Advanced Training in Cognitive Behavioural Therapy Interventions

A Case Study: The Effectiveness of a CBT-based Intervention to Reduce Social Anxiety

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Abstract

This case study looks at the social anxiety derives from presenting workshop or training session in front of other people. Anxiety has been perceived to be a natural physiological response but too much of it could hamper the normal functionality of the individual. Studies have found that the Cognitive-Behavioural interventions are effective in reducing social anxiety. The main aim of this single case study design is to examine the effectiveness of a CBT-based approach for reducing the anxiety caused by public speaking during workshop or training presentation of a 53-year-old male using an ABA_1B_1 design. For the intervention strategies, the study uses (i) cognitive restructuring, (ii) relaxation technique and (iii) modelling (with imagery exercises) to achieve its objective to help to reduce the social anxiety. The study found evidence for the effectiveness of a CBT intervention programme to reduce the participant's anxiety level. The case study concludes by outlining the limitations of the study and the recommendations for future studies.

much more detail needed in the measures outcomes

INTRODUCTION

A Case Study:

The Effectiveness of a CBT-based Intervention to Reduce Social Anxiety (due to Public Speaking)

Anxiety is one of the most prominent and pervasive emotions. Rachman (2004) has mentioned that fear and anxiety share some common features but fears tend to have specific, usually identifiable focus and to be more intense and episodic. The most intense and irrational fears are classified as phobias or anxiety disorders, of which there are seven types: panic disorder, agoraphobia, social phobia, specific phobia, generalised anxiety disorder, obsessive-compulsive disorder, and post-traumatic stress disorder (Rachman, 2004). Social Anxiety Disorder (SAD) or Social Phobia is the most common anxiety disorder (Kessler et al., 2005). According to American Psychiatric Association (APA, 2013), the essential feature of social anxiety is marked, or intense, fear or anxiety of social situations in which the individual may be scrutinised by others and fears that he will be judged as anxious, weak, crazy, stupid, boring, intimidating, dirty or unlikeable. The specific risk factors for SAD are as follows (Bates, 2015): (i) cognitive processes biased to perceive criticism and anger in others; (ii) early experience of humiliation in a social setting; (iii) parents expected and encouraged their children to avoid as a way of coping with threatening situations and (iv) rigid rules for social behaviour (for example I must always sound fluid and intelligent).

The most commonly feared specific situations include, in descending order, fear of public speaking, attendance at parties, meetings, and speaking to figures in authority (Rachman, 2004

pp. 148). Many literature have stated that socially anxious people tend to engage in considerable avoidance behaviour but some social interactions are unavoidable due to job and family commitments and hence a cause of anticipatory anxiety as well as situational anxiety. According to Pollard and Henderson study in 1988 (as cited in Rachman, 2004) the fear of public speaking, the prevalence can go as high as 70%. Social anxiety tends to emerge in late adolescence and early adulthood (Schneider & Johnson, 1992). In agreement to this, a study in Singapore by Magiati, Ponniah, Ooi, Chan, Fung and Woo (2013) reported that separation and social anxieties were most common in school-aged Singaporean children with the rates of clinically elevated symptoms of anxiety was 9.3% on the Multidimensional Anxiety Scale for Children. Another study on generalised anxiety disorder in Singapore by Lim, Ng, Chua, Chiam, Won, Lee, Fones and Kua (2005) reported that prevalence of anxiety increased in older individuals and those who had experienced one or more threatening life events showed increased odds of association with generalised anxiety disorder.

Cognitive Bhavioural Thearapy (CBT) has been found to be effective in helping people who has anxiety. CBT helps the individual identify and correct cognitive deficiencies and distortions associated with anxiety so as to effect constructive changes in their behaviours emotions (Sung et al, 2011). In a study in Singapore by Sung, Ooi, Goh, Pathy, Fung, Ang Chua and Lam (2011), factors such as regular sessions in CBT has shown effectiveness in the management of anxiety in children and adolescents with Autism Spectrum Disorders.

There are various CBT techniques to manage social anxiety. Attention training, graded exposure, slow-breathing technique and cognitive restructuring such as the interpretations of the situations that determine the emotional response are the strategies which can be used as an intervention for individual with social anxiety such as stage fright (Andrews et al, 2003). These

intervention techniques could be done in both non-social and social situation. The participant of the behavioural experiment has to identify the content which is the feelings and thoughts from the experiment which are not necessarily events which have happened. Then review what actually happens by shifting to external processing and constructing a positive data log by writing down the advantages and the disadvantages of the post mortem and then not to think about it further. Thus "re-scripting the early memories" and challenging automatic thoughts could also be used as one of the CBT techniques in helping the client with Social Anxiety. Bates (2015) lists the elements of therapy for social anxiety as follow: (i) Derive idiosyncratic model; (ii) Attention and safety behaviours experiment; (iii) Video and audio feedback; (iv) Behavioural experiments; (v) Dealing with anticipatory anxiety and post mortems; (vi) Rescripting early memories linked to intrusive images and impressions and (vii) Developing the blue-print for the future.

In this case study, the participant will use some of the above elements of therapy as interventions for the anxiety feeling when facilitating the workshop and training in front of other people. A study using the ABAB design study has found that it could be used to provide an evidence-based effective way to help patients with Social Anxiety to lessen their suffering and stop the perpetuation of their symptoms (Furukawa et al., 2013). The following sections will describe the methods of using the ABA_1B_1 design to assist the participant to lessen the anxiety level by using both the cognitive and behavioural techniques in CBT.

Methods

Participant

The aim of the case study design is to help the participant to reduce the anxiety level of his fear in public speaking. The participant is a 53-year-old Malay man from Singapore who is currently a student with the Australia's Swinburne University of Technology in the Master of Social Science in Professional Counselling programme. The participant works as a lecturer in a higher educational institution in Singapore and he has to give talks and lectures to students as well as adult learners. He also has to conduct workshops for the public too. All the workshops will be conducted in the institution's premises.

The participant's perception of the social anxiety is that other people are always criticising and evaluating his performances when he is lecturing and conducting workshops. Furthermore, all lectures and workshops will be evaluated by the students and the participants of the workshops. His anxiety level could become unbearable as he will over-prepare his class and unable to sleep well thinking of the catastrophic outcome of the sessions. He is a perfectionist as he wants to be evaluated as "excellent" (4.5 score out of 5) in the feedback session after very workshop. He feels that people will make fun of him and will criticise his ability to conduct workshop effectively as he has been in the educational field for more than 30 years.

Procedure

Single subject research methodology is important for asserting specific research questions including demonstration questions such as "Does this intervention work?" (Hammond & Gast, 2010 p. 199). For the case study, the ABA_1B_1 design was used, where "A" represents baseline monitoring period, and "B" the intervention phase. The "A_1B_1" be the repeated phases of the

monitoring period after the first round intervention phase at "B". This ABA_1B_1 makes it easier for the researcher to show that change depends on the presence of a particular intervention and there would be a stronger evidence for a causal link between the intervention techniques used and the outcome (McLeod, 2003 p. 106).

Experimental research examines the impact of an independent variable (the intervention) on a dependent variable (anxiety level). The ABA_1B_1 design was selected to address some of the methodological and reliability concerns inherent to single subject experiments. In single-subject experimental designs, a common element is as follows: replications are used to build the case that a relation exists between the independent and dependent variables (for example, in the withdrawal design, a baseline condition is used initially, the intervention is then implemented, the baseline conditions are then reinstated, and finally, the intervention is reintroduced. Theoretically in this study, the intervention is a sole change agent, and the participant's anxiety level is expected to decrease with the initial implementation of the intervention and return to the baseline level when the intervention is removed.

The period of the case study lasted for about one month. As the participant had to conduct 4 workshops during the office hours for the case study, he had in total 4 sessions of face to face presentation to adult learners. Each session of the workshop lasted for 8 hours.

Table 1 below shows the summary of the four sessions (or four phases) for the case study where the ABA^1B^1 design was carried out. For simplicity and clarity; A phase will be called the "Baseline", B phase will be called the "Intervention", A_1 phase will be called the "Withdrawal of Intervention" and B_1 phase will be called the "Final Trial with Intervention".

Table 1: The schedule for the case study

Workshop/ Training Session (ABA_1B_1)	Date	Duration (hours)	Topic of the Workshop / Training Session
1 (A: Baseline)	24th June (Wednesday)	8	Motivation & Group Behaviour
2 (B: Intervention)	1st July (Wednesday)	8	Listening & Questioning
3 (A_1: Withdraw Intervention)	8th July (Wednesday)	8	Managing Learner-Centred Classroom
4 (B_1: Final Trial with Intervention)	15th July (Wednesday)	8	Scaffolding Through Facilitation

For the A phase (Baseline), the data of the behaviour before interventions were collected and then an interval of 5 days were given the B phase (with intervention) data were collected. During the A phase and B phase, the types of activities were described under the section for interventions.

In the A_1 phase (when the intervention was withdrawn), the participant went through the public presentation for the third time. The scores were taken as in A phase and B phase. After the session, the intervention using the CBT approach was re-introduced for about 5 days before the final B_1 phase (the final trial with intervention).

Interventions

At B phase and B_1 phase (phases with intervention), the participant was given 5 days to do the activities as part of the CBT approach. The case study used (i) cognitive restructuring, (ii) relaxation technique and (iii) modelling (with imagery exercises) to achieve its objective to help reduce the anxiety caused by public presentation of the workshop and training sessions.

(i) **Cognitive Restructuring**: Changed in belief often lead to corresponding changes in behaviour (Beck, 2011 p. 226). Identifying the core belief and the negative automatic thoughts will help the participant to be aware that restructuring these thoughts will help the anxiety level to be lowered. Instead of focusing on the catastrophic outcome which may not happen, the participant may focus his thoughts on the subject matter such as the flow of the discussion during the workshop. As Heimberg (2002) reports that the findings of a large body of experimental psychopathology research suggest that it is important for clients to examine their thoughts about feared situations and the beliefs that may underlie them. The participant would fill up the "**Be Your Own Cognitive Coach Worksheet**" (BYOC) before the exposure and de-briefing after the exposure to the interventions. This worksheet will help the participant to identify the automatic thoughts, thinking errors, provide challenges to the automatic thoughts, then summarises the challenges into a rational statement to use to combat the automatic thoughts and finally listing the achievable behavioural goal such as something that is do-able and can be seen by others. The participant had also to note that if something bad would happen during the workshop and training, the worst that could happen was for him to apologise for not being aware of the situations. He could follow-up with the questions. He must note that" it is not the end of the world and he will not die" from the bad experience. As the saying goes, 'What does not kill you will make you stronger!". Cognitive restructuring techniques contain a substantive exposure component and it will allow the clients to revise their judgements about the degree of risk to which they are exposed in feared situation (Heimberg, 2002 p. 102).

(ii) **Relaxation Technique**: As cited in Heimberg (2002), there are several approaches to relaxation training which most are derived from the pioneering work of Wolpe (1958) and Bernstein and Borkovec (1973). Relaxation therapy is the use of progressive relaxation or

muscle-tension exercises or guided imagery to produce relaxation (Sapp, 2004 p. 13). For the progressive relaxation, by using self-talked the participant of the case-study has to get into a relaxed position. First step will be take few deep breaths and then to inhale – hold it and relax. Focus on the breathing and then to bring tension into the arms. Then move to the muscles in both legs; tensed and relaxed. For guided imagery, the participant will have to close his eyes and imagine a very relaxing beach scene and to picture it as clearly as possible. He should be able to hear the sound of the waves and the birds. He has to relax completely and let the mind and body experience infinite relaxation, peace and wisdom. Heimberg (2002) reiterates that relaxation for social anxiety disorder is not effective unless it is "applied" which means that clients must be able to attend to the physiologic sensations of anxiety such as the increase in the heart rate (palpitations) and they learn quickly to relax while engaging in everyday activities. There will then be a transfer of the applied relaxation skills in the anxiety-provoking situations such as during the public-speaking situation.

(iii) **Modelling (with Imagery Exercises)**: Bandura (1977) described four processes for effective modelling: (i) attention to the modelled behaviour, (ii) reproduction of the modelled behaviour, (iii) retention of what is learned and (iv) motivation to perform the behaviour (Naugle & Maher, 2003). Beck (2011) mentions that normalising and teaching clients about images reduce their anxiety and makes it more likely that they will be able to identify the images. The participant would practise inducing a coping images of him successfully conduct the workshop and training session. He would watch videos on lectures from "You-tube" and "Ted Ed" to create positive images of a good lecture. The participant could also practise substituting a more pleasant image of any catastrophic images which could elevate the anxiety. The participant would practise non-distressing images by regular practice of "switching off" a negative spontaneous image. One

of the ways would be for the participant to induce a confident and self-assured presenter during the workshop and the training session. In this image, the participant would pace himself when speaking and having eye-contact with all the participants of the workshop. Another way is to have a covert rehearsal to uncover and solve potential problems that may happen during the workshop and what could the client do to overcome the problems (Beck, 2011).

Measurements

Since the causes of anxiety are multifactorial, the case study assessed three major components of anxiety: cognitive, affective and physical. Scales were filled in weekly for four weeks in the baseline and intervention phases during the workshop / training sessions (mid-week).

The **Social Phobia Scale** (SPS; Mattick & Clarke, 1998) measures the anxiety in performance situations and assesses fear of scrutiny by others. It is a 20-items rated on a 5-point Likert Scale (0 to 4), ranging from "Not at all" (0) to "Extremely" (4), yielding a total score between 0 to 80.In an overview, the SPS scale discriminates well between individuals with social anxiety disorder, persons with other anxiety disorders, and community volunteers (Heimberg et al., 1992). The interpretation of the score will be that the higher the score the greater the social anxiety.

The **Social Interaction Anxiety Scale** (SIAS; Mattick & Clarke, 1998) measures anxiety regarding social interactions and assess social interaction anxiety. The SIAS is a 1-page Scale that contains 20-items rated on a 5-point Likert Scale (0 to 4), ranging from "Not at all" (0) to "Extremely" (4), yielding a total score between 0 to 80. In an overview, the SPS scale discriminates well between individuals with social anxiety disorder, persons with other anxiety

disorders, and community volunteers (Heimberg et al., 1992). The interpretation of the score will be that the higher the score the greater the social anxiety.

Both the SPS and the SIAS Scales have been shown to be internally consistent (as 0±88 to 0±94) and stable over time (re-test coefficients 0±90 (Mathhew & Clarke. 1998). The SPS and SIAS are typically administered together and treated as subscales of a larger measure of social anxiety.

The **Fear & Avoidance Heirarchy / Subjective Units of Discomfort Scale** (SUDS) is used to assess the participant's most difficult social situations. The Wolpe's 1982 subjective units of distress/ discomfort scale (SUDS) is a 1-page form and the dimension is a rating scale from 0 to 100%. The avoidance dimension is also a rating scale from 0 to 100%. Before using the SUDS scale, the client will list up to 10 most difficult social situations and gives SUDS and avoidance rating. During the process, the participant is asked to report how he is feeling in terms of his anxiety level for the 2 out of the10 most difficult social situations. This is preferably pertaining to the situation of the workshop / training presentation.

The participant also measured his **heart rate** using the Polar Heart Rate monitor. This is to get the indication of the increase heart rate at the start of the workshop / training and the subsequent 20 minutes workshop. The well-known symptoms of anxiety are heart palpitations with the increase beats per minute of the heart rate and the dryness of the mouth (Pargman, 2006). As study has shown that the high anxiety level is not sustainable as the heart rate cannot continue to be beating too fast for a long time as it is not physiologically possible (Watkins et al, 1998). The reading of the heart rate at the beginning of the workshop / training may indicate how anxious the participant is from the beginning of the case study as compared to the end of the programme.

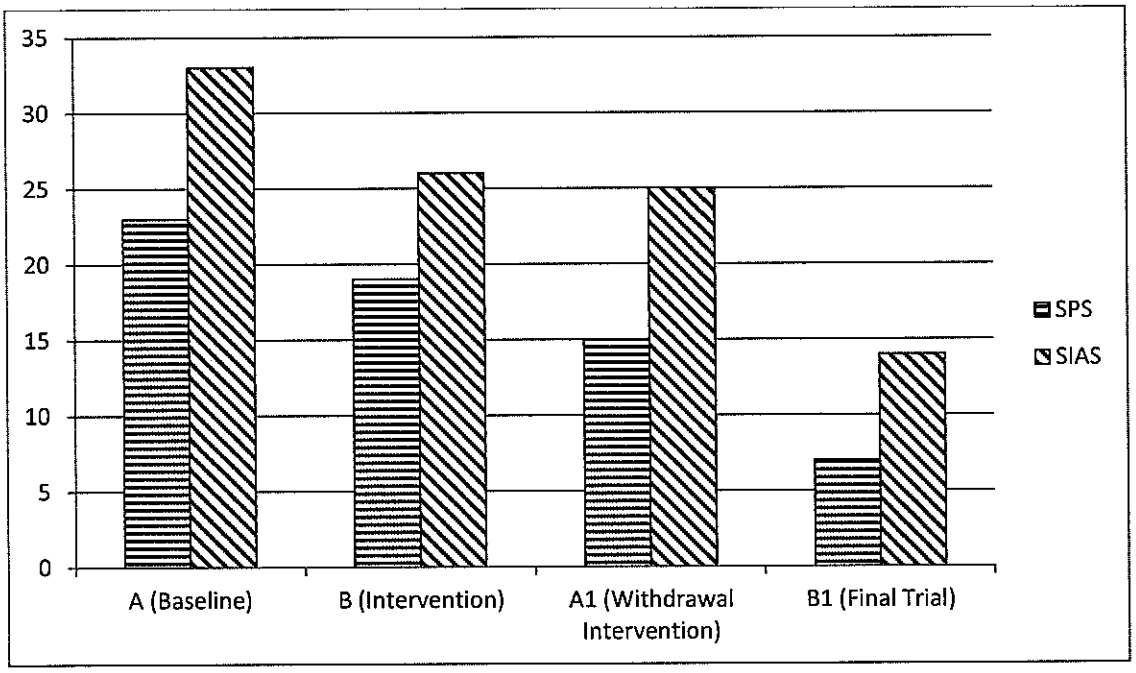
Results

There are evidences which have shown in the decrease of the participant's anxiety level based on the baseline data at the beginning of the CBT programme to the end of the programme. Figure 1, Figure 2 and Figure 3 show the summary of the levels of the Social Phobia Scale (SPS), the Social Interaction Anxiety Scale (SIAS), Subjective Units of Discomfort Scale (SUDS) and the Heart Rate respectively.

(i) SPS Score: With reference to the SPS Score (see Figure 1), in the A phase (or Baseline) readings recorded a high anxiety level score of 23. Then as the intervention started, the measurement at B phase (Intervention) recorded a drop of 17 % (Score at 19) for SPS. Consequently, the A_1 and the B_1 phases also indicated further drop in the anxiety level at 35% (Score at 15) and 70 % (Score at 7) respectively for both the readings as compared from the baseline reading at A Phase. Figure 1 below shows the graphical representation of the drop in score in the SPS Scale from A Phase (Baseline) to the B_1 (final trial). Even though there was a withdrawal of intervention in A_1 phase, the reading indicated a drop in the anxiety level.

(See also Appendices 1A to 1D showing the raw data collected by using the SPS for the 4 sessions / phases).

Figure 1: Bar graph showing anxiety level from Social Phobia Scale (SPS) and the Social Interaction Anxiety Scale (SIAS) for the ABA_1B_1 design



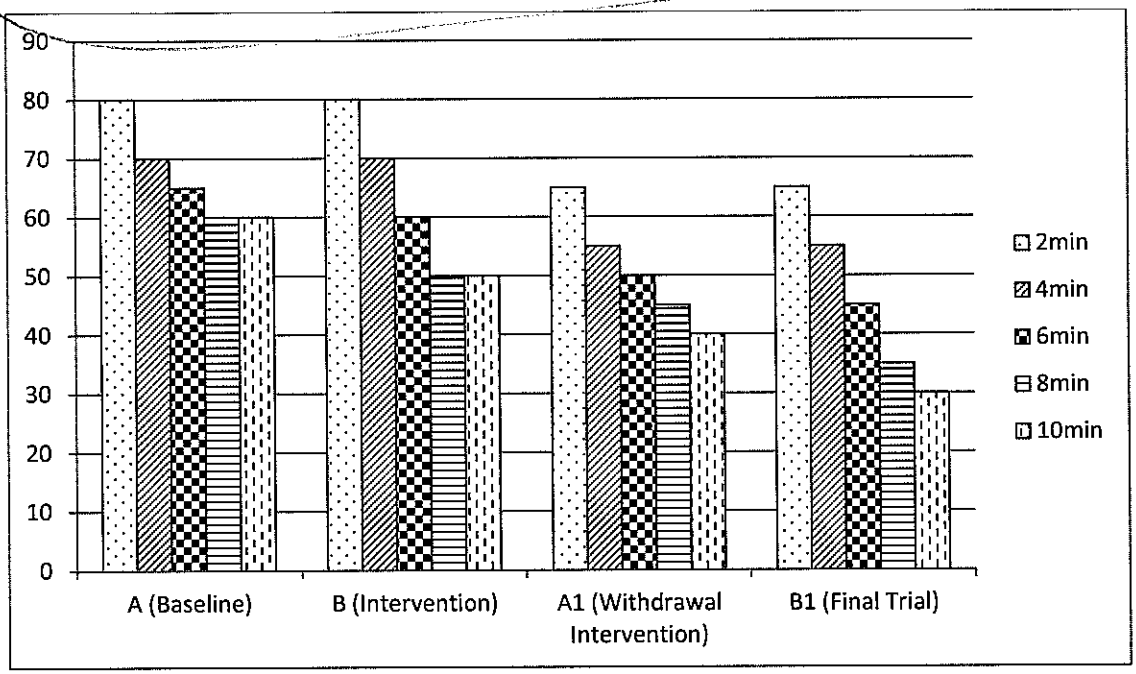
(ii) SIAS Score: With reference to the SIAS Score (see Figure 1 above), in the A phase (or Baseline) readings recorded a high anxiety level score of 33. Then as the intervention started, the measurement at B phase (Intervention) recorded a drop of 21 % (Score at 26) for SPS. Consequently, the A_1 and the B_1 phases also indicated further drop in the anxiety level at 24% (Score at 25) and 58 % (Score at 14) respectively for both the readings as compared from the baseline reading at A Phase. Figure 1 above shows the graphical representation of the drop in score in the SIAS Scale from A Phase (Baseline) to the B_1 (final trial).

(See also Appendices 2A to 2D showing the raw data collected by using the SIAS for the 4 sessions / phases)

(iii) SUDS Score: The participant listed top 10 difficult situations in which he had given a rating with regards to the SUDS score and the Avoidance Score (see Appendix 3). Then using the most difficult situation which is "To have eye contact with all participants of the workshop" the participant adapted the Exposure Session Assessment Form to give the SUDS Score for the first 10 minutes of the presentation (see Appendices 3A to 3D). For the SUDS score, there was a drop of 18% in the SUDS score from A phase (baseline) to the B1 phase for the first 2 minutes reading at the start of the workshop / training. At the end of 10 minutes of the lesson, there was a drop in SUDS score from A phase (baseline) to B1 phase of 50%.

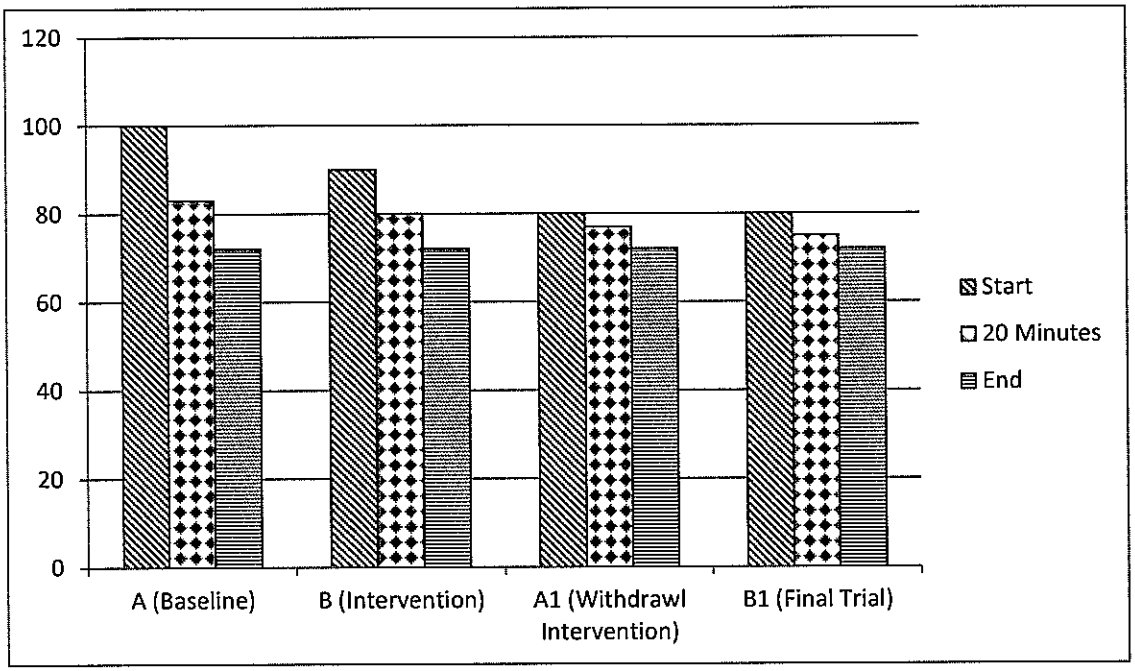
Figure 2 below summarises graphically the Scores for the SUDS taken at every 2 minutes of the first 10 minutes of the workshop presentation.

Figure 2: Bar graph showing the Subjective Units of Discomfort Scale (SUDS) for Exposure Session Assessment Form (For 10 minutes session)



(iii) Heart Rate Score: The participant's heart rate was taken by the using the Polar Heart Rate monitor for 3 readings in each of the 4 sessions / phases: (i) Start of the phase; (ii) at end of 20 minutes of the phase and (iii) at end of the workshop / training session of each phase (see Figure 3 below). The participant's heart rate shows a decline trend from A Phase (Baseline) to B1 Phase when taken at the start and at the end of the first 20 minutes of the workshop / training presentation. However there is no change at the end of the workshop / training, the heart rate remains the same to show the normalisation of the heart rate.

Figure 3: Bar graph showing the Heart Rate at "Start", at "20 minutes" and at "End" of the Workshop / Training in the ABA_1B_1 design



Discussion

The main objective of this case study is to use the CBT intervention strategies to assist the participant to lower his anxiety level when he is presenting in the workshop or training session. The intervention strategies which were used had benefited the participant as the results had shown a decrease in the level of anxiety from the baseline phase.

The case study had also shown that the decrease in the anxiety level results in the lowering of the heart rate even though there was no correspondingly decrease with the same percentage difference. The data collected showed that at the end of every workshop he conducted during the case study, the participant was experiencing a normalised heart rate. It was interesting

to note that at the 20 minutes interval, his heart rate was recorded lower than the heart rate at the "Start" for all the 4 phases. This could be indicative that the arousal state created by the anxiety was not sustainable and he could acknowledge that he would experience less anxious after the initial palpitations of the heart rate. In one experiment by Powell (2000), people whose anxiety was low or high did not perform as well as those in between (Blenkiron, 2010 pp. 117). Therefore the participant should use this opportunity to stay calm by telling himself to practise the relaxation technique such as the controlled breathing at the start of the workshop to help him lower the anxiety level through bringing down the heart rate level.

The self-monitoring by the participant may be a factor which increases the self-responsibility for the participant to be actively interested in wanting to succeed in the behavioural change experiment. According to Heidt and Marx (2003) due to the fact that self-monitoring is a relatively time-intensive task, one which requires a good deal of motivation on the part of the client, it may be less effective for individuals who have extremely hectic schedules. The participant was experiencing a hectic schedule for his full-time work and the part-time study in the Master of Social Science (Professional Counselling) during the four phases of the case study. Going through these phases would require extreme self-sacrifice and in itself could be an anxiety driven period which requires a lot of self-motivation and mental perseverance.

The Be Your Own Coach (BYOC) worksheet had been proven to be effective as the participant was made aware of the negative automatic thoughts and how he could translate those thoughts into something which would help in making the situation better which means lessen the anxiety level when speaking in the public and also to focus on the tasks. The awareness of the self-talk and also the cue for the relaxation training could also be among the contributors to the

drop of the anxiety level. (See appendices 4 and 4A for a sample of the input of the BYOC by the participant).

Limitations and Suggestions for Future Studies

Despite the noteworthy significant findings in this case study, there are limitations:

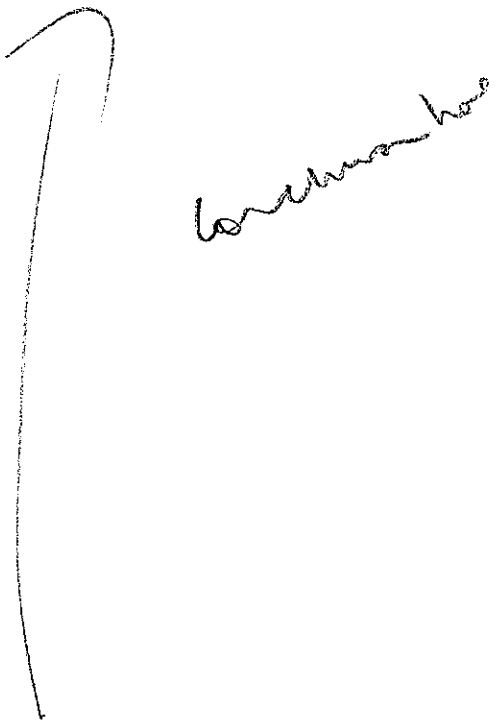
First, the A phase (baseline) was taken for only one session as a result for the lack of time as well as the number of session which the participant could have for the case study. By having only a single session to collect the baseline data would affect the period of having more data points to confirm the stability of the baseline data. Future study should have included longer observation of baseline data to give a more accurate reading with regards to baseline stability as suggested by methodologists (Kinugasa, Cerin and Hooper, 2004).

Second, the case study used a selection of CBT intervention strategies to increase the chance of success. However, the approach requires sustainability of the participant to motivate himself to continue with the techniques. Anxiety may come and go as human emotions and feelings are never consistent. The core belief and the automatic thoughts of the person may be influencing the individual to react in certain ways depending on the mood for the day. In future research, this should be mentioned in the study as moods influence the state of the mind of the participant.

Third, a single study design is particularly sensitive to the effect of the external variables. It would be important to account for this in a counselling setting, so that ineffective interventions are not maintained after initial success is accounted for by an extraneous variable, and effective interventions are not dismissed due to the presence of complicating extraneous variables. It is

necessary to interpret data carefully before reaching any conclusions in single-subject research (Kinugasa et al, 2004).

Fourth, the study did not state anything about the history of the participant's social anxiety and the effect of the interventions whether it could be sustained over a longer period. The case study dealt with the "here and now" with a limited period to experiment the change. However in reality this is a very simplistic scenario to overcome the social anxiety issue for the participant. The participant had never experienced the fear of public speaking until when he was in his mid-40s. As such it could be in agreement with a study in Singapore by Lim et al (2005) which states that the prevalence of anxiety increased in older individuals but has never been studied in details as many older people do not come forward to seek help about their generalised anxiety disorder. This can be an area for future study and how CBT can use to help to reduce older people who experienced anxiety that can be harmful to their daily functions.



Conclusion

The participant, who is currently an intern counsellor, has noted that the case study allows him to experience the need to be self-reliant and to be self-motivated to experience success when using CBT as an approach to helping clients. As Beck (2011 pp. 316) mentions that if we view ourselves as counsellor to be responsible to helping patients with every problem, we risk engendering or reinforcing dependence and deprive of the opportunity to test and strengthen the clients' skills.

The case study has allowed the participant to be in the shoes of a client as the behavioural change is authentic and he will recommend the process to those who need help in social anxiety due to public speaking in Singapore. As Maisel (2005, pp 212) mentions that the most useful and powerful way to gain self-awareness is to learn from own experience.

In any case, the goal in CBT is to facilitate remission of patients' disorders and to teach the client skills they can use throughout their lifetime (Beck, 2011). The experiential learning through the case study has enabled the participant to apply some of the tools which have been introduced in the classroom and thus benefited from the augmented learning experience which will not be easily forgotten. The participant will be able to disseminate and implement the evidence-based, effective cognitive-behavioural treatments for clients with social anxiety to lessen their suffering and stop the perpetuation of their symptoms.

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APPENDIX 1A

SOCIAL PHOBIA SCALE

(Mattick & Clarke, 1998)

For each question, please circle a number to indicate the degree to which you feel the statement is characteristic or true of you.

The rating scale is as follows:

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

		Not at all	Slightly	Moderately	Very	Extremely
1	I become anxious if I have to write in front of other people	0	(1)	2	3	4
2	I become self-conscious when using public toilets	(0)	1	2	3	4
3	I can suddenly become aware of my own voice and of others listening to me	(0)	1	2	3	4
4	I get nervous that people are staring at me as I walk down the street	0	1	(2)	3	4
5	I fear I may blush when I am with others	(0)	1	2	3	4
6	I feel self-conscious if I have to enter a room where others are already seated	0	1	2	(3)	4
7	I worry about shaking or trembling when I'm watched by other people	0	1	(2)	3	4
8	I would get tense if I had to sit facing other people on a train or a bus	0	1	2	(3)	4
9	I get panicky that others might see me faint, be sick or ill	(0)	1	2	3	4
10	I would find it difficult to drink something if in a group of people	(0)	1	2	3	4
11	It would make me feel self-conscious to eat in front of a stranger at a restaurant	(0)	1	2	3	4
12	I am worried people will think my behaviour odd	0	1	(2)	3	4
13	I would get tense if I had to carry a tray across a crowed cafeteria	0	1	(2)	3	4
14	I worry I'll lose control of myself in front of other people	0	(1)	2	3	4
15	I worry I might do something that would attract the attention of other people	0	(1)	2	3	4
16	When in an elevator, I am tense if people look at me	0	(1)	2	3	4
17	I can feel conspicuous standing in a line	(0)	1	2	3	4
18	I get tense when I speak in front of other people	0	1	2	(3)	4
19	I worry my head will shake and nod in front of others	(0)	1	2	3	4
20	I feel awkward and tense if I know people are watching me	0	1	(2)	3	4

Please circle YES or NO to the following two questions:

When in a feared social situation are you fearful of vomiting YES (NO)

When in a feared social situation are you fearful of urination or defecation YES (NO)

Total : 23

APPENDIX 1B

SOCIAL PHOBIA SCALE

(Mattick & Clarke, 1998)

For each question, please circle a number to indicate the degree to which you feel the statement is characteristic or true of you.

The rating scale is as follows:

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

		Not at all	Slightly	Moderately	Very	Extremely
1	I become anxious if I have to write in front of other people	(0)	1	2	3	4
2	I become self-conscious when using public toilets	(0)	1	2	3	4
3	I can suddenly become aware of my own voice and of others listening to me	(0)	1	2	3	4
4	I get nervous that people are staring at me as I walk down the street	0	(1)	2	3	4
5	I fear I may blush when I am with others	(0)	1	2	3	4
6	I feel self-conscious if I have to enter a room where others are already seated	0	1	(2)	3	4
7	I worry about shaking or trembling when I'm watched by other people	0	1	(2)	3	4
8	I would get tense if I had to sit facing other people on a train or a bus	0	1	(2)	3	4
9	I get panicky that others might see me faint, be sick or ill	(0)	1	2	3	4
10	I would find it difficult to drink something if in a group of people	(0)	1	2	3	4
11	It would make me feel self-conscious to eat in front of a stranger at a restaurant	(0)	1	2	3	4
12	I am worried people will think my behaviour odd	0	1	(2)	3	4
13	I would get tense if I had to carry a tray across a crowed cafeteria	0	1	(2)	3	4
14	I worry I'll lose control of myself in front of other people	0	(1)	2	3	4
15	I worry I might do something that would attract the attention of other people	0	(1)	2	3	4
16	When in an elevator, I am tense if people look at me	0	(1)	2	3	4
17	I can feel conspicuous standing in a line	(0)	1	2	3	4
18	I get tense when I speak in front of other people	0	1	2	(3)	4
19	I worry my head will shake and nod in front of others	(0)	1	2	3	4
20	I feel awkward and tense if I know people are watching me	0	1	(2)	3	4

Please circle YES or NO to the following two questions:

When in a feared social situation are you fearful of vomiting YES (NO)

When in a feared social situation are you fearful of urination or defecation YES (NO)

Total : 19

APPENDIX 1C

SOCIAL PHOBIA SCALE

(Mattick & Clarke, 1998)

For each question, please circle a number to indicate the degree to which you feel the statement is characteristic or true of you.

The rating scale is as follows:

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

		Not at all	Slightly	Moderately	Very	Extremely
1	I become anxious if I have to write in front of other people	(0)	1	2	3	4
2	I become self-conscious when using public toilets	(0)	1	2	3	4
3	I can suddenly become aware of my own voice and of others listening to me	(0)	1	2	3	4
4	I get nervous that people are staring at me as I walk down the street	0	(1)	2	3	4
5	I fear I may blush when I am with others	(0)	1	2	3	4
6	I feel self-conscious if I have to enter a room where others are already seated	0	(1)	2	3	4
7	I worry about shaking or trembling when I'm watched by other people	0	(1)	2	3	4
8	I would get tense if I had to sit facing other people on a train or a bus	0	1	(2)	3	4
9	I get panicky that others might see me faint, be sick or ill	(0)	1	2	3	4
10	I would find it difficult to drink something if in a group of people	(0)	1	2	3	4
11	It would make me feel self-conscious to eat in front of a stranger at a restaurant	(0)	1	2	3	4
12	I am worried people will think my behaviour odd	0	1	(2)	3	4
13	I would get tense if I had to carry a tray across a crowed cafeteria	0	1	(2)	3	4
14	I worry I'll lose control of myself in front of other people	0	(1)	2	3	4
15	I worry I might do something that would attract the attention of other people	0	(1)	2	3	4
16	When in an elevator, I am tense if people look at me	(0)	1	2	3	4
17	I can feel conspicuous standing in a line	(0)	1	2	3	4
18	I get tense when I speak in front of other people	0	1	(2)	3	4
19	I worry my head will shake and nod in front of others	(0)	1	2	3	4
20	I feel awkward and tense if I know people are watching me	0	1	(2)	3	4

Please circle YES or NO to the following two questions:

When in a feared social situation are you fearful of vomiting YES (NO)

When in a feared social situation are you fearful of urination or defecation YES (NO)

Total : 15

APPENDIX 1D

SOCIAL PHOBIA SCALE

(Mattick & Clarke, 1998)

For each question, please circle a number to indicate the degree to which you feel the statement is characteristic or true of you.

The rating scale is as follows:

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

		Not at all	Slightly	Moderately	Very	Extremely
1	I become anxious if I have to write in front of other people	(0)	1	2	3	4
2	I become self-conscious when using public toilets	(0)	1	2	3	4
3	I can suddenly become aware of my own voice and of others listening to me	(0)	1	2	3	4
4	I get nervous that people are staring at me as I walk down the street	(0)	1	2	3	4
5	I fear I may blush when I am with others	(0)	1	2	3	4
6	I feel self-conscious if I have to enter a room where others are already seated	0	(1)	2	3	4
7	I worry about shaking or trembling when I'm watched by other people	0	(1)	2	3	4
8	I would get tense if I had to sit facing other people on a train or a bus	0	(1)	2	3	4
9	I get panicky that others might see me faint, be sick or ill	(0)	1	2	3	4
10	I would find it difficult to drink something if in a group of people	(0)	1	2	3	4
11	It would make me feel self-conscious to eat in front of a stranger at a restaurant	(0)	1	2	3	4
12	I am worried people will think my behaviour odd	0	(1)	2	3	4
13	I would get tense if I had to carry a tray across a crowed cafeteria	0	(1)	2	3	4
14	I worry I'll lose control of myself in front of other people	(0)	1	2	3	4
15	I worry I might do something that would attract the attention of other people	(0)	1	2	3	4
16	When in an elevator, I am tense if people look at me	(0)	1	2	3	4
17	I can feel conspicuous standing in a line	(0)	1	2	3	4
18	I get tense when I speak in front of other people	0	(1)	2	3	4
19	I worry my head will shake and nod in front of others	(0)	1	2	3	4
20	I feel awkward and tense if I know people are watching me	0	(1)	2	3	4

Please circle YES or NO to the following two questions:

When in a feared social situation are you fearful of vomiting YES (NO)

When in a feared social situation are you fearful of urination or defecation YES (NO)

Total : 7

APPENDIX 2A

THE SOCIAL INTERACTION ANXIETY SCALE

(Mattick & Clarke, 1998)

For each question, please circle a number to indicate the degree to which you feel the statement is characteristic or true of you.

The rating scale is as follows:
0 = Not at all - characteristic or true of me
1 = Slightly - characteristic or true of me
2 = Moderately - characteristic or true of me
3 = Very - characteristic or true of me
4 = Extremely - characteristic or true of me

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

Total : 32

APPENDIX 2B

THE SOCIAL INTERACTION ANXIETY SCALE

(Mattick & Clarke, 1998)

For each question, please circle a number to indicate the degree to which you feel the statement is characteristic or true of you.

The rating scale is as follows:
0 = Not at all - characteristic or true of me
1 = Slightly - characteristic or true of me
2 = Moderately - characteristic or true of me
3 = Very - characteristic or true of me
4 = Extremely - characteristic or true of me

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

Total : 26

APPENDIX 2C

THE SOCIAL INTERACTION ANXIETY SCALE

(Mattick & Clarke, 1998)

For each question, please circle a number to indicate the degree to which you feel the statement is characteristic or true of you.

The rating scale is as follows:

0 = Not at all - characteristic or true of me
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3 = Very - characteristic or true of me
4 = Extremely - characteristic or true of me

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

Total : 25

APPENDIX 2D

THE SOCIAL INTERACTION ANXIETY SCALE

(Mattick & Clarke, 1998)

For each question, please circle a number to indicate the degree to which you feel the statement is characteristic or true of you.

The rating scale is as follows:

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2 = Moderately - characteristic or true of me
3 = Very - characteristic or true of me
4 = Extremely - characteristic or true of me

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

Total : 14

APPENDIX 3

Swinburne Psychology Clinic

FEAR AND AVOIDANCE HIERARCHY

Subjective Units of Discomfort Scale (SUDS)

0 5 10 15	20 25 30 35	40 45 50 55 60	65 70 75 80	85 90 100
No Anxiety Calm Relaxed	Mild Anxiety Alert able to cope	Moderate Anxiety Some trouble concentrating	Severe Anxiety Thoughts of leaving	Very Severe Anxiety Worst ever experience

Avoidance Rating

0 5 10 15	20 25 30 35 40	45 50 55 60 65	70 75 80	85 90 100
Never Avoid	Avoid once in a while	Avoid sometimes	Usually Avoid	Always Avoid

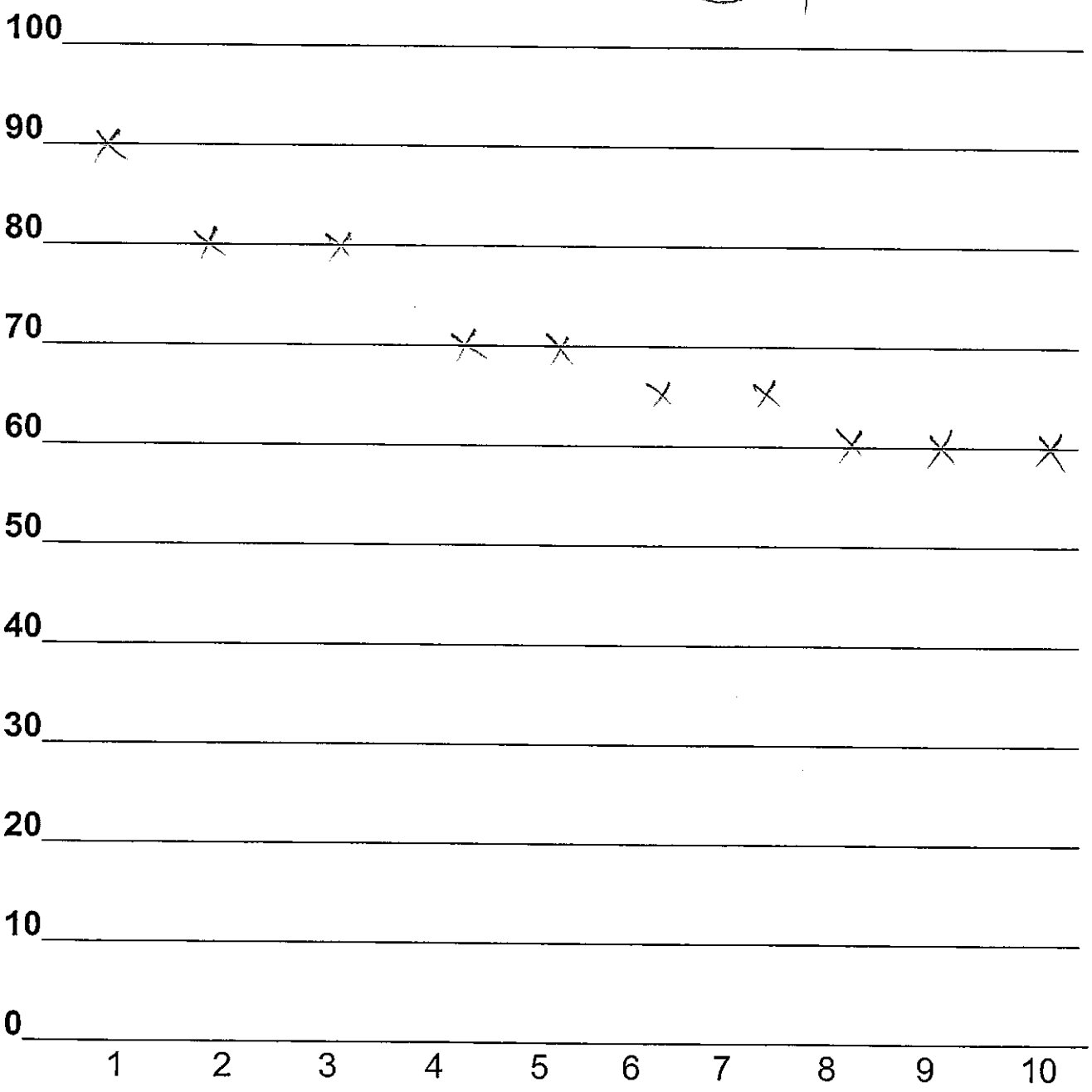
SITUATION	SUDS	AVOIDANCE
#1. most difficult situation is to have eye contact with all the participants at the beginning of the workshop.	90	100
#2. most difficult situation is to speak slowly and clearly in front of a group of strangers participants	80	90
#3. most difficult situation is to introduce myself individually to a group of strangers	70	70
#4. most difficult situation is to recollect the sequence of event after introducing myself to the aro.	65	65
#5. most difficult situation is to ask question to get the class going	60	60
#6. most difficult situation is to response to a question unexpectedly	55	55
#7. most difficult situation is to walk from one end of the room to another in front of participants	50	50
#8. most difficult situation is to write on the whiteboard the participants response	45	45
#9. most difficult situation is to rephrase the participants response to the class verbally	40	40
#10. most difficult situation is to counter argue a point raise by participant	30	30

Swinburne Psychology Clinic

Exposure Session Assessment

NAME A Phase (Baseline)

Nature of exposure Workshop Presentation: To have eye contact with all participants during the introductory part of workshop.

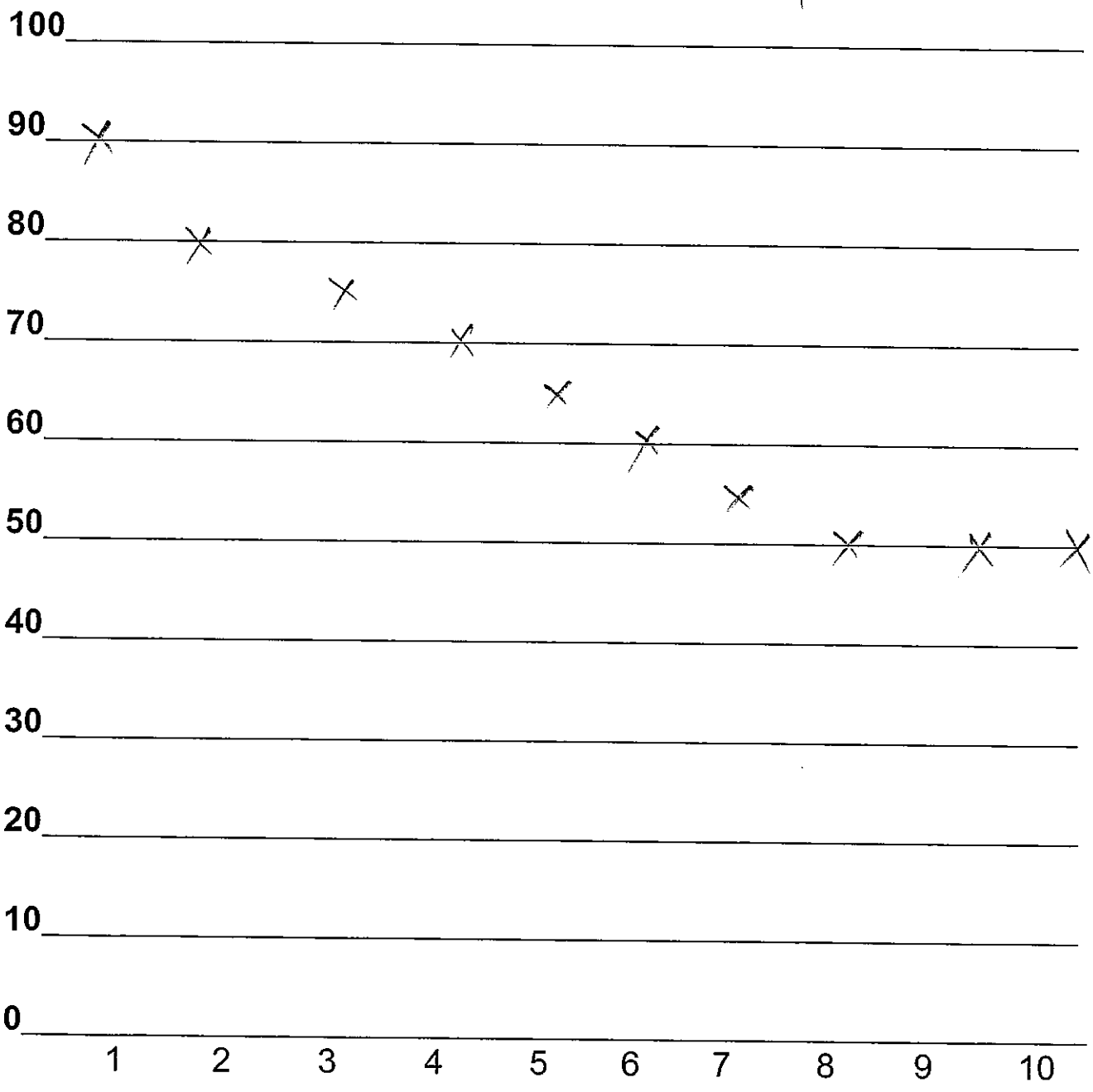


Swinburne Psychology Clinic

Exposure Session Assessment

NAME B Phase (With Intervention)

Nature of exposure Workshop presentation; To have eye contact with all participants during the introductory part of workshop

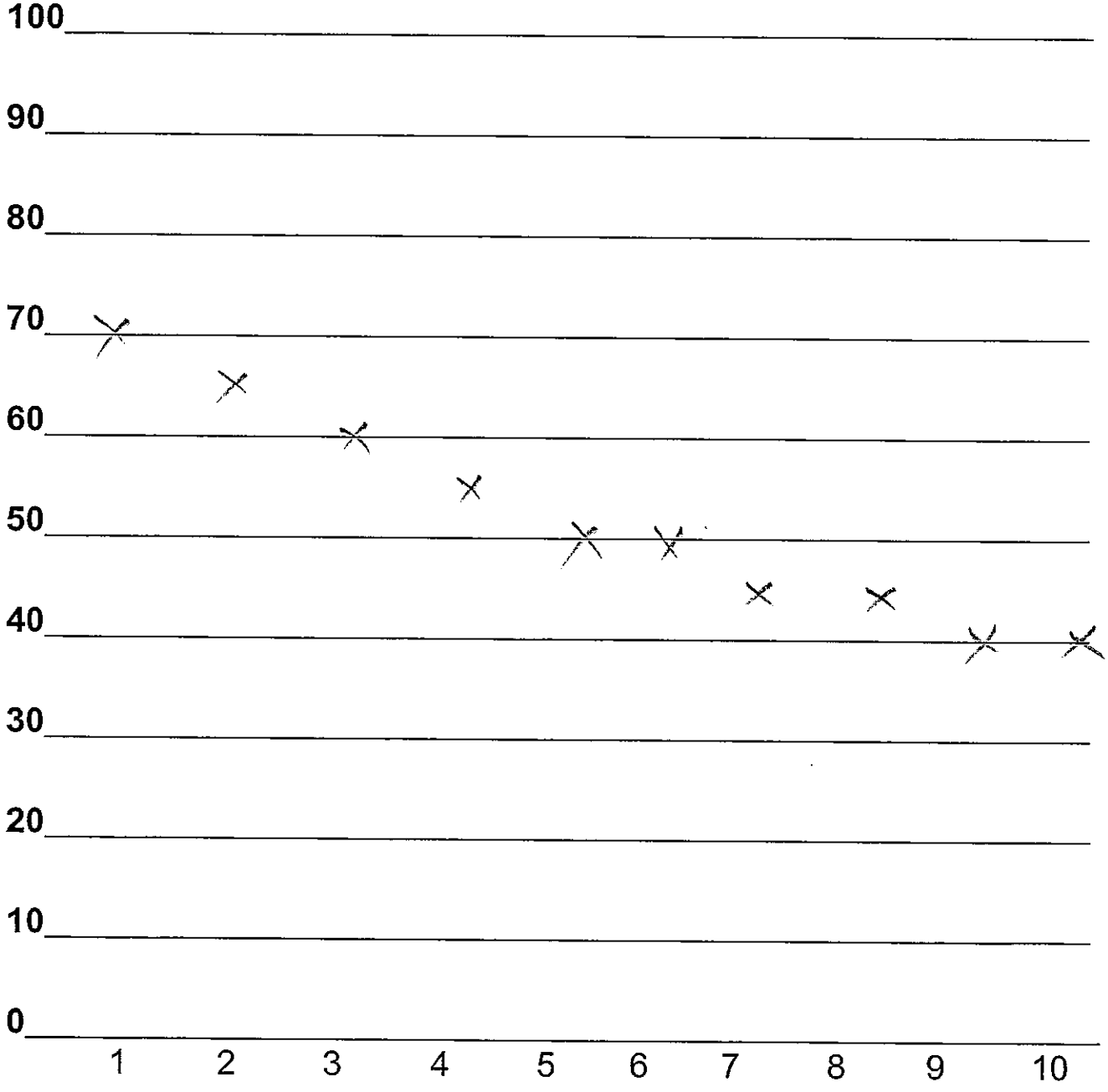


Swinburne Psychology Clinic

Exposure Session Assessment

NAME A1 Phase

Nature of exposure Workshop Presentation: To have eye contact with all participants during the introductory part of workshop.

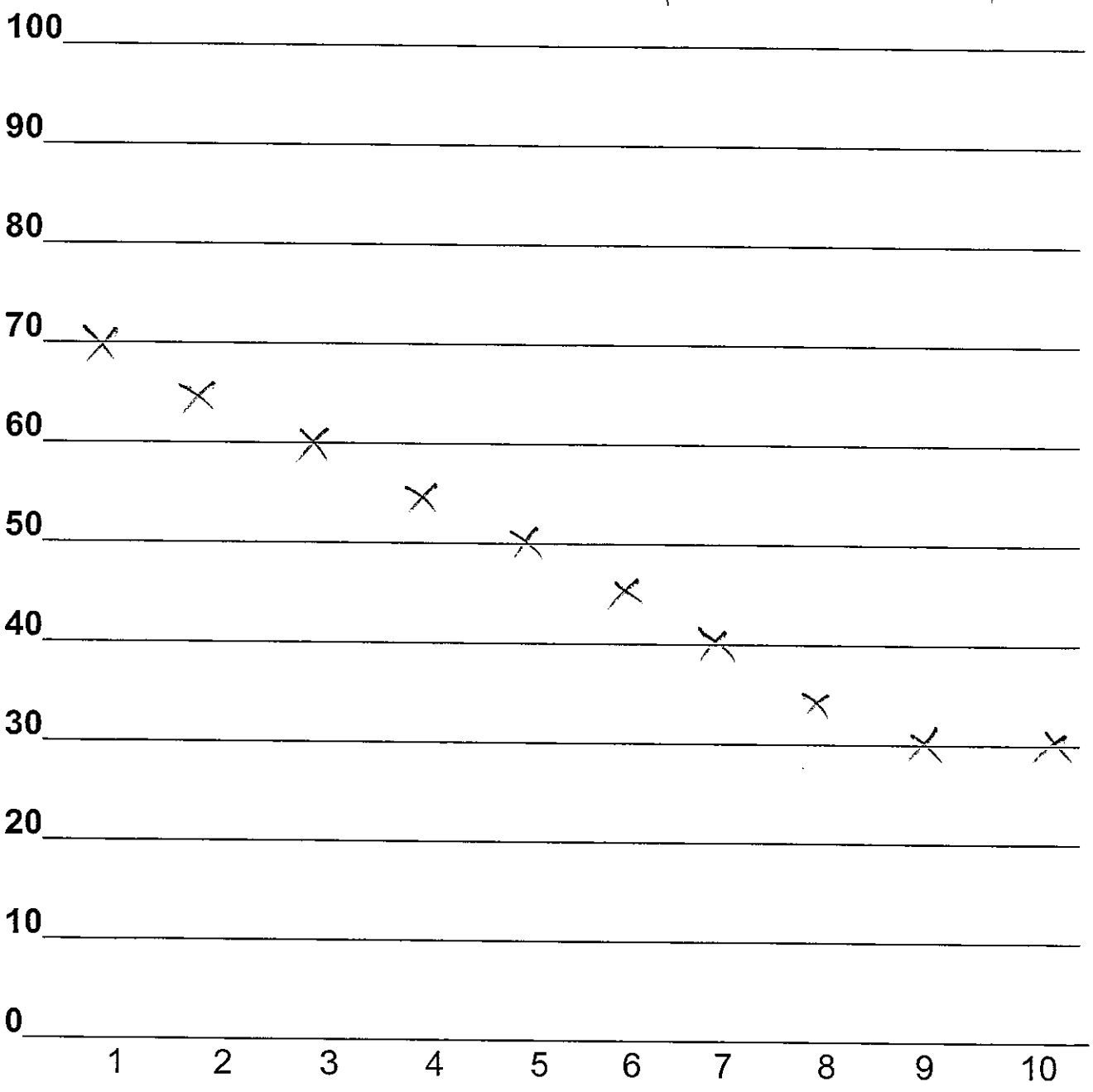


Swinburne Psychology Clinic

Exposure Session Assessment

NAME B1 Phase

Nature of exposure Workshop Presentation: To have eye contact with all participants during the introductory part of workshop.



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APPENDIX 4

Be Your Own Cognitive Coach (BYOCC) Worksheet

PREPARATION BEFORE THE EXPOSURE

1. Situation *(Briefly describe the anxiety-provoking situation)* Date 24th June 2015

Public Speaking (Workshop Presentation)

2. Automatic Thoughts (ATs)
(List the thoughts you have about this situation)

They will think I am boring and not value-adding their experience.

3. Thinking Errors (See list below)

Catastrophising

Emotions You Feel as You Think These Thoughts
(circle those that apply)
anxious & nervous, angry, frustrated, sad, irritated
embarrassed, ashamed, hateful, other_____

Thinking Errors
All-or-Nothing Thinking, Overgeneralization
Mental Filter, Disqualifying the Positive,
Mind Reading, Fortune Telling,
Catastrophising, Emotional Reasoning,
Should Statements, Labeling,
Maladaptive Thoughts

4. Challenges (Using the Disputing Questions below, challenge the most important AT(s) you listed above. Be sure to answer the question raised by the Disputing Question.)

Disputing Questions:
Do I know for certain that I am boring? What evidence do I have that I am boring?
Am I 100% sure that I am boring? Is there another explanation for being boring?
What is the worst that can happen if I am boring? How bad is that? Do I have a crystal ball?
Does boring have to lead to or equal to be successful? Is there another point of view?

5. Rational Response(s):
Summarise the challenges into a rational statement to use to combat the AT.)

I can use humour to create fun.
I can give personal examples and also ask them to share theirs.

6. Achievable Behavioural Goal
(Something that is do-able and can be seen by others)

Sharing of their experiences rather than just listening to my story.

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Be Your Own Cognitive Coach (BYOCC) Worksheet

DEBRIEFING AFTER THE EXPOSURE

7. Did you achieve your goal? *(Watch out for disqualifying the Positive!)*

Yes ; there were a lot of interactions. Therefore not boring.

8. Review the ATs you had during the exposure.

Expected ATs *(The ATs you had that you expected to have)*

My lesson is boring.

How well did the Rational Response(s) combat these ATs? *(Revise if necessary)*

Extremely well. Using humour and sharing their experience with each other helped to make lively lesson.

Unexpected ATs (*Challenge and develop Rational Responses for these for next time)*

None. Too busy focusing on making lesson interesting.

9. What did you learn? *(Summarise – main points you learned from this exposure that you can use in the future.)*

- Always back-up the ATs with evidence.
- Use creativity to challenge the automatic thoughts to make it more positive and helpful to the behaviour.

Remember, you are Investing Anxiety for a Calmer Future