COGNITIVE BEHAVIORAL GROUP THERAPY FOR SOCIAL ANXIETY – REVIEW OF RECENT RESULTS

JULIE WOJTASZEK, MHSA, MS

5/16/25

AGENDA

- CBGT Overview
- Critical Review Overview
  - Study Results
  - Session Structure
  - Manuals
  - Measures
  - Group Facilitator Competence
- CBGT Strengths & Opportunities

CBGT TREATMENT STRUCTURE AND BENEFITS

- ❖ CBT is the current gold standard treatment for SAD
- ❖ Primary modes of CBT treatment for SAD are group, individual, or a combination of both
- ❖ Benefits of group therapy (CBGT) include:
  - Participants can engage in exposures together and learn from one another[1]
  - Normalization of symptoms, a sense of belonging, mutual support, and increased accountability to complete homework[2]
  - Can also be more cost-effective and thus more accessible for participants as rates for group therapy are usually lower[3]

[1] Hofmann & Otto (2008) [2]Barkowski et al. (2016); Colhoun et al. (2021) [3]Nauphal et al. (2021)

TREATMENT EFFICACY

CBGT is effective not only in reducing SAD symptoms, but also common comorbidity symptoms, and in improving participants' overall functioning and quality of life

- A recent meta-analysis of CBGT randomized wait-list control trials found **moderate to large effect sizes** for change in SAD symptoms and general psychopathology such as depression and general anxiety[1]

- CBGT was **superior to treatment utilizing common factors** in the reduction of SAD symptoms, but not overall psychopathology

- It was found to be **equivalent to individual therapy and pharmacotherapy**

[1] Barkowski et al. (2016)

TREATMENT EFFICACY

- Studies evaluating **change in quality of life** with CBGT are less common but several recent studies found significant pre to post-improvement[1]
- Evaluations of **change in functioning** (e.g., social, occupational) are also not as common but several recent CBGT studies have evaluated this factor finding:
  - significant improvement from CBGT for those with SAD[2]
  - changes in social functioning may be predicted by changes in SAD or depression symptoms[3]

[1] Abeditehrani et al. (2023); Hayes-Skelton & Lee (2018) [2] Asher et al. (2017); Colhoun et al. (2021)
[3] Ogawa et al.(2020)

MODERATORS AND MEDIATORS

Moderators

- Gender[1]
- Level of perfectionism[2]
- Level of functional impairment and/or readiness for change[3]
- Recent review found that only the severity of symptoms and fear of negative evaluation moderated outcomes across multiple studies[4]

Mediators

- Reductions in self-focused attention, anticipatory processing, and post-event processing[5]
- Changes in perceived social cost[6]
- Decreases in fear of negative evaluation[7]

[1]Asher et al. (2019) [2]Hawley et al. (2016) [3]Peters et al. (2019) [4]Erceg-Hurn et al.(2023)
[5]Hedman et al. (2013) [6]Hoffmann (2004) [7]Auyeung et al. (2020)

MECHANISMS OF CHANGE

Mechanisms

- Cognitive reappraisal, where individuals change their interpretations of events as part of cognitive restructuring[1]
- Decentering, where individuals de-identify with their thoughts[2]
- Emotion regulation[3]
- Current research often does not identify whether unique or shared mechanisms impact the improvement of SAD symptoms, comorbid symptoms, quality of life, and changes in functioning

Further research is needed to identify and confirm moderators, mediators, and mechanisms to improve CBGT treatment since many of the current findings have not been replicated

[1]Kocovski et al. (2015) [2]Hayes-Skelton & Lee (2018) [3]Goldin et al. (2021)

TREATING SAD – CBT COMPONENTS[1]

Psychoeducation

- Overview of social anxiety symptoms, prevalence, and outcomes
- SAD conceptual model
- Description of the treatment process

Cognitive Restructuring

- Identify automatic thoughts and cognitive distortions
- Challenge maladaptive thoughts

Exposure / Behavioral Experiments[2]

- Exposure to the feared situation through in office and in vivo assignments
- Experiments designed to test whether their predictions about a situation are true

Social Skills Training

- Sometimes included to address deficits
- Could be a stand-alone component or incorporated into other components

[1]Heimberg and Becker (2002) [2]Clark and Wells(1995)

BARRIERS TO TREATMENT SUCCESS

- Access to treatment
- Lack of time for treatment
- Scheduling conflicts
- Cost
- Not seeing progress quickly enough

Goetter et al. (2020); Hansen et al. (2024); LeBlanc et al. (2020); O'Shannessy et al., 2023; Öst & Ollendick (2017); Pincus et al. (2014); Spence & Rapee (2016)

ACCEPTABILITY

Average attrition rates for traditional CBGT for SAD are around **20-25%** (one in four participants) and acceptability of the treatment is an important factor in addressing this[1]

❖Acceptability of treatment includes[2-4]:

- how participants feel about the treatment (i.e. their attitude)
- perceived burden or amount of effort involved
- alignment with their value system
- whether they understand the intervention and how it works
- opportunity costs (i.e., what they feel they have to give up to participate)
- perceived effectiveness of the treatment
- degree of self-efficacy or confidence that they can complete what is required

[1]Hofmann & Suvak (2006) [2] Sekhon et al. (2017) [3]Devilly & Borkovec (2000) [4]Sekhon et al. (2017)

CRITICAL REVIEW

Wojtaszek, J., Koch, E., Arble, E., & Loverich, T. (2024). Cognitive behavioral group therapy for social anxiety disorder – A critical review of methodological designs. *Journal of Anxiety Disorders,107, 1-11.* https://doi.org/10.1016/j.janxdis.2024.102928

CRITICAL REVIEW OVERVIEW

23 studies over a recent five year period (2018-2023)

- ❑Use of PsycInfo, Web of Science, EBSCOhost, ProQuest, PubMed, and ScienceDirect databases
- ❑Published in peer-reviewed journal
- ❑English language
- ❑Adult samples
- ❑Patients with social anxiety disorder
- ❑Used cognitive group therapy (CGT) or cognitive behavioral group therapy (CBGT) as one of the conditions
- ❑Exclusive focus on online or app based group therapy were excluded
- ❑Book chapters, case studies, and unpublished manuscripts were not included

STUDY RESULTS – STUDIES WITHOUT COMPARISON GROUPS

Results from CBGT:

- ❑Women had greater severity of pre-treatment symptoms and better response. Men were higher in treatment-seeking behavior and treatment dropout (Asher et al., 2019)
- ❑Large treatment effect sizes were maintained at long-term follow-up. Aftercare support group attendance and improvement from post-treatment was not significant (Fogarty et al., 2019)
- ❑Baseline severity of symptoms and fear of negative evaluation were found to moderate symptom trajectories (Erceg-Hurn et al., 2023)
- ❑Reductions in fear of negative evaluation were associated with reductions in SAD symptoms for rapid responders (Auyeung et al., 2020)
- ❑General and momentary post-event processing decreased over treatment and predicted lower symptom severity after (Katz et al., 2019)
- ❑Changes in decentering predicted improvements of most outcomes (Hayes-Skelton and Lee, 2018)

STUDY RESULTS – STUDIES WITHOUT COMPARISON GROUPS

Results from CBGT continued:

- Changes in social anxiety and depression symptoms predicted several aspects of social functioning changes (Ogawa et al., 2020)
- Treatment that primarily targets SAD can lead to reductions in both SAD and depressive symptoms for those who do not also meet criteria for MDD but those with a dual SAD/MDD dx may require interventions with shared factors (Rozen et al., 2022)

Results from CGT:

- Group Cognitive Therapy is effective for individuals with moderate/ severe and treatment-resistant SAD (Colhoun et al., 2021)

Results from an enhanced version of CBGT:

- Telehealth group members reported decreases in social anxiety and at least one secondary outcome (Nauphal et al., 2021)
- Imagery rescripting (IR) did not yield significant additional reductions in SAD symptoms over GCBT but did show improvements in other areas (Norton et al., 2021)

STUDY RESULTS – STUDIES WITH COMPARISON GROUPS

Compared different enhanced versions of CBGT

- Retention was comparable, between site effect sizes were not significant in a community setting compared to the setting where imagery enhanced (IE) treatment was developed, and effect sizes were large in both groups (McEvoy et al., 2018)
- IE-CBT did not demonstrate greater improvements on self-reported or clinician-rated social anxiety (McEvoy et al., 2022)
- MI prior to CBGT appears to benefit those with SAD and high functional impairment but may interfere with outcomes for those higher in readiness for change (Peters et al., 2019)
- Brief CBGT treatment effects were significantly greater than those in verbal exposure augmented cognitive behavioral therapy at post and follow-up (Singh and Samantaray, 2022)

STUDY RESULTS – STUDIES WITH COMPARISON GROUPS

Compared an enhanced version to a standard version of CBGT

- ❑No significant differences in outcomes with the addition of psychodrama (Abeditehrani et al., 2023)
- ❑Enhanced CBGT focused on negative self-imagery demonstrated better results (Ahn and Kwon, 2018)
- ❑Attention bias modification (ABM) group had greater reductions in SAD symptoms with effects maintained at follow-up. (Lazarov et al., 2018)

Compared to a group therapy with non-specific/common factors

- ❑Social anxiety and ruminative thinking decreased. No change was observed in self-compassion (Kurtoglu & Basgul, 2023)
- ❑Brief CBGT was superior to psychoeducational supportive therapy at post and follow-up with large effect sizes (Samantaray et al., 2021)

STUDY RESULTS – STUDIES WITH COMPARISON GROUPS

Compared to mindfulness-based group therapy

- CBGT outperformed MBI-SAD in reducing clinician- and self-rated SAD severity (Koszycki et al., 2021)
- CBGT and MBSR may both enhance reappraisal and acceptance emotion regulation strategies (Goldin et al., 2021)

Compared to CBGT with individual therapy

- Both interventions (CBGT and individual trial-based cognitive therapy) showed reductions in social anxiety and they were equally effective in reducing different comorbidity symptoms (Neufeld et al., 2020)

PARTICIPANT INCLUSION AND EXCLUSION CRITERIA

- Primary diagnosis of SAD was part of the inclusion criteria for all but three of the reviewed studies
- Another common criterion was that the participant was either not on medication or was stable for a certain period
- Many of the studies excluded participants with high suicidality or self-harm risk, schizophrenia, psychosis, active substance use disorder, and/or a bipolar disorder diagnosis.
- Since the list of exclusions varied by study, it is difficult to compare results and/or to conclude which specific comorbidities or other factors may or may not act as confounds within this treatment
- Also difficult to isolate the effects of the study treatment if participants are currently or have been recently engaged in other treatment(s)

SESSION STRUCTURE AND GROUP SIZE

- Standard according to Heimberg & Becker (2002) is **12 weekly, 2.5-hour sessions** and was most common among the reviewed studies
- Among reviewed studies, session structure ranged from:
  - 6 weekly sessions to 18 weekly sessions
  - 1 hr. to 4 hr. weekly sessions
  - No follow-up sessions to a 3-month follow-up session
- Group size recommendation according to Heimberg & Becker (2002) is 6 members
- Participant numbers ranged from 4-11 members among studies that provided this level of detail

MANUALS

Most studies referenced the use of some version of well-validated manuals with similar content, such as:

- **Heimberg & Becker** (Heimberg, 1995; Heimberg & Becker, 2002; Hope et al., 2006) used in 13 studies
- **Clark & Wells** (Clark & Wells, 1995; Clark et al., 2004) used in 8 studies
- **Rapee** (Rapee et al., 2009) used in 3 studies
- **Hoffman & Otto** (Hoffman & Otto, 2008) used in 2 studies
- Thirteen studies indicated developing protocols based on multiple validated manuals – examples:
  - Modified version of Heimberg & Becker (2002) and Yoon & Kwon (2013)
  - Based on Antony & Swinson (2000), Antony & Swinson (2008), and Heimberg & Becker (2008)[1]
  - Based on Rapee et al. (2009) and individual CBT protocols for SAD: Clark et al. (2003), Clark et al. (2006), Mörtberg et al. (2007), and Stangier et al. (2003)

[1] Heimberg & Becker (2008) reference was not provided in the study reference section of Auyeung et al. (2020)

MANUAL REFERENCES

- Clark, D. M., & Wells, A. (1995). **A cognitive model of social phobia**. In R. G. Heimberg, D. A. Hope, & F. R. Schneier (Eds.), Social phobia: Diagnosis, assessment, and treatment. (Vol. 41, pp. 69–93). The Guilford Press.

- Clark, D. M., Deale, A., Grey, N., Liness, S., Murray, H., Turner, C., & Wild, J. (2004). **Brief cognitive therapy for social phobia.** [Unpublished Manual.].

- Heimberg, R. G., & Becker, R. E. (2002). **Cognitive-behavioral group therapy for social phobia: Basic mechanisms and clinical strategies**. Guilford Press.

- Hofmann, S. G., & Otto, M. W. (2008). ***Practical clinical guidebooks series. Cognitive-behavior therapy for social anxiety disorder: Evidence-based and disorder-specific treatment techniques***. Routledge/Taylor & Francis Group.

- Hope, D. A., Heimberg, R. G., & Turk, C. L. (2006). **Managing social anxiety: A cognitive-behavioral therapy approach: Therapist guide.** Oxford University Press.

- Rapee, R. M., Gaston, J. E., & Abbott, M. J. (2009). **Testing the efficacy of theoretically derived improvements in the treatment of social phobia**. *Journal of Consulting and Clinical Psychology*, 77(2), 317–327. https://doi.org/10.1037/a0014800

TYPE OF MEASURES

- **Dx assessment -** semi-structured or structured interview instruments for initial SAD diagnosis and/or to identify changes in diagnosis and related symptoms

- **SAD symptoms -** assessment of social anxiety symptoms through clinician and self-report SAD measures

- **Maintaining factors, moderators, mediators, and mechanisms -** Secondary measures assessing changes in specific aspects of social anxiety per the study goals

- **Comorbidities/ general psychopathology -** assessed symptom change for common comorbid conditions such as depression and anxiety and/or a broader range of psychological issues and physical and emotional symptoms

TYPE OF MEASURES

- **Functioning/ quality of life /well-being –** assessment of functional change such as social or occupational functioning, as well as overall change in quality of life and well-being

- **Group therapy experience -** assess aspects of the group therapy experience, including working alliance, client satisfaction, group cohesion and climate ratings, treatment credibility and expectations, and homework completion

- **Physiological measurement-** objective measurements using physiological factors such as heart rate and skin conductance

MEASURES SUMMARY

Type of Measure	Measures and Number of Studies Used
Dx assessment	• Structured Clinical Interview (SCID) - 8 • Anxiety and Related Disorders Interview Schedule (ADIS) - 7 • Mini-International Neuropsychiatric Interview (MINI) - 7
SAD symptoms	• Liebowitz Social Anxiety Scale (LSAS) – 11 • Social Phobia Scale (SPS) - 8 • Social Interaction Anxiety Scale (SIAS) - 7 • Social Phobia Inventory (SPIN) – 7 • Clinical Global Impression (CGI) improvement scale - 3 • Social Phobia Anxiety Inventory (SPAI) – 1
Maintaining factors, moderators, mediators, and mechanisms	• Brief Fear of Negative Evaluation (BFNE) - 9 • Dysfunctional Belief Test (DBT), Social Probability Questionnaire/Social Cost Questionnaire (SPQ/SCQ), Post-Event Processing Questionnaire (PEPQ), Ruminative Thought Style Questionnaire (RTSQ), Social Avoidance and Distress Scale (SADS), Subtle Avoidance and Frequency Examination (SAFE), and the Self-Focused Attention Scale (SFA)

MEASURES SUMMARY

Type of Measure	Measures, and Number of Studies Used
Comorbidities/ general psychopathology	Beck Anxiety Inventory (BAI) - 2 Overall Anxiety Severity and Impairment Scale (OASIS), Patient-Reported Outcome Measurement Information System (PROMIS) - 1 Beck Depression Inventory (BDI-1or II) - 8 Overall Depression Severity and Impairment Scale (ODSIS), Patient Health Questionnaire (PHQ-9), Symptom Checklist 90 (SCL-90-R), Self-Reporting Questionnaire (SRQ-20) – 1
Functioning/ quality of life /well-being	Quality of Life Inventory (QOLI) – 2 Sheehan Disabilities Scale (SDS), Work and Social Adjustment Scale (WSAS), Rosenberg Self-Esteem Scale (RSAS), Social Adjustment Scale-Self-Report (SAS-SR), Satisfaction with Life Scale (SWLS), Work, Home Management, Social and Private Leisure Activities Scale (WHLS), Short Form 12 Mental Component Summary (SF-12-MCS) – 1

MEASURES SUMMARY

Type of Measure	Measures, Number of Studies Used
Group therapy experience	Credibility Expectancy Questionnaire (CEQ), Client Satisfaction Questionnaire (CSQ-8), Treatment Satisfaction (TS), Telemedicine Satisfaction and Acceptance Scale (TSAS), Group Cohesion Score (GCS), Group Climate Questionnaire (GCQ), Working Alliance Inventory (WAI), Homework Compliance (HC) , Homework Rating Scale-II (HRS-II) – 1
Physiological measurement	fMRI, Heart rate variability (HRV), skin conductance – 1

GROUP FACILITATOR COMPETENCE

Credentials

- Most of the studies indicated that the group therapy was **delivered by** an experienced doctoral-level psychologist and a combination of either doctoral or master's level supervised trainees as co-therapists
- Descriptions varied from "master's or doctoral-level psychologists" to "clinicians specializing in CBT with experience running >2 SAD groups" to "doctoral-level psychologists with 2-30 years of clinical experience and 2-25 years of experience as CBT therapists"

Training

- Description of **training** ranged from not provided, to "therapists received training on the treatment manuals and ongoing training," to "Dr. Heimberg provided an initial training for the therapists"

Supervision

- Description of **supervision** ranged from not provided, to "one hour weekly supervision with a licensed psychologist," to "weekly supervision with a licensed psychologist with expertise in SAD and/ or with over 20 yrs. of CBT experience"

CBGT STRENGTHS & OPPORTUNITIES

Strengths

- Unique benefits for participants
- Demonstrated treatment efficacy
- Validated manuals available to guide treatment
- Measures available to assess outcomes

Opportunities

- Member recruitment and retention
- Confirmation and incorporation of moderators, mediators, and mechanisms into treatment
- Continued research and dissemination of which manuals/versions are most effective and in what scenarios
- Consensus and communication on appropriate use of available measures

REFERENCES