A phenomenological inquiry into important moments in the group therapy experience of those with social anxiety.

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Abstract

Social Anxiety Disorder (SAD) is one of the most common psychiatric disorders (Kessler et. al., 2005), and is associated with substantial impairment and suffering (Aderka et. al., 2012). This thesis focused on the treatment of SAD in a group setting, as group interventions are widely utilised within the context of community mental health (McEvoy, 2012). Whilst group CBT treatments for SAD have demonstrated efficacy, a substantial proportion of people do not improve (Rodebaugh, Holaway & Heimberg, 2004) highlighting the need to continue efforts to enhance the protocols. The current research was directed at better understanding how people experiencing SAD change after a successful group therapy experience. It also aimed to understand the nature and impact of interpersonal and group process variables within the therapy groups. The data gathered in these two domains were utilised to identify areas in which existing group CBT treatment protocols could be enhanced.

A qualitative research paradigm was utilised in this research to explore the experience of participants taking part in group therapy treatments for SAD. Fourteen people who met DSM-IV TR criteria for SAD took part in a 9 week group therapy treatment, and then participated in a semi-structured interview. Interpretive Phenomenological Analysis of the interview transcripts found that phenomenological change in social anxiety occurred in five key areas. Three of these areas (changed views of self, others, and social encounters) are incorporated within existing theoretical frameworks and treatment protocols. The other two areas (a changed relationship to the anxiety, and a changed way of experiencing/being
with others) were novel findings in relation to existing frameworks. These new areas of change provide new targets for therapeutic interventions in the treatment of SAD.

Critical Incident Analysis of important moments in participants’ group therapy experiences revealed that interactions between the members, and relational experiences, were central to the group therapy process. A number of group therapeutic factors were found to play a prominent role in the group therapy: ‘self-understanding’; ‘interpersonal learning’; ‘instillation of hope’; ‘self-disclosure’; and ‘universality’. An emergent finding was that attachment processes may be implicated in relational experiences within the therapeutic groups. Attachment theory may therefore provide a useful framework for understanding and working with interpersonal dynamics unfolding between the group members. Overall, the findings highlight ways in which a greater focus on the relational aspects of the therapy may increase the effectiveness with which the goals of CBT may be pursued in a group context. The implications of this for practitioners treating social anxiety in a group setting are explored.
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Declaration

I declare that this thesis does not incorporate any material which has been accepted for the award to me of any other degree or diploma, except where due reference is made in the text. I further declare that to the best of my knowledge this thesis contains no material previously published or written by another person except where due reference is made in the text.

I also declare that the ethical principles and procedures specified in the document on human research and experimentation issued by the Psychology Department of Swinburne University have been adhered to, and annual/final reports have been submitted.

[Signature]

Anthony Mackie
April 2015
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Chapter 1: Introduction and Overview

Introduction

Social Anxiety Disorder (SAD) is one of the most common psychiatric disorders (Kessler et. al., 2005), and is associated with substantial impairment and suffering (Aderka et. al., 2012). A number of group CBT treatment protocols have been developed for the treatment of SAD, and have demonstrated their efficacy (Powers, Sigmarson & Emmelcamp, 2008). Unfortunately, a large proportion of participants do not respond to the existing group CBT treatment programs (Rodebaugh, Holaway & Heimberg, 2004), thereby highlighting the need for further investigation and refinement of the group protocols.

One obvious area for improvement would be to utilise the ‘group’ aspect of the therapy more effectively. Whilst the existing CBT protocols are delivered in groups, the content and focus of CBT therapy groups is generally very similar to that of individual CBT treatments (Beiling, McCabe, Antony, 2006). For example, the group CBT protocol for SAD developed by Heimberg and Becker (2002) tends to maintain a focus on individual cognitions and behaviours, with relatively little attention paid to spontaneous interactions between the members. From the perspective of the broader group therapy literature, however, interactions between the members and relational experiences in the group are thought to be the primary means by which group therapy exerts its beneficial influence (Yalom & Leszcz, 2005). If the nature and impact of such processes within CBT therapy groups could be better understood and worked with, this might provide an opportunity to enhance the treatment protocols.
Another potential area for improvement would be to identify some new targets for therapeutic intervention that may be incorporated into the treatment protocols. Whilst this process is ongoing, enhancements tend to be drawn from existing theoretical models which attempt to describe how the disorder is maintained. And so potential enhancements are limited by what is already described within those models. Another way to identify potential enhancements would be to conduct basic research into the nature of phenomenological change in social anxiety in the context of group therapy treatments. In other words, when people improve, what actually changes? There is currently very limited information in this domain (McManus, Peerbhoy, Larkin & Clark, 2010), and so insights here may prove to be another useful way to identify potential enhancements to the treatment protocols.

The current study therefore seeks to understand the nature of phenomenological change in social anxiety within the context of group therapy treatments, and the nature and impact of relational processes in these therapy groups. An overview of the thesis is set out below.

**Thesis overview**

The thesis begins with some basic information about social anxiety, and how the conceptualisation of the disorder has developed over time. This is followed by a review of literature that describes in some detail what is known about the phenomenology of the disorder. This includes information about the social context within which socially anxious individuals find themselves, as well as an examination of intrapsychic and interpersonal processes thought to be implicated in the experience of social anxiety. The intent of this chapter is to provide the reader with a detailed picture of the ‘lived experience’ of social anxiety. This provides a central
context which underpins other sections of the thesis. For example the chapters on treatment and group therapy draw heavily on this picture, and it is essential to understanding and interpreting the research findings.

The third chapter reviews CBT treatments that have been developed for social anxiety disorder. The intent of this chapter is to review what is known about the CBT treatments and their outcomes. This chapter begins with a description of the cognitive models of social anxiety developed by Clark and Wells (1995) and Rapee and Heimberg (1997). These are the two most influential models in the literature, and both have been developed into well validated treatment protocols (Clark et. al., 2003; Heimberg, 2003). The broader CBT treatment outcome literature is also explored, to investigate the efficacy of CBT more generally as a treatment for social anxiety. A number of recent enhancements to the treatment protocols are also introduced, including an interpersonal model of social anxiety (Alden & Taylor, 2011) which represents a major shift in emphasis by taking into account more of the interpersonal phenomenology of the disorder. This chapter also provides a context from which enhancements to the protocols may be considered, and identifies some specific opportunities that this research aims to address.

The fourth chapter reviews the broader group therapy literature. Key constructs that underpin this tradition are introduced first, because they provide an important context for understanding the operation of the group therapeutic factors. The group therapeutic factors are introduced, along with research findings about their utility and theoretical speculations about ‘how’ they may exert their influence. The intent of this chapter is to review what is known about groups and their therapeutic actions, and to consider this in light of what is known about social
anxiety. This provides some general ideas about how group processes might be relevant within therapy groups for social anxiety, and sets the scene for the current study which aims to investigate that question empirically. The chapter finishes with a rationale for the present study, and defines the research aims.

Chapter five sets out the method employed in this research. As the research design is somewhat novel, a rationale for the method is provided. The semi-structured interview, IPA thematic analysis (Willig, 2008), and critical incident technique (Flanagan, 1954) are explained. A statement of personal interest is provided so that something about the researcher and their perspective is known. Following this the recruitment process, participants, materials, procedure and data analysis procedures of the study are documented.

Chapter six details the results of the study. First, results pertaining to phenomenological changes identified by participants are outlined. Themes identified were: changed views/understandings of self; a changed relationship to the anxiety; changed views of others; a new way of ‘being with/experiencing’ others; and changed views of social situations. These themes represent aspects of the participants’ experience that shifted when their social anxiety improved. Each theme and sub-theme is defined, and illustrated with quotations from the group members interview transcripts. Next, results in relation to group members important therapy moments are documented. Briefly, these results indicate that interactions between the members, and relational experiences, were central to the group therapy process. In this section, example ‘important moments’ are used to illustrate each of the themes. Finally, the group therapeutic factors that were most prominent within the analysis of important moments are identified (Self-understanding, Interpersonal learning, Hope, Self-disclosure, and Universality).
Chapter seven presents a general discussion of the findings. To this end, the phenomenology of change, and the nature and impact of relational processes in the therapy groups, are discussed with regard to the previous literature. This touches on theoretical models of social anxiety, proposed mechanisms of change in group therapy, theoretical frameworks which might usefully inform the practice of group therapy, and specific potential improvements to the existing group therapy protocols. A summary of the practical implications for practitioners working with the socially anxious in groups is also provided. A final section considers limitations of the present study and suggestions for future research.

**Social anxiety basic information**

SAD is one of the most common psychiatric disorders. In the United States, Kessler et. al., (2005) found that 12% of adults had experienced SAD at some point in their life, (with 7.1% of people experiencing it within the last 12 months). In Australia, the most recent national survey of mental health revealed that 4.7% of Australians met criteria for Social Phobia in the past 12 months (Australian Bureau of Statistics, 2007). And while more women develop the disorder in Australia (5.7% of women meeting criteria, compared to 3.8% of men over a 12 month period), roughly equal numbers of men and women present for treatment (APA, 2000).

The reasons why some people develop symptoms of social anxiety are currently unknown (Bögels et. al., 2010). Whilst therapists in CBT groups often teach their group participants that social anxiety is the result of social learning, this has yet to be demonstrated empirically (although it must be acknowledged that doing so would be very difficult). There is some evidence that anxious parental reactions to stimuli can ‘rub off’ on children (Gerull & Rapee, 2002), and that certain child
rearing styles (especially a combination of rejection and overprotection) are associated with a higher risk of developing social phobia (Lieb et al., 2000). Temperament, and in particular behavioural inhibition, has also been linked to SAD (Turner, Beidel & Wolff, 1996). Genetic and neuroimaging studies have investigated the possible role of genes, neurotransmitter systems, and hyperactive brain structures/systems in the development and maintenance of SAD, but the findings here are tentative and inconclusive (Fink et al., 2009; Stein & Stein, 2008). While much important work has been done, the causes and developmental pathways of the disorder are yet to be coherently articulated.

Whilst there is little agreement as to what causes SAD, the impacts of the disorder are well documented. The overall picture is one of substantial impairment and suffering. SAD is associated with a diminished quality of life, equivalent in impact to a major depressive disorder (Wittchen & Beloch, 1996). Perhaps reflecting the ubiquitous impact of poor interpersonal functioning, the negative impacts associated with SAD cut across a number of important life domains. For example, those experiencing SAD have been found to suffer impairments in their ability to respond appropriately to others in interpersonal interactions (Alden & Taylor, 2004). They have fewer friends, find it difficult to establish and maintain romantic relationships, and are less likely to marry (Mendlowicz & Stein, 2000; Schneier et al., 1994). The difficulties they experience in interpersonal functioning also make it harder for them to successfully engage in other broad aspects of life, such as education and employment. For example, SAD has been consistently associated with school refusal, and early dropping out of school (Stein & Kean, 2000), as well as lower overall educational attainment (Katzelnick & Greist, 2001). Those experiencing SAD also face a greater risk of unemployment (Patel, Knapp,
Henderson & Baldwin, 2002), and are more likely to be employed in a job that is below their level of qualification or skill (Bruch, Fallon, Heimberg, 2003).

One of the more problematic aspects of SAD is its high level of entanglement with other psychiatric disorders. Lifetime comorbidity has been reported in the range of 69% (Schneier, Johnson, Hornig, Liebowitz, & Weissman, 1992) to 92% (Faravelli et. al., 2000). In other words, the vast majority of people experiencing SAD can expect to experience at least one other psychiatric disorder in their lifetime, which is unfortunate because comorbidity is associated with greater impairment (Keller, 2003). SAD is most likely to exist alongside other anxiety disorders (Faravelli et. al., 2000), as well as depression (Stein, Fuetsch, Muller, Hoflen & Lieb, 2001). Temporal studies indicate that SAD precedes depression in most cases (Kessler, Nelson, McGonagle, Swartz & Blazer, 1996; Weiller, Bisserbe, Boyer, Lépine & Lecrubier, 1996), which suggests that the chronic social isolation associated with SAD may lead to depression. High levels of substance dependence have also been associated with SAD (Smith & Book, 2008), but the relationship here appears to be more complex. Many people, for example, report that they initially find alcohol helpful for managing their anxiety in social settings. Over time, however, alcohol itself can cause symptoms of anxiety, establishing a vicious cycle between social anxiety and substance use (Lépine & Pélissolo, 1998).

**The development of the idea of social anxiety within the DSM**

With the recent publication of the 5th version of the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM), the diagnostic criteria for SAD underwent some small but important changes. To put these changes in their proper context, it is worth briefly considering how the concept of social anxiety has
developed over time within the DSM. Social anxiety was first acknowledged as a
disorder in DSM – III, which was released in 1980. At that time it was considered to
be a simple phobic reaction, similar to a fear of spiders or some other stimuli in the
environment, and fairly circumscribed in its impact. For example, whilst it was
acknowledged that social phobia caused impairment and suffering, it was thought
that the fear generally related to only one type of social situation (such as eating or
writing in public)(APA, 1980). As a phobia, it was also differentiated from
disorders that were conceptualised as pervasive anxiety states, such as Generalised
Anxiety Disorder. Accordingly, it was considered to be diagnostically and
phenomenologically distinct from Avoidant Personality Disorder (AVPD), which
was understood to involve more pervasive and characterological difficulties in
relating to other people.

With the release of the DSM – III revision in 1987, a ‘generalised’ specifier
was added in recognition of the many people who reported experiencing fears across
a broad range of social encounters. In addition, social phobia and AVPD were no
longer defined as mutually exclusive categories – a person could receive both
diagnoses. When DSM-IV was published in 1994 this trend continued.
Adjustments to some of the associated features of the two disorders brought them
closer together phenomenologically, and it was explicitly stated that AVPD may be
a more severe variant of generalised social phobia. At the same time, the phrase
“Social Anxiety Disorder” was added in parentheses after the title, in recognition of
the severe and pervasive nature of the disorder.

With DSM-5 the changes, though generally small, continue the trends
described above. The title has been changed from “Social Phobia” to “Social
Anxiety Disorder”. In addition, the “Generalised” specifier has been replaced with a
“Performance” specifier. This is perhaps the most significant change, as it is now assumed that anxiety across a wide range of social situations is the norm for this disorder. It is no longer a requirement that the person recognise their fears as excessive, as it has been demonstrated that people experiencing SAD are vulnerable to overestimating the dangers of social situations (McManus, Clark & Hackmann, 2000) and therefore may not recognise their fears as disproportional. This judgment is now the responsibility of the clinician, who is expected to take cultural mores into account when deciding whether or not a person’s anxiety or avoidance is out of proportion to the actual situation. There is also a new requirement that the symptoms persist for 6 months or more, which aims to ensure that people experiencing transient social fears do not attract a diagnosis. And whilst there was debate about introducing a single dimensional measure into DSM – 5 which might encompass both SAD and AVPD, this proposal was not taken up and the two disorders remain discrete diagnostic entities for the immediate future (although their similarities are noted in the text).

Of particular interest to the current study are adjustments to the criteria in terms of situations/consequences typically feared in social anxiety. Based on the findings of factor-analytic studies (Bögels et. al., 2010), the types of social situations commonly feared have been expanded from performance situations to also include social interaction situations, or situations where a person may be observed by others (for example writing in front of others). Feared consequences have also been expanded from embarrassment/humiliation to include interpersonal rejection, or offending another person. These shifts are interesting, because they make it very clear that the fear in social anxiety is fundamentally relational in nature – revolving
around a fear of being negatively evaluated by others and the interpersonal consequences which may flow on from this.

Overall, developments in the DSM over time have seen a shift in the conceptualisation of social anxiety from being understood as a fairly circumscribed phobic reaction to a specific social situation, to a broad and ongoing anxiety state linked to overall interpersonal functioning. In this sense the current formulation appears more characterological in nature - revolving around pervasive patterns in how a person makes sense of and responds to other people and their social world. This helps to differentiate social anxiety from simple shyness, and better reflects the broad impacts of the disorder, and the degree of impairment associated with it.

A final important aspect of the changes is that they place a person’s sense of self at the forefront of the disorder. For example, in DSM – 5 it is asserted that “The individual is concerned that he or she will be judged as anxious, weak, crazy, stupid, boring, intimidating, dirty, or unlikeable.” (APA, 2013, pg. 203). These changes are consistent with an emerging view that SAD involves a disturbed sense of self. For example, both cognitive (Clark & Wells, 1995; Rapee & Heimberg, 1997) and interpersonal (Alden & Taylor, 2004) models of SAD propose that a key underlying feature of the disorder is that people have a distorted and overly negative view of themselves. It is believed that this distorted sense of self is a key factor in the experience of social anxiety, with some theorists even positing this to be the core focus of concern in the disorder (Moscovitch, 2009).

Conclusion

Overall, SAD is associated with a high level of impairment that impacts across a range of domains of human functioning. As a construct it has developed
from the idea of a simple phobic reaction, to a more pervasive pattern of difficulties in relating to others that is informed by a disturbed sense of the self. In the next chapter, the lived experience of social anxiety is examined in detail.
Chapter 2: The Phenomenology of Social Anxiety Disorder

Introduction

Since the 1980s a very large body of research has been attempted to better understand various aspects of SAD. Much of this research has been informed by emerging theoretical models for understanding social anxiety. For example, cognitive models of SAD have both emerged from basic research, and also informed research aimed at confirming or better understanding the role of cognitions within the disorder. This section of the thesis considers phenomenological findings emerging from this research to provide a detailed picture of the lived experience of social anxiety. The theoretical models themselves are introduced later, in the chapter on treatment.

To provide structure, the findings are grouped into three broad areas important to understanding SAD. The first of these is the social context within which people experiencing SAD find themselves. For example, do they differ from the norm in the number and nature of their interpersonal relationships? The second main area relates to intrapsychic processes involved in SAD. For example, is social anxiety associated with particular ways of perceiving and making sense of social situations? Finally, interpersonal processes relevant to SAD are reviewed. These include characteristic ways of interacting with others, and transactional cycles that appear to be associated with SAD. Some ideas about potential mechanisms implicated in these transactional cycles are also briefly reviewed, as these have a bearing on the research questions of the thesis.
When considering the broader findings, no attempt is made to suggest causal pathways within the disorder. Such arguments are beyond the scope of this thesis. What can be noted, however, is that each of the broad domains can be conceptualised as both causes and consequences of social anxiety. They represent different aspects of a person’s experience, that manifest themselves alongside the experience of social anxiety whilst also contributing to it. For example, difficult relational experiences colour one’s thinking about the social world, and contribute to one’s experience of social isolation, which then impacts how one enters the next social encounter. In this sense the various domains of ‘social context’, ‘the intrapsychic’, and ‘the interpersonal’ are reciprocally bound to one another as part of an overall picture of the lived experience of social anxiety. The next section examines research findings that shed light on various aspects of this lived experience.

The Social Context of SAD: Living in an Impoverished Social World

Fewer and less intimate relationships than normal.

People experiencing Social Anxiety Disorder, like all human beings, live their lives embedded within a network of social relationships. What is distinct about the social world of those experiencing SAD is that their networks tend to contain fewer people. For example, they have fewer social relationships than the general population, or people with other anxiety disorders (Mendlowicz & Stein, 2000). They also report fewer friends, greater difficulty in establishing and maintaining romantic attachments, and are less likely to marry than their non-socially anxious peers (Mendlowicz & Stein, 2000; Schneier et. al., 1994).
In addition to fewer overall relationships, the relationships that people experiencing SAD do have tend to be characterised by generally low levels of intimacy and support. For example, Wenzel (2002) found that those with SAD reported lower levels of social and emotional intimacy in relationships when compared to non-anxious controls. In a similar vein, Weisman, Aderka, Marom, Hermesh and Gilboa-Schechtman (2011) found that those with SAD reported low perceived intimacy in their relationships with friends and romantic partners. Significantly, and likely to be a feature of both the low number of relationships, and the generally low levels of intimacy available within them, those with SAD report less social support as being available to them (Cramer, Polit, Torgersen & Kringlen, 2005; Davidson, Hughes, George & Blazer, 1994).

Studies looking at non-clinical populations highlight similar difficulties. For example, school children who score highly on measures of social anxiety tend to interact with other children less often (Beidel, Turner & Morris, 1999). Adolescents scoring high on social anxiety report fewer close friends, and less intimate relationships, when compared to their non-socially anxious peers (Vernberg, Abwender, Ewell & Beery, 1992). And socially anxious college students report fewer dating and sexual experiences (Dodge, Heimberg, Nyman & O’Brian, 1987).

Overall, these results suggest that those experiencing SAD inhabit a somewhat impoverished social world. They tend to have fewer and less intimate relationships than other people, and to perceive less social support as being available to them. In simpler terms their experience of the social world is more limited, and less nurturing, than is typical for human beings.
Social isolation as a cause of anxious arousal.

Before discussing other aspects of the phenomenology of SAD, it is worth noting that social isolation is more than simply an epiphenomenon of the disorder. Isolation itself is a source of stress to social organisms. For example, researchers exploring animal models of psychopathology commonly use social isolation to induce depressive symptoms in animals (Willner & Muscat, 1991). In human beings, social isolation has been shown to have a profound impact on overall health and wellbeing, comparable to high blood pressure, smoking, a lack of exercise, or obesity as a risk factor for illness and early death (House, Landis & Umbertson, 1988). Loneliness, which is a related construct that takes into account a person’s subjective feeling of being alone in the world, has also been associated with a range of negative health outcomes. These include poorer self-reported physical health (Fees, Martin, & Poon, 1999), impaired immune functioning (Pressman et al., 2005), impaired sleep (Cacioppo et al., 2002), and elevations in circulating levels of the stress hormone cortisol (Pressman et. al., 2005).

The findings on social isolation are complimented by studies that indicate that the presence of social relationships acts as a buffer against stress. For example, it has been argued by Diamond (2001) that people with a good network of long term relationships should experience less stress, because affiliative behaviours with important others are associated with the release of hormones that downregulate the hypothalamic-pituitary-adrenal (HPA) axis. This assertion is supported by a range of experimental studies (see Sbarra & Hazan, 2008, for a review). It also receives indirect support from studies that show that regular interactions with partners or family members are associated with lower blood pressure when compared to
interactions with less intimate others (Gump, Polk, Kamarck, & Shiffman, 2001; Holt-Lunstad, Uchino, Smith, Olson-Cerny, & Nealy-Moore, 2003). These findings highlight the importance of regular contact with intimate others as a buffer against stress, and the closer the relationships the stronger the buffer.

It is clear from these findings that social isolation is, in itself, a stressor. This is consistent with the arguments of attachment researchers who argue that social beings thrive most successfully in the context of good social connections. From this perspective, social isolation constitutes a threat to felt security and has a disregulating effect on the overall functioning of the organism (Sbarra & Hazan, 2008) which can lead to a chronic stress response. At the same time, social isolation cuts human beings off from their most basic emotion regulation/distress reduction strategy, which is interpersonal contact (Schore, 2012). It therefore appears that social isolation, in addition to being as aspect of the phenomenology of SAD, is a source of anxious arousal in itself. This observation is a useful one because, as is argued later, the same principle also applies to the intrapsychic and interpersonal processes implicated in SAD. All three areas appear to be both aspects of the experience of social anxiety, and also perpetuating factors in its maintenance.

Before discussing the intrapsychic and interpersonal processes implicated in SAD it is important to acknowledge that the distinction between the two is somewhat artificial, and is not meant to construct a dichotomy between what is inside a person and what is outside them. Intrapsychic phenomena such as a ‘sense of self’ are clearly impacted by previous relational experiences at the same time that they colour current ones (Bowlby, 1973). As Henry Stack Sullivan (1964) noted, the ‘interpersonal situation’ is just as likely to be found within a person’s private mental
experience as it to be found in observable interactions. Whilst acknowledging the interdependency of these constructs, the distinction is used to provide structure to a very large and disparate body of research findings of relevance to this thesis.

**Intrapsychic Processes associated with Social Anxiety Disorder**

A very large body of research has been undertaken into intrapsychic processes implicated in the experience of social anxiety. These studies are essentially an investigation of the internal experience of social anxiety. They shed light on how private mental processes are implicated in, contribute to, or maintain social anxiety. In this section the key findings from this research tradition are set out.

**Attentional biases towards social threat.**

Attentional biases in the socially anxious have been investigated in a number of studies, with mixed results. Veljaca and Rapee (1998) conducted what is perhaps the most naturalistic study in this area when they asked University students to make a short presentation before a small live audience. Presenters were asked to identify positive (such as smiling, nodding) or negative (yawning, looking at watch) reactions from audience members, in real time, by pressing a button during their speech. Although an equal number of positive and negative cues were provided by the (confederate) audience members, those presenters high on a measure of social anxiety (SA) were better at detecting the negative social cues, and worse at detecting the positive social cues, when compared to those low on SA. Veljaca and Rapee interpreted this finding as demonstrating that those high on SA showed an attentional bias towards threat. In a follow up study, however, when a video taped audience was used to ensure absolutely identical feedback was provided to all presenters, no differences were found between the high and low SA groups in the
noticing of negative social cues (Perowne & Mansell, 2002), casting some doubt on the previous finding.

In addition to these ‘naturalistic’ studies assessing attentional processes in the presence of real people, or recordings of real people, there have been a number of studies using more traditional cognitive psychology research protocols. These studies typically assess for processing biases by looking to see how social threat analogs such as words (Mattia, Heimberg, & Hope, 1993) or photographs of faces (Gilboa-Schechtman, Foa, & Amir, 1999), can interfere with cognitive processing tasks (i.e., by slowing or speeding up reaction times to target stimuli). The results from this body of research have been mixed and inconclusive (see Schultz & Heimberg, 2008, for a thoughtful review).

Overall, the findings to date are uncertain in relation to attentional biases in social anxiety. Evidence from one study suggests that, in interactions between real people, those high on SA may attend more carefully to negative social cues than to positive ones. Whilst the findings on attentional biases are interesting, if somewhat inconclusive, they generally refer to ‘in the moment’ processes which contribute to a person’s experience of anxiety. In contrast to these ‘in the moment’ processes, there are other, more enduring ways of understanding the self and one’s social world which also contribute to social anxiety, and the research findings here are much stronger.

**Negative view of self, and perceptual biases in self-related information.**

A number of studies have attempted to determine if unhelpful and distorted views about the self are a core aspects of social anxiety. The first line of evidence
in favour of this view comes from studies attempting to assess how the socially anxious perceive themselves. Weisman, Aderka, Marom, Hermesh and Gilboa-Schechtman (2011), for example, found that people with SAD perceived themselves as being inferior to others, and as having a low social rank. In related attempts to understand how self/other discrepancies might impact on social anxiety, both Strauman (1989), and Weilage and Hope (1999), found that those with Social Phobia tended to believe that they fail to live up to the standards that important others expect of them. An important recent contribution to this area was made by Moscovitch (2009), who attempted to reformulate what the fundamental focus of anxiety is in SAD. After reviewing the available literature on typical fears of the socially anxious (i.e., of negative evaluation, or of displaying visible signs of anxiety such as blushing, and so on), Moscovitch proposed that the fundamental fear underlying all of these was actually a fear that some flawed aspect of the self might be revealed to others. Whilst there is debate over this particular interpretation (Heimberg, 2009; Stopa, 2009) the research findings described here provide evidence that the socially anxious tend to view themselves (i.e., their character), or particular aspects of themselves (such as their anxious mannerisms), as being inadequate or unacceptable to others.

A second line of evidence comes from studies investigating the existence of perceptual biases amongst the socially anxious. In other words, do socially anxious people process information about themselves in a distorted (and negative) way? A number of studies have attempted to investigate this issue, by asking a socially anxious person to undertake some social task and then rate aspects of their own performance. These ratings are then compared to ratings provided by independent
observers, to see if any biases in the perception of social performance can be found. A number of studies have provided support for this notion. For example, in a public speaking task (Rapee & Lim, 1992) and a conversation task (Stopa & Clark, 1993) those with social phobia rated their performance more poorly than independent observers did. In a more recent study, Taylor and Alden (2005) found that those with SAD both overestimated their anxiety related behaviours (i.e., how anxious they looked), and underestimated their own social performance (i.e., their engagement in pro-social behaviours) relative to independent observers of the conversation.

In one particularly interesting study, researchers attempted to probe more directly for the impact of self-related schemas on perceptual distortions by manipulating an aspect of the socially anxious participants’ performance. Alden and Wallace (1995) wanted to know whether people with social phobia based their judgments of their own social performance on their pre-existing beliefs that they are inadequate (i.e., on their self-related schemas), or on their actual performance in a social interaction. To examine this they manipulated one aspect of a ‘getting to know you’ conversation, so that the socially phobic participants’ performance would be enhanced in one condition and inhibited in another. In the first condition, for example, the conversational partner expressed warmth and interest, self-disclosed freely, maintained eye contact and provided lots of encouragement. In the second condition these behaviours were minimised. The study established that changes in the conversational partner’s behaviour between conditions resulted in changes in the socially anxious participant’s social performance (i.e., their social performance was rated better in condition 1). However, in both conditions, the socially anxious
participants still underestimated their own performance by the same amount. That is, in both conditions they *overestimated* the visibility of their anxiety, and *underestimated* their warmth, and the interest they conveyed to their conversation partner, and their overall likeability, when compared to independent observers of the conversation. Alden and Wallace (1995) concluded that this provided evidence that people with social phobia have a general tendency to discount their own social performance, regardless of how well they actually perform.

In summary, there is good evidence that people with SAD tend to view themselves as inadequate in some way. And further, that these negative self-schemas exert an influence on how they process self-related information, such as information about how well they are doing in a social interaction. Both of these mechanisms are likely to arouse and maintain a person’s experience of anxiety about social encounters.

**Overestimating the danger of social situations, and relating to others.**

It has been proposed that socially anxious people tend to overestimate the danger of social situations, and that this overestimation is a key maintaining factor in the anxiety (Clark & Wells, 1995; Heimberg & Becker, 2002). Indeed, the current diagnostic criteria in the DSM-5 require that a person’s fear of social situations be “out of proportion” (APA, 2013). Studies attempting to investigate this phenomenon have typically examined socially anxious participants’ beliefs about how likely it is that they might be involved in positive or negative social events in the future, and then compared these results to the probability estimates of non-socially anxious participants.
In studies of this nature, participants with social phobia estimated negative social events as more likely to happen to them, and positive social events as less likely to happen to them, when compared to non-socially anxious controls (Lucock & Salkovskis, 1988; Gilboa-Schechtman, Franklin & Foa, 2000). In a replication of the Lucock study, Foa, Franklin, Perry and Herbert (1996) introduced an additional variable relating to the perceived ‘cost’ of negative social events. They found that patients with Generalised Social Phobia not only overestimated the probability of negative social events occurring to them in the future, they also overestimated the cost (or how bad such events would be for them personally) when compared to non-anxious controls. These findings were replicated in a study by McManus, Clark and Hackmann (2000), who found that the overestimation of the probability and cost of negative social events held up, even when comparing socially phobic participants’ estimations to those of people with another anxiety disorder.

It has also been proposed that socially anxious individuals (SAIs) tend to overestimate how dangerous other people are. For example, both Clark & Wells, (1995) and Rapee & Heimberg (1997) propose that the socially anxious tend to see others as being hostile or critical, and that this is a maintaining factor in the anxiety. Some even argue that social anxiety emerges out of dominance/submission behavioural dynamics related to pre-industrial hominid evolution (Trower & Gilbert, 1989). However, there is limited evidence in support of the view that the socially anxious perceive others as inherently hostile. In one study, Leary, Kowalski & Campbell (1988) asked people to imagine how another person might evaluate them after interactions of varying lengths. They found that, compared to those low on a measure of social anxiety, those high on social anxiety thought that they would be
evaluated more negatively in each interaction condition. In contrast to this, Alden & Wallace (1995) found in a ‘getting to know you’ conversation that those with social phobia tended to rate their conversation partner as ‘more friendly’ than did their non-anxious counterparts. At this stage, the available evidence is too limited and ambiguous to assert that SAIs have a tendency to perceive others as critical/hostile.

In summary, when compared to non-anxious people, SAIs tend to overestimate the likelihood of negative social events happening to them in the future, as well as the likely cost of such events. Conversely, they tend to underestimate the likelihood of being involved in positive social events. These assumptions about the social world no doubt work to exacerbate anxiety, and may prime them to enter into social environments in a defensive manner (i.e., a manner designed to forestall the expected negative consequences).

**Self-focused attention.**

Self-focused attention is a widely investigated phenomenon within social anxiety research. Indeed, the excessive processing of the self as a ‘social object’ is thought to be a central feature of the disorder (Clark, 2001; Heimberg, Brozovitch & Rapee, 2010). It has been proposed that self-focused attention is problematic because it heightens awareness of aspects of the self that are perceived to be inadequate, thereby amplifying the anxiety (Clark & Wells, 1995), or because it interferes with the processing of cues from the actual situation which might be inconsistent with the fear (Hackmann, Surawy & Clark, 1998), or because it diverts attentional resources away from the interaction at hand, thereby impeding social performance (Rapee & Heimberg, 1997).
In studies that investigate negative thoughts there has been a consistent finding that, whilst they are in social situations, socially anxious individuals tend to experience negative self-evaluations such as “I’m boring” (Beidel, Turner & Dancu, 1985; Cacioppo, Glass & Merluzzi, 1979; Glasgow & Arkowitz, 1975). More recently, Stopa and Clark (1993) demonstrated that during a social interaction, individuals with SAD experienced many more negative thoughts than non-anxious controls, and nearly all of the cognitions they identified were self-focused. Finally, in a study that looked to examine the impact of self-focused attention, Daly, Vangelisti and Lawrence (1989) asked participants high and low on a measure of speech anxiety to deliver a speech to an audience. In this study, those high on the measure of speech anxiety were found to experience more negative self-focused cognitions than their low speech anxiety counterparts, and they also paid less attention to their environment. Overall, these findings support the contention that cognitions in social anxiety tend to be negative and focused on the self.

More recently, researchers have turned their attention to negative self-imagery in social anxiety. It has been proposed that socially anxious individuals tend to hold in mind negative mental images of themselves, as they would appear to an observer, and that this is a maintaining feature of the disorder (Heimberg, Brozovitch, & Rapee, 2010). A number of studies have demonstrated that social situations tend to elicit an ‘observer perspective’ within socially anxious individuals (Wells & Papageorgiou, 1999) that is anxiety inducing (Hackman, Surawy & Clark, 1998). And in studies which have investigated the impact of this, it has been shown that experimentally induced negative self-imagery elevates anxiety in the socially anxious person whilst impairing their social performance from the perspective of
observers of interactions (Hirsch, Clark, Matthews & Williams, 2003), as well as interaction partners themselves (Hirsch, Meynen & Clark, 2004).

In summary, it appears that self-focused attention is both a prominent and problematic aspect of the experience of social anxiety. When they are in social situations, socially anxious individuals tend to pay a lot of attention to their own inner experience of anxiety, and also how they might be coming across to others. And it appears that this process has a negative impact on the way that they interact with others.

In conclusion, research to date has identified a range of intrapsychic mechanisms which may be contributing to SAIs’ experience of anxiety in social settings. The most strongly supported findings to date include negative views of the self, negative perceptual biases in self-related information, a tendency to overestimate the dangers of social encounters, and self-focused attention. Perceptual biases towards social ‘threat’ signals may also play a role, but more work is required to confirm or disconfirm this notion. What seems certain is that all of these things are likely to enhance a person’s experience of anxiety in social situations, and it is here that the intrapsychic mechanisms of social anxiety come to have interpersonal consequences.

**Interpersonal Processes associated with SAD**

Over the past two decades a growing number of studies have investigated ‘live’ interactions between socially anxious individuals (SAIs) and other people (or computer-generated representations of other people). These studies, broadly speaking, are an attempt to identify (via observation rather than SAI self-report)
whether social anxiety is associated with characteristic ways of behaving in interpersonal encounters. The impact of SAI's behaviours on interactional partners has also been a major area of focus. These studies are almost exclusively laboratory based. In a typical scenario, a socially anxious individual is introduced to another person and instructed to interact with them in a particular way whilst the interaction is observed through a one way mirror, or recorded for later analysis.

It is important to acknowledge that the ecological validity of these interactions is somewhat limited. Virtually all of the scenarios used in these studies disrupt normal affiliative processes by forcing an unusual amount of structure into the interaction. To provide one typical example, Meleshko and Alden (1993) asked their participants in a ‘getting to know you’ interaction to limit their conversation to a list of topics provided by the researchers. Participants were further instructed to take turns as speaker or listener, and to sit quietly whilst listening and not ask any questions of their conversation partner. In such a context, natural and spontaneously emerging affiliative behaviours are forestalled as participants are forced into interactional patterns defined by the researchers. In this sense the scenarios resemble role plays more than they do naturalistic interactions. At the same time these studies offer insights into ‘live’ interactions, which can be carefully observed. Video recording and other technologies make it possible to capture fleeting or subtle behaviours that might otherwise go unnoticed. Independent observers can cross-check their assessments with other observers, or interaction confederates, as a way of enhancing the reliability of observations. Perhaps most significantly, the subjective experience of SAI's, their interaction partners, and observers is available for assessment, providing an extremely rich source of information.
Overall, these studies provide important observational data about how SAIs behave in social interactions, and how others respond to them. They therefore further our understanding of relational processes associated with SAD. This section reviews the findings in this area. To structure the findings, the experience of the SAI in these interactions is examined first, followed by an explication of the findings in terms of the experience of interaction partners. The idea of negative interaction cycles, which emerge out of the experience of both parties to the interaction, is then considered.

The socially anxious person’s experience of interactions.

SAIs tend to experience high levels of anxiety when interacting with others.

Interaction studies rarely ask SAIs about their subjective experience of anxiety in the interaction itself. This may be because researchers are typically more interested in trait social anxiety and its relationship to other variables. Or perhaps it is simply assumed that, by definition, SAIs will be feeling anxious in these interactions. As a result there are only a small number of studies on the subjective anxiety experience of SAIs during interactions. Heerey and Kring (2007) assessed current affect immediately before participants engaged in an interaction. They found that those high on SA reported more negative affect and less positive affect relative to their non-socially anxious (NSA) counterparts. McManus, Sacadura and Clark (2008) assessed anxiety immediately after two 5 minute interactions, and found that the group high on SA reported higher levels of anxiety than the group low on SA. Alden and Beiling (1998) used a measure of physiological arousal in their study with items covering things like butterflies in the stomach, feeling pressure in the chest, and shortness of breath. They found that SAIs reported greater anxiety than controls
both before and after a ‘getting to know you’ conversation. Interestingly, SAIs also experienced a bigger increase in symptoms of physiological arousal across time periods. Based on these results it appears that SAIs do indeed experience high levels of subjective anxiety when they are interacting with others.

*SAIs tend to be motivated by self-protective concerns when they interact with others.*

Given the high levels of anxiety SAIs experience in social interactions, it might be expected that they would be motivated by self-protective concerns in these encounters. In a study aimed at identifying how social anxiety influences patterns of self-disclosure, Meleshko and Alden (1993) asked participants high and low on a measure of SA to take part in a turn-based ‘getting to know you’ conversation. They found that during this interaction SAIs were more likely to be motivated by self-protective concerns than their non-anxious counterparts. For example, they tended to avoid particular topics because their conversational partner might disapprove of them, were careful what they said to avoid saying the wrong things, and tried to behave in ways that would not draw attention to themselves. Meleshko and Alden (1993) compared this with the more “acquisitive” style adopted by their non-socially anxious participants, who were more likely to be motivated by the idea of attaining positive social outcomes and therefore tended to seek attention and recognition in the interaction.

Self-protective motives were also dominant in high SA participants in a study by Alden and Beiling (1997), who found these subjects to be motivated more strongly by self-protective concerns than those low on SA. More recently, Plasencia, Alden, and Taylor (2011) also found that patients with SAD utilised
impression management strategies (closely monitoring one’s behaviour, rehearsing before speaking, and feigned friendliness) in a laboratory social interaction. These findings support the arguments of Arkin (1981) and Leary and Kowalski (1995) who assert that, when interacting with others, SAIs are fundamentally motivated by a desire to avoid negative evaluations and tend to adopt a self-protective style of relating (e.g., by agreeing with others and voicing only common/safe opinions) to achieve this.

*SAIs tend to engage in subtle avoidance behaviours when interacting with others.*

The avoidance of people and social settings is a core aspect of social anxiety. Recently, researchers have identified that the experience of social anxiety is also associated with ‘in situ’ avoidance once social interactions are actually underway. These may be described as subtle avoidance behaviours, as they appear to keep a socially anxious person somewhat ‘hidden’ from their interactional partner. Meleshko and Alden (1993), for example, found that their socially anxious subjects avoided topics that they feared a conversation partner would disapprove of, and tried to behave in ways that would not draw attention to themselves. In a clinical study by Plasencia, Alden and Taylor (2011) participants with SAD self-reported that they avoided eye contact, limited their speech, and also limited self-disclosure during a ‘getting acquainted’ interaction. Alden and Beiling (1998) also reported that their socially anxious subjects were less intimate in their disclosures than non-anxious controls in a getting acquainted interaction.

Given that self-disclosure is the primary means by which people come to know one another, low levels of self-disclosure may be considered a primary form of
‘in situ’ avoidance. A related behavioural pattern that has also been observed is
known as “innocuous sociability” and occurs when a person simply agrees or ‘goes
along with’ everything else that a conversational partner says. For example, Leary
and Kowalski (1995) reported that SAIs tend to nod and smile more often, and
interrupt less often, than their non-anxious counterparts.

In addition to minimising verbal utterances, subtle avoidance behaviours can
also manifest themselves through non-verbal means. Mauss, Wilhelm and Gross
(2004), for example, asked subjects high on SA to engage in a social stress situation
(giving an impromptu speech). Video observers in this study rated those high on
trait SA as showing a rigid posture and facial expression compared to those low on
SA. Creed and Funder (1998) also found that observers of an interaction rated SAIs
as tending to behave in a reserved and unexpressive manner. These findings suggest
that there is a lack of animation in the social presentation of SAIs.

Apart from direct social avoidance being observed, computer-based studies
have been used to identify whether social anxiety is associated with implicit (or non-
conscious) patterns of social avoidance. To assess this, an ‘approach avoidance
task’ (AAT) paradigm has been utilised in which participants use a joystick to push
away from them (avoid), or pull towards them (approach), images of faces displayed
on a computer screen. In one study, when instructed to alternately push/pull either
faces or images of puzzles that appeared in succession, SAIs showed faster reaction
times when pushing away angry or happy faces, when compared to pulling those
faces towards them (Heuer, Rinck & Becker, 2007). This finding was partially
replicated in a study by Roelofs, Putman, Schouten, Lange, Volman and Rinck
(2010). The authors concluded that this demonstrates an indirect behavioural
tendency towards social avoidance in SAIs. In a variation on this research design, participants were asked to don a virtual reality headset and approach an avatar in a virtual supermarket. Here, SAIs approached the avatar more slowly, and maintained a greater distance from it, compared to non-anxious controls (Rinck et al., 2010). These and other studies (see Lange, Rinck & Becker, 2014, for a review) suggest that social anxiety may be associated with a range of very subtle avoidance behaviours which operate largely outside of a person’s awareness.

The findings around ‘in situ’ avoidance behaviours are quite disparate, but paint a picture of SAIs as tending to stay quiet and still when interacting with others. They tend to maintain a low profile and keep both themselves, and their reactions to things, hidden from interaction partners.

**SAIs tend to engage in fewer pro-social, or ‘approach’ behaviours.**

Consistent with the research on subtle avoidance behaviours, are related findings that SAIs tend to display fewer ‘social approach’ behaviours (compared to non-anxious controls) when interacting with others. For example, Alden and Wallace (1995) found that participants with generalised social phobia who took part in a getting acquainted interaction were rated by both conversation partners and independent observers as conveying less warmth, and displaying fewer positive verbal behaviours, than non-clinical controls. Similarly, Taylor and Alden (2006) found that those with generalised social phobia displayed fewer prosocial behaviours (appearing friendly, self-disclosing) than non-clinical controls, in a getting to know you interaction. Wenzel, Graff-Dolezal, Macho and Brendle (2005) video-taped SAIs as they communicated with their romantic partners for 10 minutes about a problem in the relationship, and then again for 10 minutes conversing about a
positive aspect of the relationship. In the opinion of independent observers of these interactions, in all conditions SAIs exhibited fewer ‘positive’ communication behaviours (e.g., offering an “I feel…” statement, giving a compliment, or showing empathy) than did non-anxious controls.

**SAIs tend not to synchronise, match, or reciprocate in kind the behaviours of interactional partners.**

Some of the findings to emerge from interactional studies may be grouped together under the idea of interpersonal co-ordination. That is, the degree to which behaviours in an interaction are synchronised in timing and form (Frank, Bernieri and Rosenthall, 1991). From an attachment perspective, this idea might be labelled attunement (Bowlby, 1969), as it refers to how aware and appropriately responsive interactional partners are to one another.

As indicated previously, numerous studies have found that social anxiety is associated with lower than normal levels of self-disclosure (Alden & Beiling, 1998; Taylor & Alden, 2006; Sparrevohn & Rapee, 2009). This suggests that, in general, SAIs may experience difficulties in ‘matching’ the disclosure levels of interaction partners. Highlighting this difficulty is Meleshko and Alden’s (1993) study where they specifically manipulated this variable, by instructing conversational confederates to adopt either a ‘high disclosure’ or ‘low disclosure’ approach in a getting to know you interaction. They found that participants high on SA disclosed to a moderate level of intimacy, regardless of the level of disclosure offered by conversational partners. In other words, those high on SA tended not to reciprocate the level of intimacy being offered by their conversational partner.
Another aspect of interpersonal co-ordination involves non-verbal behaviour. For example, it has been shown that human beings have a tendency to automatically co-ordinate aspects of their behaviour (such as posture, body movements, and facial expressions) when interacting with one another, and that this non-conscious behavioural ‘mimicry’ is associated with smoother interactions and also liking between the interaction partners (Chartrand & Bargh, 1999). It is hypothesised that this process communicates interest and attunement, and serves an affiliative function (Lakin & Chartrand, 2003).

A number of recent studies have utilised virtual reality technology to investigate this phenomenon in SAIs. In the first study, Vrijsen, Lange, Dotsch, Wigboldus and Rinck (2010) asked women high and low on measures of social anxiety to listen to a speech given by a virtual man (avatar). The head movements of experimental participants were tracked using a motion sensor, and the avatar either mirrored their head movements (after a 4 second delay), or moved around randomly. In this study, non-anxious participants rated the avatar who mirrored their own head movements more positively than the avatar that did not. Socially anxious respondents, however, rated both avatars the same. Interestingly, this rating was equivalent to the ratings non-anxious participants gave to the randomly moving avatar, suggesting that the SAIs were insensitive to whatever message the mimicry conveyed.

In a follow-up study, Vrijsen, Lange, Becker and Rinck (2010) asked people high and low on SA to watch a speech given by an avatar who displayed a fixed set of head movements. Four independent observers rated the head movements of participants, and found that socially anxious people mimicked significantly less than
the non-anxious individuals. These findings suggest that SAIs may experience some difficulties in reading and responding appropriately to subtle non-verbal behaviours important to affiliation.

Another important non-verbal interpersonal behaviour is smiling. Heerey and Kring (2007) used video recordings in their study to carefully observe and document behaviours exhibited by socially anxious and non-socially anxious controls during a ‘getting acquainted’ interaction. Observers of the interaction coded smiles as either ‘polite’ (smiles without involvement of the eye region) or ‘pleasurable’ (smiles involving a change in the shape of the eyes). Smiling behaviours were also time coded, in one second intervals, to identify who initiated a smile and who responded. In this study, when socially anxious participants initiated a smile, their non-anxious partners were more likely to respond with a matching type of smile. For the socially anxious participants this response pattern did not hold true. They were more likely to smile politely in response to both types of partner smiles. In other words, they tended not to ‘match’ the smiles of their interaction partners.

The findings around interactional co-ordination described above are somewhat limited, as researchers have only recently turned their attention towards this area. They do suggest, however, that social anxiety may be associated with difficulties in ‘tuning in’ to others and/or ‘responding in kind’. This may involve subtle physical behaviours such as head movements or smiles, or a lack of reciprocity in sharing personal information. In summary then, the experience of SAIs in an interaction is characterised by high levels of subjective anxiety. They tend to be motivated by a desire to avoid social ‘mistakes’, and enter social
encounters in a defensive manner. They tend to engage in subtle avoidance behaviours by keeping themselves and their reactions to things hidden. It also appears that they experience difficulties in synchronising their social behaviours to that of an interaction partner. In general, there appears to be a lack of pleasurable reactivity in social encounters. Possibly, they fail to read or perceive the socially affiliative quality of subtle non-verbal behaviours. A key focus of interaction studies has been to try to understand what impact the presentation of SAIs has on interaction partners. In other words, does the avoidance or the lack of social responsivity or reciprocity send a message? Does it tend to invoke a particular response in other people?

**The interaction partner’s experience of interactions.**

Findings from interaction studies are especially important because they provide insights into how the behaviours and demeanor of the socially anxious person are perceived or ‘read’ by their interactional partners. They also provide information about the impact of the SAIs behaviours on interactional partners: for example on their experience of the interaction, and their desire for future interactions with that person.

**Interaction partners notice the anxiety in the other person.**

The first important finding here is that interaction partners ‘pick up’ on the SAIs anxiety. They *perceive* their interaction partner to be visibly anxious. Voncken and Bogels (2008), for example, found that conversational confederates rated patients with SAD as having a more anxious appearance than non-clinical controls. In a ‘getting to know you’ interaction conducted by Alden and Wallace
(1995), both independent observers and interaction confederates perceived patients with SAD to exhibit more behavioural signs of anxiety than non-clinical controls. These results were replicated in an analogue sample of university students (Papsdorf & Alden, 1998). Together, the findings here indicate that interactional partners are well aware that the SAI is feeling anxious in the interaction.

**Interaction partners tend not to enjoy the interaction.**

Another important finding is that interactional partners tend not to enjoy their interaction with SAIs. Meleshko and Alden (1993), for example, found that their interaction confederates reported more discomfort in interactions with SAIs compared to non-anxious controls. This trend has also been noted by observers of interactions, who have perceived interaction partners of SAIs to dislike the interaction (Creed & Funder, 1998). One particularly interesting finding was reported by Heerey and Kring (2007) who tracked state affect throughout a ‘getting to know you’ interaction in an analogue sample of university students. In this study, when non-socially anxious participants interacted with one another they tended to experience an increase in positive affect at the end of the interaction. This pattern was absent when non-socially anxious participants interacted with socially anxious participants. In other words, interaction partners failed to experience an increase in positive affect when interacting with SAIs.

**Interaction partners tend to form negative judgments about the SAI.**

In studies where interaction partners are asked about their judgments of the other party, they tend to judge SAIs negatively. In the study by Alden and Wallace (1995) for instance, both interaction confederates and independent observers rated
those with SAD as less warm and interested than non-clinical controls. Independent observers of an interaction in the Creed and Funder (1998) study rated those higher on SA as tending to be more fearful, and less assertive. Voncken and Djik (2013) tracked evaluations over a number of interactions in their analogue study. They found that SAIs made worse first impressions than non-anxious controls in the eyes of both interaction confederates, and independent observers of the interactions.

Interaction partners can engage in unusual behaviours.

A number of studies have tried to discover whether interactional partners change their own behaviours in some way when interacting with a socially anxious person. There is limited information in this domain. Observers of interactions have perceived that interaction partners, when interacting with more socially anxious participants, tend to try to control the interaction, and engage in advice giving (Creed & Funder, 1998). In another non-clinical study, Heerey and Kring (2007) found that their non-anxious participants offered more empathy and support when interacting with socially anxious participants, than they did when interacting with other non-anxious participants. These findings are tentative, but suggest that the behaviours or demeanor of SAIs might be ‘inviting’ interactional partners into particular ways of relating to them, such as taking charge, and offering support.

Interaction partners tend not to like the SAI.

Finally, and possibly as a result of some of the factors described above (or some other variables yet to be elucidated), interaction partners tend to like socially anxious participants less than their non-anxious counterparts. Lower levels of liking have been found in clinical populations, where interaction partners and independent
observers have rated patients with SAD as less likeable than non-clinical controls (Alden & Wallace, 1995). It is also evident in analogue samples. For example, a number of studies have shown that both independent observers, and interaction partners themselves, tend to rate SAIs as less likeable than non-anxious participants (Meleshko & Alden, 1993; Voncken & Djik, 2013). And finally, from the perspective of observers of interactions, higher levels of social anxiety seem to be associated with higher levels of disliking in interaction partners (Creed & Funder, 1998).

Overall, the interactional studies provide important insights into the experience of non-anxious people when they are interacting with socially anxious individuals. Results indicate that interaction partners both notice, and are impacted by, the anxious presentation of the other party. They can feel uneasy within themselves, form negative judgments about the other person, and find themselves engaging in atypical behaviours. Perhaps most importantly, they tend to find less enjoyment in the interaction and less liking for the person when interacting with SAIs.

**Negative interaction cycles.**

When considering the overall findings from the interaction studies there is growing evidence that negative interaction cycles are a core feature of SAD. The very thing that SAIs are concerned about and try so hard to avoid (evoking negative responses from others) actually does occur, and they experience social rejection from interaction partners. That is, interaction partners tend not to desire future interactions with the SAI. This is a robust findings that is consistent across both analogue (Creed & Funder, 1998; Meleshko & Alden, 1993) and clinical (Alden &
Wallace, 1995; Voncken, Alden, Bogels, & Roelofs, 2008; Voncken, Djik, de Jong, & Roelofs, 2010) populations. A fear of negative evaluation is therefore not something for which SAIs have no evidence. It is a fear based on repeated relational experiences. Interactions often do not go smoothly for socially anxious people, and they experience a lack of interest and withdrawal by others, thereby confirming their fears about relating to others and heightening their experience of social anxiety.

**Potential mechanisms implicated in negative interaction cycles.**

Whilst negative interaction cycles are a well-documented aspect of social anxiety, the reasons *why* social anxiety is associated with social rejection are less well understood. There are a number of ideas which may be applied in an attempt to understand this phenomenon, and these are drawn from theoretical frameworks which attempt to understand and articulate relational dynamics within human interactions.

Attachment theory provides one theoretical framework for understanding the negative interaction cycles. From the perspective of attachment theory, attuned responsiveness is a core behaviour in the process of forming bonds between human beings. Attunement refers to a quality of an interaction between people. It involves being sensitive and responsive to the verbal and non-verbal cues of another. Whilst the role of attunement in newly forming adult relationships is not well articulated (Sbarra & Hazan, 2008) the evidence around its importance in infant/caregiver dyads is very well documented.

Stern (1985), for example, describes affective attunement as the most important mode of sharing inner experience between infants and their caregivers.
This occurs when the feelings of the infant (for example excitement) are matched and reflected back to them (for example via the bodily movements and vocalisations of the caregiver). The infant is thereby able to make a match between their own inner experiencing and the experience of the caregiver, which creates a sense of connection and shared experience (Stern, 1985). At its heart this is a collaborative process, in which the signals of one party are perceived and directly responded to by the other, moment to moment, as an interaction unfolds. Successful, or attuned responding generates states of positive arousal in both parties which works to strengthen attachment bonds. Attuned responding is also central to the process of interactive repair, which modulates negative arousal states emerging from an interaction (Bowlby, 1969). The relevance of this framework to understanding adult interactions is further highlighted by the growing emphasis on intersubjective processes in psychotherapy (Schore, 2012).

From this perspective, the inhibited social behaviours of SAIs may pose difficulties for attunement. For example, low levels of disclosure and emotional expression may make it difficult for SAIs to ‘match’ affective displays in an interaction, leading to misattunement. Similarly, problems in behavioural synchrony may also signal misattunement, a message which may be sent and received largely outside of conscious awareness. A lack of animation and pleasurable reactivity in SAIs in general may also create a sense of unease within interaction partners, which is a well-documented finding from the infant literature (Tronick, 2004).

A variation on this theme is provided by Porges’ ideas about the evolution of the social engagement system in human beings (Porges, 2005). Porges argues that affiliative behaviours can only proceed once individuals perceive one another as
‘safe’. The perception of safety, according to his polyvagal theory, inhibits primitive defensive behavioural systems (fight/flight/freeze) so that prosocial behavioural systems can be recruited in the service of affiliation. In this sense, his ideas echo the findings of earlier attachment researchers who demonstrated that exploratory behaviours in infants tend to be inhibited in the absence of a ‘safe base’ in the form of nearby and responsive caregivers (Ainsworth, Blehar, Waters & Wall, 1978).

According to Porges, the perception of safety is based upon social cues, such as eye contact, vocal quality, body movements and appropriately contingent social behaviours (Porges, 2005). From this perspective, the attenuated social behaviours of SAIs may be impacting on interaction partners perception of safety in the interaction. In other words, by keeping a low profile in the interaction, SAIs may not be sending enough micro-cues of safety (in terms of gaze, expressive vocalisations, reciprocal facial expressions, expressions of contingent affect, etc.) to communicate the message “I am ‘with you’ in this interaction that is unfolding between us”. From the perspective of Porges theory, this would create a sense of unease in interaction partners which would inhibit further affiliative behaviours (thereby explaining their tendency towards avoiding future encounters with the SAI).

Another concept which may be of relevance here is the notion of ‘complementarity’ (Carson, 1969), which was developed out of Harry Stack Sullivan’s ideas about emotional reciprocity (Sullivan, 1953). According to this view, interpersonal behaviours contain within them an invitation to the other party to respond in a particular way. That is, particular interpersonal behaviours or styles of
relating “pull for” a complimentary response in the other party. One finding to emerge from this literature is that affiliative behaviours in one interactional partner tend to impact upon affiliative behaviours in the other party in an additive way. For example, Sadler and Woody (2003) asked unacquainted university students to collaborate on a problem solving task for 20 minutes, and found that one person’s friendliness had a positive impact on the other party’s friendliness. From this perspective the inhibited affiliative behaviours of SAIs might constitute a non-normative response to friendliness, thereby interrupting processes of complementarity. Alternatively, something about the SAIs presentation might “pull for” particular responses in interactional partners which those interactional partners experience as aversive (e.g., they might feel like they need to work harder to get the other person to talk, or that the other person is critical of them since they are receiving no signals of affirmation).

Finally, a number of very recent studies have examined discrete psychological constructs (e.g., ‘perceived similarity’) as potential mediators of the social anxiety, social rejection relationship. Papsdorf and Alden (1998) investigated this in a sample of female university students and found that those high on a measure of social anxiety were perceived to be less similar to themselves by interaction confederates, which lead to less desire for future interactions. Other studies have found some evidence for the role of social performance, similarity, and evoked negative emotions (Voncken, Alden, Bogels & Roelofs, 2008) as well as negative beliefs and social performance (Voncken, Dijk, De Jong & Roelofs, 2010) in mediating the relationship between social anxiety and social rejection. At this stage,
it cannot be said that these results are converging or providing direct support for any
one in particular of the interaction models described above.

In summary, it is not yet clear what relational dynamics underpin the
dysfunctional interaction cycles associated with SAD. A number of potential
mechanisms have been raised, and while they are all potential ways of understanding
the phenomenon none is clearly dominant. What is clear is that some of the
concerns of SAIs about negative social outcomes are realistic. It appears that
difficult interpersonal interactions, and experiences of social rejection, may be a
common part of their experience of the social world. Negative interaction cycles
therefore appear to be an important aspect of the phenomenology of SAD, and a key
maintaining factor in the disorder.

Before concluding this chapter on the phenomenology of SAD, important
exceptions need consideration. Evidence shows that elements of the negative
interaction cycles described above break down under certain conditions. These
exceptions occur both in interpersonal behaviours typically associated with social
anxiety, as well as in the responses of interaction confederates.

An important finding here is that many of the behaviours typically associated
with social anxiety appear to be flexible and contextual. Alden and Beiling (1998)
demonstrated this in a study where they manipulated participants’ appraisals of an
upcoming interaction. Participants were told to anticipate either a smooth
interaction with someone who was similar to them and easy to relate to, or a risky
interaction with someone who was different to them and might be judgmental and
difficult to relate to. In the negative appraisal condition, SAIs tended to talk less,
and about less intimate topics than non-anxious controls, and their behaviour was
judged as less appropriate by interaction confederates. After positive situational appraisals, however, the behaviours and likeability ratings of SAIs were indistinguishable from controls. Similarly, Alden and Wallace (1995) found that when they manipulated the behaviour of interaction confederates to be either warm and supportive, or cool and distant, patients with generalised social phobia displayed more effective social behaviours when interacting with responsive confederates.

Further confirmation of the capacity of SAIs to be more socially effective comes from a study with great ecological validity conducted by Russell et. al. (2011). This study required people with generalised SAD to complete record forms after each naturally occurring social interaction over a 20 day period. The study examined the impact of situational anxiety and emotional security on the interpersonal behaviours of participants. Submissive or deferential interpersonal behaviours were more commonly reported by SAD patients than by non-clinical controls, but only when situational anxiety levels were high. On the other hand, when participants were feeling low levels of anxiety in an interaction, no differences between the groups on these kinds of behaviours were found. Moreover, agreeable and affiliative behaviours increased in interactions where participants felt emotionally secure, with the magnitude of this increase even greater amongst the SAD patients. Overall, these findings suggest that SAIs can behave quite differently (and more normatively) when they feel safe in an interaction, which is consistent with the arguments from attachment researchers described above.

Responses of interaction confederates are also influenced by pro-social behaviours from SAIs. A number of studies have deliberately manipulated social approach behaviours in SAIs to assess the impact this has on the interaction and
interaction partners. Taylor and Alden (2011) did this explicitly, by instructing their participants to drop their idiosyncratic ‘in situ’ avoidance behaviours during an interaction with a confederate. In this study, increases in social approach behaviours lead to more social acceptance and liking from interaction confederates. In an extension of this study, Taylor and Amir (2012) manipulated implicit social approach tendencies via a computer task prior to an interaction. They found that SAI s who engaged in more social approach behaviours (such as talking openly about oneself, conveying interest, being friendly etc.) invoked more positive responses in their interaction partners than those who did not. These results are consistent with other studies showing that increases in self-disclosure (another social approach behaviour) by socially anxious individuals are associated with more favourable responses from interaction partners (Gee, Antony, Koerner & Aiken, 2012; Voncken & Djik, 2013). This evidence indicates that the negative interaction cycles described earlier can be interrupted when SAI s are able to engage in more affiliative behaviours.

In summary, relational dynamics play an important role in social anxiety. The experience of social anxiety is associated with characteristic ways of behaving in interpersonal situations which tend to invoke negative reactions from others, including social rejection. These negative interaction cycles are likely to be a key maintaining factor in the disorder, as they maintain SAI s’ experience of social isolation by interrupting the process of relationship formation, whilst also confirming their worst fears about themselves and social situations. The exact mechanisms involved in this process are currently unknown, however there is some
evidence that the cycle can be broken when SAIs feel safe in an interaction and engage in more pro-social behaviours.

**Conclusion**

The experience of social anxiety is complex and multifaceted. Each of the broad domains described above are both aspects of the experience, and causative factors. Social isolation, for example, appears to be both an aspect of the disorder, and a cause of anxious arousal in itself, and the same can be said for the intrapsychic and interpersonal processes described above. The domains themselves seem also to be reciprocally bound to one another. For example, a negative interaction cycle may confirm a person’s fears about their own unworthiness, or the dangers of relating to others, whilst also contributing to their social isolation. If one is socially isolated, and having few interactions, then that upcoming conversation with a colleague at work takes on much greater importance, adding to the anxiety and making it harder to relate naturally and spontaneously, which may lead to an awkward interaction… and so the cycle continues. Of course, this formulation is speculative, but it is helpful because it encourages thinking about the reciprocal nature of the various elements. The ultimate cause of the situation may not be discernible, but once established it appears that the various elements combine in a way that is self-reinforcing.

This chapter has provided a broad survey of various aspects of the phenomenology of SAD. One of the most important benefits of this broadening understanding is that treatment protocols have been expanding and adapting in light of this emerging body of knowledge. These treatment models are examined in the next chapter.
Chapter 3: Treatments for SAD

Introduction

The past few decades have seen substantial activity in the development of treatment protocols for SAD. With regard to psychological treatments, which form the subject of this chapter, the field is dominated by cognitive behavioural treatment protocols. In particular, the models proposed by Clark and Wells (1995)/Clark (2001) and Rapee and Heimberg (1997)/Heimberg, Brosovitch and Rapee (2010) have proven very influential. More recently a number of variations or refinements have been made to CBT models (e.g., Hoffman, 2007; Moscovitch, 2009), and an interpersonal model of SAD has been proposed (Alden & Taylor, 2011).

In many ways the developments in treatment protocols for SAD represent an exemplar of the scientist/practitioner model. Theoretical models, clinical outcomes, and basic research have all contributed to an expanding awareness of the phenomenology of the disorder, which has prompted further refinements to treatment frameworks in an iterative developmental process. The findings highlight both the substantial progress made to date, and also the possibility of further gains particularly in group therapy for SAD.

In this chapter the cognitive theoretical models of SAD proposed by Clark and Wells (1995)/Clark (2001) and Rapee and Heimberg (1997)/Heimberg, Brozovitch and Rapee (2010) are introduced. A number of key issues raised within the broader treatment outcomes literature are described, as these highlight the need to investigate more fully a wider range of processes involved in group therapy for SAD. Some very recent developments within CBT treatment models for SAD are also considered.
Cognitive Theoretical Models of SAD and their Treatment Protocols

Cognitive models of SAD maintain a strong focus on the internal mental processes implicated in social anxiety. This reflects historical assumptions that social anxiety can best be understood as an intrapsychic phenomenon (as per the diagnostic criteria in DSM-III (APA, 1980) through to DSM-5, (APA 2013)) rather than a problem in relating. These cognitive models account well for much of the intrapsychic phenomenology of SAD. For example, beliefs about the self, appraisals of social situations, and attentional processes are all conceptualised as causal factors and targets for therapeutic intervention. These frameworks offer a sophisticated model of how various aspects of experience (thoughts, bodily sensations and behaviours) interact with one another within the experience of social anxiety. Interpersonal processes are mentioned (for example, it is often argued that problematic beliefs may be the result of social learning experiences) but are less well developed than in the interpersonal model of SAD (discussed later in the chapter).


The first of the two major cognitive models was proposed by Clark and Wells (1995), and updated by Clark (2001). According to this model, the experience of social anxiety starts with a cognitive event – an appraisal. When a person appraises a social situation as one in which they might face negative evaluation, it is believed that an ‘anxiety program’ is activated. This involves the initiation of a number of cognitive and behavioural processes which reinforce one another and contribute to the experience of social anxiety. The core components of this model are set out below in Figure 1.
Perceived social danger.

As outlined in Figure 1 Clark and Wells (1995) argue that for socially anxious individuals (SAI’s), social situations trigger the emergence of a range of unhelpful cognitions. These include beliefs about the self (e.g., I am unlikeable/inadequate), about ‘standards’ of social performance (I must always have something interesting to say), and about the consequences of inadequate social situation.


performance (If I’m not interesting they will dislike/reject me). These assumptions contribute to a perception that the social situation is a dangerous one which may involve negative evaluations from others.

*Processing the self as a ‘social object’.*

This perception of danger is believed to trigger a shift in attention, such that a person diverts cognitive resources onto the processing themselves as a “social object”. In other words, they start to monitor themselves carefully, to assess how they might be coming across to other people. This involves a preoccupation with internal cues of anxiety (somatic and cognitive symptoms) such as physical sensations like a racing heart or clammy hands, and also negative thoughts about the self and one’s social abilities. It is proposed that this preoccupation with the internal experience of anxiety works to amplify the anxiety. At the same time, Clark and Wells (1995) argue that SAI’s utilise this internally generated information to make inaccurate inferences about how they are coming across to others in a social situation (Spurr & Stopa, 2002). For example, a person who feels flushed may assume that they are blushing wildly when others cannot actually notice any blushing. Or they may imagine and hold in their mind a distorted image of themselves as they imagine they would appear to an observer – an image which is based on their own fears rather than what another person would actually see in the situation (Clark & Wells, 1995). For example they may imagine themselves as looking foolish, or highly anxious, which further exacerbates their experience of anxiety. This process may be likened to an excessive self-consciousness, fuelled by inaccurate and fear inducing perceptions of the self.
Safety behaviours.

The Clark and Wells (1995) model also highlights the role of a particular category of ‘in-situ’ behaviours that they define as “safety behaviours”. These are behaviours that are intended to reduce the likelihood of a feared outcome from occurring (McManus, Sacadura & Clark, 2008). Some of these behaviours might be purely internal, such as rehearsing an utterance before speaking to avoid saying something inarticulate. Others may be observable, such as holding onto an object tightly in order to hide a hand tremor. It is argued that safety behaviours contribute to anxiety in a number of ways. For example, safety behaviours perpetuate self-focused attention and self-monitoring, and can directly contribute to the actualisation of feared outcomes (e.g., a person holds on to a cup so tightly that they amplify a small hand tremor into something clearly noticeable). Clark and Wells also note that these behaviours can influence interaction partners in a negative way. For example, saying little in an effort to avoid saying the wrong thing can lead interaction partners to perceive the socially anxious individual as cold or unfriendly (Clark, 2001). They also argue that the use of safety behaviours is problematic because it precludes the processing of disconfirming evidence emerging out of a social interaction. For example, if an interaction goes smoothly, an anxious individual might attribute this to the effectiveness of their safety behaviours, rather than recognising that the outcome related to their own social competence or likeability.

Somatic and cognitive symptoms.

Clark and Wells (1995) reference the impact of bodily and cognitive symptoms of anxiety in a number of ways. As described above, they are thought to provide distorted and negative inputs into the processing of the self as a social
object, thereby heightening anxiety in a social situation. Hyper-vigilance for signs of anxiety is also thought to enhance the intensity of anxious arousal. Finally, certain safety behaviours (such as the example of tightly holding a cup described above) are believed to amplify the experience of physical sensations of anxious arousal.

**Pre and post event ruminations.**

Outside of the immediate moment of social interaction, Clark and Wells (1995) propose that socially anxious individuals ruminate about their social encounters. This can occur before the event where unpleasant social experiences are anxiously anticipated, and after the event where interactions are replayed and ruminated upon. It is believed that these replays are dominated by the socially anxious individual’s negative self-perceptions, and also negative interpretations of ambiguous social stimuli. This can result in a relatively neutral social encounter being encoded into memory as a “social failure” thereby generating distress, contributing to future avoidance, and further reinforcing unhelpful beliefs about the self and the dangerousness of social encounters (Clark, 2001).

**Limited and biased processing of external social cues.**

Clark and Wells (1995) propose that the ‘anxiety program’ described by their model is a relatively closed processing loop. The shift towards processing of the self as a ‘social object’ is believed to recruit virtually all attentional resources, with the result that the socially anxious individual is largely unaware of external social cues during an interaction. Whilst some minimal amount of external processing is believed to occur, it is thought to be negatively biased. This might include noticing
and remembering only the negative reactions of others, or perceiving neutral social stimuli in a distorted and negative manner (Clark, 2001).

**Mode of treatment and clinical outcomes.**

The Clark and Wells model has been developed into a form of individual treatment for SAD called Individual Cognitive Therapy (ICT; Clark et. al., 2003). In essence, ICT aims to develop and work with an idiosyncratic model of social anxiety for each individual seeking treatment. This involves identifying a person’s unique cognitions with regard to feared social outcomes and their perceived consequences. It also involves pinpointing any safety behaviours that the person utilises to “ward off” these feared outcomes, and ascertaining the nature of any negative images/perceptions the person holds about themselves in social settings. The elements of this idiosyncratic model (cognitions, safety behaviours, attentional processes) then become the targets of therapeutic intervention.

A core component within this treatment is the ‘behavioural experiment’, which is designed to promote cognitive change by generating experiential evidence that refutes fearful predictions about social situations (Hedman, Mortberg, Hesser, Clark, Lekander, Andersson & Ljotsson, 2013). For example, a person may fear that if they just say things as they come into their mind, then others will think they are stupid. In a behavioural experiment, the person might be encouraged to speak spontaneously, and then observe the reactions of others. Repeated experiential disconfirmation of social fears is believed to be the primary mechanism leading to cognitive change. In addition, experiential exercises are used to promote reflection and learning about the impact of safety behaviours, and self-focused attention. Video feedback is used to challenge negative self-imagery, surveys are used to
challenge expectations about the perceptions of others, and training in attentional processes is provided. Anticipatory and post event ruminations are also targeted by encouraging participants to refer to the more realistic sources of information gathered via the exercises listed above.

It has been argued by Mortberg, Clark, Sundin and Wistedt (2007) that individual therapy is the preferred format for this therapy primarily because it allows adequate time for therapists to develop an idiosyncratic model of social anxiety for each individual seeking treatment (which may be more difficult to achieve in a group setting where therapists have less time to spend working with each individual). It has also been suggested that the group format may be too demanding for some socially anxious people, because it is essentially an uncontrolled form of exposure (Stangier, Heidenreich, Peitz, Lauterbach & Clark, 2003). Individual therapy based on the Clark and Wells (1995) model has received substantial empirical support as an effective treatment for Social Anxiety Disorder (Clark et al., 2003; Clark et. al., 2006; Hedman et al., 2013; Mortberg et al., 2007; Stangier et al., 2003).

**Rapee and Heimberg (1997), Heimberg, Brozovich and Rapee (2010).**

The second major cognitive model of SAD was proposed by Rapee and Heimberg (1997) and updated by Heimberg et al. (2010). Like the Clark and Wells model, the Rapee and Heimberg model attempts to explain how anxiety is generated and maintained when socially anxious individuals enter into a social setting. The key components within this model are set out in Figure 2 below.
Figure 2 – Cognitive model of social anxiety

As represented in Figure 2, the Rapee and Heimberg (1997) model is substantially similar to the Clark and Wells (1995) model. In both models, the perception of threat (i.e., a social encounter) is thought to trigger a cascade of interacting processes which work to heighten anxiety. These include a shift in attention towards social threat cues, and an excessive monitoring of the self and how the self may be coming across to others. Both models also highlight the impact of dysfunctional avoidance behaviours, and unhelpful cognitions including distorted views of the self, unrealistic standards of performance, and frightening beliefs about the consequences of falling short of those standards. The update to the Rapee Heimberg model introduces a stronger focus onto the role of negative self-imagery (in particular images of the self from an observer perspective), and post-event processing, which both recognises emerging research in these areas and brings the model into closer alignment with Clark and Wells. Because of the similarities between the models, a detailed explanation of the various components of the Rapee Heimberg model is not undertaken, as most of them have been described above within the Clark and Wells model. There are, however, some subtle and interesting differences between the models that warrant attention. These differences relate to ‘external indicators of evaluation’ and ‘the role of safety behaviours’.

**External indicators of evaluation.**

A core claim within both models is that the experience of social anxiety is associated with an increase in self-focused attention. For Clark and Wells, this shift is thought to largely dominate awareness at the expense of awareness of the external environment (Clark, 2001). For Rapee and Heimberg the experience of social anxiety is thought to be associated with shifts in attention aimed at both internal (am I shaking?) and external (are they noticing that I am shaking?) sources of threat.
Anxious attention is conceptualised as more flexible from this perspective, with a greater awareness and sensitivity to the external environment. One interesting aspect of the updated model of Heimberg et. al. (2010) is that the nature of external threat has been redefined from negative evaluation to evaluation *per se*. This is in light of recent findings that socially anxious individuals can also fear positive evaluation (Weeks, Jakatdar & Heimberg, 2010), highlighting the potential for any kind of evaluation to act as a threat cue.

*The role of safety behaviours.*

Another difference between the models is the role attributed to safety behaviours. Whilst Heimberg, Brozovich and Rapee (2010) note that socially anxious individuals often engage in subtle avoidance behaviours when interacting with others, these behaviours are not given the same emphasis that they are within the Clark and Wells (1995) model.

*Mode of treatment and clinical outcomes.*

The Rapee and Heimberg model has been developed into a manualised group treatment protocol for social anxiety disorder called Cognitive Behavioural Group Therapy for Social Phobia (GCBT; Heimberg & Becker, 2002). The basic cognitive behavioural treatment framework is very similar to the Clark and Wells (1995) model, although there are some differences in emphasis. Both models aim to help people learn more about, and change, their own unique constellation of anxiety inducing cognitions and behaviours. Both models also rely heavily on the use of behavioural experiments, or exposures, to support this process. And both conceptualise these exposures as vehicles to promote cognitive change via the
experiential disconfirmation of fearful thoughts about the self, other people, and social situations (rather than as simple opportunities for habituation to anxiety).

One point of difference is that the Heimberg et. al. (2002) treatment protocol utilises cognitive restructuring methods to help clients manage their anxiety in the lead up to, and during, a feared social encounter via the use of ‘rational responses’. For example, a person who was worried that they might blush when asking their boss a question might develop a rational response “Even if I blush, I can still say what I need to say to my boss”. Self-statements like these can be used to help a person soothe themselves when they start to feel their anxiety rising, either before or during an interaction. This particular form of cognitive restructuring is less emphasised in the approach of Clark (2001), who maintains a stronger focus on identifying and eliminating safety behaviours.

Perhaps the primary point of difference in the approach to treatment is that the Heimberg program is designed to be delivered in a group format. In their treatment manual outlining the GCBT protocol, Heimberg and Becker (2002) argue that the group format is preferable to individual therapy when working with social anxiety. They propose that the group provides a number of benefits for a socially anxious person, including the opportunity to:

1. Directly confront a feared stimulus;
2. Test out their concerns about the perceptions of other people; and
3. Utilise the other group members to create a wide range of therapeutic simulations (i.e., behavioural experiments).

Heimberg and Becker (2002) also cite and adapt a list of general advantages of the group format developed by Sank and Shaffer (1984).
4. *Learning that others have similar problems* – many people with social anxiety do not talk to others about their difficulties, and so they often believe they are the only one so affected. Learning that others face similar difficulties can provide a powerful corrective experience.

5. *Vicarious learning* – people can learn from other group members who are successfully using the skills the treatment program aims to develop.

6. *Peer learning* – group members can learn from others in the group who experience high levels of anxiety, but still struggle on and improve. This provides a realistic coping model.

7. *Learning through helping others* – group members can help others, and be a part of a peer support system.

8. *Encouragement through seeing others succeed* – seeing others improve can generate hope within a person about their own prospects for change.

9. *Fostering independence* – the group format encourages people to rely upon themselves, rather than become dependent on the therapist.

10. *Public commitment* – joining a group is making a public commitment to change.

There is some overlap between the constructs described above, and they are not operationalised in great detail. However, they do indicate that Heimberg and Becker (2002) conceptualise the therapy group as a forum which confers some potentially unique therapeutic benefits. Unfortunately, the authors do not elaborate any further on these constructs or provide any guidance to therapists on how to facilitate their emergence in the group and maximise their impact. Group therapy based on the Rapee and Heimberg model (1997) has also received substantial empirical support as an effective treatment for Social Anxiety Disorder (Eng, Coles,

Summary

This section has reviewed the two predominant cognitive-behavioural models of SAD. Both the models of Clark and Wells (1995) and Rapee and Heimberg (1997) have led to the development of effective treatment protocols. The great strength of these models is that they are informed by a growing understanding of the phenomenology of social anxiety. It was this understanding that allowed the research teams to adapt a standard CBT approach to take into account an increasingly fine grained understanding of psychological and behavioural processes implicated in the maintenance of social anxiety. These protocols therefore target specific phenomena that have a demonstrated connection to the disorder, and they are being enhanced on an ongoing basis in light of new research findings.

One strength and limitation of these models is their strong focus on intrapsychic phenomena. It is a strength because the models take into account much of what is known about the intrapsychic phenomenology of SAD (as described in Chapter 2). It is a weakness because they are not well informed by findings that highlight the relevance of interpersonal processes in maintaining social anxiety. And because these aspects were not included in the CBT models at their inception, they have been largely absent from efforts to refine and enhance them.
Key Issues Highlighted within the Broader Treatment Outcomes Literature

In addition to research supporting the two dominant treatment models described above, there is a substantial body of research investigating the efficacy of CBT interventions more broadly in the treatment of SAD. There are a large number of treatment outcome studies, and the field has been subjected to meta-analyses on six separate occasions (Acaturk, Cuijpers, van Straten & de Graaf, 2008; Fedoroff & Taylor, 2001; Feske & Chambless, 1995; Gould, Buckminster, Pollack, Otto & Yap, 1997; Taylor, 1996; Wersebe, Sijbrandij, Cuijpers, 2013) with the broad finding that CBT interventions are effective in the treatment of social anxiety. A number of themes important to this thesis are emphasised by the findings from this broader literature. One major theme taken up is the debate between proponents of individual and group therapy, which highlights the need to learn more about the role of interpersonal and group processes in CBT therapy groups. A second theme emphasised by these findings is the limitation in knowledge about the nature of therapeutic change in social anxiety, which highlights the need to learn more about phenomenological change in SAD. Both of these themes highlight the need to investigate more fully a wider range of processes involved in group therapy for SAD.

The debate between proponents of individual and group therapy.

There has been debate in the treatment literature between the proponents of individual therapy and group therapy for SAD. This is important to consider, because it highlights the way that groups have been conceptualised within the CBT literature to date, and also opportunities for future improvements to the group protocols. Heimberg and Becker (2002) have claimed that the group is a superior
format because of the 10 advantages of the group format outlined in the description of their treatment protocol described above. In contrast to this, Clark and colleagues (Stangier, Heidenreich, Peitz, Lauterbach & Clark, 2003) have claimed that individual therapy is the superior format, and attempts to investigate this empirically have been undertaken by comparing individual and group treatments in three clinical trials.

In the first study Stangier et. al. (2003) compared individual cognitive therapy (ICT) based on the Clark and Wells (1995) model, to a locally adapted group version of the same ICT treatment protocol. Both interventions were associated with significant pre-treatment to post-treatment improvements on measures of social anxiety. It was also found that ICT was superior to the group protocol on one out of three social anxiety measures, and that significantly more people no longer met diagnostic criteria after ICT compared to the group treatment. Conversely, only those in the group condition experienced significant improvements in measures of mood and general symptomology. In a second study, Mortberg, Clark, Sundin and Wistedt (2007) compared ICT (based on the Clark & Wells, 1995 model) with a locally developed group protocol, based on the same ICT treatment model, and adapted to include psychoeducation and applied relaxation. The group protocol was somewhat unusual in that it was delivered in an intensive format (5 hours per day for 8 consecutive days, with a one week gap in the middle of treatment). In this study, both treatments were associated with significant and enduring improvements on measures of social anxiety. ICT was the stronger performer, however, leading to significantly larger reductions (almost double the effect size achieved by the group treatment) on social phobia composite scores.
In the third study Hedman, Mortberg, Hesser, Clark, Lekander, Andersson and Ljotsson (2013) investigated the role of mediators of clinical change in individual CBT therapy for SAD based on the Clark et. al. (2003) model compared to CBT group therapy for SAD based on the Heimberg and Becker (2002) model. They examined the role of avoidance, self-focused attention, anticipatory processing and post-event processing as mediators of clinical improvement within the two forms of therapy. In this study, both interventions led to significant improvements on measures of social anxiety, with ICT having a larger effect than the group treatment. Interestingly, there was also evidence of different mediational pathways being active in the two formats. In ICT, clinical improvement was mainly mediated by reductions in avoidance and self-focused attention. In the group format, improvement was mainly mediated by changes in self-focused attention and anticipatory and post-event processing. The authors tentatively concluded from this that improvements may be linked to different mechanisms within individual therapy and group therapy.

It is difficult to interpret these results. Clearly, both treatment formats have been shown to be effective. Beyond this the findings are less certain. Clark and colleagues (Hedman et al., 2013) have cited the first two studies as evidence that ICT has been shown to be superior to group CBT. However, Irving Yalom has expressed concern about claims like these noting that many CBT group protocols pay little heed to cultivating relationships between the members, thereby robbing the group of its most potent therapeutic force (Yalom & Leszcz, 2005).

This is an interesting observation, because it highlights different ways that “the group” can be conceptualised within treatment programs. An examination of the treatment procedures described within the Stangier et. al. (2003) and Mortberg
et. al. (2007) studies indicates that only the most minor adjustments were made to adapt the individual ICT protocol for delivery within a group setting. For example, in the first study, other group members were used instead of the therapist in certain roleplays. Group members were also invited, alongside the therapists, to provide feedback to other group members on their video presentations. These adaptations suggest that, for these therapists at least, the presence of other group members was considered therapeutically useful mainly because it provided extra resources that could be utilised to enhance the procedures of the individual protocol (which was applied to each group member in turn). Indeed, the authors of the second study assert that in their therapy groups all of the key therapeutic exercises were individualised. This highlights one of the criticisms that have been levelled at CBT groups, which is that they conceptualise the group in a rather unsophisticated way, as merely a passive forum within which a predominantly individual form of therapy may be delivered to a larger number of people with little thought given to the appropriateness of model migration (Richards, Burlingame, & Fuhriman, 1990).

This contrasts with treatment approaches that conceptualise ‘the group’ itself as an active agent of therapeutic change, and within which great care is taken to understand and work with the group as a therapeutic entity. This typically involves attending to concepts fundamental to the broader group therapy literature such as stage of group formation, group process, and group ‘as a whole’ phenomena such as cohesiveness (Bloch & Crouch, 1985; Yalom et al., 2005). These frameworks are discussed in more detail in Chapter 4. They are mentioned here to highlight the limited adaptation of ICT to the group format within the Stangier et. al. (2003) and Mortberg et. al. (2007) studies. This calls into question the claim of Clark and colleagues (Hedman et al., 2013) about the established superiority of the individual
format based on these two studies. A more cautious interpretation of the findings would be that a treatment protocol developed for individuals has been shown to be less effective when delivered ‘as is’ in a group setting.

The third study is more helpful, as it compares ICT with a version of cognitive therapy designed to be delivered in a group format, and provides some evidence of superiority for the individual format. It is important, however, to consider this outcome in light of the meta-analytic findings which have assessed outcomes across a broad range of studies. Gould, Buckminster, Pollack, Otto and Yap (1997) analysed 14 controlled treatment outcome studies of cognitive behavioural treatments for social phobia. In their analysis, group treatments appeared to have an advantage over individual treatments (achieving double the effect size), although this was only at the level of trend. In a subsequent analysis by Fedoroff and Taylor (2001) which examined 33 studies employing either exposure, cognitive restructuring, or a combination of the two, no significant differences were found between programs delivered in the individual or group formats.

It appears therefore that no firm conclusions can be drawn from the current literature, other than the general finding that both forms of therapy have been shown to be effective in the treatment of SAD, and there is little to currently separate them in terms of clinical outcomes. It may be, however, that there are opportunities to enhance the group protocols by better understanding and harnessing the ‘group’ aspect of the therapy.

In this respect the most recent finding of Clark and colleagues (2013) is intriguing, because it suggests that improvements in individual and group therapy might be linked to different therapeutic mechanisms. This supports the idea,
advanced by Heimberg and Becker (2002), that there are particular variables unique to the group format which confer a therapeutic benefit. These have not been investigated empirically as yet, however, and so little is known about group specific processes that may be important to clinical outcomes in CBT groups for SAD.

In the absence of published work, research is needed on the nature and impact of group process variables in CBT groups for SAD. Chapter 4 therefore provides a review of the broader group therapy literature, to establish a framework from which to assess the potential relevance of group process variables to the treatment of social anxiety. To go beyond this, to a specific understanding of the role of group processes within existing CBT group protocols, in-depth qualitative analysis of participants experiences in these groups is required.

**Broader findings with regard to the efficacy of CBT, and the need to better understand therapeutic change in social anxiety.**

The utility of CBT more broadly as a treatment for social anxiety has been investigated in a large number of treatment outcome studies. As indicated previously, six meta-analyses (Acaturk et al., 2008; Fedoroff et al., 2001; Feske et al., 1995; Gould et al., 1997; Taylor, 1996; Wersebe et al., 2013) have been conducted with the findings serving to highlight the importance of learning more about the nature of therapeutic change in social anxiety.

In the first meta-analytic study, Feske and Chambless (1995) investigated the differential effects of exposure compared to cognitive restructuring within CBT treatment programs. They analysed 21 treatment outcome studies and found that exposure with and without cognitive restructuring was equally effective in the treatment of social phobia (i.e., they both produced substantial improvements on
measures of social anxiety, cognitive symptoms, and depressed/anxious mood). One interesting finding to emerge from this analysis was that both the combination of exposure and cognitive restructuring, and exposure on its own, produced equivalent cognitive change amongst participants. There was no evidence of any incremental benefit, in terms of promoting cognitive change, when cognitive restructuring techniques were added into an exposure-based treatment program.

In the second study Taylor (1996) analysed 42 treatment outcome trials for social phobia, to compare the relative utility of various components typically found in CBT treatment programs (i.e., exposure, cognitive restructuring, exposure plus cognitive restructuring, and social skills training). He found that all treatments, including placebo, yielded significantly larger effect sizes than the wait-list condition. However, only exposure plus cognitive restructuring yielded a significantly larger effect size than placebo. He concluded that, in contrast to the findings of Feske and Chambless (1995), there was evidence that adding cognitive restructuring techniques to exposures conferred an additional benefit.

In the third study Gould, Buckminster, Pollack, Otto and Yap (1997) analysed 24 controlled treatment outcome studies of cognitive behavioural (exposure, exposure plus cognitive restructuring, and cognitive restructuring alone) and pharmacological treatments for social phobia. In this analysis all cognitive behavioural treatments were superior to control conditions, and were therefore reported as effective interventions for social phobia. The authors also found a small advantage in treatment effect size for exposure when compared to exposure plus cognitive restructuring. Gould and colleagues concluded that, if cognitive change was required for the effective treatment of social phobia, then perhaps this could be achieved without the use of cognitive restructuring techniques.
In the fourth meta-analysis Fedoroff and Taylor (2001) analysed 108 treatment outcome studies of cognitive behavioural (exposure, cognitive restructuring plus exposure, social skills training, and applied relaxation) and pharmacological treatments for social phobia. They found that all cognitive behavioural treatments were effective in reducing scores on measures of social anxiety. However, the treatment conditions did not differ from one another. Nor was there a significant difference between their impact and that of the “attention placebo” intervention. The authors concluded that all the psychological therapies were moderately effective treatments for social phobia, with similar effects.

In the fifth study Acaturk and colleagues (2008) updated the previous meta-analytic findings in light of more recent studies, and sought to enhance the quality of the findings by restricting their analysis to only randomised controlled studies. They assessed 29 studies, including 14 new studies conducted since the publication of the Fedoroff and Taylor (2001) paper. This analysis confirmed the findings of previous meta-analyses, concluding that cognitive behavioural interventions were an effective treatment for social anxiety disorder. One interesting finding was that, when subgroup analyses were conducted, the addition of specific treatment components (e.g., exposure, cognitive restructuring, social skills training or applied relaxation) made no difference to effect sizes.

Finally, Wersebe, Sijbrandij and Cuijpers (2013) maintained a particular focus on group treatments. They analysed 11 randomised controlled studies and found a large degree of variability in effect sizes achieved by the different programs. The authors did not speculate as to the source of these differences, and concluded that CBT group treatments have a moderate and significant effect (compared to control conditions) in the treatment of SAD.
Overall, the findings from the meta-analytic studies indicate that CBT interventions are effective in the treatment of social anxiety disorder. Effect sizes for CBT interventions in these analyses typically fall in the range of 0.6 to 0.8 (for both controlled and uncontrolled effect sizes), indicating a moderate to strong therapeutic impact for these treatments. Such an impact is likely to result in a large proportion of individuals experiencing clinically significant change (Rodebaugh, Holaway, Heimberg, 2004). At the same time, the results also indicate that a substantial proportion of individuals will not respond to the therapy, and the evidence for the superiority of CBT over credible control conditions (i.e., pill placebo, or a credible psychological control) is inconsistent. In summary then, whilst the CBT protocols have shown efficacy overall in reducing the symptoms of social anxiety, there remains a pressing need for further improvement.

One particularly cogent finding to emerge out of the meta-analytic studies is the lack of differences in the impact of various treatment components typically found within CBT treatments (e.g., exposure vs. cognitive restructuring vs. social skills training). It is difficult to interpret this finding. One interpretation would be that no difference has been found because they are all equally ineffective, but this seems unlikely given the treatments have a proven impact. Another interpretation, raised by Rodebaugh and colleagues (2004) is that it is difficult to effectively disentangle the treatment elements from one another. As an example they cite the debate in the literature between proponents of exposure and cognitive restructuring. They point out that even in a purely exposure-based treatment, the exposures will inevitably activate mental representations of the event, which will be discussed with the therapist (i.e., some form of cognitive restructuring will occur). They suggest that the dichotomy between exposure and cognitive restructuring is a false one,
because elements of both cognitions and of behaviours are invariably invoked and worked with in either treatment, making it impossible to disentangle their unique contribution to outcome.

In summary, whilst the meta-analytic findings have shown that CBT interventions in various forms have demonstrated effectiveness in the treatment of social anxiety, there is a pressing need for further improvement. At the same time it remains unknown which aspects of the treatment are more or less important to clinical outcomes, which makes it difficult to know exactly where efforts to improve the protocols should be targeted. This state of affairs has prompted some researchers to call for more basic research into mechanisms of clinical change in social anxiety (Hofmann, 2010).

One of the difficulties facing those who wish to better understand mechanisms of change in social anxiety is the lack of a well-articulated model of what therapeutic change actually looks like. What currently exists in the literature are some very detailed models of dysfunction. For example, the cognitive behavioural anxiety maintenance models discussed earlier in this chapter are attempts to describe how different aspects of human experience (thoughts, bodily sensations, and behaviours) come together and contribute to the particular ‘type’ of problematic human functioning described by the phenomenology of Social Anxiety Disorder. These theoretical models paint a detailed picture of what is going wrong within a person, and therapeutic change has been defined as change in relation to these models of dysfunction. This might involve a reduction in the severity of symptoms listed within a diagnostic taxonomy such as the DSM-5. Or it might involve a reduction in scores on psychometric measures thought to capture important aspects of social anxiety (such as Mattick & Clark’s (1998) Social Interaction
Anxiety Scale), or reductions in behaviours (i.e., safety behaviours) or thoughts (i.e., post-event ruminations) considered important maintaining factors within the theoretical models. In essence, therapeutic change in SAD has been conceptualised as the elimination or attenuation of aspects of functioning deemed problematic within the existing theoretical models of dysfunction.

This approach has generated impressive results in the form of the current treatment protocols. One limitation of this approach, however, is that our theoretical models are incomplete. It is possible, or indeed even likely, that important aspects of therapeutic change in social anxiety are not captured by existing theoretical models and remain to be discovered. A good example of this is the recent addition of an interpersonal model of social anxiety (Alden et al., 2011, to be discussed later). Because interpersonal processes were not incorporated into early cognitive models of SAD, their nature and impact has been largely unexamined, until very recently. And so relying on existing theoretical models is limited by the essentially confirmatory nature of the exercise.

An alternative way to generate information about therapeutic change in SAD is to ask a different sort of question. The general approach described above can be described as revolving around the question “How can we better understand and eliminate the dysfunctional aspects of the puzzle of social anxiety?”. A slightly different question would be to ask “What does better functioning look like for a socially anxious person?”. In other words, when people improve, what is different about their experience of social anxiety? A focus on phenomenological change, rather than phenomenological dysfunction, is needed to generate a better understanding of therapeutic change in social anxiety.
In closing, the broader research base into CBT treatments demonstrates their efficacy whilst also highlighting the need to further improve the protocols. Based on current knowledge, it is unclear exactly where improvements to the protocols should be targeted. One way to identify improvements to the protocols would be to build upon the understanding of what therapeutic change (beyond symptom reduction) looks like in social anxiety. This thesis therefore aims to examine the nature of phenomenological change in social anxiety.

Recent Developments in CBT Treatment Models

There have been a number of recent enhancements to CBT treatment models. Two of these developments, proposed by Hoffman (2007) and Moscovitch (2009) sit comfortably within the frameworks discussed thus far. The third enhancement, proposed by Alden and Taylor (2011), introduces a strong focus on interpersonal processes and represents a different perspective for conceptualising and working with social anxiety. Reviewing these models brings the review of the treatment protocols and their outcomes up to date, and highlights an important opportunity for enhancing the group CBT protocols.

Stefan Hoffman – ‘social mishap’ exposures.

Stefan Hoffman has proposed a new social anxiety maintenance model (Hoffman, 2007). It is substantially similar to the other CBT models, with some slight differences in emphasis. The main point of difference is that Hoffman’s model maintains a particular focus on socially anxious individual’s beliefs about social mishaps. This includes beliefs about the likelihood that a person will commit
some kind of social ‘faux pas’, and also beliefs about the likely social costs of such an event. For Hoffman, catastrophic expectations about the likelihood and cost of social blunders are a particularly important maintaining factor in social anxiety, and a crucial mediator of clinical change (Hoffman, 2004). From this perspective, the main problem with safety behaviours and other forms of avoidance is that they interrupt a person’s capacity to critically evaluate feared outcomes (i.e., social blunders) and their likely consequences.

In terms of treatment, Hoffman has argued for the application of exposures that specifically target cognitions about social mishaps. In particular, those in treatment are encouraged to deliberately bring about feared social outcomes in order to test predictions about their likely impact. So, for example, a person who is afraid of rejection might be encouraged to engage in a social mishap exposure where they deliberately bring about and experience rejection (e.g., by asking 20 random people out on a date; Hofmann, 2010). This is intended to help a person realise that being rejected does not lead to the terrible consequences that they might imagine, thereby promoting cognitive change in beliefs about the likely cost of feared social outcomes, and lessening anxiety overall about social encounters.

The impact of high expectations about social cost has been investigated in a treatment outcome study, where it was found that changes in estimated social costs mediated treatment change in two forms of treatment (Hofmann, 2004). More recently, Fang, Sawyer, Asnaani and Hoffman (2013) reported clinical observations and outcome data for a single client who participated in a group treatment program utilising social mishap exposures, and who improved substantially on measures of social anxiety. At present, the relative utility of social mishap exposures have not been directly investigated by comparing them to more traditional forms of exposure.
David Moscovitch – a new core fear in social anxiety.

In a novel conceptual paper, Moscovitch (2009) proposed that current CBT models of social anxiety do not accurately capture the true nature of fear in social anxiety. In his view, the current models place too much emphasis on “social situations” as the phobic stimulus. He argues that it is “the self” (or feared aspects of the self) that is the feared stimulus in social anxiety. For example, a person may believe that their anxious mannerisms are unacceptable, or that their character is flawed in some fundamental way. Anxiety arises at the prospect of this feared aspect of the self being exposed to public scrutiny, and social situations are feared because of this possibility.

This offers an interesting reconceptualisation of the feared stimulus in social anxiety, and has fundamental implications for the proper target of exposure exercises. From this perspective, exposures which aim to bring a person into contact with ‘feared social situations’ are off the mark and may only be partially effective. This is because, in Moscovitch’s view, it is feared aspects of the self that are the primary cause of concern, and the proper target of exposure exercises. Clinicians therefore need to work closely with clients to identify feared dimensions of the self, and then utilise social encounters to help clients reveal those feared aspects to other people, to generate new and less fearful understandings of those self-aspects. In this model higher levels of authenticity and self-disclosure in interactions become a key goal in the treatment. From this perspective, safety behaviours are conceptualised as problematic primarily because they perpetuate the concealment of feared aspects of the self from others, thereby interrupting corrective learnings about the self.
Moscovitch has proposed that there are four dimensions of feared self-aspects: perceived flaws in social skills; perceived flaws in concealing visible signs of anxiety; perceived flaws in physical appearance; and perceived flaws in character or personality; and he has conducted empirical research to validate these dimensions via the development of a negative self-portrayal scale (Moscovitch & Huyder, 2011). In a subsequent study it was shown that SAD is associated with elevated levels of self-portrayal concerns, and also that self-portrayal concerns predict the use of safety behaviours (Moscovitch, Rowa, Paulitzki, Lerullo, Chiang, Antony & McCabe, 2013). It has also been shown that self-portrayal concerns mediate the relationship between recalled teasing and social anxiety (Merrifield, Balk & Moscovitch, 2013).

**Alden and Taylor - an interpersonal model of SAD.**

Recently, Alden and Taylor (2011) proposed an interpersonal model of SAD. This model is consistent with the other CBT models in that it proposes a central role for cognitions, such as unhelpful beliefs about the self and others, in the maintenance of SAD. Where it extends these models is its focus on the role of interpersonal factors in the development and maintenance of these problematic cognitive processes, and of the disorder itself. From this perspective, interpersonal dysfunction is the core difficulty in SAD, and this is conceptualised from a relational rather than an individual perspective. In other words, social anxiety is considered to be not so much something gone wrong within an individual as it is a difficulty in relating to others that has emerged out of, and is maintained by, ongoing relational experiences. Core concepts within this model are negative interaction cycles, a circumplex model of interactions, and models of relationship formation.
The nature and impact of negative interaction cycles.

The primary point of difference with the interpersonal model, compared to the previously described CBT models, is that it takes into account much of the interpersonal phenomenology of SAD described in Chapter 2. The presence of other people is thought to activate relational schemas which contribute to the biased processing of social information, and the experience of anxiety in social settings. The anxiety is then thought to impair or inhibit normal interpersonal functioning, in the form of subtle avoidance behaviours (safety behaviours) and a lack of pro-social behaviours (Alden et al., 2011). These behaviours are experienced by other people as being cold or unfriendly, and they respond in kind. As a result socially anxious individuals experience social rejection, which further reinforces their negative self-schemas and thoughts about the social world. Negative interaction cycles, where basic human needs for affiliation (Baumeister & Leary, 1995) are frustrated, and fearful cognitions are reinforced, are considered a central maintaining feature within the disorder.

Circumplex model of interaction and models of relationship formation.

The interpersonal model also attempts to describe a number of processes thought to be implicated in, or impacted by, negative interaction cycles (Alden, Regambal & Plasencia, 2014). These include a circumplex model, which describes how interaction partners impact one another as an interaction unfolds. For example, the idea of complementarity can be invoked to explain how friendliness in one partner tends to invoke a friendly response in the other. Models of relationship formation are also drawn from the attachment framework, which highlights the role of self-disclosure and attuned responsiveness in friendship formation (Reis &
From this perspective, safety behaviours are considered a problem primarily because they provide unhelpful or non-normative inputs into these models of relating and relationship formation (Alden et al., 2014), leading to poor relational outcomes. Overall, the interpersonal model provides a framework for understanding how interpersonal processes are implicated in different aspects of social anxiety, whilst also identifying interpersonally oriented targets for therapeutic intervention.

**Treatment**

The interpersonal model has led to the development of a treatment protocol for social anxiety called Integrated Interpersonal Cognitive-Behavioural Group Treatment (ICBT) (Alden et al., 2011). The protocol maintains a strong focus on traditional cognitive behavioural techniques such as psycho-education, cognitive restructuring and exposures. In addition, treatment aims to generate insight into the role of interpersonal factors in each participant’s experience of social anxiety. Psycho-education about interpersonal principles of complementarity and relationship development is provided. Participants are also invited to notice and reflect upon their typical behaviours when interacting with others, and to consider the interpersonal message that these behaviours convey. Behavioural experiments are used to test out the impact of different ways of relating to others, both on the subjective experience of social anxiety and on the interaction itself. Overall, participants are encouraged to reflect on how their behaviours impact others, and to experiment with new ways of relating, with a particular emphasis on promoting more pro-social behaviours. The key point of difference with this treatment protocol, compared to previous CBT models, is its primary focus on enhancing a person’s capacity to develop and maintain satisfying interpersonal relationships. In
a recent clinical trial, ICBT led to social anxiety symptom reductions comparable with other group delivered CBT protocols, as well as significant increases in the frequency of social approach behaviours (e.g., inviting someone to get together for lunch, or initiating a conversation) and measures of relationship satisfaction (Alden et al., 2011).

**Summary**

In closing, recent developments in CBT models (including the ongoing developments to the Clark and Wells (1995) and Rapee and Heimberg (1997) models) illustrate that the treatment protocols continue to be enhanced by honing in on specific cognitive processes involved in the maintenance of SAD. By and large, these enhancements have tended to focus on better understanding and working with the growing understanding of intrapsychic phenomena implicated in social anxiety. That is, beliefs about the self and others, perceptions of the social world, and attentional processes that exist within an individual and contribute to their experience of social anxiety. In contrast, interpersonal processes have been less well accounted for within these models.

The interpersonal model proposed by Alden and Taylor (2011) is an important step in incorporating interpersonal aspects of social anxiety into treatment protocols. By maintaining a core focus on interpersonal relating, this model incorporates the phenomenological findings around negative interaction cycles, and provides novel therapeutic interventions that aim to work with these relational dynamics and improve interpersonal functioning. This new direction is a promising enhancement to the treatment protocols.
Conclusion

Overall, the literature on SAD treatments highlights the need to continue to work on enhancing the treatment protocols. One opportunity for improving the protocols is to develop a greater understanding of the nature of therapeutic change in social anxiety. The existing theoretical models of dysfunction in SAD are helpful here, but in a limited way because the models are inevitably incomplete. Basic research into phenomenological change in SAD is therefore required.

Another promising avenue for improvement is to gain a better understanding of the nature and impact of relational processes in therapy groups for SAD. For example, are these processes already having an impact in the group treatment protocols as they are currently formulated? And are there ways in which they might be better worked with in the group to enhance treatment outcome? There is very limited information in this domain. Exploratory research is therefore required in order to better understand the nature and impact of relational processes within CBT groups for SAD.

This offers an opportunity for improvement of particular relevance to the group format. A therapy group is a social setting, within which relational processes are constantly unfolding as the members interact with one another. If these processes can be better understood, and turned to therapeutic advantage, then the therapeutic potency of the group format can be enhanced. The next chapter reviews the broader group therapy literature, setting out a theoretical framework for understanding how relational processes are manifested in groups and contribute to therapeutic growth.
Chapter 4: Group Therapy

Introduction

The idea that groups have inherent therapeutic potential is a relatively recent one. Joseph Pratt’s (1907) psychosocial intervention for tuberculosis patients is typically reported as the first instance of group therapy (Andrews, 1995). Since that time, there has been an explosion of scientific research with more than 20,000 articles published in journals and books on various aspects of group therapy (Dies, 2003). What unites this diverse and often contradictory body of research is the belief that social experiences have the potential to support healing and psychological growth in human beings.

As this literature has developed over time a number of attempts have been made to codify, or describe, aspects of group life that confer a therapeutic benefit to the members. In the modern literature these are described as ‘group therapeutic factors’, and they are an attempt at distilling the essence of group-based mechanisms of change. A number of different taxonomies of factors have been proposed, and this chapter considers three of the most prominent models (Bloch & Crouch, 1985; Fuhriman & Burlingame, 1990; Yalom & Leszcz, 2005). Those therapeutic factors with the highest degree of overlap between the three models are described, and their potential relevance to social anxiety is considered.

In addition to the therapeutic factors, there are a number of key constructs which underpin the group therapy approach. These include ideas about the centrality of interpersonal processes in psychopathology and treatment, and concepts such as ‘working in the here and now’ and ‘the therapy group as a social
microcosm’. These concepts do not belong to any one theoretical orientation (of which there are many). Instead they represent some basic assumptions about groups, or ideas about working with groups, that most group-oriented therapists would endorse or apply in their work (even though they might call upon differing theoretical frameworks or work practices when doing so). These ideas are introduced first, because they provide an important context for the discussion of the group therapeutic factors.

At first glance, the group setting would appear to be an ideal setting for working with social anxiety. If the core problem in social anxiety is how to manage oneself and other people in a social setting, then a social setting would seem to be the ideal place to learn more about that and promote reflection and growth. But simply putting socially anxious people into a group setting is not enough. In order to maximise the benefits of this medium, it is vital to understand how groups work therapeutically and then, in addition, to consider this in light of what is known about the phenomenology of social anxiety.

Key Constructs that Underpin the Broader Group Therapy Literature

When considering the broader group therapy literature, there are a range of theoretical perspectives that have made substantial contributions to the field. These include psychodynamic (Foulkes & Anthony, 1957), interpersonal (Yalom & Leszcz, 2005), gestalt (Feder & Frew, 2008), psychodrama (Baim, Burmeister & Maciel, 2007), and existential (Saiger, 1996) frameworks. It is neither feasible, nor desirable, to provide an account of each tradition here. Instead, in this section of the thesis, some core constructs which are commonly cited across the theoretical
frameworks are introduced. These provide an important context for understanding the operation of the group therapeutic factors (to be discussed below).

It is also important to acknowledge that the kinds of therapy groups from which these constructs emerged were different in kind from what is typically understood as ‘group therapy’ within the CBT tradition. CBT groups of today are invariably ‘theme groups’. That is, groups with a closed membership, meeting for a limited time, and with a high proportion of that time dedicated to structured activities aimed at ameliorating the symptoms of a specific disorder (Yalom & Leszcz, 2005). Historically, groups like these are actually a relatively recent phenomenon first appearing in appreciable numbers in the 1980’s, spurred on by the emergence of the more reliable diagnostic categories within DSM-III and the growing demand for group treatments for specific diagnostic categories under the managed care system in the United States (Brabender, Fallon & Smolar, 2004). In the broader group therapy tradition groups have typically been diagnostically heterogeneous, met for considerably longer periods of time, and contained a large proportion of unstructured time within which the group members could freely interact with one another. Such groups provide considerably more scope for the development of interactions and relationships between the members, and this is conceptualised as central to the realisation of the therapeutic potential of the group format within the broader group therapy tradition (Yalom & Leszcz, 2005).

The key concepts themselves are not discrete categories, but tend to overlap and mutually influence one another (as do the therapeutic factors). For this reason, there is inevitably some circularity and repetition in any attempt to elucidate them. Each of the constructs can also be understood in the context of a social anxiety
therapy group, and so examples used to explicate understanding, and move an idea from the abstract to the concrete, are framed within this context.

The centrality of interpersonal functioning in psychopathology and treatment.

The first core concept underpinning the broader group therapy literature is that group therapists of all persuasions tend to think relationally about human suffering and healing. In other words, they tend to interpret dysfunction in interpersonal terms (as being a product of, and manifesting itself through, disturbed interpersonal functioning), and look to utilise social experiences as the preferred mechanism of treatment (in the form of relational experiences within the therapy group).

According to this perspective, psychopathology is fundamentally linked to relational experiences. This could be historical, in the form of early experiences with primary caregivers (i.e., attachment theory), or it could be current, in terms of maladaptive interaction cycles in the present environment. From this perspective, unhelpful relational experiences contribute to the development of working models of the self and others which generate anxiety, and distort present experiencing, thereby perpetuating problematic interpersonal functioning in a vicious cycle (Sullivan, 1953; Mitchell, 1988). The implication of this way of thinking is that experiential learning in the context of a new and different relational experience is the preferred mechanism of therapeutic change. Or put more simply, if the problem emerged relationally then a relational experience is required to shift it – and the therapy group is conceptualised as an ideal forum for achieving this.
A second core assumption is that psychopathology reveals itself, and is maintained by, problematic patterns of interpersonal behaviour. In social anxiety, for example, negative interaction cycles (described in Chapter 2) play an important role in maintaining the disorder. Group therapists from the broader tradition therefore tend to carefully observe interactions unfolding between the group members, as a way of identifying and working with any maladaptive interpersonal behaviours that emerge. In this way, negative interaction cycles can be interrupted and a process of reflexive inquiry about them can commence (Leszcz & Malat, 2012). This may involve helping a group member to better understand their interpersonal behaviours, and their impact on others, whilst also encouraging the emergence of new behaviours.

Finally, group therapists are united by their interest in the power of interactions between the group members as the preferred vehicle for promoting therapeutic growth. Irvin Yalom has adapted the term ‘corrective emotional experience’ to describe moments where a group member’s internal world undergoes change as a result of powerful interpersonal experiences in the group. For example, in a social anxiety group a member may try behaving more assertively and discover that their feared catastrophe did not ensue, which leads to a revision in their internal models of relating (Yalom & Leszcz, 2005). This is consistent with the therapeutic use of behavioural experiments within traditional CBT groups. Where it differs is that the focus is on working with spontaneously emerging behaviours as they unfold in the group, on an ongoing basis. Interactions between the members are thereby conceptualised as the core ‘engine’ of the therapy.
“Thinking group”

A core assumption within the broader group therapy literature is that for therapy to be effective it needs to be delivered through the group, rather than in a group. In other words, the group itself is conceptualised as an active agent in the therapy, and great care is taken to understand and support the group and the relationships within it. A number of concepts are relevant to this idea of ‘thinking group’.

First is the idea that the social milieu of the group is primarily responsible for providing support and opportunities for growth to the members. Irvin Yalom argues strongly for this position stating that the group, rather than the therapist, is the agent of change in group therapy (Yalom & Leszcz, 2005). Whilst different theoretical frameworks may differ in their view of the relative contribution made by the therapist(s), they all depend heavily on the presence of, and interactions between, the various group members in promoting therapeutic growth within individuals (Dies, 2003). Put more simply, the relationships and interactions between the group members (including the therapists) are thought to be the most important aspect of group therapy. This general stance is consistent with modern neurobiological theory (Gantt & Agazarian, 2013) and psychotherapy theory (Schore, 2012) which highlight the central role of relational processes within psychotherapy treatments.

Related to this is the notion that the group is an entity in itself, that needs to be accounted for within the therapy. For example, Dies (2003) argues that before group therapy there must first be a group. That is, a collection of individuals that have bonded with one another to some extent. Some therapy orientations draw on general systems theory to understand the needs, dynamics and evolution of the group
as a social entity. For example, Kepner (2000) describes the group as a complex psychosocial system which profoundly impacts the feelings and behaviours of its members, whilst also in turn being profoundly impacted by the feelings and behaviours of its members. She argues that the therapist should commit themselves to working with both the individual and the group, for the benefit of both.

Group therapists of all persuasions therefore tend to pay attention to the task of developing the group as a whole. This may involve promoting the creation of a therapeutic climate within the group, by actively setting norms of behaviour and encouraging positive interactions between the members (Dies, 2003). In a social anxiety group, for example, this might involve promoting norms around emotional expression and interpersonal risk taking. Or it may involve holding in mind developmental models of group formation, so that the goals of the therapy can be adjusted appropriately. For example, Kepner (2000) argues that there are stages of group development within which the group members experience different needs. According to this model the need of group members to affiliate and belong emerges, and must be attended to, in the very early stages of the group’s life. At this point, the primary therapeutic task revolves around setting up and supporting the developing relationships in the room. Later on, when the group advances to a different developmental stage, therapeutic tasks and goals can shift on to more challenging terrain. What is important about models like these is that they are not linear. At any time the group may experience a crisis, shifting it back to an earlier developmental stage of functioning, at which point therapeutic goals need to shift accordingly. Monitoring and attending to the developmental state of the group is an
example of one of the (many) ways that group therapists acknowledge and work with the group as a whole.

**The therapy group as a ‘social microcosm’**.

The idea of the social microcosm was popularised by Irvin Yalom, who described the therapy group as being like a naturalistic social laboratory for the study of human interactions (Yalom & Leszcz, 2005). This idea is based upon the notion that, given enough unstructured ‘free interaction’ time in the group, each group member’s ‘essence’ will eventually surface (Dies, 2003). In other words, the group members will start to relate to people in the group in the same way that they relate to people outside the group. They will therefore reveal, through their natural behaviour in the group, important information about their psychological functioning and the kinds of maladaptive interpersonal behaviours that lead them to therapy.

One aspect of the social microcosm that is particularly valued by group therapists is the wide range of people and characteristics that are available within the group (Yalom & Leszcz, 2005). This is perceived as valuable because different people in the group can act as natural prompts for the emergence of problematic fears and behaviours in other group members. For example, some socially anxious people find it particularly difficult to interact with members of the opposite sex or with people in authority (Beidel & Turner, 2007). If a group member’s interpersonal functioning is negatively impacted by interpersonal distortions along these lines, there is sure to be a powerful member of the group, or a group member of the opposite sex, who will activate these distortions and associated behaviours – thereby bringing them into the domain of therapeutic inquiry. Information gleaned in this way can be considered as particularly valid, given that it is based on the
spontaneously arising and observable behaviours of an individual. It is therefore free of self-serving biases that can distort an individual’s self-reports of their interpersonal behaviours outside of the group, and may even highlight issues that were outside a person’s conscious awareness (Bellak, 1980).

For this reason, the therapy group is conceptualised as the ideal forum within which group members’ maladaptive interpersonal beliefs and behaviours can naturally emerge and become the focus of therapeutic inquiry. And because a person’s most habitual behaviours tend to emerge within the group, when the therapists focus on the relationships between the members they are also addressing the member’s relationship difficulties outside the group. By closely tracking the interactions unfolding within the social microcosm, each person’s unique cognitive/interpersonal schemas can be illuminated and worked with in the present moment of interaction (Leszcz & Malat, 2012). This involves noticing and responding to the immediacy of interpersonal behaviours as they emerge, an approach that has come to be described in the literature as ‘working in the here and now’.

**Working in the here and now.**

The idea of maintaining a persistent focus on current experiencing was popularised by Fritz Perls, an early proponent of Gestalt therapy (Perls, Hefferline, & Goodman, 1951). It is a way of working therapeutically that encourages awareness of various aspects of current experience (cognitive, affective, bodily sensations, behaviours, etc.) and also reflection on that experience. In practical terms this involves the therapist supporting a person as they make contact with their
inner experience, and then promoting reflection and meaning making around that experience.

This approach is entirely consistent with CBT, and forms a core part of behavioural experiments in CBT therapy groups for social anxiety (Heimberg & Becker, 2002). Where ‘working in the here and now’ differs from traditional CBT group practice is the focus on ‘near relational experience’, rather than ‘far relational experience’. In other words, the focus is on a person’s current relational experiences inside the group. Rather than reflecting on social experiences outside the group, or on experiences within ‘analogues’ of real-world interactions such as role-plays, group members are guided towards examining their current experience of one another (Zimmerman, 2008). In the context of a social anxiety group, this approach may be applied to working with negative interaction cycles (described in Chapter 2), which play a maintaining role in the disorder. For example, a group member may tend to avert their gaze and offer minimal responses when interacting with group members of the opposite sex. This provides an opportunity to, with proper support, explore the meaning of the behaviour for the individual involved. Impacted group members may also be invited to talk about how the behaviour effects them, and the kind of interpersonal responses that it invokes within them, thereby furthering understanding of the cycle.

This focus on closely tracking and working with interactions unfolding between the members is a hallmark of interpersonal psychotherapy groups (Leszcz, 2007). It is believed that this focus on the here and now is one of the most potent aspects of the therapy, and differentiates it from other types of groups such as psycho-education groups or support groups. It is considered to be particularly
helpful because current interactions are thought to be more ‘alive’ to the group member, thereby granting better access to the interpersonal schemas or constructs underlying problematic behaviours (Leszcz & Malat, 2012). It is also valued because it directly interrupts the problematic interaction cycle as it is unfolding, allowing for reflection and the emergence of new and more adaptive interpersonal behaviours, which can then generalise to relationships outside of the group in an adaptive spiral (Yalom & Leszcz, 2005). It is acknowledged that giving and receiving feedback of this nature is highly confronting and anxiety inducing for people, and that considerable effort must therefore be allocated to the task of creating a ‘safe enough’ group environment to support this activity (Yalom & Leszcz, 2005).

**Cohesion and interpersonal safety.**

The concept of group cohesion is widely discussed in the broader group literature. It is a complex construct, involving aspects of both the group ‘as a whole’ and the individuals that make it up. Group cohesion will be discussed more fully below in the section on therapeutic factors, and is raised here only briefly in the context of the idea of interpersonal safety in groups.

Leszcz and Malat (2012) have argued that the challenging work of group therapy can only unfold in the context of a group that is experienced by the members as cohesive and safe. This may involve a feeling of belonging and trust between the members, and faith in the group as safe place in which personal difficulties and vulnerability may be explored. This view is consistent with findings from interpersonal neurobiology (Gantt & Agazarian, 2013) and attachment (Porges, 2005) research indicating the central role that perceptions of interpersonal safety
play in facilitating social engagement behaviours. Put most simply, people need to feel safe in the group before they will reveal intimate details about themselves, try new interpersonal behaviours, or offer meaningful feedback to others (Dies, 2003). In this sense cohesion in group therapy is an analogue of ‘the relationship’ in individual therapy in that it underpins, and is a prerequisite for, successful therapy overall (Yalom & Leszcz, 2005).

In addition to its role facilitating the overall process of therapy, cohesion has the further benefit of giving group members the experience of belonging and feeling accepted within a social group. This meets a fundamental human need (Baumeister & Leary, 1995), and is likely to be particularly relevant to those who experience social isolation as a part of their difficulties (i.e., the socially anxious). For these reasons group therapists of all persuasions think about, and take action to support, the development of a nurturing relational climate within the group (Bernard et. al., 2008).

The Group Therapeutic Factors

Therapeutic factors are components, or elements within therapy groups that are capable of exerting a beneficial influence on the group members. In this sense they are ‘features’ of the group therapy environment. They also provide a framework within which therapeutic change in an individual group member can be conceptualised and understood. For example, it might be argued (and indeed a group member may perceive it and describe it thus) that a group member felt better about themselves because they discovered that others in the group experienced similar difficulties (the therapeutic factor of ‘universality’). In this sense the therapeutic factors may best be understood, as Yalom describes them, as
mechanisms active in the group that can promote psychological growth in the members (Yalom & Leszcz, 2005).

The idea of ‘group therapeutic factors’ emerged out of a seminal study conducted in the 1950’s by Corsini and Rosenberg (1955), who lamented the confusing and often contradictory language used within publications in the group therapy field at that time. They aimed to construct a classification of therapeutic elements active within therapy groups, which would aid in understanding and support further research. To do this they reviewed some 300 papers (accounting for approximately 25% of the published material at that time) and extracted all statements that referred to any kind of therapeutic action (for example, “patient is a therapist to other patient”) (Corsini et. al., 1955, pp. 407). In what was essentially an inductive linguistic exercise, Corsini and Rosenberg then combined and collapsed more than 200 such statements down to ten mechanisms or ‘group therapeutic factors’. This paper initiated a flurry of research activity into the nature and impact of group therapeutic factors, and since that time there have been three substantial scholarly efforts to review this evolving literature and refine the list of factors.

The most influential taxonomy of group therapeutic factors has been proposed by Irvin Yalom (1975; Yalom & Leszcz, 2005). Yalom operationalised his therapeutic factors into a research tool, the Q-Sort instrument, which assesses the importance that group members place on various constituents of the therapeutic factors. This research instrument has been widely used in group therapy research (Mackenzie, 1987), and Yalom’s text “The theory and practice of group psychotherapy” has been adopted extensively by training programs and clinicians in the field. Bloch and Crouch (1985) produced what is arguably the best researched
and most lucidly articulated account of group therapeutic factors. And finally, Fuhriman and Burlingame (1990) conducted a substantial comparative analysis of individual and group psychotherapy process research in the production of their list therapeutic factors active in the group format.

In this chapter, those therapeutic factors with the highest degree of overlap across these three major taxonomies are reviewed. The factors are described and potential mechanisms of action are explored, along with any empirical findings. Table 1 below sets out the ten therapeutic factors in summary form.
Table 1

*Brief Definition of the Group Therapeutic Factors.*

<table>
<thead>
<tr>
<th>Therapeutic factor</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>Altruism</td>
<td>When one group member makes a deliberate effort to help another.</td>
</tr>
<tr>
<td>Catharsis</td>
<td>The arousal and expression of strong emotions in the group, followed by some sort of cognitive insight or learning.</td>
</tr>
<tr>
<td>Cohesion</td>
<td>Experiencing the group as a safe and supportive environment. Feeling a sense of belonging in the group.</td>
</tr>
<tr>
<td>Guidance</td>
<td>When information is imparted to group members.</td>
</tr>
<tr>
<td>Instillation of hope</td>
<td>When group members start to believe that the group can help them.</td>
</tr>
<tr>
<td>Interpersonal learning</td>
<td>Learning about how one is perceived via feedback from the other group members. And learning by trying out new behaviours in the group.</td>
</tr>
<tr>
<td>Self-disclosure</td>
<td>Revealing personal information about the self to the other group members.</td>
</tr>
<tr>
<td>Self-understanding</td>
<td>A group member learns something important about themselves or the nature of their difficulties.</td>
</tr>
<tr>
<td>Universality</td>
<td>Recognising that others experience similar difficulties.</td>
</tr>
<tr>
<td>Vicarious learning</td>
<td>Gaining some benefit from observing other group members’ engagement in the therapy process.</td>
</tr>
</tbody>
</table>

At present, there is little empirical evidence to suggest that any of these factors should be more or less important to social anxiety. At face value all of the
factors could be considered to be relevant, given that they are drawn from a therapeutic tradition with a primary focus on helping people to better understand and manage their interpersonal functioning. Upon close inspection, however, some of the change mechanisms associated with particular therapeutic factors would appear to have a direct bearing on important aspects of the phenomenology of social anxiety. Where this occurs, it is noted in the text.

It is also worth mentioning that the literature that informed Corsini and Rosenberg’s (1955) initial analysis was dominated by psychodynamic theoretical frameworks. This is neither a good thing, nor a bad thing. But it does mean that many of the concepts in the group therapeutic factors literature (for example the idea of ‘catharsis’) may be less familiar to those informed by a cognitive behavioural perspective. For this reason the author has used (so far as possible without changing the meaning) language more consistent with a CBT framework, and also provided concrete examples in the context of a social anxiety group wherever possible, in order to better communicate the general applicability of the ideas.

Altruism

Altruism occurs in a therapy group when one group member makes a deliberate effort to help another. For example, by offering words of comfort or encouragement to someone who has become distressed, or by providing information or advice, or by giving someone feedback that they find helpful. What is important about this process is that group members set aside their own needs for a moment in order to support another person. Yalom highlights the importance of this aspect of altruism by suggesting that one of its most helpful functions is to shift a group
members awareness away from their morbid self-preoccupations, and onto the needs of another person (Yalom & Leszcz, 2005).

Various aspects of altruism have been proposed as helpful. Almond (1974) has argued that, through altruism, people vicariously re-experience their own suffering and thereby gain a sense of mastery over it. Bloch and Crouch (1985) suggest that through altruism the group members self-concept is adjusted, towards an idea of the self as someone who is important to others and capable of helping them. This is consistent with Bandura’s ideas about self-efficacy and wellbeing (Bandura, 1994). According to this perspective, when a group member helps others they achieve something that is valued within the culture of the group, thereby boosting their sense of personal efficacy and self-esteem. Arguing along similar lines, Yalom proposes that altruism directly challenges a group member’s feelings of being useless and not needed by others (Yalom et. al., 2005).

In terms of research findings, altruism is listed as a therapeutic factor in all of the major taxonomies of group therapeutic factors (Bloch & Crouch, 1985; Fuhriman & Burlingame, 1990; Yalom & Leszcz, 2005). However, when group members are asked to rate the factors it is not highly ranked (Yalom et. al., 2005). This contrasts with findings from the self-help movement, where it has been shown to be highly valued. For example, when participants in self-help groups were asked what was useful for them about the group, many reported that the most helpful thing was a change in their understanding of themselves which accompanied making the shift from being helped in the group to becoming a helper of others (Carpinello, Knight & Janis, 1991) which is consistent with the potential mechanisms of altruism mentioned above. Some self-help groups also codify altruism as a core component
within their programs. For example Alcoholics Anonymous list altruism as their 12th step (to help other alcoholics recover), and there is evidence that those who help others are significantly less likely to relapse into alcoholism themselves (Pagano, Friend, Tonigan & Stout, 2004).

With regard to social anxiety, altruism may be a therapeutic factor of particular relevance. As described in chapter 2, people who experience social anxiety feel isolated from others, and often experience themselves as somehow different or inadequate. Being demonstrably helpful to another group member provides very direct evidence to challenge self-perceptions of ‘interpersonal inadequacy’. In addition, altruism has the potential to mitigate against the isolating aspects of shame that are so central to the disorder. In shame the action tendency is to move away from the other, to withdraw and hide (Kaufmann, 1996). Altruism creates movement in the opposite direction. It enhances the empathic component of a relationship, and brings people closer together, thereby countering isolation (Wright, 1994; Wallace & Nasoko, 2003).

Catharsis

Within the broader group therapy literature the idea of catharsis has a long history, and it is widely referenced (Bemak & Young, 1998). Fundamental to this concept is the arousal and expression of powerful emotions. Within some theoretical frameworks, expression per se is conceptualised as a discrete mechanism that can assist a group member. For example, Bloch and Crouch (1985) define catharsis as the expression of emotions followed by a sense of relief. Implicit in this idea is the notion that unexpressed emotions can ‘build up’ over time, creating
bottlenecks of psychic energy that contribute to psychopathology, an idea that harkens back to Freud’s earliest ideas about anxiety (Breuer & Freud, 1957).

Other researchers have defined catharsis more broadly. For example, Yalom and Leszcz (2005) propose that strong emotions are important, but not sufficient in themselves, to promote therapeutic growth in the group members. They argue that some kind of cognitive learning or insight must follow on from the arousal and expression of intense affect, in order for meaningful change to occur. Their view is based on the findings of one of the largest studies ever conducted into group therapy (Lieberman, Yalom & Miles, 1973) which attempted to identify the mechanisms of change in those participants who responded well to a group experience. This study found that ‘high learners’ had a characteristic profile, which included the arousal/expression of strong emotions in the group plus some degree of reflection and learning that followed on from that emotional experiencing. For example, participants talked about shifts in their understanding of themselves and others that were connected to such moments. In subsequent studies, when group participants were asked directly about what they found most helpful or unhelpful in their group experience, they placed a greater emphasis on the learning and insights that followed on from cathartic moments, rather than on the expression of strong emotion itself (Pennebaker, 1990; Kraus, 1997).

The key to this second definition of catharsis that entails growth and insight appears to be the relational context of the group. In a therapy group, the experience and expression of strong emotions occurs within an interpersonal context. So, for example, a member may report benefiting from expressing strongly held feelings (such as annoyance, or love) towards another individual in the group (Lieberman,
Yalom & Miles, 1973). Such an experience will challenge long held beliefs about what is allowable in terms of emotional expression. Or an emotional disclosure may invoke caring and comforting responses from other group members, which is supportive in itself and may challenge beliefs about what one can expect from others in response to vulnerability. For Yalom, the key to catharsis is that moments of high emotional intensity often occur when group members ‘try out’ new behaviours in the group. This leads to reality testing and adaptation of pathogenic beliefs, and also helps group members develop their capacity to relate to other people more openly and honestly, a cycle he has described as a ‘corrective emotional experience’ (Yalom & Leszcz, 2005).

This aspect of catharsis would seem to be particularly relevant to the socially anxious. As described in chapter 2, socially anxious individuals tend to engage in subtle avoidance behaviours and keep their emotions to themselves when interacting with others, and these behaviours appear to be implicated in the negative interaction cycles that maintain social anxiety. Seeing other group members express strong emotions is therefore likely to directly challenge internal prohibitions around emotional expression, and encourage the emergence of more spontaneous and authentic interpersonal behaviours. In addition, as group members become better at expressing their emotions in an interpersonal context, their capacity to express their needs (and get them met) in relationships is enhanced (Elliott, Watson, Goldman, Greenberg, 2004; Yalom & Leszcz, 2005).

Cohesion

Cohesion is a complex construct that has proven difficult to define. Some researchers have described it as a sense of “we-ness” (Marmarosh & Van Horn,
2010), which invokes a sense of belonging to a greater social whole. Yalom and Leszcz (2005) propose that, as a contributing factor to the therapy, ‘group cohesiveness’ in group therapy is best understood as being analogous to ‘the relationship’ in individual therapy. However, the construct of cohesion in groups is more complex because there are many more relationships to consider. For example, there is a group member’s relationship with one or more therapists (sometimes referred to as ‘alliance’ in the literature) (Woody & Adessky, 2002), but there is also the bond that exists between the group members themselves. And there is also the group members feelings of attraction towards the group itself as a whole (for example, it may be perceived as a prestigious group to be a part of). To complicate matters, there is considerable overlap between various constructs thought to contribute to cohesion. For example, the ‘esprit de corps’ of the group as a whole (a group phenomenon), vs. each individuals ‘attraction’ to the group (an individual phenomenon) (Block & Crouch, 1985).

Despite the difficulties in defining and operationalising the construct of cohesion, there is a strong overall view in the literature as to its clinical utility. One useful way to consider the research findings in this area is to utilise a distinction made by Yalom and Leszcz (2005), who assert that cohesion can be understood both as a condition for change, and as a therapeutic factor in its own right. The first point relates to the idea that a cohesive group provides an environment of safety and support that is required before group members can approach the task of therapeutic work (by self-disclosing, being open, and offering feedback for example). This is borne out by studies which indicate a positive relationship between cohesion and range of factors thought to contribute to therapeutic outcomes such as group
attendance (Ogrodniczuk, Piper & Joyce, 2006), disclosure in group (Tschuschke & Dies, 1994), participation (Budman, Soldz, Demby, Davis & Merry, 1993) and a desire to stay in the group (Marmarosh & Van Horn, 2010). Bloch and Crouch (1985) and Frank (1957) further argue that cohesion is like a kind of cement that binds the group together, allowing it to remain intact and weather momentary storms of discord or high emotion. This idea was borne out in a study conducted by Kivlighan and Lilly (1997) which found it is important that cohesion be achieved within a group before it can move on to more challenging work where conflict and discomfort emerge. These findings support the notion that cohesion both facilitates the overall therapeutic process, whilst enhancing the operation of other group factors (e.g., catharsis).

A second aspect of cohesion, according to Yalom and Leszcz (2005), is that it can operate as a therapeutic factor in its own right. In a cohesive group the members can experience a sense of belonging, and also a sense of being accepted by the others, which meets a fundamental human need (Baumeister & Leary, 1995). Yalom and Leszcz argue that the experience of acceptance offers powerful counterevidence to the idea that one is flawed or unacceptable, and that a sense of belonging directly combats feelings of isolation. Cartwright (1968) proposed that people in a cohesive group experienced a boost in feelings of personal security which is linked to concepts such as acceptance and self-esteem. Frank (1957; Frank & Frank, 1991) also proposed a direct link between cohesion and the self-esteem of group members. In his view, a cohesive group promotes esteem because group members come to learn that they can have an important impact upon one another, which enhances their sense of personal power. In addition, the feeling of belonging
to a valued group adds to the members sense of self-worth. In studies that ask group members to rank order the therapeutic factors, cohesion is rated as one of the most important therapeutic factors by both group members and the therapists who work alongside them (Butler & Fuhriman, 1983; Yalom & Leszcz, 2005).

This idea of the cohesive group as offering group members a sense of belonging, and also a sense of being a valued member of a social unit, would seem to be of particular relevance to the socially anxious whose experience is characterised by social isolation. Two studies have attempted to investigate the impact of this therapeutic factor in CBT therapy groups for social anxiety with varying results. In the first study, Woody and Adessky (2002) found that alliance (the relationship between group members and the therapists) increased throughout the life of the group, whilst cohesion (the relationships between the group members) remained unchanged, with neither variable predicting improvement in social anxiety symptoms. This study has been criticised by Yalom and Leszcz (2005) because the group protocol did not maintain a focus on developing inter-member bonds, which may have impeded the development of cohesion within the group. In a follow-up study, Taube-Schiff, Suvak, Antony, Beiling and McCabe (2007) found that cohesion increased over the life of the group, and this increase was associated with, and predicted, improvements in symptoms of social anxiety.

Guidance

The therapeutic factor of guidance occurs when information is imparted to group members. This could be in the form of didactic instruction or advice from the therapist or from one group member to another. Guidance was a core therapeutic factor for early pioneers in the group therapy movement. For example, Pratt (1907)
provided extensive information to tuberculosis patients on the nature of their illness and how to manage it effectively. With the emergence of more ‘insight’ oriented therapy groups, advice giving was shunned as generally counter-therapeutic (Resnick, 2006). It was thought that direct advice encouraged unhealthy dependence on the therapist, and robbed clients of the opportunity to come to their own insights about the nature of their difficulties and how they could usefully respond to them.

In terms of current practice, guidance has come back into favour and forms a core component of many specialist groups set up to help people with specific problems. For example, CBT groups for social anxiety disorder teach clients how to apply a specific coping response in the face of their anxiety (Clark & Wells, 1995; Heimberg & Becker, 2002). This might include cognitive restructuring of distressing thoughts, or the application of relaxation techniques such as diaphragmatic breathing. The imparting of information about techniques, as well as specific instruction in how to apply them, therefore forms a core part of the therapy. And it is generally accepted that a high degree of didactic instruction is required in order to achieve this.

The mechanism by which guidance might be helpful is partly explained above, in the sense that some element of ‘teaching’ is required to transfer skills considered important to healthy psychological functioning. It is worth mentioning, however, that guidance may also be useful in other ways. For example, guidance can enhance agency by providing a framework within which a person’s suffering can be understood (Frank & Frank, 1991). Explanations (such as the CBT model for explaining anxiety reactions) make a person’s suffering more comprehensible, and thereby generate hope that the difficulty can be grasped and overcome. In addition,
when group members offer guidance to one another (in the form of feedback, or ideas, or information) other therapeutic factors can also be stimulated. The person offering the guidance can have the experience of being helpful to another group member, for example, which activates the therapeutic factor of altruism. Such offerings also powerfully communicate interest in, and caring towards, the person who is the recipient of the information (Yalom & Leszcz, 2005).

In terms of research findings, only a few studies have attempted to investigate the impact of guidance on therapeutic outcomes and overall the results are unclear (Bloch & Crouch, 1985). Of some relevance to this question are recent studies that have attempted to isolate the impact of specific therapeutic processes on client outcomes within the CBT field. These component analysis studies compare therapeutic interventions where singular components of the therapy have been isolated. So, for example, a behavioural activation protocol is compared to protocols designed around working with automatic thoughts, or dysfunctional assumptions and core beliefs. In their review of component analysis studies Longmore and Worrell (2007) found that treatment outcomes were generally equivalent across conditions, suggesting that actually teaching people about CBT and how to apply the CBT model might be less important to therapeutic outcomes than previously assumed. Guidance may have a beneficial influence, but exactly what makes guidance beneficial is undefined at this point.

**Instillation of hope**

Psychotherapists of all orientations have long known that the instillation of hope is one of the most powerful tools in their armory (Frank & Frank, 1991). Indeed, for many clients who enter into therapy in a dejected state the emergence of
hope may be a necessary prerequisite for any change to occur at all. This therapeutic factor is activated when a group member starts to believe that the group can help them, and their situation can be improved. And while the literature on hope in the group setting is somewhat sparse, there appear to be two major aspects of therapeutic groups that engender hope in the members: faith in the therapist and their treatments, and the presence of the other group members themselves.

With regard to the first aspect, group therapists generally provide the members with some comprehensible account of their difficulty and the ways in which it can be overcome. For example, in Heimberg’s GCBT program for social anxiety, group members are provided with an explanation of the nature and role of anxiety, and how anxiety in social settings can be reduced via the application of CBT techniques (Heimberg & Becker, 2002). Explanations like these can help to make the client’s difficulty more comprehensible to them, thereby transforming it from something alien and overwhelming into something that could potentially be overcome. Such accounts also serve to enhance the status of the therapist as someone who has been formally trained in powerful therapeutic techniques, drawn from a culturally sanctioned healing modality (the discipline of psychology). These mechanisms are broadly consistent with Jerome Frank’s ideas about the generation of hope within individual psychotherapy (Frank & Frank, 1991).

The second aspect is unique to the group format, and relies upon the presence of other group members. For example, group members can offer support and assistance to one another and thereby generate hope. It is also possible in a group to observe some members improving over time. Other members therefore function as both an alternative source of help, and as a kind of evidence that change is possible
(Bloch and Crouch, 1985). Yalom acknowledges this, and advises group therapists to maximise the potential impact here by encouraging the members to take responsibility for helping one another, and by drawing the group’s attention to any observed improvements in a member’s functioning (Yalom et. al., 2005).

The research findings on this therapeutic factor are somewhat limited. When group members are asked to identify the relative value of various therapeutic factors, the instillation of hope is not ranked highly (Yalom et. al., 2005). However, there is evidence that positive expectations about an upcoming group experience correlate with higher levels of engagement and interaction in the group (Yalom, Houts, Newell, Rand, 1967). It is also noteworthy that hope appears to be a key factor utilised within the self-help movement. For example the 12-step movement, in all its various manifestations, makes prominent use of personal testimonials (of how addiction has been kept at bay), as well as using recovered addicts as leaders. Both of these strategies send a powerful message that the problem that the group is designed to address can be overcome.

**Interpersonal learning**

This therapeutic factor refers to learning that emerges from interactional processes in the group. The definition most widely cited in the literature is that of Irvin Yalom (Yalom & Leszcz, 2005) who describes it as consisting of two interrelated components: learning via feedback from other group members; and learning via the process of trying out new interpersonal behaviours in the group. Interpersonal learning is based around the idea that the misperceptions of social reality that underlie psychopathology are amenable to change through relational experiences unfolding in the group (Fuhriman & Burlingame, 1990). In this sense
there is a degree of overlap between interpersonal learning and other therapeutic factors that may involve learning or insight (for example catharsis or universality). In studies where group participants are asked to rank the factors in importance interpersonal learning is consistently ranked highly (Leong, 2008) and it is widely cited as important in the broader group therapy literature (Brabender, Fallon & Smolar, 2004; Yalom et. al., 2005).

Exactly ‘how’ interpersonal learning exerts its influence is the focus of an entire chapter in Yalom and Leszcz’s (2005) seminal text. This highlights its central role within the interpersonal model of group therapy, and also its complexity in the way that it interacts with a range of constructs important to the field such as ‘the social microcosm’ and ‘the corrective emotional experience’. In summary, interpersonal learning is conceptualised as a cyclical process with a number of stages. First is the demonstration of problematic interpersonal behaviour emerging from the social microcosm of the group. By using the immediacy of the ‘here and now’, the group can support members as they reflect on their behaviour and its interpersonal impact (a process facilitated by open and honest feedback from the other group members). This leads to personal insights, and also responses from other group members which support the person to risk new ways of behaving and relating in the group. An adaptive cycle ensues, whereby new understandings and behaviours lead to relational outcomes in the group which support further growth (in the form of more flexible and adaptive interpersonal functioning) which is then generalised to relationships outside the therapy group (Leszcz & Malat, 2012; Yalom et. al., 2005).
Central to the action of this therapeutic factor is the process of interpersonal feedback in the group. Interpersonal feedback is one of the most direct ways that a person can learn about themselves, how they are perceived by others, and how others are responding to their behaviours. It has long been a staple of interpersonally oriented individual psychotherapies as a way of raising and working with problematic beliefs about the self and the social world (Orlinsky & Howard, 1986; Teyber & McClure, 2011), but it has a particular utility in the context of group therapy. Bloch and Crouch (1985) make the important observation that feedback in individual therapy can only come from an authority figure who is a designated ‘helper’ in the context of that relationship. In the therapy group feedback comes from peers, and when multiple group members provide a consistent feedback message this is hard for the recipient to ignore (Leong, 2008; Leszcz & Malat, 2012). Feedback also has a different meaning within the context of a culture of open and honest relating between group members, which perhaps explains why group members tend to value feedback from other group members over and above that provided by the therapist (Yalom & Leszcz, 2005). In studies where different kinds of group feedback are compared, the most useful kind of feedback appears to be reflections on a group member’s observable behaviour, along with information on the observer’s reaction to that behaviour (Flowers & Booraem, 1990), which is consistent with Yalom’s conceptualisation of the interpersonal learning process.

With regard to social anxiety, interpersonal learning offers an important opportunity to learn more about how one is perceived, and how one’s own behaviours contribute to one’s interpersonal difficulties. As such, it is directly relevant to furthering understanding of the negative interaction cycles (described in
chapter 2) that occur within social anxiety, and to promoting the emergence of new behaviours that interrupt those cycles and support the emergence of new and more adaptive patterns of interaction.

**Self-disclosure**

Self-disclosure entails revealing personal information about the self to the other group members. This may involve sharing information about one’s past and the problems that brought one to therapy, or it could involve sharing one’s immediate experience, including one’s reactions to other group members. It is fundamentally different to self-disclosure in individual therapy because of the increased potential for shame (and healing) inherent in revealing aspects of one’s self in the presence of a group of other people (Farber, 2006).

At first glance self-disclosure would appear to be a simple prerequisite for therapeutic progress – if nothing is revealed there is nothing to work with. And this may be particularly true in the group format, where therapist’s do not have as much time to draw out and work with each individual’s difficulties. Group members need to disclose in order to be helped, and Yalom gives explicit instructions about this to incoming group members during his intake procedures (Yalom et. al., 2005). Beyond this obvious utility, it has also been noted that self-disclosure may mediate the operation of many other therapeutic factors. For example, it is an important process in the development of group cohesion (Kirshner, 1976), and necessary for the kinds of interactions which promote interpersonal learning (Leszcz & Malat, 2012).
As a discrete variable, self-disclosure has been examined most extensively by Jourard (1971). He argues that self-disclosure is vital to psychological health because it promotes self-understanding and growth in the social sphere. According to Jourard, we come to know ourselves by the responses we evoke in other people. In other words, when we disclose our true self to others, they respond to our authentic self, and this response helps us to understand who we really are. By comparison, people who remain hidden in social encounters have only their ‘absent self’ responded to, and learn little about themselves and their place in the social world. This idea is consistent with theoretical frameworks which consider social interactions to be crucial in the development of the self-concept (Leary & Tangney, 2012).

A second aspect of self-disclosure of interest to Jourard (1971) is its function in strengthening relationships between people. He points to the important role that disclosure plays in promoting interpersonal intimacy. This conceptualisation is helpful because it acknowledges that self-disclosure is a social act – it occurs in the context of a relationship. Unlike individual therapy, in group therapy the members enter into relationships with the other members of the group. In this context, self-disclosure is the primary means by which they may come to know one another and deepen their relationships (which may explain the link between self-disclosure and cohesion). For Jourard, self-disclosure therefore plays an important role in both supporting personal growth (at least in terms of self-understanding), whilst also promoting healthy relationships between human beings (Jourard, 1971).

Research findings regarding self-disclosure are ambivalent. There is contradictory evidence around the relationship between client self-disclosure and
therapeutic outcome (Bloch & Crouch, 1985, Yalom & Leszcz, 2005). This may be because the impact of self-disclosure is mediated by its interaction with a range of other therapeutic factors. It may also be because a more detailed picture of how the process of self-disclosure can best be turned to therapeutic advantage (i.e., self-disclosure about what, to whom, and in what context) has yet to be established.

As described in chapter 2, one of the difficulties faced by the socially anxious is a lack of intimacy in interpersonal relationships. As a result they receive little feedback on how they are perceived which could compete with their own internally generated and overly negative self-view. If a group member can disclose more of their inner experience, then the group gains access to these cognitive processes, which can then be adjusted in light of corrective feedback (Rose, Tolman, Tallant, 1985). This occurs in CBT groups, where feedback from other group members forms a core part of behavioural experiments (Heimberg & Becker, 2002). In a more interpersonally oriented group, a related but additional mechanism is activated when the group members utilise the here and now to share their experiences of one another. In this case, the adaptation of unhelpful cognitions about the self may emerge from ongoing and spontaneous feedback from peers, which is closer to the model of identity formation proposed by Jourard (1971) and may offer group members a more naturalistic pathway to adapting their self-concept. Finally, as described previously, social anxiety is associated with generally low levels of self-disclosure overall in interactions which contributes to the negative interaction cycles maintaining the disorder. The therapy group may therefore offer group members an ideal forum within which to experiment with self-disclosure and assess its impact on their interpersonal and intrapsychic experience.
Self-understanding

Self-understanding, or insight, has been conceptualised as central to the psychotherapeutic process since the days of Freud (1963). In the group therapy tradition, the most comprehensive definition has been provided by Bloch and Crouch (1985) who point out the many ways in which it may come about. For example a person may learn something important about their own personal qualities (i.e., that they are a competitive person, or that they hold certain assumptions about their own self-worth). Or they may gain greater insight into the nature of their problems, or how they are perceived by others, or how they came to be the way they are. In CBT therapy groups there is a very strong emphasis on this factor, with a core goal being to help people better understand how their own thinking and behaviours contribute to their difficulties (Clark & Wells, 1995; Heimberg & Becker, 2002).

In the broader group therapy literature promoting insight into the relationship between current functioning and early relational experiences is a long-established therapeutic goal, and forms a cornerstone of psychodynamic group thinking and practice (Slavson, 1964). Even today, this aspect of self-understanding is considered central to identifying and modifying dysfunctional interpersonal patterns (Connoly, Crits-Christoph, Shelton, Hollon, Kurtz, Barner, Butler, Baker & Thase, 1999). Interestingly, in a study conducted by Yalom, Tinkelberg and Gilula (1968), where group members were interviewed about their ranking of therapeutic factor items, they did not value this particular aspect of self-understanding. Instead, they valued “Discovering and accepting previously unknown or unacceptable parts of myself” most highly of all 60 items in the survey (Yalom & Leszcz, 2005, pg. 92). From this Yalom concluded that insight into the self gleaned from current functioning in the
context of current relationships was most highly valued by the group members. This finding is consistent with theorists who argue that the therapeutic factors of self-understanding and interpersonal learning are two sides of the same coin (Brabender, Fallon & Smolar, 2004).

In terms of research findings, in their review of 120 group therapy publications Fuhriman and Burlingame (1990) reported that ‘self-understanding’ received the highest number of endorsements across all publications combined. Group members themselves also identify self-understanding as an important dimension of therapeutic change (Bloch & Rubenstein, 1980; MacKenzie, 1987). For the socially anxious, this therapeutic factor may have particular salience given that negatively distorted views of the self and one’s social behaviours play such an important role in the phenomenology of the disorder. As argued by Lakin (1985) and Mordock, Ellis and Greenstone (1969), the therapy group may be the ideal venue within which to promote understanding of the self in the interpersonal realm.

**Universality**

When members of a therapy group are able to share their difficulties with one another then they can come to realise that they are not unique in having certain problems in their lives. The therapeutic value of this phenomenon was identified by some of the earliest proponents of the group format, such as Trigant Burrow (1927), who argued strongly for the importance of creating an environment that helped patients to realise the commonly shared nature of their intrapsychic conflicts. Modern frameworks (Yalom & Leszcz, 2005) continue to cite this mechanism, and empirical support for its importance has been provided by studies that ask group members to rank the relative importance of various therapeutic factors. For
example, both Lieberman (1983) and Butler and Fuhriman (1983) found that group members consistently ranked universality as one of the most highly valued factors operating in self-help and therapeutic groups.

Various mechanisms have been proposed to explain this process. For example, Foulkes (1965) made the point that suffering is easier for a human being to bear when one is suffering alongside others. Yalom and Leszcz (2005) have argued that many people enter therapy groups thinking that they are the only ones with particular flaws or inadequacies. When they discover others with similar problems, they are thereby relieved of the painful burden of thinking that they are uniquely (and negatively) different from their peers. Robinson (1980), whose focus was on the self-help movement, articulated a similar mechanism. He proposed that a person’s self-concept was changed by the experience of spending time in a group with others who had similar problems. In his view this involved a shift from feeling ‘odd’ and ‘different’ to more ‘normal’ in comparison with other people, which worked to reduce feelings of stigma.

As described in chapter 2, people who experience social anxiety tend to have fewer and less intimate relationships. As a result of this isolation, they may have a heightened sense of their own uniqueness. In other words, they may be unaware that others experience similar anxieties and difficulties, and tend to respond to them in the same way. For this reason, the therapeutic factor of universality may be a potent one for the socially anxious, because it has the potential to reduce feelings of aloneness and stigma. This potential is highlighted in therapy groups for other populations where secrecy and shame form a core aspect of the difficulty. For example, in therapy groups for eating disorders (Moreno, 1994), or spouse abusers
(Wallace & Nosoko, 2003), the therapeutic factor of universality is emphasised for this purpose.

**Vicarious learning**

Joseph Moreno coined the term ‘spectator therapy’ to communicate the idea that group members can gain therapeutic benefit simply by observing others in the group (Dayton, 2004). In the broader group therapy literature, this idea typically refers to group members gaining benefit from observing other group members, but it can also include benefits gained from group members watching their therapists (Fuhriman & Burlingame, 1990). Bloch and Crouch (1985) have described this factor as manifesting itself in two different ways. The first occurs when a group member identifies with another group member strongly enough that they can gain some direct benefit from watching that member’s engagement with the therapeutic process. The second form occurs when a group member recognises some positive quality in another group member, that can subsequently be imitated and thereby incorporated into the observer’s own behavioural repertoire. This second form resembles what Bandura (1977) would define as “social learning”.

In terms of ‘how’ it exerts its influence, Yalom has described vicarious learning as a transitional therapeutic factor. By observing the interpersonal behaviour of others, a group member is provided with ‘live’ examples of how it might be possible to relate to others in the group, or to engage in the tasks of therapy (Yalom & Leszcz, 2005), thereby illuminating a pathway to deeper engagement in the process. It has also been noted by Kissen (1974) that group members internalise aspects of their therapists’ personalities and that this is an important component of the treatment. Yalom also mentions this, observing that group members often report
calling upon internalised representations of the therapist (or other group members) for guidance when facing difficulties outside the group (Yalom et. al., 2005). In this way, the process of vicarious learning may assist group members by providing them with a sense of expanded possibilities.

Given the importance of social learning to human beings in general (Box & Gibson, 1999), and the ever present opportunity for vicarious learning to emerge in therapy groups, it is somewhat surprising that there has been little empirical investigation of this phenomena. Fallon (1981) studied the impact of therapist modelling with a group of outpatients presenting with difficulties in interpersonal relating. He concluded that vicarious learning occurred when patients observed their therapists to navigate their way through a difficult interaction, and that this process was helpful. Jeske (1973) focused on the role of identification in therapy groups, and found that members who reported positive change from the group reported significantly more instances of identification in their overall group therapy experience. In addition to these rather meagre findings comes the observation that group members themselves tend to rate this therapeutic factor as valued, but not as important as other factors (Lieberman, 1983).

With regard to social anxiety, this therapeutic factor would seem to offer some unique benefits. As Bloch and Crouch (1985) point out, one of the potential effects of modelling is to exert a disinhibitory effect on the observer. So, for example, a group member may observe another group member engaging in anxiety provoking behaviours (i.e., sharing personal information in the group) without coming to harm. And this may promote the idea of disclosure as a more viable behaviour for the observer. A second potential benefit relates to the limited social
world (described in chapter 2) inhabited by those who experience social anxiety. In this context, the group may offer an important new opportunity to observe different kinds of interpersonal behaviours which may be imitated and eventually integrated into a group member’s behavioural repertoire.

**Conclusion**

This chapter has explored the way in which the broader group therapy literature conceptualises ‘the group’, both as a theoretical construct and an active constituent within the therapeutic process. Those aspects of group life that are generally thought to be responsible for the improvements that individuals experience (i.e., the group therapeutic factors) have been examined in some detail, and their potential relevance to social anxiety has been considered. The purpose of this inquiry has been to further understanding of the various ways in which groups are thought to be helpful, as well as to investigate the potential relevance of these variables to therapy groups for social anxiety.

**The Current Study**

This research aims to identify ways in which the existing group CBT treatment protocols for SAD may be enhanced. In support of this broad goal, it was decided to investigate how people change after a successful group therapy experience. At present, there is little information in this domain. If the nature of phenomenological change in social anxiety can be better understood, this is likely to generate some novel targets for therapeutic intervention with which to enhance the treatment protocols.
In addition, it was decided to investigate the nature and impact of relational processes within therapy groups for social anxiety. For example, are interpersonal or group process variables contributing to the therapeutic process in these groups? And if so, can they be better understood and turned to therapeutic advantage? Again, there is very little information in this domain. If this aspect of the group therapy can be better understood, this may identify ways in which the ‘group’ aspect of the group CBT protocols may be enhanced.

**Research questions**

In contrast to a hypothetical-deductive approach, the current research adopted a predominantly exploratory approach, with a phenomenological focus. A deliberate effort was made to put aside pre-conceived constructs and understandings, and allow the participants’ own experience to guide the construction of meaning around the themes of the research. There are two broad exploratory research questions, and these are:

1. What does phenomenological change in social anxiety look like?

2. What is the nature and impact of interpersonal and group process variables in therapy groups for social anxiety?

In addition there is one ‘practical implications’ research question:

3. What are the practical implications of this for psychologists working with socially anxious people in groups?

The next chapter provides an outline of the empirical work undertaken in support of this.
Chapter 5: Method

Chapter overview

This chapter outlines a rationale for, as well as a description of, the research methodology used in this study. A statement of personal interest is provided so that something about the researcher and their perspective is known. A description of the procedure for recruiting participants is outlined, along with the inclusion criteria used in their selection, and the materials used in the study are described. Finally, the procedure for collecting the interview data is set out, and the analytical techniques which were applied to it are explained.

Rationale for the research methodology

This thesis explored the experiences of people who had taken part in a group therapy treatment for social anxiety disorder. A qualitative method was chosen because this approach is ideally suited to generating novel information in areas that have received little empirical attention (Greenhalgh & Taylor, 1997). In particular, qualitative methods are well suited to developing rich descriptive accounts of phenomenona under investigation (Smith, 2008). By examining the personal accounts of a small number of participants in depth, it is possible to generate insights into generalisable phenomena within a particular population of interest (Bradley 1992).

The use of semi-structured interviews.

Semi-structured interviews are widely used in psychological research (Smith, 2008). They are organised around a pre-defined set of open ended questions, but with the flexibility to raise other questions that emerge spontaneously out of the
interaction between the interviewer and interviewee. This method of data collection was chosen because it could generate data of direct relevance to the research questions, whilst also maintaining space for the expert interviewee to determine what is important to them (Hugh-Jones, 2010). This approach can therefore facilitate the emergence of material that was unexpected by the researcher, but relevant to the research questions.

**Interpretive phenomenological analysis (IPA) to analyse the data on phenomenological change.**

IPA was chosen as the method for analysing the rich descriptive accounts of change generated via the semi-structured interviews. The IPA method involves a number of defined steps, that facilitate engagement with the interview transcripts, and help the researcher to identify themes and integrate them into meaningful groupings both within and then across cases (Willig, 2008), thereby building up a vivid picture of the phenomenon under investigation. The systematic nature of this analytical process is well suited to conducting psychological research (Smith, 2004). Because it aims to explore the participant’s world and to adopt, as far as possible, an ‘insider’s perspective’ on the area under investigation (Smith, Flowers & Osbourne, 1997), it is ideally suited to building up an account of what positive change in social anxiety looks like from the perspective of the participants themselves.

**Critical incidents methodology to analyse the data on important moments in participants’ group therapy experience.**

The critical incidents methodology was chosen to analyse important therapy moments. This method was originally devised by Flanagan (1954) to analyse behaviours that led to success or failure in air-force missions in the second world
war. In psychology, it has been used to investigate such issues as ethical transgressions amongst graduate students (Fly, van Bark, Weinman, Kitchner & Lang, 2007) and to develop a five-stage model of culture shock (Pederson, 1994). This method aims to develop understanding of significant incidents, from the perspective of the individuals involved in them. In this study it facilitates the production of detailed accounts of particular group therapy moments, within which the affective, cognitive and behavioural elements of the participant’s experience can be identified (Gremler, 2004). It does so by directly engaging with the participant’s experience of those moments, as they describe it in their own words. This allows a vivid and detailed picture of these events to be identified, from which underlying patterns and themes can be drawn. This method is therefore well suited to generating information about the nature and impact of interpersonal and group process variables within the important therapy moments.

**Investigating two different kinds of therapy groups.**

The participants in this research describe their experiences as group members in two different kinds of therapy groups. Seven participants were drawn from CBT groups run at Swinburne University and based on the Heimberg and Becker (2002) treatment protocol. Another seven participants were drawn from a Gestalt therapy group conducted at Gestalt Therapy Australia. These different groups were investigated to ensure a depth of coverage of group processes, as it is possible that some interpersonal and group process variables might arise in the context of a Gestalt group but not be evident within CBT groups. For example, the Gestalt approach maintains a very strong focus on relational issues in the therapy. Whereas, whilst group processes are acknowledged in the group CBT treatment protocol of Heimberg et. al. (2002), this therapy aims very strongly at the cognitive and
behavioural elements of the anxiety, and more formalised exposure tasks focused on
the individual’s performance and their subjective experience during the exposure
tasks.

Personal Statement

Group therapy has been a long-term interest of mine that has been shaped by
my own experiences. Fourteen years ago, at the age of 32, I entered into a two year
long group therapy experience, in the context of a professional training program for
organisational change consultants. This program had a strong focus on helping
group members to gain insight into their own interpersonal functioning, and also on
promoting the emergence of new and more adaptive interpersonal behaviours. This
was a profound experience for me, and was connected to a period of intense personal
growth, which ultimately led to my decision to let go of an established career and
retrain as a psychologist.

In my family of origin I was the youngest of four children. Surrounded by
older siblings, I struggled to find my own voice in the family. Later on in life, I
found large social groups to be intimidating. I would often be a quiet member of
such a group, staying on the periphery of the conversation, or sequestering an
individual off to the side for a one on one interaction in which I felt more secure. I
am still often acutely self-conscious when called upon to speak in front of others.

One amusing incident that unfolded in the context of this research may help to
illustrate how my own personal experience informs the way that I think about groups
and social anxiety. In the early stages of my research I visited a training group for
Gestalt practitioners at the Gestalt Therapy Australia headquarters in Melbourne, to
talk with them about my research. I was introduced to a group of about 24 people,
sitting around on beanbags in a circle on the floor. About one minute into my 5
minute presentation I turned over a page of my notes, only to find the other side
unexpectedly blank. In this moment I lost my train of thought, and was unsure of
what I needed to say next. As the silence in the room grew longer, I suddenly felt
myself flush red with embarrassment. In this moment, I said to myself “It doesn’t
matter if you go red, just make sure you say what you need to say”. I took a deep
breath, and started talking again, struggling valiantly to control the quiver in my
voice as I expounded on the need to undertake basic research into the experience of
social anxiety! At the same time, I instinctively knew that establishing a safe
contact with someone else in the room would help to soothe me, so I maintained eye
contact with people in the room. Once I could see one or two nods or smiles coming
in my direction I started to breathe easier and could relax into the situation. I
include this story because the way that I have learned to manage myself
interpersonally inevitably informs the way that I think about relational processes in
social anxiety.

My personal interest in group therapy has also become reflected in my
professional life. During my postgraduate training I undertook a clinical placement
which involved a strong focus on groupwork. This led to an offer of employment
with that work unit and I have now accumulated approximately 350 hours
experience in facilitating and co-facilitating therapeutic groups. I would therefore
describe myself as an enthusiastic newcomer to the field who has some clinical
experience. Some of the groups I facilitated have been quite structured, whilst
others were interpersonal process groups in the style of Irvin Yalom (Yalom &
Leszcz, 2005). I have also co-facilitated two CBT therapy groups for social anxiety,
based on the Heimberg and Becker (2002) model. My experiences in these groups
have taught me just how complex group therapy is as a modality, and how the core
tasks and opportunities of group therapy are sometimes the same, and sometimes
very different, from those of individual therapy.

When reflecting on my training as a clinical psychologist in Australia, it is
disappointing how little attention was focused on the modality of group therapy. In
fact, there was no training in groupwork whatsoever. I felt very underprepared
going into my first social anxiety therapy group as a facilitator, because the
treatment protocol offered very little guidance on how best to deliver the therapy in a
group context. I suspected that there might be some unique opportunities and
challenges in this environment, but I had no instruction or guidance or even
experience on which to base this notion. And when I looked further, I found very
little in the CBT literature to guide me. I therefore wanted to develop my theory and
practice as a clinician by conducting my own research into this area.

**Participants and Materials**

The final sample comprised 14 adults, seven women and seven men. Ages
ranged from 22 to 55 with a mean age of 29.4 years. All participants were
Australian citizens living in a large metropolitan city, and were experiencing
clinically significant levels of social anxiety at the time of entering their therapy
group. They were selected into the treatment on the basis of a structured diagnostic
interview, and self-report measures of social anxiety.
Measures

The Mini-International Neuropsychiatric Interview (MINI) for DSM-IV.

The MINI (Sheehan et. al., 1998) is a short, structured diagnostic interview developed to screen for the major Axis-1 disorders in DSM-IV and ICD-10. It was designed to meet the need for a short screening tool to support clinical trials and epidemiology studies. The MINI has been shown to reliably and validly elicit symptom criteria used in making DSM-IV diagnoses (Sheehan et. al., 1998).

The Social Phobia Scale (SPS).

The Social Phobia Scale (Mattick & Clark, 1998) is a self-report questionnaire of 20 items designed to assess anxiety symptoms related to performing various tasks (writing, drinking, eating in public) while being observed by other people. The possible scores that can be obtained on this measure range from 0 to 80, where 0 indicates no anxiety and 80 denotes extreme anxiety. The SPS has been shown to possess high levels of internal consistency, and test-retest consistency, and can discriminate between social phobia and normal samples (Mattick et. al., 1998).

The Brief Fear of Negative Evaluation (BFNE-II) Scale.

The Brief Fear of Negative Evaluation Scale (Carleton, Collimore & Asmundson, 2007) is used to determine the degree to which people experience anxiety or apprehension at the prospect of being evaluated negatively by others, which is a characteristic feature of social anxiety. It comprises 12 self-report questions. Individuals who score high on this scale tend to behave in ways designed to avoid the prospect of being evaluated unfavourably. The possible scores that can be obtained on this measure range from 0 to 48, where 0 indicates no apprehension.
The BFNE-II has excellent internal consistency, and moderate convergent validity with other measures of social anxiety (Carleton et. al., 2007).

**The Social Anxiety Interaction Scale (SIAS).**

The Social Anxiety Interaction Scale (Mattick et. al., 1998) is a self-report questionnaire of 20 items that assesses anxiety related to initiating and maintaining interactions with people in social situations. In line with the SPS, the possible scores that can be obtained on the SIAS range from 0 to 80, where 0 indicates no anxiety and 80 denotes extreme anxiety. The SIAS has been shown to possess high levels of internal consistency, and test-retest consistency, and can discriminate between social phobia and normal samples (Mattick et. al., 1998).

Table 2 details the data for each participant, and for the sample.
Table 2

Social Anxiety Scale Scores Before and After Treatment

<table>
<thead>
<tr>
<th>Participants</th>
<th>SPS Pre</th>
<th>SPS Post</th>
<th>SIAS Pre</th>
<th>SIAS Post</th>
<th>BFNE-II Pre</th>
<th>BFNE-II Post</th>
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<tbody>
<tr>
<td><strong>CBT Group</strong></td>
<td></td>
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<tr>
<td>Dave</td>
<td>43</td>
<td>21</td>
<td>66</td>
<td>34</td>
<td>45</td>
<td>26</td>
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<tr>
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<td>76</td>
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<td>10</td>
<td>72</td>
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<td>40</td>
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<td>25</td>
<td>43</td>
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<td>53</td>
<td>59</td>
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<td>Kath</td>
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<td>31</td>
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<tr>
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<tr>
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<td><strong>Mean</strong></td>
<td>39.57</td>
<td>26.43</td>
<td>57.36</td>
<td>42.79</td>
<td>41.14</td>
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<tr>
<td><strong>SD</strong></td>
<td>12.73</td>
<td>12.13</td>
<td>11.38</td>
<td>12.19</td>
<td>7.98</td>
<td>12.91</td>
</tr>
</tbody>
</table>

*Note:* SPS = Social Phobia Scale, SIAS = Social Interaction Anxiety Scale, BFNE-II = Brief Fear of Negative Evaluation Scale II.

As can be seen in Table 2, eleven participants achieved a large reduction in social anxiety scores on at least two out of the three self-report measures (large in absolute terms as described by Tryggvadottir & Saevarsson, 2013, which equates to a reduction in the BFNE of six points or more, or a reduction in the SIAS/SPS of nine points or more). One participant’s scores remained largely unchanged (Adam), whilst another (Sarah) experienced modest gains and one participant experienced a worsening of symptoms (Sally).
Development of the Research Interview Schedule

A key goal of the research was to enter into the subjective world of the participants, and try to understand their personal experience. For this reason, it was essential to ensure that the interview questions were open-ended in nature and non-directive (whilst still generating information adequate to answering the research questions). In consultation with my supervisor, and another clinical psychologist who was experienced in qualitative research, a pool of prospective interview questions and probes was developed and refined for the interviews. A draft interview schedule was piloted in a practice interview with a person who had recently completed a social anxiety therapy group. On the basis of feedback from this person, and the research supervisor, the wording of some questions was changed to make them more open ended, and one question was dropped from the interview schedule.

The final interview schedule contained two main sections. In the first section the focus was on the participant’s experience of social anxiety. Participants were invited to reflect upon their experience of social anxiety, and any changes in that experience since joining the therapy group. In the second half of the interview the focus shifted on to the therapy itself, and participants were invited to reflect upon important moments in their group therapy experience. The questions and probes used in the final interview protocol are set out in Table 3 below.
Table 3
Key Questions and Associated Probes of the Interview Schedule

1. Broadly, in terms of your experience of social anxiety, has anything changed since you joined the group?

   Possible probes: What’s different? How is it different?

2. Let’s explore a typical situation where you might feel your social anxiety. What would that experience be like for you before you attended the group? And would you experience that situation differently in any way now?

   Possible probes: What would be different? How would it be different? How would you describe that difference to someone who didn’t know anything about social anxiety?

3. Were there any moments in your group therapy experience that seemed to be particularly important to you? Or that stood out to you?

   Possible probes: Can you tell me some more about that? What was it about that moment that stood out to you? What was significant about it for you?

4. Is there anything else about your experience in the group that seems important to you that we haven’t talked about?

Procedure

Recruitment procedure

To be included in this study, individuals were required to have experienced either a CBT group treatment for SAD, or a Gestalt group treatment for SAD.
Recruitment of participants from CBT groups for social anxiety.

The Swinburne Psychology Clinic is a low-cost community clinic staffed by provisional psychologists undertaking postgraduate training. This clinic offers a group CBT treatment for Social Anxiety Disorder, based on the Heimberg and Becker (2002) manualised treatment protocol. Depending on demand these groups typically run four to five times per annum, with a membership of six to nine group members. The groups are facilitated by two or three Masters and Doctoral level psychology trainees, working under the supervision of fully licensed psychologists. The researcher attended four of these groups between January 2011 and June 2012 to explain the research and invite people to participate in the study. Seven participants from three different therapy groups were recruited into the study in this way.

Recruitment of participants from a Gestalt therapy group for social anxiety.

Gestalt Therapy Australia (GTA) is a centre of excellence in relational gestalt therapy training which has been training gestalt practitioners in Melbourne for 15 years. An agreement was entered into with GTA to participate in this research. GTA provided a venue, and a clinician (a fully licensed psychologist) to facilitate a therapy group with nine members, which was conducted from June to August 2011. The researcher attended this group to explain the research and invite participants to be a part of the study, and seven participants were recruited in this way.

Shared intake procedure for both therapy groups.

The same intake procedure was used for both kinds of therapy groups. Potential group members attended a face to face structured clinical interview with a
provisionally licenced psychologist at the Swinburne Psychology Clinic. Psychiatric diagnoses were established via the ‘MINI’ International Neuropsychiatric Interview (Sheehan et. al., 1998), and those currently experiencing substance abuse or psychosis were excluded from the groups and referred elsewhere. Those meeting DSM-IV TR criteria for Social Anxiety were offered the choice of attending either one of the regularly scheduled CBT group treatments at the Swinburne Psychology Clinic, or a Gestalt group treatment at the GTA centre. At the commencement, and also at the end of the treatment, group members completed three measures of social anxiety that are widely used in the research literature: the Social Phobia Scale (Mattick & Clark, 1998); the Brief Fear of Negative Evaluation Scale II (Carleton, Collimore & Asmundson, 2007); and the Social Interaction Anxiety Scale (Mattick & Clark, 1998).

**Special marketing drive to recruit participants into the Gestalt group.**

Under the agreement with GTA, the Gestalt group therapist was available to conduct the group from June to August 2011. In order to recruit adequate numbers to fill this group for a specified start date, a special marketing campaign was undertaken with advertisements placed in a local newspaper and on Facebook. This lead to a large number of people expressing interest, and between April and May of 2011 the researcher (a provisionally licensed psychologist) conducted 16 intake assessments at the Swinburne Psychology Clinic, as per the intake procedure described above. Those meeting intake criteria were given a choice of attending either the Gestalt group, or the next available CBT group.
The group therapy treatments.

All participants attended a 9 week group therapy treatment for Social Anxiety Disorder, after which they were interviewed by the researcher. A brief summary of the CBT and Gestalt group therapy interventions is set out below.

The CBT groups.

The group CBT treatment for social anxiety followed the manualised treatment protocol of Heimberg and Becker (2002), with the addition of a module on ‘Mindful awareness’. It was conducted over nine 1.5 hour sessions, by two or three Masters or Doctoral level psychology trainees working under supervision in a University clinic. The structure of the group was as follows. In sessions 1 and 2, group members received a rationale and instructions for exposure, cognitive restructuring, and home-work assignments. They were also introduced to the idea of mindful acceptance, and practiced a mindfulness exercise as well as cognitive restructuring skills. Thereafter, each session began with a brief mindfulness exercise and a discussion of homework exercises completed in the previous week. The remainder of the session was then dedicated to planned behavioural experiments (i.e., ‘exposure exercises’). The therapists lead group members through individualised exposures to role-played simulations of each patient’s feared situations, which was preceded and followed by therapist-directed cognitive restructuring exercises. Patients were also coached in the application of rational thinking during the exposure itself. Two group members completed such planned behavioural experiments each week, whilst the other group members assisted by helping out with the role plays, and contributing to the post role play discussions. Towards the end of each session, therapists worked with each patient to develop
homework assignments for completion during the upcoming week. Homework typically consisted of exposures to real-life situations whilst patients practiced pre and post-exposure cognitive restructuring. The overall goal of the therapy was to teach patients to become their own cognitive-behavioural therapists. These groups typically contained six to eight group members.

The Gestalt group.

There is no manualised Gestalt treatment protocol for social anxiety disorder. A statement from the group therapist about the nature of the therapy is therefore set out below.

Statement from the Gestalt group therapist about the nature of the treatment.

The treatment protocol for the Gestalt Therapy group for Social Anxiety is based on the principles of contextualism, phenomenology and a dialogic attitude. These theories support the facilitator to respond to, and investigate, both the intrapsychic phenomena of group members and to link this phenomenon to the group process and interpsychic life of the group. The group experience is used as a resource to support group members as they individually and collectively work with their self-beliefs and experiences of social anxiety within the group and in their worlds.

One therapist facilitated the group, which contained nine group members. The group process was conducted once a week for 2 hours for 9 weeks. The group members were asked to keep a written reflection of their weekly group experience. This reflection was for their private use unless they wanted to share some of their reflections with the group.
Each group meeting would follow a structure. The structure of the group process was explained to the members, including that the structure was flexible and would be adjusted according to group expressed needs. In this way the internalized rules and structures of the group are co-constructed. The group would begin with an introduction exercise. An example of this is in the first group meeting everyone was asked to use art materials to draw their name on a card in such a manner that it would convey something about them. Each member was then supported to present their name and talk about why they chose to present their name with the colour and form they had used.

Drawing on the material generated with the opening exercise, the facilitator would encourage members to respond to other member contributions and the impact or meaning it may have held for them. This intervention would generate an interaction either between group members or with a group member and the facilitator. With each of these interactions, in particular those between the group member and the facilitator, the group would be encouraged to make a response to the individual member and the work they had engaged in. This intervention is designed to create the opportunity to use the resources of the group members to respond to the individual so that he/she could hear the impact that they had on the group. This experience would offer to all group members’ new information about their social narrative, thus creating the opportunity for them to experience themselves differently from their reflexively formed catastrophising and anticipatory fears held in response to social settings.

As the group continued to form and develop, initial feelings of safety and connection were built up. The typical structure of each evening would be an opening exercise or reflection on a short presentation from the facilitator in response to the
material from the previous week’s meeting. Examples of these topics were the nature of shame, understanding emotions, repeated and needed emotional experiences, and the neurology of fear and anxiety. The facilitator would check-in with group members asking each of them to respond to the topic or to reflect on their week and make some links between that and their experience in the group.

As group members found internal support, often assisted by a conversation with the facilitator, they would make contributions to the group process. They did this by articulating their experiences with social anxiety and making links to their experience in the group or to the material being discussed. The overarching goal of the group was to offer an alternative immediate and lived social experience to the group members, compared to their usual interactions, so that they could have a contemporary experience of themselves engaging differently in the social world. This offered group members the opportunity to build new narratives about their felt-self-experience in social settings.

**Research interview procedure.**

After the therapy groups ended, those who agreed to participate in the research were interviewed by the researcher (this occurred within three months from the date of their final group session). All of the interviews were conducted face-to-face by the researcher, between July 2011 and August 2012. All interviews were conducted at the Swinburne Psychology Clinic, except for one which occurred at a participant’s home at their request. Interviews typically lasted from 60 - 90 minutes. In each case the interview was recorded, but this did not commence until participants had acknowledged their consent to participate in the interview and recording (see Appendix 1 - Informed Consent Form).
The interview style prioritised building rapport, and collaborative meaning making, to ensure as far as possible that the researcher and participant jointly attempted to understand and reflect on the participant’s experience. Reflective listening was employed to clarify meaning. To ensure uniformity each participant was asked all of the questions contained within the interview schedule, but space was also provided for the emergence of new or unexpected material of significance to the participant. The interview schedule was used as a guide, rather than a formal script.

In some of the first interviews with CBT group participants, a number of people identified and described important moments that occurred outside of their therapy group. For example, they described attending a previously avoided social situation, or having an important interaction with a friend outside of the group. In the group CBT protocol of Heimberg and Becker (2002), ‘homework exercises’ form a core part of the treatment protocol, and this typically involves setting behavioural goals that are pursued outside of the group, and subsequently discussed in the following group session. It was therefore decided to include such moments in the study, as there was a rationale for considering them to be part of the therapy, and also because the participants themselves considered these moments to be significant in the context of their group therapy experience. Five out of the 37 important moments occurred in this context (three from CBT group members and two from Gestalt group members).

**Analysis of the interview data**

Audio recordings were transcribed by the researcher, and subjected to analysis. Interpretive phenomenological analysis (IPA), in accordance with the
procedure outlined by Willig (2008), was utilised to analyse those aspects of the transcripts that related to phenomenological change. The important group therapy moments were analysed via the critical incidents technique, as described by Gremler (2004). A detailed description of the analysis follows.

**Phenomenological change in social anxiety data analysis.**

As the focus of this research was on positive change, only the interview data of those participants whose experience of social anxiety improved were included in this section of the analysis. Improvement was identified by a combination of subjective report during the interview, and change in the self-report measures of social anxiety completed after the therapy. Tryggvadottir and Saevarsson (2013) have proposed that a reduction in the BFNE of six points, and a reduction in the SIAS and SPS of nine points, is large in absolute terms. As the BFNE II, SIAS and SPS all measure different aspects of social anxiety, it was decided to define improvement as a large absolute reduction in at least two out of the three social anxiety measures, combined with a subjective report from the participants at interview that their social anxiety had improved. Eleven out of fourteen participants met these criteria, and their transcripts were included in this part of the analysis.

In line with Willig’s (2008) model of IPA analysis, the inductive analysis of those sections of the interview transcripts pertaining to phenomenological change consisted of five stages.

*Stage 1 – Initial encounter with the text.*

The first stage of analysis involved reading and re-reading the entire transcripts. At this stage, initial reactions to the data were noted in the margins.
Anything that appeared to be important or of interest was noted, so that it could be returned to. The main objective at this stage was to obtain a holistic perspective of the interview, so that any future interpretations would remain grounded within the participant’s perspective (Breakwell, Hammond, Smith & Fife-Shaw, 2006).

**Stage 2 – Identifying and labelling themes.**

In the second stage, each transcript was carefully assessed for units of meaning that related to phenomenological change. Each distinct theme that characterised such a section within the transcript was documented in a short statement. At this stage every effort was made to stay as close to the participant’s meaning as possible, and these initial themes were a combination of the participant’s own words, and psychological constructs. For example, some themes that emerged at Stage 2 were ‘anxiety is OK’ and ‘letting go of hiding the anxiety’.

**Stage 3 – Clustering of themes.**

In the third stage of analysis, inductive reasoning was applied in order to bring some structure to the themes identified in the previous stage. Themes from across the entire dataset were brought together and considered, and themes with a similar content were clustered together. So, for example, the themes of ‘letting go of hiding the anxiety’ and ‘actively revealing one’s anxiety’ were brought together into a single theme of ‘congruence/authenticity’. Hierarchical relationships between the themes were also identified and in this way the themes of ‘congruence/authenticity’ and ‘giving others more attention’ were identified as subordinate to a larger theme of ‘being with others differently’.
**Stage 4 – Production of a summary table and defining the themes.**

The structured themes were then brought together in a summary table, and illustrated with relevant quotations from the interview transcripts. At this stage all of the quotes for each theme across the entire dataset were considered together. From this, a more carefully worded label was drafted for each theme, alongside a definition which described its essential features. Exemplar quotes to illustrate the theme were also selected for reporting in the results section.

**Stage 5 – Integration of cases and production of a ‘Model of phenomenological change in social anxiety’.**

The data across all cases were integrated to generate a model of phenomenological change in social anxiety consisting of five key dimensions. This model captures the quality of the participant’s shared experience of phenomenological change in social anxiety, and the structure of this model is reproduced in communicating the findings in the results section.

**Important group therapy moments data analysis.**

All 14 transcripts were included in the analysis of important therapy moments. In line with Gremler’s (2008) model of the critical incident technique, the analysis of important moments consisted of four steps.

**Step 1 – Creation of narratives of the important moments from the raw data.**

Participants rarely offered a neatly packaged narrative of their important moments. It was therefore necessary, as a first step, to disentangle the chronology of events from the interview transcripts. This involved creating a narrative which described each important moment. In this step, no attempt was made to condense or
summarise the story. Rather, the researcher attempted to capture as accurately as possible their understanding of the incident, in all of its aspects, as it had been described to them by the group member.

**Step 2 – Identification of a general frame of reference to describe the important moments, and production of an ‘Important moments summary table’.

Once the narratives had been extracted from the raw data, a general frame of reference was identified in order to describe and categorise the important moments, in accordance with Gremler’s (2004) model of critical incident analysis. Gremler recommends that such a frame of reference should be informed by the aims of the study, and any previously developed classification schemes that already exist within the area of study. A general frame of reference, consisting of two foci, was selected:

Foci 1 - “What happened?” (Events); and

Foci 2 - “Why was that important to the group member?” (Salience).

This framework was selected because a general aim of the study is to generate information relevant to furthering understanding of the nature and impact of interpersonal and group process variables in the therapy groups. An understanding of ‘events’ and ‘salience’ within these moments can highlight the nature of any interactions, and also the meaning that they held for the participants. In addition, this general framework is well suited to identifying the presence or absence of elements of a previously established classification scheme that exists in this field (the group therapeutic factors). The group therapeutic factors are defined in such a way that they describe a therapy event, and its hypothesised impact. For example,
the therapeutic factor of Universality involves an ‘event’ (group member A listens to
group member B) and also an impact (group member A discovers that group
member B faces similar difficulties, and so group member A is relieved of the
burden of thinking that they are uniquely and negatively different to other people).
A general classification scheme of ‘events’ and ‘salience’ is therefore sensitive to
detecting such factors because of the kind of information it generates.

Each important moment narrative was analysed from the perspective of this
general frame of reference, leading to the creation of an “Important moments
summary table”. This table contained a brief summary of “What happened?” and
“Why was that important to the group member?” for each of the important moments.
An example extract is provided below in Table 4.

Table 4

Extract from Important Moments Summary Table

<table>
<thead>
<tr>
<th>What happened?</th>
<th>Why was that significant to the group member?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The group member listened to another person in the group talk about their experience of social anxiety.</td>
<td>Adjustment of the self-concept. Destigmatising. “I’m not the only one. I’m not so bad/different to others as I thought I was”.</td>
</tr>
</tbody>
</table>

**Step 3 – Inductive analysis of data contained within the ‘Important moments summary table’, and production of a ‘Key elements of important moments framework’**.

The data in the ‘Important moments summary table’ was then subjected to an
inductive analysis, to generate main categories and sub-categories that describe the
incidents from the perspective of the two foci of the basic frame of reference (Grove
& Fisk, 1997). For example, within the foci of ‘What happened?’, a main category
of ‘Engaging in new behaviours’ was identified. And further analysis revealed that this category contained within it two sub-categories of new behaviours: ‘Being more congruent/authentic in an interaction’; and ‘Attempting a previously avoided behaviour/situation’. This analysis lead to the production of a ‘Key elements of important moments’ framework, which sets out the structure of the main categories and sub-categories within each foci. This framework for describing the important moments is reproduced to communicate the research findings in the results section.

**Step 4 – Analysis of relationships between elements of the two foci within the general frame of reference.**

Finally, relationships between key elements across the different foci were considered. This was done by using the unique identifier code for each important moment to compare where it was located within the ‘Key elements of important moments’ framework of each foci. In this way, it was possible to identify that certain therapy ‘events’ were closely linked to moments that were identified as ‘salient’ for particular reasons (i.e., there was a high overlap between them – many moments coded to event ‘A’ were also coded to salience ‘B’).

**Group therapeutic factors data analysis.**

The data in the important moments summary table was also analysed from the perspective of the group therapeutic factors. For each important moment, information contained within the two foci of the general frame of reference was considered in light of the proposed action of each of the group therapeutic factors described in Chapter 4. Based on this analysis, each group therapeutic factor whose action was consistent with the description of an important moment was identified as prominent within that moment. An example is provided in Table 5 below.
Table 5

*Extract from Important Moments Summary Table updated to include Group Therapeutic Factors*

<table>
<thead>
<tr>
<th>What happened?</th>
<th>Why was that significant to the group member?</th>
<th>Prominent group therapeutic factors</th>
</tr>
</thead>
</table>
| The group member listened to another person in the group talk about their experience of social anxiety. | Adjustment of the self-concept. De-stigmatising. “I’m not the only one. I’m not so bad/different to others as I thought I was”. | Universality  
Self-understanding  
Self-disclosure (of another person) |

The number of important moments that each group therapeutic factor was prominent within was then summed across the entire data set and considered. The most prominent factor overall was linked to sixteen different important moments. It was decided to use the frequency midpoint of the most prominent factor as a cut-off point in identifying which factors would be considered as prominent overall within the dataset. In other words, those factors that were linked to eight or more important moments were defined as prominent overall, and this resulted in the identification of four group therapeutic factors as ‘most prominent’ within the important moments.

**Summary**

This chapter has outlined the rationale for the methodology employed in this study, and described each step in the research process. It also included a personal statement from the researcher. The next chapter sets out the results of the study.
Chapter 6: Results

Chapter Overview

This chapter presents the results of the analysis of group members’ interview transcripts. There are two sections in the chapter, and the first of these describes the nature of phenomenological change in those who responded well to the treatment. This provides a detailed picture of “what changed?” for those that improved, and sets the scene for the second section which describes “important moments” in the participants’ group therapy experience. These moments were often linked to the changes described in the first section, and provide important information about the nature and impact of interpersonal and group process variables within the therapy groups.

Within each section, the core categories of themes are described first so that the broadest level of findings may be considered as a whole. The themes and sub-themes related to the categories are then described in more detail, and illustrated with quotations from the interview transcripts. As described in the Method section of the thesis, participant’s experiences in two different kinds of group therapy treatments were considered because it was thought that certain group process variables might arise in the context of a Gestalt group that were not evident within CBT groups. However, analysis of the data revealed no such differences and so the analysis of all cases was combined.
Section 1 – Results of the IPA Thematic Analysis: the Nature of Phenomenological Change in Social Anxiety

On the basis of the IPA analysis of the interview transcripts, five broad categories of phenomenological change were identified. These core categories are set out and described in Table 6.

Table 6

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Changed understanding and</td>
<td>This category revolved around a shift in participants understanding of themselves, and the expectations/demands that they placed upon themselves. They came to see their anxiety (and by extension themselves) as less pathological, and more normal. They were able to identify and reassess some of the demands that they placed on themselves to function socially in particular ways, and they found a way to be kinder to themselves when they did have a bad experience. Overall, they became more accepting and compassionate towards themselves and their experience of social anxiety.</td>
</tr>
</tbody>
</table>
Table 6 (Cont). – Core categories of phenomenological change in social anxiety

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. A changed relationship to the anxiety</td>
<td>Those who improved often talked about experiencing a shift in the way that they related to their anxiety. This included things like becoming more familiar with their experience of anxiety, developing a stance of greater acceptance towards it, and responding to it differently (by engaging with it, rather than taking flight from it). The metaphor of ‘making friends’ is used here to capture the essential nature of this change in participants’ relationship towards their experience of social anxiety.</td>
</tr>
<tr>
<td>3. Changed view of other people.</td>
<td>Participants that improved described important shifts in how they perceived and made sense of other people. They were surprised to learn that social anxiety was a common experience, and that other people experienced it, and were not so different to themselves in that respect. They also reported a growing belief in a benign social world. That is, they started to experience other people less as a potential source of judgement and hostility, and more as a potential source of acceptance/support.</td>
</tr>
</tbody>
</table>
Table 6 (Cont.) – Core categories of phenomenological change in social anxiety

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. “Being with” others differently/experiencing others differently.</td>
<td>Almost all interviewees who improved talked about being with others differently and experiencing them differently. In particular, they found themselves behaving more authentically in their interactions with others, being more attentive towards other people, and enjoying them more. There was a growing recognition that most of the social cues in their environment were ambiguous, and an associated ‘easing off’ of catastrophic interpretations of the looks and words of other people. Positive interaction cycles, which tended to reinforce new or emergent behaviours, were also described.</td>
</tr>
<tr>
<td>5. Changed view of social encounters.</td>
<td>Some respondents who improved described a change in the way that they perceived and made sense out of social encounters. They talked about feeling less responsible for the success or failure of an interaction, and also less responsible for the responses of other people. Specific situations of concern (i.e., particular types of social situations or interactions) were also reconceptualised in a way that reduced their anxiety inducing potential.</td>
</tr>
</tbody>
</table>
The five broad categories of phenomenological change identified in this study were: Changed understanding/expectations of self, A changed relationship to the anxiety, Changed views of other people, Being with/experiencing others differently, and a Changed view of social encounters.

The phenomenological changes described in this section are drawn from interviews with 11 different participants who experienced an improvement in their experience of social anxiety. Different people noticed and reflected upon different things, and there was no one individual who described all of the categories set out here. Instead, the categories and associated themes represent a variety of different ways in which participants’ experience of social anxiety shifted.

The categories of phenomenological change are now considered in detail. A definition of each category and its associated themes is presented first in a table format, so that the category may be considered as a whole. A more detailed synopsis of each theme is then provided, along with quotations from the interview transcripts that illustrate the central meaning of the theme.
**Category 1 - Changed understandings/expectations of self.**

Participants experienced a shift in the way that they understood and related to themselves.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>My anxiety is not a sign that I am weird/deviant/flawed.</td>
<td>Interviewees no longer perceived their anxiety to be evidence that they were somehow uniquely different from (and worse than) other people.</td>
</tr>
<tr>
<td>Lowered demands on self to function in a particular way.</td>
<td>Respondents lowered the demands that they placed on themselves regarding social functioning. They became more accepting of how they ‘actually were’ socially.</td>
</tr>
<tr>
<td>Being kinder/easier on self.</td>
<td>Participants developed a more compassionate stance towards themselves, and their experience of anxiety. They judged themselves less harshly for feeling anxious or committing a perceived social blunder.</td>
</tr>
</tbody>
</table>

*My anxiety is not a sign that I am weird/deviant/flawed.*

Six participants talked about a shift in how they made sense of their experience of social anxiety, in terms of what the anxiety signified about them as a person. Prior to the group, for example, they considered the fact that they
experienced anxiety in social settings to be evidence that they were different to normal people, and somehow flawed. They felt that something was wrong with them, that set them apart from others. Here Heidi describes how she used to feel in a social setting:

_I was really socially anxious, and I would beat myself up about it, and would feel really ashamed of it, and try and hide it in situations where I feel like ‘I don’t want people to notice that’... [] I thought it was a weakness I suppose. I didn’t like that aspect of myself at all. []’cos it’s not... something you think of... someone being that anxious in such a situation._ (Heidi)

As the group therapy progressed this attitude seemed to shift. People talked about developing a different attitude towards their anxiety, and what it meant about them as a person.

_...just understanding that it is a common part of what happens. Part of the human experience... There’s nothing too unusual about it... [] [because] I guess, there’s fear, that I’m not a normal functioning member of society. [] Just knowing that it’s a normal thing, that was reasonably important._ (John)

People who talked about this theme described a growing recognition that their experience of social anxiety was a common one and a part of the broader human experience, rather than something which differentiated them (in a negative way) from others. This recognition appeared to reflect a more compassionate and accepting stance towards the self and one’s own experience of anxiety.
**Lowered demands on the self to function in a particular way.**

Four interviewees talked about lowering the demands that they placed on themselves about their own social functioning. For example, Kath used to expect that she should be able to talk to everyone at work, and would judge herself negatively when this did not occur. In the following quote she describes how she has adjusted her expectations in this area.

> Like if I don’t have anything to say, that’s fine! Like talking to people at work, if I talk to them that’s fine, and if I don’t, that’s fine as well. I don’t have that real high expectation that I’ve always got to be talking to someone, or that I’ve always got to connect with everyone here, or I’ve got to make friends here. I’m just not worried so much about that. (Kath)

Heidi also discussed lowering the demands that she placed on herself. In this quote she reflects on the impact that this might have on her future judgements about her own social performance.

> I guess, like I was saying, acknowledging that I’m not able to be like some other people, and be able to achieve those things in social situations, like being able to talk up lots, or easily initiate conversation with people. Like I’m gonna be quite anxious in a lot of situations, and have to set smaller goals, or expect less from it, I suppose. And still... like be happy just with talking to somebody for a bit, and it still being anxious. And that being better than what’s happened before. That’s the kind of thing that I need to aim for, rather than just like ‘talking to everyone’. (Heidi)
Overall those who talked about this theme described letting go of perfectionistic standards of social behaviour such as ‘I need to talk to everyone’. They also became more accepting of the way that they actually were.

**Being kinder/easier on the self.**

Six interviewees talked about developing a more compassionate attitude towards themselves. This was manifested in different ways. For example, Ben would often criticise himself for simply having the experience of feeling anxious (which he interpreted as a sign of personal failure). In the following quote he describes a softening of that stance:

> Yeah that’s really important. And I’ve noticed that there’s more times now, even though it’s still hard for me, there’s more times I can go “I’m feeling like this for a reason. There’s a long history of events that have happened, that make this… in the past this was a valid way of coping, and even though it’s not so helpful now, I can’t just snap out of it”. So... yeah... yeah... (Ben)

Others talked about becoming more understanding towards themselves when they behaved socially in a way that they perceived to be incorrect.

[The therapist] *used to speak a lot about being easier on yourself, and sort of, um... not, you know, just not being that hard on yourself. So basically, if I do something wrong I just go... I just sort of unravel it a little bit. You know I’m not turning it into a catastrophe kind of thing. I’m just sort of saying “Well, look, I did something silly with that bartender or whoever it was. And that’s all it was. It’s one bartender, and he will probably forget all about it within*
"15 minutes or whatever". I just sort of rationalise it a little bit more sensibly.

(Lucas)

Overall, people who talked about this theme described becoming more kind and understanding towards themselves when they felt anxious and/or behaved in a way that they perceived as inadequate.

**Category 2 - A changed relationship to the anxiety (‘making friends’ with the anxiety).**

Participants experienced a shift in the way that they understood and related to their experience of social anxiety.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowing/understanding the anxiety better.</td>
<td>Interviewees described becoming more familiar with their experience of anxiety. It became more comprehensible to them. They experienced their anxiety “less” as something alien and frightening, and “more” as something that was known, and could be contended with.</td>
</tr>
</tbody>
</table>
| Thinking differently about the anxiety. | Interviewees reported a shift in their perception - or how they thought about their social anxiety. It was recognised and accepted as a normal aspect of human experience, rather than something pathological within them that needed to be eliminated. They became less anxious about ‘being anxious’.
<table>
<thead>
<tr>
<th>Theme (Cont.)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responding differently to the anxiety.</td>
<td>Participants described responding to their experience of social anxiety in a different way. They were more accepting of the experience when it emerged, and less caught up in a struggle to eliminate and/or hide that experience from others. They also reported becoming better at soothing and supporting themselves through a moment when their social anxiety flared up, and letting go of the anxiety once the moment had passed.</td>
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</table>

**Knowing/understanding the anxiety better.**

Seven interviewees talked about becoming more familiar with their experience of social anxiety, and understanding it better. This occurred at different levels of awareness. For example, some people came into the group without a prior understanding, or even a vocabulary, which they could use to help them make sense of what they were experiencing when they were anxious. Beverley talked about this, and the impact that learning a model of anxiety had on helping her to interpret and respond to her inner experience of anxiety:

> Well it’s just because now I know the words, and I know what’s going on, and I’ve been shown the symptoms and all that sort of stuff, and it’s like... oh yeah, I’ll remember a time when I was doing that, and I’ll go “Oh... it’s that, it’s avoidance behaviour, or it’s this, it’s something else”, so that’s how. It’s
because I can word it out now, whereas before it was just this horrible feeling. Whereas now... it has names and it has... it’s kind of more... and that’s how I can now talk myself out of it. Because I know what it is, whereas previously I didn’t... I just knew that I hated that feeling that I would have, and I would often do whatever it was I could to avoid it... and that 60-70% of the time meant that I wouldn’t go to what I was invited to. (Beverley)

Or in the words of Yukie:

I didn’t identify that I experienced these feelings and emotions because of social anxiety. Now the awareness is more, so therefore I know how to tackle that. (Yukie)

For others, their experiences in the group helped them to identify something important about their own idiosyncratic model of anxiety. In other words, they became more aware of how their own behaviours, or self-talk, or construals of situations, contributed to their experience of social anxiety. For example, Kath talked about writing down her anxious thoughts, and the impact this had on raising her awareness around her own self-talk.

...writing down the thoughts, the thinking errors and so on... that practice helped with making you more aware of these kinds of situations. It makes you more aware, and I’ve said this before to people... they might say something to themselves all the time, and they’re not aware of it, but once you’ve spoken to someone, then the next time they say it they might be like “Oh! I just said that thing to myself”. So yeah, just being more aware of what you’re thinking, and... yeah, all that sort of stuff. (Kath)
Overall, those who improved described an enhanced awareness of, and a greater understanding of, their own experience of social anxiety. It became less alien/frightening, and more familiar and comprehensible to them.

**Thinking differently about the anxiety.**

Many participants entered the group holding the idea that their anxiety was a ‘problem’, and if it could just be eradicated then everything would be OK. This was noted by John during his interview.

> And it seemed like a common thing with the people within the group. The thought that “I’ve got this anxiety and I’ll go along to the group, and I’ll get cured, and then at the end of it I’ll be super confident, and all the rest of it”.

(John)

Amongst those that improved throughout the life of the group, almost all (8/11) talked about a shift in their attitude towards their anxiety – to a stance of greater acceptance of anxiety as a normal aspect of life.

> I suppose before then I was thinking, like looking for a quick fix or something that could just solve it. But through hearing about stuff, and learning stuff from [the therapist], I’ve realised that it’s more something that you just have to live with and deal with, and can improve in some situations. (Heidi)

> I realise now that it’s a normal thing. Everybody has it. In certain situations, people will be a bit nervous. [...] so it’s not the anxiety itself that’s the problem. It’s allowing the anxiety to stop you doing things, that’s the problem! (John)
Overall, the respondents reported a shift in their perception - or how they thought about their social anxiety. In particular, there was a growing recognition that social anxiety was a normal part of life, rather than something pathological that needed to be eliminated.

**Responding differently to the anxiety.**

All eleven group members who improved talked about a change in the way that they responded to their experience of social anxiety. This was evident in four key areas.

1. **Letting go of the struggle to control/eliminate the anxiety**

Some interviewees talked about responding with a stance of greater acceptance when they felt themselves becoming anxious in a social setting. They were able to ‘let go’ of trying to control this aspect of their experience. This was well articulated by Inka:

…when I… go and see someone, I still, I’m anxious, and it’s awkward for me, and… but, you know, I’ve just sort of… well if I get anxious, I just sort of try and think ‘Well, what’s the worst that can happen?’ They might think I’m anxious. And that’s not really so big a deal. And when I sort of play it down like that, I don’t get as anxious, because I’m not trying so hard. The harder I try, the more I feel like… on the spiral of anxiety. So I’m sort of defusing it, if you know what I mean? (Inka)
And also Dave:

*I think that’s a big change now. When I’m feeling anxious, I can just sort of stare it in the face, and wait for it to subside. Just sit with it... and tolerate it better. And not try to fight back, or worry that it’s about to take over.* (Dave)

2. Letting go of the struggle to hide the anxiety from others

Alongside this greater stance of acceptance came a lessened concern that others might ‘see’ their anxious mannerisms. People described “letting go” of their struggle to hide their anxiety from others. In the words of Glen:

*...being less, um, concerned about being anxious. Like, just sort of... yeah just being more comfortable with appearing to be anxious, or worried.* (Glen)

Lucas and Kath went on to explain the impact that this ‘letting go’ had had on their overall experience in a social setting.

*People just have those sort of abilities to ‘sense the anxiety’. So now I more go... when I see people and I’m feeling anxious, I just sort of, look at them and think ‘you’re going to know anyway’ so I just sort of, I’m more present in terms of the anxiety, and letting them see my vulnerabilities, and just saying ‘Well hi, I’m still here, and...’. Not from a trying to cover it up perspective... It’s much easier to go out the door knowing that you can do that. That you’re not constantly on guard.* (Lucas)

*...once you’re OK with something, and it doesn’t take up such a massive portion of your consciousness, you can kind of move forward. You’re not held*
back as much... yeah, the anxiety is always gonna be there, but I’m ok with that now. And all of the things that you sort of hold onto, that you don’t want to let people see, like being nervous, and shaking, and all that kind of stuff. Once you kind of let go of a bit of that you’ve got more sort of space to be able to do what you need to do, or focus more on what they’re saying, or contribute more. (Kath)

3. Active coping in response to the experience of anxiety – engage rather than avoid

Another difference that many people talked about was a more active engagement with their experience of anxiety, as it emerged in the moment. This engagement typically took the form of active coping/soothing strategies that the person learned within their therapy group. The following quotation from Ben is a good example.

I’ve noticed that there’s a bit of a delay, or a buffer, from... say an event happens that triggers extreme anxiety... I won’t be so reactive, and I won’t sort of lose grounding immediately, like I traditionally would have in the past. Part of it is, in the group, we... we’d go through scenarios each week, and we’d be given a sheet full of scenarios to take home, and we’d have to choose an anxiety provoking situation, and then go through the process, the sheets, when you ask a disputing question... like are you 100% sure, or something like that. And I actually found that I would think this... that would go through my head, whilst I was in feeling the panic rise, or whatever else, other symptoms that might arise when I was in the situation... and that would give me a bit of
I wouldn’t get carried away as quickly... A bit more observing yeah, and because there was that going on, I would then remember to breathe, which I think would keep me a bit more present as well, and I wouldn’t fly away with my thoughts. (Ben)

Interviewees talked about many experiences like these where they were able to notice and respond to their anxiety at an early stage, and thereby stop their anxiety from escalating. They also talked about being able to soothe themselves sufficiently so that they could ‘hang in there’ in a social situation and not flee from it. These experiences were felt to be empowering, and gave them a greater faith in their capacity to tolerate and live with their experience of social anxiety. In the words of Beverley:

It’s still there but I’m in control of it... I just breathe deeply. I’ve sort of got a strategy of dealing with it... So it’s that kind of thing where it’s still there but I’ve got some control over it... whereas before it was completely and utterly controlling me. (Beverley)

4. Getting better at “letting go” of the anxiety – becoming less anxious about feeling anxious.

Six participants described an important shift in getting better at ‘letting go’ of their anxiety. They found that they were spending less time worrying about upcoming social encounters, or ruminating about them afterwards. And they used phrases like “getting over it”, or “moving on” to describe how they were able to
disengage from this aspect of their anxiety when it did arise. Lucas describes a major change for him in this area:

… a lot of my problems were actually post event sort of anxiety. Like I would do something that I perceived to be... blameworthy, or just sort of embarrassing in some way. And then within my mind it would sort of snowball into something more significant. So my, sort of reactions to these sort of events have improved drastically [said with emphasis]. And that was a real huge thing. Because when I was working, for example, there would be a little thing which would sort of set me off, and it could just be as simple as trying to get a sandwich, and I’d think that the person getting me the sandwich didn’t like me or something like that. And then it would snowball into something huge. So I think just the ability to sort of, what the... I think the Gestalt methods have helped me in terms of, just being easier on myself in terms of when I do something which I perceive to be incorrect. (Lucas)

This capacity to ‘let it go’ was described as coming about in different ways. Some people would reframe a problematic situation, whilst others would utilise self-compassion towards their experience, and still others reported being unaware of how it came about – they simply noticed the change in their experience. However it came about the impact was substantial, on anxiety before, during, and after social events. This is best captured in a quote from Inka:

And so I think I’ve just, like when I have a horrible... like I still have those anxiety experiences, but now I’m just like ‘It’s not such a big deal”. It’s horrible at the time, but afterwards I just put it aside and go on. I don’t sort of agonise myself with it, for hours, you know. [...] So, you know, I can get over
that and move on, and... that’s made a massive difference, in that sense. And then, sort of knowing that... it, it’s not built up into such a horrible thing. It actually makes the experience less traumatic as well. ‘cos I know ‘Well, it’s not the end of the world... and I can do it’... I can survive it, and it’s not as bad... like I just don’t make it into this full blown horrible thing. (Inka)

Overall, whilst people continued to have the experience of feeling socially anxious, they reported spending less time ‘stuck’ in the experience of worrying about that.

**Responding differently to the anxiety – integration.**

Overall, the interviewees described responding to their experience of social anxiety in a different way. They were more accepting of the experience when it emerged, and less caught up in a struggle to eliminate and/or hide that experience from others. They also reported becoming better at soothing and supporting themselves through a moment where their social anxiety flared up, and also letting go of the anxiety once the moment had passed. This different way of responding appeared to reduce their anxiety and support further social engagement.
**Category 3 – A changed view of other people.**

Interviewees experienced a shift in the way that they perceived other people.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
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<tbody>
<tr>
<td>Other people experience anxiety</td>
<td>There was a growing recognition that other people also experience anxiety in social situations, and struggle with that.</td>
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<tr>
<td>too.</td>
<td></td>
</tr>
<tr>
<td>Other people are not as</td>
<td>Participants moved away from perceiving others as hostile/judgemental as I thought. and towards seeing other people as hostile/dangerous, and towards seeing other people as potential sources of acceptance and support. There was a growing belief in a more benign social world.</td>
</tr>
<tr>
<td>hostile/judgemental as I thought.</td>
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</table>

**Other people experience anxiety too.**

Many people entered the group thinking that they were the only one who experienced social anxiety. Yukie expresses what was a widely held sentiment:

*I was kind of happy to know that other people experience the same, so I’m not the only one. Because, from my friends and everyone from people I know, I’m the only one.* (Yukie)

Participants were surprised to learn that social anxiety was more common than they had imagined. In the following quote, Mikael is talking about how his assumptions about other people had changed after discovering that others in the group whom he
had perceived to be “confident looking” actually experienced debilitating levels of social anxiety.

From that... and from hearing ‘X’ and ‘Y’ and ‘Z’ talk, has just sort of helped me realise that everyone, regardless of how I might interpret their personality to be, is likely to be just as nervous as I am about talking. So, that’s what’s different. I’m not going to be so judgmental from now on. (Mikael)

It was also common for interviewees to reflect upon the impact that this realisation had on them. For example, in the following quote, Kath talks about how this new insight has changed her perception of other people and also herself.

...to hear about your stories [the therapist’s], and the other guys [other group members], about getting nervous when you talk in front of other people and stuff. Just made me realise that everyone has got this to some degree. Or everyone has something... and that makes you feel not so ostracised, and like, you’re kind of by yourself. (Kath)

Overall, interviewees talked about a growing recognition that other people commonly experience social anxiety. This insight appeared to shift their assumptions about other people (they suffer from anxiety also, it’s hard for them too) and by extension themselves (I am not different from/worse than others).

Others are not as hostile/judgemental as I thought.

Almost all (8 of 11) of those who improved talked about a shift in their perception of other people, in the general direction of perceiving others less as a potential source of threat, and more as a potential source of acceptance and support. It is difficult to describe this theme concisely, because the shift in attribution was
unique to each group member’s particular fears about other people. For example, Ben, who experienced fears that people would harm him literally, talked about perceiving others as less dangerous in terms of a threat to his personal integrity:

*I think generally I don’t see them as dangerous, automatically dangerous.*

(Ben)

In contrast, Inka, who feared personal attacks on her character, started to see others as less harshly judgemental towards her:

*I guess, it has changed in the sense that I’m doubting more of my beliefs in the sense that everyone is horribly judgemental about me. Because if they [the other group members] are not... maybe other people aren’t.* (Inka)

These shifts in the perception of others also extended to intimate relationships. Here, Lucas is talking about how his relationships with his friends have improved in recent times, and he describes a change that he has noticed in the way that he perceives them.

*... like my social anxiety was largely around... I thought people weren’t very nice... I generally was seeing the negative side of people. So I was seeing people as being pretty self-centred, and sort of not accommodating towards myself. And basically now I do tend to see nicer sides of people. Just for instance just with my friends much more. They are much closer to me now. And I can tell that they care about me more. So I can see the more caring side of people now.* (Lucas)

In summary, people who talked about this theme described an important shift in the way that they perceived other people’s thoughts or intentions towards themselves.
This shift could be described as seeing other people, and the social environment in general, in a more benign and potentially supportive light.

**Category 4 – A new way of being with/experiencing others.**

Participants experienced a shift in their experience of being with others. They found themselves experiencing and responding to others differently.

<table>
<thead>
<tr>
<th>Theme</th>
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</thead>
<tbody>
<tr>
<td>Being more congruent/authentic/open in</td>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>interactions with others.</td>
<td>Interviewees described maintaining a consistency between their internal experience and their outwards behaviour (e.g., not trying to hide their anxiety, or actively revealing it to others). They behaved more openly and authentically when interacting with others.</td>
</tr>
<tr>
<td>‘Easing off’ of catastrophic interpretations of the looks and words of others.</td>
<td>There was a shift towards seeing social cues as being open to a broader range of interpretations. People described becoming less certain that particular social cues could/should be interpreted negatively.</td>
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<tr>
<td>Attending more to other people.</td>
<td>People found themselves paying less attention to their own inner experience of anxiety, and more attention to the people that they were interacting with.</td>
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<tr>
<td>Enjoying others more.</td>
<td>Participants described getting more pleasure out of their interactions with other people.</td>
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<tr>
<td>Theme (Cont.)</td>
<td>Description</td>
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<td>--------------</td>
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<tr>
<td>Positive interaction cycles</td>
<td>Interviewees described interaction cycles where they tried out a new behaviour/way of relating, and received immediate feedback from others that reinforced that new behaviour/way of relating.</td>
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**Being more congruent/authentic/open in interactions with others.**

Four group members talked about becoming more ‘congruent’ in their interactions with other people. Most commonly, they described congruence as maintaining a consistency between their inner experience and their outwards behaviour. So, for example, they stopped trying to conceal their experience of anxiety from others if they were feeling anxious in a situation. This was well described by Glen.

*Being more honest with your emotional state I guess. Not sort of fleeing from it, and being sort of inwardly and outwardly consistent… I think that’s sort of related to what I was saying earlier about being less, um, concerned about being anxious. Like, just sort of… yeah just being more comfortable with appearing to be anxious, or worried.* (Glen)

Or in the words of Lucas:

*... you know, a lot of my anxiety was around, trying to be something I wasn’t to satisfy other people. But I’ve found that there’s sort of better reaction to me when I just, sort of, maintain this, what I call “Real Lucas”. So pretty much,*
throughout the day, I just basically continually tell myself... just be who I am.

(Lucas)

Whilst this experience of being more congruent/authentic in their interactions was challenging, group members described it as something that reduced their anxiety in social settings and generated positive responses from other people.

‘Easing off’ of catastrophic interpretations of the looks and words of others.

Four participants described a shift in how they evaluated or made sense of social cues in their environment. Overall, this shift could be described as a move away from a rigid and negative style of interpreting social cues, and towards perceiving social cues as being open to a broader range of interpretations. For example, in the following quote, Beverley made reference to an experience she had in the therapy group in which she learned that many of her assumptions about the intentions of other people were unwarranted. She described how this realisation has helped her to view other people’s behaviours as more open to interpretation (i.e., she no longer automatically assumes a hostile intent), and the impact this has had on her experience in social settings.

It reinforced for me that the stuff that goes on in my head, like when I’m making judgements about people, and trying to assess who they are, I don’t have anywhere near as much information as I think I do. And that just reminds myself to hold back, and not just sort of say “I don’t like the way that person responded” and that’s it! Or anything like that. Just to sort of be like “you’ve got no idea what happened there, so don’t worry about it”. Which is
really useful for me, it’s incredibly useful to me, because it means that I don’t feel offended, and all that sort of stuff, which is huge. (Beverley)

Or in the words of Kath:

...just the realisations that you’ve come to, when something’s happened, and normally you might feel this way, but now you’re kind of going “Nah..”, like if someone makes a comment to you, and normally you might take offense at that, but now you’re going “Well, that could mean a whole range of things”.

(Kath)

Overall, group members described an “easing off” of catastrophic interpretations of the looks, words, and responses of others. They perceived social cues as being open to a broader range of interpretations than they did previously, which appeared to have the effect of making their social environment less threatening.

**Attending more to other people - being more ‘present’ in interactions.**

Four people talked about experiencing a shift in what they attended to, or focused on, when they were interacting with others. They noticed that they were paying less attention to their own inner experience of anxiety, and more attention to the people that they were interacting with. For example, Dave noticed a big difference in this area. In the following quote, he is talking about his experience in the early stages of the therapy group, when he was feeling very socially anxious being in the group, and comparing that to his experience towards the end of the group when he was feeling much more relaxed.

...very, in my head. Very kind of bubble, sort of. Yeah, a sort of narrow attention, sort of, inward focus. Really hyper-aware of myself, and kind of like
I had a mirror mounted on my head and kind of looking in it back at myself.
And, um, yeah, but then later on not focusing on myself. Just on everyone else
in the room and on the topic. Yeah. (Dave)

Inka also talked about this change of focus during her interview. In this quote she
describes how she is now finding it a little easier to just ‘sit with’ her anxiety in a
social situation, enabling her to attend and engage more fully in a conversation.

Ummm…I’m kind of able to partake a little bit more in conversations. I used
to not really hear what people were saying, because I was so worried about
being anxious. So now I’m able to be a little bit more present than I was. []
it’s not as bad because I’m... um... it’s not escalating. I sort of just like “OK.
I still feel anxious but I’ll deal with it”, so, um, and then I’m able to sort of be
more present in the conversation and sort of, might even have a little bit of fun
actually. (Inka)

Overall, those who talked about this theme said that they were getting less ‘caught
up’ in focusing so intently on their own anxiety experience when they were
interacting with others. As a result they were finding it easier to attend to, and be
responsive to, the person and the situation in front of them.

Enjoying others more.

Five people talked about enjoying others more, and deriving more pleasure
from social encounters in general. This is well captured by Glen:

...the state of mind that I’m in now, I experience people more ‘how they are’ I
think. I’m able to enjoy a lot of people’s company. Um.. yeah without sort of,
constant worry about, what they might be thinking. Um... yeah, like on Friday
night I had a friend’s art exhibition opening night. And he’s had quite a few exhibitions over the years and, like for some reason, it’s just that environment just makes me super anxious, but on Friday night I just really enjoyed it, and was really interested in people. And I don’t really know what happened, because I was sort of nervous going there. But yeah, I think that’s the main difference I think, enjoying other people. (Glen)

And also Ben:

Like I still enjoy other people’s company. But now it’s a real enjoyment, rather than feeling like I have to be with someone because that’s what I should be doing, or it will keep me occupied or distracted, because the last thing I want to do is be alone with my thoughts. (Ben)

Overall, participants who talked about this theme described getting more pleasure out of their interactions with others, compared to what was typical for them before the group.

**Positive interaction cycles.**

Four interviewees talked about changes in their own behaviour leading to positive feedback/responses from other people. Typically, this related to them behaving in a more open and engaging manner, and getting feedback from interaction partners that reinforced that new behaviour. In the words of Kath:

...I’m connecting with people. And it’s not that I don’t care [about the anxiety], it’s that I care less. And so I’m not wrapped up with how people perceive me... I’ve just got a good response from people because I’m a bit more open. (Kath)
This was also mentioned in terms of more intimate relationships, where changes in the way that group members related to their friends lead to a deepening of those relationships. In the following quotes, both Dave and Lucas talk about this experience.

*There’s been a few friendships that have, people I’ve known for years and years, and suddenly we’ve got a lot closer. All of a sudden, sort of midway through the group. And I think it’s, like, probably because I was using them as homework, without them knowing that. So, when they asked ‘What have you been up to?’, I thought, well, I’ve got to give an answer, and relay some personal anecdotes and things that I usually wouldn’t. And then, that just snowballs into more conversation, and more self-disclosure, and it didn’t take much for some friendships to really accelerate. Which was really surprising.*

(Dave)

*One thing I’ve really noticed is that my friends love me a lot more now.
They’re just so appreciative that I’m a much more caring and understanding person, more attentive.* (Lucas)

When participants talked about these changes, they spoke with animation and excitement. It was clear that they treasured this new way of being with others.
Category 5 - Changed views about ‘social encounters’.

Interviewees experienced a shift in how they perceived social encounters.

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<thead>
<tr>
<th>Theme</th>
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<tbody>
<tr>
<td>I am not fully responsible for problematic social encounters</td>
<td>There was a growing recognition that a social encounter is a shared experience, with no one party fully responsible for the outcome. Group members also described letting go of the idea that they were responsible for the experience of another person in a social encounter.</td>
</tr>
<tr>
<td>Specific social situations are not as bad/scary as I thought</td>
<td>Participants experienced a shift in how they construed a particular social situation that had been a concern for them. This reconstrual reduced the anxiety they felt in those situations.</td>
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</table>

I am not fully responsible for problematic social encounters.

Five people talked about feeling less responsible for the way that social encounters unfolded. Two different aspects of this shift were described. At the first level, there was a growing recognition that a social encounter is a shared experience, with both parties contributing to it equally. This was experienced as ‘taking the pressure off’ in social situations, as described here by Glen.

Like not feeling like I have to sort of keep the conversation going. You know, there’s two people here and it’s 50/50. And if it doesn’t... if something breaks
down, or if it's awkward, well it takes two to tango. And it's not all on me.

(Glen)

This was described in very similar terms by Mikael, who went on to mention the impact that this shift has had on his experience of conversations.

I don't feel responsible, and I feel less guilty about not being able to think of anything to say. (Mikael)

At the second level, group members described a shift away from the idea that they were fully responsible for the experience of other people in a social encounter. They started to recognise that unexpected or unpleasant responses from others might have nothing to do with them, but instead relate to some difficulty experienced within that other person. In the following quote, Yukie describes this shift and the impact it has had on her ability to tolerate a situation where someone at work does not understand her immediately (a situation that previously caused her great distress).

...sometimes when something disappointing happens now I don't think it's all me. It's especially helpful that one. I guess it's simple to think it's not all about me, but then with social anxiety, that's something I couldn't see before. I can now slightly see that people do certain things because of their personality. Previously I didn't have that. Or I couldn't see it that way. Previously it was like 'I'm the stupid person'. If they don't understand something then something is wrong with me. Now I'm a bit more confident about telling things... if they don't understand... then they don't understand. It's not about me. So it's much easier at work now. (Yukie)
Overall, people who mentioned this theme talked about taking less responsibility for problematic social encounters. They no longer assumed that these situations were their fault, or evidence of their own inadequacy.

**Specific social situations are not as bad/scary as I thought.**

Three respondents talked about a shift in their construals of specific social situations that were a concern for them. In each case the reconstrual was quite specific, relating to a particular social setting rather than ‘relating to other people’ in a general sense. For example, Beverley described a shift in how she made sense of a situation in which another person disagreed with her. In the following quote she describes this change, which emerged from an interaction she had with another group member (who enjoyed arguments and offered another perspective on them). Here she starts by referring to the impact of that interaction.

> It’s changed my perception of when people are argumentative with me about my point of view. I used to see it as an attack on me... and that really threatened me, and made me feel distressed and all that sort of stuff. So yeah, looking at it from a different point of view. Looking at it as an opportunity point of view, to get information, and perhaps find out new information, or challenge your information... I hadn’t thought of any of that at all. (Beverley)

Another group member, Mikael, worried about running out of things to say and going blank during a conversation. Here he describes his shift in perception about what a conversation is.

> ...it’s no big deal. No-one’s gonna die. And that’s something that I didn’t understand before. I sort of always felt, you know... if you’re sitting there you
have to be able to have a good conversation with somebody. Whereas now it’s much more like ‘Whatever’, if it’s going well it’s going well. If it isn’t, go and talk to someone else. So that’s definitely changed. (Mikael)

Each of the group members who talked about this theme experienced a shift in how they made sense of specific social situations that were a concern for them. It appears that these reconstruals made these situations less anxiety inducing to them.

**Conclusion: Phenomenological change in social anxiety.**

IPA analysis of the interview transcripts revealed five core categories of phenomenological change amongst those group members who had a positive response to the therapy. All eleven participants talked about a change in the way that they related to their experience of social anxiety. It became more familiar to them, and better understood, which helped them to better support themselves through a difficult moment. They also became more accepting towards the experience itself, which made it less distressing when it did come along, and easier to let go of afterwards. This increased stance of acceptance towards the experience of social anxiety also appeared to be central to the second category of phenomenological change which was mentioned by ten interviewees (changed view/understanding/expectations of self). Within this category, people described letting go of the idea that their anxiety was a sign that they were different to others and somehow flawed. There was a greater acceptance of the experience of anxiety, and also the self as a person who experiences anxiety. Alongside this shift came lowered demands on the self to function socially in a particular way, and more compassion for the self for feeling anxious or committing a perceived social blunder.
Nine respondents talked about changes in how they viewed other people, and changes in how they experienced being with others. They came to recognise that other people also experienced social anxiety, and were not so different to themselves. They also came to view others as more benign and less dangerous. In their interactions with others, they described being more attentive towards others, and more authentic/open in their own presentation. The way that they interpreted others softened, as they recognised a greater degree of ambiguity in the potential meaning of social cues in their environment. They described a real enjoyment in being with others and receiving positive responses to their new interpersonal behaviours.

Finally, six participants talked about changes in the way that they perceived social encounters. Specific situations of concern came to be reformulated in a less anxiety inducing manner. And they felt less responsible for the outcome of social interactions, and for the responses of other people. Recognising that the responses of others might relate to that other person’s unique personality or difficulties may be particularly important, as it was mentioned by many people within this category and it has the potential to generalise out across all social encounters.

This data addresses the first research question “What is the nature of phenomenological change in social anxiety?”, and sets the scene for the exploration of “Important moments” in the therapy which were often described by participants as being connected to these changes. In the next section of the results, the findings on important moments in participants’ group therapy experience are set out. This provides information relevant to understanding the nature and impact of interpersonal and group process variables within the therapy groups.
Section 2 – Results of the Critical Incidents Analysis of Important Moments in Participants’ Group Therapy Experience

Group members identified and described a total of 37 ‘important moments’ that took place during their group therapy experience. These moments were analysed in light of the two foci of interest established within the general frame of reference for analysing the important moments.

<table>
<thead>
<tr>
<th>Foci</th>
<th>Describes the important moment in terms of…</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Observable events</td>
<td>What were participants doing during their important moments?</td>
</tr>
<tr>
<td>2. Salience</td>
<td>Why were these moments important to the participants?</td>
</tr>
</tbody>
</table>

For each foci a definition of the themes and any associated sub-themes are presented first, in a table format, so that the entire data set for that foci can be considered at a glance. A more detailed synopsis of themes and sub-themes is then provided, and an ‘example important moment’ is described to illustrate the central meaning of the theme. The results of the analysis of the important moments from the perspective of the group therapeutic factors is then set out.
Foci 1 analysis (observable events).

What happened during the important moments?

During the interviews, participants were asked to describe what happened during their important moments. And as the analysis of these moments unfolded, a number of themes and sub-themes were identified. Each moment was ultimately coded to only one theme or sub-theme, because the categories were mutually exclusive. In other words, each moment could only be coded as one ‘type’ of event. The core themes and sub-themes for what the group member was doing are set out below in Table 7.

Table 7

What was the Participant Doing During Their Important Moment?

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Jumping in…</td>
<td>engaging</td>
<td>Moments in which a group member was actively engaged in a social interaction.</td>
</tr>
<tr>
<td></td>
<td>socially</td>
<td>Most typically, they were stretching their interpersonal repertoire, by behaving in a way that was new or unusual for them.</td>
</tr>
<tr>
<td></td>
<td>(n = 15)</td>
<td></td>
</tr>
<tr>
<td>1.1 Being more</td>
<td>congruent/authentic/in an interaction</td>
<td>Participants spontaneously risked being more ‘open’ in an interaction. They stopped trying to hide their anxiety, or actively revealed it to an interaction partner.</td>
</tr>
<tr>
<td></td>
<td>(n = 8)</td>
<td></td>
</tr>
</tbody>
</table>
Table 7 (Cont.) *What was the Participant Doing During Their Important Moment?*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>Attempting a previously avoided behaviour/situation (n = 7)</td>
<td>Participants deliberately engaged in a social situation or behaviour that they had been avoiding, or that had been a particular concern for them.</td>
</tr>
<tr>
<td>2.</td>
<td>Listening to another group member (n = 9)</td>
<td>Moments in which a participant was listening to another group member speak about their experience of anxiety.</td>
</tr>
<tr>
<td>3.</td>
<td>Listening to the therapist (n = 3)</td>
<td>Moments in which the participant was listening to the therapist(s) explain a model of social anxiety</td>
</tr>
<tr>
<td>4.</td>
<td>Other (n = 10)</td>
<td>A range of moments that did not clump together into a theme, or fit within any of the existing themes described above.</td>
</tr>
</tbody>
</table>

**Theme 1. Jumping in… engaging socially.**

By far the largest category of important moments (n=15) were ones in which group members were actively engaged in a social interaction. Typically this involved them stretching their interpersonal repertoire in some way, by behaving in a way that was new or unusual for them. For example, there were moments where group members tried relating to others in a different way, or engaged in a previously
avoided social situation, or tried out a new or rarely used interpersonal behaviour. In the midst of these experiences, or in reflecting upon them afterwards, participants reported that they experienced insights that helped to reduce their anxiety going forwards. For example, they reported learning that they were more socially capable than they thought they were, or that a particular situation could be experienced differently to what they had feared, or that other people (and their perceptions) were somehow different to what they had imagined. These moments emerged from planned behavioural experiments, as well as spontaneous interactions with other people inside or outside the group. During the analysis, two sub-themes were identified within this theme. These are defined below, and an example moment is described to illustrate each of them.

1.1 Being more congruent/authentic/open in an interaction.

The largest (8 moments) sub-theme within this grouping were moments in which group members tried being more congruent in their interactions with others. Congruence refers to maintaining consistency between one’s inner experience and outwards behaviour. It could also be described as being more ‘authentic’ or ‘real’ when interacting with others. Most commonly, participants described moments where they either stopped trying to hide their anxiety from others, or actively talked to others about their experience of anxiety. None of these moments emerged from planned behavioural experiments. Rather, they all occurred when participants spontaneously risked being more open in an interaction. An example of two different types of congruent behaviour are set out below.
Example moment – Dave: not trying to hide the anxiety.

Dave attended dinner at a restaurant to celebrate his friend’s birthday, and there were some new people there (normally a trigger for his social anxiety). Dave decided that, since he had already participated in an exposure task in the group that week, and completed all of his homework exercises, he was going to give himself ‘a night off’. He would go back to his usual shy self, and just sit and enjoy the food, and not even try to talk to anyone.

... but then strangely, by giving up, I ended up saying more than usual, and having conversations with people.

Dave went on to explain how he used the resources available within the group in an effort to make sense of this experience.

And we talked about that in the group, and tried to work out why, on the instance that I decided to give up, I actually had a really really good experience. And the theory was that, because I’d decided that this didn’t count, that this wasn’t a test, that I was happy to be shy and seem shy, and that it didn’t matter, I wasn’t rehearsing things to say, and focusing on coming up with things to say, and censoring and filtering, that I could actually then listen to what people were saying, and I had working memory capacity left for thoughts, and related conversation topics to pop into my head, and then I could say them. And so by giving up I had all this extra cognitive capacity to partake [in the conversation].

This experience, and the inner reflections prompted by the meaning making efforts of the other group members, had an impact on how Dave now understands and
relates to his experience of social anxiety. Rather than engage in a struggle with it, or try to eliminate it, he is experimenting with a stance of greater acceptance towards the experience:

Strangely enough. If I try... what I’ve found has been working pretty well, is “not trying” to not be inhibited. Like, not trying to overcome the shyness, not trying to overcome social anxiety, paradoxically, seems to mean that I can [do that] more easily.

Example moment – Heidi: actively revealing one’s experience of anxiety.

Heidi attended a dinner party for her friend’s birthday. She found this anxiety inducing and struggled to contribute to the group conversation. At the end of the night a friend escorted her to the front of the house. This was an old friend from high school, and Heidi had never spoken to her about the anxiety she feels in social situations. As she was leaving the party, Heidi opened up to her friend.

So then at the end as I was leaving, she walked me out, and I said something like “Sorry”, I didn’t really need to apologise for it anyway, but, I said “Sorry I’m so anxious, I just don’t talk much. Like I’d really like to, and I still like being invited to these things and stuff, and I really like you as a friend.”

This disclosure lead to a moment of real closeness and connection between Heidi and her friend, and the friend was very supportive and accepting towards Heidi and her experience of anxiety. As she described this moment Heidi reflected on the impact it has had on deepening her relationship with this friend.
I’ve felt closer to her since then. I’m seeing her today actually. But I felt like, maybe we’re on our way to being closer friends again, and me being more relaxed around her, maybe that was a step towards that. I hope it was.

She also described learning from this experience (and other situations where she has spoken up about her feelings of social anxiety) that other people are not so judgmental and critical about her anxiety as she had previously assumed.

I felt a bit better about it. That people were understanding about it, and compassionate about it. And people who I did want to be friends with, understood that I was like that at some times, and were OK with that. [] It’s a bit of relief, that they’re not actually thinking ‘oh… that’s really weak’, or ‘I can’t believe you think that’. But for the most part, they are really understanding about it.

1.2 Attempting a previously avoided social situation/behaviour.

Seven important moments occurred when participants deliberately engaged in a social situation or behaviour that they had been avoiding, or that had been a particular concern for them. Examples included things like giving a speech, asserting oneself in an interaction, or attending a particular type of social gathering. Some of these moments emerged spontaneously, but planned behavioural experiments were particularly prominent (4 out of 7) within this cluster of moments.

Example moment – Dave: attending a party.

Dave tends to worry that he might say something that could offend another person. He engaged in a planned behavioural experiment in the group, where he interacted with a stranger in a simulated party environment. After Dave was
introduced to the stranger the host of the party, who was in another area of the room, said “Come on in here, everybody’s in here”. There was a silence, and then Dave responded to the host in a joking manner “Is this where all the cool people are hanging out?”. The stranger then said to Dave “Oh, thanks a lot, yeah, so I’m not cool am I?”. When Dave had the thought that his comment could be interpreted as a put down, he felt shocking, and his anxiety escalated dramatically.

In the post behavioural experiment analysis Dave criticised himself harshly in front of the other group members for his joke about “the cool people”. But to his surprise, the other group members disagreed strongly with his perspective. They said that it wasn’t offensive, that the stranger was only continuing the joke with her response, and that it wasn’t a social ‘faux pas’ at all. In the following quotes Dave is reflecting on how the feedback from the other group members had a big impact on how he made sense of that experience. And also how this experience is helping him to place less faith in some of the catastrophic interpretations he makes about his own social behaviours.

*And it only kind of hit me afterwards... the contrast between how sure I was that I’d completely made a fool of myself. And absolutely everyone else saw it in a diametrically opposed light. And it just really brought home how I cannot trust my perception of whether I’ve screwed up or not... when I’m anxious I just don’t see it clearly at all. So I keep on coming back to that, as a reason not to trust my, kind of, instinct to criticise myself.*

*I’m just hoping that that moment stays with me. Or that I can just make a permanent habit of not jumping to conclusions about the appropriateness of things that I said or have done.*
Theme 2. Listening to another group member talk about their experience of social anxiety.

The second largest category of important moments (n=9) were ones in which participants were listening to another group member speak about their experience of anxiety. Sometimes these were “Ah-ha” moments, when a person suddenly gained some important insight. For example, listening to another group member describe how they set perfectionistic standards for their own social performance helped Heidi to recognise that tendency within herself. In other cases the moments unfolded over time, as various group members shared different aspects of their experience. This helped John, for example, to recognise that his experience of anxiety was not evidence that he was fundamentally (and negatively) different to other people. These moments were not more or less prominent in any particular aspect of the group therapy. They simply emerged from the natural sharing of experience that unfolded as the therapy groups progressed.

Example moment – Mikael: hearing from the ‘confident looking’ people in the group.

When Mikael entered the therapy group, one of the difficulties he experienced in his life was a tendency to “freeze up” around people that he perceived to be confident. He worried that such people would view his lack of conversational skills (and therefore himself) negatively. In the therapy group this scenario was reproduced when Mikael discovered that there were three ‘confident looking’ people in his group. In the following quote he describes his perception of these group members, and also the inhibiting impact that their presence had on him.
...they’re the sort of people that I imagine sitting in a bar, surrounded by lots of friends, just having an awesome time. You know, loudest in the group... you know, the way that they dressed, and the way that they sat, and all that sort of... it comes together. So that made me feel a bit more self-conscious. []...you feel like if you start talking about that sort of stuff [the anxiety] that they might judge you. [] ...and that sort of made me feel a bit more uncomfortable, and a bit embarrassed about talking.

As the group progressed and these three group members talked about their experiences, Mikael was very surprised to discover that his assumptions about them were wrong and that they actually suffered from debilitating levels of social anxiety. This helped him to shift some of the assumptions that he makes about other people, and to recognise that he is not so different to them.

...from hearing ‘X’ and ‘Y’ and ‘Z’ talk, has just sort of helped me realise that everyone, regardless of how I might interpret their personality to be, is likely to be just as nervous as I am about talking. [] The best way of describing it, that I can think of putting it, is that I’ve seen like the other side of the wall. That’s exactly what I’m saying. It’s a mirror image. So, the group sort of helped me realise that the grass isn’t always greener on the other side.

The stories of the others provided Mikael with an experience that directly contradicted his assumptions. He saw the struggles, and the suffering of these ‘confident looking’ people, and recognised that they were not so different to him. Mikael described this as a profound realisation, that has helped him to back away from some of the frightening assumptions he makes about other people and be more open to meeting and talking with a broader range of people.
It’s more acceptance, that everyone’s just different. And that they are probably all socially anxious... ‘Cos I used to go into a group and size it up quite quickly. And I could tell you within the first 5 minutes, the people that I’d attempt to talk to. Say, OK, a dinner party, and I don’t know anyone else except for one person. Previously, within the first 10 minutes, I would have been able to tell you who I would have ended up having a conversation with. But now it would be.... hazy, I wouldn’t be able to tell you. I’d just try and have a conversation with whoever wanted to listen.

Theme 3. Listening to the therapist describe a model of social anxiety.

Learning an explanatory model (which described what social anxiety is, where it comes from, and how it can be overcome) was listed as an important moment by three interviewees. In all cases they reported that this helped them to better understand and make sense of their own experience of anxiety. This enhanced understanding was also experienced as empowering. For example, participants described this as helping them to better understand their experience of social anxiety, what causes it/triggers it, or how to support themselves through a difficult moment.

Example moment – Yukie: learning about how social anxiety can develop.

An important moment occurred for Yukie when she heard the therapist describe how social anxiety can occur as the result of developmental experiences.

*First day, when [the therapist] was explaining, he said something like we weren’t born with that. That there are causes why it happens. And that made*
sense to me. I could understand why I got this. I sort of knew, but that was kind of the ‘click’. Why I got it. So that’s very encouraging to know that I wasn’t born with this. It had been learned. And that’s encouraging. I kind of know that I can do something about it.

Placing her experience within a developmental framework helped Yukie to contextualise her experience of social anxiety within her own life story. It was no longer a random, uncontrollable experience. There was a reason for it, which made sense to her. And she experienced the idea that it was a learned response as very encouraging.

...because I know that things I learn I can unlearn. I know that I can unlearn this... So knowing that I can unlearn, that makes sense to me, and then I can change. I feel more hopeful.

Theme 4. Other types of moments.

A final category of ‘other types of moments’ contains 10 moments which were diverse in nature and did not clump together into any one category, or fit within any of the existing categories described above. In these moments, a range of different events were unfolding. For example, participants: observed other group members relate to one another; mastered a technique of the therapy; or received words of comfort/encouragement from others.
Foci 1 - Observable events: Integrated summary.

The important moments were analysed at the level of observable events to help answer the question “What happened?” in those moments that participants identified as important to them in their group therapy experience. The results here indicate that important moments unfolded most commonly when participants were actively engaged in an interaction with another person. An important finding here relates to the ‘type’ of interaction. Whilst planned behavioural experiments were prominent, they accounted for less than half of such moments within the CBT groups (the Gestalt group did not utilise planned experiments). In other words, important moments were most likely to emerge in the context of unplanned or spontaneous interactions between the members. Another interesting finding emerges when the results here are considered in light of the results to be described below within the second foci of ‘Salience’. Of the two new behaviours described here (being more congruent/authentic, and attempting a previously avoided behaviour/situation) the former was much more strongly linked to the intersubjective experience of “Positive interaction cycles”. In other words, greater congruence, or authenticity, seemed to have a relational payoff (the group member received positive feedback from others which tended to reinforce the new behaviour) that was largely missing from the planned behavioural experiments.

Listening to others in the group speak about their experience was identified as the second most frequent context within which the important moments unfolded. This indicates that members of the therapy groups highly valued learning more about the other human beings in the room, and experienced a wide range of benefits from doing so. Finally, hearing the therapists talk about social anxiety was an important,
if infrequent, source of important moments. Overall, these findings indicate that, when group members are asked to self-identify important moments from their group therapy experience, they tend to choose moments where they were interacting with others or listening to other group members talk about their experiences. On occasion, hearing from the therapist(s) is described as important.

This analysis has provided important information about the kinds of events that occur in therapy groups that participants identify as important. The next foci of the general frame of reference considers “why” these moments were important to the group members.

Foci 2 analysis (Salience)

*What was significant/most salient about the important moment for the participant?*

Participants were asked what stood out, or what was significant to them, about their important moments. When the moments were analysed at this foci, a range of themes emerged, which could be clumped into two superordinate themes of ‘subjective insights’, and ‘intersubjective experiences’. Notably, the themes at this level of analysis are not like the ‘What happened?’ themes, which were mutually exclusive. There is overlap between the themes of this foci, because it was common for participants to describe a moment as being important to them for more than one reason. For example, a person might identify a moment as important because they had the experience of feeling prized and valued by others, and then go on to describe a positive shift in their self-concept as being connected to this. It is therefore most helpful to think of these themes not as discrete categories, but rather as aspects of the
moments that participants identified as important to them. The core themes and sub-themes for this foci are set out in Table 8 below.

Table 8 – *What was Significant about the Important Moments for the Participants?*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Subjective insights</td>
<td>(n = 23)</td>
<td>Moments in which participants attained some kind of subjective insight. In these moments people learned something important, or came to some new realisation, that was helpful to them. An experience of ‘intrapsychic insight’ was central to these moments.</td>
</tr>
<tr>
<td>1.1 Becoming more aware of one’s experience of anxiety (n = 14)</td>
<td>Participants learned something important about their own experience of social anxiety. For example, they became more familiar with the various ways it was affecting them, or they came to understand how their own construals of other people or situations contributed to their anxiety.</td>
<td></td>
</tr>
<tr>
<td>1.2 Experiencing a positive shift in their self-concept (n = 9)</td>
<td>Participants experienced a positive shift in their sense of self. For example, they discovered that they were more capable socially than they thought they were, or that they were less characterologically flawed than they thought they were.</td>
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</tr>
</tbody>
</table>
Table 8 (Cont.) – *What was Significant about the Important Moments for the Participants?*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Intersubjective experiences</td>
<td>(n = 17)</td>
<td>Moments in which the participants’ experience of another person, or their involvement with another person, was most salient. In these moments participants felt close to another person, or were comforted and soothed by another, or felt wounded by another. An experience of ‘relatedness’ was central to these moments.</td>
</tr>
<tr>
<td>2.1 Feeling valued and accepted by others (n = 8)</td>
<td>Participants experienced their contribution to the group, or some aspect of themselves personally, as being prized by others.</td>
<td></td>
</tr>
<tr>
<td>2.2 Positive interaction cycles (n = 7)</td>
<td>People tried out a new behaviour, or way of relating, and received feedback from others that reinforced this change in behaviour.</td>
<td></td>
</tr>
<tr>
<td>2.3 Moments of interpersonal rupture/repair (n = 5)</td>
<td>People felt wounded/estranged from others and wanted to withdraw from them. Or they felt prized/valued by others and wanted to engage with them more fully. Some important moments moved sequentially through both experiences in a rupture and repair cycle.</td>
<td></td>
</tr>
</tbody>
</table>
Theme 1 - Subjective insights.

When the important moments were considered in terms of salience, the largest number of moments fell into the superordinate theme of subjective insights. These moments were important to people because they came to some sort of realisation within themselves that was helpful in relation to their social anxiety. These subjective insights emerged out of both spontaneous interactions as well as planned behavioural experiments. It is worth noting, however, that planned behavioural experiments were particularly likely to lead to subjective insights. For example, all of the planned behavioural experiments identified in the context of ‘Attempting a previously avoided behaviour/situation’ above, were also moments that group members identified as important to them because of subjective insights. During the analysis, two sub-themes emerged within this category. These are defined below, and an example moment is described to illustrate each of them.

1.1 Becoming more familiar with their own experience of social anxiety.

Fourteen important moments were one’s in which participants learned something important about their own experience of social anxiety. Given the unique nature of each person’s experience of social anxiety, there were a wide range of insights reported by different people. For example, participants identified moments in which they became more familiar with the physical sensations of anxiety, or learned how to name/label aspects of their experience for the first time. They also identified moments when they learned something important about their own idiosyncratic model of social anxiety. For example, discovering interpersonal behaviours of their own that made social situations more difficult for them, or becoming more aware of their own self-talk, or the way that they construed
particular situations of concern, or other people, or set unrealistic standards of social performance. Although there was great variety in the particular kinds of insight obtained, group members’ experience of these insights were generally consistent—they experienced them as empowering. People talked about being in a better position to assess the truthfulness of their fearful thoughts, or to soothe themselves through a moment of anxiety, or to decide themselves if setting such high standards was what they really wanted.

*Example moment – Beverley: having a disagreement with another person.*

Prior to entering the group Beverley experienced high levels of anxiety when another person would disagree with her. She found these situations extremely difficult, and found herself responding in ways that she perceived to be out of proportion. For example, she could become hostile towards the other person and/or flee the situation. This was causing her difficulties both at work, and in her private life. Beverley described an important moment that revolved around this theme and unfolded over two group therapy sessions. In the first session, when she talked about her fears of having a disagreement with another person, one of the other group members spoke up and said that he enjoyed such interactions. He said that it was enjoyable to him because he could explore an issue in more depth, and learn more about it. Hearing this different perspective was a very great surprise to Beverley, and prompted her to start thinking about how she made sense of such situations herself.

*I was blown away by that. I was absolutely and utterly blown away by that comment – that he enjoyed that kind of thing. And I thought about it all that night.*
The following week, Beverley took part in a planned behavioural experiment within which she had a disagreement with another person about whether or not it was OK to spank children. In the discussion after the behavioural experiment, Beverley’s construal of such events was explored in some detail. It was through this discussion that she realised, for the first time, that she had been making sense of these interactions in a very particular way (as a dangerous struggle, where she was under attack from the other party, and ill-equipped to defend herself) which was exacerbating her anxiety. Here Beverley describes how this process of exploring her experience, and hearing the views of others, aided her with this insight:

*So… the idea that, um, that there might be a different way of looking at it was huge for me. It was kind of the revelation… it might have been the whole process of, um, realising… putting words to it and realising it. ‘Cos previously I would just feel all of the emotions and freak out and know that I just couldn’t cope with that. Whereas, these other people were giving me suggestions, and putting in words how they see it, which was a very different way of looking at it than I did. And also, when you go through the process afterwards [after the behavioural experiment]… [The therapists] were all sort of, “And why do you feel like that?”, “And how does it…”, sort of teasing it out of me, and forcing me to word it. That was huge, because I’d never worded it, and I’d never really realised what was going on, like I’d never even pinpointed that I have a problem there, and it happens consistently and all the time, whenever I’m in that situation, and the reason for it is… and this is what’s going on… so that was huge.*
Beverley received more benefits from this behavioural experiment. For example, she learned that she is more capable of defending herself in an argument than she thought, and she also discovered that she has the capacity to enjoy (to a degree) interactions of this nature. But in terms of the theme under discussion, this important moment is typical in the sense that Beverley gained important insights into her experience of anxiety in a social situation of particular concern. And these insights contributed to a reconceptualisation of the situation that diminished her anxiety moving forwards.

*I’ll see the whole situation slightly differently now. More about the actual topic, compared to more about them actually attacking me. Because it’s much more of a, um… it feels like a real battle, for me, whereas others just see it as a conversation. Um, and that’s huge for me. So I might... I have a small amount of that in my experience now, as opposed to completely and utterly, you know, somebody has duelled with me, chosen me to have a duel with, and I’m terrified of my skills, sort of thing. Now it’s much more about the topic, and do they have any reasonable information that could either change my opinion, or make my point of view obsolete, or whatever.*

1.2 Experiencing a positive shift in their sense of self.

There were nine important moments within which participants experienced a positive shift in their sense of self. These shifts clustered into two main areas. The first shift revolved around the idea that “I am more capable than I thought I was”. So, for example, people described important moments where they realised that they could adequately assert their needs in an interaction, or engage in particular social behaviours, or situations that they had previously been avoiding. Planned
behavioural experiments were particularly prominent here (accounting for three out four such moments). The second shift revolved around the idea of “I am not as bad/flawed as I thought I was”. So, for example, interviewees described moments in which they recognised that their social anxiety was not a sign that they were characterologically deficient in some way. Or they discovered that others could accept some aspect of themselves that they experienced as shameful, and kept hidden. These moments were more likely (three out of four such moments) to emerge from spontaneous interactions within which group members had the experience of feeling prized by another, or being accepted by another.

Example moment – Inka: sharing an experience of shame with the others

Inka was able to speak to the group about an experience in which she was shamed by members of her family. Inka had been raised in a religious environment, and when she became pregnant at a young age her parents strongly expressed their disapproval of this. As she explained:

I was just so ashamed, and my parents made me so ashamed... Like my Mum would sit on my couch and sob for hours, just because she was so disappointed in her daughter.

Inka internalised this shame, and was terrified that other people would find out she had been a young mother and respond to her in a similar vein. In the group she was able to talk about this experience, and she received unexpected feedback from the others.

So I said that to the group, and I really got some amazing feedback, saying that they would never think that. They would think that I was brave, and that
I’d done an amazing job being so young and looking after 3 children. And that was... that was profound to me. Like I couldn’t... I couldn’t ask for more than to have a group of people go around and say those things, because... that’s what really started my social anxiety. And it was really great to hear that everyone doesn’t think that, and... so now I’m not quite as afraid and ashamed. Like, it takes a lot to sort of have years of ingrained thoughts about myself... like it’s not disappeared. But that was probably the best moment in the group for me, to hear that.

The acceptance she experienced from the other group members provided a different kind of information to Inka about herself – information which directly challenged her existing sense of self. The integration of this different, more positive, sense of self is ongoing, as revealed in the following quote. What is also revealed is the change in Inka’s behaviour (no longer automatically hiding this self-aspect from others) which is both informed by, and also supports, this changed sense of self.

They said it was brave. To do what I did. And that it must be really hard work. And they thought it was something to admire, rather than automatically think that I’m a terrible person. So that was really confronting... it was good confronting, but it was so opposite of what I believed. And I’m still sort of sitting with it really. Like it’s... I think about it, and... the other day I said [to someone] I did have 3 kids and I sort of gauged the reaction, and it wasn’t that bad. So I sort of feel encouraged by that. So now I’ll be brave enough to say that I do, you know. So it’s sort of changed that aspect.
Theme 2 - Intersubjective experiences.

Intersubjective experiences revolve around the psychological relationship between people. What is significant in these moments is the participant’s experience of another person, or the experience of being involved with another person. Many different types of intersubjective experiences were described. For example, participants identified important moments in which they felt close to another person in the group, or experienced being comforted or soothed by another. There were moments in which people felt prized and validated by others, as well as moments of feeling devalued or estranged from others. Some of the most complex moments were experiences of interpersonal rupture and repair, and these often incorporated many of the above mentioned experiences as they unfolded over time throughout a sequence of interactions. Positive interaction cycles, where people tried relating to others in a different way, and received feedback from interaction partners that reinforced that new behaviour, were also prominent. These intersubjective experiences emerged almost exclusively in the context of spontaneous interactions between the group members. For example, only one out of nine such moments in the CBT groups occurred during a planned behavioural experiment (the Gestalt group did not utilise such experiments). The three sub-themes within this category are defined below, and an example moment is described to illustrate each of them.

2.1 An experience of feeling accepted and valued by others.

The largest sub-theme of intersubjective experiences (8 moments) were moments in which participants had the experience of feeling accepted and valued by
others. Either their contribution to the group, or some aspect of themselves personally, was prized by others. This experience was highly valued by people, and motivated them to enter into the life of the group (or enter into individual relationships) more fully.

*Example moment – Lucas: feeling valued by another group member.*

In Lucas’s therapy group, the members started up their own informal social group. Each week they would go out for a drink together after the therapy group had ended. At one of these extra group events, Lucas had been feeling particularly anxious and negative about himself. He hardly spoke during the social event, and as he was standing on the train platform later that night, on his way home, he was berating himself for all of his perceived inadequacies. At this moment, he received a phone call from another group member who had been at the social event. Lucas felt very touched by this gesture:

*She called me when I was standing at the train station at my lowest point.*

*And... basically, I just sort of said to myself at that point... I think it was a... it was kind of the acceptance, because, I was at the absolute worst I could be, I perceived myself to be the worst that I could be for that two hours, and still... that she would still contact me, there was some sort of element of acceptance there... and it made me just decide from that moment that I'm just going to try and be more real, and connect to people more.*

As he described this moment, Lucas said that he felt very moved by the fact that this person had accepted him and shown an interest in him. He found this powerfully
motivating and felt a determination arise within him, to keep trying in the group and to allow the real person that he was to come through.

2.2 Positive interaction cycles.

Seven intersubjective experiences fitted into the theme of ‘positive interaction cycles’. These were interaction cycles within which a person tried out a new behaviour, or way of relating, and received feedback that reinforced this change in behaviour. Sometimes this was described in the context of a single interaction, and sometimes it unfolded in a repeated pattern over multiple interactions. In these latter cases the positive interaction cycles appeared to develop into a new style of relating, or being with others, in the group. For example, over the life of the group some members became more active and assertive, or more friendly and responsive to others, or less domineering (all of which evoked positive responses from other group members in their respective groups).

Example moment – Dave: engaging more and more in the life of the group.

When Dave first joined the therapy group he found it very difficult to speak up during group discussions. He tended to stay very quiet, and would speak only when asked a direct question by one of the therapists. Dave described a small incident in which he had the experience of breaking the ice and having a positive interaction with another group member. This person had copied a homework exercise that Dave had spoken about in a previous group therapy session. In the following quote, he is describing the moment in the group when she shared this information with him.
...she said ‘Oh, I did your... I did that thing that you did [a homework exercise].’ And so I felt, like, finally we’ve talked about something. So that was good, and, and, yeah, that she liked the idea, it was useful for her. [I]
And then when she was trying to explain something to one of the therapists, the therapist wasn’t quite getting it, and I could kind of rephrase what she was saying to the therapist, and she was like “Yeah, that’s what I mean!” and then I feel like “Oh yeah, we’ve got more of a connection because I understood what you meant by that.”... [I] It... yeah, instantly felt... um, It’s not like I felt warmer towards her, because I wanted to talk to her beforehand, and I just felt like I couldn’t or shouldn’t or it wouldn’t be welcome. But I felt like the ice had broken, and then in subsequent weeks we’d say hello, and things like that. So it just felt like a wall had fallen down.

As the group progressed, Dave had more experiences like this, where he would contribute in the group somehow and receive positive responses from other people. He described this experience as having a number of different impacts on his experience of being in the group. For example, he felt more valued and accepted within the group.

I think, just a feeling that I was giving as much as I was receiving, and so I’d earned my place in the group. And if people found my feedback, or my exposure tasks useful, then that was sort of validation of me, or an acceptance of me. [I] Yeah, I’m a useful member of the group. That’s a really good feeling.

And he felt more entitled to the resources and support of the group.
I think it made me feel like I had more permission then… like I had earned the right to… everyone to focus on me and give me advice and feedback on my exposures and thoughts when my turn came around. Yeah, an ongoing thing for me is the feeling like... feeling guilty for imposing on people, and, I don’t like to receive more than I’m giving out.

Dave also described how his behaviour in the group started to change.

I started butting in more than... not a whole lot... but more than usual (which is nothing). So I felt like I had the right to interrupt, and, make a suggestion or something. Rather than waiting to be called on. [...] nobody minded that I interrupted, or they said ‘Yeah, good point’ or whatever [which] reinforced that. And so that happened a lot more. I felt more able to make jokes, and things like that.

The last quote highlights the substantial changes that Dave was able to achieve in the group in terms of a greater engagement with the others and in the life of the group. It also illustrates well the cyclical nature of these particular moments, which were characterised overall by new behaviours unfolding in the context of positive relational experiences that tended to reinforce those new behaviours (or ways of relating). It is worth noting that there was a high degree of overlap between this intersubjective experience and the therapy event (Foci 1) of ‘Being more congruent/authentic in an interaction’. Five out of seven of these positive interaction cycles unfolded when a participant was behaving in a more congruent/authentic manner.
2.3 Moments of interpersonal rupture and/or repair.

Five intersubjective experiences involved interpersonal ruptures, or rupture and repair cycles. Interpersonal ruptures (2 moments) were moments in which people felt wounded, or estranged from others, and these moments were associated with a tendency to withdraw from contact with the other(s). Rupture and repair cycles (3 moments) involved a rupture as described above, followed by a repair experience where relational bonds were strengthened and there was a tendency towards greater involvement with the other(s).

The example moment used below to illustrate this sub-theme is unusually long. This is because it is a complex moment, but also because it contains within it good examples of many of the different types of intersubjective experiences that various group members identified as their important moments (e.g., being soothed/comforted by another, or feeling prized/validated by another, or feeling close to another, or feeling wounded by/estranged from another). For these reasons, this moment will be described in greater detail.

Example moment – Ben: an experience of interpersonal rupture and repair.

Ben described as an important moment “…an interaction with a facilitator, which triggered a shame response”. As Ben’s second group therapy session started, he was feeling somewhat anxious because he had forgotten to write down the homework exercises that he had completed during the previous week. When the time to discuss the homework tasks in the group arrived, Ben asked one of the therapists if he could have a sheet and a pen to quickly write up his homework.
And I said “Oh, actually, could I have one of those sheets, because I couldn’t bring one?”. And she said “Oh, ok”, and then I said “And can I have a pen please, I didn’t bring one”, and then she said “Oh, you’re...” [she] said “Oh you’re a... hassle, or a bother...”, or “You’re a nuisance?”, some word like that.

Ben felt immediately unsure about this comment, and wondered if it was just a joke, or if there was some criticism within it. He tried to soothe himself, telling himself that it was just a joke, that it was no big deal, and that he shouldn’t worry about it. But it touched a nerve, because Ben had received that message from his father many times when he was growing up. Suddenly, Ben’s anxiety escalated dramatically. In the following quote he describes this escalation, and the impact that it had on how he perceived the social environment around him.

*And as the seconds went on, and it happened fairly quickly, that nerve just got more and more... roused... like I felt myself getting hot and flushed and felt like tunnel vision, like the room was closing in and I felt like all those people were... they weren’t people that I had met last week, and whom I felt reasonably comfortable around [but instead] it felt like at any moment they could sort of... they’ll be in on the joke, and sort of laugh, and “Ahh look at you... you’re upset at what she said. And it’s true you’re a bother”. [I] I thought any one of these people could turn at any time now.*

Ben felt flustered, and couldn’t think clearly.
... truth be told actually, my brain sort of... I couldn’t really process at that
time either, so even if I had wanted to write stuff down [the homework] I
couldn’t have remembered.

He felt wronged, and insulted by the therapist.

Stuff this! Bugger this, I’m not going to come here and be spoken to like
that”, and it just got blown right up in my mind. And I thought ‘Safe place’
my ass.

And he felt a desire to move away from the therapist.

I just wanted her to stay away.

He was also aware of feeling hostile towards the therapist.

And she gave me the pen, and I had the bit of paper, and then she said “If you
can just quickly write yours out, and then join that group of 2 over there”.
And I sat down and I thought “Fuck you, fuck it, nah... I’m not going to do
it”.

At the same time Ben experienced guilt about not complying with the request. He
also vacillated between feeling wronged, and thinking that there was something
wrong with him for feeling wronged. He experienced a strongly self-critical voice
berating him for not contributing when he had agreed to contribute to the process by
joining the group. All of this contributed to a growing determination to leave the
group.

And I remember thinking if I could peel myself off this chair, and not worry
about the shame of walking, of running the gauntlet... I’d be up and out of
there. But I kept thinking what would she think, what would he think, what would she think, and so on. And I thought “OK, at the break I’m just gonna go”.

When the break arrived Ben was aware of a great need to take action, to do something, or he might walk out of the group forever. He approached the therapist who had made the comment about ‘being a bother’. In the following quote, he describes a part of this interaction, and the impact that the therapist’s response had on him.

And I just said to her “Listen I think, I’ve been severely triggered”, and [the therapist] said “Ohhhh...” she said, “Yep”... she said “I’m so sorry that I said that”, and she looked at me in the eye when she said it, and I could see that... well it seemed like she really meant it... unless she was putting on a good act... and straight away I didn’t feel as hostile, or at battle stations like I had.

Ben went on to describe the significance of this response to him.

She said “Look, I only meant it as a joke, but I can see how that has triggered you, and affected you.”. And I thought “Wow! She is actually admitting that something she’s done has had an effect on me, a negative effect, instead of just saying [he puts on a voice here] “Ahhh... it’s the way you’re taking it!” Yeah, that’s my Dad’s voice. “It shouldn’t matter what other people say, it’s the way that you take it you know, you choose to take it positive or negative... you’ve gotta take it positive. And if you don’t like it just ignore it”.
Instead of the powerfully invalidating response that he was so used to receiving, Ben experienced a different kind of response from the therapist.

...here was someone that I’d only known for a week... who seemed to be genuinely acknowledging my concern as legitimate, and I thought ‘Wow!’; I was almost dumbfounded, you know... it was almost like I was stopped in my tracks... and it was like there wasn’t anything else that had to be said.

In this moment he felt a sense of closeness and connection with the therapist.

It was like a genuine connection, like... an interest, you know... Yeah it just felt like I was connecting on a mature, real level with another human being. Yeah... yeah... [long pause] and I said to her at the time, I said “I’ll stay... I want to stay, and I want you to know that your reaction has played a big part in that. That you didn’t downplay or dismiss that”.

After this interaction, Ben re-joined the group as it reconvened at the conclusion of the break period. He noticed that his experience of being in the group again was decidedly different to what it had been before, and that he felt much more motivated to engage and interact with the others.

I noticed at the time too walking back into the room... I think ordinarily I’d feel shame... and to my surprise at the time I didn’t. And I felt, when we sat down I felt relatively safe, as safe as I could feel with people I’d only met the week before. Yeah I felt relatively safe, and at ease, and I wasn’t hypervigilant, or paranoid, and I really had a desire to interact. Um, and I found myself, you know, when questions were asked, or ‘Does someone want to share their thoughts or experiences or whatever?’ I’d put my hand up,
without feeling shame, or too much fear, I spoke. And I remember being
pleasantly surprised that “Wow, here I was 10 minutes ago ready to leave, or
just disappear somehow… and now here I am, out in the open again”, and I
thought “this is so different!”

This moment provides a good example of the core elements that were typical within
this category of intersubjective experiences. Shame, arising out of some incident in
the group, generated an interpersonal rupture – group members experienced a desire
to hide or withdraw from the others. In those instances where the interpersonal
rupture was repaired, group members experienced a deepened connection and felt
motivated to engage more fully with others.

**Intersubjective experiences and relational motivations – the tendency to**

‘move towards’ or ‘move away from’ others.

Finally, when the cluster of intersubjective experiences is considered as a
whole, it is apparent that these experiences contain within them a relational
motivational component. In other words, these experiences are connected to
inclinations to either ‘move towards’ or ‘move away’ from others. They have a
tendency to facilitate a deeper engagement with others, or to work in the opposite
direction. For example, when the intersubjective experience was one of feeling
accepted and valued by others, in all eight instances participants described a
tendency towards making more contact with others, being more visible, not hiding,
trying harder to engage, and so on. In other words, there was a tendency towards
affiliation and social engagement. Conversely, in the four moments where group
members felt devalued or wounded, they talked about a tendency to avoid
engagement in the work/life of the group, or to withdraw and hide from others. In
three out of these four instances, the participant contemplated leaving the group altogether. It therefore appears that these intersubjective experiences have an impact on relational engagement or disengagement within the therapy group.

*Foci 2 - Salience: integrated summary.*

The important moments were analysed at the foci of salience in an attempt to understand “why” particular moments held significance for participants, and the analysis established two core categories in this domain. The first and most commonly occurring category relates to insights, or understandings, arrived at within an individual. People identified moments as important because they learned something, or recognised something, that helped them to better understand and manage their difficulty or to see themselves in a more positive light. While these moments commonly emerged out of interactions with others, it was the intrapsychic insight that people described as most significant. The second category, intersubjective experiences, were different in kind. Whilst they often involved insights, the most significant thing about them for the participant was their experience of being in contact with another person. For example feeling close to them, experiencing their support or encouragement, feeling prized, or feeling wounded. These moments were often characterised by the experience of strong emotions, and appeared to have an impact on relational engagement and disengagement within the group. The results here demonstrate that relational processes are widespread within this category of important moments. Overall, the results from this foci of analysis indicate that group members tend to identify therapy moments as important because they gained some important insight, or had a meaningful interaction with another person.
The group therapeutic factors: which factors were most prominent in group members’ descriptions of their important moments?

During the analysis of the important therapy moments from the perspective of the group therapeutic factors, four group therapeutic factors emerged as being particularly prominent. These were ‘Self-understanding’ (16 moments), ‘Interpersonal learning’ (13 moments), ‘Instillation of hope’ (11 moments), and ‘Self-disclosure’ (9 moments). In addition, there was one therapeutic factor that was widely mentioned overall by group members (12 out of 14 interviews), even though it was rarely prominent (2 moments) within the important moments. This was the therapeutic factor of ‘Universality’.

The group therapeutic factors are proposed to be “mechanisms of change” within the broader group therapy literature. In this study, however, the therapeutic factors have not been linked to outcome via statistical analysis, and no claim is being made about them as causal agents in the therapy. The moments were analysed from this perspective simply to identify which factors were most prominent within group therapy events that participants identified as important to them. And like the “Salience” foci of analysis there is some overlap between these factors because sometimes more than one factor was prominent within a single important moment. The therapeutic factors and a brief description are set out in Table 9.
Table 9

*Group Therapeutic Factors that were Prominent within the Important Moments*

<table>
<thead>
<tr>
<th>Therapeutic factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-understanding</td>
<td>Moments in which people learned something important about themselves, or the nature of their difficulties.</td>
</tr>
<tr>
<td>Interpersonal learning</td>
<td>Moments in which participants learned something important by trying out new behaviours in the group, or by getting feedback about themselves from the other group members.</td>
</tr>
<tr>
<td>Instillation of hope</td>
<td>Moments in which group members felt a renewed hope that their difficulties might be overcome.</td>
</tr>
<tr>
<td>Self-disclosure</td>
<td>Moments in which a people shared personal information about themselves in the group.</td>
</tr>
<tr>
<td>Universality</td>
<td>Moments in which participants recognised that others experienced similar difficulties.</td>
</tr>
</tbody>
</table>

*Self-understanding*

There were 15 important moments in which the group therapeutic factor of ‘self-understanding’ was prominent. In these moments, people learned something important about themselves or the nature of their difficulties. Insights into the nature of one’s difficulties were most commonly reported (8 moments). So, for example,
interviewees described becoming more aware of their experience of social anxiety, or how their behaviours, or construals of people and situations, contributed to their difficulties. This was well described by Beverley:

> I’m a bit more enlightened now about that dark side of me that I really struggled with, um, and now I’ve got a real sense of ‘why’ I struggle with it, and how I struggle with it, and how to work with it, it’s kind of a section of me that I have a little bit more of an understanding of now. (Beverley)

The next most common insight reported (5 moments) was insight into the self. For example, people described becoming more aware of their qualities as a person, or learning that they were more capable socially than they thought they were. The value of self-understanding therefore appeared to relate predominantly to current functioning in the context of existing relationships. Gaining insight into ‘how’ someone came to be the way they were was rarely mentioned as important by interviewees. Finally, this therapeutic factor had a high degree of overlap with the factor of ‘Interpersonal learning’. Eight moments, or more than half of all moments in which self-understanding was prominent, were also moments in which interpersonal learning was prominent.

**Interpersonal learning**

Interpersonal learning was a prominent factor in thirteen important moments. In all thirteen of these moments, participants were behaving interpersonally in a way that was novel or unusual for them (e.g., being more assertive, behaving in a more extraverted manner, attempting a new behaviour) and learned something important through that experience. The kind of learning most commonly reported (8
moments) by people related to their own social functioning. That is, they learned that they were more capable socially than they thought they were, or that particular social situations were not as bad as they had feared. Feedback from other group members was also important in moments where interpersonal learning was prominent, with participants receiving feedback on how they were perceived by others in 7 out of the total of 13 moments. To illustrate, in the following quote, Kath describes how feedback from the others helped her to realise that her anxious mannerisms were not as obvious and pronounced as she had feared.

...when I've been in it previously [feeling anxious in a social situation], you only take your viewpoint of it. Because other people don’t normally give you any feedback. So to go through an exposure, and know what I’m feeling, and then to get the feedback from other people, and hearing them say “You didn’t really look nervous”, or “You did really well”, kind of, um, made me realise that I can sort of switch my thinking when I am in those sorts of situations. I think that was a major sort of hurdle that I was able to sort of, not get over, but move towards. Like now I’m not so worried about appearing nervous, and I’m not so worried about all of those things that were preventing me from doing everything. (Kath)

As mentioned above, there was a high degree of overlap between this therapeutic factor and the therapeutic factor of “Self-understanding”. It is also noteworthy that this therapeutic factor overlapped almost completely with one of the intersubjective experiences described in the second foci of analysis (Salience). In six out of seven moments where the most salient feature was that group members experienced a
positive interaction cycle, that moment was also one in which the therapeutic factor of interpersonal learning was prominent.

**Instillation of hope**

Interviewees described 11 important moments in which they experienced a renewed sense of hope about their own situation, or about their future. The most notable finding within this cluster of moments was the degree of overlap between the therapeutic factor of ‘Hope’ and the therapeutic factor of ‘Guidance’. In five out of eleven important moments where hope was prominent, the therapeutic factor of guidance was also prominent. For example, participants often described their hope as arising at a time when they were receiving direct instruction or guidance from the therapists (for example, when the therapists were providing psychoeducation about social anxiety, or instructing group members in how to apply the techniques of the therapy). This was experienced as empowering (i.e., it helped them feel more confident about their ability to overcome their difficulties). In the following quote, for example, John talks about feeling more hopeful because his experience of anxiety has been placed within an explanatory framework which makes it both less deviant, and more comprehensible, to him.

*Yeah, it was something that I'd never discussed with anybody. It was something I just felt I had to deal with. And so yeah, to hear from these other people who were having exactly the same experiences. And to hear from the people running the group that this is why it is happening... it was great. It really lifted a weight from my shoulders.* (John)
A second finding of note, with regard to this therapeutic factor, relates to moments in which group members experienced cycles of interpersonal rupture and repair. There were only three such moments, but the therapeutic factor of hope was prominent in each of them. In these cases the hope had a specific interpersonal focus. Participants talked about feeling more hopeful that other people might respond positively to them, or like them, or extend more kindness (and less hostility) towards them. In the following quote, Ben describes his renewed hopes in this area, and he also mentions the significance of the therapist’s behaviour in this (the moment itself is described in detail under the heading of “Intersubjective experiences” above).

> And it comes back to, I think... sorry to diverge... but maybe why I’ve been feeling better about everything in the last few months, and more able to be with my anxiety and fear, and not let it consume me... [is] that I know that there are people, because I’ve come into contact with them... um... there are people who aren’t automatically going to be dismissive of everything. Those people do exist, so, so that gives me strength to put up with the times... when people have dismissed me. (Ben)

After experiencing many and repeated instances where his needs were dismissed by others, the different response from the therapist was very important to Ben and generated hope that other people might be more responsive to his needs in the future.

**Self-disclosure**

There were nine moments in which the therapeutic factor of ‘self-disclosure’ was prominent. In these moments, information of a personal nature was shared and
this disclosure was described as having an important impact. Both one’s own self-disclosure, and the disclosure of others, was central to these moments. There are two noteworthy findings with regard to this therapeutic factor. First, self-disclosure seemed to have a relational impact. In seven of nine moments where self-disclosure was prominent, people talked about feeling accepted by others, or more at ease with others, or inspired to speak up and engage more with others. This was reflected in the overlap between this therapeutic factor, and the intersubjective experience of “Feeling accepted and valued by others”. In half of the moments where participants described having this experience of feeling accepted, self-disclosure was also identified as a prominent therapeutic factor. For example, as described previously, Inka was able to talk in the group about something that she felt shameful about and had kept hidden from others. In the following quote she is reflecting on the impact that this disclosure, and also the disclosures of others, had on her experience of feeling accepted in the group.

_I guess that I felt like an accepted person, and I always feel like I’m not acceptable, so it was really good to feel like I was OK. That I was a part of something, and that people were trusting me with their personal stories, and that people were accepting the most shameful things about me. So that was a really unique bond, bonding experience to be a part of that._ (Inka)

The other finding of note was that self-disclosure about one’s own experience seemed linked to a reduction in anxiety. When people talked to others about their own distress (about their social anxiety or some other aspect of the self) they subsequently felt less anxious. This was the case in all five moments where group members’ own self-disclosure was prominent. In the words of Glen:
I think that’s powerful, to be sort of talking about what you are experiencing now, because I think that everyone was highly anxious, and... and to sort of deal with that. And I guess you notice how immediately, how immediate the effect of admitting that you are anxious dissipates that anxiety, by just talking about it. Just talking about it lessens the intensity.

...like I was saying, the anxiety, the fear about having a panic attack became less. And, yeah, I reckon that is probably linked to having, you know, having revealed myself. I told everybody that I have had panic attacks, and I... so what does it matter even if I have one. Like it’s... you can sort of let go of that a little bit. (Glen)

As illustrated by the quotes above, self-disclosure played an important role in strengthening relationships within the group. It was also connected to a reduction in anxiety for those that disclosed. Group members described feeling less anxious immediately after their disclosure, and also moving forwards with those people to whom they had disclosed.

**Universality**

When the important moments were analysed in terms of the group therapeutic factors, the factor of universality was not widely prominent (being a central factor in only 2 out of 37 moments). When the transcripts were considered as a whole, however, this factor was widely mentioned by participants. In twelve out of fourteen interviews, people spontaneously talked about how important it was to them to discover that others in the group experienced similar difficulties. When considering the quotes around this theme as a whole, it was clear that group
members valued this experience for two primary reasons. The first was that this experience helped to mitigate the sense of feeling alone that many group members struggled with.

...just to be in the same room with people who have similar or same problems... helps you to feel like you’re not alone in the whole experience.

(Sarah)

The second value described by participants was that the experience helped to counter stigma. Many people felt that their social anxiety was the worst, or they were fundamentally different and inferior to others, or their experience was weird (and so were they). Universality provided a powerful counterforce to this idea, as described within the following two quotes by Dave and Inka.

It did just feel good to be able to relate to everyone. And to see that we all had those similar experiences. Maybe that kind of made it seem like more of a condition. More of a psych disorder, rather than a fundamental part of my unique personality. Because... the fact that we’ve all got very similar thoughts and symptoms means that it’s... I made me feel like social anxiety was less fundamentally me, and more something that happened to me. (Dave)

I think that was the best thing about the group. Just listening to other people’s experiences and sharing with them. Um... ‘cos I always felt like I was always so alone in my anxiety and socially, and... I was just such a weirdo. But, everyone in the group, like, they were just so similar to me. They had the same thoughts. Like it might come out in different ways, different things that they feel anxious about, but the core thing is the same. And to have
a room full of nine people, feeling the same way as you, and describing the same sort of agonising situations that I go through every day, was amazing.

(Inka)

Whilst universality was not prominent in the analysis of important moments, it nevertheless appears that this factor is widely regarded as important by members of social anxiety therapy groups. This phenomenon (prominent overall but not prominent within the important moments) was not repeated for any other therapeutic factor, suggesting that there may be something unique about the way that universality contributes to the group therapeutic process.

**Therapeutic factors integrated summary.**

This analysis established that four therapeutic factors were most prominent within this sample of important moments, with one additional therapeutic factor identified as important when considering the interview transcripts as a whole. The most prominent factor within the important moments was “Self-understanding”, which had a very high overlap with the next most prominent factor of “Interpersonal learning”. The third most prominent therapeutic factor was “Instillation of hope”, which in turn overlapped to a high degree with another therapeutic factor “Guidance”. A specific kind of hope (about future relationships with other people) was connected to intersubjective experiences of “Rupture and repair cycles”. Self-disclosure was the fourth most prominent factor, and was identified by participants as having an impact on strengthening relationships in the group and reducing anxiety. Finally, the therapeutic factor of Universality was identified as an additional important factor which might exert its influence on the group therapeutic process in a unique way when compared to the other factors.
Conclusion

The results of this study have demonstrated that phenomenological change in social anxiety occurs across a range of different areas. These appear to represent different aspects of experience that change when a person’s social anxiety improves. In addition, the analysis of important moments has revealed that interactions between the group members, and relational experiences, were central to the therapy process in the groups within this study. In the next section of the thesis these results are considered in the context of this study’s research questions, and the theoretical frameworks that informed them. Clinical implications of these findings are examined as are limitations and extensions to the research.
Chapter 7: Discussion

The research in this thesis sought to better understand, and identify potential improvements to, group CBT treatments for social anxiety. In support of this broad aim the nature of change in social anxiety as perceived by the participants in group therapy programs was examined. It was found that when people improve change occurs across a range of different aspects of experience. The nature and impact of relational processes in therapy groups for social anxiety was also investigated and it was found that interactions between the members, and relational experiences, were central to the group therapy process. This chapter interprets these findings, and explores their practical implications for clinicians working in groups with the socially anxious.

In the first section of the chapter the findings on the nature of phenomenological change are interpreted, and this is followed by an examination of the results on important moments in the participant’s group therapy experience. The potential role of attachment processes within these moments is considered, and then the findings with regard to the group therapeutic factors are discussed. Implications for practitioners are set out, as well as the strengths and limitations of the study, and ideas for further research.

On the Nature of Phenomenological Change in Social Anxiety

This research established that phenomenological change in social anxiety after psychological treatment occurs across a range of areas. In other words, there are many different aspects of experience that change when people improve. Some of these aspects are well accounted for within the existing theoretical models and treatment protocols described in Chapter 3: for example cognitions about the self,
others, and social situations. Other aspects are more novel in terms of the existing frameworks, such as a person’s relationship to their experience of social anxiety. The key aspects of phenomenological change are set out in Figure 3.
Figure 3- Model of phenomenological change in social anxiety

- A changed relationship to the anxiety
- Changed understanding and expectations of self
- Changed view of other people
- Changed view of social encounters
- “Being with” others differently/experiencing others differently

Confirming existing theoretical frameworks
Extending existing theoretical frameworks
As depicted in Figure 3, this research identifies two novel areas of phenomenological change in social anxiety, and confirmed three others that are well covered within existing theoretical frameworks. The confirmatory findings are discussed first, followed by the novel findings.

**Confirmation of existing theoretical models and treatment frameworks.**

As illustrated in Figure 3, the results support a conclusion that cognitive change across a range of domains is central to growth in social anxiety. Those people that improved described shifts in the way that they thought about social encounters, themselves, and other people.

*A changed view of social encounters.*

Change in the way that individuals viewed their social encounters was manifested in two main areas. First was a shift in the perception of specific social situations or interactions that were of concern to the person. The experiences that people had in the group disconfirmed the degree of perceived threat associated with these situations, which resulted in people perceiving them as less difficult or fearful. This provides support for the views of Clark and Wells (1995) and Heimberg and Becker (2002) that overestimating the danger of social situations is an important maintaining factor in social anxiety. More commonly described, however, was a shift in the person’s perception of *who* was responsible for social outcomes. Group members talked about feeling less responsible for the success or failure of social interactions than they did before the group therapy. They came to recognise that unexpected or unpleasant responses from others were often the result of some difficulty that was internal to that other person. As a result, they no longer
automatically perceived awkward interactions to be their fault and/or evidence of their own inadequacy.

This is a novel finding compared to mechanisms proposed by the established models, and suggests that a greater emphasis on working with feelings of responsibility in social interactions may be helpful. At present, the existing models tend to highlight cognitions about the dangerousness of social situations (Clark, 2001; Heimberg, Brozovitch & Rapee, 2010), or in the case of Hoffman (2007) the likelihood and cost of social blunders. In both cases the therapy targets specific situations or specific social outcomes of concern to an individual, which then become the focus of experiential exercises designed to test and modify those cognitions. Whilst these existing models are flexible enough to respond to any particular misinterpretations of events that contribute to anxiety, feelings of responsibility within social encounters have not been highlighted as a specific issue of concern. The results of this study suggest that this variable is particularly important to positive change in social anxiety, and so a greater emphasis on this issue in the treatment protocols may be helpful. Such an approach is applicable or generalisable across all social situations, with the additional benefit that it directly counters feelings of self-blame and personal inadequacy that may arise from internal attributions for negative social events (Kinderman & Bentall, 1997).

A changed view of the self.

The primary nature of the shift in participants’ sense of self revolved around experiencing the self as less deviant. People were able to let go of the idea that they were somehow different and inferior to others because they experienced anxiety in social situations. They came to see this experience, and by extension themselves, as
more normal. And so a greater acceptance of the experience of anxiety and a greater acceptance of the self in general were key aspects of phenomenological change in those that improved. This finding confirms a core theme within the existing cognitive models (Clark, 2001; Heimberg et. al., 2010) that overly negative cognitions about the self are an important element of the experience of social anxiety.

It is also noteworthy that two of the dimensions of ‘feared self-aspects’ proposed by Moscovitch (Moscovitch & Huyder, 2011) were reflected in the results. Specifically, group members described a lessening of their fears that others might find their character unacceptable, and a lessening of fears that others might find their anxious mannerisms unacceptable. This suggests the possibility of a revised understanding of Moscovitch’s model of social anxiety. One criticism that has been levelled at this model is that it is difficult to understand how a perception or belief about the self could logically be construed as a feared stimulus (Stopa, 2009). The results of this study suggest that an alternative application of Moscovitch’s model is that it reflects ‘aspects of change’ important to social anxiety, rather than aspects of the self which act as a ‘phobic stimuli’ to the self. In other words, his model may be describing what a person changes ‘from’ and ‘to’ when things improve. For example, “I have changed my view of myself. I used to think that I was a person who was characterologically flawed, with unacceptable anxious mannerisms… but now I see myself and my anxious mannerisms as basically acceptable”. The alignment between Moscovitch’s domains of feared self-aspects, and the model of phenomenological change identified within this study, is in favour of such a reconceptualisation.
Another interesting finding relates to ‘how’ these changes in group members’ views of themselves came about. Moscovitch (2009) argues that therapists should help people identify their feared self-aspects, and then encourage them to reveal those self-aspects to others in order to generate refuting evidence. There was indeed evidence of this process in the therapy groups. People talked in the group about their fears of their own inadequacy, and they described feedback from the others as contributing to a shift in how they understood themselves. It was more common, however, to hear them describe these shifts as coming about in another way. Learning about the experiences of the other group members, and discovering that they had similar fears and had responded to them in a similar way, was more often described as leading to these kinds of shifts. It therefore appears that many positive shifts in this domain came about through a kind of social referencing in the group, which is consistent with the arguments of Yalom and Leszcz (2005) about how the group therapeutic factor of ‘Universality’ exerts its influence. This would appear to be a different mechanism for promoting change in this area that is unique to the group format (i.e., it is activated by the social context of a therapy group).

Finally, the present results are consistent with the results from the analysis of important moments. ‘Experiencing a positive shift in the self-concept’ was identified as a key form of subjective insight that occurred within group members’ important moments. Taken together, these findings indicate that concerns about the self are a particularly cogent area of cognitions in social anxiety. And they are consistent with the way that the conceptualisation of social anxiety disorder has developed over time. As described in Chapter 1, this has involved a shift away from the idea of social anxiety is a simple phobic reaction, and towards the idea that is related to problematic ways of understanding the self and the self in a social context.
Overall, these findings underscore the importance of working with ‘the self’ in treatments for SAD.

**A changed view of others.**

The way that other people were viewed and understood emerged as another important area of cognitive change in this study, and this was observed in two key areas. A somewhat novel finding was that group members highly valued learning that “others experience anxiety too”. As previously discussed, this insight appeared to contribute to positive shifts in people’s understanding of themselves and their own difficulties, as they adjusted what they ‘knew’ of themselves in light of what they learned about other people. The other shift involved seeing other people as less inherently hostile and judgemental. This second finding provides support for the claim of Clark (2001) and Heimberg et. al. (2010) that socially anxious individuals tend to perceive others as being hostile and critical, and that this perception is a maintaining factor in the anxiety. Overall, these findings support a continued focus on working with perceptions of others within the treatment protocols.

**Conclusion**

The present findings demonstrate that representations of social situations, the self, and other people are important to access and work with in the therapy because these are aspect of experience that change when people improve. Ideas about the self, including views about one’s responsibility within social interactions, appear to be particularly cogent areas for investigation and therapeutic intervention. In addition, social referencing was found to play an important role in helping to promote positive shifts in the self-concept. This suggests that helping the group
members to learn more about one another may be an important goal in therapy
groups for the socially anxious.

**Extension of existing theoretical models and treatment frameworks.**

As described in Figure 3, the results around phenomenological change in
social anxiety suggest a number of potentially novel areas for clinical investigation
and therapeutic intervention. These include a person’s ‘way of experiencing/being
with others’, and the way that they relate to their experience of social anxiety.

**A new way of experiencing and being with others.**

A novel finding of this research is that group members identified relating to
others differently, and experiencing them differently, as a key aspect of
phenomenological change in social anxiety. They talked about perceiving the
behaviours and responses of others in a more ambiguous light, which helped them to
experience those others as less frightening or threatening. They also let go to some
degree their attempts to hide their anxiety from others, and were more spontaneous
and open in the way that they related. They became more attentive towards those
they were interacting with, and experienced greater enjoyment in their company.
Finally, they received positive, affirming responses from other people that reinforced
these new ways of relating.

These findings are intriguing because they mirror, in reverse, many elements
of the negative interaction cycles described within Alden and Taylor’s (2011)
interpersonal model of social anxiety (see Chapter 3). According to this model,
anxiety in social settings interrupts or inhibits normal affiliative behaviours within
the socially anxious person. They engage in subtle avoidance behaviours, and initiate few pro-social behaviours, which interaction partners experience as cold and unfriendly, leading to experiences of interpersonal rejection. The results of this study highlight the significance of this model, because those that improved described a constellation of experiences and behaviours (as described above) in direct opposition to this. In those that improved, the ‘self-protective style’ of relating shown to be so problematic in the research on negative interaction cycles (Alden & Wallace, 1995; Heerey & Kring, 2007) appeared to unravel or come apart, and this was associated with better relational outcomes (enjoying others more, and positive interaction cycles). This supports Alden and Taylors’s (2011) central claim that relational dynamics and interaction cycles are an important target for therapeutic attention.

The finding that ‘attending more to other people’ was an important aspect of this new way of being is also significant theoretically. Respondents described attending less to their inner experience of anxiety, and more to their interaction partner and the social situation. A reduction in self-focused attention was therefore a key aspect of phenomenological change in those that improved. This finding is consistent with a recent finding that changes in self-focused attention mediate therapeutic improvement in social anxiety (Mortberg, Hoffart, Boecking & Clark, 2015). The mechanism by which self-focused attention contributes to social anxiety, however, is less well understood. It has been noted that self-focused attention may be problematic because it amplifies the inner experience of anxiety (Mortberg et. al., 2015); or it interferes with processing cues from the actual social situation that might be inconsistent with the fear (Hackmann, Surawy, & Clark, 1998); or it diverts attentional resources away from the task at hand therefore impairing a person’s
ability to follow and appropriately respond in an interaction (Rapee & Heimberg, 1997). The current findings align best with the third proposition, and offer an extension of this idea by suggesting a dynamic that explains in relational (rather than intrapsychic) terms how self-focused attention impairs interactions.

In this study, participants described being able to be more ‘present’ and responsive to interaction partners, whilst at the same time being more congruent or open in their own presentation. The attachment process of ‘attunement’ therefore presents itself as a possible mechanism that is active within this new way of being with others. As discussed in Chapter 2, interpersonal attunement involves people being sensitive and appropriately responsive towards one another, and is considered to be a central aspect of social functioning in human beings (Mikulincer & Shaver, 2007). Within this context, being more attentive to another makes it easier for a person to ‘tune-in’ to and respond appropriately to their interaction partner. And conversely, being more congruent/open/authentic makes it easier for their interaction partner to ‘tune-in’ and respond appropriately to them. From an attachment perspective these aspects combine in support of the dyadic relational process of attunement, which enables the members of a dyad to co-ordinate their attention and activity, thereby supporting a smooth interaction within which basic needs for affiliation can be met (Baumeister & Leary, 1995; Vertue, 2003). This conjecture receives further support from other aspects of this ‘new way of being with others’ that were described by the group members. Pleasure and interest have been defined as key indicators of attuned interactions between human beings (Stern, 1985), and this was evidenced by the greater pleasure in interactions, and the positive interaction cycles, described by participants.
This offers a fundamentally different way of conceptualising how self-focused attention is a problematic aspect within social anxiety. From this perspective, it is problematic because it interrupts a relational dynamic, or process, that is essential to social functioning in human beings. And the implication of this is that a shift in how self-focused attention is emphasised and worked with in the therapy may be helpful. Traditionally, behavioural experiments have been used to promote insight into the impact that self-focused attention has on inner experience (Mortberg et. al., 2015). An alternative suggested by these findings would be to explore its impact in a relational context. So, for example, self-focused attention may be considered within the broader context of trying to create a better attuned interaction with another person (i.e., by being more attentive, open/authentic, and responsive to the other). Such an approach would be consistent with the treatment protocol of Alden and Taylor (2011), which maintains a focus on helping members to gain insight into relational dynamics within interactions.

_A changed relationship to the anxiety._

A second novel finding of this research is that group members identified a changed relationship to their experience of social anxiety as a key aspect of phenomenological change. A metaphor of ‘making friends with the anxiety’ was offered to capture the essential nature of this change, which occurred in three main areas. These were an increased awareness/understanding of the anxiety experience, a stance of greater acceptance towards the experience of anxiety, and a more active engagement with it as it emerged in the moment.

The first area of ‘awareness’, and the third area of ‘active engagement’ are already well conceptualised and responded to within the existing treatment
protocols. For example, within the Clark and Wells (1995) protocol, working closely with a person to build up an idiosyncratic model of their anxiety is a core aspect of the therapy. This involves enhancing awareness of all aspects of experience pertinent to the social anxiety. The value of this is approach is confirmed by the current results, as participants highly valued gaining a more detailed understanding of their social anxiety. They described this as being central to their capacity to better understand what was happening and respond to it in a more helpful way. A more active engagement with the experience of anxiety is also well covered within the existing protocols, as the treatments are primarily oriented around this task (i.e., helping people respond more proactively to their experience of anxiety).

The findings with regard to ‘acceptance’ are an unexpected outcome of this research. Those that improved talked about developing a more accepting stance towards their anxiety, and this was manifested in a range of different areas. For example, people talked about being more accepting of the experience as it emerged in the moment. They let go of trying to avoid or control the experience, or hide it from others, and they also judged themselves less harshly for having an anxious moment. They also described worrying less about the experience of ‘feeling anxious’, which eliminated much pre and post event ruminating about such moments. Finally, they talked about becoming more accepting of themselves as a person who experienced social anxiety. And so acceptance of the experience seemed to be connected to a greater acceptance of the self, and more compassion for the self. Acceptance was therefore important within two of the domains of phenomenological change (relationship to the anxiety, and views of self), highlighting its overall importance to the picture of clinical improvement in this study.
The prominence of this aspect of phenomenological change was unexpected. It is, however, consistent with the ‘third wave’ of CBT modalities which emphasise acceptance of experience over suppression of experience. For example, Acceptance and Commitment Therapy (Hayes, Strosahl & Wilson, 1999) maintains a strong focus on helping people to transform their relationship to difficult thoughts and feelings. From this perspective, the struggle to control or alter the experience of anxiety (rather than the anxiety itself) is conceptualised as problematic, and the goal of the therapy is to reduce the impact of the anxiety through cultivating a stance of mindful acceptance towards it, an approach that has recently been applied with success in the treatment of social anxiety disorder (Kocovski, Fleming & Rector, 2009). Familiarity with experience, and acceptance of experience, are central to this process. And both of these were reflected as core aspects within ‘a changed relationship to the anxiety’, highlighting the potential relevance of this approach to the treatment of social anxiety.

The present findings are also consistent with a number of very recent studies which have attempted to better understand the nature of therapeutic change in social anxiety as it is experienced from the perspective of the socially anxious person. For example, McManus, Peerbhoy, Larkin and Clark (2010) asked participants in their IPA study to reflect upon the impact of their experience of individual CBT for social phobia. In this study, participants talked about developing a stance of greater acceptance towards their anxiety and themselves, extending more compassion towards themselves, and worrying less about appearing anxious in front of others. The researchers concluded from this that greater acceptance of the anxiety was a major change apparent within improved functioning after the therapy. Even more recently Jensen, Hougaard and Fishman (2013) conducted an intensive case study of
an individual socially anxious client who experienced rapid symptom improvement in the context of a group-based CBT treatment. In this study, the client attributed much of her improvement to her gradual acceptance of her social anxiety symptoms, and to ‘letting go’ of her attempts to control them. Even though acceptance of unpleasant inner experience was not emphasised within either of these two treatment protocols, it nevertheless emerged as important to the picture of clinical improvement.

The implication of this finding is that a change of emphasis in the treatment protocols may be desirable. CBT protocols, such as those of Clark (2001) and Heimberg et. al. (2010) aim explicitly at ‘reducing’ anxiety. The findings of this research suggest that anxiety ‘toleration’ may be a more helpful goal. First, because that better reflects what socially anxious people themselves (rather than theoretical models of the disorder) identify as important to the picture of therapeutic change. And second because, as indicated in the results of this study, acceptance of the experience is linked to a greater acceptance of the self.

**Important Moments in the Participants’ Group Therapy Experience**

This research found that interactions between the members, and meaningful interpersonal experiences, played a central role in the group therapy process. This supports Heimberg and Becker’s (2002) general claim, that the group format confers a number of unique benefits to the therapeutic process that emerge from the social context of a therapy group. At the same time, the results provide enough information about the nature of these interactions and relational experiences to inform some general principles about ‘how’ they might best be supported and
Therapy events that were linked to important moments.

Important moments were most likely to arise when group members were engaging in an interaction with another person. Typically, these were moments when the group member was stretching their interpersonal repertoire in some way, by behaving in a way that was new or unusual for them. For example, behaving in a more congruent/authentic manner in an interaction, or attempting a previously avoided behaviour/situation. Interactions were therefore the most common springboard for the kinds of insights and relational experiences that group members identified as important in their group therapy experience. This finding is consistent with a core claim of the broader group therapy literature, which is that member to member interactions are the ‘engine’ of therapeutic action in a group setting (Yalom & Leszcz, 2005).

The results also indicate that planned behavioural experiments play an important role in the therapy. These experiments were prominent in that cluster of moments which involved group members attempting a previously avoided behaviour/situation. This is consistent with research that indicates that participants within CBT treatment programs highly value that aspect of the therapy which revolves around deliberately testing things out and confronting fears (Nilsson, Svensson, Sandell & Clinton, 2007). Overall, however, the results suggest that a shift in emphasis may be helpful. On the whole, from the perspective of the group therapy participants, important therapy moments more often emerged out of spontaneous interactions between the members than they did out of planned
behavioural experiments. This suggests that a greater emphasis on tracking and working with unplanned interactions in the group treatment protocols is warranted.

An intriguing finding to emerge from this research is the discovery that the two different kinds of new behaviours most commonly mentioned by the group members (being more congruent/authentic, and attempting a previously avoided situation/behaviour) were linked to moments identified as important for different reasons. Congruence/authenticity, for example, was linked to positive interaction cycles, whilst attempting previously avoided behaviours/situations was linked to the attainment of subjective insights. This finding raises two practical implications.

First, it suggests that behavioural interventions in these two areas may be utilised to promote different kinds of outcomes of clinical interest. Planned behavioural experiments, for example, may be particularly well suited to promoting the experiential disconfirmation of problematic beliefs (as highlighted within cognitive models of SAD such as those of Clark, 2001, and Heimberg et. al., 2010). Whilst greater congruence/authenticity may be particularly well suited to changing interaction dynamics in a way that engenders more positive relational outcomes (as highlighted within the interpersonal model of SAD proposed by Alden & Taylor, 2011).

The second implication relates to the finding that important moments were equally likely to emerge out of either context. In the current protocols a very large amount of time is dedicated to helping group members confront a hierarchy of feared situations in the context of planned behavioural experiments (Clark et. al., 2006; Heimberg et. al., 2002). The results of this study suggest that helping group members relate to others in a more open and authentic manner may be just as
important as helping them to confront feared situations. And creating space for unplanned interaction in the group may be particularly important here, because these moments emerged when participants spontaneously and courageously revealed some true aspect of themselves in an interaction. Moments like these cannot be scheduled, they can only be encouraged by establishing a relational climate in the group that supports that.

Finally, ‘listening to the other group members’ was also identified as a common context within which important moments emerged. Listening to the others, and learning more about them, therefore emerged as an important aspect within the group therapy. This idea receives further support from the prominence of the group therapeutic factor of ‘Universality’, and also from the important role that social referencing played in facilitating positive shifts in group members’ self-concepts.

On the salience of important moments.

The results on the salience of important moments will be interpreted in two parts. In the first part the salience results overall are explored. In the second part, the potential role of attachment processes within the intersubjective moments is considered.

Part 1 – General interpretation of the salience of important therapy moments.

Subjective insights emerged as central to the group therapy process. The largest number of important moments were identified as such because group members learned something important about themselves or about their experience of social anxiety. For example, they described gaining insight into how their own
thoughts or behaviours contributed to their difficulties, or they learned that they were not so negatively different to other people as they had feared. These findings align with the results on the nature of phenomenological change in social anxiety, confirming that enhanced awareness of experience, and cognitive change, are key aspects in both the important moments and in phenomenological change. This provides support for the strong focus on awareness and cognitive change within the existing CBT treatment protocols (Clark, 2001; Heimberg et. al., 2010).

Intersubjective experiences also emerged as important to the group therapy process. Moments of interpersonal closeness, or connection, or prizing, or rupture were widely identified as important moments by the participants. This is a somewhat novel finding in terms of the dominant CBT treatment protocols (i.e., Clark, 2001; Heimberg et. al., 2010) which do not target such experiences within their treatments. It is, however, consistent with the interpersonal model of social anxiety proposed by Alden and Taylor (2011). Such experiences are expected from the perspective of this model, because of the central role that relational experiences are thought to play in the treatment of social anxiety.

A key finding of this study is that intersubjective experiences were often associated with subjective insights, and in particular with positive shifts in the self-concept. This indicates that spontaneously arising relational experiences in the group (e.g., feeling prized by another, or experiencing acceptance from another) were a potent mechanism for promoting such shifts. This is consistent with a central claim of the broader group therapy literature (Yalom & Leszcz, 2005), and also the model of Alden and Taylor (2011), that relational experiences in the group offer an ideal opportunity to raise awareness of, and promote adaptive change in, relational dynamics, cognitions, self-schemas, and so on. Such experiences are prototypical of
the action of the group therapeutic factor ‘Interpersonal learning’, which is discussed in more detail below.

The finding that these intersubjective experiences had a direct bearing on relational engagement and disengagement in the group is a novel finding. This raises two implications, one which is practical (discussed here) and another more theoretical (discussed below in the section on attachment processes). At a practical level, these experiences are important as they reflect some of the core concerns of the socially anxious. Social disengagement is a core aspect of the experience of social anxiety, and so moments of disengagement and engagement between the group members would appear to provide important opportunities for therapeutic exploration. These moments were also implicated in engagement in the therapy process in general. Attending to, and working with such moments therefore presents itself as an important goal for the therapy.

Interpersonal ruptures were not common in the therapy groups, but they are important because three different participants seriously considered leaving the group after such incidents. These people described feeling wounded, or inadequate in the eyes of others, along with a desire to hide or flee from the other or the situation. The phenomenology of these moments (along with the participants explicit use of the word ‘shame’) therefore suggests that an experience of shame was central to these moments. Shame has been conceptualised as an experience that breaks relational connectedness. For example, both Kaufmann (2004) and Schore (2003) describe shame as resulting from the breaking of the interpersonal bridge, and it has been posited that such experiences are implicated in the regulation of social behaviour in human beings (Yellin & White, 2012). According to the models of Kauffman and Schore ‘repairing’ the relational bridge, by re-establishing a safe interpersonal
connection, is the antidote to shame. And that is what was observed in this study. In
the interpersonal rupture and repair cycles, empathic and validating responses from
other people helped to soothe the shamed individual and re-connect them to others in
the group.

Identification of the importance of interpersonal ruptures in the therapy is
significant, because the reasons that people ‘drop out’ of therapy groups are little
researched and poorly understood (Yalom, 1966; Rice, 1996). And no research has
been undertaken to investigate this phenomenon within social anxiety therapy
groups. The present findings indicate that shaming experiences occur in these
groups, and that these have the potential to result in group members leaving the
group. They also suggest that an understanding of shame and its relational dynamics
can help inform an adequate response to such experiences in the group. And this
may be particularly important when working with this clinical population, given that
fear of judgement and social withdrawal are so central to the experience of social
anxiety.

**Part 2 - Speculation on the role of attachment processes within
intersubjective experiences, and potential implications of this for the group
CBT protocols.**

The phenomenology of the intersubjective experiences raises an interesting
theoretical implication. Group members described strong emotions, and a tendency
to move towards or away from others, as being connected to these moments, and this
is consistent with the idea that attachment processes are implicated in these
moments. Bowlby argued that the psychology of emotion and the psychology of
affectional bonds are one and the same (Bowlby, 1979). And it is clear from infant
research that emotions and associated relational motivational tendencies (i.e., moving towards or away from the other) are central to the understanding of attachment dynamics between infants and their caregivers (Cassidy & Shaver, 2010). Very recently, researchers have begun to turn their attention towards attachment processes between adult human beings (Mikulincer & Shaver, 2007). This has mostly been confined to the examination of adult love relationships, and in this context attachment processes have been implicated in bonding and rupture experiences between romantic partners that are characterised by strong emotions (Johnson & Whiffen, 2003). One explanation of these intersubjective experiences could therefore be that they relate to attachment processes unfolding between the group members.

Although this interpretation is tentative, it is intriguing. Whilst attachment theory has been used to advance understanding of relational dynamics between infants and their caregivers (Tronick, 2004) and within romantic dyads (Johnson, 2004), it has only very recently been suggested that it might also help with understanding interactions between the members of a therapy group (Badenoch & Cox, 2013). To the author’s knowledge, the findings here offer the first empirical evidence consistent with the idea that attachment processes are making an important contribution to the therapeutic process in social anxiety therapy groups.

The implication of this is that the existing group CBT protocols may be enhanced by introducing an attachment perspective for understanding and working with these intersubjective experiences in the group. To date, CBT theoretical frameworks have tended to focus on the negative emotions and efforts to control them (Safran & Segal, 1990). Attachment theory provides a framework for understanding both positive and negative emotions, and in particular how these
emotions relate to relational dynamics unfolding between human beings (Trevarthan, 2009). It therefore provides an excellent framework from which to consider these intersubjective moments, which revolved around feelings of closeness and connection, or warmth, or wounding, in the context of relational experiences. Integrating an attachment perspective into the CBT groups therefore offers an opportunity to deepen understanding of these complex relational experiences, thereby enhancing the likelihood that they may be turned to therapeutic advantage.

**The Group Therapeutic Factors**

This research found that a number of group therapeutic factors were particularly prominent in the social anxiety therapy groups. Most of these were identified as important within the analysis of important moments, but one factor ‘Universality’ emerged as prominent within the interview transcripts as a whole.

**Universality**

Universality emerged as highly important in group members overall therapy experience. Almost all of the group members spontaneously mentioned how important it was to them to discover that other people experienced similar difficulties, and had responded to them in a similar way. This had a profoundly de-stigmatising effect, as group members started to reconsider what they understood about themselves in light of what they were learning about other people, which is consistent with Robinson’s (1980) arguments about the way that universality counters stigma.

The prominence of universality suggests that there may be a direct link between this therapeutic factor and some of the core concerns of the socially
anxious. When considering the transcripts as a whole, one of the most difficult aspects of social anxiety described by the group members was the idea that “I am alone… and I am different to others in some negative way”. Universality directly countered this idea by helping people to recognise the commonly shared nature of their difficulties. It is, as Yalom has described it, a ‘welcome to the human race’ experience (Yalom & Leszcz, 2005, pg 6). And such experiences may be particularly pertinent for the socially anxious, because they tend not to share their experience of social anxiety with others.

Finally, it appears that universality may exert its influence somewhat differently to the other therapeutic factors. It was prominent overall rather than in the important moments. This suggests that it may be somewhat of a ‘background’ factor, exerting its influence slowly over time as the group members come to learn more about one another. Overall, the finding here supports the notion that universality is a particularly potent factor for those whose experience is characterised by shame and isolation (Wallace & Nasoko, 2003) such as the socially anxious.

**Self-understanding**

Self-understanding emerged as the most prominent factor overall within the analysis of important moments, and this is consistent with other research findings that have also identified this factor as pre-eminent in the group therapy process (Fuhriman & Burlingame, 1990; MacKenzie, 1987). As described above, under the results for ‘salience’, group members most commonly described learning something helpful about the nature of their difficulties, or about themselves as a person. It is interesting that helpful insights into the self tended to revolve around a person’s
understanding of their current functioning in the context of their current relationships (rather than insights into the way that they came to be the way they are). It is unclear, however, if this finding provides support for a strong focus on current functioning (at the expense of historical insight) within the treatment protocols, or if it is simply a by-product of a lack of focus on developmental concerns within the treatment programs in the current study.

In this study there was a high degree of overlap between the therapeutic factors of ‘self-understanding’ and ‘interpersonal learning’. That is, it was common for both of these factors to be identified as prominent within an important moment. This appears to be a methodological issue. The way that interpersonal learning has been defined in the literature means that it inevitably involves an element of greater self-understanding. The extent of overlap between these two constructs has been not been previously described in the literature, however, and this is likely due to the fact that the vast bulk of therapeutic factor studies have utilise the forced card-sort procedure originally devised by Irvin Yalom (Brabender, Fallon & Smolar, 2004). Such a procedure is not well suited to revealing any such overlaps because it only allows for categorical responses.

Overall, in this study, a better understanding of the self was central to both the phenomenology of change, and also the important therapy moments. The prominence of the therapeutic factor of self-understanding reflects this, and confirms that it is a factor of particular relevance within therapy groups for the socially anxious.
Interpersonal learning

As previously discussed, interactions between the members were the most common context in which group members gained important insights about themselves and their social anxiety. People learned by trying out new behaviours in the group, and they also gained insights via the feedback they received from others. The group therapeutic factor of interpersonal learning is therefore identified as central to the therapeutic process in the therapy groups in this study, consistent with claims for the importance of this factor within the broader group therapy literature (Bloch & Crouch, 1985; Yalom & Leszcz, 2005).

At the same time, the present results suggest a somewhat different mechanism which might be implicated in explaining how interpersonal learning exerts its influence within the group therapy process. As it is defined within the dominant models of Bloch and Crouch (1985), Fuhriman and Burlingame (1990), and Yalom and Leszcz (2005), interpersonal learning is described as a cycle in which therapist facilitated insight leads to more adaptive behaviours in the group member that invoke positive responses from other people. According to this model, group members attain conscious insight into their own maladaptive relational patterns and it is this that allows them to choose something different moving forwards.

Whilst there was evidence of this in the therapy groups in this study, the nature of the intersubjective experiences in the groups encourages speculation that a different, and more implicit, mechanism was also at play. The idea that interactions contribute to implicit knowledge about the relational self is a cornerstone of attachment theory (Bowlby, 1973). For example, infants learn very early in life
what kinds of affectionate approaches will be accepted or rejected by their caregivers, and this guides the way that they attempt to regulate themselves through contact with their caregiver (Lyons-Ruth, Repacholi, McLeod & Silva, 1991). Such knowledge has been described as implicit relational knowledge by Stern et. al. (1998) as it is thought to operate largely outside of conscious awareness whilst informing the way that the self and the social world are experienced. Repeated relational experiences are thought to contribute to the development of relatively stable systems of implicit relational knowledge about ‘the self’ and ‘being with others’, which have been described by such terms as ‘Internal working models’ of attachment (Bowlby, 1973) or ‘Schemas of being with’ (Stern, 1995).

In a therapeutic context, Stern and colleagues (Stern et. al., 1998) have proposed that new relational experiences in therapy can rearrange a person’s implicit relational knowledge, and that this is a key mechanism of change in psychotherapy. They argue that special ‘moments of meeting’, which are affectively charged and involve some new experience within the relationship, change that relationship as it is implicitly known. This change then alters the mental actions and behaviours that are capable of emerging in that newly formed context (Stern et. al., 1998). This description is a better fit with what was observed in many of the intersubjective experiences in this study. For example, in the positive interaction cycle described by Dave, he took a risk and spontaneously attempted new ways of relating to others in the group. These were responded to positively, and as these experiences were repeated he started to experience both himself and the social environment of the group differently, which supported the emergence of an expanded ‘range’ of interpersonal behaviours in the group (‘butting in’, telling jokes, and so on). Or in the case of Ben’s rupture and repair cycle, he described this experience as being
linked to a renewed hope within him that other people might be more responsive to his needs in the future. In these cases there was no evidence of therapist prompted insight leading to the emergence of new behaviours and cognitive change. Rather, this process appeared to be driven by interpersonal risk taking in the context of satisfying (i.e., need meeting) relational experiences. In other words, it was the efforts of the group members to relate to one another in a constructive manner that appeared to drive this process.

The implication of this is that there may be an additional pathway by which the therapeutic factor of interpersonal learning comes about in therapy groups. Relational experiences in the group may be modifying implicit relational knowledge in a way that is therapeutically beneficial, in a process that emerges largely out of the natural and spontaneous efforts of the group members to relate to one another. Such a mechanism is more naturalistic in the sense that it more closely reflects the way that interactions are thought to contribute to the development of relational knowledge and behaviours in the context of human development (Cassidy & Shaver, 2010). This reaffirms the importance of unstructured interactions in the group, and suggests that an important goal of the therapy should be to create a relational climate which supports and promotes the kind of interpersonal risk taking that is so central to this process. It also highlights the importance of creating time in the group to reflect on important relational experiences, so that these implicit learnings can become the focus of conscious reflection.

**Hope**

The instillation of hope also emerged as a salient therapeutic factor in the therapy groups. Group members described a renewed sense of hope about their own
situation, or their future, or about other people. This was unexpected, as this factor
does not tend to rate highly amongst group therapy members in general (Yalom &
Leszcz, 2005). The overlap that was observed between the therapeutic factors of
‘hope’ and guidance’ is an interesting one. Hope was often described as emerging
when the therapists were explaining something, or providing direct guidance. This
is consistent with the ideas of Jerome Frank (Frank & Frank, 1991) that explanations
or theoretical models are helpful because they provide a context within which a
person’s suffering can be better understood and responded to.

Participants also described hope as being connected to becoming more
familiar with the entirety of their experience of social anxiety. For example,
learning how to ‘name’ aspects of their experience for the first time, or recognising
that certain feelings or behaviours were connected to their social anxiety. It
therefore appears that enhancing awareness of the experience itself is helpful. This
is consistent with the ideas of Bohart and Greenberg (1997) who argue that it is
helpful to move distressing experiences out of the realm of felt-experience and into
the symbolic world of language and conscious cognition so that they can be better
understood and grappled with. Supporting such a process is a core goal within many
experiential therapies (Gendlin, 1988) where it is thought to alleviate confusion by
clarifying experience. Such a process was identified as important in this study.
Overall the results here support the strong focus on psychoeducation and the
collaborative exploration of experience of social anxiety within the existing CBT
protocols.
Self-disclosure

Self-disclosure played an important role in the therapy groups. Specifically, it was prominent within the important moments, and it appeared to have an impact on strengthening relationships in the group, and also on reducing anxiety in the person who disclosed. The findings here offer partial support to Jourard’s (1971) assertion that self-disclosure is important to self-understanding. This was indeed the case, but in this research it was the self-disclosure of others that led to changes in the way that group members understood themselves. As described previously, social referencing played an important role here, which suggests that learning about the experience of others is particularly helpful for this clinical population.

Self-disclosure also played an important role in strengthening relationships in the group. This is consistent with the idea that self-disclosure is important to relationship formation (Laurenceau, Barrett & Pietromonaco, 1998). And it appears likely that this is linked to the relational dynamics that surrounded important disclosures in the groups. For example, disclosures of a distressing nature often led to comforting or accepting responses from other people, and/or inspired more disclosures from other group members. And so group members came to know more of one another in a context of reciprocal sharing and care, which would be likely to strengthen the bonds between them. There was also a relationship between group members’ own self-disclosure and a reduction in their experience of anxiety in the group. Self-disclosure therefore appeared to make a complex and important contribution to the group therapy experience. Promoting a culture of self-disclosure in the therapy groups is therefore identified as an important goal for the therapy.
Implications for Clinical Work

The findings of this research are very positive for the existing group CBT protocols. In this study, even though the CBT groups did not maintain a specific focus on group phenomena, such phenomena nevertheless emerged and made an important contribution to the therapy. This is an important finding, and it supports Yalom’s assertion that clinically helpful interactions and relational experiences arise quite naturally out of the social milieu of a therapy group (Yalom & Leszcz, 2005). This provides an important opportunity for enhancing the group CBT protocols. Currently, these opportunities are not taken full advantage of within the therapy, because group processes are not overtly discussed within these treatment protocols (with the exception of Alden and Taylor’s (2011) treatment model). Working more deliberately and consciously with the ‘group’ aspect of the therapy therefore presents itself as an important opportunity to enhance the protocols.

The overarching implication of this for clinicians is that a shift in emphasis in the treatment protocols may be helpful. At present the protocols do a very good job of working ‘within’ individuals in the therapy groups. In other words, individuals are well supported to learn more about their difficulties, attempt new behaviours, gain important insights, and so on. Where the existing protocols are less well developed, is in working ‘between’ the group members. In other words, utilising interactions and relational experiences between the members to provide support and advance the therapy. This research suggests that attending to both domains may enhance the group CBT protocols. A number of specific principles to assist clinicians in this regard are set out below.
Thinking of the group as ‘one big behavioural experiment’.

Unplanned interactions were an important aspect of the therapeutic process in the therapy groups in this study. The implication of this is that all interactions, from the moment a person first walks into the group, are potentially important to the therapy. A shift in mindset, in terms of where and how the therapy is promulgated, may therefore be helpful. In the current treatment protocols, the therapeutic focus tends to be on planned interactions occurring in the context of behavioural experiments. In this context, great care is taken to ensure that a group members anxiety remains within tolerable limits, whilst new behaviours are attempted and reflected upon in order to advance the therapy. The findings of this research suggest that this same attention and concern should be extended to all interactions unfolding in the group. This is not to suggest that every interaction should become a focus of therapeutic activity, but that every interaction may be considered from a therapeutic perspective, as a potentially fruitful opportunity to provide support, or enhance an emerging relationship, or promote reflection and insight. This shift in emphasis requires an explicit expansion to the task of the group therapist; to include monitoring all interactions in the group, and tracking and responding to the emergent needs of all of the different group members in an ongoing fashion. Such a shift would help to ensure that therapeutic opportunities arising out of spontaneous interactions are better recognised and supported within the treatment.

Consider and respond to relational experiences, and support the relationships in the room.

Relational experiences that unfolded as the group members spontaneously related to one another were important to the therapeutic process in the therapy
groups in this study. This has three general implications for enhancing the existing protocols. First, is to acknowledge that the therapy may be enhanced by encouraging and supporting a process whereby the group members come to know one another more deeply, and build stronger connections with one another. In other words, relationship formation may be supported more explicitly within the treatment protocols. Second, relational experiences may be conceptualised as particularly important aspects of the therapeutic work. As this research indicates, there are some moments that are more important than others in group therapy - pivotal moments of healing and injury that need to be responded to. Observing interactions in the group through an attachment ‘lens’ may be particularly helpful in identifying such moments. Finally, if implicit learning is an important outcome of these relational experiences it is important to promote reflection and insight around them in an effort to make these learnings more explicit.

**Attending to the social climate of the ‘group as a whole’**.

Finally, and in order to support the shifts in emphasis suggested above, it is important to consider the relational climate within the group as a whole. If spontaneous interactions between the members are going to be used to support the therapeutic process, it becomes important to develop an environment in the group which supports interpersonal risk-taking. From an attachment perspective, emotional availability and responsiveness are the key to a safe connection that supports exploratory behaviours (Johnson, 2004; Tronick, 2007). This suggests that a central task of the therapy is to develop a relational climate in the group which is characterised by a strong sense of welcome, warmth and safety, and within which the group members are encouraged to relate to one another in an honest and supportive manner. The role of the therapist is therefore extended to one in which
cultural norms in the group are carefully and deliberately cultivated in order to create a therapeutic ‘holding environment’ (Lucas, 1988) that supports the relational aspects of the therapy.

**Strengths and Limitations**

A strength of this research is its exploratory nature. Aside from the group therapeutic factors, all of the categories of meaning emerged from the group members own perspectives on what was important to them in the therapy. The findings on the centrality of interactions and relational experiences in the group therapy is therefore a robust one. In addition, the exploratory nature of the study allowed for the emergence of material that was unexpected by the researcher, but relevant to the research question, such as the findings on the potential role of attachment processes in the groups. This lays the groundwork for future theory development in the group therapy field.

Another strength of this research is its novelty. The perspective of participants in social anxiety therapy groups has rarely been investigated (McManus et. al., 2010), which is a limitation in current knowledge about group therapy as an intervention for SAD. In addition, asking participants to evaluate or comment upon their group therapy experience is consistent with the highly collaborative nature of CBT (Dattilio & Hanna, 2012). And it supports a broader move within the healthcare system towards trying to understand and respond to the perspective of users of health services (Borg & Karlsson, 2009).

The findings of this research also need to be considered in light of several potential limitations. First, participants were asked to identify moments that were significant to them in some way. This has provided important insights into moments
that were unusual or special to the participants, but more usual or ordinary incidents in the group therapy were not explored. It is therefore possible that certain aspects of the group therapy of relevance to the research questions were overlooked because they were considered more mundane or ordinary from the perspective of the participants. In a similar vein, the focus on important ‘moments’ may have made this research protocol less sensitive to aspects of group life that may make a more slow and consistent contribution to the therapy, such as the therapeutic factor of group cohesion (Taube-Schiff, Suvak, Antony, Bieling, & McCabe, 2007).

A further limitation is that the results are based on the author’s personal interpretation of the interview data. Substantial effort was made to ensure validity in the data analysis process by accounting for personal biases, and adhering to methodologies recommended as robust within the research literature. While there was no cross-validation by a second independent researcher, the data themes and results were verified through consultation with the author’s supervisor. As with all qualitative research, the reader is advised to consider the author’s ‘personal statement’ and form their own view of any potential biases that might have inadvertently impacted the data analysis.

**Directions for Future Research**

A number of ideas for future research are highlighted by the results of this study. The current findings are suggestive of the idea that attachment processes are active within intersubjective experiences in the therapy groups, but this requires confirmation through further study. Recently, McClusky (2005) has developed a methodology for assessing attunement facilitating behaviours in psychotherapy. This method assesses verbal and non-verbal (e.g., gaze, body language, tone of
voice) elements which impact the regulation of closeness and distance between the members of a therapy dyad, and this instrument may be suitable for investigating the presence of attachment behaviours in therapy groups. Video recordings, which are a staple of the infant research (Tronick, 2007), would assist by allowing for a careful and methodical examination of interactions.

Another important task for future research is to develop a greater understanding of attachment dynamics between adults in therapy groups. This involves considering the systems aspect of attachment theory, which explains relational dynamics unfolding in the context of dyadic attachment functioning. These dynamics are well documented in the infant literature (Stern, 1985; Tronick, 2007), but researchers have only recently turned their attention to adult/adult attachment dynamics (Mikulincer & Shaver, 2007). Between adults, a number of specific relational dynamics have been identified that contribute to negative outcomes in romantic dyads. For example pursue/withdraw dynamics, where one partner attacks the other for being unresponsive and the other party responds by withdrawing even further (Johnson, 2004). These behaviours can be understood as attempts to maintain basic attachment needs for connection and safety, that have become dysfunctional because the couple is ‘stuck’ in a pattern of relating that exascerbates their difficulties. To the authors knowledge, there is no research at present which illuminates the nature and impact of adult attachment dynamics as they unfold between adults in the context of a therapeutic group. A better understanding here would help clinicians to identify and work with such dynamics as they arise in the context of group members efforts to build and maintain bonds of companionship with one another.
Finally, and at a practical level, it is important to investigate how the group protocols can be adapted to bring a stronger focus onto the relational aspects of the therapy, whilst maintaining the integrity of the existing CBT programs. Some adjustments may be fairly straightforward. For example, the focus of homework discussions typically revolves around exploring relational experiences outside the group (Heimberg et. al., 2002). Using that time to reflect on relational experiences inside the group would support a stronger focus on intragroup relational dynamics with relatively little change to the existing protocols. Other changes may be more difficult to integrate. For example, making more time for unstructured interactions in the group would require either a longer intervention, or the loss of some existing aspect of the programs. Finally, the issue of therapist training needs consideration. Working as a group clinician with a relational focus requires specialised skills. For example, the American Group Psychotherapy Association (2015) has formal requirements for its members in education in the theory of group therapy, accumulation of clinical experience in groups, and group therapy supervision. Investigation into the need for further training in the development of CBT practitioners, to develop them as “group CBT practioners” is therefore warranted.

Conclusion

Overall this study provides empirical evidence about the nature of change in social anxiety from the point of view of socially anxious individuals. By focusing on the lived experience of the participants themselves, this research was able to identify two areas of change that are relatively novel in terms of existing theoretical models. These findings suggest a shift in emphasis towards anxiety toleration (rather than reduction), and a greater emphasis on relational dynamics (in line with
Alden & Taylor, 2011), are potentially fruitful areas for further therapeutic inquiry and attention in the treatment protocols.

This study also established evidence regarding the nature and impact of relational processes in social anxiety therapy groups. This demonstrates that interactions and relational experiences play a central role in these groups, and highlights the relevance of a number of the group therapeutic factors to this process. Overall, this indicates that a greater focus on these aspects of the group therapy may further assist with enhancing the treatment protocols.

The finding that attachment processes may be implicated in important relational experiences in therapy groups for social anxiety is perhaps the most theoretically significant finding. Attachment theory offers an overall framework for thinking about relationships, and particularly those aspects of relationships that are shaped by threat and the need for security (central concerns for the socially anxious). It is also a systemic theory that describes how inner emotional experiencing and interpersonal behaviours and feedback loops come together within human social functioning. As such, it is ideally placed to help therapists work within a person (i.e., how a person constructs their inner experience of relatedness) and between people (with the interactions and interpersonal dynamics unfolding in the room). This way of utilising attachment theory to inform therapeutic practice has proven to be successful in the field of couples counselling (Johnson, 2004) but is yet to be extended into the field of group therapy.

Finally, the potential enhancements to the protocols identified within this study are not intended to compete with or replace the fundamental tenets of the cognitive behavioural treatment protocols. Rather, they represent an opportunity to
enhance them. As highlighted within this study, relational experiences played a central role in supporting cognitive and behavioural change in the group members (and vice versa). A greater focus on the relational aspects of the therapy can therefore increase the effectiveness with which the goals of CBT may be pursued in a group context.
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Appendix 1 – Consent form

Consent form

Project Title: A phenomenological inquiry into important moments in the group therapy experience of those with social anxiety.

Principal Investigator(s): Mr Anthony Mackie and Prof. Glen Bates

1. I consent to participate in the project named above. I have been provided a copy of the project information statement and this consent form and any questions I have asked have been answered to my satisfaction.

2. Please circle your response to the following:
   - I agree to be interviewed by the researcher [Yes No]
   - I agree to allow the interview to be recorded by electronic device [Yes No]
   - I agree to allow the use of non-identifying direct quotations in any future publication [Yes No]

3. I acknowledge that:
   (a) my participation is voluntary and that I am free to withdraw from the project at any time without explanation;
   (b) the project is for the purpose of research and not for profit;
   (c) any personal or health information about me which is gathered in the course of and as the result of my participating in this project will be (i) collected and retained for the purpose of this project and (ii) accessed and analysed by the researcher(s) for the purpose of conducting this project;
   (d) my anonymity is preserved and I will not be identified in publications or otherwise without my express written consent.

By signing this document I agree to participate in this project.

Name of Participant: ………………………………………………………………………

Signature & Date: ………………………………………………………………………
Appendix 2 – Ethics clearance (Document on human research and experimentation)

Dear Glen and Anthony,

**SUHREC Project 2010/303 A phenomenological inquiry into important moments in the group therapy experience of those with social anxiety**

Prof Glen Bates FLSS Mr Anthony Mackie
Approved Duration: 28/02/2011 to 30/09/2011 [Adjusted]

I refer to the ethical review of the above project protocol undertaken on behalf of Swinburne's Human Research Ethics Committee (SUHREC) by SUHREC Subcommittee (SHESC2) at a meeting held on 13 December 2010. Your response to the review as e-mailed on 31 January 2011 was put to a nominated SHESC2 delegate and the Chair of SUHREC for review.

I am pleased to advise that, as submitted to date, the project has approval to proceed in line with standard on-going ethics clearance conditions here outlined.

- All human research activity undertaken under Swinburne auspices must conform to Swinburne and external regulatory standards, including the National Statement on Ethical Conduct in Human Research and with respect to secure data use, retention and disposal.

- The named Swinburne Chief Investigator/Supervisor remains responsible for any personnel appointed to or associated with the project being made aware of ethics clearance conditions, including research and consent procedures or instruments approved. Any change in chief investigator/supervisor requires timely notification and SUHREC endorsement.

- The above project has been approved as submitted for ethical review by or on behalf of SUHREC. Amendments to approved procedures or instruments ordinarily require prior ethical appraisal/clearance. SUHREC must be notified immediately or as soon as possible thereafter of (a) any serious or unexpected adverse effects on participants and any redress measures; (b) proposed changes in protocols; and (c) unforeseen events which might affect continued ethical acceptability of the project.

- At a minimum, an annual report on the progress of the project is required as well as at the conclusion (or abandonment) of the project.

- A duly authorised external or internal audit of the project may be undertaken at any time.

Please contact me if you have any queries about on-going ethics clearance. The SUHREC project number should be quoted in communication. Chief Investigators/Supervisors and Student Researchers should retain a copy of this e-mail as part of project record-keeping.

Best wishes for the project.

Yours sincerely

Ann Gaeth for
Kaye Goldenberg
Secretary, SHESC2

Date: Mon, 28 Feb 2011 10:10:50 +1100
From: AGAETH@groupwise.swin.edu.au
Appendix 3 – Copyright statement

I warrant that I have obtained, where necessary, permission from the copyright owners to use any third party copyright material reproduced in the thesis (such as artwork, images, unpublished documents), or to use any of my own published work (such as journal articles) in which the copyright is held by another party (such as a publisher, co-author).

Anthony Mackie
29 April 2015