
Cognitive Behavioral Therapy for Social Anxiety Disorder: Intrapersonal and Interpersonal Aspects and Clinical Application

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Abstract

Research on social anxiety disorder (SAD), and its treatment, widely focuses on intrapersonal aspects. There also exists an increasing body of literature concentrating on its interpersonal dimensions. This chapter will present an overview about both intrapersonal and interpersonal approaches to SAD. This will be followed by a clinical application including dyadic and group session fostering the intra- and interpersonal perspective in cognitive behavioral therapy, in addition to the derivation of the patient's individual model of SAD based on *Clark and Wells* model of treating SAD.

Keywords: cognitive behavioral therapy, social anxiety disorder, social phobia, disorder, model, interpersonal, intrapersonal

1. Introduction

1.1. Social anxiety disorders

SAD is among the most prevalent mental disorders (lifetime prevalence, 7–16%) [1]. It is characterized by fear of negative evaluation (e.g. rejection, humiliation, embarrassment) or offending others lasting six or more months, accompanied by actively avoiding social situations, or staying with them with intense fear or anxiety. The fear is out of proportion to the actual threat posed by the social situation, depending on the sociocultural context. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) updated SAD criteria with a special focus on separating social interactions (e.g., conversations), felt observation (e.g., dinner), and performance

situations (e.g., oral exams); “humiliation” and “embarrassment” are subsumed under the broader term “negative evaluation,” the core fear in SAD; and including patients’ sociocultural context allows for the better evaluation of the “excessive or unreasonable” fear described in the former version of the DSM [2, 3]. SAD is associated with considerable psychosocial and occupational handicaps and with an increased risk of comorbid mental impairment and suicidality [4, 5]. Remission rates are low (e.g., 20% in the first 2 years) compared with affective disorders and other anxiety disorders [6]. Thus, effective treatments are in high demand.

Cognitive behavioral therapy (CBT) for SAD appears effective in a range of formats demonstrating a general effect size of $d = 0.70$ [7]. Effect sizes however vary considerably. The following parameters have shown substantial influence on CBT’s efficacy: *setting*, with larger effect sizes in individual versus group settings; *data collection*, with larger effect sizes in observer ratings (e.g., $d = 1.93$, Liebowitz Social Anxiety Scale (LSAS)) versus self-reports (e.g., $d = 1.23$, LSAS-SR); *number of measures* and *treatment duration*, with larger effect sizes on composite measures in short treatments (e.g., $d = 2.14$ on the Social Phobia Composite, in a 4-month treatment) versus single measures in long treatments (e.g., $d = 1.23$ – 1.32 on the LSAS-SR, in an 8-month treatment); and *calculation of outcome*, with larger effect sizes calculated by odds ratios of remission and response (e.g., 36–86 and 56–86%, respectively) versus calculation of pre-post differences [8–13].

2. Intra- and interpersonal aspects of social anxiety disorders

On a theoretical and therapeutic level, SAD can be described and treated with a focus on individually impaired internal processes and modes of behavior. This includes the amplitude of emotional life (e.g., unease, nervousness, panic) and somatic experiences (e.g., sweating and hot flashes) in specific social situations. Core cognitive processes refer to dysfunctional beliefs and self-focused attention, limiting the perception of external stimuli. It also includes modes of behavior depending on how strongly the patient avoids the feared situations. On the other hand, SAD can also be described and treated with the focus on the affected social system. This includes problems while interacting with others (e.g., arguing) and one’s overall experience within the social system (e.g., belonging, cohesion, flexibility, accord). The convergence of both foci makes SAD an intra- and interpersonal disorder: symptoms of fear arise when the affected person experiences that he or she may attract critical attention from others; these symptoms in turn constrain the person’s ability to successfully build and maintain social relationships [14].

Intrapersonal models. Cognitive behavioral models on SAD are largely intrapersonal models. There is a common ground between the models of the first generation. *Beck, Emery, and Greenberg* [15] explain SAD by distorted cognitive schemata (e.g., “No matter what I do, I’ll make a mistake!”) resulting from negative interaction with significant others in early childhood to youth. Once generated, these schemata are activated in stressful and challenging situations in the kind of unconditional negative core beliefs (e.g., “I am inept!”) and conditional beliefs (e.g., “If I show myself, I’ll behave stupid!”). Successful treatment of SAD should change these problematic negative cognitive schemata. There however still is the question why some schemata do not change though people are exposed to lots of positive situations.

Clark and Wells added characteristics of information processing to explain the maintenance of SAD: (1) self-focused attention, (2) safety and/or avoidance behavior, and (3) fearful anticipation before an event and negative rumination after it. *Rapee and Heimberg* [16] emphasize the anticipated while overestimated performance standards that others have stimulating fear of scrutiny and contributing to SAD. Differences between these models refer to the attentional focus that is understood as a person's shift to monitoring internal versus external cues. In the first model, treating SAD primarily means to direct the patient's attention toward inward to increase the person's sense of self so that safety behaviors are identified, understood, and finally dropped. In the second model, treatment is aimed at training socially anxious individuals to direct their attention away from the mental representation of the self toward the task at hand and to indicators of nonnegative reactions from others [16].

The second generation of cognitive behavioral models of SAD argues that the former approaches are too unspecific considering disorder-specific characteristics and with regard to the importance of the self in understanding SAD. *Hofmann* [17] agrees with the former models in hypothesizing that people with SAD anticipate social standards too high while heavily doubting to achieve them which results in an increased apprehension when entering social situations and heightened self-focused attention. The new component in his model refers to the affected person's strategy to purposefully fail so that others' expectations of them do not increase. People with SAD are described of perceiving their inability to meet expectations in tandem with the deficiency in setting social goals as well as planning and implementing actions for goal attainment. All models so far agree in hypothesizing that socially anxious people have intact social skills, but anxiety, negative cognitions, and avoidance behaviors impede social interactions. Consequently, treating SAD primarily highlights the work with defining and achieving social goals and with improving the patients' perception of their social skills rather than training them in specific skills. *Moscovitch* [18] and *Stopa* [19] criticize the former models having approached the self too little in understanding SAD. According to *Moscovitch* [18], they imprecisely concentrated on the negative evaluation as the feared consequence rather than the feared stimulus that occurs in SAD. The feared stimulus refers to the characteristics of the self that the person with SAD perceives as being deficient. It is these self-attributes themselves rather than the social situation, which are the most direct and sensible targets to work with. Self-attributes are understood quite stable compared to the activation of self-schemata at certain times and in certain social situations as proposed by the above-described models. These self-attributes can be divided into four dimensions: (1) perceived deficiency in social skills ("I will make a mistake!"), (2) perceived visibility of anxiety ("I will blush!", "I will sweat!"), (3) perceived deficiency in physical appearance ("I am ugly!"), and (4) perceived personal deficiency ("I am damn stupid!"). Treating SAD thus means the functional analysis of these self-attributes and dimension-specific exposure aiming at the discovery of the person's authentic, non-concealed selves to others in the service of correcting their maladaptive perception of themselves. According to *Stopa* [19], maladaptive self-perception grounds in limited retrieval of multiple self-representations rather than the understanding of the self as a whole and self-attributes to be feared stimuli. The complexity of the self emerges in its conceptualization unfolding three categories: (1) content refers to information about the self (e.g., many negative statements in SAD) as well as the way in which that information is represented (e.g., logical versus figural verbalization) and is addressed by the former cognitive

behavioral models when referring to mental representations of the self; (2) process refers to the strategies used to evaluate the self (e.g., higher accessibility to negative information in SAD) and is addressed by the former cognitive behavioral models when speaking of attentional biases; and (3) self-structure refers to the organization of self-knowledge (e.g., priority of negative information in SAD). Consequently, treatments of SAD should create preferential access to more positive and functional self-representations by inhibiting access to negative self-representations.

Interpersonal models. Interpersonal models understand social behavior as an interactive process involving at least two social interaction partners who are sensitive to and shaped by the behavior of the other person. The relational literature is extensive, and with the focus on SAD, Alden et al. offer three relational models to illustrate key concepts in adaptive relational functioning. The *circumplex model* [20, 21] allows the description of social interactions on two dimensions, affiliation and dominance, which can be organized to create a circular space. Interactions are perceived more satisfactory when interaction partners display correspondence on affiliation (e.g., friendly actions of one person are faced with friendliness from the interaction partner), and reciprocity on dominance (e.g., dominant behavior meets submissive behavior) [22]. Increasing complementarity has been shown to interact with positive reciprocal social interactions [23–25], while decreasing complementarity is associated with greater interpersonal distress [26]. Kiesler [27] adds the description of an interpersonal transaction cycle which refers to the phenomenon that expectations about the other person influence one's initial behavior and can stimulate a response that in turn confirms the preconceptions in a self-fulfilling prophecy. For example, if a person with SAD expects the other person to negatively evaluate their social interaction, the other person will be more likely to do so. Close relationships, however, need intimacy. In the *intimacy model*, Reis and Shaver [28] understand intimacy as feeling “validated, cared for, and closely connected with another person” (p. 385). It implicates self-disclosure and responsiveness as the two core dimensions which together facilitate rapport in interactions between unacquainted strangers [29] and closeness in partnerships [30]. The *risk regulation model* [31] emphasizes the so-called audacious trust, i.e., the belief that the partner loves one even at times when behavioral cues are less clear, to simulate felt security which in turn is understood as a precondition for commitment in close relationships. Interestingly, and reminiscent of the underpinnings in Stopa's [19] model described above, trust is associated with greater activation of brain structures responsible for regulating social pain accompanied by lower self-report of social pain [32].

Glancing at relational functioning in SAD, interpersonal models strive for the consideration of prosocial concepts (e.g., trust, belonging, security, and responsiveness), extending the well-established research on dysfunctional social interactions. Alden et al. offer a three-level perspective: (a) the macro-level addresses rather loose contacts, (b) the meso-level involves friendships and acquaintanceships, and (c) the micro-level encompasses intimate relationships.

Macro-level (loose contacts): interpersonal models understand SAD to be stimulated by contextualized relational schemata (e.g., “If I show myself in this situation, others will criticize or even reject me!”). Like the cognitive behavioral models, they result from negative interaction with significant others in one's early years. They involve increased negative expectation when

interacting with others resulting in some sort of self-protective or avoidance behavior. As a consequence, the individual fails to connect with others and to establish healthy and intimate relationships which in turn maintains and even fosters social anxiety. However, the main difference and additional specification, respectively, refer to how agency is attributed to the affected person. Interpersonal models deal with the way people with SAD can elicit negative evaluations to a greater extent compared to the cognitive behavioral models. Russel et al. [33] found that people with SAD displayed increased submissive behavior in feared situations, whereas where they experienced emotional security, they showed complementary affiliative behavior. Such research demonstrates that people with SAD recognize when they can connect and that they adjust their behavior depending on the social context.

Meso-level (friendships and acquaintanceships): the intimacy model suggests that reciprocal self-disclosure is crucial for the development of friendships. Meleshko and Alden [34] found socially anxious people less likely to reciprocate the level of intimacy displayed by their interaction partner which resulted in less interest in future contact with them. Vonken et al. [48] found that partners' negative reactions of people with SAD and their perception of dissimilarity together explained substantial variance in the rejection of socially anxious people. It thus can be inferred that it is both the socially anxious person and the interaction partner who participate in the establishment of a negative interpersonal cycle in which both individuals reciprocally attempt to avoid negative emotions while gradually distancing from another, reducing their partner's interest in them and thereby impeding the development of a closer relationship. Similarly to Russel et al. [33], Alden et al. [35] however also found that people with SAD are able to be open with others when they do not anticipate negative reactions.

Micro-level (intimate relationships): as proposed by the above-described interpersonal models, intimate relationships require a complex set of behaviors (e.g., self-disclosure), processes (e.g., complementarity), and cognitions (e.g., felt trust). Research on SAD demonstrated reduction of perceived closeness in socially anxious individuals when confronted with a partner's anticipated negative critique. Contrariwise, the opposite was found for nonsocially anxious individuals [36, 37]. It also appears that people with high SAD symptoms use fewer positive interaction skills (e.g., compliments, empathy, nonverbal behavior) and display more negative communication (e.g., blaming) compared to people with low SAD symptoms. There were no differences in behavior of the partners of socially anxious and nonsocially anxious people [38]. According to the circumplex model described above, individuals with SAD are more likely to choose a partner with a dominant and cold interaction style. However, detailed research on partners' characteristics of socially anxious people still is missing.

Summary. The main difference between the intrapersonal (cognitive-behavioral) and interpersonal (social system) models refers to how they define the *central driver of the development and maintenance of SAD*: (1) cognitive behavioral models center cognitive biases and negative core beliefs, whereas social system models emphasize interpersonal functioning; (2) cognitive behavioral models perceive social anxiety characterized by negative self-schemata or fear of personal deficiencies, whereas social system models understand social anxiety as a strategic problem resulting from a variety of reciprocal interactional experience; (3) cognitive behavioral models are engaged with an individual that is highly concerned with failing to live up its

own, whereas social system models deal with an individual that fears to fail up to the expectations of others; and (4) cognitive behavioral models refer to interactions with close persons as well as with complete strangers, whereas social system models have a greater focus on relationships with important others. This becomes obvious when analyzing the understanding of *safety and self-protective behavior*, respectively. Both the cognitive-behavioral and social systems models emphasize these strategies in the light of avoiding scrutiny while exacerbating distorted mental processes in the long term. They however propose different explanations as to why this is the case: most cognitive behavioral models refer to the prevention of habituating to anxiety and correcting their maladaptive perception of how others, even strangers, evaluate them; most social system models refer to the disruption of relationships and the ability to enter meaningful social relationships .

3. Treatment of a social anxiety disorder: a case study

3.1. Setting and treatment conditions

The therapy consisted of mainly weekly hours of therapy, in sum 25 h. Dyadic sessions took 60 min, and group sessions lasted 120 min.

3.2. Patient data

Diagnosis (ICD-10). Social phobia (F40.1), moderate depressive episode (F32.1)

Anamnesis. The 23-year-old medical student reported excessive anxiety, above all when being confronted with fellow students or authorities in performance situations (e.g., blood draw, state exam). He feared to behave unskillfully or to say something stupid and that others evaluate him negatively. Consequently, he tried to avoid such situations or got through them while suffering from extreme anxiety. At his first view in the outpatient clinic, he reported to stay at home all the day and presented intense worries about his future because of feeling much insecurity how to go on with his studies. He had stopped to follow joyful activities and his pleasure, felt much “blues,” could not sleep, felt exhausted, had difficulties to concentrate, and make any decision. This state already lasted 8 months.

The patient never was in psychotherapy or pharmacotherapy before. Psychosomatic disorders in his family were unknown. The patient reported minor alcohol use in positive social situations (e.g., a beer with a friend on Saturday evening). He denied the use of any additional legal or illegal drugs, at present and in the past.

Life history. The patient described himself to be the third oldest child of a six-person family (father: engineer; mother, house wife; sisters: +8 years and +6 years; brother: -5 years). The very busy, successful, and well-known father was not often seen at home since the patient’s 17th birthday. The development of a secure and trustful father-son contact thus firstly started 9 years ago. The mother was described as a very caring and calm person. The patient felt good contact to his siblings. Age differences however made it hard to establish secure and close ties.

The patient grew up in a highly performance- and achievement-oriented family. He was almost always best at school (“Merit is not my problem!”) and developed a couple of good friendship in elementary school and in puberty. In the development of these relationships, time was very important so that the patient got into contact and became intimate with his friends step by step. At all times, he concurrently felt much shyness and great nervousness when being confronted with strangers. He chose the medical studies by his own interest and felt much enthusiasm if there were not “these painful heart attacks.”

Currently, the patient lived in a shared apartment with fellow students. He did sports, liked cooking, and spent his weekends with his family and friends at home.

3.3. Test diagnostics: before therapy started (independent blind diagnostician)

SCID diagnostics [39] demonstrated the criteria for SAD and a moderate depressive episode. *Standard diagnostics*: The *Symptom Checklist (SCL-K-9)* [40, 41] showed a superior psychological symptom pressure ($T = 72$). The *Brief Symptom Checklist (BSI)* [42] showed superior depression ($T = 66$), social uncertainty ($T = 62$), and phobic anxiety ($T = 64$). *Disorder-specific diagnostics*: The *Liebowitz Social Anxiety Scale (LSAS-SR)* [43] total score was at 105 (cutoff, 30), the *Social Interaction Anxiety Scale (SIAS)* at 46 (cutoff, 35), the *Social Phobia Scale (SPS)* at 29 (cutoff, 24) [44, 45], and the *Beck Depression Inventory (BDI)* [46] at 17 (mild depression).

3.4. Analysis of behavior and life conditions (macro- and microanalysis)

Macroanalysis. The patient’s areas of problem can be interpreted against the context of his life history. A parental home in which the patient felt less secure bonds (e.g., marital quarreling, absence of the father, felt significant age difference between sisters and brothers) but much pressure to perform (e.g., praise for A grades, neglect of B grades, harsh critique for C grades) accounted for strong feelings of humiliation when anticipating failures or negative evaluations. As a consequence, the patient developed dysfunctional core beliefs (e.g., “Excellent performance is essential to be noticed and to survive well in contact with others!”) and interpersonal deficits (e.g., lack of perception and inadequate expression of needs; lack of spontaneous contact, communication, and interaction with strangers and authorities). The patient decreasingly experienced positive social contacts and his self-worth strongly reduced. Finally, he limited his social contacts to only those people he had met in childhood and youth and which have grown over years in his hometown. As a consequence, he suffered from depressive decompensation and panic attacks at his university place.

Microanalysis. The *microanalysis* is displayed in **Table 1**.

3.5. Therapy goal and treatment plan

The therapy goals and treatment plan are listed in **Table 2**.

Organic (O)	Increased arousal in general, due to negatively priming experiences of distress in the patient's life history when being confronted with social interaction and/or performance situations
Attitude (A)	"Excellent performance is essential to be noticed and to survive well in contact with others!"
Situation _{extern}	Contact with an authority
Situation _{intern}	Anxiety, tension
Reaction	
Cognitively	"Watch it: Don't look incompetent! Don't make a mistake! Don't sweat!"
Emotionally	Anxiety, due to anticipated failure or negative evaluation; shame, due to the inability to perform better; helplessness
Physiologically	Accelerated heart beat; sweating, above all hands and axillary
Behaviorally	Low voice to mutism, restlessness (e.g., wriggling, rightly drawing clothes) to freezing (e.g., immobility), glimpsing, and avoidance of eye contact
Consequences	
Short term	
C+	Being cared for by significant others (e.g., mother)
C _i /+	Getting into contact with strangers and becoming friends with others at the university place
C _i /-	Tension, failure, negative evaluation
C-	Self-criticism, feelings of shame, and guilt ("I have to perform better!")
Long term	
C+	Staying in contact with those who are well known since years
C _i /+	Pass exams, feelings of self-efficacy and competency, development of an integrative social network
C _i /-	Ambivalence in the negotiation of a self-determined moderate conduct of life
C-	Accelerated vigilance of social environmental stimuli, decreased capacity to discriminate between performance situations and daily life situations without pressure to perform, experience of insufficiency, and consolidation of shame and guilt feelings (vicious circle)

Table 1. Microanalysis.

3.6. Course of treatment

The therapy started with dyadic sessions (patient, therapist) in which the development of a *stable therapeutic relationship* was of major importance and facilitated by the therapist's complementarity behavior. The therapist paid much attention to value the patient as a person and to validate his behavior in the good as well as his bad times to assure the therapeutic alliance. She also empowered the patient to test the therapeutic bond by facilitating autonomous decision-making, e.g., in the creation of homework assignments. The patient thus perceived increased self-worth, commitment for treatment success, and responsibility for his life already at the beginning of therapy though still being in a state of carefulness.

Therapy goal	Treatment plan
1. Development of a stable therapeutic relationship	Above all, complementarity behavior of the therapist (i.e., valuing, validating, assuring)
2. Preventing depressive decompensation, stabilization of mood, and promotion of activities	Development and stabilization of social and professional resources (e.g., sport, cooking, family, friends, medical knowledge, and skills), applying sleeping, eating, and movement protocols (i.e., circadian rhythm)
3. Formulation of an individual model of the disorder and explanation of the social anxiety	Cognitive behavioral therapy, including individualized analyses of behavior in social evaluation situation (e.g., blood draws, exams)
4. Identification and cognitive restructuring of irrational beliefs	Training to identify cognitive schemata that increase anxiety while anticipating negative social evaluation and decrease self-worth and training to control such situation (e.g., reality checks, decatastrophizing).
5. Reduction of safety/avoidance behavior	Individualized exposure to social anxiety including guidance for self-constitution
6. Development of a positive self-concept	Interventions to increase self-worth and self-confidence
7. Promotion of skills to cope with intra- and interpersonal conflicts	Training of social skills: e.g., perception and expression of individual intra- and interpersonal needs, interests, and ideas; showing constructive criticism ("to argue"); accepting both praise and criticism; and making use of it

Table 2. Therapy goal and treatment plan.

Preventing depressive decompensation: it also was of major importance to develop and stabilize the patient's social and professional resources (e.g., sport, cooking, family, friends, medical knowledge, and skills). Sleeping, eating, and movement protocols, and their evaluation in the dyadic sessions, help the implementation of an appropriate circadian rhythm. It emerged that it was very tough for the patient to allow himself and perceive positive feelings in social situation without anticipated high-performance standards (e.g., in leisure time). Group session started in this first one-third of therapy, and the positive feedback from the other group participants helped the patient to stabilize his self-worth and to spare time without the pressure to perform. This was the reason why he had the heart to spontaneously bring home-baked cookies to the third group session and notably allowed to be evaluated by the group members and therapist. He noticed how he promptly felt insecure and anxious while anticipating criticism. The reflection of his original motivation, i.e., "I made cookies because I like baking" versus "I made cookies because I will be loved by others," empowered him to accept the group members' feedback and above all to grasp their otherwise less perceived positive reactions.

The analysis of the patient's goal to restore a healthy and individualized circadian rhythm moved the patient to the reflection of his needs and dreams (i.e., "I would like") in differentiation to those assumed from his parents and society (i.e., "I should be"). The similarly caring and demanding therapist behavior assisted the patient to find and perform an individual day-to-day routine with sufficient bedtime in between and to overcome several trials and errors en route. He created a morning ritual with several ingredients such as organic herbal tea

and home-baked sweet rolls for breakfast in the sunroom, including the reading of *The Times* magazine. Most impressively for him however was his self-permission of this ritual taking 1 h before starting with “the rest of my day.” He then started at 8.45–9.15 am with his day and was very surprised as well as much relieved that those asked in the reality checks organized the starting of their day equally in a small city where most people live only 15 min from their work place. The sweet rolls’ flavor additionally attracted his roommates so that finally they joint his morning time. In times of experimenting with new recipes, the patient finally discovered that both positive and negative feedbacks meant to him and that sometimes criticism accounted better for social closeness (e.g., “When I disliked the rolls’ taste, my roommates’ critique made me even stronger—because I feel connected in our joint feeling of bad taste”). This experience strengthened the patient very much. He now felt how to wow himself as well as to wow others “when I do what I like to do and do not think that much about what I think I should do.”

After the emotional stabilization and relapse prevention, the patient and therapist derived an *individual model of the SAD* including the patient’s explanatory model of the social anxiety in interaction and performance situations with anticipated negative evaluation (see macro- and microanalysis). This model included biographical material, the functionality of the set of problems and information about the development and maintenance of the social anxiety, and was enriched according to Clark and Wells’ cognitive behavioral models (**Figure 1**). The patient and therapist choose a recent and concrete social situation in which the patient showed anxiety and got through the event instead of avoiding it. First, the therapist asked for the negative cognitions and wrote them into the model template on a flip chart. Secondly, she asked for anxiety symptoms, i.e., how the patient felt when thinking the negative thoughts. Thirdly, the patient was asked for his security behavior. Finally, self-perception was introduced as the central model component by the therapist, directing the patient’s attention toward inward on the one hand and the anticipated impression by others in this social situation on the other hand.

The central position of the self-focused attention became clear when the patient presented and discussed this individualized model with the other patients in the group session (“I rather concentrate on *my* mistakes and forget to face *others!*”). The patient recognized that this was the central feature in the maintenance of his social anxiety (“If I do not dare to look the others into their eyes, I will never know whom I am sitting vis-à-vis!”). This was followed by the drafting of an individualized anxiety graph, again in the dyadic setting. The situation was a blood draw in the context of conducting a medical exam, with the patient’s fellow students and assistant medical director at present. The patient recognized that the perceived anxiety did not grow sky high like fooled by anticipatory anxiety. This caused much relieve, and social anxiety reduced anew. Additionally, the demonstration of negative effects of self-focused attention and safety behavior in role plays with strangers generated another two findings for the patient: Firstly, his safety behavior did not help him to reduce his social anxiety but rather contributed to its increase, while unexpectedly he felt more relaxation in social contacts with the stranger in times without its performance. Secondly, and again unexpectedly, the stranger reported that the patient’s safety behavior made him insecure and performed social distance rather approach. Similarly, the patient described that he had misinterpreted the stranger’s increasing low voice in terms of social rejection. He made the corrective experience that self-confident

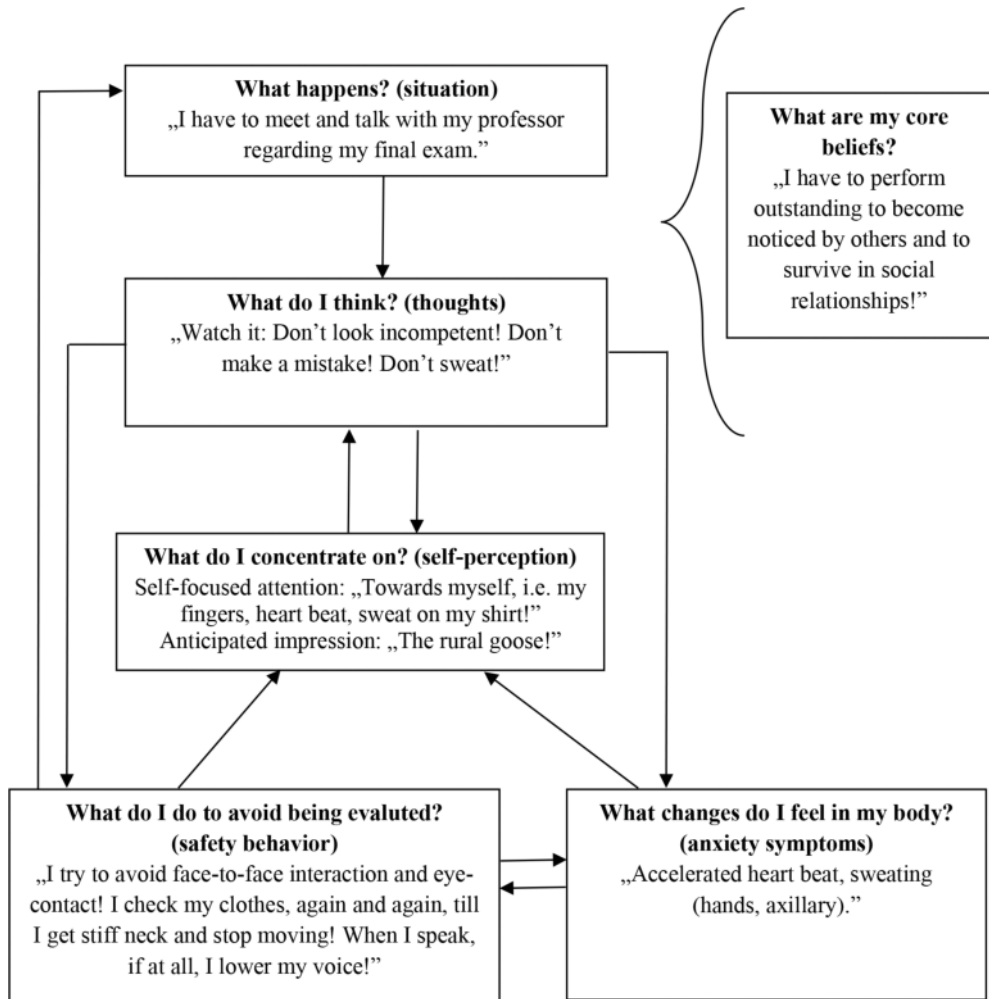


Figure 1. Individualized disorder model of SAD.

behavior from one person, like him, stimulates self-confident behavior from the other person, like the stranger in the role play, and that such an assuring social interaction incorporates the reduction of misperception with respect to negative social evaluation. This reciprocally reinforced feelings of safety and social bond when interacting with others. Watching the patient's video from this role play and its discussion as well as the patient's experience with the others in the group session, again, contributed to the fostering of the new recognitions and feelings and, thus, the patient's self-worth.

These successful therapeutic steps were accompanied by the patient's increasing distancing and humorous attitude toward his safety and avoidance behavior. He noticed that safety and avoidance behavior, among others, was responsible for his decreased self-determined life

in which "I had gone crazy." The distancing from his social anxiety, which simultaneously decreased more and more, strongly supported him in the *identification and cognitive restructuring of irrational beliefs*. Finally, and again subsequent to a role play, he formulated "I have social anxieties, but they do not have me any longer!", "I have an influence on how much anxiety and relaxation are tolerable when interacting with others!", and also "I have social anxieties, and so do others!".

The increased feeling of control over his life made it easier for the patient to get engaged into the following *rational of exposure*. The patient formulated approach goals (Grosse Holtforth, Grawe, Tamcan, [47]) in the preparation phase of the exposure procedure (short term, e.g., "to pass the state exam," "to pass the conductance of medical exams," and "to stay in contact with the professor"; long term, e.g., "to live a life of my own," "living appropriately independent from my parents while still staying in good contact with them," and "differentiating between what I like to do and what I think I should do but do not necessarily have to do"). Individualized body exercises served the increased vigor and corporeal tension so that the patient could easily step out of his anxiety-related rumination before the exposure and also in his daily routine. Subsequent to the identification and restructuring of the irrational beliefs, the patient developed alternative ways of thinking and behaving in contrast to his safety and avoidance behavior (e.g., "The professors often do not know who I am and where I come from," instead of "I always feel as if I have this post-it on my forehead, the rural goose!, which is well seen by everybody!"). He used a scaling from 0 ("no anxiety") to 100 ("terrifying panic") for self-observation during the self-conducted exposure in his daily environment and recognized that his anticipatory anxiety (e.g., "10: The assistant medical director and the fellow students will see my stupidity and incompetency and will reject me!") often exceeded the situation with his highest felt anxiety ("8–9: They will give me a D for my medical skills!"). He experienced the positive power of active behavior reducing anxiety (e.g., "attending the appointment with the professor and/or fellow students") and the negative power of avoidance increasing anxiety and anticipated negative evaluation (e.g., "staying in the car, facing all possible scenario of failure in a certain social interaction or performance situation"). This experience and its reflection with others in the group sessions helped him to reduce social anxiety (before exposure, 10; after three exposures, 3). He continuously confronted himself with numerous anxiety situations that he had avoided in previous times. Step by step he faced them with increased calmness and initiated social contacts even with strangers in both interaction and performance situations. Finally, he passed the state exam successfully and in an appropriate biopsychological arousal.

In summary, the patient initiated and practiced meaningful intra- and interpersonal changes in line with his self-formulated therapy goals over the course of 1 and a half year of therapy. On the intrapersonal level, he reported the following experience of most importance "that I have had the heart to face myself and others and to look into their eyes so that now I can evaluate them better and how they face me." On the interpersonal level, he attributed the highest importance to the following experience "that I now have the power to tell others when I feel anxious of being negatively evaluated and that I can ask them whether they feel the same." In summary, he concluded that his social anxiety had decreased from "over 100%" to "about 35%."

3.7. Therapy outcome and test diagnostics: at the end of therapy (independent blind diagnostician)

SCID diagnostics demonstrated a remission of the SAD and depressive episode. The patient showed a well understanding for the complexity of his symptomatology and confrontation with otherwise too much anxiety causing social interaction and performance situations. Safety and avoidance behavior was no longer seen. *Standard diagnostics*: The *Symptom Checklist (SCL-K-9)* showed the psychological symptom pressure on average ($T = 57, D = -14, p < 0.05$). The *Brief Symptom Checklist (BSCL)* also showed all values on average. *Disorder-specific diagnostics*: The *Liebowitz Social Anxiety Scale (LSAS-SR)* total score was at 42 (cutoff, 30; $LSAS_{prä} = 105$), the *Social Interaction Anxiety Scale (SIAS)* at 17 (cutoff, 35; $SIAS_{prä} = 46$), the *Social Phobia Scale (SPS)* at 11 (cutoff, 24; $SPS_{prä} = 29$), and the *Beck Depression Inventory (BDI)* at 2 (no depression; $BDI_{prä} = 17$).

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