

Treatment of Social Anxiety Disorder: A Case Study of a 19-Year-Old Male

An Empirically Supported Treatment Case Study  
Submitted to the Faculty  
of the Psychology Department

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MASTERS OF ARTS

Psychology Department

By

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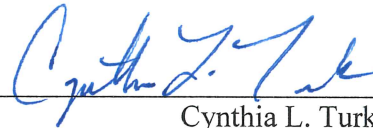
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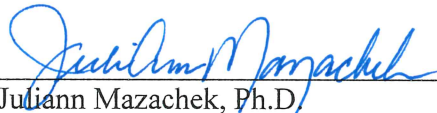
TREATMENT OF SOCIAL ANXIETY DISORDER: A CASE STUDY OF A 19-  
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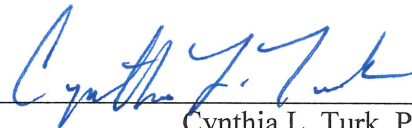
MASTER OF ARTS DEGREE



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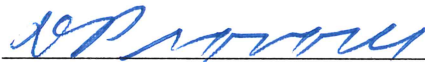


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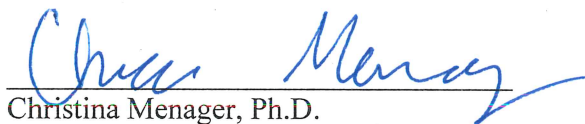
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## Acknowledgments

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### **Abstract**

The purpose of the present study was to assess, diagnose, and treat Social Anxiety Disorder. Luke presented to treatment as a 19-year-old male college student struggling to engage in peer interaction. Luke was assessed with a general history interview, the Mini-International Neuropsychiatric Interview (MINI 7.0), the Social Anxiety section of the Anxiety Disorder Interview Schedule (ADIS-V), as well as a battery of self-report assessments. Luke's primary diagnosis was Social Anxiety Disorder with secondary diagnosis of Major Depressive Disorder, mild. Luke attended nine Cognitive Behavioral Therapy (CBT) treatment sessions that utilized in-session, in-vivo, and social mishap exposures. Client attended sessions regularly and clearly understood the theory presented to him, evidenced by seeking opportunities to challenge himself to confront anxiety in her personal life.

### Treatment of Social Anxiety Disorder: A Case Study of a 19-Year-Old Male

The core symptomatology of social anxiety disorder (SAD), as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association [APA], 2013), is fear or intense anxiety about social situation(s) in which the individual may be scrutinized by others. Individuals with SAD fear others will know they are anxious and will be negatively evaluated, causing these situations to almost always provoke fear. The social or performance situations are avoided or endured with intense fear or anxiety. To assign the diagnosis of Social Anxiety Disorder, the client must experience anxiety that is out of proportion to the actual threat, have the anxiety symptoms for at least 6 months, experience clinically significant distress, and the symptoms cannot be attributed to another mental or medical condition.

SAD affects a significant percentage of the population. In the United States, the estimated 12-month prevalence is approximately 7% (DSM-5; APA, 2013). Prevalence rates decrease with age; for older adults, the estimated 12-month prevalence is approximately 2% to 5%. In the general population, higher rates of SAD are found in females than males are equivalent or slightly higher for males in clinical samples. Gender roles and social expectations may help explain the heightened help-seeking behavior among male patients (Yang et al., 2011).

Social anxiety can lead to significant impairment. Its diagnostic criteria includes avoidance of social or performance situations which directly interferes with social and occupational participation (Dahl & Dahl, 2010). Socially anxious individuals, in comparison to non-socially anxious individuals, scored lower in terms of their physical functioning, social functioning, and general health (Acarturk, Graaf, Straten, Have, & Cuijpers, 2008). Some individuals with SAD use alcohol as a subtle avoidance strategy during social interaction, having

social anxiety is a risk factor for developing alcohol use disorder (Buckner et al., 2008). For untreated individuals, the disorder has a persistent course (Dewit, Osborne, Offord, & MacDonald, 1999).

Since SAD first appeared as “social phobia” in the DSM-III (APA, 1980), there have been several models used to conceptualize its etiology and maintenance. Clark and Wells (1995) and Rapee and Heimberg (1997) introduced cognitive-behavioral models that have been influential in understanding SAD. More recently, Craske et al. (2008) has improved our understanding of the mechanisms underlying exposure therapy.

### **Theoretical Foundation of Development Social Anxiety**

#### **Cognitive Component of Social Anxiety**

Rapee and Heimberg’s (1997) cognitive model of SAD suggests that, when an individual with SAD enters a social situation, they will create a mental representation of their external appearance and behavior. This mental representation is presumably from the vantage point of the audience. As socially anxious individuals are fixed on their internal experience, they are more likely to assume that their current appearance and behavior are negative and unacceptable. The socially anxious individual focuses their attentional resources on this internal representation and any perceived threat within the social environment. Engaging in these mental tasks decreases cognitive resources for attending to the social task at hand. Additionally, anxious individuals have an attention bias toward negative real-life social threat cues (e.g., others whispering about them), guaranteeing that they will detect information consistent with their negative beliefs. In a laboratory demonstration of attention bias, Mattia, Heimberg, and Hope (1993) utilized an emotional Stroop color-naming task to demonstrate that individuals with social phobia had greater response latency interference in color-naming with social threat words in comparison to

the control group. That is, socially anxious individuals had more difficulty disengaging their attention from the content of the social threat words (e.g., boring, stupid) and engaging in the color-naming task than controls. The individual combines their mental representation of their external appearance with their internal experience, creating automatic thoughts in the form of predictions about the audience's expectations, their ability to meet those expectations, the likelihood of negative evaluation, and the social consequences of being judged negatively.

Clark and Wells (1995) propose that socially anxious individuals use interoceptive information (e.g., feeling warm) to construct an impression of themselves (e.g., looking red and sweaty), which they assume reflects what others observe. Safety behaviors are frequently utilized (e.g., wearing lightweight clothing) to ward off outcomes they view as catastrophic (e.g., other people seeing them sweat). Safety behaviors are utilized with the intent to reduce the risk of negative evaluation. However, safety behaviors prevent the individual from fully and unambiguously disconfirming their unrealistic, anxiety-provoking beliefs (e.g., most people will reject me if they see me sweat).

These cognitive models of social anxiety suggest the problem persists because the individual is not processing the corrective information in their environment due to avoidance behaviors, negative cognitions, and attentional bias. Hope, Heimberg, and Turk (2010) use the phrase "wearing amber-colored glasses" to describe the phenomenon--that socially anxious clients view the world through a caution lens. Treatment interventions based on these models utilize cognitive restructuring to dispute negative automatic thoughts allowing the client to develop thoughts that accurately represent the client's experience; these new thoughts are referred to as a rational response. The client will develop rational responses for different exposures through treatment, to overcome avoidance, counter safety behaviors, shift to externally

focused processing, correct negative self-image, and test predictions about negative evaluations by others (Clark & Wells, 1995).

### **Behavioral Component of Social Anxiety**

The behavior that maintains social anxiety is avoidance (Foa & Kozak, 1986). Avoidance can be completely avoiding the situation (e.g., stay home) or subtle behavioral changes that reduce the individual's worry in that situation (e.g., not making eye contact, drinking alcohol, wearing neutral colors to blend in). As clients use avoidance, they are not exposing themselves to the feared situation, preventing corrective learning from occurring. Furthermore, avoidance decreases anxiety, resulting in negative reinforcement of avoidance behaviors.

### **Mechanisms Underlying Exposure Therapy**

Exposure is a therapy technique that places the socially anxious client in a feared social situation repeatedly and for a prolonged period. Exposures are utilized to help anxious individuals face feared situations while remaining psychologically engaged, allowing the natural conditioning process involved in fear reduction to occur (Heimberg, 2002). Most variations of cognitive behavioral therapy for SAD utilize exposure as a central component of treatment.

Exposures provide the client with an opportunity for the activated fear response to result in corrective learning through integration of information that is incompatible with the structure of the previously learned fear response (Craske et al., 2008). Within a Pavlovian conditioning approach, the inhibitory learning model states: the original Conditioned Stimulus (CS) – Unconditioned Stimulus (US) association that leads to fear response is not erased during extinction. Rather, secondary inhibitory learning about the CS-US develops. The individual learns the CS no longer predicts the US (Bouton, 1993). As time passes from learning about the new CS-US association that occurs in exposure therapy, the original CS-US association returns,

triggering the fear response, thus providing evidence for the need for continued exposures once treatment is complete (Craske & Mystkowski, 2006). Drawing from the extinction learning and memory literature, “desirable difficulties” are activities used to vary conditions while learning as a means of enhancing long-term learning (Bjork, Dunlosky, & Kornell, 2013). The concept behind “desirable difficulties” can be utilized through exposure treatment by putting a higher value on fear toleration rather than fear reduction.

Figure 1 details the inhibitory extinction model as it applies to exposure therapy (Craske & Mystkowski, 2006). A socially anxious individual enters treatment with a threat expectancy: “If I am socially rejected, it would be unbearable.” A result of exposure therapy is the development of a competing non-threat expectancy: “If I am socially rejected, I will survive.” After completion of exposure therapy, the level of fear that is experienced when the possibility of social evaluation is re-encountered is dependent upon which expectancy (threat or non-threat) is activated. Craske (2015) describes four factors that increase the likelihood of activating the threat expectancy (strengthening the pre-exposure fear response) following completion of exposure therapy: (1) increased time between exposures post-treatment, (2) change in context from extinction to retest, (3) unpredicted adverse events following exposure therapy (i.e., being negatively evaluated in a non-feared social situation), and (4) experiencing a relevant adversity event (i.e. being negatively evaluated in a feared social situation).

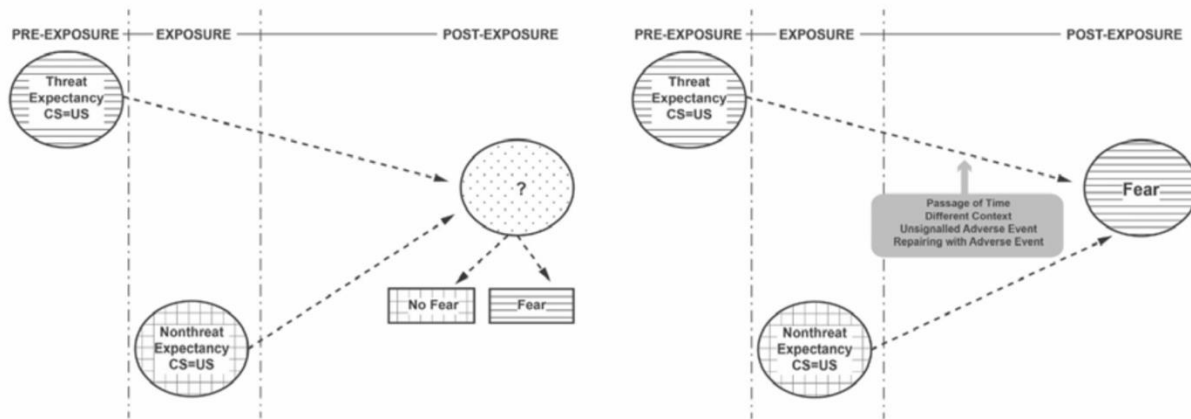


Figure 1: Craske and Mystkowski's inhibitory extinction model as it applies to exposure therapy (Craske & Mystkowski, 2006)

### Empirical Support for Treatment

Research indicates effective anxiety treatments target patient-specific problems. A recent meta-analysis examining the psychological treatment of anxiety disorders within 135 randomized control trials (RCT) found that problem-focused treatments (e.g., treatments that target client specific problems) are most effective at treating anxiety disorders and suggests that expectations created by explanation and therapeutic actions may play a critical role in reducing symptoms (Yulish et al., 2017). Thus, the results support the notion that a focus on patients' problems and patients' understanding of the rationale for treatment are important aspects of psychotherapy for symptom relief.

A meta-analysis examining the effectiveness of various psychological treatments for SAD in adults within 29 randomized studies ( $N=1628$ ) confirmed the positive findings of earlier meta-analyses (Acarturk, Cuijpers, van Straten, & Graff, 2009). That is, treatments including cognitive behavioral therapy, cognitive therapy, social skills training, relaxation, and exposure produced an overall effect size of 0.70.

### **Cognitive-Behavioral Therapy**

Cognitive Behavioral Therapy (CBT) is a combination of exposure therapy and cognitive therapy that is widely used in the treatment for SAD. CBT is posited to be an effective treatment for SAD (Hofmann & Smits, 2008). Three recent studies representative of this literature are reviewed below.

A randomized controlled trial ( $N=90$ ) compared cognitive-behavioral group therapy (CBGT) and exposure group therapy (EGT). The findings indicated no significant difference between the treatments at post-treatment (Hofmann, 2004). Examination of effect sizes favored CBGT. CBGT was associated with moderate reduction in specific somatic symptoms and dysfunctional cognitions and behaviors across situations measured using the Social Phobia and Anxiety Inventory ( $d=0.72$ ; SPAI: Turner, Beidel, Dancu, & Stanley, 1989), as well as a large reduction in impaired social communication as measured by the Social Cost Questionnaire ( $d=0.92$ ; SCQ; Foa et al., 1996) from pre- to posttest. In comparison, clients treated with EGT exhibited slightly weaker reductions in SPAI ( $d = 0.52$ ) and a moderate reduction in SCQ scores ( $d = 0.49$ ) from pre- to posttest. The reduction of SPAI scores, from pretest to the 6-month follow up for EGT ( $d = 0.68$ ) and CBGT ( $d = 1.55$ ), support the notion that cognitive treatments have a lasting effect on social anxiety following treatment termination.

Clark et al. (2006) conducted a randomized control trial ( $N=62$ ) that compared cognitive therapy (CT) with exposure therapy combined with applied relaxation (EXP + AR). Participants in the CT condition showed more improvement on social anxiety measures in comparison to the EXP + AR condition with a large effect size (1.17). Clinically significant improvement in social anxiety symptoms was achieved for 86% of participants in CT, 45% of participants in EXP + AR, but 0% of participants in the control group.

Individual versus group treatment using cognitive therapy for social phobia was evaluated by Stangier, Heidenreich, Peitz, Lauterbach, and Clark (2003). Their study concluded that individual cognitive therapy was superior to group cognitive therapy as evidenced by 50% of the individual treatment patients and 13.6% of group treatment patients no longer meeting the criteria for social phobia at post-treatment. Stangier and colleagues proposed that the individual format may facilitate thorough assessment and modification of safety behaviors, attentional strategies, and dysfunctional assumptions as a possible explanation for the greater effectiveness of individual cognitive therapy.

Therefore, an intervention that emphasizes patient-specific problems in an individual therapy setting would the therapist, to note and address subtle safety behaviors, attentional strategies, and dysfunctional thoughts as they are observed. An effective treatment of social anxiety would focus around exposure treatment but contain psychoeducation on cognitive therapy and teach the client how to utilize cognitive restructuring.

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

#### **Social Development**

Luke is a 19-year-old Caucasian male that lives with his mid- to high socioeconomic status parents and 2 younger sisters (ages 17 & 15) in a midsize city in the Midwestern United States. He presented for treatment over the summer before he began his sophomore year of college. Luke's father traveled for work frequently while Luke was in high school, and his mother took on most parenting roles. Luke and his mother reported they disagree frequently about how to accomplish tasks and chores but have a strong relationship. Luke reported he was not close with his father and was reluctant to answer questions about their relationship. Luke and his mother reported he maintains good relationships with his younger sisters.

Luke has multiple support systems, including friends from high school and a few friends from college. Luke, however, does not enjoy being around some of his friends from high school, because he has observed them being harsh or mean to others and fears they would do or say the same things about him. Luke's mother reported that Luke has always been "perfectionistic and aims to please". His mother reported she is concerned with Luke making negative self-statements (e.g., I am awful). Luke expressed he has trouble connecting with other people and frequently experiences worry related to how people perceive him. His worries include: where to look, how to stand, what people want him to say, and always trying to say what the person wants to hear. Luke also reported experiencing worry about being the center of attention or receiving evaluative feedback, whether the feedback is good or bad.

### **Education and Work**

Luke attended a large high school in a midsized Midwestern city, where he earned mostly As and Bs. Luke and his mother reported he never had to study in high school. Luke's mom described him as "naturally bright." Luke attended a state university and failed 2 classes, then transferred to a similar size university the following semester where he earned all Bs (last semester). Luke is currently enrolled in a summer physics class at a local junior college and will return to the college he transferred to in the fall semester for his sophomore year as a full time engineering major. In addition to being a full-time student, Luke has been employed part-time at various manual labor jobs.

### **Psychiatric History**

Luke first sought treatment for depression and anxiety symptoms during his freshman year of high school. He has since seen 3-4 therapists for about three sessions each. Luke reported that his mom had wanted him to see those therapists, and he would tell therapists what they

wanted to hear so he could stop going to therapy. Following his first concussion, he sat out of basketball for a season and experienced his first episode of depression. In the summer of 2017, Luke was diagnosed with Attention Deficit Hyperactivity Disorder, predominantly inattentive presentation and prescribed Vyvanse (30 mg), but reported he only takes when he needs to focus (e.g., studying for an exam) because he does not like symptoms of depression he experiences after taking the medication.

### **Medical/Developmental History**

Mrs. Smith denied substance use during pregnancy and reported she had a healthy pregnancy with Luke. Mrs Smith denied any complications during the birthing process. Mrs. Smith reported Luke met his gross motor, fine motor, and language milestones appropriately. Luke reported he visits the doctor yearly for physicals. Luke reported he has had three concussions while playing basketball between 2012 and 2016. Luke and his mother reported he has experienced no other medical concerns.

### **Diagnostic Interviews**

Luke presented to a mid-size private practice outpatient anxiety clinic with “anxiety about making friends.” Luke was self-referred and asked his mom (Mrs. Smith) to join him on his first session. Prior to the diagnostic interview, Luke received the clinic’s standard set of measures via mail, filled them out and returned them. Luke was administered a general clinical interview, the Mini-International Neuropsychiatric Interview (MINI 7.0), and the social anxiety disorder module from the Anxiety Disorders Interview Schedule (ADIS).

**Mini International Neuropsychiatric Interview.** The Mini International Neuropsychiatric Interview (MINI-5; Sheehan, 2015) is a brief structured interview designed to assess the major psychiatric disorders in the DSM-5 and ICD-10. The MINI queries the DSM-5

diagnostic criteria for anxiety disorders, bipolar disorders, depressive disorders, obsessive-compulsive and related disorders, trauma- and stressor- related disorders, feeding and eating disorders, and substance-related and addictive disorders. The MINI-5 is composed of 17 diagnostic modules. At the beginning of each module, screener questions corresponding to the main criteria of the disorder are presented. At the end of each module, diagnostic box(es) permit the clinician to indicate whether DSM-5 criteria are met for each disorder. The MINI has concordance with the SCID-P diagnoses with a  $k$  of 0.51 for current social phobia and a  $k$  of .60 for lifetime social phobia (Sheehan et al. 1998). The MINI has strong inter-rater reliability for current social phobia ( $k=0.94$ ) and lifetime social phobia ( $k=0.88$ ). The MINI-5 has test/retest reliability of  $k=0.65$  for current social phobia to  $k=0.68$  for lifetime social phobia.

The client endorsed symptoms warranting diagnoses in two areas. Social anxiety disorder was evidenced by excessive anxiety about social scrutiny, fear of judgment by others, and fear that he will act in a way that shows his anxiety. He reported these situations always triggered anxiety, which was excessive or unreasonable, and he tried to avoid these situations when possible. Luke reported he has experienced these worries since middle school, when he had to sit out of basketball for a season (i.e. “I won’t be good when I play next season” or “my friends won’t want to be my friend after this season”).

The client endorsed symptoms for both current (onset of fall 2017) and past depressive episodes (8th grade). Symptoms included: depressed mood, anhedonia, difficulty sleeping, restlessness, low energy, guilt/feelings of worthlessness (e.g., “world is against him”), and inattention/indecision. The client reported these symptoms were impairing and distressing as evidenced by lack of motivation to interact with friends and to accomplish goals.

Luke reported panic symptoms including: accelerated heart rate, sweating, and fear of losing control. His panic symptoms always had a clear trigger, reached a peak in a matter of minutes, and dissipated in roughly 10 minutes. He reported experiencing some panic attacks last summer, and his most recent panic attack was triggered when he was unable to complete a computer assignment and had to turn it in late. Luke reported no worry or change in behavior related to future panic attacks. Luke's limited symptom attacks do not meet DSM-5 criteria for Panic Disorder or Panic Attack Specifier.

**Anxiety Disorders Interview Schedule.** The Anxiety Disorders Interview Schedule (ADIS-5; Brown & Barlow, 2014) module for social anxiety disorder queries 12 social situations. Therapist utilized those 12 social situations to gain a clear picture of the client's anxiety by having the client rate each situation on a 10-point Likert scale ranging from 1 (no anxiety) to 10 (most anxiety ever experienced). Client ranked the following situations high anxiety: Talking in front of a group/formal speaking (9), Being assertive: asking others to change their behavior (8), Being assertive: refusing unreasonable requests (8), moderate anxiety: Parties (7), Speaking with unfamiliar people (7), Talking to persons in authority (7), Initiating a conversation (7), Participating at meetings/classes (5), Dating situations (5), Maintaining a conversation (5), and low anxiety: Eating in public (0), Using public restrooms (0), and Writing in public (signing checks, filling out forms) (0).

### **Self-Report Measures**

Luke filled out the standard battery of measures prior to the diagnostic interview to aid in treatment planning and prior to termination session to assess treatment progress. Pre- and post-treatment scores on all self-report measures can be found in Table 1. Pre- and post-treatment hierarchy ratings can be found in Table 2.

### Adult General Measures

**Depression, Anxiety, and Stress Scale.** The Depression, Anxiety, and Stress Scale (DASS; S. H. Lovibond & P. F. Lovibond, 1995) is a self-report scale designed to measure the three related negative emotional states of depression, anxiety, and tension/stress. The DASS a 42-item scale containing 3 subscales (Depression, Anxiety, and Stress), 14 items pertaining to Depression (e.g., I couldn't seem to experience any positive feeling at all), Anxiety (e.g., I was aware of dryness of my mouth), Stress (e.g., I found myself getting upset by quite trivial things). Each item is rated on a 4-point Likert scale from 0 (did not apply to me at all) to 3 (applied to me very much, or most of the time). An individual's total score can be calculated by summing all items for each subscale. A high score indicates more severe distress. The depression subscale has cutoffs of 28+ (extremely severe), 21-27 (severe), 14-20 (Moderate), 10-13 (mild), 0-9 (normal). The anxiety subscale has cutoffs of 20+ (extremely severe), 15-19 (severe), 10-14 (moderate), 8-9 (mild), 0-7 (normal). The Stress subscale cutoff of 34+ (extremely severe), 26-33 (severe), 19-25 (moderate), 15-18 (mild), 0-14 (normal). The internal consistency (coefficient alpha) of the DASS is strong for each scale: Depression 0.91; Anxiety 0.84; Stress 0.90. The DASS has strong convergent validity; DASS Anxiety scale was highly correlated with the Beck Anxiety Inventory ( $r = .81$ ), while the DASS Depression scale and the Beck Depression Inventory were less correlated ( $r = .74$ ). Discriminate validity and test-retest reliability have not been thoroughly examined for the DASS. Luke's depression score of 34 indicated severe difficulty with a depressed emotional state. His anxiety score of 8 indicated a mild anxious emotional state. His stress score of 12 indicated a normal state of stress.

**Sheehan Disability Scale.** The Sheehan Disability Scale (SDS; Sheehan et al., 1996) assesses functional impairment across three domains: school/work, social life, and family/home

responsibilities. The SDS is comprised of three questions, 1 for each domain, scored from 0 (not at all) to 10 (very severely). Summing across items produce total score ranges from 0 (unimpaired) to 30 (highly impaired). Internal consistency, convergent/divergent validity, and test-retest reliability have not been examined for the SDS. At pretest, Luke's score of 16 total indicated moderate impairment at a broad level, with Luke's score of 9 on the social domain indicated high impairment in social settings.

**Satisfaction with Life Scale.** The Satisfaction with Life Scale (SWLS; Diener, Larsen, & Griffin, 1985) is a 5-item self-report scale designed to measure global cognitive judgments of one's life satisfaction. Each item (e.g., "In most ways my life is close to my ideal") is rated on a 7 point Likert scale from 1 (strongly disagree) to 7 (strongly agree). An individual's total score is calculated by summing all response items, producing a range from 5-35, with higher score reflecting greater life satisfaction. A high score (35-31; extremely satisfied) indicates satisfaction, a median score (20; neutral) indicates neither satisfaction nor dissatisfaction, and a low score (5-9; extremely dissatisfied) indicates dissatisfaction with one's life. The SWLS has strong internal consistency with a coefficient alpha of 0.85 and strong test-retest reliability at 1 month ( $r = .84$ ). Pavot and Diener (1993) reported the SWLS has good convergent validity with other measures of life satisfaction and shows discriminant validity from emotional well-being measures. At pretest, Luke's SWLS total score of 9 indicated extreme dissatisfaction with his life.

### **Social Anxiety Measures**

**Social Phobia Inventory.** The Social Phobia Inventory (SPIN; Connor et al., 2000) is a 17-item self-report scale designed to evaluate social fear (e.g., people in authority, parties, of being criticized), avoidance (e.g., talking to strangers, speaking to people, being the center of attention), and physiological discomfort (e.g., blushing, sweating, palpating, or shaking in front

of people). Each item is rated on a five-point Likert scale from 0 (not at all) to 4 (extremely). An individual's total score can be calculated by summing all items. A cutoff score of 19 distinguished between participants with and without social anxiety disorder with a diagnostic efficiency of 79% (Connor et al., 2000). Internal consistency for the SPIN total score across clinical and combined samples ranged from .82 to .95 (Connor et al. 2000; Antony, Coons, McCabe, Ashbaugh, & Swinson, 2005). Antony et al. (2005) found strong correlations between initial and pretreatment assessments, with 1 to 3 weeks between the two administrations ( $r = .86$ ,  $p < .001$ ). The SPIN has strong convergent and divergent validity. Other measures of social anxiety have been shown to be significantly associated with the SPIN total ( $r$ 's = .60 to .71) and subscale scores ( $r$ 's = .23 to .71), while measures of depression ( $r$ 's = .01 to .13), anxiety ( $r$ 's = .01 to .13), and stress ( $r$ 's = .03 to .19) yielded smaller correlations (Antony et al., 2005). With a 1-3 week gap the SPIN has strong test-retest reliability for the total score ( $r = .86$ ), Fear ( $r = .84$ ), Avoidance ( $r = .83$ ), and Physiological ( $r = .78$ ). Luke's total score of 38, at pretest, was clinically significant and consistent with a diagnosis of social anxiety disorder.

**Social Interaction Anxiety Scale.** The Social Interaction Anxiety Scale (SIAS; Mattick & Clark, 1998) is a self-report measure comprised of 20 items designed to measure fear in social interaction situations, ranging from individual to group conversations (e.g., I have difficulty making eye contact with others). 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). The total score is derived by summing the items after reversing items 5, 9, and 11, and can range from 0-80. Higher scores are indicative of more severe social interaction anxiety. A cutoff of 34 or higher has been found to accurately identify cases of social anxiety disorder (Heimberg, Muller, Holt, & Holt, 1992). This cutoff correctly classified 82% of individuals with social anxiety

disorder. The SIAS has strong reliability. Carleton et al. (2009) report a range for Cronbach's alpha of .89 to .93, suggesting high internal consistency. The SIAS has high test-retest reliability over 4 to 12 weeks with  $r$ 's ranging from .86 to .92 (Mattick & Clarke, 1998). Other measures of social anxiety have been shown to be significantly associated with the SIAS ( $r$ 's = .74-.66) while measures of general anxiety ( $r$ 's = .45-.58), depression ( $r = .47$ ), and locus of control ( $r = .30$ ) yielded smaller correlations (Mattick & Clarke, 1998).. Client's total score of 57 at pretest indicates clinically significant social interaction anxiety and is consistent with a diagnosis of social anxiety disorder.

**Social Phobia Scale.** The Social Phobia Scale (SPS; Mattick & Clark, 1998) is a self-report measure comprised of 20 items designed to gauge fear of observational and performance situations, such as being the center of attention or public speaking. 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). An individual's total score is derived by taking the sum of all items, and can range from 0-80. Higher scores are indicative of more severe anxiety. Heimberg et al. (1992) used a cutoff of 24 to classify individuals with and without social anxiety disorder, accurately identifying 73% of the social anxiety group. The SPS has strong reliability. Carleton et al. (2009) report an *alpha* of .93 for both undergraduate and clinical samples, suggesting high internal consistency. The SPS has high test-retest reliability over 4 to 12 weeks with  $r$ 's ranging from .66 to .93 (Heimberg et al., 1992). Other measures of social anxiety have been shown to be significantly associated with the SPS ( $r$ 's = .64-.75) while measures of general anxiety ( $r$ 's = .42-.57), depression ( $r = .54$ ), and locus of control ( $r$ 's = .31) yielded smaller correlations (Mattick & Clarke, 1998). Luke's total score of 28 at pretest indicates clinically significant fear of being observed by others; this score is consistent with a diagnosis of social anxiety disorder.

**Social Interactions Self-Statement Test.** The Social Interactions Self-Statement Test (SISST; Glass et al., 1982) is a 30-item self-report measure for cognitive assessment of social anxiety, designed to measure the frequency of 15 positive (e.g., I can usually talk to guys pretty well) and 15 negative (e.g., I hope I don't make a fool of myself) self-statements in heterosocial situations. The frequency of each item is rated on a five-point Likert scale from 1 (hardly ever) to 5 (very often). An individual's subscale scores can be calculated by adding the numerical responses for the subscales: positive thoughts (SISST-P; sum of items 2, 4, 6, 9, 10, 12-14, 17, 18, 24, 25, 27, 28, 30) and negative thoughts (SISST-N; sum of items 1, 3, 5, 7, 8, 11, 15, 16, 19-23, 26, 29). The SISST-P and SISST-N have a range of scores from 15-75. Subscales with high scores indicate that type of thought (i.e. positive/facilitative or negative/debilitative) occurs more frequently than low subscale scores. Internal consistency within student samples ranged from .85 to .89 for the SISST-P and .91 for the SISST-N (A. Osman, Markway, & J. Osman, 1992). Becker, Namour, Zayfert, and Hegel (2001) found that individuals with social anxiety score significantly higher on the negative scale ( $F(1,249) = 20.89, p < .0001$ ) and significantly lower on the positive scale ( $F(1,258) = 51.12, p < .0001$ ) when compared to individuals without social anxiety. Becker et al. (2001) compared the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988) and the Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979) with the SISST. The BAI was shown to have a small but significant correlation with the SISST-N (.17); the BDI was shown to have a significant correlation with both the SISST-N (.45) and the SISST-P (-.33). Test-retest reliability has not been examined for the SISST. Luke's SISST-P subscale score of 29 at pretest indicates infrequent positive self-statements. Luke's SISST-N subscale score of 51 at pretest indicates frequent negative self-statements.

**Brief Fear of Negative Evaluation Scale, Straightforward items.** The Brief Fear of Negative Evaluation Scale, version 2, (BFNE-II; Carleton, Collimore, McCabe, & Anthony, 2011) is an 8-item self-report instrument designed to measure the fear of being evaluated negatively by others, which is the core feature of social anxiety disorder (e.g., “When I am talking to someone, I worry about what they may be thinking about me.”). Each item is rated on a five-point Likert scale, ranging from 1 (Not at all characteristic of me) to 5 (Extremely characteristic of me). The total score is the sum of all items. The BFNE-II total score can range from 8 to 40. The BFNE-II has high internal consistency ( $\alpha = .95$ ). The BFNE-S has adequate convergent and divergent validity evidenced by significant correlation with other measures of Social Anxiety (SIAS,  $r = .46$ ; SPS,  $r = .40$ ) and the BDI ( $r = .31$ ), respectively. Test-retest reliability has been demonstrated to be acceptable with all  $r_s > .62$ , ranging from hours to months at retest. Luke’s total score of 38 at pretest indicates clinically significant fear of negative evaluation.

**Fear of Positive Evaluation Scale.** The Fear of Positive Evaluation Scale (FPES; Weeks, Heimberg, & Rodebaugh, 2007) is a 10 item self-report measure designed to assess fear of positive evaluation within different social hierarchy dynamics and in groups (e.g., I feel uneasy when I receive praise from authority figures). Each item is rated on a ten-point Likert scale, ranging from 0 (not at all true) to 9 (very true). An individual’s total score is the sum of all responses and can range from 0-90. The internal consistency of the FPES is strong, documented as an *alpha* of .80. The FPES demonstrated good 5-week test-retest reliability of .70. Weeks et al. (2008) reported that the FPES produced a weaker correlation with the discriminant measures of generalized anxiety (.34), worry (.33), and depression (.40); however, the FPES is more strongly related to the SIAS-S (.48). Luke’s total score of 46 at pretest is clinically significant.

For example, Luke endorsed a 7 on the ten-point Likert scale for “I generally feel uncomfortable when people give me compliments,” “I try to choose clothes that will give people little impression of what I like,” and “I feel uneasy when I receive praise from authority figures”.

**Fear and Avoidance Hierarchy.** A Fear and Avoidance Hierarchy is a list of situations in which the client experiences problematic social anxiety. The first step in developing a Fear and Avoidance Hierarchy is to brainstorm a list of potential situations including specific events (e.g., “attend high school reunion”) or general categories (e.g., “conversations with strangers). Next, the client and therapist considered which dimensions or constructs make the more general situations on the list anxiety-provoking. Utilizing the Subjective Units of Discomfort Scale (SUDS; Wolpe & Lazarus, 1967) ranging from 0 (no anxiety; not necessarily happy but calm and relaxed) to 10 (Worst anxiety the person has experienced or can imagine experiencing in a social situation), Luke rated the fear/anxiety each situation would provoke. Luke rated his behavioral avoidance for each situation on a similar scale from 0 (no avoidance at all) to 10 (completely avoids the situation). Finally, Luke rank ordered the situations from 1 to 10, where 1 was the situation with the highest SUDS. Hope (1993) describes understanding the dimensions that impact a client’s anxiety improves the therapist’s ability to gauge exposures to make them more or less difficult to achieve success in therapy (see Table 2). The hierarchy can also serve as an individualized measure of treatment outcome.

Table 1 *Self-Report Measures*

| <u>Measures</u>                       | <u>Pre-Treatment</u>      | <u>Post-Treatment</u> |
|---------------------------------------|---------------------------|-----------------------|
| <b>DASS</b>                           |                           |                       |
| Depression                            | 34, Severe                | 2, Normal             |
| Anxiety                               | 8, Mild                   | 2, Normal             |
| Stress                                | 12, Normal                | 8, Normal             |
| <b>SDS</b>                            |                           |                       |
| Work                                  | 3                         | 1                     |
| Social                                | 9                         | 2                     |
| Home                                  | 4                         | 0                     |
| Total                                 | 16, Clinical              | 3, non-clinical       |
| <b>SWLS</b>                           | 9, Extremely dissatisfied | 20, Normal            |
| <b><u>Social Anxiety Measures</u></b> |                           |                       |
| <b>SPIN</b>                           | 38                        | 19                    |
| <b>SIAS</b>                           | 57                        | 27                    |
| <b>SPS</b>                            | 28                        | 7                     |
| <b>BFNES</b>                          | 38                        | 18                    |
| <b>FPES</b>                           | 46                        | 26                    |
| <b>SISST</b>                          |                           |                       |
| Positive Thoughts                     | 29                        | 42                    |
| Negative Thoughts                     | 51                        | 28                    |

Note: Client filled out the self-report measures at the start and end of treatment. DASS =

Depression, Anxiety, and Stress Scale. SDS = Sheehan Disability Scale. SWLS = Satisfaction

with Life Scale. SPIN = Social Phobia Inventory. SIAS = Social Interaction Anxiety Scale. SPS = Social Phobia Scale. BFNES = Brief Fear of Negative Evaluation Scale. FPES = Fear of Positive Evaluation Scale. SISST = Social Interaction Self-Statement Test.

Table 2

*Fear Hierarchy*

| Situation   | SUDS          |                |
|---|---------------|----------------|
|   | Pre-treatment | Post-treatment |
| Starting a conversation with a stranger   | 6             | 1              |
| Introducing yourself to other therapists in this office                               | 4             | 0              |
| Answering questions in class  | 4             | 0              |
| Answering a question incorrectly in class   | 6             | 1              |
| Asking a "silly" question in class  | 5             | 0              |
| If you get a question incorrectly on homework, only do it once. (Not the three times) | 5             | 3              |
| Only working 4 minutes on a difficult question  | 5             | 3              |
| Sharing opinion in class if asked   | 5             | 0              |
| Sharing opinion in class if NOT asked   | 9             | 2              |
| Pro/Con: listed questions having to choose with heather                               | 7             | 0              |
| Pro/Con: listed questions having to choose with different therapist                   | 8             | 0              |
| Either or questions, disagreeing with heather (surface level questions)               | 3             | 0              |
| Disagree with mom about something trivial   | 2             | 1              |
| Smile at a stranger   | 6             | 0              |
| Small talk with cashier   | 4             | 0              |
| Ask easy question like location of milk at grocery store                              | 2             | 0              |
| Asking to cut someone in line   | 9             | 1              |
| Singing the ABC's in front of heather   | 7             | 0              |
| Small talk with a staff member  | 7             | 0              |
| Giving heather criticism about office decor/outfit                                    | 7             | 0              |

Note: Client was prompted with each of the social situations and gave his SUDS rating at the start of treatment and at the end of treatment.

**Diagnosis:**

300.23 (F40.11) Social Anxiety Disorder (Social Phobia), generalized

296.32 (F.33.1) Major Depressive Disorder, Recurrent, Moderate

**Differential Diagnosis:**

**300.01 (F41.0) Panic Disorder/ Panic Attack Specifier.** Luke reported experiencing “panic attacks”, however he only endorsed experiencing 3 of the 12 symptoms of a panic attack (4 of the 12 symptoms are required for diagnosis). Luke’s panic attacks do not meet criteria A for panic disorder because the panic attacks he describes are limited symptom panic attacks, have a clear trigger, and are not unexpected. Luke also does not meet criteria B for panic disorder as he has not experienced persistent concern about future panic attacks nor has he experienced a maladaptive behavior change in relation to these attacks. These attacks do not appear to be attributable to physiological effects of a substance or medical condition. These attacks are not better explained by another mental disorder.

**300.02 (F41.1) Generalized Anxiety Disorder.** Luke did report worry in relation to school performance and social interactions. Luke described his worry about school performance was focused on the teacher’s and other students’ opinion of his performance rather than worry about the work itself. Luke does not meet DSM-V criteria for generalized anxiety disorder, as his worry is only present when he believes his behavior or performance is being evaluated.

**301.4 (F60.5) Obsessive-Compulsive Personality Disorder.** Luke described an academic pattern of over-preparation and perfectionism. A period of intense work is followed by burnout, leading to avoidance, which results in a failure to complete tasks. This perfectionism that interferes with task completion is the only symptom Luke experiences, of the 8 symptoms of

Obsessive-Compulsive Personality Disorder. Luke attributes his desire for perfection to his fear of others' negative evaluation.

### **Case Conceptualization**

#### **Etiology**

Luke's mother reported experiencing difficulties with anxiety but that she never sought treatment. Luke may have inherited a biological predisposition to anxiety from his mother. This genetic predisposition may be expressed as being emotionally reactive to environmental changes. Barlow (2000) discusses the consensus that anxiety and related emotional disorders like depression have a common genetic basis; environmental factors account for the specific manifestation of the disorders. No rigorous evidence suggests there is a single gene specifically linked to anxiety (Barlow, 2000). Rather weak contributions from different genes seem to contribute to a generalized biological vulnerability to anxiety, suggesting a polygenic model of conceptualizing the biological predisposition.

Luke's mother reported Luke experiencing anxiety about his performance going back to elementary school. Luke's mother reported she always wanted the "best" for Luke, including high grades, strong friendships, competitive athletic ability, and good physical health. Luke learned that by attempting to be the "best version" of himself, he would need to constant improvement, which put him in a perpetual state of inadequacy as he strove for perfection. Additionally, Luke's father was frequently away for business when Luke was a child. When his father was present, he did not interact with the children frequently, which may have contributed to Luke's core belief of not being good enough. These early learning experiences may have fostered an external locus of control (Barlow, 2000).

Luke had early learning experiences that taught him that other people can be dangerous. Luke first noticed his anxiety symptoms and worry about his peer's evaluation of his performance when he got a concussion in the 8<sup>th</sup> grade. Following his concussion, Luke had to sit out of basketball for a year. Luke reported that he felt like he let his team down; he thought he wouldn't fit in or be at the same skill level when he could return to basketball the following year. Additionally, in 6<sup>th</sup>-12<sup>th</sup> grade, Luke had a mixed friend group including some people who only spoke nicely of others and other people who offered a lot of negative judgements towards others. Luke learned through these experiences that other people can be threatening and judgmental and, therefore, should be feared.

### **Maintenance**

Starting around 8<sup>th</sup> grade, Luke began acting cautiously in social situations. Luke engaged in safety behaviors to blend in with his peers and avoid drawing attention to himself. Luke was cautious to dress in neutral colors and avoid engaging in behaviors that would make him stand out (e.g., smiling).

When Luke began college, he struggled to engage in social interactions his freshman year of college. He used behavioral avoidance to cope with his anxiety and stayed in his dorm room instead of interacting with new people his first couple weeks at school. Avoiding social interactions reduced Luke's anxiety, negatively reinforcing avoidance and increasing the likelihood that he would avoid social interactions again in the future. His avoidance increased his fear of social situations.

At the end of his first-semester, Luke transferred to a different university where he already had some social support, with the hope of a fresh start. Luke's anxiety in social situations was still present at the new university (second semester, freshman year). He experienced an urge

to stay in his dorm room when invited to spend time with peers and avoided engaging in behaviors or wearing clothing that could make him stand out.

Additionally, Luke's social anxiety negatively impacted his academic performance. Luke set high standards for himself most of his life and meeting these high standards would help him to avoid the negative evaluation of others. Luke reported giving "100% effort" on his school work for the first half of each semester, leading to a "burn out," evidenced by missing a class or skipping a homework assignment. Luke worried that the negative evaluation he would receive from missing a class/assignment would be too much to handle, so he avoided class. Avoiding class reduced anxiety in the short term, negatively reinforcing not attending class. He had negative cognitions relating to missing class and getting bad grades, which also increased his anxiety for the following class period and encouraged avoidance.

### **Treatment**

Prior to the first session, client completed and mailed in the pre-treatment assessment questionnaire measures. The first session began with therapist explaining and client providing informed consent to treatment. Luke then received psychoeducation on the three components of anxiety (i.e., thoughts, physiological responses, and behavior), how anxiety develops and perpetuates (i.e., genetics, cognitions, safety behaviors, and avoidance), and how exposure works to break the cycle of anxiety by entering feared situations and learning the situation is not harmful.

Luke actively listened and participated during the psychoeducation pieces of treatment, evidenced by providing examples for how the model has applied to his life. Luke provided an example of when he moved into the dorms at his first college and his new roommates invited him to join them. Luke had negative automatic thoughts (e.g., "I am weird;" "They won't want to

be my friend”), then he noticed his physiological response (e.g., sweaty palms, heart racing, tight stomach), and finally he engaged in an avoidance behavior (e.g., telling his roommates he cannot join them). Luke related to the idea that each component interacted with the other components, resulting in a spiral of anxiety.

Therapist introduced the “Bring It On” framework that stems from Craske, Kircanski, Zelikowsky, Mystkowski, Chowdhury, and Baker’s (2008) inhibitory learning model. This framework posits that exposure therapy is most effective when the exposures are encountered across time and varying contexts. The “Bring It On” framework encouraged Luke to engage in natural exposures that appear in his daily life. Luke was invested in actively finding anxiety provoking situations to challenge his anxiety, evidenced by coming to session with reports of his “Bring It On” exposures (e.g., wearing a silly hat around friends).

Luke also engaged in social mishap exposures that target his cognitions related to exaggerated social costs. These exposures allowed him to confront and experience the actual consequences of social mishaps without using any avoidance strategies, such as staying quiet, avoiding eye contact, or avoiding the situation all together. Fang et al. (2013) discusses that social mishap exposure practice is associated with significant improvement in treatment gains. Luke engaged in social mishap exposures, in session as well as out of session. The in-session exposures were introduced at the start of the session (e.g., “today you will pet a stuffed animal and wave at passing cars, then you will go into local businesses and ask questions you already know the answer to”). Luke shared his feared outcome (e.g., “someone I know might see me and think I am weird”) and the exposures began (e.g., Luke stood on a corner petting a stuffed animal, waving, and got a lot of positive reactions. Luke went into businesses and asked questions). To wrap up the session, we debriefed by discussing the differences in the feared

outcome and the real outcome (e.g., people were pleasant). Luke was able to complete his most challenging items on his fear and avoidance hierarchy by the end of treatment.

The final aspect of Luke's treatment was to counter his perfectionistic tendencies through development of realistic standards for evaluation. Therapist worked through the *Perfectionism in Perspective* (Fursland, Raykos, & Steele, 2009) workbook to develop a plan for managing perfectionistic standards of evaluation throughout the next semester.

During the termination session, client and therapist reflected on Luke's achievements through comparing scores from pre and post treatment measures on the SPIN, SIAS, SPS, SISST, BFNE, and the FPES. Luke scored in the average range on every social anxiety measure. Following treatment, he also reported his daily life at work and his social life have improved since he began treatment. Luke really "bought on" the treatment and challenged himself daily to engage in exposures on his own time. We encouraged Luke to maintain this mindset following treatment termination to maintain his gains. Luke scheduled booster session appointment with another therapist in the clinic to touch base on perfectionism two months following his termination session.

### **Transcript: Self Evaluation**

#### **What I Did Well**

The transcribed session provided an opportunity for me to read a session and highlight areas where I excelled during the exposure session. One of my strengths throughout the transcribed session was praising the client when he engaged in good therapeutic work (specifically challenging himself outside of session). I also did well spending most of the session time engaged in exposures with the client and in sitting with the discomfort in the room during the exposures (e.g., sitting in silence and engaging in mindful eye contact). Within the

transcribed session I reinforced psychoeducation previously discussed (i.e., the reason behind out of session exposures and the “bring it on” framework). The exposures I had the client engage in during the transcribed session targeted a variety of his fears and included a new individual, which maximizes the effects of the exposure, as noted in the inhibitory learning model. This session specifically targeted sitting with silence, which aligns with a fear of people thinking he is weird if he doesn’t talk during haircuts. Utilizing the social mishap theory, I structured these exposures to encourage client to be silent and allow the possibility for the client to be negatively evaluated.

### **Needs Improvement**

The session provided an opportunity for me to read a session and highlight areas of weakness in my therapeutic work and how I could improve upon them and grow as a clinician. One major area that could be improved is the beginning of the session. Luke was describing that the thought of failure increases his anxiety, and the anxiety tells him he needs to study. The exposure to this situation would be to sit with the thought of failure rather than to avoid studying. During the in-session exposures I could have taken more frequent ratings of Luke’s SUDS (before, during, and after each separate exposure) to discuss with Luke, post-exposure, the patterns of how his fear changed throughout the duration of the exposure. The final area I believe I could have improved in the transcribed session would be, to concretize the change with Luke at the end of the session. I could have asked Luke to describe what he learned that day, which would have allowed him to fully process the exposure in session with me, allowing him to take more with him for his out of session exposures.

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## Appendix A

## Depression, Anxiety, and Stress Scale

| <b>DASS</b>  |  | <i>Name:</i> |   |   |   | <i>Date:</i> |
|--|--|--------------|---|---|---|--------------|
| <p>Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you <i>over the past week</i>. There are no right or wrong answers. Do not spend too much time on any statement.</p> <p><i>The rating scale is as follows:</i></p> <p>0 Did not apply to me at all<br/>           1 Applied to me to some degree, or some of the time<br/>           2 Applied to me to a considerable degree, or a good part of time<br/>           3 Applied to me very much, or most of the time</p> |  |              |   |   |   |              |
| 1  | I found myself getting upset by quite trivial things   | 0            | 1 | 2 | 3 |              |
| 2  | I was aware of dryness of my mouth   | 0            | 1 | 2 | 3 |              |
| 3  | I couldn't seem to experience any positive feeling at all  | 0            | 1 | 2 | 3 |              |
| 4  | I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion) | 0            | 1 | 2 | 3 |              |
| 5  | I just couldn't seem to get going  | 0            | 1 | 2 | 3 |              |
| 6  | I tended to over-react to situations   | 0            | 1 | 2 | 3 |              |
| 7  | I had a feeling of shakiness (eg, legs going to give way)  | 0            | 1 | 2 | 3 |              |
| 8  | I found it difficult to relax  | 0            | 1 | 2 | 3 |              |
| 9  | I found myself in situations that made me so anxious I was most relieved when they ended                                 | 0            | 1 | 2 | 3 |              |
| 10   | I felt that I had nothing to look forward to   | 0            | 1 | 2 | 3 |              |
| 11   | I found myself getting upset rather easily   | 0            | 1 | 2 | 3 |              |
| 12   | I felt that I was using a lot of nervous energy  | 0            | 1 | 2 | 3 |              |
| 13   | I felt sad and depressed   | 0            | 1 | 2 | 3 |              |
| 14   | I found myself getting impatient when I was delayed in any way (eg, elevators, traffic lights, being kept waiting)       | 0            | 1 | 2 | 3 |              |
| 15   | I had a feeling of faintness   | 0            | 1 | 2 | 3 |              |
| 16   | I felt that I had lost interest in just about everything   | 0            | 1 | 2 | 3 |              |
| 17   | I felt I wasn't worth much as a person   | 0            | 1 | 2 | 3 |              |
| 18   | I felt that I was rather touchy  | 0            | 1 | 2 | 3 |              |
| 19   | I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion                       | 0            | 1 | 2 | 3 |              |
| 20   | I felt scared without any good reason  | 0            | 1 | 2 | 3 |              |
| 21   | I felt that life wasn't worthwhile   | 0            | 1 | 2 | 3 |              |

| <i>Reminder of rating scale:</i> |  |   |   |     |
|----------------------------------|--|---|---|-----|
| 0                                | Did not apply to me at all   |   |   |     |
| 1                                | Applied to me to some degree, or some of the time  |   |   |     |
| 2                                | Applied to me to a considerable degree, or a good part of time   |   |   |     |
| 3                                | Applied to me very much, or most of the time   |   |   |     |
| 22                               | I found it hard to wind down   | 0 | 1 | 2 3 |
| 23                               | I had difficulty in swallowing   | 0 | 1 | 2 3 |
| 24                               | I couldn't seem to get any enjoyment out of the things I did   | 0 | 1 | 2 3 |
| 25                               | I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat) | 0 | 1 | 2 3 |
| 26                               | I felt down-hearted and blue   | 0 | 1 | 2 3 |
| 27                               | I found that I was very irritable  | 0 | 1 | 2 3 |
| 28                               | I felt I was close to panic  | 0 | 1 | 2 3 |
| 29                               | I found it hard to calm down after something upset me  | 0 | 1 | 2 3 |
| 30                               | I feared that I would be "thrown" by some trivial but unfamiliar task  | 0 | 1 | 2 3 |
| 31                               | I was unable to become enthusiastic about anything   | 0 | 1 | 2 3 |
| 32                               | I found it difficult to tolerate interruptions to what I was doing   | 0 | 1 | 2 3 |
| 33                               | I was in a state of nervous tension  | 0 | 1 | 2 3 |
| 34                               | I felt I was pretty worthless  | 0 | 1 | 2 3 |
| 35                               | I was intolerant of anything that kept me from getting on with what I was doing  | 0 | 1 | 2 3 |
| 36                               | I felt terrified   | 0 | 1 | 2 3 |
| 37                               | I could see nothing in the future to be hopeful about  | 0 | 1 | 2 3 |
| 38                               | I felt that life was meaningless   | 0 | 1 | 2 3 |
| 39                               | I found myself getting agitated  | 0 | 1 | 2 3 |
| 40                               | I was worried about situations in which I might panic and make a fool of myself  | 0 | 1 | 2 3 |
| 41                               | I experienced trembling (eg, in the hands)   | 0 | 1 | 2 3 |
| 42                               | I found it difficult to work up the initiative to do things  | 0 | 1 | 2 3 |

**Appendix B**

**Sheehan Disability Scale**

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

### Satisfaction With Life Scale

Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

- 7 - Strongly agree
- 6 - Agree
- 5 - Slightly agree
- 4 - Neither agree nor disagree
- 3 - Slightly disagree
- 2 - Disagree
- 1 - Strongly disagree

\_\_\_\_\_ In most ways my life is close to my ideal.

\_\_\_\_\_ The conditions of my life are excellent.

\_\_\_\_\_ I am satisfied with my life.

\_\_\_\_\_ So far I have gotten the important things I want in life.

\_\_\_\_\_ If I could live my life over, I would change almost nothing.

- 31 - 35 Extremely satisfied
- 26 - 30 Satisfied
- 21 - 25 Slightly satisfied
- 20     Neutral
- 15 - 19 Slightly dissatisfied
- 10 - 14 Dissatisfied
- 5 - 9   Extremely dissatisfied

## Appendix D

### Social Phobia Inventory

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 E

### Social Interaction Anxiety Scale

**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 Scale

#### SPS

For each question, please fill in the blank with a number to indicate the degree to which you feel the statement is characteristic or true of 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

- 0  1. I become anxious if I have to write in front of other people.
- 0  2. I become self-conscious when using public toilets.
- 0  3. I can suddenly become aware of my own voice and of others listening to me.
- 0  4. I get nervous that people are staring at me as I walk down the street.
- 0  5. I fear I may blush when I am with others.
- 0  6. I feel self-conscious if I have to enter a room where others are already seated.
- 0  7. I worry about shaking or trembling when I'm watched by other people.
- 0  8. I would get tense if I had to sit facing other people on a bus or a train.
- 0  9. I get panicky that others might see me faint or be sick or ill.
- 0  10. I would find it difficult to drink something if in a group of people.
- 0  11. It would make me feel self-conscious to eat in front of a stranger at a restaurant.
- 0  12. I am worried people will think my behavior odd.
- 0  13. I would get tense if I had to carry a tray across a crowded cafeteria.
- 0  14. I worry I'll lose control of myself in front of other people.
- 0  15. I worry I might do something to attract the attention of other people.
- 0  16. When in an elevator, I am tense if people look at me.
- 0  17. I can feel conspicuous standing in a line.
- 0  18. I can get tense when I speak in front of other people.
- 0  19. I worry my head will shake or nod in front of others.
- 0  20. I feel awkward and tense if I know people are watching me.

**Appendix G**

## Brief Fear of Negative Evaluation Scale

Read each of the following statements carefully and indicate how characteristic it is of you according to the following scale:

- 1 = Not at all characteristic of me
- 2 = Slightly characteristic of me
- 3 = Moderately characteristic of me
- 4 = Very characteristic of me
- 5 = Extremely characteristic of me

- \_\_\_\_\_ 1. I worry about what other people will think of me even when I know it doesn't make any difference.
- \_\_\_\_\_ 2. I am unconcerned even if I know people are forming an unfavorable impression of me.
- \_\_\_\_\_ 3. I am frequently afraid of other people noticing my shortcomings.
- \_\_\_\_\_ 4. I rarely worry about what kind of impression I am making on someone.
- \_\_\_\_\_ 5. I am afraid others will not approve of me.
- \_\_\_\_\_ 6. I am afraid that people will find fault with me.
- \_\_\_\_\_ 7. Other people's opinions of me do not bother me.
- \_\_\_\_\_ 8. When I am talking to someone, I worry about what they may be thinking about me.
- \_\_\_\_\_ 9. I am usually worried about what kind of impression I make.
- \_\_\_\_\_ 10. If I know someone is judging me, it has little effect on me.
- \_\_\_\_\_ 11. Sometimes I think I am too concerned with what other people think of me.
- \_\_\_\_\_ 12. I often worry that I will say or do the wrong things.





## Appendix I

## Social Interaction Self-Statement Test

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

## SISST

Directions

It is obvious that people think a variety of things when they are involved in different social situations.

Below is a list of things which you may have thought to yourself at some time before, during, and after the conversation in which you were just engaged. Read each item and decide how frequently you may have been thinking a similar thought before, during, and after the conversation. Utilize the following scale to indicate the nature of your thoughts. Put the appropriate number in the space to the left of each item.

| 1               | 2               | 3               | 4               | 5               |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| hardly ever     | rarely          | sometimes       | often           | very often      |
| had the thought | had the thought | had the thought | had the thought | had the thought |

Please answer as honestly as possible.

- \_\_\_ 1. When I can't think of anything to say I can feel myself getting very anxious.
- \_\_\_ 2. I can usually talk to guys pretty well.
- \_\_\_ 3. I hope I don't make a fool of myself.
- \_\_\_ 4. I'm beginning to feel more at ease.
- \_\_\_ 5. I'm really afraid of what he'll think of me.
- \_\_\_ 6. No worries, no fears, no anxieties.
- \_\_\_ 7. I'm scared to death.
- \_\_\_ 8. He probably won't be interested in me.
- \_\_\_ 9. Maybe I can put him at ease by starting things going.
- \_\_\_ 10. Instead of worrying I can figure out how best to get to know him.
- \_\_\_ 11. I'm not too comfortable meeting guys so things are bound to go wrong.
- \_\_\_ 12. What the heck, the worst that can happen is that he won't go for me.
- \_\_\_ 13. He may want to talk to me as much as I want to talk to him.
- \_\_\_ 14. This will be a good opportunity.
- \_\_\_ 15. If I blow this conversation, I'll really lose my confidence.

- \_\_\_ 16. What I say will probably sound stupid.
- \_\_\_ 17. What do I have to lose? It's worth a try
- \_\_\_ 18. This is an awkward situation but I can handle it.
- \_\_\_ 19. Wow - I don't want to do this.
- \_\_\_ 20. It would crush me if he didn't respond to me.
- \_\_\_ 21. I've just got to make a good impression on him or I'll feel terrible.
- \_\_\_ 22. You're such an inhibited idiot.
- \_\_\_ 23. I'll probably "bomb out" anyway.
- \_\_\_ 24. I can handle anything.
- \_\_\_ 25. Even if things don't go well it's no catastrophe.
- \_\_\_ 26. I feel awkward and dumb; he's bound to notice.
- \_\_\_ 27. We probably have a lot in common.
- \_\_\_ 28. Maybe we'll hit it off real well.
- \_\_\_ 29. I wish I could leave and avoid the whole situation.
- \_\_\_ 30. Ah! Throw caution to the wind.

## Appendix J

### Session Transcript

T: What has been going on that you would like to discuss before we begin the exposure?

C: Umm nothing too much. My physics class has been getting getting kind of stressful. It's getting a lot harder. It kind of gives me anxiety to think about it a lot but, I just kind of work hard for it. It hasn't brought up too many issues yet.

T: So what are your anxious thoughts about your class?

C: Just that like, what if I don't. I need to get a C in it to get credit for it. Right now I am at a high C. My grade has just been dropping so I have just been worried about what a waste of a summer if I do get a D or what ever. I always do this at the end of the semester. Worry a lot about, but really I shouldn't be worried. There is only two weeks left and not a lot of assignments. I will probably be at a high C by the end of the semester.

T: What is the anxiety telling you to do?

C: Just that I should be studying harder. I already study a lot for it, and it is a pretty hard class.

T: So, your anxious thoughts are that this is going to be a waste of the summer and you will fail the class.

C: Yeah, I'll have to take the class again. Stuff like that.

T: And that is telling you that you should be studying harder. Your coping thought is that we have two weeks left, everything will be fine, I am going to pass it.

*\*\* Therapist has briefly checked in with how client has used cognitive restructuring with relation to his class and within the context of the "Bring It On" framework \*\**

*++ Therapist could have spent more time allowing client to discuss how the cognitive restructuring changed his ability to function in the classroom ++*

C: Yeah, mmhmm.

T: How have you been doing talking in class? Have you been raising your hand?

C: I mean it's been probably about the same. I don't talk the most in class, but I do ask questions occasionally.

T: Are these questions you already know the answer to?

C: No, I usually ask questions. But it's not like me. If I have a question, I usually move past it.

T: Are you still having anxiety about asking questions in class?

C: Not as much. If I do have a question, I feel more comfortable asking it.

T: Great. And even when you do have anxiety about asking a question, you are able to do the opposite and go ahead and ask?

C: Yeah.

T: That is awesome. Anything else we need to hit before we go ahead and start the exposures?

*\*\* Therapist was discussing client's engagement in exposures outside of session. This aids in the generalizability of his treatment as previously discussed with relation to the inhibitory learning model. Therapist maintained agenda. \*\**

C: No, I think we are good.

T: Alright, I am going to go ahead and outline the exposures we will do today. First, we will start with exposures we did last time. Then, we will do different ones with another therapist in the office.

So for starters we will do more either/or questions. Last time, you would offer a reason why you picked one answer over another. Is it more anxiety provoking if you aren't allowed to give a reason why?

C: I think it probably depends. But yeah, maybe.

T: We will try these ones without giving a reason why. What is your number now?

C: 3.

T: pool party or arcade party?

C: Pool party.

T: Football or basketball?

C: Basketball.

T: Fireman or police man?

C: Fireman.

T: Tattoos or piercings?

C: Tattoos.

T: Smoke tobacco or chew tobacco?

C: Smoke.

T: increase taxes or cut funding?

C: Cut funding.

T: Black lives matter or all lives matter?

C: All lives matter.

T: What is your number?

C: 4.

T: Gay or straight?

C: Straight.

T: Conceal carry or open carry?

C: Conceal carry.

T: Abortion or adoption?

C: Adoption.

T: Immigration control or drug control?

C: Drug control.

T: Male or female president?

C: Male.

T: Death sentence or life in prison?

C: Life in prison.

T: Gang violence or terrorist attack?

C: Gang violence.

T: Armed robbery or kidnapping?

C: Armed robbery.

T: Mass bombing or mass shooting?

C: Mass bombing.

T: What is your SUDS now?

C: 5.

T: Okay, was that more difficult for the ones you were not allowed to give a reason for?

C: Yeah, for some of them probably.

*\*\* In line with the desirable difficulties piece of Craske's inhibitory learning model of exposure therapy therapist checked in, to make sure client was doing the harder version of the exposures considering his SUDS were only at a 5 at the end of the exposure\*\**

*++ Therapist frequently referred to SUDS as "your number" and could have asked client for SUDS more frequently. ++*

T: Alright, now we are going to sing the ABC's with eye contact.

C: ABCDEFHJIGKLMNOPQRSTUVWXYZ, now I know my ABC's, next time wont you sing with me?

T: What is your SUDS?

C: 3.

T: Now we will do it one more time.

C: ABCDEFHJIGKLMNOPQRSTUVWXYZ, now I know my ABC's, next time wont you sing with me?

T:What is your number now?

C: 3.

T: Okay. Have you ever heard of mindful eye contact?

C: No.

T: Mindful eye contact is where you make eye contact with someone for a specific amount of time, then you don't say anything or do anything you just make eye contact. We will do that for 1 minute. What is your number?

C: I think, 5.

T: Okay, go.

*[1 minute of silence and mindful eye contact]*

T: What is your number now?

C: 4.

T: What were some of your thoughts for that one?

C: When should I blink? I don't know, Should I smile or not?

T: Why was smiling something you were thinking about?

C: I don't know, I just kind of. I dunno, I don't want to look mad or sad.

*++ Although therapist was attempting to move quickly through the exposures to keep the client's anxiety elevated throughout exposures, therapist could have processed this further to reveal what client fears would happen if he were to look mad or sad ++*

T: Alright, the last thing we will do before we bring in Luke. We will simulate the hair dresser scenario where we will be mostly in silence for 5 minutes. You can bring up small talk if you would like. Okay, I am setting my timer here. What is your suds?

C: 3.

*[2.5 minutes of silence during the exposure]*

T: What is your number?

C: Like a 2.

*[2.5 minutes of silence during the exposure]*

T: What is your number now?

C: 1.

T: What thoughts did you have during the silence?

C: Probably just, should I say something.

T: And what did anxiety tell you to do?

C: That I should, so then I didn't.

T: Great! So anxiety was telling you one thing, and you did the opposite. So great!

*\*\* Therapist concretized and reinforced the change. \*\**

C: Mmhmm.

T: Alright, so now I will bring Luke in, then we will start off with you introducing yourself and, since you mentioned smiling earlier, we will have you smile during your introduction. Then we

will do criticisms. You will give Luke two criticisms about his appearance, then we will do ABC's, then mindful eye contact. Ready?

C: Yeah.

T: Alright, what is your number right now?

C: Probably a 6 or 7.

T: Okay, I will go grab him and I will be right back.

*[Therapist leaves the room]*

*[Therapist enters the room with Luke]*

T: So we will go ahead and do the introduction.

C: I'm Luke.

L: I'm also Luke.

C: Umm, I'll go. I am a computer science major at \*university\*. I am a freshman, going into my sophomore year next fall, and I like basketball.

L: Cool, did you watch the world cup this last weekend?

C: Yes.

L: Did you have a favorite team you were rooting for?

C: Yeah, I actually lived in Croatia for two years, so I was rooting for Croatia.

L: It was a good game.

C: Uhh huh, yeah.

T: Very good. So now, Luke [client] would you give Luke two criticisms about his appearance? Do you want to stand up and give us a twirl?

L: Yeah, well put together today compared to other days.

C: Well I don't like your shirt, it is pink. Um. And uh your pants are a little too short.

T: Okay, what is your number?

C: 4.

T: Okay now we will sing the ABC's.

C: ABCDEFHJIGKLMNOPQRSTUVWXYZ, now I know my ABC's, next time wont you sing with me?

T: What is your number?

C: 5.

T: Okay, start again.

C: ABCDEFHJIGKLMNOPQRSTUVWXYZ, now I know my ABC's, next time wont you sing with me?

T: Lets do it one more time.

C: ABCDEFHJIGKLMNOPQRSTUVWXYZ, now I know my ABC's, next time wont you sing with me?

T: What is your number now?

C: Still 5.

T: Alright, now we will do one minute of mindful eye contact. So, Luke do you want to explain to Luke what mindful eye contact is?

C: It's kind of like a staring contest. Just a minute of eye contact.

L: Okay

T: Okay, lets start.

*[1 minute of silence during mindful eye contact]*

T: Okay, that is time. Thank you very much Luke for your time. I appreciate it.

*[Luke exited the room]*

T: Alright, what is your number now?

C: 4.

T: What were your thoughts going through different ones of those?

C: I don't know, it was weird since it was someone I don't really know. The introduction was fine, um, I kind of just tried to tell myself he has probably done this with a lot of different people. It's not weird or anything.

T: And did that help?

C: Yeah, it kind of helped.

T: Okay, so just like in the bring it on framework, when anxiety is telling you one thing and you want to just agree with it and let it go. That is the rationalizing piece of that. Instead of anxiety telling you the sky is purple, that was anxiety telling you the sky was blue. Did that make you less anxious thinking that he has done this with other people?

C: Yeah.

*\*\* Therapist continued to link how our thoughts connect to how anxious we get in different situations \*\**

*++ Therapist could have continued to process this to ensure client was not using subtle avoidance by pretending Luke is a mental health professional, which makes the treatment less generalizable ++*

T: So you said the introduction was fine and didn't cause you much anxiety. Tell me about the criticism.

C: It was probably the worst one of all of them, just because I have never met him before. My thoughts are just, He probably doesn't feel good to just be criticized by someone he just met.

T: Yeah, um, I thought you did great. Your criticisms were clear. With the shirt you said you didn't like it, it is pink. I thought they were good criticisms that you were not trying to sugar coat them. You were really doing the opposite of what anxiety was telling you to do, and that is great! How about the ABC's?

C: Yeah, I just feel like I have done it with you guys and it has gotten easier. So doing it with someone I have never met was just a little bit easier than it would have been before.

T: Yeah. So that is the point of doing all these exposures, right? So we do all these weird things in session and when you go into your regular life those things won't be as weird. Like making eye contact isn't as weird.

C: Yeah.

T: And smiling for no reason isn't something you wonder "should I do this, should I not do this?" So that is exactly what we are going for. Doing things that seem awkward to a point where they don't seem awkward any more, and they aren't causing anxiety. How about the mindful eye contact?

*\*\* Therapist continued to incorporate the rationale for exposure therapy into post-exposure processing to concretize the difference from pre-treatment to current level of functioning, this also aids in choosing future exposures to challenge client \*\**

C: That wasn't too bad, I don't know if I really had any thoughts, I just kind of didn't think about it.

T: Awesome, just like a staring contest.

C: Yeah.

T: Okay, what questions do you have about all we did today?

C: I don't have any.

T: Okay, I am going to give you more of these papers to fill out for anxious beliefs and you can take those home with you.

C: These are the same as the ones from a couple weeks ago.

T: Yes, and did you get the e-mail with the other one.

C: I probably did.

T: Okay, I will double check and make sure we sent it and I will send that other one as well.

C: What would be the name?

T: Heather Smith.

C: Yeah, it looks like I got those.

T: Okay, and then I will get those for you and I will see you next time, Tuesday at 1. That is what we decided with your new job. How is your new job going?

C: I actually haven't started it yet, I should be starting it next week.

T: Alright, well we will see you right before you start then.

C: Sounds good, thank you.

T: Alright, there you go sir. Thank you.

C: Thank you.