a mess. I'm just thinking about all these things I shouldn't be thinking about, and I feel bad I'm even thinking about things. I'm just like "Your grandmother died, what's it matter if you cry in front of people?" And you have to stand up and speak. It shouldn't matter but it's still right there.

T: Yeah, unfortunately it's not just going to go away and it's something you'll have to work on continuously.

*\*\*Reminding client treatment is not a quick fix and the client will need to continuously work on her fear/anxiety.*

C: Yeah, I'm just dreading all the events.

T: Like what?

C: Well, there's the memorial services and the actual funeral and there's mass after. It's just a lot of socializing and I don't want to do it and on top of that I haven't really spoken to my dad and he's taking it really hard, that's his best friend

T: Is that his mother?

C: Yeah, so I'm just like going to be dealing with a lot of emotions and not communicating correctly. But at the same time, I don't really know my extended family that well, it's just I don't know all the emotions...I don't know.

T: That's a lot to deal with.

C: Also, just feel bad because I wasn't around more and feel kind of shame of "you just show up for the funeral, of course."

T: Well, you did go see her and didn't avoid in that moment, which is really great. You made that choice instead of your anxiety. Was there a reason why you feel you weren't as close with her?

*\*\*Reinforcing the client for confronting a feared outcome and not avoiding. Also, gathering more information about how anxiety interferes to utilize as a reason for change later, if needed.*

C: Well because I avoided so many social events with my family over the years because of my anxiety she would ask me, "how come you weren't around more?" and things like that. And I just couldn't tell them that. I know one of the things we talked about was about having a conversation with her, making a list, and possibly telling her about the anxiety thing.

T: Yeah.

C: It was something I wanted to do but she wasn't all there.

T: Yeah. That is a difficult decision.

C: I felt guilty and still feel guilty. I feel like having anxiety just like stole a lot of moment that I could have had with her. I mean I still have good memories and I just wish I was around more with my family, and I didn't let it, I wish I didn't let it make me hide so much.

T: That is really difficult.

C: Yeah. I'm trying to get through session without crying.

T: That's okay, I know you just said you don't like crying in front of people. And you know this is a safe place you can express your emotions.

C: Yeah, I just feel like anxiety has stolen so much. I don't really care much about my career and going to parties, just that it's affected my ability to relate to my family. That's what sucks about it.

T: Yeah, it's really controlling your life right now. I can tell family is very important to you.

*\*\*Reflection of content to demonstrate understanding and enhance the therapeutic alliance. Also enhances motivation for change.*

C: Yeah, "She's pretty much just showing up when people die." Like "Oh where you been this whole time?" I feel bad that I even have to explain, or I just wish I could go back in time.

T: How are you feeling that you couldn't express those reasons to your grandma?

C: Well, I knew she loved me regardless and the times I did spend with her, so it's not completely like oh I missed this time with you. I have good memories with my grandma, it's not like I didn't completely not know her, but I could've known her better.

T: You feel like anxiety got in the way of that.

C: Yeah.

T: How are you feeling about potentially telling your other family members that "Hey I don't only show up when these things happen and the reason I didn't is because of my anxiety."

C: I think they'll laugh.

T: Really?

C: My family is not that family that believes in counseling. It's either your nuts and crazy or suck it up and deal with it. It's hard.

T: Mental health is stigmatized quite a bit and it's hard when you feel like you can't tell your own family how you're feeling. I guess what I'm wondering is, you know you can't tell your family. Well not that you can't tell your family, you know they are going to react this way and how would it feel for you to tell them? You know regardless of their reaction.

*\*\*I was attempting to help the client understand, regardless of her family's reaction to her social anxiety, it would be beneficial (based on previous sessions) for her seeing as she has an abundance of guilt relating to missing family events.*

C: It would be a relief. Just so I don't have to feel. It takes so much energy to hide it all the time. Well, I guess call me crazy but at least you know my struggle and it's not you.

T: I'm going to challenge you a little bit on the word crazy. I know we've had this conversation before that your family does feel like mental health equals craziness. How do you feel about that?

*\*\*I could have said something differently than, "I'm going to challenge you a little bit on the word crazy" as it conveys these are the client's thoughts and not her own families. Instead, I could have validated the client's feelings in the moment and inquired about where she learned that mental health equals craziness.*

C: Of course, I wouldn't be here if I felt that way, I think everyone needs counseling. It would help. It would help a lot of people in my family actually.

T: It's interesting how the people who stigmatize mental health could really benefit from it too. It's also so unfortunate they don't allow themselves the opportunity to express how they are feeling and be their true selves.

C: Yeah.

T: So, I don't want you to think that because you are here for your social anxiety, we can't deviate from that. What do you want to work on today?

*\*\*Providing good clinical judgement and allowing the client to decide if she wanted to continue discussing her recent loss or if she wanted to continue treatment specifically with her social anxiety. Also, enhancing client's ability to be assertive and decide what she wants to continue working on instead of therapist deciding.*

C: Umm... in the book it mentioned like I guess attacking your automatic thoughts, questioning them, and answering them with the rational thoughts and I've been trying to do that, and I haven't been really successful with that when it comes to like worrying about my family. There's a lot of issues going on with my family outside of my grandma dying.

T: Oh really?

C: I just worry about them a lot. My role in my family has always been to take care of them.

T: The middle child.

C: Yeah, the middle. And I'm having a hard time doing that being here in Kansas, but I still feel like a strong responsibility to that and it's just stressing me out.

T: That makes sense because that's what you knew in childhood, that's what you were taught so it makes sense that you feel that strong responsibility.

*\*\*Reflecting on the client's childhood experience and connecting that to her current situation. However, I could have added "How useful is that to you now?" to convey she isn't in the same situation in childhood and placing herself in the "parent" role is maintaining her anxiety.*

C: I'm also aware that it's not my job to save my family and do that so I guess I'm just trying to not stress out so much about fixing things, being the fixer. It's not my job to fix things all the time. But when I don't try to, I freak out. This past week I've lost a lot of sleep because I'm up all night just worry about my family, like what can I do to fix all these problems and it's just driving me nuts. I've been trying to do that back and forth in my head. It does help but then it's just like the next day I'm back where I was before.

*\*\*The client is referring to cognitive restructuring.*

T: Yeah, are you saying what you read in the book the challenging and disputing that helps but then the next day you're back where you started?

C: Yeah, just at square one and I don't know, I didn't learn anything because I'm applying it and I'm trying to do it. I don't see any progress because I just go back to where I started.

T: And that makes sense because we haven't talked about cognitive restructuring yet. Throughout treatment there will be times that things may not work, and we can problem solve those concerns together. Also, cognitive restructuring is going to take time just like riding a bike it takes practice. That's actually what we were going to work on today.

*\*\*Reinforcing the client to continue trying cognitive restructuring while also explaining therapeutic techniques take practice.*

C: Well good.

T: Because this is your time and I wanted to make sure that we did what benefits you the most and I know there's been a lot going on in the past couple of weeks. I wanted to acknowledge the past couple of weeks have been hard for you from what you've said.

C: Okay, it is hard. I don't know I guess there's nothing else I can think of besides having to see my family and talking to them.

T: Learning about cognitive restructuring will help when you have those thoughts about seeing your family and going to the funeral, so if you want, we can work on that today.

C: That sounds good.

*\*\*Most of the remainder of session was spent providing psychoeducation on amber colored glasses and therapeutically challenging the client to take a different perspective outside of her own anxiety. The client was hesitant to metaphorically take off the amber colored glasses.*

T: Okay, so did you happen to re-read the chapter about amber colored glasses? I know how we talked about the last edition didn't have that in there.

C: I didn't re-read it, but I remember what it's about.

T: Okay that's fine. The homework from two weeks ago I believe it was monitoring your automatic thoughts, the worksheet.

C: 5.2?

T: Yes, so hold on to that and we will talk about that closer to the end.

*\*\*More consistent with the manual, I should have discussed the homework instead of waiting until the end because ultimately, we ran out of time.*

C: Okay.

T: What do you remember about cognitive restructuring in the chapter?

C: Specifically? I don't remember a lot.

T: Anything that stood out?

C: About like identifying automatic thoughts that pop into your head and then finding the thinking errors things that are wrong with that and then challenging them and answering those questions that come up and doing a back-and-forth thing. Like anxious Lilly and rational Lilly. Then trying to find a rational or a key point and that's all I remember.

T: That was awesome! You just told me all the steps of cognitive restructuring, so you are way ahead. Basically, what you described is cognitive restructuring, when we talk about cognitive restructuring we start with the cognitive model. The cognitive model is when we have situations that lead to thoughts or beliefs and those lead to feelings and behavior. What we want to do is focus on those thoughts. What do you remember about the scenario at the beginning of the chapter about Jerry and Rich at the mailbox?

*\*\*Providing psychoeducation on the cognitive model to explain the importance of our thoughts.*

C: I think both of them wanted to ask her out. I don't remember which one it was, but one took a different route and the other talked himself out of it.

T: Exactly. Jerry was the one that talked himself out of it, what do you remember about the difference between the thoughts?

*\*\*Client is learning to recognize how anxious thoughts can change the outcome of an interaction.*

C: Uh, well the other guy way more positive. I guess he wasn't so discouraged so easily, he was like "oh if she's acting this way it has nothing to do with me" and Jerry was more "oh her body language, it doesn't seem like she wants to talk to me" kind of just like mind reading and guessing how she is feeling and thinking. Pretty much doesn't know for sure because he didn't ask her, he didn't try.

T: Wow so you said you didn't remember a lot and you do! Yeah, Jerry had thoughts of "I'm bothering her" "she doesn't want to talk to me" while Rich, the other guy, had thoughts of "well maybe she didn't hear me" and Jerry ended up walking away and not talking to her. While Rich

ended up asking her to go on a coffee date with her. You can see the difference between the thoughts, like you said.

C: Yeah.

T: It's not the event itself that's causing anxiety, it's how Jerry interpreted the event. We have the same situation with two different guys and two different outcomes because of how Jerry interpreted the event. What questions do you have about the cognitive model?

*\*\*Explaining the relationship between situations, thoughts, and feelings and the interpretation of events may lead to different outcomes, reinforcing the cognitive model.*

C: Sounds about right, I'm usually Jerry, and talk myself out of everything.

T: We really want to get you to where you're usually Rich. How else do you identify with that situation?

C: Well, I guess I have it in my mind that I can read people's behavior or something, so I usually just go with that and go with my intuition that I'm bothering them and make a lot of assumptions. I don't usually ask just act on whatever I think is going on.

T: How often do you feel those assumptions are correct?

*\*\*Slowly introducing the concept of challenging assumptions and thoughts, consistent with cognitive restructuring.*

C: I guess I don't know. I'm just like oh they don't want to be bothered or they don't like me in the room, and I just walk off.

T: Well, we are going to learn to look at those assumptions as hypothesis and really challenge them by asking ourselves questions and then look to see how valid they were, if they were true or not. Get you to the point where you ask those questions versus just walking away. How does that sound?

C: Asking them?

T: No being able to think more about those assumptions and really challenge them like you are a scientist.

C: Hmm, I guess that would make more sense.

T: What do you remember about automatic thoughts?

C: Umm, we don't really control them they are just a stream of consciousness, but they are thoughts that happen so frequently that you think it's you that created those thoughts. Umm when in reality you just kind of... just because you think something doesn't mean it's who you are.

T: Yeah, you're on the right track. It's negative beliefs we have about ourselves, others, the world around us and like you said we can't control them, they happen so natural that sometimes we don't even know they are happening. I want to clarify the goal is to not get rid of these thoughts. The goal is to really look at them as if they are a hypothesis and challenge those and see how valid those thoughts really are.

*\*\*Consistent with cognitive behavioral therapy, the goal is not to replace or get rid of anxious thoughts, instead learn how to recognize, and challenge the validity of those thoughts.*

C: Hmm.

T: What do you remember about rose-colored glasses?

C: It's seeing another perspective of like what the other guy did, Rich and having his perspective and thinking more positively. Thinking outside of your own thoughts, just challenge them and maybe this isn't what's happening. This is what I think is happening and maybe it's not true. Just looking for a good outcome not just expecting one, instead of the opposite and being pessimistic.

T: Yeah, nice job. What do you remember about amber colored glasses?

C: It's the opposite, Jerry.

T: Yes, stole the words right out of my mouth! So, we can think of a traffic light, and we have green, yellow, red. The yellow tells us caution, danger ahead slow down. That's what the amber colored glasses do. When we put those on, we view the world in a more cautious state and there are things that could be dangerous and having those on changes our perception of what's going on around us. When we do that, events are perceived differently.

*\*\*It would have been beneficial and more consistent with the manual had I stated automatic thoughts are a product of amber-colored glasses.*

C: But doesn't ambered colored glass kind of protect you sometimes? Like if you just assume a good outcome wherever you are. For example, if you go to the hood...you're like "I'm just going to have rose-colored glasses on here, no."

T: How well does having those amber colored glasses on all the time help?

C: All the time?

T: All the time.

C: It's not good.

T: Yeah, while we want to be cautious in certain situations, like the one you just gave, we also want to be aware we can take them off. We don't want them on 24/7 because we're interpreting the world around us and these events differently. That leads us to avoid certain things and not be our true self. Great question.

*\*\*Reinforcing perceived threat leads to avoidance, while validating the client's concern for actual dangerous situations.*

C: When do you know to take the amber-colored glasses off and put on the rose-colored glasses?

T: What would you say to that?

*\*\*Here I should have explained we are not replacing the amber-colored glasses with an overly optimistic perspective (i.e., rose-colored glasses).*

C: Well, I have amber-colored glasses on all the time, because I did grow up in the hood and my safety was always at risk.

T: Exactly.

C: Anywhere I go now, even though I'm out of there, I still don't feel safe as a woman.

T: Completely agree. I think the difference is you're applying that to situations that are actually dangerous and so typically when we have the amber-colored glasses on it's when things aren't dangerous, and we just perceive them to be dangerous. I completely understand where you are coming from in being a woman and being more aware of our surroundings. That's just something, unfortunately, we have to deal with a lot. There are dangerous situations for women.

C: I'm scared I'm going to take off the amber-colored glasses and then something bad is going to happen because I wished for the best.

T: We don't have to go straight from the amber-colored glasses to the rose-colored glasses, we just want you to be glasses free, take all the glasses off.

*\*\*Validating client's concern, while still being consistent with treatment.*

C: Yeah.

T: I do understand there are situations that are dangerous and at the same time there are situations that we interpret to be dangerous that aren't and that leads us to avoid, miss out on things we could've done. How are you feeling about going without glasses?

C: It would be nice, but I guess like more than just the environment you are in, I feel in general people aren't safe. So, it's hard, ambers always on because I'm around people and people are unpredictable.

T: Where did you learn people aren't safe?

C: Hmm, from experience but also, we talked about my parents were just always questioning people's motives and intentions basically said everyone's two faced. They're always nice and will smile in your face and talk about you behind your back.

T: And if you had those amber-colored glasses on all the time with people, you don't allow yourself to learn new experiences, you don't allow yourself to learn people aren't always dangerous. We really want to take those off so you can get those new experiences, the new data, and use that in the future too so you know people aren't always as dangerous as you feel they are.

C: Hmm.

T: It makes sense when you were in high school and getting bullied that's what you learned, you learned people are dangerous and you did what you had to do to survive that situation, same with your parents. And now I want us to learn that you're out of that situation and people aren't always dangerous.

*\*\*The client continued to express concern with taking off the ambered-colored glasses. I showed good clinical judgement with continuing to discuss these concerns instead of moving on.*

C: Yeah.

T: You're hitting me with all these good questions!

C: I guess I would rather not be surprised. If you're coming from amber like if something bad happens, you're just like "Oh well I expected that." When you trust in people and expect the best out of them with rose-colored glasses and they let you down it's just like I don't know.

*\*\*Once again, I should have reinforced we are not replacing amber-colored glasses with rose-colored glasses.*

T: What happens when you have those amber-colored glasses on and you're expecting someone to let you down and they don't? You've already set yourself up to expect this is going to happen and when it doesn't happen, having those amber-colored glasses on we only look at the negatives. We view even neutral things as negative, when having those off would help us say "Okay so this experience doesn't align with the experience I had previously."

*\*\*Reinforcing the cognitive model.*

C: It's kind of like of, well they haven't done it yet, give it time. Which is not fair because people will disappoint you, that's part of being human, I know that. I know that I disappoint people all the time.

T: It sounds like with those expectations, we don't allow people to not disappoint us.

C: Nope.

T: How do you think not allowing people to... let me rephrase. How helpful is that? How has that helped you?

C: It hasn't really.

T: Hmm.

C: You can't really have relationships with people.

T: And if you always think people are dangerous, no wonder you don't want to talk to people or have those relationships.

C: Yeah.

T: How comfortable do you feel taking those glasses off?

C: Not comfortable at all.

*\*\*The client was laughing, and I felt it was appropriate to challenge her thinking even more.*

T: That's going to be something that is uncomfortable for a while and then eventually...

C: I like feeling safe, feeling in control, what little control I do have. I feel like taking off the glasses is just like basically getting thrown to the wolves.

T: Everything I've heard for the past couple weeks or months we've been working together is the opposite of what you just said. I feel from what I've heard you say and the examples you provided that having these glasses on hasn't allowed you to be in control. You talked about not being able to go to a new park with your husband because you're concerned of new environments, you said you walk into rooms and immediately find exits. I can see how that makes you feel like you're in control and that your anxiety is actually controlling you because you're doing these things. I know that's hard to hear. How are you feeling right now?

C: I guess I never thought about it like that. It's just an illusion but I still feel like I don't know. I know that's not reality, but I still feel like that's better than taking those glasses off. The illusion of being in control is a lot better.

T: Wouldn't you want the reality of control instead of the illusion?

C: Yes.

T: How do you think you could get there?

C: I really don't know. I just think life's "are you ever going to be in control of anything?" I don't know, I would like to feel like I'm in control of some things.

T: And you are.

C: Anxiety is in control.

T: I want us to get to the point where anxiety is no longer in control, I hope that you really allow yourself to let go, maybe a little bit at a time, of the illusion of being in control and take off those glasses and perceive the world in a different way.

C: I don't know what that would look like. I've had anxiety for so long, I can't even imagine what that would look like.

T: Take a guess. What do you want to look like?

C: If I was free from anxiety?

T: Yes. If you had a magic wand what would your life look like if you could just have it away?

C: I would go shopping any time of the day.

T: What else?

C: I would walk down the street by myself, not a night because I'm still a woman.

T: Right, there is a great example of how you were able to take those glasses off and then still understand as a woman there are dangerous situations. What else?

*\*\*Reinforcing the client's ability to recognize perceived threat versus actual threat.*

C: Be more open with people, more real, more me. Make room for relationships to grow and disappoint, things like that.

T: Yeah.

C: We all struggle with certain thing mentally; I would just like to form and keep relationships with my family and the few friends I have now.

T: I hope you can get to that point. I think you are doing the most you can right now by coming to session, now allow yourself the opportunity to experience life without those amber-colored glasses.

C: Yeah.

T: What questions do you have? You had some good ones.

C: Throwing curve balls. I guess I just want to know what it would look like.

T: Well, you just told me what it would look like. Being able to walk down the street, go to the store without a back-and-forth battle about when is the best time to go when less people will be there, where can I go...

C: Just go.

T: Just go.

C: Yeah.

T: It sounds like you're familiar with thinking errors, you've already said one, mind reading. What do you remember about thinking errors?

C: Thinking errors are thoughts we have over and over again and it's second nature to have them. We just have to ignore them; we just assume thoughts are us and don't really challenge them because we have them so much.

T: You're thinking of automatic thoughts a little bit, one thing I would add is thinking errors are also ways we think about a situation that may not portray the situation accurately. The goal is to also challenge thinking errors and see how valid they are. I printed a list of thinking errors. Reading over those, which ones do you identify the most with?

*\*\*Consistent with the manual and cognitive restructuring, I am providing psychoeducation about thinking errors.*

C: All or nothing for sure.

T: Yeah.

C: Catastrophizing, disqualifying the positives, mind reading, should statements.

T: What we do with thinking errors is we label automatic thoughts with them, there can be multiple thinking errors on one automatic thought. Next time, we'll finish up with cognitive restructuring because we are almost out of time to work through an example. What questions do you have about thinking errors?

C: Could you be more specific about what mental filters is?

T: Yeah, it's like what we talked about with amber-colored glasses, we have a situation, and we only pay attention to negative things. We don't allow for neutral or positive details to pass through that filter. Does that make sense?

C: Yes.

T: Good question. What other questions do you have?

C: Unhelpful thoughts. Aren't they all unhelpful?

T: Unhelpful thoughts are thoughts that may be true like, "I'm feeling uncomfortable" that don't contain illogical errors. These thoughts are not useful and we may dwell on them causing us to become more anxious. It's important to look at what might be behind the unhelpful thought. For example, what's the concern with feeling uncomfortable? Well, someone may notice and think in incompetent. Really look at what this unhelpful thought could mean. Does that make sense?

C: Yeah.

T: How do you feel about everything we've talked about today?

C: I feel good, it's a lot to think about.

T: I want you to keep filling out the worksheet and bring it back next time. We will use those to work through cognitive restructuring as examples. What questions do you have?

*\*\*Consistent with the manual, the client is tracking her 3 components of anxiety.*

C: It looks pretty straight forward.

T: Does Friday at the same time still work for you?

C: Yes, thank you.

T: I'll walk you out! Thank you for coming in today.