

**TREATING SOCIAL ANXIETY IN ADOLESCENTS: TEN GROUP THERAPY
LESSON PLANS**

ALISON MAZUR-ELMER

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Abstract

This project provides a comprehensive overview of the research literature on social anxiety disorder (SAD) in adolescents and concludes by offering a set of 10 group therapy lesson plans for SAD that therapists can use in their practice. The overview includes a description of social anxiety disorder and highlights various theories of anxiety. The etiology of social anxiety disorder, sex and age differences in the development of anxiety, the maintenance of SAD, and the assessment of SAD are also addressed. The project devotes considerable attention to the treatment of social anxiety disorder through the use of cognitive behavioural therapy. The view that group therapy is a valid form of treatment for social anxiety disorder is advocated throughout this applied project.

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Chapter One

Introduction

This project is intended to provide counsellors with an increased understanding of adolescent social anxiety, including but not limited to the assessment and treatment of social anxiety in adolescents. Furthermore, it is intended to address the growing phenomenon of social anxiety disorder in adolescents, provide a rationale for and a description of facilitator sample lesson plans designed to be used in the treatment of social anxiety in adolescents (see Appendix A). This chapter provides a brief introduction to social anxiety disorder, identifies the purpose and importance of the final project, articulates the writer's reasons for choosing the final project, outlines the structure and format of the final project, and provides a glossary of terms utilized throughout the project.

Mental illnesses touch the lives of the majority of Canadians, impacting relationships, education, productivity, and overall quality of life (Health Canada, 2002). According to Health Canada, approximately 20% of individuals will experience a mental illness during their lifetime and the remaining 80% will be affected by mental illness in family members, friends or colleagues.

Of all the mental disorders, anxiety disorders affect the greatest number of children and adolescents (Reinecke, Dattilio, & Freeman, 2006). Although certain fears and anxieties may be both normative and transient in particular developmental periods, the level of fear or anxiety in some adolescents exceeds developmental expectations, significantly undermining functioning at home, at school, and with peers (Kazdin & Weisz, 1998).

Social anxiety disorder (SAD) is a chronic condition characterized by heightened self-consciousness and exaggerated fear of negative evaluation, which may be limited or generalized to a variety of social contexts (Brady & Kendall, 1992). The fourth edition of the Diagnostic Statistical Manual for Mental Disorders, Text Revision (DSM-IV-TR) defines the essential features of SAD as, “A marked and persistent fear of social or performance situations in which embarrassment may occur” (American Psychiatric Association, 2000, p. 450).

Project Rationale

Social anxiety disorder is a condition warranting attention by both clinicians and researchers. With onset in late-childhood, social anxiety disorder can interfere with friendships, academics, and critical developmental tasks (Velting & Albano, 2001). Left untreated, the consequences of social anxiety disorder are far-reaching in to adulthood, resulting in serious compromises to an individual’s ability to live independently and to his or her full potential (Reinecke et al., 2006).

Evidence suggests that social anxiety disorder is not a transient problem from which young people necessarily recover without some form of intervention; which is why attention to childhood social anxiety is important (Kashdan & Herbert, 2001; Spence, Donovan, & Brechman-Toussaint, 2000). Beidel, Fink, and Turner (1996) conducted a six month study of 26 children aged 7 to 12 years who received a diagnosis of SAD, but did not receive treatment. The majority (62 %) retained their diagnosis over the six month follow-up period. Only 17% of the children showed dissipation of their social anxiety over the six-month follow-up. Studies with socially anxious adults indicate that the majority of adults had late childhood onset (Zaider & Heimberg, 2003).

Statement of Personal Interest

I am addressing the topic of social anxiety in adolescents as despite being one of the most prevalent disorders of childhood and adolescence, social anxiety disorder paradoxically stands out as one of the least recognized, researched, and treated paediatric disorders (Kashdan & Herbert, 2001). The high prevalence, seriousness, and early onset of SAD make a review of the literature on adolescent SAD timely. Epidemiological studies have found SAD to be the most common anxiety disorder and the third most prevalent psychiatric condition in the United States, affecting up to 15% of individuals at some point during their lifetime (Khalid-Khan, Santibanez, McMicken, & Rynn, 2007). Studies in other western nations (e.g., Canada & Australia) noted similar prevalence rates (Iancu, Levin, & Hermesh, 2006).

Studies have demonstrated that psychosocial treatments, specifically cognitive behavioural therapy and group therapy, are efficacious in treating paediatric SAD (Khalid-Khan, Santibanez, McMicken, & Rynn, 2007). As such, I am interested in examining the efficacy of cognitive behavioural group therapy for adolescents with social anxiety.

Furthermore, as I treat a high percentage of adolescents who qualify for a diagnosis of SAD, I felt it necessary to create a series of sample lesson plans that target this particular age group. Due to the cognitive, social, and emotional advances during the teen years, I wanted to create a manualized CBT program for youth that is based upon the developmental abilities of this age group. Additionally, I thought it essential to create a resource that is practical and implements creative strategies for engaging with youth in

treatment. My intention was to create a resource that could be utilized by myself and other therapists in the treatment of social anxiety.

Project Structure

Methods utilized to complete this project will be presented in Chapter Two. Chapter Three provides a literature review beginning with a description of social anxiety and developmental considerations in adolescents. Theories of anxiety will also be presented in Chapter Three, including the etiology of SAD, gender differences in the development of anxiety, the maintenance of SAD, and the treatment of SAD through cognitive behavioural therapy. Additionally, group therapy will be presented as a form of treatment for SAD and the pros and cons of this modality in the treatment of SAD will be explored. Chapter Four focuses on assessment tools used to assess for adolescent social anxiety. Chapter Five provides an overview of key issues that should be involved in a group therapy program and the attached lesson plans found in Appendix A. Chapter Six outlines the strengths and limitations of the literature review and provides direction for future research.

Glossary

Adolescence: A transitional stage of physical and mental human development that occurs between childhood and adulthood. This transition involves biological (i.e., pubertal), social, and psychological changes.

Anxiety: A state of apprehension, uncertainty, and fear resulting from the anticipation of a realistic or fantasized threatening event or situation, often impairing physical and psychological functioning.

Behavioural Theory: A school of psychology that studies observable and quantifiable aspects of behaviour and excludes subjective phenomena, such as emotions or motives.

Biological Models: A theoretical view that holds that mental disorders are caused by abnormal somatic processes or defects.

Cognitive Distortion: Pervasive and systematic error in reasoning.

Cognitive Restructuring: An active attempt to alter maladaptive thought patterns and replace them with more adaptive cognitions.

Cognitive Theory: An approach that focuses on how thoughts and personal beliefs play a role in the development of maladaptive behaviour including negative schemata and interpretations of ones self, the world and the future.

Comorbidity: The co-occurrence of two disorders, as when a person is both anxious and depressed.

Diagnostic and Statistical Manual of Mental Disorders (DSM-4th Edition-Text Revision):
A publication of the American Psychiatric Association delineating specific and discrete symptoms of mental disorders.

Facilitator: An individual who leads a group in accomplishing specific goals.

Group Therapy: A form of psychotherapy in which one or more therapists treat a small group of clients together as a group. Refers to any form of psychotherapy when delivered in a group format, including cognitive behavioural therapy or interpersonal therapy, but is usually applied to psychodynamic group therapy (where the group context and group process is explicitly utilized as a mechanism

of change by developing, exploring and examining interpersonal relationships within the group).

Panic Attack: A clinical term used to describe the experience of intense fear, resulting in physiological arousal and a variety of somatic and cognitive symptoms.

Psychopathology: A term which refers to either the study of mental illness or mental distress, or the manifestation of behaviors and experiences which may be indicative of mental illness or psychological impairment, such as abnormal, maladaptive behavior or mental activity.

Social Anxiety: Refers to the tendency to be nervous or uncomfortable in social situations, usually because of fear about doing something embarrassing, making a bad impression, or being judged negatively by others.

State Anxiety: An unpleasant emotional arousal in the face of perceived or real threatening demands or dangers.

Systematic Desensitization: A step-by-step procedure for replacing anxiety with relaxation while gradually increasing exposure to an anxiety-producing situation or object.

Chapter Two

Methods

This chapter outlines the research methods that were used to complete this project. Correspondingly, this chapter includes a synopsis of the literature reviewed, as well as the search terms and databases that were explored.

This project explores what the literature reveals about: (a) the definition and classification of social anxiety; (b) the epidemiology, course, and prognosis of social anxiety; (c) co-morbidity with other disorders; (d) diagnosis of social anxiety and instruments utilized to assess for social anxiety; (e) treatment of social anxiety disorder in adolescents; (f) psychosocial treatments and their effectiveness; and (g) group therapy for adolescents.

The literature review used the following electronic databases: Child Development and Adolescent Studies; PsychInfo; Psychology and Behavioral Sciences Collection; Mental Measurements Yearbook; and Internet resources such as Google Scholar. Search terms used included but were not limited to: adolescence; youth; development; anxiety; social anxiety; phobia disorder; assessment; diagnosis; epidemiology; co-morbidity; treatment; cognitive behavioural therapy; psychosocial interventions; and group therapy.

This project explored studies and materials from peer-reviewed journal articles, books, manuals, workbooks, and handbooks that examined the impact and treatment of social anxiety in adolescents. This project did not involve human subjects. Some of the material in the appendices of this project was originally part of an assignment in one of my past courses. However, the material included in the appendices has been substantially

expanded, redesigned and revised to be of service to therapists interested in working with SAD clients.

Chapter Three

Literature Review: Treating Social Anxiety in Adolescents

The intent of this paper is to provide a comprehensive overview of the research literature related to social anxiety in adolescents. Given that adolescence is a developmental period that constitutes potential for conflict as well as opportunity for growth, understanding the conflicts that arise for individuals attempting to overcome barriers and obstacles along their developmental paths may provide insights into the subsequent development and expression of emotional difficulties. This chapter will therefore begin with a review of the normative and atypical developmental processes of adolescents. Following this, components of anxiety will be discussed including; (a) a description of social anxiety; (b) theories of anxiety, including the onset and etiology of SAD; (c) gender differences in the development of SAD; (d) co-morbidity; (e) maintenance of SAD; and (f) treatment of SAD. The chapter will also present empirical reviews supporting the efficacy of cognitive behavioural group therapy in the treatment of SAD.

Adolescence: Developmental Considerations

Adolescent development is described in the literature in terms of three processes: biological, cognitive and socio-emotional (Santrok, 2001). Biological processes consist of an individual's unique biological make-up, which genetically influences behaviour and development (Santrok). Biologically determined processes of development were dominant viewpoints in the early twentieth century. For example, Stanley Hall (as cited in Santrok), often thought of as the father of scientific study of adolescence, believed that

development was predominantly biologically determined, with environmental factors playing a minimal role.

Cognitive processes incorporate changes in an individual's thinking throughout the course of development (Albano & Kendall, 2002). This view emphasizes that adolescents have sophisticated thinking abilities and are motivated to understand and construct their own cognitive worlds (Albano & Kendall). Theorists focus on individual differences involving complex cognitive abilities including problem solving abilities, memory capacity, and decision making (Albano & Kendall). Current strides within this perspective include examining how individuals within this age group apply critical thinking and are able to adapt competently within their environment (Albano & Kendall).

Socio-emotional processes involve the development of individual emotions in relation to social contexts and other people (Santrok, 2001). Research suggests that important context in child and adolescent development includes family, peer, school and culture (Santrok). In addition, social and personality development interact with environmental situations to further complicate this investigative process (Santrok).

In summary, biological, cognitive and socio-emotional processes are intricately related and constantly interacting. A holistic perspective of adolescent development purports that changes in adolescent development are an outcome of all three processes (Santrok, 2001).

Normative Versus Atypical Development

One of the greatest challenges it appears in studying adolescents is reaching an understanding of the nature of normal versus abnormal development, and the relationship between the two. Given that the literature on adolescent psychopathology seems to lag

behind that of adult psychopathology (Kashdan & Herbert, 2001), it is not surprising that there is a gap in what we know about adolescent psychopathology. Researchers are still unclear on several issues pertaining to the development of psychopathology in adolescence, some of which will be outlined next.

First, many theorists have questioned whether the development of psychopathology in adolescence is a result endogenous to the child, an outcome due to environmental circumstance, or a reaction to both (Mash & Dozois, 1996). Second, theorists have pondered how to conceptualize the development of psychopathology – is it categorically distinct from normal functioning, or, is it an extreme point on a continuum of development (Mash & Dozois). Third, psychopathology can be viewed as a static or dynamic process influenced by both individual developmental changes and environmental chances (Mash & Dozois).

Most theorists agree that adolescents are faced with numerous developmental demands, from dealing with hormonal changes to emotional regulation, while in an attempt to successfully adapt (Dozois & Dobson, 2004; Kashdan & Herbert, 2001; Price & Lento, 2001). Moreover, psychopathology lends itself to a form of maladaptation resulting from difficulties in adapting to developmental demands (Dozois & Dobson). Understanding atypical development is only possible when looking at the whole picture of normative development.

Many theories have been developed in an attempt to explain development in terms of stages, focusing on specific changes that occur at each stage, and progressing to the next stage in order to reach a functional level as an adult. For instance, Piaget's (as cited in Berk, 2000) theory emphasized that a critical stage in adolescence was developing

abstract thinking. Another stage theorist, Eric Erikson (as cited in Berk) focused on psycho-social stages within adolescent development proposing that this is a period where each adolescent formulates their own identity. The risk of identity confusion is included in Erikson's psychosocial stages identified as occurring in the transition between childhood and adulthood (as cited in Berk). Erikson (as cited in Berk) described this risk as feelings of isolation, doubt, anxiety and indecision. Furthermore, these traits may interfere with the individual's ability to enter the next stage of development (Berk).

Research has demonstrated that adolescence is a critical period for understanding the etiology and course of emotional disorders (Price & Lento, 2001). Chorpita and Barlow (1998) developed a model to test the effects of early life experiences and perceived lack of control on the development of specific cognitions that certain events may be out of one's control. Findings demonstrated that the specific cognitions tested represented a psychological vulnerability for the development of both anxiety and depression. Chorpita and Barlow inferred that if a lack of perceived control over a given situation makes one vulnerable to maladjustment, then perceived control might contribute to normative development.

Unfortunately, anxiety is often dismissed as a developmentally normal component of a teenager's life (Price & Ingram, 2001). This perception may explain the lack of existing research about emotional difficulties in adolescence.

Theorists have also examined abnormal development in adolescence by focusing on individuals who are generally at risk. No single theory has been able to capture the whole picture of normative or abnormal development (Price & Ingram, 2001). The inability of a single theory to explain all aspects should not be seen as a shortcoming.

However, studying specific aspects of abnormal development may be advantageous in preventative approaches.

Social Anxiety

According to the fourth edition of the Diagnostic Statistical Manual IV-TR (American Psychiatric Association, 2000) anxiety disorders can be broken into the following types: panic disorders; agoraphobia; specific phobia; social phobia; obsessive-compulsive disorder; posttraumatic stress disorder; acute distress disorder; generalized anxiety disorder; anxiety disorder due to a general medical condition; substance-induced anxiety; and anxiety disorder not otherwise specified. Several symptoms are common to the range of anxiety disorders, such as “a sense of uncontrollability focused on possible future threat, danger, or other anticipated, potentially negative events” (American Psychiatric Association, p. 429).

Upon exposure to social situations, an individual may experience anxiety in the form of situational specific or situationally predisposed panic attacks (Khalid-Khan et al., 2007). The individual with SAD will endure social situations with intense distress and/or escape from it in order to avoid anxiety-provoking situations (Khalid-Khan et al.). As such, the consequence of the anxiety and resultant avoidance patterns often impairs and interferes with the individual’s normal routine, social and/or family life, or occupational/academic functioning (Khalid-Khan et al.). According to Kearney (2001), youth with SAD may avoid and/or be unable to tolerate a wide and generalized range of situations and activities, which may include the ability to attend or stay in school.

Theories of Anxiety

Anxiety Versus Fear

Fear and anxiety can be experienced at minimal levels and can be normal and adaptive in many situations. In its adaptive form, anxiety serves a protective function for the individual, alerting him or her to danger and motivating certain adaptive behaviours to avoid stress or negative experiences (Albano & Kendall, 2002). Such motivation arises from physiological arousal occurring in the form of autonomic nervous system activity (Albano & Kendall). These responses prepare an individual to respond with appropriate motor behaviour in stressful situations (Albano & Kendall).

Certain fear and anxiety reactions have been well documented as normal and expected processes at different developmental levels; for example, young children often fear the dark, separation, and small animals, while adolescents often fear evaluations (tests, oral presentations and social situations) (Albano, Causey, & Carter 2001; Castellanos & Hunter, 1999).

Etiology of SAD

Psychodynamic, cognitive behavioural and, more recently integrated theories, have all attempted to explain the origins of anxiety. Psychodynamic theories have focused mainly on underlying unresolved conflicts that individuals express through the symptomatology of anxiety (Davison, Neale, Blakstein, & Fleet, 2005). For example, a teen might be anxious due to his unresolved feelings of anger towards his father. Sigmund Freud (as cited in Barlow & Durand, 2005) viewed anxiety as a defence mechanism for repressed and unconscious impulses; however, there is little empirical evidence to support psychodynamic assumptions (Davison et al.).

Cognitive theorists assert that social anxiety is related to emotions caused by negative interpretations and beliefs (Antony & Swinson, 2000). Anxiety and fear often occur when a person interprets a situation as threatening or dangerous. Although fearful predictions and interpretations are sometimes accurate, they are often exaggerated or inaccurate (Antony & Swinson). Anxious thinking begins and persists when people, such as teens, make incorrect assumptions about what is likely to happen in a given situation, the quality of their own performance, and what other people are thinking of them (Antony & Swinson). The goal of cognitive therapy is to think more realistically, rather than just more positively (Antony & Swinson).

Behavioural theorists view anxiety as a product of learning through processes such as modelling and classical conditioning (Kashdan & Herbert, 2001). Anxiety has also been linked to a sense of little control over perceived future events (Chorpita & Barlow, 1988). The behavioural model assumes that psychopathology is environmentally determined. Information regarding the influence of parental and other family environmental factors on the development and maintenance of social anxiety come from studies that examine adults' with social anxiety (Velting & Albano, 2001). These studies include retrospective reports of parenting styles and early home environments.

One study found that socially anxious adults perceived their parents as placing excessive concern on the opinions of others and as having promoted less family sociability (Bruch & Heimberg, 2004, as cited in Velting & Albano, 2001). Another study reported that socially anxious adolescents' perceived their parents as being more socially isolating of their children, less socially active, overly concerned about the

opinions of others, and more ashamed of their children's shyness and poor performance (Caster, Inderbitzen, & Hope, 1999, as cited in Velting & Albano).

Onset of SAD

The onset of some types of anxiety disorders tends to be in early adulthood, whereas others tend to emerge in childhood or adolescence (Dozois & Dobson, 2004). According to Khalid-Khan et al. (2007), the onset of SAD occurs at a relatively early age, with the average onset being 15.5 years.

Gender Differences in the Development of SAD

According to Bekker and van Mens-Verhulst (2007) anxiety in females is much more prevalent than in males. Research has reported that as early as age six, girls are twice as likely as boys to experience anxiety symptoms (Lewinsohn, Zinbarg, Seeley, Lewinsohn, & Sack, 1997). Some researchers have theorized that females may have a genetic or biological predisposition in developing internalizing disorders (Lewinsohn, Gotlib, Lewinsohn, Seeley, & Allen, 1998). Others proposed that gender differences in anxiety disorders are linked to differences in parent-child interaction styles (Bekker & van Mens-Verhulst).

Twin studies are able to disentangle genetic and environmental influences by comparing within-pair similarity for a group of monozygotic twins who are genetic clones, and dizygotic twins who share on average half their segregating genes (Plomin, Defries, McClearn, & McGuffin, 2001). Findings from twin studies confirm that genetic factors play a significant role in the development of anxiety disorders including SAD (Eley & Gregory, 2001). One large twin study found concordance rates of 24.4% for female monozygotic twins, relative to 15.3% for dizygotic twins (Kendler et al., 1992, as

cited in Kashdan & Herbert, 2001). Unfortunately, twin studies examining gender differences in the development of social anxiety are inconclusive. However, research consistently shows that a heritable temperamental trait known as behavioural inhibition is commonly an antecedent to the development of social anxiety disorder (Hirshfeld-Becker, Biederman, & Henin, 2007). Studies in twins confirm that social anxiety traits are heritable and that susceptibility of SAD involves the interplay of disorder-specific and non-specific genetic factors (Bienvenu, Hetternan, Neale, Prescott, & Kendler, 2007).

Parent-child attachment has been the subject of much debate and empirical investigation (Neville King et al., 2006). Childhood anxiety has been associated with parenting styles characterized by limited or inconsistent expressions of care and warmth and extreme displays of overprotection and control (Neville King et al.). A gender-specific version of attachment theory asserts that the symbiotic phase between same-sex mother-daughter relationships is much longer, more enduring, and more intense for girls than it is for boys (Bekker & van Mens-Verhulst, 2007). As a result, it is suggested that girls have more problems with individuation and separation, boys with commitment and displaying their dependency needs (Bekker & van Mens-Verhulst). The fact that insecure attachment might be expressed in sex-specific insecure attachment styles and patterns of autonomy, means that connectedness may contribute to the unequal prevalence of many mental disorders, including anxiety disorder (Bekker & van Mens-Verhulst).

Genetic factors and parent-child interactions are significant factors in the development of SAD. Other contributing factors may however include traumatic conditioning, peer relationships, and parental psychopathology (Vasey & Dadds, 2001). Given the lack of research examining predictors of gender differences in adolescent

anxiety, it is important that future research attempt to gain an understanding of the mechanisms interacting to cause gender effects.

Co-morbidity

Social anxiety disorder rarely occurs as a sole diagnosis as individuals with SAD are at significant risk for co-morbidity (Bekker & van Mens-Verhulst, 2007; Stein, 2000). Most commonly, these individuals will develop other anxiety disorders, such as panic disorder or agoraphobia (Stein), mood disorders, and/or substance abuse (vans Mens-Verhulst; Zaider & Heimberg, 2003).

Individuals with SAD frequently present with additional anxiety symptoms that exacerbate their social anxiety and also add to overall functional impairment (Zaider & Heimberg, 2003). According to Zaider and Heimberg, individuals with SAD who also meet criteria for panic disorder, experience significantly more fear and avoidance of social situations, as well as higher levels of impairment, than individuals without these coexisting disorders. One of the most frequently co-morbid disorders among those with SAD is generalized anxiety disorder (GAD) (Zaider & Heimberg). Co-morbidity rates as high as 33% in clinical samples have been reported (Zaider & Heimberg). Another disorder that often accompanies SAD is alcohol abuse or dependence, affecting approximately 20% of individuals with SAD.

Maintenance of SAD

There are three psychological factors hypothesized to maintain SAD: cognitive biases; deficits in social skills; and operant conditioning (Kashdan & Herbert, 2001). According to cognitive models, SAD is maintained through the maintenance of maladaptive beliefs and the subsequent somatic arousal induced by the resultant negative

thoughts (Clark & Wells, 1995; Musa & Lepine, 2000). In other words, teens with SAD hold beliefs that they will predictably behave in ways that will elicit rejection or negative evaluation of others. These beliefs, in turn, manifest in physiological and behavioural symptoms of anxiety (Musa & Lepine). Physiological reactions such as blushing, sweating, and heart palpitations are then interpreted as evidence of negative performance, thereby increasing teens' anxiety (Kashdan & Herbert).

Deficits in social skills have also been theorized to contribute to the maintenance of SAD. Studies examining social performance in adolescents with and without SAD found that adolescents with SAD significantly more anxious and demonstrating poorer social performance on behavioural assessment tasks relative to nonanxious controls (Beidel et al., 1999; Spence et al., 2000).

Operant conditioning, such as negative reinforcement of avoidance behaviours, is hypothesized to work in conjunction with parent-child interaction styles, peer relations, and perceived and imagined social threat or trauma in the maintenance of SAD (Kashdan & Herbert, 2001). Negative reinforcement may occur when one avoids phobic situations and experiences a sense of relief upon the termination of anticipatory anxiety (Kashdan & Herbert). For younger children, parents may actually reinforce their child's anxiety by collaborating in avoidance behaviours (Vasey & Ollendick, 2000, as cited in Kashdan & Herbert). The unfortunate consequences of these operant factors is that avoidance coping patterns can have damaging effects on developmental tasks and can become more difficult to change with age (Vasey & Ollendick, as cited in Kashdan & Herbert).

Despite the growing research on the phenomenology of SAD, little is known about the cause of the disorder. However, several theories have been proposed to

contribute to the etiology of social phobia, including: genetic influences; temperament; family history; learning and environmental experiences; parenting styles; poor interpersonal skills; and bias in pre- and post-attentive cognitive processing (Albano & Kendall, 2000; Spence et al., 2000). The following section provides a review of CBT, following with an examination of treatment interventions.

Review of Cognitive Behavioural Theory

The past decade has seen an increase in research on the treatment of adolescents with social anxiety disorder. From this literature, two treatments have garnered the most empirical support: cognitive behavioural therapy (CBT) and pharmacotherapy (Ginsburg & Grover, 2005; Rowa & Antony, 2005). The following section will introduce the reader to cognitive behavioural theory. Due to the fact that this project was designed to present CBT as a treatment modality for SAD, pharmacotherapy is not addressed. Following is an introduction to cognitive behavioural theory.

Cognitive theorists assert that personality is created by the relations between temperament and cognitive schemas (Beck & Weishaar, 2005). An individual's fundamental beliefs and assumptions are considered to make up cognitive schemas and such schemas develop early in life through personal experiences and identification with significant others (Beck & Weishaar). According to Beck and Weishaar, these concepts are reinforced by further learning experiences, which, in turn, influence the formation of beliefs, values, and attitudes. Cognitive theory "maintains that people respond to life events through a combination of cognitive, affective, motivational and behavioural responses" (Beck & Weishaar, p. 238).

Cognitive theory emphasizes the role of information processing in human responses and adaptation (Beck & Weishaar, 2005). When an individual perceives that the situation requires a response, for example, cognitive, emotional, motivational, and behavioural schemas get mobilized (Beck & Weishaar). Furthermore, cognitive theory maintains that all individuals have cognitive schemas that contain perceptions of themselves and others, goals and expectations, memories, fantasies, and previous learning. These are believed to greatly influence, if not control, the processing of information (Beck & Weishaar).

Cognitive theorists also assert that well-adjusted functioning is present when an individual is making reasonable and adaptive interpretations of events (Beck & Weishaar, 2005). Therefore, it is assumed that it is not life events that determine well-adjusted functioning but a realistic view of self and others (Beck & Weishaar).

Alternately, cognitive theory assumes that maladaptive responses sometimes occur because “of misperceptions, misinterpretations, or dysfunctional, idiosyncratic interpretations of situations” (Beck & Weishaar, 2005, p. 238). It is purported that one’s negative internal dialogue can lead to maladaptive responses (Corey, 1991). According to Corey, the ways in which one “monitors and instructs themselves, gives themselves praise or criticism, interprets events, and makes predictions shed considerable light on the dynamics of emotional disorders” (p. 345).

Schemas can be adaptive or dysfunctional, and are dormant until engaged by specific stimuli, such as specific stressors or circumstances (Beck & Weishaar, 2005). When faced with a stressor that is too great to handle, a disorder such as anxiety can occur (Jordens, 2001). This means that without a stressor, a person with a disposition to

anxiety is no more likely to feel anxious than a person without a disposition to anxiety (Abela & D'Allessandro, 2002). Anxiety disorders include errors in reasoning called cognitive distortions, which contribute to ongoing symptoms (Beck & Weishaar).

Furthermore, interpretations based on schemas can be biased depending on past experiences and learning (Beck & Weishaar, 2005). These biases contribute to cognitive vulnerability, which, along with a person's temperament, can increase psychological distress (Beck & Weishaar). For example, a person who believes that speaking in front of a group will result in ridicule will more likely experience psychological distress in a group setting that requires conversation, compared to someone who is not concerned about how they are perceived by others. The individual's schemas have been based upon interpretations of past experiences and are biased because it is highly unlikely that he or she would be mocked.

Following, some of the more popular cognitive behavioural interventions used to treat social anxiety will be highlighted. Subsequent to this, focus will be given to the research that supports these interventions through a group therapy format.

Treating SAD in Adolescents with Cognitive Behavioural Therapy

Although there has been considerable investigation of treatments for childhood anxiety disorders in general (Zaider & Heimber, 2003), few studies have examined interventions specifically designed to treat social anxiety among children and adolescents (Zaider & Heimber). However, most studies of treatments for anxiety disorders in adolescents, including those designed specifically to treat social anxiety, have used some combination of cognitive and behavioural interventions (Zaider & Heimber). Overall, cognitive behavioural therapy (CBT) assumes that anxiety consists of physiological,

cognitive, and behavioural components (Ginsburg & Grover, 2005). As such, CBT, whether in the form of group, family, or individual modalities, typically involves teaching skills that address each of these three components (Ginsburg & Grover). As a result, substantial evidence points to the efficacy of CBT for children and adolescents who have a range of anxiety disorders (Zaider & Heimber). Such findings are reported in this paper under the section titled effectiveness of cognitive behavioural group therapy.

Cognitive theory, as outlined, asserts that what we feel is influenced by what we think, and in order to feel better we need to avoid dysfunctional thoughts (Corey, 1991). In an effort to alter an individual's thoughts and feelings, cognitive therapy was created as "an insight therapy that emphasizes recognizing and changing negative thoughts and maladaptive beliefs" (Corey, p. 344). Cognitive therapy attempts to correct flawed information processing and to help the client adjust the assumptions that sustain maladaptive behaviours and emotions (Beck & Weishaar, 2005).

Cognitive behavioural therapy usually involves teaching skills, in group, family, or individual contexts (Ginsburg & Grover, 2005). Skills taught tend to focus on developing cognitive, affective, and behavioural skills through a structured set of sessions (Corey & Corey, 2006).

The following section provides an overview of the components used in the treatment of SAD beginning with psychoeducation. Please note that the following interventions have been included in the sample lesson plans provided in the appendices of this project.

Psychoeducation

Much of CBT material can be presented in a psychoeducational format because of the assumption that once an individual recognizes negative thoughts and maladaptive beliefs, corrections in information processing can be made (Beck & Weishaar, 2005). The treatment for SAD usually begins with a psychoeducational component in which information is provided about SAD and anxiety is discussed as a normal response (Ginsburg & Grover, 2005; Khalid-Khan et al., 2007). Cognitive, somatic, and behavioural components of anxiety are explained as well as specific symptoms of SAD (Khalid-Khan et al.). The following section will highlight the various cognitive behavioural techniques used in the treatment of social anxiety disorder; including systematic desensitisation, relaxation training, cognitive restructuring, and social skills training.

Systematic Desensitization

Treatment usually combines exposure principles with cognitive restructuring tools, although some forms of CBT rely more heavily on cognitive techniques and behavioural experiments than on exposure (Clark et al., 2003). The most widely taught cognitive behavioural skills that target the physiological symptoms of social anxiety, involve training in relaxation strategies (Ginsburg & Grover, 2005; Khalid-Khan et al., 2007) and systematic desensitization, a complex but very practical intervention strategy that has been used for several decades (Antony & Swinson, 2000). The use of exposure is based on models of fear development that implicate the learned nature of particular fears and the instrumental role that avoidance plays in maintaining anxiety (Clark et al.). In exposure treatment, clients develop an exposure hierarchy, or a list of feared situations,

that ranges from moderately to extremely anxiety provoking (Clark et al.). Using this hierarchy as a guide, clients are encouraged to repeatedly and systematically expose themselves to their feared situations, while in a relaxed state, staying in the situation until their anxiety has subsided. This procedure can be done in vivo or imagined.

Exposure to feared situations and feelings is a powerful method of learning that avoidance is neither necessary nor helpful in the long run. By confronting their fears, individuals discover that many of their anxious beliefs and interpretations are untrue or exaggerated (Antony & Swinson, 2000). In addition, their interpersonal skills improve as they have more opportunities to engage in various types of social interaction (Antony & Swinson).

According to Kashdan and Herbert (2001), exposure is a cornerstone of all cognitive behavioural interventions for anxiety disorders. However, a combination of exposure, cognitive restructuring and social skills training is most effective in reducing social anxiety symptoms and impairment (Zaider & Heimberg, 2003).

Relaxation Training

Applied relaxation aims to combat the physiological effects of social anxiety. Individuals are provided instruction on progressive muscle relaxation, cue-controlled relaxation, and skill generalization in social situations (Rowa & Antony, 2005). Deep relaxation can help reduce anxiety (Antony & Swinson, 2000). Regular practice of deep relaxation of 20 to 30 minutes on a daily basis can produce, over time, a generalization of relaxation; that is, after several weeks of practicing deep relaxation once per day, individuals will tend to feel more relaxed all the time (Antony & Swinson).

Rational-Emotive Therapy

A long-term cognitive-based intervention is rational-emotive therapy (RET), originally developed by Albert Ellis (as cited in Merrell, 2001) several decades ago. Rational-emotive therapy, otherwise referred to as rational-emotive behaviour therapy (REBT), is based on the assumption that many emotional problems such as depression and anxiety are caused by irrational thinking and mistaken assumptions (Merrell). These maladaptive thoughts, are said in turn, to lead to low self-esteem, unnecessary guilt and shame, psychological stress, and maladaptive problem-solving (Merrell). Practitioners who have modified the RET approach to use with children and adolescents have identified common irrational thoughts or beliefs more specific to this younger age group, including: “Nobody likes me,” “There is something wrong with me,” and “I can’t try this because everyone will laugh at me” (Merrell). In the RET approach, the irrational-negative thoughts are first identified, then actively disputed, and finally replaced with positive and more realistic patterns of thinking (Merrell). Examples of countering internal negative thoughts with positive realistic thoughts include: “Nobody likes me,” becomes “Not everyone likes me, but I know that Alyssa likes me,” and “I can’t try this because everyone will laugh at me,” becomes “If I try this and people laugh at me, I will survive” (Merrell).

Social Skills Training

Social skills’ training has long been used as an intervention for socially withdrawn and anxious adolescents (Ginsburg & Grover, 2005; Merrell, 2001; Reinecke et al., 2006; Velting & Albano, 2001). Most socially withdrawn youth tend to experience significant anxiety regarding their social experiences (Ginsburg & Grover). They may

feel a great deal of fear in tackling common school situations, such as answering a teacher's questions in front of the whole class, speaking in public, asking questions of teachers or other students, or initiating conversations with peers (Merrell). In addition to exhibiting shyness and withdrawal, and not interacting with their peers, socially withdrawn or anxious youth often have poor social problem-solving skills (Ginsburg & Grover; Reinecke et al.; Velting & Albano) and are less likely than their peers to engage in social problem solving after they have experienced a failure in trying to deal with a social situation (Merrell). They are likely to give up and withdraw from social situations rather than experience the discomfort and embarrassment they perceive will occur if they fail in these situations (Merrell). For socially anxious and withdrawn adolescents, social skills training offers a practical intervention tool to increase their ability to deal with social situations (Ginsburg & Grover; Merrell; Reinecke et al.; Velting & Albano).

Overall, most clinical researchers now believe that CBT is the treatment of choice for youth with internalizing disorders including SAD (March & Wells, 2003). Therapists have modified these treatment programs in their own way but despite these modifications, all these interventions share three common components: psychoeducation, exposure, and skill building (Khalid-Khan et al., 2007).

Effectiveness of Cognitive Behavioural Group Therapy in the Treatment of SAD

Current empirical reviews support the efficacy of cognitive behavioural group therapy for anxiety disorders in youth. According to Albano and Kendall (2002), cognitive behavioural therapy used to treat children and adolescents with anxiety is based upon both sound theoretical and empirical underpinnings. Results of a 2005 study of 12 male and female adolescents, ages 13-18, with a primary diagnosis of social anxiety

disorder supported cognitive behavioural group therapy as an effective treatment for adolescents with SAD (Baer & Garland, 2005). The study was a randomized, waitlist control study that evaluated the effectiveness of a 12-week behavioural group treatment program. The adolescents with social anxiety were randomly assigned to the behavioural treatment group or the waitlist control group. The intervention was a behavioural treatment model consisting of 12 weekly, 90-minute group sessions with six adolescents and two leaders. Group sessions included psychoeducation, social skills training, individual exposure therapy, and group peer generalization sessions.

Both groups were assessed using objective and subjective outcome measures. The objective measures included the Anxiety Disorders Interview Schedule (ADIS) and self-report, both assessed by independent nonblinded clinical evaluators. The subjective measures included the Social Phobia and Anxiety Inventory (SPAI), a self-report instrument assessing cognitive, somatic, and behavioural dimensions of social anxiety, and the Beck Depression Inventory (BDI). Assessments were performed at baseline and immediately after the treatment or waitlist period.

Results indicated that the adolescents showed significant improvement in social anxiety symptoms ($p < .03$) (Baer & Garland, 2005). The mean pre-treatment ADIS interference score for both groups (treatment and waitlist) of 5.36 decreased to 3.27 post-treatment, whereas the mean pre-waitlist (waitlist group only) ADIS interference score of 5.67 decreased to 5.33 post-treatment (Baer & Garland).

Results of a similar magnitude were obtained for subjective ratings of participant social anxiety symptoms using the SPAI. The mean change from pre- to post-treatment

SPAI total score was -28.5, and the mean change from pre- to post-waitlist score was -9.8, with a *p* score of .05 (Baer & Garland, 2005).

Overall, Baer and Garland's (2005) study demonstrated the effectiveness of CBT in the treatment of social anxiety. These findings are similar to the work done by Spence, Donovan, and Brechman-Toussaint (2000) who evaluated the effectiveness of an integrated cognitive behavioural group treatment program for socially anxious children and adolescents. The study included 50 children aged 7 to 14 years with a principal diagnosis of social anxiety. Participants were randomly assigned to either a 12-session cognitive behavioural group treatment program or a wait list control group. Interventions emphasized social skills training, but also included anxiety management methods, graded exposure in vivo, and cognitive restructuring (Spence et al.).

Clinical diagnosis was assessed pre- and post-treatment using a modified version of the Anxiety Disorders Interview Schedule, Child and Parent Versions (ADIS-C-P). In addition, a clinical severity rating was given based on the parent's interference ratings, total symptoms endorsed, and clinician assessment of level of disturbance and disability produced.

The integrated cognitive-behavioural group program produced significant reductions in social anxiety (Spence et al., 2000), as assessed by both parent and child report. The effects were statistically and clinically significant as indicated by a reduction in the percentage of children in the treatment conditions who retained a clinical diagnosis of social phobia at post treatment (Spence et al.). Forty-two percent of the children met diagnostic criteria for social anxiety post treatment and 47% of the children met diagnostic criteria for social anxiety at a 12-month follow-up (Spence et al.). Such

improvements were not evident for the wait list control children; 93% showed minimal change during the treatment period (Spence et al.).

Overall, Spence et al. (2000), as did Baer and Garland (2005), found that cognitive behavioural treatments are credible interventions in the treatment of social anxiety. Further support of these findings was obtained by Hayward et al. (2000). These authors examined the efficacy of cognitive behavioural group therapy for adolescents.

These authors compared 12 female adolescents with social anxiety that were treated with the same cognitive behavioural group therapy program with 23 wait-list controls (Hayward et al., 2000). The mean age of participants was 15.8 years. The Social Phobia and Anxiety Inventory (SPAI) and the Anxiety Disorders Interview Schedule, Child and Parent Versions (ADIS-C-P) were used as pre- and post-treatment measures.

The cognitive behavioural group treatment program was delivered over 16-weeks and each session was 90 minutes in duration. Sessions focused on providing group members with information about social anxiety, skill-building (including social skills), social problem-solving skills, assertiveness, and cognitive restructuring. Participants also engaged in vivo and simulated within-session exposure to feared social situations (Hayward et al., 2000).

The primary criterion for efficacy at posttreatment was the rating of interference from the ADIS-C-P. Results showed significant reductions ($p < .03$) in interference in the treatment condition compared with the untreated condition on both the parent and child interference ratings (Hayward et al., 2000). On the zero to eight interference score, mean scores on ratings decreased nearly 50% in both the child and parent interviews (Hayward et al.). There were also significant differences ($p < .04$) by treatment condition in the

SPAI at posttreatment (Hayward et al.). At post treatment 55% of the subjects in the treatment condition still met criteria for social anxiety on the ADIS, whereas 96% of the subjects in the untreated condition met criteria for social anxiety ($p < .05$) (Hayward et al.).

Results provide support for a moderate short-term effect of cognitive behavioural group therapy for the treatment of social anxiety in female adolescents. However, long-term effects did not appear to be evident as these differences were not present one year later (Hayward et al., 2000).

Summary of Findings

Evidence for cognitive behavioural treatments indicates that such treatments are credible interventions and superior to wait-list controls (Baer & Garland, 2005; Hayward et al., 2000; Spence, 2000). The evidence also suggests that group therapy providing a combination of social skills training, cognitive restructuring, and graded exposure offers promise as an effective treatment (Baer & Garland; Hayward et al.; Spence).

Furthermore, group therapy for adolescents complements the normal developmental tasks and provides a place where participants can safely share similarities and take risks with others (Baer & Garland; Hayward et al.; Spence).

Despite the successful results in treating anxiety disorders, these studies have some limitations. First, most of the studies compared the treatment against a wait-list condition rather than another active treatment. Second, there was a wide range in the ages of participants, with ages ranging from 7 to 18 years. Most psychosocial treatments need to be modified for a particular developmental age. Third, there are inconsistencies in the literature in identifying the effective and necessary components of treatment packages;

that is, exposure versus social skills training versus cognitive therapy versus cognitive behavioural therapy.

It would be beneficial if future research focused on controlled trials of combined treatments (i.e., comparisons of medication, CBT, and the combination of pharmacotherapy and CBT). Studies examining the long-term benefits of CBT and the use of relapse prevention sessions to reduce relapse rates may also be useful. In addition, studies that have diverse populations and a wide age range are needed to evaluate if these protocols can be generalized to other populations.

As demonstrated in these studies, group therapy is an effective modality to deliver CBT. As such, the following section will highlight the benefits of group therapy for adolescents, as well as, address some of the factors required to be taken in to consideration when forming a group therapy program for anxious teens.

Group Therapy for Adolescents

To continue to offer a framework for providing a SAD group for youth, this last section of the chapter will focus on the merits of using group work to help youth overcome SAD. Group processes, such as the similarities of participants, the development of social skills, fears impacting group therapy, and how to get the anxious individual to group therapy, will all be discussed.

Group therapy is a useful method for helping youth overcome a wide range of emotional and behavioural problems (Ginsburg & Grover, 2005; Khalid-Khan et al., 2007). According to Yalom (1995), there is much support for group therapy in response to research indicating the effectiveness of group therapy, on its own and in comparison to other psychotherapies.

Of all the psychotherapy modalities, group psychotherapy, in particular, complements the normal developmental tasks that further youth capacities for social interaction and intimacy (Shechtman, 2004, as cited in Corey & Corey, 2006). The group is a natural setting for adolescents: they are taught in groups, live in groups, and often play in groups. Social interaction is a key aspect of the developmental process, and as suggested by Bandura (1989), most social learning takes place by observing others and the results of their actions. Adolescents are excellent at being able to learn from one another while teaching appropriate skills as they grow (Corey & Corey, 2006).

Because the peer group has enormous power for influencing behaviour, group therapy should be considered a primary rather than an auxiliary form of child psychotherapy (Shechtman, 2004, as cited in Corey & Corey, 2006). Furthermore, since adolescence is a time of rising psychosocial vulnerability where either psychopathology or self-actualization can occur (Gunther & Crandles, 1998), social learning may be the best treatment for them.

Discovering Similarities

Group counselling can help adolescents discover that they are not unique in their struggles (Corey & Corey, 2006). Despite the complexity of human problems, certain common denominators are clearly evident, and group therapy members soon come to recognize their similarities through sharing in a group environment (Antony & Swinson, 2000; Corey & Corey; Yalom, 1995). Group therapy can provide these individuals with an opportunity to confide in and be validated and accepted by others (Corey & Corey). When group members confide in and feel accepted by others, it can be said that they have established cohesiveness (Yalom). As Yalom noted, cohesiveness is a significant factor in

successful group therapy outcome. In conditions of acceptance and understanding, group members may be more inclined to express and explore their experiences, and relate more deeply to others (Yalom). For the socially anxious individual, being comfortable enough to engage in self-disclosure is an important factor in becoming more confident (Merrell, 2001).

Developing Social Skills

Group work provides anxious individuals the opportunity to interact with other group members as they do in their social spheres (Yalom, 1995). Participants will inevitably display their interpersonal behaviour in the therapy group; these interactions will provide group members and leader(s) the opportunity to offer feedback, ultimately helping members learn how to develop distortion-free, rewarding interpersonal relationships (Yalom).

According to Yalom (1995), the development of social skills is a therapeutic factor that operates in all therapy groups, although the nature of the skills taught and the process vary depending on the type of group therapy. In some groups, members may be asked to role-play certain scenarios and in other groups, social learning is more indirect (Corey & Corey, 2006). Therapy groups provide members with the opportunity to acquire highly developed social skills: they can learn how to be helpfully responsive to others; acquire conflict resolution skills; and develop empathic skills (Antony & Swinson, 2000; Yalom).

Fears Impacting Enrolment in Group Therapy

Adolescents are often reluctant to attend group therapy for a number of reasons. For example, some teens may be suspicious of anything recommended by their parents or

other adults (Gunther & Crandles, 1998). Some fear that the therapist will interrogate them and tell them what to do. Others are frightened that they will encounter someone they know, and that they will be stigmatized (Gunther & Crandles). The older the participant, the more likely they are to show fear and the greater the likelihood that they will be less willing to enter group therapy (Gunther & Crandles).

One disadvantage of group work for the socially anxious individual is that it can be intimidating because of the unknowns (e.g., who will be in attendance, fear of having to talk in public, etc.). However, even though individuals with social anxiety are often terrified of starting group treatment, the fear of speaking in front of the group usually diminishes after the first few weeks (Antony & Swinson, 2000; Corey & Corey, 2006). Counsellors need to learn how to encourage the socially anxious individual to attend group therapy as group therapy has so many benefits, as previously outlined.

Getting the Anxious Individual to Group Therapy

Pregroup contact with adolescents and their parents in the form of a family meeting, for example, is a critical step in building the foundation for a working alliance (Malekoff, 2004). Some of the orienting information for the clinician to keep in mind when first meeting with the adolescent and his or her parents is: (a) how can the prospective member benefit from the group; (b) what actually happens in the group; (c) what is special about group work; and (d) what is the purpose of the group (Malekoff). Furthermore, demystifying the group process through the use of storytelling allows clinicians to share past encounters with groups to bring experiences a little closer to life for the adolescent (Malekoff). In addition, pregroup contact allows the prospective member to share his or her expectations, hopes, and fears (Malekoff). By tuning in to the

individual's group sensitivities, the clinician takes an important step toward allaying fears and creating a vision of how the new situation can be different (Malekoff). Through this process, the potential member begins to develop a sense of trust and safety with the clinician, a critical component in the early stages of group formation (Malekoff).

With the documented evidence that youth respond well to CBT and group work, this project, containing 10 group lesson plans, is highly relevant. The lesson plans provided in the appendix include many of the cognitive behavioural tools reviewed in this chapter.

Summary

Social anxiety in adolescents is a prevalent condition that causes significant functional impairment. Social anxiety disorder in adolescents is a serious condition with onset early in life, which often persists over the course of the lifespan (Khalid-Khan et al., 2007). Failure to intervene early with effective treatments may render the youth vulnerable to impairments in a wide range of functioning, resulting in harmful effects on his or her long-term emotional development (Khalid-Khan et al.).

Cognitive behavioural therapy is the most widely used psychological treatment for social anxiety (Rowa & Antony, 2005). Treatment from the cognitive behavioural perspective assumes that anxiety is a normal and expected emotion comprised of biological, behavioural, and psychological components (Albano & Kendall, 2002). Both cognitive and behavioural methods are used to dispute maladaptive beliefs and encourage more realistic adaptive thinking (Beck & Weishaar, 2005). Methods involve encouraging the client to take risks and practice new behaviours in a safe environment (Beck & Weishaar). The cognitive therapist's view is that the new experiences of the client will

validate the use of new behaviours (Beck & Weishaar). Furthermore, it is assumed that the emotions triggered through the use of new behaviours will also enhance behaviour (Beck & Weishaar).

Evidence for cognitive behavioural group therapy suggests that providing a combination of social skills training, cognitive restructuring, and graded exposure offers promise as an effective treatment for adolescents with SAD (Baer & Garland, 2005; Hayward et al., 2000; Spence et al., 2000).

The challenge of preventing the consequences of SAD lies in early diagnosis (Khalid-Khan et al., 2007). Instruments for assessing anxiety in youth, including social anxiety specifically, have proliferated in the past decade (Ginsburg & Grover, 2005). In the next chapter, the more common assessment measures for adolescent social anxiety will be discussed.

Chapter Four

Assessing for Social Anxiety Disorder

This chapter was created to highlight the need and purpose of assessing for SAD, in particular with adolescents. Furthermore, it is intended to introduce the reader to instruments utilized in the assessment of SAD. One of the instruments introduced, the Multidimensional Anxiety Scale for Children (March, 1997), is intended to be utilized in the screening process of the proposed group program discussed in Chapter Five.

Purpose for Assessment

Assessment of children's emotional and behavioural problems can serve several purposes, regardless if it is for screening for group admission. First, a thorough assessment is often necessary for identifying problems accurately (Ginsburg & Grover, 2005). Second, assessment is usually essential for formal classification of behavioural and emotional problems or disorders (Ginsburg & Grover). Although formal classification (using the DSM-IV-TR or other special classification systems) is not always necessary (Ginsburg & Grover), tools used to classify behavioural and emotional disorders often serve quantifiable purposes, such as access to services, remuneration, and/or third-party payment for services. Additionally, classification systems provide a common framework for professionals to use in communicating and understanding the problem (Reinecke et al., 2006). Moreover, a thorough assessment should provide many of the details needed to develop an intervention plan targeted specifically at the areas of greatest concern (Ginsburg & Grover; Merrell, 2001; Reinecke et al.). Assessment information can provide a baseline with which to gauge treatment progress or evaluate the effectiveness of particular interventions (Ginsburg & Grover; Merrell).

The process of assessment is more complex than simply making a determination regarding whether a particular problem exists. Effective assessment provides a strong foundation for understanding the problem that has been identified and developing an appropriate plan for intervention (Ginsburg & Grover, 2005; Merrell, 2001). Assessing anxiety, depression, and related internalizing problems of children and youth can be particularly challenging (Merrell). One of the persistent challenges in assessing internalizing problems is that so many of the symptoms are not easily observed through external measures (Merrell). Therefore, obtaining the child's self-report through interviewing and using self-report instruments is more important with internalizing problems than with externalizing problems such as conduct disorder, which is easier to evaluate through direct behavioural observation and behavioural rating scales (Merrell).

Furthermore, the clinical evaluation of youth suspected of having SAD is essential considering normal personality variations in sociability and introversion are not always clinical in nature (Reinecke et al., 2006). Consequently, while a shy individual may enter cognitive behavioural therapy to learn specific assertiveness skills, it would be unacceptable to automatically assume a diagnosis of social anxiety disorder (Reinecke et al.). This approach is particularly important for the proposed group program, as the treatment approaches are designed to treat SAD and do not account for variations in personality.

Accordingly, Reinecke et al. (2006) suggested a multimodal assessment involving multiple informants and both objective and subjective assessments in order to accurately diagnose and initiate treatment planning. The following section will review instruments

widely used for assessing anxiety disorders in adolescents, some of which will be useful to those wanting to incorporate screening into a group for SAD.

Assessment Instruments

Instruments for assessing anxiety disorders in children have increased in the past decade (Ginsburg & Grover, 2005). The types of instruments now available vary widely and include structured diagnostic interviews, paper and pencil rating scales, physiological assessments, and observational procedures (Ginsburg & Grover). These instruments vary along several dimensions, such as their goal or purpose, complexity and training requirements, length of time to administer, and utility or feasibility across settings (Ginsburg & Grover).

The most comprehensive assessment of social anxiety in children includes a multi-method approach in which information about the child and his or her symptoms is obtained across multiple contexts and modalities and from a variety of informants, such as parents, teachers, peers, and the children themselves (Ginsburg & Grover, 2005; Merrell, 2001; Reinecke et al., 2006). However, for most therapists, the primary goal of using standardized assessment tools is to screen for social anxiety (Ginsburg & Grover). One of the most popular and psychometrically sound of the broad-band rating scales is the Multidimensional Anxiety Rating Scale for Children (MASC) (Ginsburg & Grover; March, 1997; Reinecke et al.). The following section provides an overview of the MASC.

Multidimensional Anxiety Scale for Children (MASC)

The MASC was developed to assess a wide spectrum of common anxiety symptoms in children and adolescents ranging in age from eight to nineteen (March, Parker, Sullivan, Stallings, & Conners, 1997). It is a 39-item self-report measure that is

intended to be used as a component of an overall clinical evaluation as well as in research settings (Christopher, 1997). Christopher noted that in contrast to the clinician-administered diagnosis interview, the paper-and-pencil self-report scales allow for a relatively time-and cost-efficient means of gathering information from multiple informants (child, parent, teacher). Information gathered across sources is important in order to understand the child's presentation across settings, as well as how each person in the youth's environment perceives the child (Ginsburg & Grover, 2005; March et al.; Reinecke et al., 2006).

Recommended uses for the MASC include routine screening in settings such as schools, counselling clinics, residential treatment centers, child protective services, young offender centers, and private practice settings (Christopher, 1997). Potential users of the instrument identified by Christopher included psychologists, physicians, social workers, counsellors, teachers, and paediatric nurses. Forms can be administered in a clinic, school, or home setting (March, 1997). Most individual measures take 10 to 15 minutes to complete, and child measures require a second- or third-grade reading level (March). Multitudes of rating scales exist to assess a number of constructs in youth such as depression, anger, and family functioning (March).

The MASC contains four main factors: physical symptoms; social anxiety; harm avoidance; and separation/panic anxiety (March, 1997). For the most part, the empirically derived factor structure of the MASC matches the DSM-IV-TR diagnostic clusters of SAD, separation/panic anxiety, and, averaged across all four factors, generalized anxiety disorder (Reinecke et al., 2006). In addition, gender and age norms provide empirical quantification of distress and impairment (March). The MASC is also sensitive to

discriminating youth with anxiety disorders from youth with depression or no disorder (March).

The Anxiety Disorders Interview Schedule for the DSM-IV-TR

The diagnostic interview in clinical practice provides the clinician with a reliable tool for gathering diagnostic and screening information, identifying and quantifying symptoms and areas of impairment, and defining the targets for therapeutic change (Reinecke et al., 2006). The ADIS comprises companion child and parent interviews designed to help the practitioner diagnose children with emotional disorders, where anxiety is a prominent component (Silverman & Albano, 2004). Problem behaviours and diagnoses include: school refusal, separation anxiety, social phobia, specific phobia, panic disorder, agoraphobia, obsessive compulsive disorder, and post traumatic stress disorder (Silverman & Albano). Interview questions in the Child Interview are specifically designed to be sensitive and understandable at varied age levels (Silverman & Albano; Silverman & Eisen, 1992; Silverman & Nelles, 1988).

The Child and Parent Interview Schedules for the ADIS for DSM-IV are each semi-structured interviews organized diagnostically to permit differential diagnoses among all anxiety disorders (Silverman & Albano, 2004). In addition, sections for assessing mood and externalizing disorders are included to allow comprehensive assessment of a child's full diagnostic picture (Silverman & Albano). These sections are particularly important for evaluation of co-morbidity patterns that often accompany anxiety disorders (Reinecke et al., 2006). The diagnostic sections of the Child and Parent Interview Schedules allow sufficient information to formulate a thorough treatment plan for the child's presenting problems (Silverman & Albano). The Child and Parent

Interview Schedules both contain comprehensive sections for assessing the functions and patterns of disorders in youth (Silverman & Albano). Screening sections include assessing for substance abuse; psychosis; selective mutism; eating disorders; somatoform disorders; and specific developmental and learning disorders of childhood and adolescence (Silverman & Albano).

In sum, both the MASC and the ADIS can be applied to a variety of situations where comprehensive assessment of anxiety disturbances in adolescents is required. Both instruments can be used by a variety of professionals. Although neither assessment instruments are recommended as single information sources, their results provide baseline clinical impressions (Christopher, 1997; Khalid-Khan et al., 2007).

This project recommends incorporating the MASC to measure potential group participants for social anxiety. The next chapter provides an overview of the group therapy manual including screening for group members, ethical considerations, and group marketing. The 10 group lesson plans are attached as appendix items.

Chapter Five

Overview of the Group Therapy Program and Lesson Plans

Sample lesson plans designed to assist therapists in facilitating a group therapy program for adolescents diagnosed with SAD, are included as an appendix within this paper. The lesson plans have been created for adolescents ranging in age from 13 to 16 years.

These lesson plans are intended to assist therapists who already have a good understanding of social anxiety group therapy processes. The lesson plans provide therapists with ample treatment strategies to assist the socially anxious adolescent in overcoming their anxieties and improving their overall quality of life.

The lesson plans as previously indicated, follow a cognitive-behavioural therapy perspective. Thus, some of the lessons will educate clients about the nature of social anxiety and provide treatment management strategies. Other lessons will teach evaluation skills enabling those with social anxiety to assess their main features of the disorder. Furthermore, a combination of social skills training and anxiety management methods such as cognitive restructuring, and graded exposure are offered.

The following is an overview of issues that should be part of a SAD group program. Four main themes are addressed: (a) screening for group members; (b) ethical considerations; (c) group marketing; (d) and lesson plans.

Group Screening

Screening involves an interview style meeting with prospective members and his or her parents (Malekoff, 2004). Parents and their adolescent attend a screening interview with one or both facilitators to determine the adolescent's compatibility with the group

(Malekoff). It is suggested that consideration for group membership be in accordance with the following inclusion and exclusion criteria (Malekoff).

According to Yalom (1995), good group therapy begins with good member selection. Criterion for inclusion should include only individuals that have primary problems with anxiety. Individuals with a secondary or co-morbid psychiatric disorder can be included as long as their primary presenting issue is anxiety. Group members must be between the ages of 13 and 16 years. There should be a combination of male and female participants from culturally diverse backgrounds (Corey & Corey, 2006).

Yalom (1995) asserted that the most obvious criteria for inclusion is the individual's motivation. Therefore, individuals that are motivated and committed to the group therapy process should also meet the criteria for inclusion.

Included in the screening process, both the adolescent and parent(s) are required to complete a MASC (see Chapter Four). Results of the MASC should indicate a marked and persistent fear of one or more social or performance situations (American Psychiatric Association, 2000).

According to Yalom (1995), selection of group members is more a process of deselection rather than selection. Individuals presenting with signs and symptoms of anxiety should not be included in this group if they are experiencing an acute situational crisis. These individuals would be better treated through immediate individual crisis intervention therapy.

Those who present as unmotivated or uncommitted should also be excluded-for example, if a parent wants their adolescent to participate in the group, but the adolescent is not interested. Individuals who are unmotivated to attend the group may prematurely

terminate from the group (Yalom, 1995). Such termination can have adverse effects on the remaining group members, creating a chain effect where other members may terminate (Yalom).

Ethical Considerations

Informed Consent

The Canadian Psychological Code of Ethics requires psychologists to seek as “full and active participation as possible from others in decisions that affect them, respecting and integrating as much as possible their opinions and wishes” (Canadian Psychological Association, 2001, p. 49). In an effort to ensure that participants are willing to participate in this group, a consent form has been developed outlining the nature and purpose of the group, confidentiality issues, participant and leader roles, qualifications and theoretical orientations of the leaders (Corey & Corey, 2006) (see Appendix B).

Expectations of Group Facilitators

Cognitive behavioural therapy requires a clinician to have considerable training and expertise to help youth and parents make effective behavioural changes over a specified period of time. Kendall and colleagues recommend a flexible, clinically sensitive, and developmentally appropriate application of CBT for youth with anxiety disorders (Kendall & Chu, 2000; Kendall et al., 1998). This flexibility must be driven by the therapist’s training and expertise in working with youth of various ages and demographic backgrounds, and knowledge of child and adolescent development and the specific challenges of various developmental stages (Albano & Kendall, 2002). Finally, a firm foundation in cognitive behavioural theory and the principles of applied CBT is essential. Albano and Kendall warn therapists that CBT is not simply a ‘toolbox’ of

techniques, but involves a theoretical and empirical approach to understanding, assessing, and treating anxiety disorders (see Appendix B for a description of Facilitator Roles).

Supervision

It is advised that the facilitators spend time debriefing with each other and arrange for peer supervision and/or consultation as necessary. Debriefing between facilitators should occur after each session. Facilitator debriefing questions are provided at the end of each week's lesson plans to guide the process. Furthermore, group leaders are recommended to be proactive and meet with a supervisor weekly for one hour (DeLucia-Waack, 1999). These supervision meetings should provide a safe and confidential forum for group leaders to discuss: (a) their own developing self-awareness; (b) issues of counter-transference that arise in the group work; (c) group leaders' reactions to group members; (d) issues that arise between co-leaders and the processes being used to resolve these issues; and (e) goals and plans for future sessions (DeLucia-Waack).

Expectations of Group Participants

Group members should be voluntary and are expected to attend each session. Each member should be encouraged to participate to the degree they are able. Group members must maintain the confidentiality of other group members (see Appendix B for a description of Participant Roles).

Assessment of Client Satisfaction

A feedback form is distributed weekly and at the end of the group program (see Appendices D and E for Sample Evaluation Forms). One weekly feedback form and a program evaluation form have been created for the purpose of this project and are

intended to provide facilitators with sample forms. Individual facilitators are encouraged to create/adapt feedback forms from week to week.

Group Structure

A series of eight lesson plans are included as an appendix in addition to pre- and post-group sessions (for a total of 10 sessions). A pre-group meeting should take place approximately three weeks prior to the start date of the group. According to Corey and Corey (2006), pre-group meetings are beneficial in that they provide group members with a chance to meet other members before the initial group session. This meeting also provides participants with further information about the program in order to help members determine their level of commitment to the group process (Corey & Corey). A post-meeting should occur approximately one month after the group. At this time, progress and obstacles will be discussed and additional ways to practice skills will be highlighted. Lesson plans are designed to be delivered weekly over an eight week period. Sessions are 90 minutes.

Parent Meetings

According to Fisher, Masia-Warner, and Klein (2004), many parents have a limited understanding of the symptoms and impairment associated with social anxiety. They may interpret socially anxious behaviours as part of their child's personality, or as something from which their child will mature. In addition, parents are often frustrated with their child's avoidance behaviours, and fail to understand such behaviours. Therefore, parent meetings should be conducted to teach parents about social anxiety and the group program being offered. Outlines for parent meetings are not included in this project and will therefore need to be created by individual facilitators.

Group Marketing

Because the group consists of adolescents, it is important to ensure that in addition to targeting the community of parents, adolescents are also targeted. Targeting the adolescent community can be done by contacting local guidance counsellors and providing them with program information. Posters could also be displayed in the common areas of schools. Newsletters distributed through local agencies such as community resource centres provide marketing opportunities as well. Other local agencies, such as mental health clinics, should be provided with program information in the event that they can identify a client who may benefit from such a group. Advertisements in the local newspaper would also be useful.

Overview of Lesson Plans

As noted, Appendix A provides sample lesson plans to use in the treatment of SAD in youth. This treatment program incorporates supported CBT strategies – interventions mentioned in Chapter Three. Targeted areas include: (a) understanding of anxiety, including the cognitive, behavioural, and physiological manifestations of anxiety; (b) the detection of automatic thoughts and the identification of beliefs, the evaluation of automatic thoughts and beliefs, and the changing of negative automatic thoughts and maladaptive beliefs; (c) systematic desensitization including relaxation training, guided imagery, mindfulness, and graded exposure.

Finally, the last chapter will present a summary of the literature presented. It will review the strengths and limitations of the literature presented, in addition to making suggestions for future research ideas.

Chapter Six

Synopsis

This chapter includes a summary of the literature presented, a discussion of the strengths and limitations of the empirical reviews presented, and implications for future research. A comprehensive list of references is provided at the end of this chapter.

Social anxiety disorder (SAD) is characterized by intense fear of embarrassment, humiliation, and negative evaluation by others in social situations, and a tendency to avoid feared situations (Kashdan & Herbert, 2001). The term social anxiety may implicitly categorize SAD as a form of specific phobia, thereby risking the trivialization of the chronic course and severe impairment associated with SAD. However, impressive strides have been made in our understanding of SAD. For example, we now know a great deal more about the phenomenology of the disorder. In particular, it is now accepted that SAD is much more common and more debilitating than originally believed (Khalid-Khan et al., 2007).

Social anxiety disorder is a chronic and debilitating condition that onsets early in life and can extend into adulthood (Kashdan & Herbert, 2001; Velting & Albano, 2001). Because social situations occur throughout the lifespan and are necessary to achieve both social and non-social goals, it is not surprising that SAD leads to significant distress and impairment (Khalid-Khan et al., 2007; Lecrubier et al., 2000).

Understanding the difference between normal and pathological fear is often difficult (Albano et al., 2001). Adolescence is a critical developmental stage of identity formation and social skill development in which concerns about peer acceptance and body image become dominant (Santrok, 2001). Distinguishing normal levels of such

concerns from clinically significant levels can sometimes pose significant challenges for the clinician.

The vast majority of adolescents with SAD go unrecognized by both parents and professionals, including school personnel (Kashdan & Herbert, 2001). By definition, individuals with SAD are highly concerned about others' perceptions of them, and therefore tend not to behave in ways that would draw attention to themselves (Kashdan & Herbert).

Three factors hypothesized to be involved in the maintenance of SAD are: cognitive biases; deficits in social skills; and operant conditioning (Kashdan & Herbert, 2001). According to cognitive models, the core of SAD is a strong desire to make a favourable presentation to others coupled with the perceived inability to do so (Antony & Swinson, 2000). These individuals hold beliefs that they will predictably behave in ways that will elicit rejection or negative evaluation from others (Antony & Swinson). These beliefs are primed by perceived social evaluative situations, resulting in negative self-statements and pre-occupation with one's social performance, which in turn lead to physiological and behavioural manifestations of anxiety (Musa & Lepine, 2000). According to cognitive models, this self-focused attention then interferes with satisfactory social functioning (Antony & Swinson; Kashdan & Herbert).

Deficits in social skills have also been theorized to contribute to the maintenance of SAD (Spence et al., 2000). However, it is important to note that although problems with social behaviour may reflect skill deficits, they may just as easily reflect an inability to perform behaviours because of excessive anxiety, which are potentially available. Operant factors, especially negative reinforcement of avoidance behaviours, are

hypothesized to work in conjunction with parent-child interaction styles, peer relations, and perceived and imagined social threat or trauma in the maintenance of SAD (Kashdan & Herbert, 2001). Furthermore, negative reinforcement may occur when one avoids phobic situations and experiences a sense of relief from anxiety (Albano, 1995).

These factors are not mutually exclusive. Vicious feedback cycles involving multiple contributors may develop. For example, cognitive biases may lead to anxiety in social situations, which induces avoidance behaviours, which may lead to social skill problems, leading in turn to further increases in social anxiety.

Treatment researchers have developed a variety of techniques involving cognitive behavioural therapy for adolescent anxiety. The specific combination of techniques used varies somewhat from one clinician to another, but there are common features involving education and behavioural exposure. As part of the educational component, teens learn about the biological arousal associated with anxious feelings, and they may identify their own distinctive pattern (Ginsburg & Grover, 2005; Khalid-Khan et al., 2007). They may also learn specific skills, such as relaxation, to use in managing their arousal (Rowa & Antony, 2005). Another common educational focus involves identifying, testing, and modifying negative cognitions (Clark et al., 2003; Merrell, 2001). Additionally, a key element to all CBT techniques to treat adolescent anxiety is exposure (Antony & Swinson, 2000).

Strengths of the Literature Review and Lesson Plans

Evidence of the positive effects of CBT for adolescent anxiety is quite encouraging. Randomized controlled clinical trials have shown beneficial effects at immediate posttreatment, with good maintenance of gains one year later (Baer &

Garland, 2005; Hayward et al., 2000; Spence et al., 2000). The CBT findings for adolescent anxiety are exemplary in several ways. First, the studies have focused on cases serious enough to warrant a formal diagnosis, based on standardized assessment procedures, and cases involving comorbid conditions have been included. Second, the studies have included assessment of clinical significance, and striking reductions have been shown in the percentage of treated youth who qualify for anxiety diagnosis, as compared with much more modest reductions in wait-listed youth. Third, the studies have tracked treated youth over longer posttreatment follow-up periods than most studies and have shown gains made by treated youth stand up well.

These findings support the application of the lesson plans included in this project. Specifically, the skills used to target SAD in the above noted studies are the same skills employed in these lesson plans. Therefore, significant reductions in anxious symptomatology, with gains maintained at least up to one year, can be expected.

Limitations of the Literature Review and of the Lesson Plans

Although there are reports of the psychosocial treatment of adolescent SAD in the literature dating back almost two decades, the systematic study of such interventions has only recently begun. Although SAD is quite common among children and adolescents, the vast majority of research on the disorder has focused on adult samples. As a result, most treatments that have been developed for children and adolescent SAD are essentially modifications of existing adult intervention programs. Although the theoretical underpinnings, rationale, and intervention strategies are adapted to the developmental level of the target population, it remains to be seen if truly unique

treatment components are necessary to maximize results for child and adolescent populations.

An additional limitation of the literature on the treatment of adolescent SAD is that most literature consists almost exclusively of variations of cognitive and behavioural therapy. Although there have been isolated reports of psychodynamic psychotherapy, there have been no controlled outcome evaluations of such interventions (Kashdan & Herbert, 2001). The efficacy of adolescent SAD treatments is therefore limited to CBT intervention programs.

Another limitation is that all of the studies of the treatment of childhood and adolescent SAD have evaluated the target treatment program against wait-list control groups rather than alternative treatment or placebo. The issue of what conditions constitute an appropriate baseline against which to evaluate the efficacy of psychosocial treatments is controversial (Seligman, 1995). Some view a comparison against no treatment or wait-list conditions as a promising step toward empirical validation (Seligman). Although wait-list designs control for time-related effects such as spontaneous remission and statistical regression, mood and anxiety disorders have been shown to be at least somewhat responsive to virtually any credible intervention, thereby rendering studies using no treatment or wait-list controls of little scientific importance (Kazdin, 1998). Such designs do not address non-specific treatment effect and placebo effects (Kazdin).

Due to the fact that most research consists primarily of CBT interventions, the attached lesson plans were based on this treatment literature. Unfortunately, the fact that the lesson plans are based solely on one form of treatment can be seen as a short-coming.

Furthermore, there is limited parental involvement throughout the delivery of these lesson plans. According to Kashdan and Herbert (2001), there is utility in parental involvement in the treatment of SAD. Therefore, further study to determine the relative inclusion of family members in the treatment of SAD would be beneficial.

Areas of Future Research

Although the treatment outcome literature on psychosocial interventions for adolescent SAD is in its infancy, there is reason for considerable optimism. Several studies have documented the efficacy of CBT for adolescents with SAD relative to wait-list controls (Baer & Garland, 2005; Hayward et al., 2000; Spence et al., 2000). Cognitive behavioural group therapy for adolescents is the only intervention to date specifically targeting adolescents with SAD. Initial results are promising, at least for the short-term, although no studies have yet evaluated CBGT against an alternative treatment to rule out placebo and non-specific effects. Therefore, an important area of research would be to compare CBGT to other forms of treatment and placebo. Furthermore, follow-up controlled studies are needed to determine the long-term benefits of CBT and whether booster sessions of CBT lead to reduce relapsed rates.

In addition to comparing studies of treatment for adolescent SAD, future research needs to focus on controlled trials of combined treatments such as comparisons of medication, CBT, and the combination of pharmacotherapy and CBT. These approaches would help clinicians to determine whether combined treatment is more effective for symptom reduction than either medication or CBT alone.

Another important avenue for future investigation is the utility of including parental involvement in the treatment of SAD. Parental involvement can range from

being involved in the psychoeducation sessions of treatment to being active participants in a program designed to educate parents of adolescents with SAD. Research is also needed to assess the transportability of the treatments mentioned throughout this paper – from highly specialized clinical research settings to naturalistic settings such as community clinics and schools.

In order to ensure the effectiveness and appropriateness of the lesson plans, it would be beneficial to conduct focus groups. Such focus groups could be conducted with others who have an interest in this area of study or work, and are designed to seek feedback and gather ideas about additional avenues that may need exploration. Furthermore, these lesson plans require empirical testing. This requirement could be completed using pre- and post-treatment measures such as the MASC. Additionally, individual feedback could be used to interpret the effectiveness of the program. Individual feedback could be obtained in the form of evaluation forms or personal interviews.

Closing Remarks

In completing this project, my intention has been to (a) provide a detailed description of SAD; (b) recommend specific skills needed to overcome problems with SAD and provide exercises for mastering these skills and; (c) demonstrate that cognitive-behavioural therapy is an effective form of treatment for those youth who participate in either individualized treatments or more specialized social anxiety groups.

As a student of counselling study and practice, it has been valuable to closely examine SAD and current treatment options. Upon reflection, I have concluded that although some of the theories of anxiety and proposed treatments for SAD present as

being separate and distinct; it is not one theory or the other that makes a difference in intervention alone. I have come to appreciate that marrying the elements of all theories is necessary in order to be responsible and responsive to the client's needs. In my personal experience working with adolescents and families, I have been most successful in approaching clients in a humanistic and holistic manner, incorporating a variety of elements from various theories. The preparation for this project has reaffirmed for me the need to fuse theoretical concepts in an effort to meet the personal needs of the clients I have the opportunity to serve.

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Appendix A

Group Therapy Lesson Plans

Treating Social Anxiety in Adolescents

Pre-Group Session

NOTE; Please refer to Chapters 3, 4, 5 and 6 for the context of these lesson plans as well as necessary components that need to be considered before implementing these plans.

Treating Social Anxiety in Adolescents

Pre-Group Session

Objectives:

1. Participants will have an understanding of program goals and agenda.
2. Participants will have an understanding of group expectations.
3. Participants will be able to identify their level of commitment to the program.
4. Participants will develop group guidelines to be adhered to for the remainder of the program.

Advance Preparation:

1. Post session agenda.
2. Ensure flip-chart is available.
3. Prepare copies of the information sheet, program agenda and consent form.
4. Index cards and feedback form required.
5. Review session agenda.

Time	Topic	Facilitation Instructions	Notes/ Directions	Supplies Needed
10 min.	Introductions	Ask participants to identify themselves by telling us their name and something they enjoy doing.		
40 min.	What is group therapy? Overview of program	Facilitators discuss what group therapy is. Overview of program (agenda, benefits/risks, confidentiality, participant and leader roles).	Refer to Informed Consent Form – Appendix A and Group Therapy Information Sheet – Appendix B	Appendix A - Informed Consent Form Appendix B - Group Therapy Information Sheet
20 min.	Developing Group Guidelines	Ask participants to identify and develop a list of group guidelines. Have participants list guidelines they want included for the group on index card provided. Once participants have completed this task, index cards can be given to a facilitator.	Record guidelines on a flip-chart for future reference.	Index cards Flipchart

5 min.	Group Feedback/Closing	Have participants fill out Feedback Form.		Feedback Forms
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Facilitator Debriefing Questions:

1. Are there any participants that appear to be ambivalent about participating in the group post the pre-group meeting?
2. Did we address any/all cultural diversity concerns?
3. How are we doing? Are we working well together?

Additional Resources for the Facilitator(s):

Corey, M., & Corey, G. (2006). *Process and practice groups*. Belmont, CA: Thomson Brooks/Cole.

Yalom, I. (1995). *The theory and practice of group psychotherapy*. New York, NY: Basic Books.

Feedback Form 1

1. How did you feel coming here today?
2. How do you feel now?
3. Did something or someone help to make you feel more comfortable here today? If yes, what or who?

Treating Social Anxiety in Adolescents

Session 1 – Group Formation

Treating Social Anxiety in Adolescents

Session 1 – Group Formation

Objectives:

1. Participants will begin to develop cohesiveness.
2. Participants will identify their individual goals.

Advance Preparation:

1. Post session Agenda.
2. Post the guidelines (completed in pre-group meeting).
3. Ensure flipchart available.
4. Prepare copies of Scavenger Hunt.
5. Prepare copies of feedback form.
6. Review lesson plan in preparation for lesson delivery.

Time	Topic	Facilitation Instructions	Notes/ Directions	Supplies Needed
15 min.	Welcome & Re-Introductions	Ask participants to re-introduce themselves and tell us what their favourite movie or book is. Ask participants if they have any afterthoughts or unresolved feelings from the pre-group meeting. Ask participants how they are feeling about being here today?		
15 min.	Review Group Guidelines	Review group guidelines developed in the pre-group meeting. Ask if there are any questions?	Post guidelines (flipchart) made in pre-group meeting up on wall for reference.	Recorded guidelines completed in pre-group meeting.

15 min.	Activity – Scavenger Hunt	Explain how the game works; walk around the group and try to find someone in this group who matches each question. Have them sign their name next to the question.	This is your chance to get to know everyone in some way, have fun!	Scavenger Hunt (included with session plan)
10 min.	Goals	Have participants identify three goals they hope to accomplish in group. Have participants write these goals down on an index card provided and give to facilitator when complete.	No need to put your name on index card.	Index cards
15 min.	Dyad Activity	Have participants break into dyads with the person to their right. Have them take turns discussing how they are currently feeling and what their fears and expectations are related to participating in the program.	While this activity is taking place, have one facilitator record the group's common goals on flipchart.	
15 min.	Identification of Group Goals	Have participant's re-join the group. Facilitator to identify recorded goals on flipchart with group.	Highlight common goals.	Flipchart
5 min.	Check-Out	Have participants complete weekly feedback form		Copies of the weekly feedback form

Facilitator Debriefing Questions:

1. What stood out for you the most during today's session?
2. Are you being affected personally by any of the participants?
3. Can we meet the expectations of the group members or do we need to discuss such expectations further?
4. Is anything getting in the way of our ability to effectively lead this group?

5. How did you feel leading/co-leading the group? How are we working together?

Additional Resources for the Facilitator(s):

Corey, M., & Corey, G. (2006). *Process and practice groups*. Belmont, CA: Thomson Brooks/Cole.

Yalom, I. (1995). *The theory and practice of group psychotherapy*. New York, NY: Basic Books.

Scavenger Hunt¹

This is a person-to-person scavenger hunt. Walk around and try to find someone in this group who matches each question. Have them sign their name on the line next to the question. This is your chance to get to know everyone in group. Have fun!

1. Someone with the same colour of eyes as you.
2. Someone born in the same year as you.
3. Someone who has the same astrological sign as you.
4. Someone who likes to sing in the shower.
5. Someone who has the same favourite dessert as you.
6. Someone who has 7 or more letters in their first name.
7. Someone who has the same television show as you.
8. Someone who is an only child.
9. Someone who can speak more than one language.
10. Someone who has a pet.
11. Someone who likes to laugh.
12. Someone who has been on an airplane.
13. Someone who has a job.
14. Someone who loves pizza.
15. Someone who plays a musical instrument.

¹ Created by Alison Mazur-Elmer

Treating Social Anxiety in Adolescents

Session 2 – Anxiety-What does it mean to me?

Treating Social Anxiety in Adolescents

Session 2 – Anxiety-What does it mean to me?

Objectives:

1. Group participants will have a better understanding of anxiety and how it personally impacts them.
2. Participants will continue to develop cohesiveness.

Advance Preparation:

1. Post session Agenda.
2. Prepare copies of anxiety checklist and feedback form.
3. Review lesson plan in preparation for lesson delivery.

Time	Topic	Facilitation Instructions	Notes/ Directions	Supplies Needed
15 min.	Checking In	Ask participants if they have any afterthoughts or unresolved feelings from Session 1. Ask participants to use one word to describe how they are feeling about being here today?		
15 min.	Overview of anxiety	Refer to Facilitator Notes.		
20 min.	Anxiety Checklist	Have participants fill out Anxiety Checklist. Once completed pair up with the person to your left and review each others checklist – identifying similarities and differences.		Handout 1
35 min.	Group Feedback	Have participants return to the group. Ask them to share what they discovered in completing the Anxiety Checklist. What did they learn about themselves? Were they surprised to find that their partner had similar symptoms?		

5 min.	Check-Out	Have participants complete weekly feedback form		Copies of the weekly feedback form
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Facilitator Debriefing Questions:

1. What stood out for you the most during today's session?
2. Are you being affected personally by any of the participants?
3. Are we providing the right amount of structure?
4. Is anything getting in the way of our ability to effectively lead this group?
5. How did you feel leading/co-leading the group? How are we working together?

Additional Resources for the Facilitator(s):

Corey, M., & Corey, G. (2006). *Process and practice groups*. Belmont, CA: Thomson Brooks/Cole.

Yalom, I. (1995). *The theory and practice of group psychotherapy*. New York, NY: Basic Books.

Facilitator Notes:**What is Anxiety?²**

Anxiety is the feeling we get when our body responds to a frightening or threatening experience. It has been called the fight or flight response. It is simply your body preparing for action either to fight danger or run away from it as fast as possible. The purpose of the physical symptoms of anxiety therefore is to prepare your body to cope with threat. To understand what is happening in your body, imagine that you are about to be attacked. As soon as you are aware of the threat your muscles tense ready for action. Your heart beats faster to carry blood to your muscles and brain, where it is most needed. You breathe faster to provide oxygen which is needed for energy. You sweat to stop your body overheating. Your mouth becomes dry and your stomach may have butterflies.

The fight or flight response is a really basic system that probably goes back to the days of cave men, and is present in animals who depend on it for their survival. Fortunately, nowadays we are not often in such life or death situations, but unfortunately many of the stresses we do face can't be fought or run away from, so the symptoms don't help. In fact they often make us feel worse, especially if we don't understand them.

What causes anxiety?

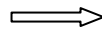
There are many reasons why someone becomes anxious.

- Some people may have an anxious personality and have learned to worry.
- Others may have a series of stressful life events to cope with, for example grief, divorce.

² Taken from Brady & Kendall (1992); Merrell (2001)

- Others may be under pressure, at school or at home.

What keeps anxiety going?



Thoughts (something awful is going to happen to me)

Feeling anxious

Feel bodily symptoms

Feeling anxious

*Anxiety often becomes a vicious circle where our symptoms, thoughts and behaviour keeps the anxiety going.

Handout 1 – Session 2

Anxiety Checklist³

Anxiety impacts us in at least four different ways. It affects:

- | | |
|-------------------|-------------------------|
| The way we feel. | The way our body works. |
| The way we think. | The way we behave. |

Place a check mark next to those symptoms you experience regularly.

How you feel

- Anxious, nervous, worried, frightened
- Feeling something dreadful is going to happen
- Tense, stressed, uptight, on edge, unsettled
- Unreal, strange, woozy, detached
- Panicky

How you think

- Constant worrying
- Can't concentrate
- Thoughts racing
- Mind jumping from one thing to another
- Imagining the worst and dwelling on it

What happens to your body?

- Heart pounds, races, skips a beat
- Chest feels tight or painful
- Tingling or numbness in toes or fingers
- Stomach churning or “butterflies”

³ Created by Alison Mazur-Elmer

- Feeling of having to go to the bathroom
- Feeling jumpy or restless
- Tense muscles (headache)
- Sweating
- Breathing changes
- Dizzy, light headed

What you do?

- Pace up and down
- Talk quickly or more than usual
- Become quiet
- Become irritable
- Eat more or less
- Avoid feared situations

Treating Social Anxiety in Adolescents

Session 3 – Disputing Irrational Thoughts

Treating Social Anxiety in Adolescents

Session 3 – Disputing Irrational Thoughts

Objectives:

1. The relationship between thoughts, feelings, and behaviours will be explored and understood by participants.
2. Irrational maladaptive thoughts will be identified, disputed, and replaced with more realistic and productive thoughts.

Advance Preparation:

1. Post session agenda.
2. Prepare copies of handouts.
3. Ensure flipchart is available.
4. Review lesson plans in preparation for lesson delivery.

Time	Topic	Facilitation Instructions	Notes/ Directions	Supplies Needed
15 min.	Checking in: review/reflect from last session	Ask participants if they were more aware of their thoughts, feelings, and body over the last week. If yes, how so and in what context? Ask participants to identify one thing that they are aware of right now.		
15 min.	Connection between thoughts, feelings, and behaviours – how irrational thoughts are developed and maintained	Group leaders will highlight the relationship between thoughts, feelings, and behaviour. Provide handouts 1 & 2.	Use facilitator notes below.	Flipchart Handouts 1 & 2

25 min.	Identifying personal irrational thoughts	Have participant's complete handout #3 (using handouts 1 & 2 as a reference). Completion of handout #3 should indicate participant's frequent maladaptive thoughts. Once complete, have participants find a partner of their choice to discuss/dispute each other's thoughts, replacing them with more adaptive thoughts.		Copies of Handout #3 and pencils
20 min.	Processing irrational thoughts with group	Discuss the activity as a group; was it difficult to complete; how was it to replace negative thoughts with more positive thoughts, etc. Ask participants (whoever wants to share) to share their frequent irrational thoughts with the group and the thoughts they have chosen to replace them with.		
15 min.	Check-Out	Have participants share with the group one thing they will practice over the week.		
	Continued	Have participants complete weekly feedback form.		Copies of the weekly feedback form.

Facilitator Notes:

Negative emotions are caused by negative thoughts and beliefs.⁴ People who interpret a given situation in different ways are likely to experience different emotions. For example, imagine that a friend of yours has cancelled a dinner date at the last minute, without providing a reason. Some of the possible interpretations for this are:

“My friend has been hurt or is ill” – Anxiety or Worry

“My friend isn’t treating me with the respect I deserve” – Anger

“My friend doesn’t care about me” – Sadness

“Thank goodness the dinner has been cancelled; I am always so nervous when I have to eat with others” – Relief

“I guess something else came up. Everyone changes plans from time to time, including me” – Neutral

Anxiety and fear result when a person interprets a situation as threatening or dangerous.

Although fearful predictions and interpretations are sometimes accurate, they are often exaggerated and inaccurate. You have been given a handout of a list of thoughts and assumptions that can contribute to social anxiety. With this as a reference please complete Handout #3.

Facilitator Debriefing Questions:

1. What were the common themes related to irrational thoughts?
2. How can we help the participants engage in more realistic thinking in future sessions?
3. Are participants actively working towards their goals at this point?

⁴ Antony, M., & Swinson, R. (2000). *The shyness and social anxiety workbook*. Oakland, CA: New Harbinger Publications, Inc.

Additional Resources for the Facilitator(s):

Kendall, P., & Hedtke, K. (2006). *Cognitive-behaviour therapy for anxious children:*

therapist manual (3rd ed.). Ardmore, PA: Workbook Publishing, Inc.

Merrell, K. W. (2001). *Helping students overcome depression and anxiety: A practical*

guide. New York, NY: The Guilford Press.

Promising Practices Network. (2008). Programs That Work: The Coping Cat Program at

<http://www.promisingpractices.net/proprograminfo>

Session 3 – Disputing Irrational Thoughts

Handout #1 – Examples of Anxious Thoughts & Beliefs⁵

- It is important that everyone like me
- If I give a presentation, I will make a fool of myself
- If I make a mistake, people will be angry with me
- People should not look at me the wrong way
- It is awful to blush, shake, or sweat in front of others
- People can tell when I'm anxious
- People find me unattractive
- Anxiety is a sign of weakness
- I should not appear anxious
- No one likes me
- Everything bad is my fault
- I always say dumb things
- I'll never make any good friends
- Something bad is going to happen
- I am worthless
- There is something wrong with me
- I'm stupid

⁵ Adapted from M. Antony and R. Swinson (2000). *Phobic Disorders and Panic in Adults: A guide to assessment and treatment*. Washington, DC: American Psychological Association.

Merrell, K. W. (2001). *Helping students overcome depression and anxiety: A practical guide*. New York, NY: The Guilford Press.

Session 3 – Disputing Irrational Thoughts
Handout #2 – Identifying Thinking Errors⁶
 Am I making any of these Thinking Errors?

Binocular Vision

Do I look at negative things in a way that makes them seem bigger than they really are? Do I look at good things in a way that makes them seem smaller than they really are?

Black-and-White Thinking

Do I think about things only in extreme or opposite ways (e.g., good or bad, all or nothing, black or white)?

Dark Glasses

Do I think only about the bad side of things?

Fortune-Telling

Do I make predictions about what will happen in the future, without enough information?

Making It Personal

Do I make things my responsibility that I don't need to? Do I blame myself for things that I can not control?

Overgeneralizing

Do I make general conclusions based only on one event?

Labelling

Do I put simple, unfair, and negative labels on people or things that are really more complicated than the label?

Discounting the Positive

Do I ignore positive things or thoughts by telling myself they don't really matter?
 Can I accept a compliment from another person without thinking it isn't really so?
 Do I twist good situations into things that are bad?

Beating Up on Myself or Others

Do I insist or demand that things "should" or "must" be done a certain way?

⁶ Copied From Kenneth W. Merrell (2001). Copyright by The Guilford Press. Permission to photocopy this worksheet is granted to purchasers of this book for personal use only.

**Session 3 – Disputing Irrational Thoughts
Handout #3**

Situation #1:

My Negative Automatic Thought:

Feelings:

Thinking Error:

Replacement Thought:

Situation #2:

My Negative Automatic Thought:

Feelings:

Thinking Error:

Replacement Thought:

Situation #3:

My Negative Automatic Thought:

Feelings:

Thinking Error:

Replacement Thought:

Situation #4:

My Negative Automatic Thought:

Feelings:

Thinking Error:

Replacement Thought:

Treating Social Anxiety in Adolescents

Session 4 – Externalization

Treating Social Anxiety in Adolescents

Session 4 – Externalization

Objectives:

1. Participants will become aware of how they physically experience emotions.
2. Participants will have the opportunity to externalize their emotions through a body tracing activity.

Advance Preparation:

1. Post session agenda.
2. Prepare required supplies.
3. Review lesson plan in preparation for lesson delivery.

Time	Topic	Facilitation Instructions	Notes/ Directions	Supplies Needed
15 min.	Checking in: review/reflect from last session	Ask participants to identify any insights/thoughts they had about last week's session. Ask participants to share any experiences they have had over the week using last weeks taught skills (disputing irrational thoughts)		
30 min.	Body Tracing- externalizing emotions	Explain to participants that they are going to engage in a body tracing activity. See facilitator notes for instructions. Ask participants to find a partner they feel comfortable with.		Coloured markers, tracing paper

30 min.	Processing the body tracing activity	Have participants share their experiences with the group related to their participation in the body tracing activity.	How did they feel? What did they discover about their body? How is anxiety related to their body? What colours did they use to describe their sensations? Why?	
15 min.	Check-Out	Have participants share one thing with the group that they will practice over the week.		
	Continued	Have participants complete weekly feedback form.		Copies of the weekly feedback form.

Facilitator Notes:

Method for Body Tracing:

- Choose a partner you feel comfortable with as they will be getting in your space.
- The partner being traced chooses a coloured marker, lies down on the tracing paper provided.
- The partner completing the tracing should maintain appropriate boundaries and respect their partner's need for safety and comfort.
- The partner being traced should think of a time they have experienced anxiety, all while thinking about the shapes, colours, or textures they notice in their body from head to toe. Switch partners once tracing is complete on the first partner.
- Once both partners have been traced, each partner colours their emotions inside their body – highlighting where they feel anxiety in their body.

Facilitator Debriefing Questions:

1. Were participants able to identify their physical sensations related to their anxiety? To what degree were they able to process this?
2. Were our objectives clear?

Additional Resources for the Facilitator(s):

Kendall, P., & Hedtke, K. (2006). *Cognitive-behaviour therapy for anxious children: therapist manual* (3rd ed.). Ardmore, PA: Workbook Publishing, Inc.

Merrell, K. W. (2001). *Helping students overcome depression and anxiety: A practical guide*. New York, NY: The Guilford Press.

Promising Practices Network. (2008). Programs That Work: The Coping Cat Program at <http://www.promisingpractices.net/proprograminfo>

Treating Social Anxiety in Adolescents

Session 5 – Relaxation Training

Treating Social Anxiety in Adolescents

Session 5 – Relaxation Training

Objectives:

1. Group participants will learn relaxation/guided imagery techniques.
2. Techniques taught will provide participants with the required skills for future exposure activities.

Advance Preparation:

1. Post session agenda.
2. Choose relaxation script.
3. Prepare handout - relaxation script.
4. Review lesson plan in preparation for lesson delivery.

Time	Topic	Facilitation Instructions	Notes/ Directions	Supplies Needed
15 min.	Checking in: review/reflect from last session	Ask participants to identify any insights/thoughts they have in regards to last week's session. Ask participants to share any experiences over the last week related to an increased awareness of how he or she physically experiences their emotions. Ask participants to draw awareness to their body right now. Ask them to identify what they are aware of.		
20 min.	Benefits/Risks of relaxation training	Discussion of the benefits and risks of relaxation training. Ask participants what they think the benefits and/or risks are.	See Facilitator Notes.	

20 min.	Applied relaxation training	Have participant's engage in a group relaxation exercise. Facilitator to read the script. Encourage participants to practice techniques over the next week.	Choose Script 1 or 2 attached.	Handout copies of the relaxation scripts for practice over the week.
30 min.	Processing the relaxation activity	Have participants share their experiences with the group related to their participation in the relaxation exercise.		
5 min.	Check-Out	Have participants complete weekly feedback form.		Copies of the weekly feedback form.

Facilitator Notes:

Benefits of Relaxation⁷

- ✓ Deep relaxation can help reduce anxiety. Regular practice of deep relaxation of 20 to 30 minutes on a daily basis can produce, over time, a generalization of relaxation to the rest of your life. That is, after several weeks of practicing deep relaxation once per day, you will tend to feel more relaxed all the time.
- ✓ Reduces the frequency and severity of panic attacks.
- ✓ Increased energy level.
- ✓ Prevention and/or reduction of migraines, headaches, ulcers, and so on.
- ✓ Decreased muscular tension.
- ✓ Decrease in heart rate and blood pressure.

⁷ Antony, M., & Swinson, R. (2000). *The shyness and social anxiety workbook*. Oakland, CA: New Harbinger Publications, Inc.

Facilitator Debriefing Questions:

1. Were participants fully able to enter a state of relaxation? If not, what do you think the contributing barriers were?
2. Is there anything we could do to make the environment more relaxing?

Additional Resources for the Facilitator(s):

Kendall, P., & Hedtke, K. (2006). *Cognitive-behaviour therapy for anxious children: therapist manual* (3rd ed.). Ardmore, PA: Workbook Publishing, Inc.

Merrell, K. W. (2001). *Helping students overcome depression and anxiety: A practical guide*. New York, NY: The Guilford Press.

Promising Practices Network. (2008). Programs That Work: The Coping Cat Program at <http://www.promisingpractices.net/proprograminfo>

Session 4 – Relaxation Training

Relaxation Script 1⁸

Find a quiet comfortable place.

Get into a relaxed and comfortable position.

Close your eyes.

Think of relaxing every muscle in your body, from the top of your head to the tips of your toes.

Focus on your breathing; draw deep, full breaths, let them out slowly, and feel yourself relax as you breathe out.

As you exhale, imagine releasing any remaining tension from your body, mind, or thoughts, letting all your stress and worries go.

With every breath you inhale, feel your body drifting down deeper...down deeper into total relaxation.

Now imagine yourself in the midst of a peaceful scene. This could be the beach, the forest, somewhere you've been before, or somewhere you imagine.

Imagine your peaceful place as vividly as possible, as if you were really there.

What do you see? What do you hear? What do you smell? How do you feel?

Feeling relaxed and peaceful in your special place, continue to draw deep full breaths, letting them out slowly – feel yourself relax as you breathe out.

⁸ Script written by: Alison Mazur-Elmer

Session 4 – Relaxation Training

Visualization/Relaxation Script 2

Creating Your Special Place⁹

In creating your special place you will be constructing a retreat for relaxation and guidance. This place may be indoors or out. In structuring your place, follow a few guidelines:

Allow a private entry to your place.
Make it peaceful, comfortable, and safe.

A special place might be at the end of a path that leads to a pond. Grass is under your feet, the pond is about thirty yards away, and mountains are in the distance. You can feel the coolness of the air in this shady spot. The mockingbird is singing. The sun is bright on the pond. The honeysuckle's pungent odour attracts the bee buzzing over the flower with its sweet nectar.

To go to your special place, lie down and be totally comfortable. Close your eyes...walk slowly to a quiet place in your mind...your place can be inside or outside...it needs to be peaceful and safe...picture yourself unloading your anxieties, your worries...notice the view in the distance...What do you smell?...What do you hear?...Notice what is before you...reach out and touch it...How does it feel?...Smell it...hear it...make the temperature comfortable...be safe here...look around for a special spot, a private spot...

Find the path to this place...feel the ground with your feet...look above you...What do you see?...Hear?...Smell?...Walk down this path until you can enter your own quiet, comfortable, safe place.

You have arrived at your special place...What is under your feet?...How does it feel?...Take several steps...what do you see above you? What do you hear? Do you hear something else? Reach and touch something...What is the texture? Are there paints nearby, or is there sand to draw in, clay to work? Go to them, handle them, smell them. These are your special tools. Look as far as you can see...what do you see? What do you hear? What aromas do you notice?

⁹ Script taken from Wells (1990).

Sit or lie in your special place...notice its smells, sounds, sights...this is your place and nothing can harm you here..if danger is here, expel it...spend a couple of minutes realizing you are relaxed, safe, and comfortable.

Memorize this place's smells, tastes, sights, sounds...you can come back and relax here whenever you want...leave by the same path or entrance...notice the ground, touch things near you...look far away and appreciate the view...remind yourself this special place you created can be entered whenever you wish. Say an affirmation such as, "I can relax here" or, "This is my special place".

Now slowly open your eyes and spend a few seconds appreciating your relaxation.

Treating Social Anxiety in Adolescents

Session 6 – Introduction to Exposure

Treating Social Anxiety in Adolescents

Session 6 – Introduction to Exposure

Objectives:

1. Group participants will identify their fears from least to most feared.
2. Participants will challenge their fears (imaginal desensitization) while in a state of relaxation.

Advance Preparation:

1. Post session agenda.
2. Purchase index cards.
3. Prepare extra copies of relaxation script.
4. Prepare copies of feedback form.
5. Review lesson plan in preparation for lesson delivery.

Time	Topic	Facilitation Instructions	Notes/ Directions	Supplies Needed
15 min.	Checking in: review/reflect from last session	Ask participants to identify any insights/thoughts they have had about last week's session. Ask participants to share any experiences they have had over the week using last weeks or any other weeks taught skills- did anyone practice the relaxation exercise completed last week? How did it go? Ask participants to rate how they feel in this moment using a scale of 1-10, with 1 being extremely relaxed and 10 being highly anxious.		

10 min.	Anxiety Hierarchy	Have participants develop an anxiety hierarchy using a scale of 10-100 with 10 representing low anxiety and 100 representing a high anxiety response. Cards should be assigned ratings in multiples of 10 (10, 20, up to 100). The higher the number, the more fear or discomfort that one would feel in that situation.	Participants rate anxiety-producing stimuli from least to most feared.	10 index cards per participant/one card for each fear
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30 min.	Relaxation & Exposure Activity	<p>Have participant's partner up with a partner of choice. Partner #1 should read the relaxation script given in last week's session, while partner #2 spends about 3 mins. relaxing in a comfortable position. Partner #1 should then ask Partner #2 to imagine the situations from his/her anxiety hierarchy, beginning with the least feared situation. If participants begin to feel even a small amount of anxiety or tension, they should signal to their partner by raising their hand. If the signal is given, partner #1 should ask them to imagine a zero-level scene and guide them through the steps until a state of relaxation has once again been reached. Once partner #2 has signalled that this state has been reached, participant #1 instructs partner #2 to imagine the scene once again. The cycle continues until partner #2 can imagine the initial scene without fear or anxiety.</p>	<p>Instruct participants to imagine the scene vividly, as if they were actually there.</p> <p>Each partner will have 15 min. to engage in the exercise.</p> <p>Facilitator to indicate switch time.</p>	Copies of relaxation script from last week's session
30 min.	Group Process of Activity	<p>Have participants share their experiences with the group related to their participation in the exposure activity.</p>		
5 min.	Check-Out	<p>Have participants complete weekly feedback form.</p>		Copies of the weekly feedback form

Facilitator Debriefing Questions:

1. What were the group's common fears?
2. How do you think the participants responded to the dyad exercise? Do you think they got the most from it?
3. Is there anything that we should consider changing?

Additional Resources for the Facilitator(s):

Kendall, P., & Hedtke, K. (2006). *Cognitive-behaviour therapy for anxious children: therapist manual* (3rd ed.). Ardmore, PA: Workbook Publishing, Inc.

Merrell, K. W. (2001). *Helping students overcome depression and anxiety: A practical guide*. New York, NY: The Guilford Press.

Promising Practices Network. (2008). Programs That Work: The Coping Cat Program at <http://www.promisingpractices.net/proprograminfo>

Treating Social Anxiety in Adolescents

Session 7 – Mindfulness

Treating Social Anxiety in Adolescents

Session 7 – Mindfulness

Objectives:

1. Group participants will develop an understanding of mindfulness and the benefits of practicing mindfulness.
2. Participants will have the opportunity to practice mindfulness by engaging in a mindfulness activity.

Advance Preparation:

1. Post session agenda.
2. Purchase item(s) for mindfulness activity.
3. Prepare copies of feedback form.
4. Review lesson plan in preparation for lesson delivery.

Time	Topic	Facilitation Instructions	Notes/ Directions	Supplies Needed
15 min.	Checking in: review/reflect from last session	Ask participants to identify any insights/thoughts they have had about last week's session. Ask participants to share any experiences they had over the week practicing exposure.		
10 min.	Mindfulness – What is it?	Mindfulness is the act of keeping your focus on the present moment. When you practice mindfulness on a regular basis, it can help keep your anxiety at a lower level. Practicing mindfulness at the time you feel anxiety can help you manage it and bring yourself back to a peaceful state.	See Facilitator Notes for further information on mindfulness	

30 min.	Mindfulness Activity	Using some type of food, have the participants eat this food slowly while practicing to focus on the present. Instruct the group to use all five senses to experience the activity. Ask participants to pay close attention to exactly what they are seeing, hearing, feeling, smelling, and tasting as they do this.	Advise participants that whenever they notice themselves feeling anxious it is because they have moved their thinking into the future or the past. Remind them when their mind wanders away to bring it back to what they are doing in the present moment.	Food (strawberries, smarties, jelly beans)
30 min.	Group Process of Activity	Have participants share their experiences with the group related to their participation in the activity.		
5 min.	Check-Out	Have participants complete weekly feedback form.		Copies of the weekly feedback form

Facilitator Notes:

Mindfulness:¹⁰

Being mindful means that you are paying attention to, and therefore living in, the present moment. Most of the time, our minds are reaching forward to the future, and we often start to worry about things that are unknown. This raises our anxiety level. Or our minds are reaching back into the past, and we may feel guilt or regret about something we have done or said. This raises our anxiety level, too.

Being mindful means being non-judgemental and accepting about whatever is happening in the present moment. Focusing on the present moment can help you let go of anxiety.

¹⁰ Schab, L. (2005). *The anxiety workbook for teens*. Norwalk, CT: Instant Help Publications.

Practicing mindfulness can decrease your anxiety as well as enrich your life experiences because you are more fully present in everything that you do.

Facilitator Debriefing Questions:

1. Where is the group at in terms of the program? Are they ready for termination?
2. How can we better prepare the group for termination?
3. Is there anything we need to discuss with the group prior to termination next session?

Additional Resources for the Facilitator(s):

Kendall, P., & Hedtke, K. (2006). *Cognitive-behaviour therapy for anxious children: therapist manual* (3rd ed.). Ardmore, PA: Workbook Publishing, Inc.

Merrell, K. W. (2001). *Helping students overcome depression and anxiety: A practical guide*. New York, NY: The Guilford Press.

Promising Practices Network. (2008). Programs That Work: The Coping Cat Program at <http://www.promisingpractices.net/proprograminfo>

Treating Social Anxiety in Adolescents

Session 8 – Termination

Treating Social Anxiety in Adolescents

Session 8 – Termination

Objectives:

1. Group participants will have an increased awareness of how they are feeling in regards to termination with the group.
2. Participants will have the opportunity to discuss what they have learned, what skills they will continue to utilize, and how they will continue to work towards their goals.

Advance Preparation:

1. Post session agenda.
2. Prepare copies of evaluation form.
3. Review lesson plan in preparation for lesson delivery.

Time	Topic	Facilitation Instructions	Notes/ Directions	Supplies Needed
15 min.	Checking in:	Ask participants to identify what they are aware of with this being the last session.		
60 min.	Group Processing	Spend this time processing where the group is at. Discussion may include: how the group is feeling about termination, what skills they will continue to utilize on their own, and their fears related to the future.		
15 min.	Check-Out	Ask participants to identify one tool that they will take with them (i.e. mindfulness). Have participants complete Program Evaluation Form.		Copies of Program Evaluation Form

Facilitator Debriefing Questions:

1. How did the group seem to handle termination?
2. Is there something we could have done to better prepare the group for termination?
3. How did we work together? What would we change? What did we do well?

Additional Resources for the Facilitator(s):

Kendall, P., & Hedtke, K. (2006). *Cognitive-behaviour therapy for anxious children: therapist manual* (3rd ed.). Ardmore, PA: Workbook Publishing, Inc.

Merrell, K. W. (2001). *Helping students overcome depression and anxiety: A practical guide*. New York, NY: The Guilford Press.

Promising Practices Network. (2008). Programs That Work: The Coping Cat Program at <http://www.promisingpractices.net/proprograminfo>

Treating Social Anxiety in Adolescents

Post-Group Session

Treating Social Anxiety in Adolescents

Post-Group Session

Objectives:

1. Group participants will have an opportunity to share how they have been coping post the group program.
2. Participants will have an opportunity to address any presenting/unresolved issues.

Advance Preparation:

1. Post session agenda.
2. Review session agenda.

Time	Topic	Facilitation Instructions	Notes/ Directions	Supplies Needed
10 min.	Checking in:	Ask participants to describe how they have been doing over the last four weeks using one word.		
60 min.	Group Processing	Use this time for group members to share how they have been doing. Discussion questions can include: What strategies have you been finding useful/not so useful? Where are you at in terms of your goals? What do you need from the group or others? What will you do to continue to work towards your goals?		

20 min.	Closing	<p>Ask participants if they have anything they want to say in closing – any unfinished business.</p> <p>Activity: Have participants pass a ball between them. Who ever has the ball shares a tip with the other group members related to how to deal with anxiety.</p>	Ball is passed in random order between participants.	Ball or other item easily tossed
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Facilitator Debriefing Questions:

1. How does everyone appear to be coping post the group program?
2. Is there anything we can do to address any of the issues presented today?

Additional Resources for the Facilitator(s):

Corey, M., & Corey, G. (2006). *Process and practice groups*. Belmont, CA: Thomson Brooks/Cole.

Yalom, I. (1995). *The theory and practice of group psychotherapy*. New York, NY: Basic Books.

Appendix B

Consent Form¹¹

Welcome. If you are participating in this group it is because you are experiencing anxiety in your life in some way and you are hoping to either get rid of it or to learn how to handle it. There is no one who doesn't feel anxious at some time. It is even more common to feel anxious during adolescence, because so many changes are taking place in your body, your mind, and your emotions.

Anxiety is a common and very treatable condition. Working through the activities in this program will give you some ideas on how to both prevent and handle your anxiety. Some of the activities may seem unusual at first. You may be asked to try doing things that are very new to you. Even if the suggestions seem really different from what you are used to, we encourage you to give them a try. You will also find that while some activities work very well for you, others may not help at all. That is normal. You are a unique person and you will have to discover the activities that work best for you.

There is one thing that the activities have in common: they won't help if you do them just once. They are tools, intended for you to carry with you and use over and over throughout your life. The more you practice using them, the better you will become at managing anxiety.

In addition to the benefits of participating in this program, there are risks to participating in group counselling. You may experience discomfort as you take risks to disclose uncomfortable aspects of your life. Furthermore, people in your life may react differently to you as a result of some the changes you make in your life.

¹¹ Consent Form Created by Alison Mazur-Elmer

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what this program is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand the information.

Confidentiality¹²

- In maintaining a group environment where members feel safe and comfortable expressing feelings and disclosing information, it is imperative that facilitators and group members respect each other's privacy and confidentiality. This means that facilitators and group members are expected to refrain from sharing information about each other outside of the group. However, because facilitators cannot guarantee the respect of confidentiality outside of group sessions, group members are advised to share only what they feel comfortable disclosing.
- Confidential information will only be shared with others with the informed consent of those involved, or in a manner that the persons involved cannot be identified, except as required or justified by law, or in circumstances of actual or possible serious physical harm or death. For instance, facilitators must break confidentiality when:
 - A group member reveals an intent to harm him/herself
 - A group member reveals an intent to harm others

¹² Confidentiality Guidelines taken from the Canadian Psychological Association (2001). *Canadian code of ethics for psychologists* (3rd ed.). Ottawa: Author.

- There is a suspicion or confirmation of child abuse
- Information is subpoenaed for use in a court proceeding
- Information pertaining to the individual related to session activities, will be recorded and deemed private information necessary for the provision of continuous goal attainment. All information will be collected, stored, and handled in a way that attends to security and privacy. Once records are no longer required they will be destroyed.

Will you be talking to my parents about my participation in the group?

As a general rule, the facilitators will not be talking with parents or guardians about your group participation. Parents could get general information about how therapy is going by setting up an appointment (review session) with you and the group facilitators. Even then, specific information would not be provided. The exception to this occurs if there is a concern that you are in some real danger (i.e. suicidal). In that case you would be advised that one of the facilitators would be contacting your parents or guardian.

Roles and Responsibilities of Group Members and Facilitators

(taken from Chen & Rybak, 2004; Corey & Corey, 2006)

- Once you have agreed to participate in this group counselling program, you are expected to attend every session. If you are unable to make it to a session, you are required to let the group know one week in advance. If you are unable to give a week's notice, contact one of the group facilitators as a soon as possible.
- Members must respect each other without judgement or ridicule

- Participants will willingly express fears, hopes, concerns, reservations, and expectations concerning the group
- Leaders will help members establish concrete goals
- Leaders will deal openly with member's concerns and questions
- Leaders will assist members to share what they are thinking and feeling about what is occurring in the group
- Leaders will teach members about the nature of anxiety and skills to reduce anxiety

*Attached is a handout outlining the ethical responsibilities of the facilitator(s)

Leader Qualifications

Your leaders both hold degrees in psychology (social work) and one of your leaders is a registered psychologist. Both are trained in group therapy and are well versed in the nature of anxiety. Both also have experience working with adolescents your age.

Both leaders subscribe to the assumptions of cognitive therapy, particularly as related to the treatment of social anxiety. Following are some of the assumptions maintained:

- Negative emotions are caused by negative interpretations and beliefs
- Anxiety and fear result when a person interprets a situation as threatening or dangerous
- You are the expert regarding your own thoughts and feelings

The goal of cognitive therapy is to be able to think more realistically rather than simply to think positively (Antony & Swinson, 2000).

Complaints

If you have a concern or complaint about the group counselling program, it is best to speak directly to a group facilitator. We value and welcome your concerns and will endeavour to assist you with resolving any issues that are impeding your progress with the group program. In addition, please see the following handout 'Ethical Responsibilities of the Group Facilitators' concerning the process for formalized complaints.

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in this group and agree to the noted guidelines.

I _____ have read this Informed Consent form and agree to accept the responsibilities of my role as a participant. I also understand the nature of this group and the roles and responsibilities of my group leaders.

Participant's Signature: _____

Legal Guardian's Printed Name & Signature: _____

Date: _____

Ethical Responsibilities of the Group Facilitators

The Canadian Psychological Association recognizes its responsibility to help assure ethical behaviour on the part of the psychologist. Attempts to ensure the facilitator's ethical behaviour and attitudes are adhered to throughout the delivery of this program, will be the responsibility of the facilitator(s) and the client(s). Following, we have identified some of the ethical principles, values, and standards consistent with the Canadian Code of Ethics for Psychologists that will guide our practice throughout the delivery of this program. If at any time you believe that unethical behaviour is taking place within the group, you can contact the Canadian Psychological Association at, 1-888-472-0657 to file a complaint.

Guiding Principles taken from the Canadian Code of Ethics for Psychologist (2001)¹³:

- I. 16** – Seek as full and active participation as possible from others in decisions that affect them, respecting and integrating as much as possible their opinions and wishes
- I. 18** – Respect the expressed wishes of the person to involve others in their decision making regarding informed consent
- I. 44** – Clarify what measure will be taken to protect confidentiality, and what responsibilities family and group members have for the protection of each other's confidentiality
- II. 1** – Protect and promote the welfare of clients
- II. 14** – Be sufficiently sensitive to and acknowledgeable about individual, group, community, and cultural differences and vulnerabilities to discern what will benefit and not harm persons involved in activities
- II. 21** – Strive to provide and / or obtain the best possible service for those needing and seeking psychological services

¹³ Canadian Psychological Association (2001). *Canadian code of ethics for psychologists* (3rd ed.). Ottawa: Author.

Appendix C

Group Therapy Information Sheet

What is group therapy?

Group therapy consists of about eight young people and one or two therapists (facilitators) getting together on a weekly basis to discuss issues related to anxiety. There is a focus on developing skills to address social anxiety.

Who goes to group therapy?

People come from a range of problems but one thing everyone has in common is anxiety.

How long do I stay in group?

This program is 8 weeks long, one session each week. Four weeks post our last session we will meet again for a post group session to see how everyone is doing.

What do the therapists do in the group?

The therapists' job is to make sure the process is safe, both emotionally and physically, for everyone in the group. This does not mean the therapists take charge of the group. Rather, it means that the therapists help group members take charge of themselves. This also means that the therapists do not prevent group members from leaving the room, but nor do they ensure safety outside the room.

Who decides what gets talked about in the group?

The therapists set the agenda but group members guide this process by raising related issues.

What will I get out of group therapy?

You will get a chance to learn about:

- ✓ Anxiety and how it is impacting you
- ✓ Skills to combat anxiety
- ✓ How to give and receive support
- ✓ How to care about yourself

Most young people experience increased self-esteem, self confidence and a sense of greater independence.

What is required of me in the group?

You are asked to:

- ✓ Keep information about group members confidential
- ✓ Attend every week; advise the group, in advance if possible, if you are to be absent.
- ✓ Talk about issues and listen to others in a respectful manner

Will you be talking to my parents about my participation in the group?

As a general rule, the facilitators will not be talking with parents or guardians about your group participation. Parents can get general information about how therapy is going by setting up an appointment (review session) with you and the group facilitators. Even then, specific information would not be provided. The exception to this occurs if there is a concern that you are in some real danger (i.e. suicidal). In that case you would be advised that one of the facilitators would be contacting your parents or guardian.

Rights

You have the right to decide whether to participate in this group program. You also have the right to end your participation in this group at any time. However, if you decide to terminate your participation with the group, please advise one of the facilitators prior to doing so.

Appendix D

Weekly Feedback Form¹⁴

Thank you for taking the time to complete this feedback form. Your feedback is important.

Please mark, as appropriate:

Was today's topic useful to you?

1 2 3 4 5 6 7 8 9 10

Not Useful Useful

Over the last week, has your anxiety:

Increased Decreased Stayed the same

Are you becoming more confident dealing with your anxiety?

Yes No Somewhat

Overall, do you feel comfortable in this group?

Most of the time Sometimes Never








What can the facilitators do to help make the group a safer place for you?

¹⁴ Feedback Form Created by Alison Mazur-Elmer

Appendix E

Program Evaluation Form¹⁵

Thank you for taking the time to complete this evaluation. Your feedback is valuable to us.

Please mark, as appropriate;	Excellent	Fair	Poor
Did you enjoy this program?	<input type="checkbox"/> :)		<input type="checkbox"/> :(
Did it meet your expectations?	<input type="checkbox"/> :)		<input type="checkbox"/> :(
Program Content:			
• cover expected information	<input type="checkbox"/> :)		<input type="checkbox"/> :(
• provide relevant and valuable information	<input type="checkbox"/> :)		<input type="checkbox"/> :(
Facilitator(s):			
• knowledgeable of the subject	<input type="checkbox"/> :)		<input type="checkbox"/> :(
• communicated information clearly	<input type="checkbox"/> :)		<input type="checkbox"/> :(
• made the sessions appropriate for you	<input type="checkbox"/> :)		<input type="checkbox"/> :(

¹⁵ Program Evaluation Form Created by Alison Mazur-Elmer

- encouraged group involvement



Facility & Resources:

- the space was suitable for the program



- convenient for you



- handouts were useful



- suitable training aids (videos, etc.)



What did you like best or find the most valuable from the sessions?

What did you dislike or find the least valuable from the sessions?

Would you like a follow up or advanced program to this program?

Do you have any suggestion how we could improve this program?

We welcome other comments you may have.