# Social Anxiety Treatment **via Telehealth**

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# Pros of virtual treatment of SAD

- Access to trained therapists (particularly in nonmetropolitan areas)
- Convenience regarding time, transportation and cost
- Helps mitigate concerns regarding social stigma and fear of negative evaluation
- Provides options for different types of exposures (i.e., exposure to sharing about personal items)
- In vivo feedback from self-view when utilizing videoconferencing platforms such as Zoom
- It allows the use of screen sharing as well as chat function if desired, and for groups, it allows break-out rooms
- Matches the communication modality of the most common age group that seeks treatment
- May lower the barrier for seeking treatment for those who prefer online communication (fear of failure↓ , self-esteem↑ when communicating using preferred medium)

# Cons of virtual treatment of SAD

- Lack of multisensory experience, reduced information for therapist; possibly, but not necessarily, reduced exposure for client
- Potential technical difficulties
- For groups, limited observance of nonverbal communication and technical hassle with breakout rooms for dyad or triad conversations
- Limits group size, both because it's harder to keep track of reactions and to have "air time" for everyone. Optimal 4-7.
- Other Telehealth-related concerns that are not specific to SAD (ethical, legal concerns, etc.)

# Virtual reality and prepandemic research

- **How much does "real life" translate into virtual reality?**

For example, a study completed in virtual reality showed that socially anxious individuals do show avoidance behaviors even in virtual reality environments (i.e., if an avatar stopped in front of the participant, participants avoided gaze contact and backward head movements) (Wieser et al., 2010).

Another study showed that SAD symptoms reduced after virtual reality treatment and participants exhibited greater activity in brain regions responsible for self-referential and autobiographical memory processes while viewing positive words during postintervention fMRI scans. Interestingly, the greater the blood oxygen level dependent changes related to positive self-referential processing, the lower the SA (Hur et al. 2021).

- **Virtual exposure can be effective**

A study comparing virtual reality exposure and traditional exposure therapy for public speaking (as compared to the control group) found that there were significant improvements one year later for both exposure arms when compared to the waitlisted control group and no differences on outcome measures between active treatment groups, except the virtual group showed somewhat less reduced fear of negative evaluation (Anderson et al., 2013).

Another small study in Second Life (Yuen et al., 2013) found significant (pretreatment to follow-up) improvements in social anxiety symptoms, depression, disability and quality of life.

An article reviewing RCT-s of virtual reality exposure therapy suggested that there were no significant differences in efficacy between cognitive behavior therapy and virtual reality exposure therapy (Emmelkamp et al., 2020).

# Postpandemic research

- Lacks RCT-s! A Dutch 15-week RCT explored face-to-face CBT in comparison to blended face-to-face CBT and asynchronous iCBT protocol that patients completed in their own time, showing improvement in both groups (Romjin et al., 2021). Another, Swedish trial explored iCBT for children and adolescents facilitated by therapist with more general iSUPPORT and found iCBT more effective (Nordh et al. 2021). Neither researched Telehealth directly.
- A preliminary study by exploring an 8-week Telehealth protocol concluded that the Telehealth modality was feasible to implement in an outpatient mental health clinic, acceptable to participants, and associated with reduction in symptoms of social anxiety, general anxiety, depression, and stress.
- Warnock-Parkes et al. (2020) suggested that treating social anxiety disorder remotely with cognitive therapy allows the adaptation of all the key features of face-to-face therapy (including video feedback, attention training, behavioral experiments and memory-focused techniques) can be adapted for remote delivery. They also provide helpful tips for clinicians.
- An article discussing Telehealth exposure-based group sessions for SAD (Peros et al., 2021) also reviewed the benefits and challenges in detail.

# Translating SAD treatment to Telehealth:
## Interventions that lend themselves well to virtual settings

- Psychoeducation (cognitive model, what maintains and what improves social anxiety; the function of emotions and how people connect based on emotions)
- In individual settings, using the therapeutic relationship as basis for work, e.g., testing hypotheses, practicing disclosure, fact-checking, modeling emotionally meaningful ways of connecting and so on)
- In group settings, fostering group members' connections to each other, teaching "social cement strategies" such as sharing, asking questions, giving compliments
- Fostering asking questions, giving/receiving feedback etc.
- Teaching, modeling and practicing social skills, including assertiveness skills
- Teaching and practicing mindfulness and grounding skills (past-present-future metaphor)
- Teaching distress tolerance skills
- Trouble shooting of challenging situations (family parties, work functions, etc.); having a simple 2-3 step plan
- Cognitive restructuring/ reframing strategies
- Modeling validation and normalization
- Behavioral experiments
- Encouraging people to come up with individualized exposures that are relevant for them, in groups potentially making it a group challenge (e.g., public speaking with feedback, or buying adult diapers)
- Shaping and reinforcement

# Different levels of psychological intervention

(not particular to Telehealth, but especially important due to limited nonverbal and personal contact)

- Intrapsychological/individual:
- "What were you worried might happen if you approached that girl?"
- "What makes it hard for you to initiate conversations?"
- Interactional/interpersonal:
- "What was it like for you to give me feedback?"
- "Do you experience any difficulties connecting to others in this group?"
- "How did you relate to what Y just shared about the fear of rejection?"
- Group or dyad as a system:
- "How would you describe us as a team working together?"
- "What are some of the strengths that you see when you look at this group?"
- "How do you feel about coming to this group?"

In the group, we want to do most of the work on the interactional and group level, otherwise it becomes individual therapy. In individual therapy it can be tempting to rely on just individual level, but using other levels gives the work different kind of depth and perspective.

# First session structure for 1-hour weekly group

(session duration can range - there could be 45-minute groups; most people get tired and overwhelmed by an hour and half)

- Introduction

  (Structured, i.e., "Tell us three things about yourself;" group leader sets the example so be purposeful. If you talk about dogs, everyone will mention pets)

- Group rules and agreement

  (Attendance rules, confidentiality, not having sessions in public places, behavioral rules – e.g., what if they happen to meet outside the group with other people present)

- Creating safety

  ("What is that you don't want to happen in this group?"; "imagine it was the worst group ever, what went wrong?")

- Individual and group goals

  ("Imagine it was the best group ever; what went right?"; "What is it that you do want to happen in this group?"; tie the goals together for the whole group)

- Introduce a weekly commitment between sessions

  (an exposure, homework task, etc.)

# Sample structure for ongoing group

- 1. Group members check in (social highlights and lowlights, facilitate sharing by others). NOT individual therapy!
  - “Who else has experienced a situation like that?” "What thoughts or feelings came up for you as you listened to X sharing?

- 2. Psychoeducational piece or skill teaching:
  - A concept, strategy, skill that you would normally focus on even in individual CBT
  - It can be pre-planned or derive from what people shared
  - Most effective if you identify a common theme from what group members are working on

- 3. Application of learning - usually practice of social, mindfulness and/or emotion regulation skills
  - Discussion on how a certain concept applies to their life
  - Practice of assertiveness skills, role plays of difficult situations
  - Practice slowing down speech pace and lowering voice to regulate emotions
  - Practice disclosure / “opposite action” to shame
  - Practice small talk, asking questions
  - Practice making a choice ("choose someone to ask a question that interests you…?")
  - Practice asking for, sharing and giving feedback – e.g., what is it like to be in this group, “How do I come across?”
  - Practice receiving personal feedback - “What is it like for you to hear what others are saying?"
  - Practice of “social double” – e.g., "How would other people in the group handle that? What would you do in X’s shoes?”

- 4. What's going to be your commitment/homework this week?
  - Actionable step or risk that people are willing to take
  - Help set realistic commitments; ask how likely they are to follow through with it; if less than 90%, troubleshoot

- 5. Wrap-up/closure: (can be a phrase or longer depending on how much time is left)
  - "What was it like for you to be in the group today?“; "What are you taking from the group?"
  - "Share one word/phrase/sentence that summarizes your experience in the group today"

# Addressing possible problematic situations in group settings

- Connection cuts off ☺ - have a plan or a co-leader
- Someone shares something triggering
- Someone does not connect to the group
- Someone misses group often
- Someone does not speak up
- Someone starts giving unasked advice
- Other…?

# Therapist Pitfalls

- We may fail to see individual behavior as an indication of a system level problem.
- We start to do serial individual therapy - relating to each member but not helping them relate to each other.
- We may tend to give too much feedback as therapists, thus maintaining the power role of the evaluator; instead we should aim to shift the evaluator role to themselves - "How do you think you did in that situation?" - and reinforce adaptive coping without patronizing or evaluating - "Looks like using compliments helped you to connect to your coworkers."
- We may forget to ask for feedback for ourselves; people with social anxiety may not volunteer it!
- We may focus too much on problems and problem-solving and forget to allow for some easy, playful connection and discussion of similarities such as hobbies or passions.
- We fail to recognize skills and strengths, and use shaping in an appropriate manner. If someone said they thought about talking to a co-worker, went by their cubicle but then retreated – we want to reinforce the fact that they took the steps in that direction, figuratively and literally.
- We may forget to ask for permission before feedback or advice is given.
- We may facilitate a "poly-anna" type of atmosphere where people feel forced to only share positive things or give positive feedback to each other if an honest question is asked ("Do I come across intimidating?"). Distorted feedback protects from reality and doesn't facilitate adaptation.

# References


- Anderson, P. L., Price, M., Edwards, S. M., Obasaju, M. A., Schmertz, S. K., Zimand, E., & Calamaras, M. R. (2013). Virtual reality exposure therapy for social anxiety disorder: a randomized controlled trial. *Journal of Consulting and Clinical Psychology, 81*(5), 751–760. https://doi.org/10.1037/a0033559
- Emmelkamp, P., Meyerbröker, K., & Morina, N. (2020). Virtual Reality Therapy in Social Anxiety Disorder. *Current Psychiatry Reports, 22*(7), 32. https://doi.org/10.1007/s11920-020-01156-1
- Hur, J. W., Shin, H., Jung, D., Lee, H. J., Lee, S., Kim, G. J., Cho, C. Y., Choi, S., Lee, S. M., & Cho, C. H. (2021). Virtual Reality-Based Psychotherapy in Social Anxiety Disorder: fMRI Study Using a Self-Referential Task. *JMIR Mental Health, 8*(4), e25731. https://doi.org/10.2196/25731
- Nordh, M., Wahlund, T., Jolstedt, M., Sahlin, H., Bjureberg, J., Ahlen, J., Lalouni, M., Salomonsson, S., Vigerland, S., Lavner, M., Öst, L.-G., Lenhard, F., Hesser, H., Mataix-Cols, D., Högström, J., & Serlachius, E. (2021). Therapist-guided Internet-delivered cognitive behavioral therapy vs Internet-delivered supportive therapy for children and adolescents with social anxiety disorder: A randomized clinical trial. *JAMA Psychiatry, 78*(7), 705–713. https://doi.org/10.1001/jamapsychiatry.2021.0469
- Peros, O. M., Webb, L., Fox, S., Bernstein, A., & Hoffman, L. (2021). Conducting Exposure-Based Groups via Telehealth for Adolescents and Young Adults With Social Anxiety Disorder. *Cognitive and behavioral practice, 28*(4), 679–689. https://doi.org/10.1016/j.cbpra.2021.04.001
- Romijn, G., Batelaan, N., Koning, J., van Balkom, A., de Leeuw, A., Benning, F., Hakkaart van Roijen, L., & Riper, H. (2021). Acceptability, effectiveness and cost-effectiveness of blended cognitive-behavioural therapy (bCBT) versus face-to-face CBT (ftfCBT) for anxiety disorders in specialised mental health care: A 15-week randomised controlled trial with 1-year follow-up. *PloS One, 16*(11), e0259493. https://doi.org/10.1371/journal.pone.0259493
- Warnock-Parkes, E., Wild, J., Thew, G., Kerr, A., Grey, N., Stott, R., . . . Clark, D. (2020). Treating social anxiety disorder remotely with cognitive therapy. *The Cognitive Behaviour Therapist, 13*, E30. doi:10.1017/S1754470X2000032X
- Wieser, M. J., Pauli, P., Grosseibl, M., Molzow, I., & Mühlberger, A. (2010). Virtual social interactions in social anxiety--the impact of sex, gaze, and interpersonal distance. *Cyberpsychology, Behavior and Social networking, 13*(5), 547–554. https://doi.org/10.1089/cyber.2009.0432
- Yuen, E.K., Herbert, J.D., Forman, E.M., Goetter, E.M., Comer, R., Bradley, J.C. (2013). Treatment of social anxiety disorder using online virtual environments in second life. *Behavior Therapy, 44*(1),51-61. doi: 10.1016/j.beth.2012.06.001.