Cognitive-behavioral group therapy for social anxiety and social incompetence: a social skills perspective.

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The Netherlands, Maarn/Nijmegen, 2014

Preface

Cognitive-behavioral therapy (CBT) effectiveness to the treatment of social anxiety and social anxiety disorder has been demonstrated in a large number of investigations, and it is now days the treatment of choice (e.g. Heimberg, 2002). The major approaches of CBT that are applied are exposure, cognitive restructuring, and social skills training. In this book, we present a comprehensive group social skills training (SST), which has been proven to be effective in the treatment of heterogeneous populations of psychiatric patients, and subtypes of socially anxious and social incompetent patients (Dam-Baggen & Kraaimaat, 1986, 2000a, 2000b). This book is a guide book and presents our experience and research with psychiatric in- and outpatients with SST over the last thirty years. We present a selected review of the literature and focus attention predominantly to the use of the treatment plan and procedures of group SST. The treatment model is based on a 'learning by interaction' paradigm and combines the use of associative learning principles with those of social and cognitive learning. The present SST is composed of three successive phases. First, deficits in social performance are addressed by the training of basic social skills (e.g. eye contact, listening, giving and receiving feedback). Second phase is the training of specific and complex social skills (e.g. making and refusing requests, initiating and continuing a conversation). Conjointly with the training of basic and specific skills feelings of anxiety are addressed by exposure, the modification of negative self-evaluation, and self-focused attention. Third, generalization, transfer and long-term stability of results are achieved by the introduction of self-management methods consisting of self-monitoring, self-evaluation, self-reinforcement, goal setting, and problem solving. The main methods used in this comprehensive group SST are modeling, behavior rehearsal, exposure by successive approximation, feedback, social reinforcement, and self-management methods. Our comprehensive SST integrates various behavioral and cognitive methods around the practice of social skills in social situations that have been found to generally elicit anxiety. In this respect, it differs from treatments in which cognitive and behavioral modules are separately offered.

The described group SST was developed for and evaluated in high socially anxious and/or social incompetent psychiatric patients with heterogeneous and often chronic psychopathology. This goal is reflected by the choice of the components of the treatment as well as by step by step setup of the learning process. The treatment has the format of a group treatment that can be applied independently as well as in combination with additional

treatments aimed at other symptoms or problem behaviors. The SST runs the following stages: behavioral assessment, functional analysis, behavior change methods, and evaluation of effects. Because of the many advantages of group treatment with this kind of interpersonal problem, the present treatment model has a group therapy format but it may also be adapted to a dyadic patient-therapist set-up. In every section of the book, we offer the reader training variations and suggestions for use.

Within the cognitive-behavioral therapies, SST is one of the more complex treatments to perform. The various components of the treatment are described in details to illustrate this complexity. However, we do not recommend a strict application of the described treatment components. The present book is certainly not a treatment protocol but serves only as a guideline, and it should be adjusted with respect to content and form to each patient or patient setting (e.g. psychopathology, problem behaviors, educational level and age; in- and outpatients; individual or group format).

The book is intended for use by practicing clinicians with a background in behavior therapy. The book provides for experienced behavior therapists a comprehensive SST model that is applicable in a variety of patient settings and formats. For beginning behavior therapists, the book may provide several detailed examples of the components of cognitive-behavioral group therapy. Note that this book is not a self-help manual and not designed for laymen. We hope that the described treatment model will contribute to the professional use of SST with a variety of clinical populations. This book is a complete revision and update of "Sociaalvaardigheidstherapie: een cognitief gedragstherapeutische groepsbehandeling" (Dam-Baggen & Kraaimaat, 2000c). After a chapter in which the theoretical principles of SST are shortly addressed, the treatment is subsequently described in several chapters with explicit attention for the treatment plan by each of the phases of the SST. Each chapter contains examples of homework assignments and session plans, while the appendices provide a treatment contract, brochures for patients, and examples of goals and criteria for separate social responses.

Finally, we would like to thank our patients, staff and students for their invaluable suggestions and contributions to this SST.

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Content

1 Theoretical background

1.1 Introduction

In the literature ‘social anxiety’ is an umbrella construct that consists of different cognitive-emotional and behavioral features such as subjective anxiety and/or distress in social situations, negative self-evaluation in social interactions, submissive and inadequate interpersonal behavior, and avoidance of social situations (e.g. Beidel & Turner, 1998).

Buss (1980) was one of the first to define social anxiety as self-consciousness referring to a feeling of being observed in the sense of being on stage. To be publicly self-aware is seen by this author as the basis of social anxiety. He distinguishes the following four varieties of social anxiety: embarrassment, shame, audience anxiety, and shyness. Leitenberg (1990) prefers the term social-evaluative anxiety with as a central core the cognitive-emotional aspect of social anxiety, namely the fear of the other of holding a negative impression and the biased perception of not living up to the perceived standards of the other. In the above mentioned cognitive-emotional definitions, the perception of the other person is central of the fear, and with the exception of avoidance of social situations little attention is given to interactional and behavioral aspects of social anxiety. That is to say; the socially anxious subject is more or less conceived in a relatively unchanging social situation and not in an interpersonal and changing interaction. The behavioral and interactional aspects of social anxiety are represented by terms such as social skill or social performance deficits. In addition, many synonyms are found in the literature describing inadequate or adequate social behavior, such as aggressiveness, self-assertion, personal effectiveness, social incompetence, non-assertiveness, communication skills, interpersonal effectiveness and interpersonal problems (e.g. Alberti & Emmons, 1995; Salter, 1949; Liberman, DeRisi & Mueser, 1989).

The present comprehensive social skills training (SST) is aimed at the enhancement of social competence, the reduction of anxiety, and avoidance behavior in social situations. The SST shares with other behavior therapies for social anxiety disorder (also social phobia) the aim of a reduction of anxiety in social situations (e.g. Scholing & Emmelkamp, 1993). An important difference with current exposure and cognitive restructuring strategies for social anxiety disorder is that SST gives priority to a chain of social interactions over the anticipation, confrontation, and evaluation of a social situation. Thus the emphasis in SST is more on interpersonal than on intrapersonal characteristics of social anxiety. Many psychiatric patients not only fear and avoid social situations, but also demonstrate deficits in their social

performance. Hence, we prefer to combine graded exposure with shaping, the practice of social skills, and with cognitive restructuring. Evaluation studies supported this conception and showed a relatively larger effectiveness of comprehensive group SST compared with plain cognitive behavioral group therapy (e.g. Dam-Baggen & Kraaimaat, 1986, 2000a, 200b; Herbert, Gaudiano, Rheingold et al., 2005).

1.2 Social anxiety, social anxiety disorder (social phobia) and social functioning

The psychological conceptualization of social anxiety differs from that of the psychiatric DSM-IV/V classifications of social phobia (social anxiety disorder, SAD) and avoidant personality disorder. Social anxiety is a disposition supposed to be normally distributed in the general population. The latter non-categorical and dimensional conceptualization is more common in clinical psychological assessment and makes it not quite right to speak of the prevalence of social anxiety, as is also the case with other dimensional concepts such as intelligence and neuroticism. Social interactions are crucial in the development and functioning of individuals, and this might explain why so many people report to be hindered to some extent by social anxiety and/or social performance deficits. Estimates are that 4 to 10% of the average population experience shyness or a relatively high level of social anxiety as a major problem, and seek help for it (Pilkonis, 1977; Zimbardo, 1977).

Social phobia (also social anxiety disorder; SAD) is a psychiatric category in DSM-IV/V (APA, 1994, 2013). To be diagnosed as suffering from social phobia DSM criteria have to be fulfilled such as marked and persistent fear for one or more social or performance situations. In DSM-IV speech or performance anxiety are examples of ‘simple’ social phobia, while the specifier ‘generalized’ social phobia refers to fear of a broad range of social situations. In recent DSM-V some important changes were made, the emphasis is now on ‘social anxiety disorder’ (also social phobia) which refers to fear of a broad range of social situations and the specifier ‘generalized’ was deleted, while the newly added specifier ‘performance only’ refers to fear restricted to speak or to perform in public. The main criteria of avoidant personality disorder (APD) according DSM-IV/V emphasize the avoidance of social (intimate) and occupational contacts because of fears of criticism, disapproval, and rejection. There is considerable overlap of the diagnoses generalized social phobia (recently SAD) and avoidant personality disorder as one might expect (e.g. Turner et al., 1991; Bögels, Alden, Beidel et al., 2010).

The categorical approach of social phobia showed that 2 to 4% of the adult population might be characterized as social phobic and that lifetime prevalence varied from 3 to 13% (Chapman, Mannuzza & Flyer, 1995; Kessler, McGonacle, Zhao et al., 1994; Ruscio, Brown, Chiu et al., 2008). In the USA about 11% of men and 15% of women meet DSM-IV criteria for social phobia at some point in their lives, while about one third of them report only speaking performance fears (Heimberg, Liebowitz, Hope & Schneier, 1995; Kesler, Stein & Berglund, 1998). SAD has a relatively early onset and follows an unremitting course with significant functional impairments (Aderka, Hofman, Nickerson et al., 2012). Next to a somewhat higher lifetime prevalence of social phobia in women in comparison to men, there is suggestive evidence that men and women differ in which social interactions that cause them fear. It was found that men reported less anxiety than women in standing up for their rights. In addition, men reported more anxiety in expressing positive feelings (Dam-Baggen & Kraaimaat, 1987b). In an epidemiologic study, it was found that women with SAD had a greater number of feared social situations and more fears to professional situations, whereas men were more likely to have fears about dating (Xu, Schneider, Heimberg et al., 2012).

There is ample evidence that interpersonal distress and maladaptive interactions play an important role in a wide range of psychological disorders. An incidence rate of 7 to 16% of social inadequacy was found in psychiatric populations (e.g. Bryant, Trower, Yardley et al., 1976; Curran, Miller, Zwick et al., 1980). Psychopathology, emotional disturbances, and social functioning are highly interrelated (e.g. Keltner & Kring, 1998). Many aspects of social anxiety go along with psychiatric disorders such as depression, agoraphobia, schizophrenia, and substance dependence or abuse (e.g. Hayes, Halford & Varghese, 1995; Libet & Lewinsohn, 1973; Marshall, 1994; Monti and Fingeret,1987). Of interest in this respect is the study of Penn, Hope, Spaulding & Kucera (1994) who compared patients with schizophrenia, patients with affective and anxiety disorders, and normal subjects on social anxiety, social skills, and perceptual skill. The patients with schizophrenia were found to score highest on social anxiety, and lowest on social skills and social perception, compared with the other groups. Particularly, the patients with schizophrenia were found to be more handicapped in social situations because of their limited ability to perceive the non-verbal aspects of the interaction. With regard to the DSM-IV category of social phobia (also SAD) a high co-morbidity was revealed with panic disorder (45%), depressive disorder (17%), dysthymic disorder (12%) and alcohol abuse (20%) (e.g. Amies, Gelder & Shaw, 1983; Beidel & Turner, 1998; Degonda & Angst, 1993; Ruiter, Rijken, Garssen et al., 1989). DSM-IV avoidant personality disorder (APD) is registered in about 22 to 70 % in cases of social phobia,

specifically in those with generalized social phobia (Hope & Heimberg, 1993). The interrelatedness of impaired social functioning and psychopathology is further supported by the efficacy of SST for different forms of psychopathology such as depression (Hersen, Bellack, Himmelhoch & Thase, 1984), schizophrenia, and severe mental illness (Kurtz & Mueser, 2008; Liberman, DeRisi & Mueser, 1989). In addition, particular styles of interaction associated with social anxiety may contribute to the perpetuation of psychopathology. So it was found in an early study that high social anxiety and social skill deficits contribute to recidivism and dropout of treatment in psychiatric patients (Zigler & Glick, 1986).

Besides a relatively high co-occurrence of social anxious feelings and impaired social functioning in persons with psychopathology, similar figures are reported in persons with physical handicaps and impairments related to speech, hearing, vision, movement or physical malformations. The negative evaluation of their social performance by others and themselves is in these subjects an important factor contributing to comorbidity (e.g. Kraaimaat, Vanryckeghem & Dam-Baggen, 2002).

Psychiatric classifications according to DSM-IV/V have the advantage that the co-occurrence of social phobia and other psychiatric disorders has a high probability to be observed. In addition, the advance of social anxiety disorder (social phobia) as a separate category of anxiety disorder is that it stimulates research with regard to epidemiology, biological and psychological factors involved, and treatment evaluation. Psychiatric diagnoses are accepted and sometimes even requested by society as reasons for a claim of health and social care services. However, the disadvantage of the DSM diagnosis of social anxiety disorder with its emphasis on intrapersonal and situational aspects is that the overt behavioral and interactional aspects of social anxiety may be missed or neglected. The research approach through a DSM-IV/V lens of social anxiety disorder with its sole focus on negative emotion and avoidance behavior cuts off the view of inadequate social skills and impaired communicative behavior in socially anxious persons. Comorbidity is the rule in patients with a high need for care (e.g. Kessler, Chiu, Demler & Walters, 2005). Therefore, research that limits itself to a clear cut DSM IV/V definition of social anxiety disorder and exclude comorbidity underestimates the severity and complexity of what is at stake. As such, it is no surprise that in recent cognitive behavioral theories of social phobia cognitive and emotional factors prevail. At the lower end of the severity spectrum, SAD categorization contributes to an underestimation of subclinical manifestations and a neglect of the possibility that various manifestation of social anxiety might contribute to the development and maintenance of psychopathology. A combination of DSM-IV/V classification and a dimensional approach is

used in good clinical practice to address some of these disadvantages (e.g. the Anxiety Disorders Interview Schedule-Revised/ADIS-R , DiNardo, Brown & Barlow, 1994, and the Inventory Interpersonal Situations/ISS, Dam-Baggen & Kraaimaat, 1999; the Social Interaction Anxiety Scale, Mattick & Clarke, 1998).

Social and interpersonal problems bring most people for psychiatric or psychological consultation and are an important focus of many treatment plans. Besides a therapeutic goal, increasing social competence may have also a significant preventive purpose, because it 'may override or buffer the noxious effects of stress and vulnerability, in reducing relapses, interrupting chronicity, and improving psychosocial functioning' (Liberman, DeRisi, Mueser, 1989). Noteworthy in this respect is that in theories of mental and physical health relatively much attention has been given to an environmental factor such as social support. Several studies found supportive evidence that stress is specifically associated with mental and physical symptoms under low levels of social support. Notwithstanding this the role of the subject's social functioning in studies of social support is a rather unexplored territory. It was already Henderson (1984) who stated that social support only could be achieved in social relationships that can be established and maintained by the skills needed to initiate and maintain social contacts. Moreover, giving and receiving social support (also social reliance) are important skills in maintaining a balanced relationship (e.g. Argyle & Henderson, 1985). Some support for the latter statement was found in an early study with psychiatric patients, which showed that social skills were associated, both with the range of the social network as well as with experienced social support (Dam-Baggen & Kraaimaat, 1994). In addition, in college freshmen social skills were found to be prospective predictive of the development of social support and friendship formation (Cohen, Sherrod & Clark, 1986). From developmental and social-personality research, starting with the ideas of Leary (1973), there is now days sufficient evidence that interpersonal interactions follow principles of complementarity. Consequently showing that social reticence and avoidance contribute to be negatively perceived by others and impair the development of intimate and close relationships. There is a renewed interest in CBT in the role of self-disclosure of individuals with social anxiety. But only modifying beliefs and expectations might not be enough as was shown in the evaluation study of Alden & Taylor (2011) in which a standard cognitive behavioral regimen was complemented by relational strategies derived from interpersonal psychotherapy (IPT). Although positive changes were demonstrated in social functioning, their cognitive approach did not result in changing social support and their study certainly warrants further research.

1.3 Main theories of social anxiety and social deficits

Various theories were developed to explain the etiology and maintenance of social anxiety, social phobia (SAD) and social deficits. In chronological order three main approaches may be distinguished, namely anxiety inhibition theories, social skills deficit theories and cognitive behavioral theories. Clearly, it is beyond our purpose to offer a comprehensive review of the literature, but within the scope of this book a short review of each approach will be presented.

Anxiety inhibition theories

Wolpe (1958, 1979) was one of the first to postulate a relationship between anxiety and social behavior. He assumed that the socially anxious person has the appropriate social skills in his or her repertoire to handle the situation but that the disruptive effects of anxiety leads to impaired social performance. According to Wolpe, treatment should be directed at the reduction of the classically conditioned anxiety with respect to social situations. Later on, the relationship between arousal/anxiety and instrumental behavior was elaborated by two-factor theories of learning (e.g. Gray, 1975; Mowrer, 1960). Anxiety inhibition theories assume that avoidance of social situations and performance of safety behaviors impede the extinction of social anxiety (e.g. Alden & Bieling, 1998). These theories are supported by the finding that exposure aimed at the reduction of avoidance behavior by exposing the person to the feared situation has shown to be effective in social phobic persons (e.g. Butler, Cullington, Munby et al., 1984). The mechanisms underlying the effects of exposure are not quite clear. A leading assumption is that exposure does not lead to unlearn, but generates new learning that competes with the original fear response (Bouton, 2002). Indirect support for the anxiety inhibition hypothesis comes from several studies that found a marked overlap between social phobic and clinically anxious groups in the impairment of basic social skills (e.g. eye contact, silences) and marked differences between the aforementioned groups with non-clinically comparison groups (e.g. Baker & Edelman, 2002; Roelofs, Putman, Schouten et al., 2010; Voncken & Bögels, 2008).

Social skills deficit theories

In a different approach, it is assumed that socially anxious persons do not have the adequate skills to their disposal that are needed for a sufficient social interaction; that's to say, these skills have not or insufficiently been learned, inadequate skills have been learned or previously acquired skills are no longer available. (e.g. Eisler, Hersen & Miller, 1973; Lazarus, 1971). It is hypothesized that a lack of social skills and consequent negative reactions contribute to the development and maintenance of social anxiety. Many studies showed differences in social skills between high and low socially anxious normal persons

(e.g. McFall, Winnett, Bordewick et al., 1982; Pitcher & Meikle, 1980) and between high and low socially anxious psychiatric patients (e.g. Beidel & Turner, 1998; Dam-Baggen & Kraaimaat, 1987a). But some other studies failed to demonstrate differences between persons with high and low social anxiety (e.g. Rapee & Lim, 1992). These divergent findings between studies might be due to differences in subtypes of social anxiety (performance versus general social anxiety), to excluding severe patients and those patients with comorbidity, as well as to differences in the observed social skills (molar versus molecular ones). There is ample evidence that social skill deficits are a maintaining factor in social anxiety and contribute to a negative appraisal, less intimate relationships, social isolation and rejection (e.g. Aderka, Hofman, Nicherson et al., 2012). The view of social skills deficits is also indirectly supported by the effectiveness of treatments directed at the reduction of social anxiety by social skills training (e.g. Bellack & Hersen, 1979; Liberman, De Risi & Mueser, 1989; Dam-Baggen & Kraaimaat, 1986, 2000a).

Cognitive behavioral theories

Cognitive and cognitive-behavioral views of social anxiety emphasize the role of cognitive dysfunction which is assumed to make the person vulnerable to social anxiety, elicits social anxiety and/or impedes social behavior (e.g. Beck, Emery & Greenberg, 1985; Clark & Wells, 1995; Rapee & Heimberg, 1997). This cognitive viewpoint is not particular for social anxiety but is assumed to be general for all anxiety disorders (Rachman, 1998). The term cognitive dysfunction refers to a broad range of maladaptive cognitions such as irrational thoughts, faulty interpretations or misattributions, negative outcome expectancies, catastrophically thinking, negative self-evaluation, too high standards, underestimation of own skills and insufficient self-reinforcement. Clark & Wells (1995) suggest that the combination of self-focused attention and maladaptive cognitions is the central process that generates social anxiety, impairs social performance, and precludes the perception of information inconsistent with social fear. Similarly, Rapee & Heimberg (1997) assume that self-focused attention is critical in the maintenance of social anxiety, and they also emphasize the role of vigilance to potential negative evaluative cues from the environment. Both models assume that patients with social anxiety disorder have a negatively biased estimate of their social performance. In addition, current theories also stress the role of avoidance in the development and maintenance of social anxiety disorder by suggesting that avoidance blocks access to information that is incompatible with fear-related cognitions (e.g. Hofmann, 2007). Support for the impact of cognitive dysfunctions on social anxiety was found in several experimental studies comparing low and high socially anxious patients and non-clinical

samples with regard to irrational thoughts (Alden & Safran, 1978), negative self-evaluation (Clark & Arkowitz, 1975; Dam-Baggen & Kraaimaat, 1987a) and negative outcome expectancies (Kuperminc & Heimberg, 1983). More recent studies with clinical and non-clinical subjects examined the role of specific attention processes in social anxiety and found support that socially anxious persons engage in both internal and external focus (self-focused attention and vigilance-avoidance of social threats) throughout the course of a social situation (Bögels & Mansell, 2004; Schultz & Heimberg, 2008; Voncken, Dijk, DeJong et al., 2010). Thus, the subjects' attentional focus that precludes correcting environmental information may be a central factor in the maintenance of social fears. The hypothesis that cognitive dysfunctions influence social anxiety and social performance is also indirectly supported by the effectiveness of treatments directed at the modification of expectancies, negative beliefs and hindering thoughts, self-focused attention (e.g. Bögels, 2006; Kanter & Goldfried, 1979; Kaplan, 1982; Mulkens, Bögels, deJong, & Louwers, 2001; Dam-**B**aggen & Kraaimaat, 2000a).

Summary and interpretation

The role of anxiety inhibition, social skills deficits, and cognitive dysfunctions in social anxiety appears to be supported by the outcome of experimental, cross-sectional and treatment evaluation research. Generally, CBT treatments that emphasize cognitive and/or behavioral strategies report similar rates of efficacy. But some studies who compared plain cognitive therapy without behavioral elements with comprehensive SST, found the latter approach to be more effective in high socially anxious psychiatric patients (e.g. Dam-Baggen & Kraaimaat, 2000a). Combining cognitive and behavioral strategies may produce the most gains in those patients with high levels of anxiety, social impairment and/or comorbidity (see also Rodebaugh, Holway & Heimberg, 2004). So, it is plausible that cognitive and behavioral factors, single or in combination, contribute to social anxiety and social inadequacy. At present it is unclear which strategy or combination of strategies makes the largest contribution to a positive treatment outcome in which patient. Furthermore, mechanisms and procedures underlying cognitive or behavioral treatments overlap (e.g. role playing and exposure; corrective feedback after exposure and modification of negative beliefs) and current CBT treatments differed more in emphasis on cognitive or behavioral features than in real differences (Rodebaugh, Holaway & Heimberg, 2004). Last but not least, even single treatment procedures rarely deal with one deficit or problem at a time (e.g. anxiety as well as avoidance, memory as well as interpretation bias).

Persons may differ in the determinants and mechanisms that are at the base of their

impaired social functioning. For example, inadequate social performance might be due to extreme feelings of anxiety but also to dysfunctional cognitive processes (e.g. self-focused attention of negative self-evaluation, impaired social perception) and/or social skill deficits. In clinical practice, one may encounter patients with socially anxious feelings without social skill deficits (e.g. performance social phobia) as well as those with relatively low anxious feelings, a wide range of social skill deficits and widespread avoidance of social situations (e.g. reticent and isolated psychiatric patients).

'Social anxiety' should be best conceived of as multiple determined and reflected in the following interrelated response systems: cognitive, emotional and overt behavioral. This view is in line with early theories of anxiety as the one initiated by Lang (1971, 1985). His distinction of emotions in a verbal-cognitive, behavioral and physiological-somatic response system and his view on the interrelatedness of these systems opened new ways in the study and treatment of fear and anxiety. Now days Lang's view is supported by neurobiological theories and current findings from functional neuroimaging studies demonstrating the role and dynamic interconnectedness of brain areas involved in the cognitive, behavioral and somatic processing of emotional experiences (e.g. LeDoux, 1996). For example, a meta-analysis of functional neuroimaging studies in patients with various anxiety disorders showed a high activity among anxiety patients in brain structures linked to negative emotion. Furthermore, a differential activity between patients with anxiety disorders was found in structures associated with the generation and regulation of anxiety (Etkin & Wager, 2007). In addition, cross-sectional and experimental studies in a variety of anxiety disorders revealed that the relationship between these systems is generally low (interdependent), and that therapeutic interventions often modulate systems at different rates (see also emotional desynchrony; Rachman, 1998). In a recent study Aderka, McLean, Huppert et al. (2013) investigated fear, avoidance and physiological symptoms during cognitive behavioral therapy for patients with generalized social anxiety disorder. In this study fear, avoidance, and physical symptoms were found to be associated throughout treatment, but along the course of treatment within these relations a more prominent role was found for avoidance. Note that cognitive and behavioral avoidance play a central role in theories of anxiety inhibition, social skills deficits, as well as cognitive behavioral theories of social anxiety. Furthermore, environmental and individual factors appear to influence differentially verbal-cognitive, behavioral and physiological-somatic response systems. In an experimental study in which psychiatric patients were confronted with two social anxiety eliciting situations, refusing a request and initiating a conversation, it was revealed that across situations cognitive, and autonomic

variables were more stable and influenced by personal characteristics, while behavioral responses were more variable and influenced by situational aspects (Dam-Baggen, Heck & Kraaimaat, 1992).

In line with the conception of 'social anxiety' as multiple determined and consisting of interdependent cognitive, emotional, and behavioral response systems, we assume that the modification of these systems is best realized by an emphasis on learning principles that mainly control these systems (see also Razran, 1971). In general, a focus on classical conditioning and extinction procedures might be most effective for the modification of psychophysiological responses underlying feelings of anxiety. Principles of social learning are advocated in shaping and modifying complex social responses. While the emphasis on the use of cognitive learning strategies might be most efficient in changing maladaptive cognitions and optimizing self-control.

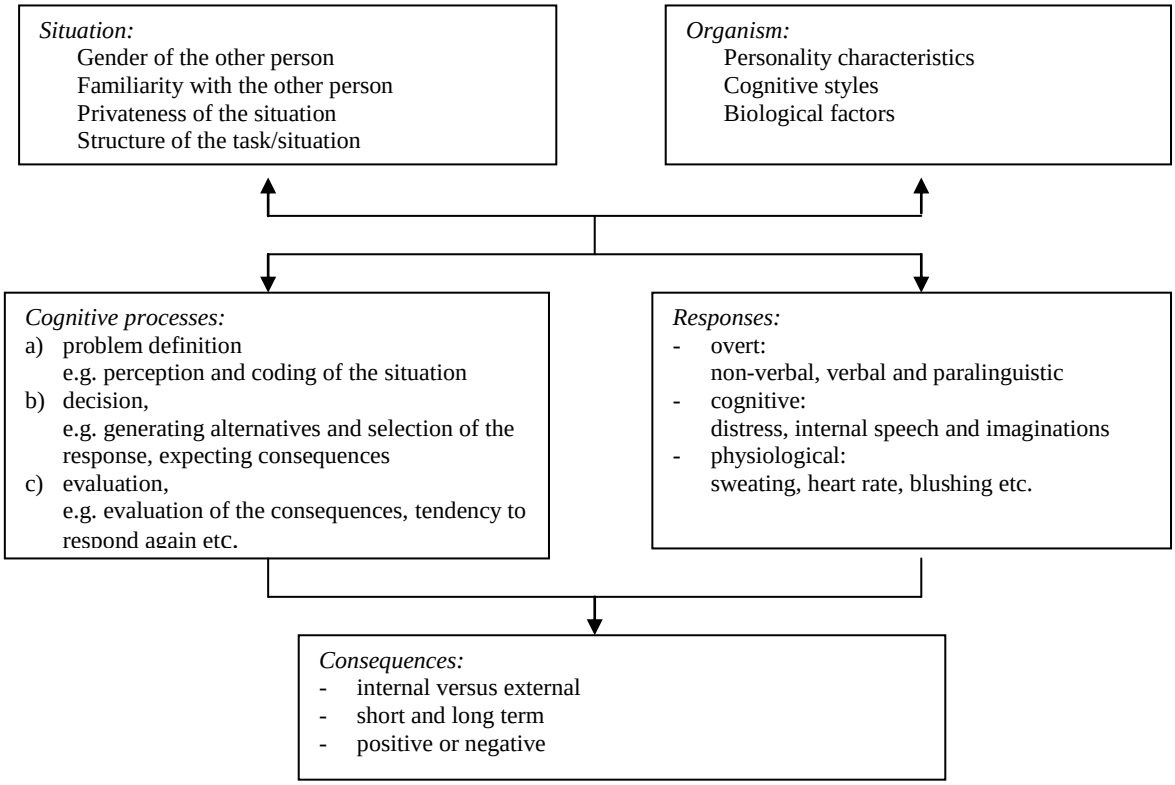
In brief, we advocate in the treatment of patients with severe 'social anxiety' a comprehensive approach of response systems as well as integration of learning principles in treatment methods.

1.4 A behavioral model of social anxiety

Current theories of social anxiety in clinical psychology and behavior therapy are more or less focused on the role of one or two systems of the three-part response system (i.e. verbal-cognitive, behavioral, physiological-somatic) in subjects with social anxiety disorder (SAD). There is a large and fragmented body of research on components of emotion, how emotions structure social relationships and the nature of emotional and social disturbances in psychopathology (e.g. Keltner & Kring, 1998). However, a comprehensive theoretical model of social anxiety as well as social incompetence that is applicable for a broad psychiatric population is still lacking and may be even of limited utility. The state of the art is that the interrelationship of the components of social anxiety and social incompetence are not similar in various mental disorders. In addition, the same cluster of symptoms might arise from different etiological, underlying or sustaining mechanisms in different cases. Strong arguments that a clinical case formulation or functional analysis in which environmental, interpersonal and/or psychological factors and functional relationships have been identified, should be a core part of the individual assessment (e.g. Haynes & O'Brien, 2000).

In Figure 1, a heuristic behavioral model of social anxiety and social incompetence is presented that involves antecedent, subject (organism, cognitive, response) and consequent cues and factors as well as the assumed interrelationships between these elements. Arrows represent the possible feedback loops between elements.

Figure 1: A behavioral model of social anxiety and social incompetence



The following case description illustrates the composing elements of the behavioral model as revealed by the behavioral assessment of a high socially anxious person:

Sean J. is a 36-year-old man who is referred by his general practitioner to the outpatient care of a psychiatric hospital for treatment of anxiety and depression. He is married, has two children, and worked as a controller. He was discharged when his office was taken over. He is unemployed for two years now, and he is trying to get a new job. From the general intake procedure it appears that, next to social anxiety and avoidance of social situations, he is worrying a lot about a wide range of somatic sensations (somatization), is living socially isolated and feeling depressed (preliminary diagnosis 'dysthymic disorder').

Response. In social interactions, Sean is often unclear in expressing his wishes, opinions and feelings (overt behavior - verbal). In the few situations that he expresses his opinion,

makes or refuses a request, gives a compliment or states a positive self-evaluation, he is mumbling, avoiding eye contact or looking at the other person at the wrong moments, and is sitting/standing crouched (overt behavior - nonverbal). His latency time is long; in addition, he is speaking shortly and monotone (overt behavior - paralinguistic). Sean reports high distress before and during the social interaction (cognitive - distress); he is sweating and reports heart fluttering (physiological). Before and during the situation, he is thinking things like “my opinion does not matter”, “people don’t like me”, “others know things better than I do”, “I wish this situation was over”, “I don’t want to quarrel”, “what should they think about me”, etc. (cognitive - internal speech). He imagines being rejected or ridiculed by what he is saying or doing (cognitive- imaginations).

Sean strongly hinders himself by thinking about what might happen instead of perceiving the facts and cues of the events (cognitive - problem definition). So he often chooses the wrong moment (cues) to express his opinion toward others. Generating alternatives to solve social situations is a difficult task for him. In addition, because of his negative expectancies, he mainly generates "solutions" which actually inhibit his interactions with other persons, such as reticent or aggressive behaviors (cognitive - decision). It seems difficult for him to foresee the possible and actual consequences of his reactions (cognitive - evaluation).

Organism. Sean reports not to have learned how to express his wishes, opinions and feelings towards others. His parents modeled him not to bother other persons (cognitive style). Mistakes were not allowed in his family: all things had to be perfect. He says that his attitude is still very perfectionistic that he judges making mistakes disastrous and himself inferior (cognitive style). That his high standards just serve to preserve his feelings of being inadequate, is an eye opener for him.

Situation. Many social situations cause him discomfort, especially initiating contacts, refusing requests and expressing his opinions, wishes or feelings towards others. The more private the subject of the interaction or, the higher the status of the other person is the more discomfort he experiences.

*Consequence*s. The consequences of Sean's behavior reinforce his stereotypical beliefs about himself and his problems in social interactions. His inadequate social responses elicit negative reactions of others (external, short term), thus confirming his negative self-evaluations (internal, short term), next leading to more discomfort in future similar situations (internal, long term) and finally loss of social contacts (external, long term). As a consequence, new situations are faced with an ‘updated’ learning history, which leads to a downward spiral of more and more problems in social interactions.

1.5 The treatment model of this SST

In comprehensive SST principles of classical and operant conditioning are combined with social and cognitive learning principles to achieve the following two main goals: a) the acquisition and extension of social skills, the reduction of anxiety in social situations and enhancement of positive self-evaluation, and b) the achievement of the cognitive skills that are needed for an independent use of behavior change methods in daily life.

In the acquisition of social skills, we use the following procedures: modeling, behavior rehearsal and discrimination training. Instructions, feedback, reinforcement and successive approximation (graded practice) are used to enlarge the effects of these procedures.

Most complex human behavior, including social skills, is learned observationally through modeling (Bandura, 1977). Modeling is mainly based on the principles of social learning. With the help of processes of observational learning new behavior patterns can be acquired, previously learned but inhibited behaviors disinhibited and inadequate behaviors modified or inhibited (e.g. aggression). According to Bandura (1977) observational learning is governed by four component processes: a) attentional processes, learning by attending to and perceiving the significant features accurately of the modeled behavior, b) retention processes, the modeled behavior should be remembered, c) motor reproduction processes, symbolic representations of the modeled behavior should be converted in appropriate actions, and d) motivational processes, acquired behaviors will be performed more likely if they result in valuable outcomes. In our treatment attentional processes are influenced by using attractive model situations, by the use of concrete instructions of the therapist to the group members with respect to what features of behavior should be observed, and by the use of criteria to evaluate the effectiveness of the modeled behavior. Semantic retention is facilitated by the use of criteria: not the concrete modeled behavior should be remembered but abstract aspects of it as formulated in criteria. Motor reproduction is again influenced by the criteria but also by execution and rehearsal of the behavior followed by feedback leading to corrective actions. Motivational processes are influenced by using successful modeling situations, by graded rehearsal and practice, and by positive evaluative reactions of therapist and group members.

Behavior rehearsal is based on the principles of operant conditioning and is often applied in combination with graded practice (successive approximation). The goal of behavior rehearsal is to overlearn relatively complex social skills in order to make them automatic. The use of a practice hierarchy of situations ranging from easy to difficult (from less to high discomfort respectively) serves two functions: to facilitate the acquirement of complex skills and to support the extinction of the anxiety response. Discrimination learning is used to apply

previously learned behaviors in new situations.

The function of feedback in behavior rehearsal may be explained in operant as well as cognitive learning principles. Feedback may be given as positive or negative reinforcement, as information about the application, and as a suggestion for improvement. Next to strengthening the desired behavior, another role of feedback is to correct the subject's negative cognitions about his or her performance. In addition to verbal and non-verbal feedback from the therapist or group members, it is also possible to display to the patient audio or video recordings of his behavior exercises. The effect of audio and video feedback is highly dependent on the skill of self-observation. It was found that video playback influences more the non-verbal than the verbal behaviors. Note that the effects of audio and video playback are highly unpredictable without explicit instructions of what should be observed. Last but not least audio/video playback is rather time consuming.

In the acquisition of cognitive skills, we use procedures such as self-monitoring, self-evaluation and self-reinforcement (see Kanfer & Gaelick-Buys, 1991) together with problem solving strategies in order to facilitate the generalization and transfer to other social situations (see D'Zurilla, 1986). The learning principles and procedures underlying these cognitive strategies can be found by Bandura (1977) and Gagné (1985). In the self-management phase participants are taught: to distinguish between facts and thoughts, to set goals and sub-goals, to monitor the behavior, to set adequate demands and criteria for their behavior, to adjust inadequate demands, to ask for and give feedback, to reinforce themselves, to work stepwise, and to generate alternative solutions for a problematic situation (see Chapters 4-6).

Self-management procedures are an important supplement to the procedures applied by the therapist. With self-management procedures, behavior modification is reached without direct support of the therapist or other persons. Self-management can be used when clients are sufficiently motivated and skilled to apply their own behavior modification programs. Self-management methods are also indicated when the problematic behavior stems from deficits in self-observation and self-evaluation (Kanfer & Gaelick-Buys, 1991). Last but not least self-management methods enhance the transfer of training effects to patients real life situations. The following three steps are distinguished in self-management: self-monitoring, self-evaluation and self-reinforcement. It should be noted that some behavior therapeutic procedures (functional analysis, graded exposure, progressive relaxation etc.) might function as a self-management procedure when applied independently by the patient.

Self-monitoring is observation and administration of behavior by the client himself. It helps the patient to be aware of the nature and frequency of his or her behavior and the

situation in which it occurs. It also serves as a measure for behavior change. Self-monitoring may have reactive effects, which means that the observed behavior changes by monitoring. This reactive effect usually disappears after some time.

Self-evaluation and self-reinforcement are assumed to have similar effects like external reinforcement. Positive self-reinforcement may be of a material (e.g. coffee) as well as a verbal-symbolic ("good job", “well done”) nature. Applying negative consequences on behavior often consists of self-criticism, self-punishment or the abstinence of positive reinforcement. Sometimes positive self-reinforcement has to be explicitly acquired by modeling and/or by rehearsing positive self-statements (first aloud and then sub-vocally). Internal reinforcement compared with external reinforcement has the advantage that it leads to independence towards other persons. Bandura (1977) assumes a relationship between the standards or demands someone puts on himself and the way he is thinking about himself. Too high standards lead to negative self-statements, which, if frequently applied, may lead to pathological reactions. Treatments directed to concrete self-observations and setting realistic (sub)goals foster positive self-reinforcement.

A general format for self-management procedures is given by problem solving strategies (D'Zurilla, 1986; Nezu, Nezu & Lombardo, 2004). The advantage of this format is that patients acquire a second order self-management method in which self-monitoring, self-evaluation and self-reinforcement are integrated. D'Zurilla (1986) defines problem solving as a process, in which a number of alternative responses are generated to solve the problematic situation and which increases the probability that the most effective response is chosen from the alternatives. He supposes that the ineffectively handling of problematic situations contributes to various disorders. Effective problem solving is seen as a skill that can be acquired. D'Zurilla distinguishes 5 steps in this process: a) general orientation: observing yourself, self-disclosing the mechanisms that contribute to behavior, cognitions, and feelings, b) definition of the problem in behavioral terms and setting goals and sub-goals; the emphasis is on specific and concrete formulation of the problem to get clear which features are relevant, c) generating alternatives ('brainstorming'); strategies, as well as specific responses, are included, d) decision-making: before the response is executed the alternatives should be tested with previously formulated criteria and probable consequences (personally, social; short and long term), and e) verification: the response is executed, tested on the results and modified.

2 Assessment

2.1 Introduction

In the international arena of behavior therapy treatment protocols for patients with specific DSM syndromes are more the rule than the exception. Our approach deviates from this practice in many ways. We present not a treatment protocol, but a treatment guideline that has to be adapted to the needs of patients, therapist and settings. Furthermore, attention has to be paid to the factors and mechanisms that are at stake at the level of the individual patient or the selected group of patients. And last but not least a balance has to be found between an individual patient's needs and those of the other patients. To serve this approach, behavioral assessment plays a central role at the begin of our SST. The main goal is to answer the question which treatment is best tailored to the problems of a patient (Haynes & O'Brien, 2000; Nezu, Nezu & Lombardo, 2004). The following two phases are distinguished in behavioral assessment:

a) the general identification of a patient's behavior problem and the patterns of covariance among multiple behavior problems;

b) the clinical case conceptualization.

In the general identification phase, available information from different sources is gathered before the intake interview by the clinician in charge (e.g. written reports from referring general practitioner, social workers, psychiatric nurses, psychiatrists, and patient). It goes without saying that a thorough shifting of information and sources is needed with respect of utility, reliability and validity. Nonetheless, the information that rests is inadequate and too general to guide behavioral interventions, because, at this stage, functional relationships were not identified. However, this first phase is an important one in the decision to refer patients to SST or not. This comprehensive orientation of behavior problems, including the possible co-morbidity with other (e.g. medical or social) problems might reveal that SST is not the proper treatment at that moment or even at all, which excludes patients from going through additional SST assessment. In some cases, this comprehensive orientation might lead to the use of other treatment approaches before or as an adjunct to SST.

The phase of clinical case conceptualization provides a hypothesized model of a patient based on pretreatment information in which behaviors, environmental events and their functional relationships are identified. A combination of quantitative as well as qualitative, nomothetic as well as idiosyncratic, approach is used to achieve this goal. In this phase self-report inventories and behavior observation scales are used to collect information. A

behavioral interview is a crucial part of this phase. Starting point for this interview are data gathered with the questionnaires and observation scales. Both sources of information should lead to one or several functional analyses. In each functional analysis estimates are made concerning the relationships and the sequences of a patient's behavior problems and goals as well as conclusions about the relative modifiability and the magnitude of effects of the causal variables that affect his or her behavior problems and goals (e.g. Haynes & O'Brien, 2000).

2.2 General identification of a patient's behavior problems

The general identification phase of the patient's behavior problems is concluded with an intake interview by the clinician in charge. In this interview, the complaints and problem behaviors are further assessed that cause the patient to seek help. As an adjunct to this interview we highly recommend the use of standardized methods and instruments, such as semi-structured interviews and questionnaires.

An example of a semi-structured interview for clinical populations is the Anxiety Disorder Interview Schedule-Revised (ADIS-R; DiNardo, Brown & Barlow, 1994). The benefit of a semi-structured interview by a trained clinician is that the reliability of the data collection is improved. The ADIS systematically collects information with respect to symptoms of Anxiety disorders, Mood disorders, Somatoform disorders, Eating disorders, Substance use disorders and Psychotic disorders. Use of medication and information with respect to the etiology is assessed too with the ADIS.

For a comprehensive assessment of general functioning self-report questionnaires are often used. Self-report inventories are efficient and time saving because the patient himself completes them. The disadvantage is that some patients are not able to endorse the questionnaires in a reliable way because of a lack of self-observation, agitation, manifest psychosis, or mental retardation. Some examples of inventories: the Symptom Checklist (SCL-90-R; Derogatis, 1977) is used as a multidimensional psychopathology index that indicates psychopathology severity, while the Fear Survey Schedule (FSS-III; Wolpe & Lang, 1964), the Fear Questionnaire (FQ; Marks & Mathews, 1979) and the State-Trait Anxiety Questionnaire (STAI; Spielberger, Gorsuch, Lushene at al., 1983) may assess more specific information with respect to general anxiety and fear (see Antony, Orsillo & Roemer, 2001).

After this comprehensive assessment, the interrelationships between problematic behaviors are estimated and made explicit in a preliminary model. This is an important step because social functioning is often associated with other manifestations of psychopathology. Next, this descriptive model contributes to the decision whether and when treatment of other

(non-social) problem behaviors is needed next to SST. Sometimes, it should even be preferred to postpone SST participation until treatment of interfering problem behaviors has been taken place (e.g. addictions, psychosis).

2.3 Clinical case formulation

Two clinical case formulation models characterize the field, the clinical pathogenesis map (Nezu, Nezu & Lombardo, 2004) and the functional analytic clinical case model (Haynes & O'Brien, 2000). Both approaches serve their purpose, but they differ in terminology and level of abstraction or specificity of their hypothesized models. For example, Nezu, Nezu & Lombardo (2004) are using an adaptation of the problem-solving model of D'Zurilla, while Haynes & O'Brien (2000) propose causal models in functional analysis. The problem-solving method of Nezu, Nezu & Lombardo and the functional analytic approach of Haynes & O'Brien both take into account the utility of standardized treatments, treatment protocols, and the specific individual determinants of the problematic behavior. For an introduction of these models, the reader is referred to the publications of the latter authors. For a space and didactic reasons, we restrict ourselves in this book to a global working model of social anxiety and social incompetence (Figure 1, Chapter 2) that consists of a selection from the literature of possible relevant stimuli, factors and elements. See for a clarification of this model the two case illustrations in Box 1 (page 27 and 28).

The main functions of this second assessment phase are a) problem description, b) identifying controlling variables, c) selection of treatment and d) pretest of treatment outcome. The following assessment techniques are used in clinical practice: self-report questionnaires, behavioral observation, and behavioral interview.

2.3.1 *Self-report questionnaires*

Anxiety/discomfort is measured by questionnaires such as the Fear of Negative Evaluation Scale (FNE: Watson & Friend, 1969), the Social Anxiety Inventory (SAI: Richardson & Tasto, 1976), and the Assertion Inventory (AI: Gambrill & Richey, 1975). Discomfort and avoidance are measured by the Social Avoidance and Distress Scale (SADS: Watson & Friend, 1969), the Social Phobia and Anxiety Inventory (SPAI: Turner, Beidel, Dancu et al., 1989), and the Social Phobia Scale (SPS: Mattick & Clarke, 1998).

Social response frequency, as indicative of social (in)competence, is measured by questionnaires such as the Wolpe-Lazarus Assertiveness Schedule (WLAS: Wolpe & Lazarus, 1966; Hersen, Bellack, Turner et al., 1979), the Rathus Assertiveness Schedule (RAS: Rathus, 1973) and the Assertion Inventory (AI: Gambrill & Richey, 1975).

The Inventory of Interpersonal Situations (IIS: Dam-Baggen & Kraaimaat, 1987, 1999, 2000) was developed to measure both discomfort in social situations and social (in)competence. The IIS consists of 35 items with respect to social interactions and have to be scored twice. First, all items are rated on a five point Likert scale on Discomfort and next, on a separate page, items are rated again for Frequency of occurrence. Five subscales have empirically been derived for Discomfort, as well as Frequency: Giving criticism, Expressing opinion, Giving compliments, Initiating contacts, and Positive self-statements. The scores of the subscales give information as to which specific situations and social responses treatment have to be directed. Further information and a specimen copy of the ISS are presented in Appendix 5.

Because a person's functioning in social relationships influences his or her social network and the experience of social support, we suggest exploring social support. In the literature, many methods for measuring social support have been described. These methods measure various aspects of social support such as social integration, social participation, diverse functions of social support and the number of social ties. Examples are The Social Support Questionnaire (SSQ: Sarason, Levine, Basham et al., 1983) and the Interpersonal Support Evaluation List (ISEL: Cohen, Mermelstein, Kamarck et al., 1985).

2.3.2 *Behavior observation.*

Self-report inventories are not suitable to assess the quality of a person's verbal and non-verbal behavior in social interactions. More concrete information about these features can be collected by self-monitoring or direct behavioral observation by the therapist or significant others (for example by means of the Brief Social Phobia Scale; Davidson, Potts, Richichi et al., 1991). There is a lack of standardized behavior tests that are applicable in clinical practice. The only procedure frequently used for the assessment of social skills is the Simulated Social Interaction Test (SSIT; Curran, 1982). In addition, in experimental studies naturalistic role-play situations with a confederate have been used. For example, in one of our studies, two situations were used: refusing a request and initiating a conversation (Dam-Baggen & Kraaimaat, 1987a, 1999). The overt behaviors of the subjects were recorded with video recording and rated by independent judges on duration of speech, latency time, number of verbal clauses, volume, intonation, duration of gaze and quality of gaze (see Dam-Baggen, Heck & Kraaimaat, 1992). Because of time investment and costs, video recordings of role-play situations are not feasible for a clinical setting. However, time and costs should not impede to explore the behavior repertoire of the patient by a short role-play during the behavioral interview. We recommend the use of an exploring role-play when the patient is not

able to report concretely what he or she said and did in a particular social situation. Helpful in judging role-play behavior is the Social Phobia Rating System (Fydrich, Chambless, Perry et al., 1998) that collects information about gaze, quality of the voice and duration of speech, discomfort and conversation flow.

2.4 The pretreatment assessment procedure of this SST

The SST pretreatment assessment is part of the clinical case formulation and has also the function of a pretest. Hence, it should be held shortly before the beginning of the treatment. We assume here that the potential participants are referred to the SST by psychiatrists or clinical psychologists. This means that the identification of a client's behavior problem and the patterns of covariance among multiple behavior problems have already taken place before the patient is referred to the SST. It speaks for itself that this information should accompany the referral to SST. If the therapist thinks on the basis of these referral data that the SST is not an appropriate treatment for this patient at that moment or even at all, the patient is not admitted to the SST pretreatment assessment. The pretreatment assessment for this SST consists of self-report inventories and a concluding behavioral interview. The general data collected in the identification phase of the assessment and the focused data collected at the start of the clinical case formulation, serve as a starting point for the behavioral interview. Excessive emotions, behavior reactions, dysfunctional cognitions as well as deficits in social skills are explored and elaborated in one or more functional analyses to serve the clinical case formulation.

Self-report inventories. In order to facilitate the selection procedure, a biographical questionnaire (data on problem behaviors, occupation, marriage, interpersonal relationships, family etc.) is used as well as various self-report inventories for the measurement of general and social aspects of functioning, such as the SCL-90, the FSS-III, the SPAI, the IIS and the SSQ (see 2.2 and 2.3.1). Note that some of these questionnaires may already have been part of the problem identification phase. The two main criteria for admittance are that potential participants report problems in interactions with other persons (formulated in terms such as anxiety in social situations, shyness, no idea as to what to do/say in interpersonal situations, etc.) and that they are motivated to change this by treatment. By comparing the data of the self-report inventories with reference groups, the first selection for the SST could be done. We recommend exploring also the relationships between the data of the questionnaires. For

instance, the data of the Discomfort and the Frequency scale of the IIS could show whether a person with a low level of discomfort will be a faulty referral (is not really socially anxious) or also avoids very effectively social situations (in the case of low level of frequency) and thus may profit from treatment.

Behavioral interview. The data of the questionnaires are used in the behavioral interview and serve as a starting point for the exploration of problem behaviors and factors that may interfere with the treatment. The therapist should interview the potential participants himself for the following reasons: a) the interview provides him the necessary information to decide whether the patient should be admitted to the SST, b) if yes, patient and therapist together will formulate specific treatment goals for that participant, c) it gives him the opportunity to provide the patient information with respect to the procedure and content of the treatment, and d) the general aims of the SST could be made explicit.

To explore whether the patient could be admitted to the treatment, the following topics should be discussed with the potential participant (please formulate in own words):

- What situations are difficult for you (where, with whom, your own contribution)?
- What are your excesses and deficits in social interactions?
- What are your assets in interpersonal relationships (where, with whom, your personal contribution)?
- What did you already change; what was (were) the effect(s)?
- What would you like to change in your behavior, that is to say what goals could be set for the treatment?
- Which persons do you speak during the day?
- What do you expect from the treatment?

After this exploration of what situations and responses are avoided and/or performed in what manner, therapist and participant jointly formulate the specific treatment goals.
In Box 1, two case descriptions illustrate the various steps undertaken in this process.

Box 1: Illustrations of pretreatment assessment and the formulation of treatment goals

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Case 1: Peter is a 38 year old man who is referred to the ambulant service of a psychiatric hospital because of work problems. The general intake shows that Peter, accountant in a medium-sized company, has a lot of trouble to concentrate on his work, experiences much distress and suffers from physical complaints like headache, stomachache etc. He feels less and less able to do his job well and is afraid that his boss will dismiss him in due

time.

Peter lives in a medium-sized town has a wife and two children, a 15-year old boy and a 13-year-old girl. He reports that he did his work well before, but it demands more and more, and he can not cope with it anymore. At home, his wife is the "boss": she "runs" the family, including the upbringing of the children. Although he would like to be more involved, he is also glad that the family is not very demanding. He realizes that he loses grip on the children, but says to have no trouble with it because he does not want to bother his wife.

The referring clinician reports that Peter has a long history of troubles with standing up for his rights. He seldom or never refuses a request. Because of increased demands, his work accumulates. Peter's position at home seems also a main result of his low level of standing up for himself.

The self-report inventories do not show extraordinary complaints and other problem areas. On the SCL-90 Peter scores above the mean of a reference group of psychiatric patients with respect to feelings of being injured. Anxiety and social anxiety questionnaires show high scores on the scales measuring discomfort in social situations (e.g. Discomfort scale of the IIS) compared with reference groups psychiatric patient as well as a relatively low score on the frequency of performing a behavior in social situations (e.g. Frequency scale of the IIS). In addition, Peter reports having a small social network and perceiving less emotional social support (SSQ).

The behavioral interview shows the following:

- Peter's behavior is characterized by less "standing up for your rights" behavior such as refusing a request, expressing his opinion, giving criticism etc. (Response - overt). The few occasions he performs these behaviors, he is often not very clear in his wishes and opinions and "not present " (Response - overt). As a result, Peter's wishes and opinions are less and less considered by others, both in his work as well as at home (Consequences). In his work, he cannot cope anymore with the demands and he often feels very distressed (Consequences). Peter conceives his physical complaints as a result of the experienced distress (Consequences). He tends to retire more and more from social situations (Response - overt), which keeps him gradually out of it (Consequences).
- Peter is afraid to be disliked and rejected; this seems to be a catastrophe for him (Response - cognitive). He does everything to avoid quarrels and conflicts (Response - overt) and perceives many discussions as quarrels (Response - cognitive).
- Peter holds high standards for himself (Response -cognitive and probably Organism - cognitive style) in order to prevent being rejected (Response - cognitive). Although he is not often criticized, he has trouble with receiving criticism: he does not know what to say (Response - overt). At first Peter received in his work many compliments for his efforts and diligence (Consequences), but this led to higher standards for himself and finally reached a deadlock (Consequences).

Together with Peter the following treatment goals were formulated:

- Learning to clearly express his wishes, opinions and desires; to learn to receive/handle negative feedback;
- Learning to set adequate standards for himself;
- Learning to achieve more correspondence between his thoughts and the facts/events.

Case 2: Mary is a 27-year-old shop assistant who was referred to the clinical treatment unit of a psychiatric hospital by the general physician. In the referral letter, he reports her strong feelings of depression and binge eating. Mary is very lonely and thinks that people dislike and avoid her. It bothers her much to initiate and maintain contacts; after a short period everybody retires from her. She has no idea how to change this and is

isolated and depressed. She asked the general physician for medication against her depression and diet to fight her binge eating. However, her physician advised a clinical treatment.

The general intake procedure held by admittance to the clinic describes the following picture: Mary is single and lives in a small town. She is one of the youngest children from a working-class family and says that the family members have no interest in each other. Her father was busy with his work day and night to earn enough money for his large family. Her mother worked as a cleaning lady to supplement his income. Both parents do not have time to care for the family. The children went their own way and were loud mouthed. Mary learned that one can "survive" by just thinking for her and not taking into account other persons "because other people do not care for me either ". This pattern was continued the rest of her life and even reinforced in her school life. For some children, her cheeky and bold behavior served as an example. Now Mary is living "on her own" she experiences that this behavior puts other persons off which makes her very lonely. She never had friends and her colleagues keep her at a distance. Sometimes she gets the feedback of being too meddling. In the evening being alone at her home, she regularly has episodes of binge eating. She eats all she can get and feels miserable afterwards. Mary thinks that her depression and binge eating will disappear when she learns to be a more "social" person. The unit staff decides to refer her to SST.

The psychological screening reveals a high level of psycho neuroticism (SCL-90), especially a high score on the hostility scale. Questionnaires measuring general and social anxiety show low scores for fear and discomfort in social situations (e.g. Discomfort scale of the IIS) compared with a reference group of psychiatric patients and low scores for the frequency of occurrence of social responses (e.g. Frequency scale of the IIS). Mary reports a limited social network and less social support (SSQ).

The behavioral interview shows the following points:

- Mary shows an aggressive attitude verbally as well as non-verbally towards other persons (Response - overt). She does not take into account the goals of other persons in social situations. She is a bad listener and often interrupts other persons. She has high demands towards other people and makes conflicts often if she is hindered in reaching her goals (Response - overt). At short term, her behavior is reinforced but at long term people stay away (Consequences).
- It is difficult for her to discriminate between what is her business and what is not: her feeling is that people have to live according to her values and standards (Response - cognitive; Organism -cognitive style) and she gives a lot of negative feedback and criticisms if this does not happen (Response - overt).
- In the behavioral interview she attributes depressive feelings to her loneliness and to her feeling of impotence to change without help (Organism - cognitive style). She agrees to participate in the SST with the following goals:
  - Learning to express clearly her wishes, opinions and desires while giving room to other persons; learning to give and receive compliments and criticisms adequately.
  - Learning to discriminate between what regards her and what not, and leave responsibility to other persons.

At the end of the behavioral interview, the therapist may decide whether the patient is qualified for the SST. If this is the case, admittance could be promised. But, besides the patient's qualification for admittance various other features may play an important role in the

formation of the group. We suggest informing the potential participant if he is qualified, but to postpone the definitive decision until all potential participants have been interviewed.

Points of special interest. The data of the questionnaires (scores and interpretations) should be available and used during the behavioral interview. We suggest refusing admittance of participants who are not able with the help of the therapist to formulate treatment goals during the behavioral interview. The reason is that group treatment, once started, does not provide many opportunities to formulate treatment goals for individual participants. Goals for behavior change that are unclear and implicit do contribute more to dropout from group treatment than in individual treatment. Dropouts could have a large and far-reaching negative impact on group cohesion and motivation of the remaining group members.

If it is revealed during the behavioral interview that the treatment does not fit the patient's problem behavior, the therapist supplies this feedback to the patient at the end of the interview. The benefit of the refusal at that point in time is that the refusal can be discussed, what is more, informative for the patient than a refusal by phone call or letter. If possible, the therapist should propose treatment alternatives.

3. SST treatment plan and selection of participants

3.1 Outline of the treatment

The SST consists of 20 sessions of 1.5 hour: 17 sessions weekly are followed by 3 sessions monthly. The general identification phase results in the first selection of potential participants (see 2.2). Part of the clinical case formulation is a pretreatment assessment including a behavioral interview to collect further information for the functional analysis (see 2.3 and 2.4). If the therapist judges the potential participant as qualified for SST, he discusses the treatment contract with the patient at the end of the behavioral interview (an example of a treatment contract in Appendix 1).

The treatment consists of three phases that are linked and partly overlapping:

1. basic social skills
2. specific social skills
3. self-management skills

The following procedures are applied: hierarchical presentation of the social situations, modeling followed by reinforcement, instructions, behavior rehearsal, role change, feedback, shaping, social reinforcement, and homework assignments.

The step-by-step approach involves working from simple to complex social responses within the 20 sessions. For example, a basic skill as active listening is conceived of as a requirement for specific social responses such as "refusing a request" and "expressing your opinion". Another example of this stepwise format is the training of the social responses: firstly, responses in general situations are used; next, these situations have to be individualized; finally the participants learn to anticipate their own practice situations for each response, making the step from simulated situation (that is to say, exercised within the session) to their daily life situation. In the course of treatment, the active role of the therapist(s) is gradually diminished. At the start of the treatment the participants are mainly externally reinforced by therapist(s) and co-participants, later on they learn to apply self-reinforcement (see 6.5 Self-reinforcement).

This format of the SST implicates that the content of the sessions has a subsequent order, which makes it difficult and inefficient to miss one or more sessions. The content of one session has a follow-up in the next session. The benefit of this format is that in a short period (about 4 months) effectively and efficiently behavior change is pursued. The most appropriate form for this kind of treatment is a closed group with one or two therapists. The present format of SST is based on a closed group (see Figure 1).

Figure 1. Outline of the treatment: components and the sessions in which they were dealt with.

Session	*Basic social skills*	*Specific social skills*	*Self-management skills*
1	Observing		
2	Active listening and 1st feedback step		
3	Introduction non-verbal behavior Exercise voice Exercise eye contact and 2nd feedback step		
4	Exercise sitting position and 3rd feedback step Exercise standing position		
5	Exercise and 4th feedback step	1st specific response , general practice situations and rating on discomfort	1st homework assignment adequate standards
6		Repetition 1st response with own practice situations	Repetition of homework assignment adequate standards
7		2nd response with self-generated practice situations	1st homework assignment tracing inadequate standards
8		3rd response etc.	Repetition homework tracing inadequate standards
9		4th response	1st homework assignment program for non-social activity
10		5th response	Repetition homework assignment program for non-social activity
11		6th response	Homework assignment program for 6th response
12		7th response	Homework assignment program for 7th as well as in advance for 8th response
13		8th response	Adjusting program for 8th response and making one for 9th response
14		9th response	Same for 9th and 10th response
15		10th response	Same for 10th and 11th response

16		11th response	Same for 11th response
17	Evaluation		Program for giving criticism
18		Giving criticism	Adjusting program giving criticism and making program for receiving criticism
19		Receiving criticism	Adjusting program receiving criticism
20	Evaluation		

3.2 Session plan

Each session, regardless the phase of the treatment, consists of the following components: a) discussion of homework assignments, e.g. report by one or two participants, evaluation by all participants (what did you learn last week), b) exercise of a (social) skill (theme of the session), c) new homework assignments, and d) evaluation of the session (what did you learn this session).

Exercises of social skills are the core of the sessions and take up the most time. It is a prerequisite that everybody actively participates in these exercises. The theme of the session depends on the phase (basic, specific social and self-management skills) of the treatment. For each session, a plan is made by the therapist(s) (example of a session plan: see Box 13). The outline of the treatment is made beforehand (see also Figure 1) with the exception of the order in which the social skills are trained because the participants contribute to this order. The training of social skill might be replaced by the training of a self-management skill (see Chapter 6, Self-management skills).

3.3 Homework assignments and target behavior

Homework assignments follow directly from the content of the session. We recommend especially in group treatment to present them in written form (examples are given in Boxes 4, 5 and 6). The advantages of this approach outline by far the disadvantages; for instance, it spares time at the end of the session, the assignments can be formulated as clear as possible (it prevents from vaguely noted assignments by the participants themselves), and the homework assignments are the responsibility of the participants instead of that of the therapist.
Deviations from the session plan and ad hoc homework assignments require great experience and flexibility from the therapists.

The participants make written reports of the assignments according to guidelines given by the therapist, and they bring these reports to the sessions. One or more participants report of their homework assignments at the beginning of each session (because of time sparing only one participant for each homework assignment). We prefer to give positive feedback to all participants; so they hand in a copy of their written reports of the homework assignments. This positive feedback for each participant has many benefits in the beginning of the treatment but costs the therapist a lot of time. In the second part of the homework discussion, each participant evaluates shortly what he/she has learned by doing his or her homework assignments. This evaluation results in target behaviors (intentions) for the session that may differ for each participant and each session. At the end of the session, each participant is invited to tell what he/she has learned in the session. Subsequently the target behaviors (intentions) for next week are formulated with the help of the therapist. This target behavior may be derived from the session theme, but also be specific for an individual participant.

3.4 Group treatment

The group is a means to reach the personal goals of the members. In addition, the participants serve as the first context for the aimed behavior changes. In other words, those group processes (e.g. cohesion and cooperation) are stimulated that contribute in reaching the participants' goals (e.g. Rose & Smokowski, 2001). The size of the group depends on the number of therapists: we recommend 6-8 and 8-10 members with one and two therapists respectively.

The acquisition of social skills in group treatment has the following advantages over individual treatment: a) a group provides more models and more reinforcement potentialities; rehearsal of problem situations is possible with various persons in vivo, b) the heterogeneity of participants (e.g. age, gender, and educational level) facilitates generalization of social responses, c) a group provides a wide range of social responses and problem solving strategies, d) working in subgroups without a therapist stimulates the acquisition of self-management procedures, e) group pressure and support facilitate personal changes, f) interactions between participants provide the therapist the opportunity to assess relevant behaviors, g) the experience that other persons have similar problems decreases one's exceptionality and facilitates group cohesion.

Before starting the group, it should be assessed for each potential participant whether group therapy is appropriate and how the group should be composed. These issues are discussed in the final paragraphs of this chapter.

3.5 Therapist(s)

In group therapy, the choice is between one or two therapists. There is to our knowledge no evidence that two group therapists are more effective than one, at least when they are experienced. Thus in most cases one therapist may be sufficient and certainly less costly than two. Highly experienced behavior therapists are recommended especially with experience with SST and group therapy. Working with individual patients provides many challenges, dealing with a group of patients increases complexities. It should be noted that the problem behavior to which the treatment is directed, also occurs within the social interactions within the sessions. This means that the therapist should be able to handle a patient's current problem behavior within a session, while taking into account both the prerequisites of the treatment program and the aims of the other participants. Finally, if SST is combined with another treatment, the therapist should pay attention to the tuning in of both treatments.

The advantages and disadvantages of working with co-therapists will not be discussed here (see Rose & Smokowski, 2001). However,specific benefit for SST is that there is more time for exercises with two therapists than with one therapist, to practice with (varying) subgroups, and it provides two different models with respect to social behavior. Note that SST with its emphasis on practicing overt behavior is certainly not an armchair treatment. If one therapist leads the SST, the format of various exercises should be adjusted such as the exercises for observing and active listening, as well as various procedures such as modeling and behavior rehearsal.

3.6 Selection of participants

The first step in the decision to admit a patient to the treatment should be based on the pretreatment assessment concerning social anxiety and social skills. If the treatment goals meet the behavior problems of the patient, a positive decision will follow. However, group treatment asks not only for fitting the treatment goals, but also for the ability to function in and as a group. This implicates that the pretreatment assessment should also address issues concerning the assets of functioning in a group, while also some general criteria could be set for the composition of the group.

The main criterion for participation in the SST is that a potential participant reports inadequate behavior and/or anxiety in social situations as (one of their) problems. With the exclusion of manifest psychotic behavior and mental retardation no selection takes place on the kind and intensity of other problem behavior. If indicated, treatment for other problem

behavior is simultaneously presented with the SST. Persons with different inadequate social behaviors are admitted to the SST group. Hence, persons who are distressed in social situations, who strongly avoid and/or have less social skills at their disposal (being 'nonassertive' like Peter), as well as persons who behave mainly aggressive (like Mary) are admitted to the SST.

Patients are admitted with either gradually increasing ages or within a restricted range of age. The aim is to keep the in-between distance between group members as short as possible and to increase the mutual modeling value of the group members. With respect to educational level, we prefer groups with rather small differences in educational level. Certain homogeneity with respect to these features prevents from too large differences in pace and choice of target behaviors that might impede the progress of the treatment. With respect to gender, we prefer mixed groups because they reflect daily life.

The question whether group treatment is the appropriate treatment for this client corresponds to a certain extent with the exclusion criteria. Patients with manifest psychosis, substance abuse or mental retardation should be excluded from the treatment. Whether other patient characteristics will hinder functioning in a group depends on the composition of the group. In general, patients with issues that need a lot of extraordinary attention by the therapist should be excluded or at least their admittance should be postponed. This could be the case for patients with a very high level of anxiety because of the impeding effect of their anxiety level on behavior change, as well as for patients with many maintaining consequences of their avoidance behavior. Medication to relief anxiety states also could be a reason to exclude a patient from the SST group, because of the risk that he/she will attribute an improvement to the medication instead of to own efforts. Group treatment should also be postponed for patients that could not stand even minor confrontations in the behavioral interview. The number and strength of confrontations are not completely controllable by the therapist, and there is a high risk that the latter patients drop out.

Points of special interest. With respect to kind and intensity of problem behavior, we exclude members who might find themselves in a unique position. This counts for the degree of skill deficits, (for example, one person with many deficits in a group of patients with few or small deficits and vice versa), as well as for the kind of problem behavior (for example, a predominantly aggressive person in a group of nonassertive persons or vice versa). When persons with aggressive behavior are admitted to the group, it is important to spell out their goals for the treatment. Non-assertive responding persons often reinforce aggressive behavior because they perceive this behavior as an alternative for their skill deficits. However, these

reinforcing aspects of aggressive behavior may hinder the development to more adequate social behavior.

Age and educational level might create unique positions. Participants may use their age as an excuse for not changing their behavior or for less active effort to change, (for example, by saying that young people better have learned to stand up for their rights than older people). Group members should not differ too much in their capacity to comprehend instructions and written material because of the kind of practice exercises. Finally, although groups with either sex are preferred, it should be possible to work with groups of only one of the sexes because of practical reasons.

Assessment of issues that take too much attention of the therapist within the sessions have to be explored in the behavioral interview.

3.7 Treatment contract

Aim. Treatment aims, procedures and appointments (number of sessions, duration of the sessions, announcing absence etc.) are offered in a treatment contract. With this contract, we outline the aims and procedures of the treatment, spell out the appointments about the dates, number and duration of sessions as well as focus the participants on their efforts. Verbal or written appointments about goals and individual dedication generally enlarge the commitment of the participant (see Appendix 1: Treatment contract).

Procedure. After the composition of the group by the therapist, a written acknowledgement of participation is sent to the participants. The treatment contract that was already discussed but not signed in the behavioral interview is sent along with this acknowledgement. Participants are asked to read the contract and bring it to the first session. In the first session participants as well as therapist sign the contracts (in duplicate), with the goal to increase the commitment of the participants with the aims of the SST. One copy is for the participant and one of each participant for the therapist.

Points of interest. Some participants do forget to bring the treatment contract to the session, so we recommend the therapist to have extra copies. Despite explanation about the aims of the treatment contract in the behavioral interview and again in the first session, participants with relatively low level of education may have trouble to understand the implications of the written treatment contract.

3.8 Introduction into the group

Procedure. At the start of the first session participants introduce themselves by telling their name, place of residence, and something about their family; the therapist(s) bear the brunt. It is proposed to use first names, what is exercised immediately. The introduction consists also of a look around in the treatment room and if appropriate the audiovisual equipment.

Points of interest. If video recordings are used, we recommend informing the participants about this procedure during the behavioral interview. This provides participants who do not agree with this condition, the opportunity to withdraw before the start of the treatment (instead of doing this in the first session). In the first session also agreements should be made about how to handle personal information of other group members (see Appendix 1: Treatment contract).

4 Basic social skills

4.1 Introduction

The SST phase of the basic social skills centers on skills such as observing, active listening, and giving and receiving feedback as well as non-verbal aspects of social behavior. Deficits in some basic skills such as eye contact, sitting position, posture, volume, and articulation may also function as 'safety behaviors'. An important difference with standard exposure procedures is that exposure of the patients' safety behavior such as avoiding eye contact is followed up by shaping and modeling until an adequate performance of gaze behavior is achieved. In Figure 2, an overview is given of various exercises and feedback procedures used in this phase. In the third column, the step-by-step organization of the feedback procedure is described and how separate steps are interwoven with the other exercises.

Figure 2. Overview of exercises and the step-by-step format of the feedback procedure

Session	*Exercise*	*Feedback procedure (see 4.2.3)*
1	Observing (see 4.2.1)	
2	Active listening (see 4.2.2)	After each step of the listening exercise: feedback about own listening and the summary
3	Non-verbal behaviors (see 4.3) Voice volume and articulation	After each step of the voice exercise: feedback about aspects of own voice
3*	Eye contact and gaze (see 4.3.3)	After each step of the eye contact exercise: giving feedback about own eye contact and asking feedback from the antagonist
4	Sitting position (see 4.3.4)	After each step: feedback about own behavior; a) what I did well and b) what should I change; followed by asking feedback from the antagonist
4*	Standing position (see 4.3.4)	After each step: feedback procedure similar as with the sitting position
5	Facial expression (see 4.3.5)	After each step: feedback about what I did well and what I should change; followed by asking feedback from the antagonist

* This format is based on two non-verbal behaviors per session. If only one behavior is exercised, the following exercises pass on to the next sessions.

Observing, listening, and giving and receiving feedback are conceived as prerequisites for the acquisition and performance of specific social skills. These basic skills are necessary preconditions for observational learning. They also form the basis for the performance of more complex social behaviors. Especially, observing and listening are needed for tailoring one's response to others. In the observing exercise participants learn to discriminate their

interpretations from factual descriptions of what has happened (observations). This skill makes it possible to tailor one's behavior to the real situation instead of to what one thinks that was the case (interpretation). Note that this exercise also confronts participants with their dysfunctional cognitions. Concretely describing what happens is also an important prerequisite for feedback. In the feedback exercises, group members learn to reinforce each other's behavior positively and to do constructive proposals for behavior change. These exercises are also a significant source of confronting the patients with the difference between their expected (negative) feedback and real feedback about their social behavior.

Nonverbal features of behavior are an important part of the exercises and are trained separately. Non-verbal behaviors are the context and vehicle of what is said and are the other person's first impression. The next nonverbal behaviors play an important role in social situations: voice volume, articulation, eye contact, posture, facial expression and distance. We recommend using circumscribed situations and training only one nonverbal behavior each exercise. In addition, further assessment of the individual participant's nonverbal behavior is also one of the purposes of these exercises. Finally, it is aimed that group members learn to observe their non-verbal behavior and learn to formulate goals for change if needed.
The effectiveness of social behavior depends partly upon the extent to which nonverbal and verbal behaviors are attuned to each other. In addition, the patient's non-verbal behavior has to be congruent with his verbal behavior. A well formulated but flustered request will not result in the desired effect. An example of a frequent incongruence is smiling while expressing anger or distress. We suggest paying attention to attuning non-verbal behavior to the goals one has in the situation as well as to the verbal content of the message. The non-verbal aspects return repeatedly in the various exercises. Separate nonverbal exercises (e.g. gaze, loudness) that precede the exercises of the specific social skills (see next chapter), result in a relatively large improvement in the beginning of the treatment. Even so, exercises of observing and listening ameliorate attention processes that enhance observational learning and reduce self-focused attention. Finally, the nonverbal exercises at the begin of therapy pay of in training time of the other social responses.

In brief, the following main goals of the phase of the basic skills are distinguished:
a) learning to observe behavior of other persons in order to tune in own behavior, b) learning to listen and to let this known by the recapitulation of the other's words, c) assessing own non-verbal behavior, and d) formulating treatment goals with respect to the desired change of own nonverbal behavior. First training nonverbal behaviors facilitates the training of the specific social skills. Besides, fine-tuning of the individual functional analyses as well as the

refinement of treatment goals takes mainly place in this phase of the treatment.

In adjunct to the above mentioned treatment goals, this phase of treatment has the aim that participants acquire the elements of the treatment procedures. The exercises are structured in a stepwise way so that participants learn to perform successively: role-plays, to give and receive feedback in a real, positive as well as constructive and at change directed way, to rehearse while improving aspects of behavior, to formulate concrete target behaviors for change, and to make short and realistic reports of their exercises in daily life situations. The investment of time in the first phase of treatment to achieve these goals pays of in efficiency in the next treatment phases of specific social skills and self-management.

4.2 Observing, listening, and giving feedback

4.2.1 Observing interactions

Purpose. The aims of the observation exercise are learning to look at and listen to own and other people's behavior and to describe this. This exercise takes up one session. We recommend starting treatment with this exercise. The participants learn to identify observations from interpretations. Because of the inhibiting aspects of biased interpretations in changing and improving (social) skills, the aim is that the group members learn to adjust their behavior to the real facts instead of to what they are thinking about the situation. Rehearsing the observation skill in following exercises enables the participants to acquire this skill in about five sessions.

Procedure. The observation exercise consists of two short role-plays performed by the therapist. The instruction of the exercise contains the purpose of being able to describe behavior concretely in the process of changing one's own behavior (i.e. learning to look at and listen to the behavior of others and to describe this). In the first role-play, the participants are assigned to look what happens and to note this afterwards. The therapist lists these notes on a white board or flip-over in separating observations from interpretations, (for example, in two columns), however, without naming these categories. The participants are asked during the listing, to think about the reason of the difference without naming it, until the listing of all notes is finished. In a group discussion, both columns are defined while the concepts of observations (facts) and interpretations (conclusions, impressions etc.) are illustrated with the help of examples from the listing. The purpose of this distinction is again elaborated as well as the risks of using interpretations in daily life.

For the second role-play, the instruction is to note only observations of what happened. In the group, it is discussed whether the observations represent facts and if not, why not. All

group members are expected and invited to participate in this discussion.

The aims of the observation exercise require role-play situations that leave room for the attribution of thoughts and feelings to the role players. We often use the following situation: Someone sitting next to you in an airplane or bus is reading a newspaper or magazine. He/she is looking for something in his/her bag and pockets while muttering things like: "well, obviously I put it away safely, but where?" Finally the traveler ends up by saying things like: "all right, we will not then!" and retakes his reading. Another proven example is: In the street someone walks back and forth, apparently waiting for someone or something. This person stares into the distance, looks in his diary, grumbles things like "Darned, I thought I was in time" and finally leaves.

This exercise makes clear that interpretations that are not based on observations impede adjusting one's behavior to what happens in the situation. Furthermore, it is vital to clarify that interpretations are not 'bad' or 'good' and that we all make interpretations. However, interpretations have to be recognized and adjusted into the direction of the facts as much as possible.

At the end of the session participants are asked to read and study the brochure "Observing" (see Appendix 2: Observing) and to execute the assignments at the end of the brochure. In order to apply the difference between observations and interpretations in daily life participants are instructed to observe twice a person from their environment. And to distinguish in their written report of these observations between facts and impressions. Box 2 provides the last homework assignment in italic, while the report is from Mary.

Box 2. Mary's report of the homework assignment "Observing"

In the next week, please watch someone with whom you are familiar, during a short time (about 1 min), without showing that you are performing an assignment. Please describe the situation afterwards with the help of the following points:

Who was it	my boss
Where was it (place)	in the shop
When (day and time of the day)	last Friday afternoon
What was the other person doing	he went to one of my colleagues
What did the other person say,	"do you know where I can find the new stock towels"
What did you think about the other person and his behavior? (Interpretation)	he obviously thinks that she steals them

In the next session, (session 2; see Figure 2) the homework of last week is the first point at the agenda of the group. Firstly, the brochure 'Observing' is discussed with respect to questions about the content. Next, the individual participants are asked to paraphrase the essence of the

content. Finally, the answers on some of the assignments in the text are discussed. The next step is that one of the group members reports his account of one of the observed daily life situations. At the end of the homework discussion, every participant provides an evaluation of what was learned by performing the homework assignments (see also 3.3).

In addition to the abovementioned goals of this exercise, it is also aimed to introduce to the participants the procedure of role-playing (in this case by the therapist) without requiring from them an active role. Participants often do not like the idea of doing role-plays in a group. For this reason, role-playing is introduced stepwise in the exercises of listening and the nonverbal behaviors.

Points of interest. The didactical purpose of this exercise is that participants discover themselves the difference between observations and interpretations with the help of the two columns on the whiteboard or flip-over. This implicates that it should be prevented from referring to this difference in the instruction of the exercise, while it is quite important that aims and scope of the exercise are presented. Next, the role-plays by the therapist should give enough room to interpretations to be able to illustrate the distinction of observations. It is tempting to formulate to many goals for this exercise with the result that the main goal ‘learning to distinguish between observations and interpretations’ gets lost. We recommend using neutral matters for the role-plays that have no relation with the treatment and the setting. Start and end of a role-play should be marked clearly, and assure group members that there is no need to be complete in writing their reports of the observed role-play.

Variations and other elaborations. The next steps of this exercise depend on the level of the group and the aims of the treatment. For example, if it is revealed in the next session that the difference between observations and interpretations has not become clear for the greatest part of the group, a new role-play could be presented to clarify this difference. Sometimes a new explanation with the help of examples from the brochure in combination with extra homework assignments will do. Do not demand too much from participants who struggle with the distinction because the following exercises offer new opportunities to rehearse. Another suggestion is to vary the level of difficulty of the homework by choosing situations of which one makes part or just not.

The observation exercise is also relevant as the first step in some cognitive procedures. For example, it can be used in recognizing of what are the facts and what the thoughts in the report of the situation. Another purpose could be to learn that other interpretations could be made from the same facts, for example, by adding to the homework assignment the question to think of two (minimal) alternative interpretations for the described situation. In the

situation of Box 2, Mary answered the question "What other interpretations are possible in this situation" with giving the following alternatives: a) he seems a little bit absent-minded and b) what a nitpicking about towels. This 'subsequence' of the observation exercise should be equipped by an explanation about the aims of this extension and the therapist's modeling of alternative interpretations.

In this exercise, a pitfall for less experienced therapists is using cognitive methods to modify the participants' interpretations. It is apparent that these interpretations represent a style of thought that might be attacked by approaches suggested by Ellis et al. (e.g. Ellis & Grieger, 1986) or Beck et al. (e.g. Beck, Emery & Greenberg, 1985). However, if the therapist accepts this pitfall, those participants who tend to "avoid by introspection" will certainly reinforce him. There is ample evidence that irrational cognitions and dysfunctional styles of thought do change sufficiently with the current training of social skills and self-management skills (Dam-Baggen & Kraaimaat, 2000a, 200b). If this is not the case, then we suggest introducing cognitive methods directed at changing dysfunctional cognitions not earlier than at the end of the SST.

4.2.2 Active listening

Purpose. The aims of this exercise are: to learn to listen to another person, to paraphrase this in own words, to tune in one's responses to those of the other person, and to let the other person know that you have heard what he did say. In addition, the distinction between observations and interpretations is applied to what is said.

The listening exercise runs in pairs who exercise concurrently. This format permits a lot of rehearsals for everybody within a restricted period. The level of difficulty of the exercise is rather low, because no spectators are included. This is important because socially anxious persons are often very troubled by being observed, whereas this is the first exercise with the active participation of all group members. The therapist also participates in the exercise, because of his model function and to prevent from being a spectator. This format demands much from instruction and modeling of the exercise by the therapist. In addition, the final goals of what should be acquired may vary a lot depending on setting and participants. For example, for some patients it might be too demanding at this stage to paraphrase empathetically (i.e. paraphrasing the other persons feelings). Sometimes it is even too difficult to paraphrase in using the words of the antagonist.

Procedure. In the general instruction, the goals are stated and illustrated as well as the three subsequent steps of exercising listening: a) literally repeating the words of the

antagonist, b) summarizing in the words of the antagonist, and c) summarizing in your own (fresh) words. Only the last step is appropriate for use in daily life. It is recommended to write the three steps on a white board or flip-over. The course of the exercise: the group is divided into pairs sitting face to face. The pairs form two circles; the inner circle is created by one part of the pairs sitting backwards to the inside of the circle, and the outside circle is formed by the other part of the pairs sitting face to face to the inner circle. The therapist illustrates with an example what is meant by the first step 'literal repetition'. Next the procedure with the pairs is explained (with the help of a white board or flip-over): person A says a phrase to person B referring to the programmed subject; B repeats literally A's words whereupon A responds with "yes" or "no" indicating whether it was right or not. Same procedure in the reverse direction: B says a phrase on the same subject, A repeats literally and B provides feedback by "yes" or "no". Again it is A's turn and so on; this procedure is continued for about five minutes. If one of the partners says "no" as feedback to the other person, it should not be discussed why the feedback was "no", but is the exercise continued. "No" means: "Be prepared! Next time better ". Before the participants perform the exercise, the therapists (or a therapist with the help of a group member) model the whole step that is to say, the procedure as well as the literal repetition. All pairs rehearse concurrently with the help of neutral subjects such as what you like in your habitat, your favorite radio- or TV channel, your hobbies etc. With this procedure, we pursue that participants exchange information about themselves in a neutral to a positive manner. After five minutes, the therapist finishes the rehearsal. Then each participant is asked to tell how he did perform. The therapist helps them to talk about their own performance in terms of observations. Then the next step is presented 'summarizing in the words of the other person'. This step is modeled too by the therapist with the help of a new theme. The first person is asked to say 2 à 3 phrases, which have to be summarized by the other person of the pair. This step costs more rehearsal time than the first step, so take about 10 minutes for it. After the rehearsal is finished, each participant again tells how he did perform during the rehearsal. The procedure for the last step 'summarizing in fresh words' is similar to the antecedent steps: introduction and modeling by the therapist, rehearsal of about 10 minutes and feedback by each participant on own behavior, all this with a new theme. Each step should be repeated as often as needed. After each step, the outside circle moves up one place in order to do the next rehearsal with a new partner. Several exercise situations are introduced by changing partners and themes. A secondary aim of this exercise is that the group members provide each other with information about themselves, which is not problem oriented and present themselves to the group members. The therapist

takes part in case of an uneven number of participants.

The homework assignments follow directly from the exercises: summarize shortly in fresh words what the other person said during a conversation. This assignment is performed twice with different persons. In Box 3 the assignment is given in italic; the report is Peter's.

Box 3. Peter's report of the homework assignment "Listening and summarizing"

Start a conversation with someone you are familiar with. Let the other person know that you are listening by summarizing shortly during this conversation what he/she said. Watch the other's reaction to your summary. The conversation is continued after your summary. Do not tell the other person it is an exercise.
Create a report of the situation with the help of the following points:

With whom you were talking	Jane
Where	at my job place
When	Monday, 12h15
About what theme you were talking	her holidays of last month
What the other person said,	"We made a tour in France, starting near Calais, crossing Normandy and the landing beaches, next the south coast of Brittany, etcetera
What did you say in summarizing	"So you did see a lot of sights and did do many things … "
How did the other respond	"yes, we did!" and she continued telling about her holidays

In the next session, the performed homework assignments are discussed: one or two participants read aloud their report of the "listening and summarizing" assignment and each participant evaluates the performance of his or her assignment.

Points of interest. The listening exercise has a complex instruction with a lot of information. We recommend dividing the instruction into parts and using a white board or flap-over. First, the aims of the exercise are given and then the different steps (and written on a white board or flap-over). Introduce the procedure not earlier than in the explanation of the first step. Modeling of 'listening' behavior should be explicitly distinguished from modeling of the procedure of the exercise. Some therapists choose to skip the first step "literally repeating ", because they think this part of the exercise is too easy for their group members. However, this step is not easy at all, and it brings a lot of working points, especially when the therapist invites the group members to lengthen gradually their phrases. The modeling of summarizing behavior is especially difficult if there is no co-therapist available. To give the therapist the opportunity to model summarizing as clearly as possible, the antagonist (e.g. one of the participants) should be able to report more than a few sentences. Especially in the case of socially anxious patients who often are brief, this implies an explicit choice of the antagonist for the modeling.

Patients might find it hard to skip parts of what was said by the other person and to use fresh words because of their evaluation anxiety. Please pay attention to the positive effects of

short summaries in fresh words. Because high socially anxious and reticent persons are not very used in talking and summarizing, they don't like the idea to apply this in daily life. We suggest that the therapist demonstrate this behavior during this discussion in a simple and direct way in order to show how 'normally' summarizing is, and what the effects are on the conversation and the other person. A short demonstration often has more impact than verbal persuasion. Another bottleneck could be that participants avoid doing their homework assignments because they are not able of or find it hard to initiate a conversation. Please assure them that any conversation is appropriate, whether it is started by the other person or themselves. Finally, we strongly discourage participants to take as the theme for this group exercise the reason for their referral or their problem behavior.

4.2.3 Giving and receiving feedback

In the evaluation of the various exercises, a lot of attention is paid to reinforce yourself, followed by the feedback of therapist and other group members. Before each exercise, the target behaviors for that exercise have been formulated for each participant. The feedback directly refers to the performance of these targets. We prefer verbal feedback by group members and therapist to audio- and video playback. Audio- and video playback have certain disadvantages. It is time consuming and might be very confronting. Especially in group treatments the advantages of audio- and video playback do not outstand the disadvantages. We prefer to use structured feedback by the group members about their own and other's behavior. An additional benefit of this procedure is that every individual group member has to participate actively, whether it is his or her turn or not. Finally, it should be noted that feedback is more effective the faster it follows the behavior, is concrete and direct and consists of positive as well as negative aspects.

Purpose. With the procedure of giving and receiving feedback, we intend to teach the participants to reinforce their own and other's behavior as well as to be concrete, specific and direct in evaluating behavior. In addition, participants practice in doing proposals for behavior change instead of giving negative judgments. Finally, they learn to be evaluated and to ask for feedback. By directing the attention of the participants to specific aspects of behavior by the use of instructions and criteria, it is facilitated that (only) effective behavior is acquired. Examples of social reinforcements as used in the sessions are: "Great to succeed in doing your request"; "Excellent"; "Good to see that you tried it"; "Your voice was clear and loud"; "Your gaze was good when you started talking"; and "You did express your opinion clearly as possible" .

Procedure. Giving feedback by group members and therapist is introduced stepwise in the exercises of listening and the non-verbal behaviors (see 4.2.2 and 4.3). The first step in learning to give concrete feedback was part of the observing exercise in teaching the group members to describe the behavior as concretely as possible. In de next step, the listening exercise, the participants have to evaluate their listening behavior on request of the therapist. With the help of the received feedback in terms “yes” or “no”, they were enabled to make remarks about own listening behavior. The next steps in learning to give and receive feedback are linked to the exercises of the non-verbal behaviors. For instance, in the first session every group member evaluates his rehearsal followed by feedback by the therapist. The therapist demonstrates this with the help of an example and thus models how to evaluate concretely and specifically own performance. The feedback of own behavior is always followed by feedback of the therapist, which has the aim to reinforce the rehearsed behavior and to model giving feedback. In the next exercise of the nonverbal behaviors, the evaluation is extended in such a way that, after feedback of own performance, the antagonist is asked for feedback ("What do you think of my behavior?"). The therapist leads this evaluation and will give his feedback in the end. In the next exercise of the nonverbal behaviors the evaluation is divided in: "What did I do well" (self-reinforcement) and "What should I modify in my behavior and how" (this holds for own feedback as well as for asking feedback from the antagonist). In the last nonverbal exercise, the whole procedure is applied: each participant evaluates own performance, followed by asking for feedback from the antagonist, then from the other group members, and finally the therapist gives his feedback. From now on, this full procedure is applied in the evaluation of the rehearsed behavior in all exercises.

Points of interest. The feedback exercise runs parallel with the listening exercise and the separate exercises for the non-verbal behaviors, but is also possible in combination with other exercises, dependent on the composition and organization of the treatment. The last step of the feedback procedure (own behavior, asking the antagonist, asking the other group members, the therapist; what did I do well, and what should I modify) is applied after all exercises if that is desirable and there is time. It should be noted that the feedback procedure should be handled flexible in order to facilitate a quick progress of the exercises and the shaping procedure. The therapist structures the feedback procedure and he may start shaping at one or more of the following critical moments: direct after the evaluation of one who rehearses (the protagonist), after the feedback of the antagonist, after the feedback of the other group members or his own feedback. We recommend starting with shaping as early as possible, specifically when real modifications are mentioned, instead of running through the

whole feedback procedure. After shaping the whole feedback procedure may be still run through, while comparing the performance before and after shaping.

Giving feedback is highly facilitated by specifying in advance the concrete features to work on or, in other words, which criteria should be fulfilled (see also 6.4 Self-evaluation). These criteria should be formulated in terms of observable behavior, should refer to verbal as well as non-verbal features, and should be geared to the intended effects.
The (written) feedback of the therapist on the reports of the homework assignments should refer to these concrete aspects of behavior (i.e. criteria). Some examples of (written) reinforcements by the therapist: "Excellent report of the homework assignments", "Great that you succeeded in summarizing that conversation; the reaction of the other person did reflect this too" and “Your refusal was clear and to the point, very good”.

It is of interest that participants learn to decide independently which elements and features do make their behavior effective (“which aspects of behavior do contribute”). With the acquisition of giving and asking for feedback, the initial impetus is given to self-managed behavior change (see also: 6 Self-management skills).

4.3 Non-verbal behaviors

Nonverbal behaviors are an important source of information about the individual’s emotional state and distance to other persons in social interaction. Eye gaze may relay various social intentions such as submission, disinterest or even rejection. Specifically, direct gaze is a clear signal of attending someone and a potential start of a social interaction (Wieser, Pauli , Alpers & Muhlberber, 2009). Vocal characteristics such as loudness, speech rate and time, pauses, pitch, and prosody, were in some studies found to discriminate between high and low socially anxious persons. Illustrative of the body posture of socially anxious persons are a slumped and closed posture, rigidness and fidgeting (see Gilboa-Schechtman & Schachar-Lavie, 2013). Psychiatric patients with problems in social interactions often show deficit non-verbal behaviors, which are generalized to a variety of social situations and may have the function of avoidance or safety behaviors, such as talking too softly and less direct gaze (e.g. Baker & Edelmann, 2002; Dam-Baggen & Kraaimaat, 1987a).
Because deficit non-verbal behaviors occur across various social responses and situations, we deal with these behaviors separately and preceding the more complex and specific social skills. The benefit of this approach is that participants start with changing relative simple behaviors that result in significant improvements in their social functioning. For example, by talking more clearly and loudly, by improving their gaze and by other oriented posture, they

already may improve their interactions with other people. The second goal of this part of the SST is to learn to tune in non-verbal to verbal behaviors, so that body language and words do support each other.

The exercises for the non-verbal behaviors are preceded by a short general introduction while the following behaviors are taken into account:

- voice: talking audibly (volume and articulation);
- eye contact: regularly looking at and away;
- posture: other-oriented depending of the situation (sitting and standing);
- facial expression: attuned to the verbal content;
- distance: attuned to the situation and the verbal content.

4.3.1 Introduction of the non-verbal behaviors

The introduction to this part of the treatment raises the importance of non-verbal behavior in interactions, especially with respect to the fine-tuning of verbal behavior and the goals in that social situation. To illustrate this, a role-play could be used that shows the following ways of responding in the same situation: ‘aggressive’, ‘nonassertive’ and ‘assertive’ responses. The instruction for the group is to watch the differences in non-verbal behavior between the three scenes. The remarked differences in non-verbal features are discussed in terms of observations instead of interpretations. The discussion of the three scenes should also refer to the effects of the various behavior styles. Finally, each group member discloses his/her behavior style in social interactions. For this exercise, we use a videotaped role-play that shows the three responding styles.

If such a videotaped role-play is not available, we recommend making one. The benefits exceed by far the costs of time and money because of the clearness and repeatability of the demonstrated behavior.

4.3.2 Voice volume and articulation

Purpose. The aim of the exercise is to demonstrate the effects of loud and clearly speaking and, if needed, to formulate targets to change. Other features (such as talking too fast) could be treated if they are present in one or more group members and appear to be impeding in social interactions.

Procedure. In the introduction of the exercise, the emphasis is on voice volume and articulation in referring to the disadvantages of talking too softly, too loud or mumble (The

purpose is to speak audibly and not to speak standard or civilized English). We use an exercise in a circle in which each group member practices without playing a role-play. The exercise consists of three rounds. In the first round every group member, the therapist as the former one takes his turn to say a short sentence to the neighbor, for example: "The weather is nice/bad today". The emphasis in this exercise is on talking per se and not on what is said. After the first round, the therapist discusses in general the differences in loudness and clearness across the group. No individual feedback is given in this phase of the exercise. In the second round again every participant says a similar short sentence to the other neighbor. This time every participant evaluates his/her own loudness and clearness, followed by feedback from the therapist. If needed, targets for change are formulated. Also, this time the therapist takes the first turn and evaluates (models) his practice. When everybody has got his/her turn in practicing, the last round comes with a similar sentence and the assignment to increase volume or clearness. At the start, the therapist refers to the targets to change for every participant and takes care that the feedback refers to these targets. Everybody evaluates their practice followed by feedback from the therapist. The therapist should be actively reinforcing. In this round shaping takes place until the last target of talking sufficiently loud and clear is achieved.

The homework assignment follows directly from the exercise and is similar to that of the listening exercise (Box 3) except the extension that the loudness and clearness of own voice should be observed and described (bold in Box 4).

Box 4: Peter's homework assignment of his voice

Start a conversation with a friend. Summarize shortly in fresh words what the other person did say during that conversation. ***Watch the loudness and clearness of your voice****. Describe the situation with the help of the following points:*

With whom you were talking	With Gary, a friend,
Where	at my home, in the living room
When	Thursday, 10 PM
About what you are talking	a ride with the truck
What the other person said	"Well they stopped us to check our licenses. And it lasted a long time. Nobody did help us …."
What did you say in summarizing	"So you had to wait a very long time"
How did the other respond	Gary removed his hand from his head and said: "Yes, and I was fed up".
What about your loudness and clearness	I talked loudly enough, but not at all clearly
Would you like to change aspects of your voice and if yes, what	I would like to talk more clearly

4.3.3 Eye contact and gaze

Purpose. In the introduction, the importance of eye contact and gaze in social interactions is emphasized. Eye contact (also called mutual gaze) facilitates the maintenance of contact with the other person and provides information for the regulation of conversation. Eye contact is especially important at the beginning and the end of a clause and functions as a significant cue for beginning or ending an utterance, while in the meantime looking at and away the other person alternate.

In an early study, it was found that about 60 percent of the conversation involved some form of gazing, while about 30 percent involved mutual gazing. In addition, average gaze length appeared to be about three seconds long, whereas eye contact (mutual gaze) lasted just over one second before being broken (Argyle & Cook, 1976). Holding gaze for as little as three seconds longer than average can come across as aggressiveness and is almost always taken negatively or offensive. The overall amount of eye contact varies with the length of the conversation, the topic and gender of the person (Kleinke, 1986). There is ample evidence that a mutual gaze is perceived as threatening by socially anxious individuals and might lead to avoidance of eye contact (Schulze, Renneberg & Lobmaier, 2013).

The aim of the exercise is to evaluate and modify if necessary own eye contact and gaze (i.e. direction, duration, shift).

Procedure. This exercise is practiced in the circle of the group too; in this case, however, not with the neighbor but an opposite group member, thus approaching the format of a role-play. The exercise consists of telling something to the opposite participant while looking at this person at the beginning and the end and meanwhile alternating looking at and away. The opposite should respond with a summary. In the evaluation, the participant evaluates individual eye contact: when and how much he looked at (feedback on individual behavior: see 4.2.3; see also Figure 2). Next, the participant is invited to ask the antagonist for feedback on his/her eye contact (when and how much, and adequate or not; feedback of the antagonist). The summary is evaluated shortly (and reinforced), because it is only a secondary aim of the exercise. The therapist models the eye contact and the feedback procedure before the participants start their practice. Every group member gets his or her turn. If needed, shaping takes place: eye contact at the start of an utterance, subsequently looking at and away, and finally eye contact at the end of talking.

The homework assignment is similar as that of the listening exercise, but now extended with the assignment to evaluate own eye contact during a conversation (see Box 4).

4.3.4 Posture

Purpose. In the introduction, the facilitative role of an other-oriented and open posture in initiating and maintaining social interactions is emphasized. Contact will be impeded especially by an averted and crouched posture. The purpose of the exercise is to explore the effects on the interaction of various postures.

Procedure. In this exercise attention is given to a sitting as well as a standing position. For both positions, the exercise consists of two parts; first an exploration of which bodily features contribute to an other-oriented or an averted posture. Next a role-play is used to practice an other-oriented posture in a social encounter.

In the exploration of the sitting position, the variety of postures within the group of participants is discussed. Next, various postures are tried out and evaluated with respect to the orientation on others, and its invitation to contact. A general guideline is to attune your posture at your goals at the situation.

This is the first time in the SST that the therapist models by using a short role-play. That is to say, every participant practices in a sitting position that posture that corresponds with his/her verbal behavior and is attuned into his/her goals in that situation. A situation suitable for this role-play is: a friend joins you at a birthday party or coffee break and starts a conversation. This role-play may take place in the circle while the other group members act as visitors or colleagues and do not actively participate in the role-play. The instruction for this exercise is to turn actively to the arriving friend in order to show that he/she is welcome. It has to be emphasized that the exercise only considers the posture and not aspects of the verbal behavior. In the evaluation of the practice the next step of the feedback procedure is introduced, namely first feedback with respect to positive features and then on what could be improved (see 4.2.3; see also Figure 2). This feedback step is applied in feedback on own as well as on other's behavior. ("what did I/you do well in turning to the other" and "what might be improved in my/your behavior? The therapist models the other-oriented posture as well as the step in the feedback procedure before the group members are going to practice. If needed, shaping takes place.

The standing position is practiced in a similar way: several standing postures are explored and tried out with respect to their orientation on others. The guideline is again: attune your posture to your goals in the situation. The short role-play for the standing position is situated outside the circle and is modeled by the therapist. A role-play suitable for this situation is: a friend joins you at a bus- or metro station starting a conversation. The job is: turn actively to the other person. The evaluation is similar as in the sitting exercise (e.g. feedback on own and

other's behavior, what was well done and what might be improved). If needed, shaping takes place.

The homework assignments are similar to those of the listening exercise, but in this case they are extended with the assignment to assess your posture, once sitting and once standing, in two different conversations (see Box 5).

Box 5: Summary of Peter's homework assignments for the non-verbal behaviors (posture sitting and standing, facial expression and distance).

Start a conversation with a friend. Summarize shortly in fresh words what the other person said during that conversation. ***Watch one of your non-verbal behaviors*** *(posture sitting and standing, facial expression and distance). Describe the situation with the help of the following points:*	
With whom you were talking	With Gary
Where	At home in the living room, sitting opposite Gary
When	Monday, 10 PM
About what you are talking	A ride with the truck
What did you say in summarizing	"So you had to wait for your licenses"
How did the other react	Gary removed his hand from his head and said:" Yes, and I was fed up a little bit".
or	
How did you look at the other person	I looked at Gary when I started my summary and stayed looking until I finished my talk
or	
How was your sitting posture	I was sitting with my legs crossed, just opposite to Gary
or	
How was your facial expression	I frowned my brows when talking
or	
How was the distance to the other	I was sitting at a distance of about 1.5m from Gary with the table in between us
Would you like to change anything and if yes, what?	I would like to talk more loudly and to articulate clearly

4.3.5 Facial expression

Purpose. In the introduction for this exercise, the importance of attuning of facial expression and the content of our words are emphasized. The therapist demonstrates the effect of incongruence (for example saying, "I am bored" with a smile). The aim is again an assessment of own facial expression and if needed to change it.

Procedure. The exercise is executed in the circle with opposite pairs alternately practicing. The assignment for each pair is: tell something to your opposite partner with attuned emotion (astonishment, joy, aversion, irritation etc.) that is expressed by your face. The antagonist should respond with a summary. Feedback should refer to the attuning of the facial expression, and the verbal content (Note that the summary is only evaluated shortly, because summarizing is only a secondary goal). In the evaluation, a new step is introduced

namely asking the other group members to give feedback after the own feedback, and that of the antagonist are given (“what do you think of my performance”; that is to say, what did I do well and what might be improved) (see 4.2.3; see Figure 2). The therapist models the exercise of the facial expression as well as the new step in the feedback procedure. If needed shaping of a better adjustment of facial expression on the verbal content takes place.

The homework assignment is similar as for the previous non-verbal behaviors with the exception that the facial expression should be observed and described (see Box 5).

4.3.6 Distance to the other person

Purpose. In this exercise, the significance of attuning the distance to your goals and verbal content is emphasized. The therapist demonstrates how distance varies with the intimacy of the verbal message and the situation. The aim of this exercise is again to assess how one uses distance in social interactions and if needed, to improve this.

Procedure. The exercise could be performed whether sitting or standing, within or outside the circle. The instruction is to tell a short story to the antagonist while taking into account the distance that should be attuned to your goals in the situation and the verbal content (moving the chair, leaning towards the other person, making a step backwards or forwards etc.). The antagonist has to respond with a summary. The evaluation procedure is similar as in the previous step of the non-verbal behaviors; that is to say the full procedure is walked through.

The homework assignment is similar as with the prior non-verbal behaviors but now with the task to evaluate, attune and describe your distance to the other person (see Box 5).

4.3.7 Points of interest for the non-verbal behaviors

These exercises aim to clarify how non-verbal behaviors facilitate or impede social interactions. The exercises are rather simple. Nonetheless, the procedures are complex because several secondary goals are also included. Secondary goals are stepwise learning: to perform role-plays, to give and receive feedback, to give a short verbal summary etc. The sequence of the exercises is more or less arbitrary, and sequence, as well as procedure, are adapted with respect to secondary goals.

The above mentioned exercises may be extended to other non-verbal behaviors (latency, variety in gestures, intonation, etc.). Note if that is the case homework assignments have to be extended, and more behaviors should be practiced in daily life. Generally we deal with the

exercises for voice and eye contact within one session, sitting and standing in the next session, and facial expression in the following session. Note that the step by step progression of the feedback procedure takes successively more time in the later sessions. Distance is seldom dealt with in a separate session and may be combined with the standing posture because of time limitations.

4.3.8 Individual target behavior

In addition to the usual homework assignments, every group member has his/her distinct target behaviors with respect to the non-verbal aspects. Softly speaking of a patient may be a generalized habit that takes more effort to change than may be achieved by the regular homework assignments. Differences between group members ask for individually tailored targets.

Procedure. To give the participants opportunity to work at their own particular problem behavior, every participant chooses at the end of the session a non-verbal behavior, the so-called target behavior (a learning goal or point of interest) that gets explicit attention in the next week (homework and the next session). For example, "I am going to speak louder next week" or "I am going to look more at the other person in a social interaction". Choosing such a target behavior facilitates behavior change independent of the group homework assignments. At the end of the session, this individual target behavior is evaluated too. In the homework assignments for the next session, every participant chooses a target behavior (the same or a new one, dependent on the progress). Target behaviors make it possible to change and shape idiosyncratic problem behaviors for each separate participant.

Points of interest. The most occurring bottleneck for this part of the treatment is that the group members say in their evaluation that they paid attention to their target behavior. It should be noted that paying attention is not a sufficient condition for producing behavior change. The therapist should ask explicitly the participants to report their progress, in order to be able to reinforce and to learn them to perceive their progress themselves (self-reinforcement). Reminding your target behavior is the responsibility of the group member and not of the therapist! The evaluation of the target behavior should start with the question: "On what target behavior did you work this session/last week?". Followed by the question: "How did you do?" If someone does not remind his target behavior. It gives information about his efforts to work on!

Finally, in Box 6 example is given of a complete set of homework assignments as are given to the participants in this phase of the SST.

Box 6. Homework assignments of the fourth session (Basic social skills)

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1. Please practice listening and summarizing in some of your (small) talks of next week. Summarize once during that talk what the other person said. Watch your sitting posture during your talk: how other oriented was it. Describe the situation afterwards with help of the following points: (see Box 3 and 4)

2. Repeat assignment 1 with another person while you are standing. Watch your standing posture: : how other oriented was it. Describe the situation afterwards with help of the following points: (see Box 3 and 4)

3. Please work on your voice, eye contact or posture during your talks. Do not choose too difficult situations and determine beforehand on which non-verbal behavior you are going to work.

4. In the attached list you will find 16 social responses or social skills. Cut the list to get 16 small cards with responses and make a rank order: (see Box 7)

5. Specific social skills

5.1 Introduction

One of the main purposes of SST is the acquisition of complex social responses (i.e. social skills) by means of social or observational learning and behavior rehearsal. Because the literature revealed that a generalization from one to another response is not warranted, a variety of separate social responses is rehearsed and practiced in a diversity of situations.

The rehearsal of social responses has a format to create optimal conditions for the learning of social skills. That is to say, each session builds on the content of the previous session. And every participant gets his or her turn in the rehearsal procedure of each session. The following premises serve as the basis of the rehearsal procedure:

- The social skills are roughly ranked from simple to complex (for example, giving criticism not earlier than at the end of treatment) and are clustered according to their content (for example, doing, refusing, and receiving a request in one cluster);
- Each session only one social skill is trained, the same one for everybody;
- For each social skill participants bring their list of practice situations to the session;
- Rehearsal of the skill takes place in situations that are expected to occur in order to achieve that new behavior is performed in upcoming real life situations;
- Each session, each group member, gets his/her turn in the rehearsal. The central idea is that in the case of complex skills, modeling contributes to the acquisition of new skills but real practice is the essential core;
- The homework assignments follow directly from the exercises in the session (that is to say, practice in daily life situations is only encouraged **after** a response is rehearsed within the session).

Procedure. In the SST, a taxonomy of 16 social skills is used that are derived from studies on social behavior (e.g. Dam-Baggen & Kraaimaat, 1999). In Box 7, these skills are presented with their clustering (ties).

Within an SST with 20 sessions, about 12 of these 16 skills could be rehearsed. The independent application of non-rehearsed skills after finishing the treatment is supported with the help of self-management skills (see Chapter 6, Self- management skills). Within the limits of a stepwise program and considering the clustering of social skills, each treatment group has a say in the selection of which skills will be treated. The procedure is that each participant ranks the 16 skills according to his

Box 7. The taxonomy of 16 specific social responses and their clustering

1. Starting a conversation	5. Expressing an opinion *
1. Ending a situation	6. Asking for information
2. Doing a request	7. Standing up for your rights *
2. Refusing a request *	8. Giving a compliment to someone
2. Receiving a request	8. Positive self-evaluation *
3. To criticize*	8. Receiving a compliment *
3. Receiving criticism	9. Making an offer
4. Inviting someone	9. Getting an offer

* For a description see Appendix 4 'Examples of goals, criteria and general practice situations'

or her preference with the help of small cards. This ranking is requested in one of the homework assignments that precede the phase of the specific social skills (see Box 8).

Box 8. Assignment to rank the 16 social responses according to your preference of them being treated in the SST.

At this list, you will find 16 social responses or skills. Cut them out until you have 16 cards and rank these 16 cards as follows:

- First the card with the response you preferred most to be practiced in this SST,
- Second the card with the response that you preferred subsequently to be practiced,
- Third the card with the subsequent preferred response
- And so on, until all 16 cards have been ranked.

The result is a stock of 16 cards ranked from your most preferred to the less preferred response to deal with in this SST. Now please make a list of the ranking order of the cards. At the top, please write the response of the first card, next the response of the second card followed by the response of the third card and so on until the 16th response is written at the bottom of your list.

From these individual rankings, a group ranking is derived that is distributed to the group members. A stock taking of the group rankings of 25 treatments shows a Top Six of the following most chosen responses: expressing opinion, receiving criticism, standing up for your rights, refusing a request, giving criticism, and starting a conversation.

In this chapter, we describe the phase of specific social skills including its particular components such as generating practice situations, modeling, behavior rehearsal and shaping, and the use of subgroups. The procedures used in this phase of the SST are interwoven with components of the phases of 'basic social skills' and 'self-management skills', such as giving feedback (see 4.2.3), and learning to set goals, criteria and to foresee practice situations (see 6.4). In Figure 3, an overview is given of the components of the phase of the specific social skills.

Figure 3. Components of the phase of the specific social skills and respective sessions

Session	*Exercise*	*Homework assignment*
1	Basic skills (see Figure 2)	
2	Idem	
3	Idem	Participants rank the 16 specific social responses.
4	Idem	Turning in the individual rankings of responses.
5	Idem	Therapist presents the group ranking. Choice of the 1e practice response.
6	Introduction of general practice situations for the 1st response and rating these according to discomfort. From the group ranking of general practice situations follows the 1st practice situation. Each participant transfers general situation to own. Modeling of the response by the therapist. Everybody rehearses his/her own situation.	Practicing the 1st response in daily life. Preparing new response (generating practice situations).
7	Listing of practice situations. Modeling by the therapist. Everybody rehearses their situation.	Practicing the response in daily life. Preparing a new response.
8 et seq.	See 7	See 7

5.2 Practice situations

Each social response takes one session, except in the case that participants and/or therapist consider that more time is needed (e.g. dependent of progress in daily life). For behavior rehearsal and practice we use situations that might occur next weeks. By this approach participants learn to anticipate at possible forthcoming situations and to recognize them as practice situations.

Procedure. In the first session of this phase, 5 to 6 practice situations for one social skill or response are used which are formulated in general terms. Such practice situations could be derived by the therapists from information obtained at the assessment of the participants. These general practice situations should be familiar, appropriate and plausible for the group. In Box 9, several general practice situations for 'doing a request' appropriate for an adult psychiatric population are given (for examples for other responses see Appendix 4, ‘Examples of goals, criteria and general practice situations’)

Box 9. General practice situations for 'doing a request'

Doing a request:

1. Asking a friend to lend you a book, CD, DVD, bike, camera and the like.
2. Asking a housemate, your spouse or one of your children to do the work for you, for example, watering the flowers, setting the rubbish bin outside or to run an errand.
3. Asking a friend to accompany you to the cinema, a shop, and the like.
4. Asking a housemate or colleague to run an errand.
5. Asking a friend to order and pay both of your theater tickets in advance.

The list with general situations is distributed in the first session of the specific social skills phase (figure 3, session 6). After the situations have been rated on the amount of discomfort by the group members, the situation with the less amount of distress for the group is chosen as the first practice situation (see 6.3, Self-application of graded practice). Next, this general situation has to be reframed by each group member to a situation in his/her own daily life (see Box 10). The transposed own practice situations are then used to rehearse the concerning response within the session.

Box 10. Transposition of general practice situations to situations of group members

Doing a request:
First general practice situation:
Asking a friend to lend you a book, CD, DVD, bike etc.
Similar situation Peter:
I will ask John, one of my best friends, to lend me a particular DVD.
Similar situation Mary:
I will ask Joyce, my best friend, to lend me her sewing machine.

Second general practice situation:
Asking a friend to accompany you to the cinema, a shop etc.
Similar situation Peter:
I will ask Cathy, my wife, to accompany me in a ride on the bike.
Similar situation Mary:
I will ask Elisabeth, my neighbor, to accompany me to the cinema.

After the response is rehearsed within the session, the homework assignment will be to apply the practiced social skill in own daily life situations. To facilitate their assignments, the participants are asked to think of 6 real practice situations with the help of the distributed list of general practice situations. In Box 11, the homework assignment is given (*italic*) together with the practice situations that Peter thought of.

Box 11. Generating practice situations to be able to perform the homework assignments

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Please think of 6 practice situations for doing a request that probably will occur next week. Helpful in doing this is the list of general situations distributed in the session. Describe for each situation to whom you would like to address your request and the subject of the request.

Peter's practice situations for applying doing a request in daily:

Person:	*Request*:
- to my neighbor X	to help me with a job
- to my wife T	to accompany me in buying new shoes
- to my brother Y	to make a bike ride in the weekend
- to my neighbor a P	to lend me his racer because mine is being repaired
- to my daughter C	to buy reparation materials for her bike
- to my son K	to leave immediately when picking him up from soccer

The next step is that the group members learn to produce own practice situations for the rehearsal within the sessions. The homework assignment for the next session is to think of about 6 practice situations concerning the planned response. These situations should have a high probability of occurrence. Group members have to bring their list to the session. Box 12 gives an example of Mary's list of practice situations for the response 'refusing a request'.

Box 12. Mary's practice situations thought of before the session

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a. The response for the next session will be 'refusing a request.
c. Please list 6 situations that you would like to refuse. Describe from whom you will receive a request and the subject of the request.

Mary's practice situations before the session:

Person:	*What is requested:*
- by my colleague P	to change services because she already has an engagement
- by my neighbor J	to take care of her bird during her holidays
- by my chef L	to take an extra service with Easter
- by my sister Z	to join her for holidays
- by my brother R	to lend him my camera
- by my mother	to bear her a helping hand on her birthday

The response is rehearsed within the session with the help of these practice situations. Next, this list of situations will serve as practice list in daily life (homework).

Points of interest. A frequently occurring problem in thinking up practice situations is that the situation is described too vague with respect to person and subject of the interaction. Because of ambiguity, it often will not be clear what the concrete situation is. Also, participants have difficulty to think up of possible upcoming situations: they are not used to anticipate of whom they are going to meet and what they are going to do/say to these persons. Giving examples by therapist and other group members is often sufficient help in learning to produce situations. Another strategy is to

propose to ask the other group members about their approach in generating situations. For example: making a list of whom you are going to meet and in which situation; monitoring each performance of the response will bring new ideas for similar situations in the future etc. The therapist should be attentive that the group member decides which of the suggested strategies he or she is going to use in generating practice situations. Note that initiating situations such as starting a conversation, doing a request, giving a compliment, asking for information, and giving criticism are easier to foresee and to plan than situations that are initiated by the other person such as refusing a request, receiving a compliment, and receiving criticism. In the latter case participants have to anticipate on the expected behavior of the other in a certain situation. In Box 13, an example is given of the plan of the first session in the phase of the specific social skills.

Box 13. Plan of the first session of the specific social skills (session 6)

In the *homework discussion*, a group member reports one of his/her practice situations of the non-verbal behaviors; next everybody evaluates what he/she learned last week while executing the homework assignments as well as with respect to his/her target behavior.

This is the first session of the phase of the specific social skills. According to the group ranking order of social responses the first rehearsal response will be 'doing a request'.

So, the *theme of the session* will be 'doing a request'. The rehearsal of doing a request will be limited to those situations in which the other person is expected to comply with the request. This procedure prevents from learning to receive a refusal and a too early stage.

Preceding the session the assignment was given to think up of the goals one could have with doing a request. These goals are discussed in the session and other goals may be added (see 6.4 Self-evaluation). After this short discussion,hand out of goals will be distributed among the participants. In addition, the question of the importance of thinking up of goals for a social response is addressed to the group.

Next, the criteria are discussed that have to be fulfilled to be as effective as possible in performing the response. To think about the criteria was also assigned in the homework preceding the session (see 6.4 Self-evaluation). After the discussion of the criteria a hand-out with these criteria is distributed, and the question of relevance is also addressed.

Next step is to distribute the list with general practice situations for 'doing a request' (see box 9). The group members have to indicate for each situation their level of discomfort on a 10 point SUD scale (see 6.3 Self application of graded practice). The discomfort scores of all group members are collected on a white board or flip-over, thus leading to a group ranking of the situations. The situation with the lowest degree of discomfort for the group is used as the first practice situation. The purpose of this stepwise approach is shortly discussed.

Then the group members are asked to transpose the chosen general practice situation to a concrete own practice situation (see Box 10). The therapist models this procedure and transposes the general situation to a real practice situation from his daily life.

In the next step, the therapist models 'doing a request' with the help of his own situation. The attention of the group is directed to his request and the question whether his request fulfills the criteria. In the evaluation, the modeled response is explicitly compared with the criteria.

(In all subsequent sessions of the phase of the 'Specific social skills' the group members bring their list with practice situations to the session and rehearse the response in their 'easiest' situation (see Box 12).

Then all group members rehearse the response turn by turn. The evaluation of the rehearsal is done by performing the complete feedback procedure (see 4.2.3)

In the case of two therapists, the group will be divided into two subgroups for the rehearsal. Each subgroup evaluates what has been learned with rehearsing 'doing a request'. In the plenary group, these points are reported by one of the subgroup members (see 5.5 Working with subgroups).

The *homework assignments* are distributed and explained.

Finally, everybody *evaluates* in one or two sentences what he/she has learned during this session.

5.3 Modeling

Social or observational learning is important, next to behavioral rehearsal, in the process of acquiring new complex skills. This is the reason why new skills are modeled, and participants are instructed to focus on specific aspects of the rehearsed response (the so-called criteria; see 6.4 Self-evaluation). With this instruction, we direct the attention of the participants to the characteristics of adequate behavior, which could be used as criteria in rehearsing the response.

Several procedures for modeling are available for group therapy namely with the help of videotaped models, by the therapist and one or more group members. We prefer modeling by the therapist because of the efficiency. At first, modeling of behavior and procedures by the therapist gives more flexibility to tailor the modeled behavior to the skill level of the participants than is the case with video modeling. The second advantage is that it gives the therapist the opportunity to model other aspects of the learning process such as the choice of the rehearsal situation, to deal with receiving negative feedback, and again rehearse the skill as a consequence of this feedback.

Procedure. After discussing the appropriateness of some of the practice situations for that social skill or response, every group member is asked to choose a situation from his listing to rehearse within the session. This situation should elicit a relatively low level of discomfort (see 6.3 Self-application of graded practice) in order to enlarge as much as possible chance of success. The chosen situations are written on a white board or flip-over for each participant. The therapist also writes down his situation for the modeling. This situation should be appropriate and fulfill the following features: give the group members the possibility to identify with, reflect their own experiences, and be not too difficult for them to perform. Preceding the modeling procedure the situation is shortly outlined and set up with several attributes. In the instruction for the modeling, the therapist asks the group members to watch his or her performance and to consider which aspects of the behavior contribute in achieving one's goals (i.e. to fulfill the criteria, see 6.4 Self-evaluation). The therapist performs the modeling with the co-therapist or a group member; both latter persons are functioning as antagonist. After the modeling, it will be discussed in the group which aspects of the modeled behavior contributed to a successful performance and which aspects might be improved. If essential elements are mentioned to be improved, the therapist repeats the modeling role-play in order to improve his or her performance.

In later phases of the SST, the modeling might be skipped provided that the group members have learned which features make that particular social behavior effective.

Points of interest. Please direct the attention of the group explicitly to those aspects of behavior that are intended to be modeled. To facilitate this attention, the modeled situation should be short and should only consist of the modeled response followed by the reaction of the antagonist. In the case of

reacting responses, however, the modeled response should be preceded by the eliciting response, (for example, ‘refusing a request’ should be preceded by the request). The model situations should fit the daily life situations of the participants.

Live modeling is easiest to perform with two therapists. The most efficient is that they cooperate in the procedure; that is to say, one therapist models the response and the other functions as antagonist and responds to the modeled response. If only one therapist is available, he asks a group member to help with the modeling in the function of antagonist. So, the therapist himself models the response! It goes without saying that the procedure, as well as the modeled behavior, requires a very skilled therapist. Essential in modeling with a group member as antagonist is to instruct him/her very well, especially in the case of eliciting behavior because this precedes the response to be modeled (for example, a request that should elicit the refusal). Live modeling may be alternated by video modeling. However, video modeling might be more difficult to tune in to the skill level of the group and might be less appealing and is indeed more passive.

5.4 Behavior rehearsal and shaping

Behavior rehearsal has the purpose to improve and refine the newly learned social skills. The more complex the learned skills, the more important the rehearsal is. Behavior rehearsal is often accompanied by instructions (what to do or to change), feedback (reinforcement and suggestions for change), and shaping until the final requirements are achieved. The SST program is organized in such a way that all group members get the opportunity to rehearse the social response within the session.

Procedure. The role plays of the behavior rehearsal procedure make use of the practice situations that are brought to the session (see 6.3 Self-application of graded practice). After the modeling, the therapist will ask the group members who will start the rehearsal. If nobody comes forward, the therapist invites a group member to start (see for fanciful solutions Rose & Smokowski, 2001). Next, the protagonist will be asked to outline shortly his practice situation, followed by the set-up of the scene with the help of some attributes. Then the therapist invites one or more group members to take the role of the antagonist. We recommend that everybody should take the role of antagonist in turn because it provides the opportunity to experience the effects of adequate social behavior. Also, active participation in the role plays as antagonist contributes a lot to the learning process since the antagonists learns quickly to distinguish which are the essential features of adequate social behavior. The therapist provides the antagonist the instruction to respond tailored to the rehearsed response, that is to say, if the response is vague and unclear the antagonist should ask questions until the response is clear but, if the response is clear and direct, the antagonist should reinforce the response by complying or entering into the matter, etcetera. This procedure is aimed to provide immediate

feedback on the rehearsed behavior during the role play. For the antagonist, this procedure provides an extra training moment; he or she should learn to evaluate quickly the behavior of the other person in order to respond adequately. The role plays should be short (just as the modeling) and also should consist of the rehearsed response and its reply. After the role play, the feedback procedure including shaping is performed as already described (see 4.2.3). Before the performance of the response is shaped, the protagonist reminds the specific behavioral aspects that have to be improved, providing that this is not too much at once. Shaping is continued until the final criteria are achieved, considering the skill level of the participant and the phase of the treatment. If the role play concerns reacting behavior, for instance, refusing a request, the situation starts with the eliciting response, in this example the request. This eliciting behavior should correspond as much as possible with the request that will be made in the daily life situation. Thus, the therapist asks the protagonist to formulate on the forehand as concrete as possible the eliciting response with respect to verbal and non-verbal behavior. The antagonist should perform this eliciting response as faithful as possible in order to facilitate the rehearsal of the skill. After the rehearsal is finished, it should firstly be investigated whether the eliciting response indeed did correspond with the expected eliciting behavior. If not, the eliciting behavior has to be adjusted first, and the situation has to be rehearsed once again. In the feedback procedure, only the rehearsed behavior should be evaluated and subsequently shaped if necessary.

A hint for the rehearsal procedure of reacting responses: it is time sparing to ask the participants to think of and write down the eliciting response directly after the discussion of the practice situations. This procedure prevents from doing this again with every separate practice situation which takes much time. The homework assignments follow directly from the rehearsal in the session in assigning to apply in daily life what was learned in the session (see Box 14: *assignment in italics*).

Box 14. Mary's homework assignment with respect to the application in daily life of social responses

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Think of 6 practice situations for 'giving compliments' that probably will happen next week.
Describe from each situation to whom and with respect to what you would like to compliment someone.
Next, rank order these situations according to their level of discomfort.
Please practice two of these situations with the lowest level of discomfort applying what you have learned.

Describe the situation with the help of the following points:

-whom did you gave a compliment	My colleague Rose
- where	At my work
- when	During the coffee break
- about what	Her preparation of today's job
- what did you say giving him/her a compliment	Hi Rose, great that you already did such a large job in preparing today's work; that will help us a lot.
- what was the reaction of the other person	Yea isn't it great! You're welcome.
- how did you give your compliment :	
- what did you do well and	My compliment was direct and positive
- what would you lime to improve	I would like to look more and speak somewhat softer

In the last phase of the treatment (follow-up sessions), the behavior rehearsal procedure will be replaced by verbal rehearsal. That is to say, from that moment only verbal behavior will be rehearsed, followed by feedback with respect to the criteria and, if needed, repeatedly shaped. In contrary with behavior rehearsal in which verbal and non-verbal behavior together are rehearsed with the help of role plays and attributes, verbal rehearsal does not take place in role plays but merely in a conversation situation.

Points of interest. Sometimes it is difficult to determine during the behavior rehearsal procedure when it will be appropriate to switch over to shaping and to skip the remainder of feedback procedure. The guideline is to switch to shaping as soon as suggestions for change are given. So, as soon as the protagonist indicates concrete and realistic behavioral features to be changed, the therapist should switch to shaping. The complete feedback procedure may then go through after the second or third rehearsal in comparing the previous rehearsals with the last one. The therapist may also switch to shaping, when the protagonist does not, but the antagonist does indicate concrete features to be changed that make sense for protagonist and therapist. The therapist prevents from too high demands set for the protagonist. Next, the therapist is attentive of avoidance behavior such as preventing from giving negative feedback. Difficult to determine in individual cases is whether the final requirements have been achieved because these may vary across situations and participants. We think it very important that therapists dare to lower their demands to certain group members compared with other group members. How frequent and how long behavior should be rehearsed depends from the resting session time. Remember the premise that everybody should rehearse the response within the session whether it is only once or twice! The therapist indicates the antagonists and is attentive that everybody undertakes this role.

Correspondence between the antagonist and the person in the real life situation is no issue, because the treatment it is aimed to attune the response to the actual *behavior* of the other person in the interaction and not to his/her (attributed) qualities or characteristics. For the same reason, the protagonist is not permitted to choose the antagonist. In addition, by this procedure it is prevented that the choice of the antagonist will serve as a popularity poll of group members or just contributes to avoidance of difficult antagonists or negative feedback.

The step of behavior rehearsal to verbal rehearsal is taken in the period between the last regular onto the first follow-up session. If it is not easy for group members to verbalize the response only, it may be less difficult to direct the response to another group member or to the therapist or to use a ‘bare’ role play, that’s to say without setting and attributes.

In Box 15, an example is given of the complete set of homework assignments of the first session of the phase of the Specific social skills (Figure 3, session 6).

Box 15. Homework assignments of the first session of the Specific social skills (session 6)

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1. Think of two easy situations to apply 'doing a request', with the help of the listing of practice situations you have got in the session.
First, describe for each situation what you are planning to say doing your request Note for each situation:
- To whom you will direct your request
- Where you will do your request
- When
- What you would like to ask
- What you are going to say in doing your request.

After you did this for each situation, please ask yourself whether you fulfilled the criteria. If this is not the case, please describe concretely which aspects you would like to improve.
(After a few sessions the assignment to literally prepare the practice situations is skipped)
Please apply in both situations what you've learned with respect to doing a request. Please write a report after each situation (see Box 13).

2. The next skill is 'refusing a request'. In preparing the next session please think of the following:
a. The goals one could achieve with refusing a request. Write these goals down and bring them to the session (see 6.4 Self-evaluation).
b. The criteria that are relevant in order to refuse a request effectively. Write these criteria down and bring them to the session too (see 6.4 Self-evaluation).
c. Think of 6 practice situations for refusing a request that probably might occur next week. Note for each situation the person who asks you the request, and which aspects you would like to refuse. Write these situations up and bring them to the session.

3. Please indicate every day on the self monitoring form whether you did perform the mentioned response or not (see Box 17). Start with doing a request. Bring one copy to the session, the original report is yours.

4. Please read and study the §§ I t/m III from the brochure "Demands, activities and evaluation" (see for this assignment Box 26)

5.5 Working with subgroups

If two therapists are available, the group may be divided into two subgroups that will do the rehearsals in a separate room. The advantage of this procedure is that longer and more intensive rehearsal could take place than in the total group. However, time has to be reserved in the total group for the exchange of the results of each subgroup. As soon as the two subgroups are joined again one person of each subgroup reports the learning points from his subgroup.

Point of interest. Prevent the formation of subgroups by changing their composition each session.

6 Self-management skills

6.1 Introduction

One of the main purposes of the SST is that participants acquire a cognitive strategy that will help them to solve their problems in social interactions independently. To achieve this purpose participants learn the procedures that are applied in the treatment methods (for principles of rule learning and problem solving see Gagné, 1985; D'Zurilla, 1986). If a method for behavior change is applied without direct help of the therapist, it is called a self-management method. The application of self-management methods is called self-control. In this phase of the therapy, we use written information and instruction materials. The strategy that is aimed to achieve self-control consists of the following components:

a) Self-monitoring of performance and avoidance of social responses;

b) Self-directed use of graded practice of social responses;

c) Self-evaluation of the performed response with support of previously determined criteria;

d) Self-reinforcement;

e) Application of a problem solving strategy by successively making use of components (a) through (d).

In Figure 4, the components of the self-management phase are given as well as their time schedule in the SST. In sessions 5 to 12 the components a, b, c and d are consecutively presented with the help of the homework assignments. The last component, the problem solving strategy, is presented in the 13th session.

Figure 4. Overview of the phase of the Self-management skills

Session	*Homework to prepare the session*	*Self-management within the session*	*Homework following from the session*
1 thru. 4	No self-management assignments	None	No self-management assignments.
5	Generating goals and criteria for the response	Learning to rank order situations	
6	a. Idem as in session 5 b. Generating practice situations and make a rank order of them	a. Practice according to rank order of situations	a. Practice according to rank order of situations. b. Brochure 'Demands, etc.' sections I thru III, and identifying adequate performance criteria.
7	a. Idem as in 5 b. Idem as in 6	a. Idem as in 5	a. Idem as in 6 b. Repeating 6
8 thru 13	a. Idem as in 5 b. Idem as in 6	a. Idem as in 5	a. Idem as in 6
8 *			b. Setting performance criteria for practice and feedback. c. Brochure 'Demands, etc.' sections V and VI, and identifying deadlocks.

9 *			d. Repeating 8
10 *			c. Brochure 'Demands, etc.' section IV and program for a non-social activity.
11 *			c. Repeating c. from 10
12 *			c. Program for the rehearsal response of the session.
13 *			c. As in 12
14thru 16	a. and b. as in 13 c. Preparing a program for the practice response.	Idem according program of the practice response	a. and b. as in 13 c. as in 13
17		Evaluating therapy, and making plans about how to continue with what you've learned.	
18 en 19	See 14 thru 16	See 14 thru 16 Evaluating last month and new plans.	See 14 thru 16
20		Evaluating treatment and new plan about how to continue.	

* The parts of these sessions in column 2 and 3 are similar (see session 8 thru 13)

6.2 Self-monitoring

Purpose. Self-monitoring is aimed to provide the participants insight in the occurrence and course across time of the monitored behavior. The participants' daily monitoring of performance and avoidance of social responses enhances attention for their goals and facilitates the process of control.

Procedure. The self-report inventories completed by the participants in the assessment phase can be viewed as a first step for self-monitoring by directing the attention of the participants on their problems in social interactions. A next step, important for a clear description of the behavior to be monitored, are the reports of the homework assignments (see Box 14 and 16). And last, scoring the occurrence of performance and avoidance of social responses (see Box 17). When a skill is rehearsed within the session, the assignment is given to apply this skill in daily life situations. Afterwards, the participants have to make a report of their performance of the social skill (including antecedents and consequents) with help of guidelines given by the therapist (see Box 14 and 16).

Box 16. Peter's report of the homework assignment with respect to doing a request.

Think of 6 situations that can be used for practicing 'doing a request'. Practice two situations with the smallest amount of discomfort and apply what you have learned within the session. Describe these situations afterwards with help of the following points:

- *To whom did you direct your request*	Carl
- *Where was it*	at my home
- When *(day and time of the day)*	on Sunday afternoon
- What was your request	to help me to hang paint at the wall
- What did you say when asking your request	" Carl, I would like you to help me to hang this painting at the wall, because I don't succeed at my own "?
- *How did the other person react*	"You're welcome! Let's do it now!"
- *Evaluate your request*	
- *What did you do well, and*	my request was concrete, specific and direct
- What *would you like to change*	I would like to speak louder

In addition, the participants get the assignment to monitor daily the frequency of performing and avoiding the respective response with the help of a form (*italic* in Box 17).

Box 17. Peter's monitoring form after 4 responses

Ask yourself at the end of each day which social skills you have applied and how many times.
Note each performance on this form by scoring that behavior in the column 'yes' of the particular day.
Also note every time you did not perform the behavior while you could have by scoring 'no'. We recommend doing the scoring at several prearranged times a day.

	Wednesday *		Thursday		Friday		Saturday		Sunday		Monday		Tuesday	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Doing a request †	11	1	111		1	11	1		11		111	1	1	
Refusing a request		1	1	11				1	1	1		1	1	
Responding to a request		1	1	1			1		1		1		11	
Initiate a conversation	11		111		11	1	111		11	11	1		111	
……														
……														
……														

* The SST day in this case is Wednesday and the first monitoring day;
† The responses are ordered according to their presentation in the SST.

Self-monitoring of a specific social skill is introduced not earlier than that skill has been rehearsed within the session, and monitoring of that skill is continued until the end of treatment. The next social response follows the same procedure, what means that each session the number of responses that should be monitored is extended with one response.

Points of interest. A limitation of self-monitoring is that the registered behavior not always corresponds with the actual behavior. In addition, self-monitoring has often reactive effects that fade out after some time. These are negligible limitations because in this case self-monitoring is not used for treatment evaluation purposes, but mainly has an informative function that facilitates the process of behavior change. Self-monitoring also provides some general information about avoidance

behavior. For example, ‘not performed’ may indicate that the situation did not occur, that the situation or response was not recognized (e.g. in the case of refusing a request: “Well, one is obliged to help if someone asks for!”), but also that the response or situation was avoided (e.g. did not return to the shop with incomplete stuff).

6.3 Self-application of graded practice.

Purpose. Participants learn to use a stepwise approach in order to achieve their final goals without a deadlock.

Procedure. A stepwise approach to the final goals is made explicit and exercised with the help of the practice situations for a specific social response. This means that the practice situations have to be rank ordered according to the amount of discomfort and complexity. Prerequisites for the use of graded exposure are that one is capable of observing him/herself and others and to formulate concretely final and sub goals. The response should be part of the available repertoire of social responses. We distinguish 3 steps in self-directed use of graded practice: a) rating situations according to the level of elicited discomfort, b) rank ordering of the situations to the level of discomfort, and c) thinking up of in-between steps for the rank order of situations.

6.3.1 Rating of situations to level of discomfort

In this first step group members learn to judge and rate practice situations to their level of discomfort. The behavior rehearsal within the session starts with the situation lowest for the group in the hierarchy of discomfort and the participant with the lowest level of discomfort for this situation. This procedure is aimed to prevent of too high levels of discomfort and probable sensitization. The participant with the highest discomfort will get the last turn in the rehearsal procedure; in order to achieve that some anxiety reduction will take place by observational learning. In the homework assignments, the group members have also to practice situations with the lowest ratings of discomfort.

Procedure. In the first session of this phase, the group members are asked to rate the general practice situations of a particular social response (see 5.2) on discomfort with the help of a 10-point SUD-scale (from 0 = not at all, thru 10 = highest discomfort ever experienced). The personal discomfort scores are collected with the help of a white board or flip over. From these individual scores, a group hierarchy for that response is derived. The situation with the least amount of discomfort according to the group hierarchy will be the first practice situation within the session. The participant with the lowest rating is the first to rehearse the response within the session. (see Box 18). The rehearsal takes place on the hand of each participant’s own situations (see 5.2).

Box 18. General practice situations for 'doing a request' from Box 9, sum of discomfort ratings by the group members (n=7)

Doing a request:	*sum of discomfort **
1. Asking a friend to loan you a book, DVD, camera or alike knowing that he would not like to do.	54
2. Asking a housemate, your husband, your wife, or one of your children to do a job for you, for example, watering the flowers, setting the rubbish bin outside, greasing the hinges.	20
3. Asking a friend to accompany you to the cinema, a shop, and the like.	14
4. Asking a housemate or colleague to run an errand.	24
5. Asking a friend to pay your theater tickets in advance.	36

* This is the sum of the scores of 7 group members on a 10 point SUD-scale

6.3.2 Hierarchy of practice situations

Now participants are able to rate a situation on discomfort, the next step is to learn to rank their practice situations. After the group members have made a list of own practice situations, we ask them to put at the head of the list the situation with the lowest amount of discomfort, then the situation with the second lowest amount of discomfort and so on, until at the bottom of the list the situation with the highest amount of discomfort is placed. The situations should be described with the help of the features 'person' and 'subject of the interaction' (about what) (see Box 19).

Box 19. Peter's rank order of situations with respect to 'compliment giving'

Now please think of 6 practice situations for 'compliment giving' that you expect to happen. Describe each situation according to whom and about what you would like to give a compliment. Rank order these practice situations on the amount of discomfort they cause you. At the head of the list set the situation with the lowest amount of discomfort, then the situation with the second lowest amount, and so on, until the situation at the bottom of the list with the highest amount of discomfort

Peter's situations in ranking order from less to much discomfort:

Person:	*Compliment:*
- My wife	for her washing my sport gear
- Son K	for repairing his bike
- Daughter M	for the paper she has written
- Neighbor J	for the restructuring he did with respect to his garden
- Colleague G	for a task he did very well and fast
- My boss E	for his listening to a problem with my job

Once having learned to rank practice situations, the participants have to do so also for the practice situations they will bring to the sessions. This ranking of situations before the session is a prerequisite for a rehearsal within the session in which only situations with relative low amount of discomfort are used (see Box 20).

Box 20. Peter's ranking order made before the session

In the next session refusing a request will be rehearsed. Think of 6 situations in which you would like to refuse a request and put them in rank order according to their level of discomfort. Bring your rank order to the session.

Peter's situations that he thought of before the session:

Discomfort:	*Person:*	*What will be asked from me:*
- 1	My wife T	to grease the hinges of the door
- 2	My daughter M	to help her with a school job when I am working
- 3	Son K	to go out for a bike trip
- 4	Friend J	to replace someone in a bridge drive
- 7	My neighbor J	to chop down a tree in my garden because he darkens his home (I am willing to trim the tree)
- 9	My colleague G	to help him with a job when I am working

6.3.3 Generating in-between steps in the rank order of practice situations

The steps between practice situations in a rank order may vary a lot in their amount of discomfort. Sometimes a step between two consequent situations may be rather small (showing a relatively small amount of discomfort), while, on the contrary, the next step may be very large (a large difference in discomfort). In order to prevent that group members rehearse too difficult situations, they learn how to narrow and enlarge the steps between two consequent situations. For example, narrowing is achieved by introducing an easier person with a similar easy subject, or a similar easy person with an easier subject (see Box 21a). Making in-between steps is exercised within the session with the ranking orders of the group members. Be alert that the once attributed discomfort might change by rehearsal of the response (e.g. as an effect of modeling, graded exposure, enlargement or extension of skills, and matching of expectations and experiences). This strategy of graded practice is not only applied to social responses, but on every other behavior that has to be increased or decreased.

Box 21a. In-between steps in Peter's rank order of 'refusing a request'

Original situations:

Discomfort:	*Person:*	*What will be asked from me:*
- 7	My neighbor J	To chop down a tree in my garden because he darkens his home
- 9	Colleague G	To help him with a job when I am very busy

Two possible in-between steps:

- 8	Colleague Z (easier person)	To help him with a job when I am very busy
or:		
- 8	My neighbor M	To make a common entry in the garden (easier subject)

Points of interest. It appeared that ranking situations is an easy job for most participants. Many people do have experience in daily life with graded practice, and this means that they do understand the principles and goals in due time. However, thought up of in-between steps is more difficult job,

because it demands comparison of different persons and subjects. This is a difficult task for people with limited capacity to make abstractions. It may help to suggest that keeping one variable unchanged (thus "same" instead of "similar") the other variable may be varied (one step more difficult or easier). This procedure is demonstrated with the situations of Box 21b. Mind that the different situations should be described concretely and specifically (to person and subject), since vague en general descriptions hinder the rating of discomfort and creating in-between steps.

Box 21b. In-between steps in the rank order of practice situations for 'refusing a request'

Original sequence of situations:		
Discomfort:	*Person:*	*What will be asked from me:*
- 7	My neighbor J	To chop down a tree in my garden that darkens his home.
- 9	Colleague G	To help him with a job when I am busy.
Two alternatives for an in-between step:		
- 8	Colleague G	To do some shopping for her during the lunch. (easier subject)
or:		
- 8	My neighbor M (easier person!)	To chop down a tree in my garden that darkens his home.

6.4 Self-evaluation

A crucial part of self-control is being able to evaluate yourself and thus being independent of others (therapist, group members, partner, friends, and so on). We teach the participants the following skills that are relevant for self-evaluation: a) to ask themselves which goals could be achieved in a particular situation or with a particular response, b) to think up the criteria which one will fulfill in a certain situation, and c) to compare your behavior with the criteria. These skills are rehearsed within the sessions and then gradually applied in the patients' daily life situation with the help of the homework assignments. By directing the participants' attention onto what they would like to achieve with a particular response, what they did well and what might be improved, we aim them to learn to produce solutions for future problem situations. In the following section of the paragraph, the goals and procedures of the mentioned self-evaluation skills will be described and discussed.

6.4.1 Goals intended for a social response

Purpose. Participants learn to think about what they would like to achieve with a social response, in other words, which goals might be achieved. They try to find answers on the question, which profits the use of a certain skill, will bring. This is the first step in the decision what to do with a situation or an action. Clarifying goals and intended outcomes will influence the motivation to perform the social response.

Procedure. Before a social response will be rehearsed within a session, participants will get the homework assignment to produce all possible goals for that response and bring their report to the session. Within the session, all their goals will be listed (Box 22). By this way, we aim to teach the group members to make their goals explicit and to adjust them to the situation.

Box 22. Generating goals: Mary's report of goals for the coming session.

The response that will be rehearsed in the next session is 'refusing a request'.

a. *Please think of what you would like to achieve with refusing a request. In other words, what goals might be achieved when refusing a request?*

Mary's goals:

a. Standing up for your rights.
b. Being able to choose by yourself how to use your time.
c. There are limits!
d. Feeling more comfortable.
e. Letting know to others who you are.

Points of interest. Making goals insufficiently explicit often is accompanied by dysfunctional cognitions which serve as avoidance behavior such as: "The other wouldn't like me..." (request, refusal and so on), "No matter, if it is important for him/her" (when a request should be refused), or "Well, I really don't mind so much" (when giving criticism). This avoidance behavior is characterized by giving priority to the supposed goals of the other one and by being afraid for negative consequences on own behavior. By making the goals explicit participants and therapist get insight in hidden meanings. For example: "On the one hand I don't like to visit my mother that evening, but on the other side I don't want to disappoint her". Let other group members help to disclose conflicting and unfeasible goals.

To prevent that group members will write down the goals during the listing and thus participate less actively in the group discussion; we have made handouts for each response with the most frequent occurring goals. Announce beforehand that these handouts will be distributed at the end of the group discussion. In addition, the handouts may be of use in the rehearsal and use of a particular response or in generating goals for other responses.

6.4.2 Criteria for effectively performing a social response

Purpose. Before a certain social response will be rehearsed within the session, the participants have to think about their ways for effectively performing the response (criteria). By generating criteria (behavior features you would like to fulfill when refusing a request, standing up for your rights and so on) participants will learn which features make social behavior effective and adequate. By means

of these criteria patients are able to choose for themselves whether their performance was adequate and which behavior features might be changed.

Procedure. Before a social response will be rehearsed within a session, participants will get the homework assignment to produce and write down important criteria for the response next to the goals they did generate (Box 23a and 23b). Within the session, all criteria will be listed and afterwards distributed to the participants on a handout.

Box 23a. Mary's criteria for 'refusing a request'

The response that will be rehearsed in the next session is 'refusing a request'.
a. See Box 22: Generating goals.
b. Please think of which aspects of your behavior might be important in refusing a request. Take into account verbal as well as nonverbal aspects:

Mary's criteria:
- Saying "no" in a clear way
- Being friendly, do not use hard words
- Apologizing for your request
- Proposing another solution
- Eye contact
- Saying "no" by shaking your head

Box 23b. Peter's criteria

The response that will be rehearsed next session is 'giving a compliment'.
a. See Box 22: Generating goals.
b. Please think of the features of your behavior that will be important for effectively compliment giving. With others words, which features might help you to give a heartfelt compliment.

Peter's criteria:
- Turning to the other person
- Talking to the other one and addressing to him/her with his/her name
- Eye contact
- Talking sufficiently loud
- Saying concretely what I do like, without beating around the bush
- Hearty and warm
- Spontaneous

Within the sessions, the criteria will be used in the modeling and behavior rehearsal procedures. Using these criteria help the participants to identify which aspects of behavior are relevant. In addition, the criteria are important in the evaluation of the rehearsed response by means of the feedback procedure. Please ask the participants to produce the criteria for every response, since the criteria may vary across responses. Make sure that the participants choose for every response, which criteria they would like to fulfill in a particular practice situation (Box 24).

Box 24. Peter's use of the criteria in daily life situations.

Refusing a request:

- *Please formulate the criteria you would like to fulfill in this situation:*
  I would like to say short and to the point that I refuse to work overtime today;
- *What did you really say to the other person refusing his request:*
  "No, today I do not want to work overtime, since that do not suit me at all. Another day will be okay".
- *Did you fulfill your criteria?*
  I said shortly and to the point "no" and was clear in my restriction that it only was for today. In addition, I proposed an alternative.
  I fulfilled my criteria. But it wasn't easy!!

Points of interest. Even with the help of handouts in generating criteria for a new response, it takes some exercising before the participants are sufficiently able to produce criteria for themselves. Please let the participants see that the criteria do vary indeed somewhat across responses, but that some of the criteria count for each response (such as being concrete and specific, saying "me" and "I", eye contact, addressing to the other by saying "you"). Be alert that the criteria will be formulated as actual behavior (see Box 25, bold sections) and not as vague such as "be interested with and without words".

Box 25. Mary evaluated her practice with the help of criteria

Report of the practice situation 'giving compliment':	
- *With whom*	My mother
- *Where*	at her home
- *When*	during dinner
- ***Formulate the criteria you would like to fulfill***	I would like to be positively and clearly address myself to her.
- *What did you say giving the compliment*	"Hi Ma, you did a good job today in cooking"
- *How responded the other one*	"O, yes, sure? Well, thank you"
- *Check your* ***compliment with help of the criteria***	I addressed my mother and said "you" to her and was positively.
- *Would you like to change aspects of* ***your compliment***	No, I am content.

The criteria will not only be used to discuss the performance of the rehearsed response, but will also be used in daily life when practicing and adjusting social responses. When the participants are able to produce criteria for their behavior, as well as to evaluate and adjust their behavior with the help of criteria, then they might be able to practice responses for themselves that are not handled within the treatment.

6.5 Self-reinforcement

Purpose. Problems in social interactions do lead to negative self-evaluations and vice versa in many socially anxious persons. Aim of the treatment is to stop this downward spiral. One point of action is

to improve and extend the social skill repertoire. Another one is to improve the self-evaluation and positive self-reinforcement in order to help maintain the newly learned skills. In the SST information will be given on the processes that bring about positive and negative consequences on behavior and one's own role in these processes. Positive consequences will be achieved by performance criteria if they are adjusted at the performance level of that moment. The performance criterion should not be higher than the performance level. In this part of the treatment participants learn to trace and, if needed, to readjust, their performance criteria. Next they learn to apply self-reinforcement either in the form of positive self-statements ("Well, I did that work very well " and so on) or as material reinforcers.

Procedure. In the introduction onto self-evaluation and self-reinforcement we use a brochure 'Demands, activities and evaluation' (see Appendix 3). Two steps are distinguished namely a) identifying adequate performance criteria and b) tracing impeding performance criteria ('deadlocks'). This part of the treatment starts in about the sixth session of the SST (see also Figure 2).

6.5.1 Identifying demands

The first step is the identification of demands and performance criteria with the help of the brochure 'Demands, activities and evaluation' and the accompanying homework assignments. People often think that they do not set demands for themselves and are surprised to discover that they indeed do so. Identifying demands starts with the identification of adequately set demands, that's to say, situations in which one is pleased with oneself. First, the participants will read the text with respect to the relation between these three aspects in the brochure "Demands, activities and evaluation" (sections I to III); afterwards they should describe an example of a situation in which they were pleased with the results (Box 26).

Box 26. Mary's report of the homework assignment: adequate demands.

Read and study the sections I to III from the brochure 'Demands, activities and evaluation'. Describe an activity you did that satisfied you, thus that would lead to a positive evaluation of yourself. Every activity is appropriate for this task; there is no need to take a social activity.
Use the following points in describing the situation:

- What was your activity, e.g. what are you doing or saying?	Writing an email to a friend
- What was your demand? Your performance criteria?	I would like to do that within a quarter of an hour
- How did you positively evaluate yourself? That's to say, what did you say to yourself.	"So, I did this job fast and well today, great!"

Aims of this assignment are that participants identify (and describe) which demands and underlying performance criteria they did set for that activity and in addition describe their positive self-

statement. In the next session, first the text of the brochure will be discussed (unclear text, questions and remarks) and then the core of the content will be summarized. Finally, one of the group members will be asked to read aloud his/her report of a satisfying situation.

The mentioned assignment is up till now not limited to social activities and may concern all activities from everyday life. Be aware that, in the beginning, the task should not concern problem behavior since this is more difficult. In addition, many social activities are rather complex in identifying the set demands and in specifying performance criteria. At first the participants' demands may be rather global, later on when they become more precise and may converge with their specific performance criteria. We recommend giving this assignment minimally twice.

When the participants are able to identify their demands for non-social activities, the next will be to learn them to set adequate demands preceding an activity, with the aim to be pleased with the results afterwards. In Box 27 we give an example of an assignment in which it is asked to set the performance criteria beforehand, to evaluate own behavior, and to reinforce yourself (see bold points).

Box 27. Peter's application of self-evaluation and self-reinforcement while practicing 'doing a request'.

Please apply twice 'doing a request'.
Set the performance criteria preceding each situation

To whom did you direct your request	My boss
When	Friday afternoon at 5pm
Where	in his office
What about your request	a day off
Which criteria did you set	I will be clear and to the point saying what I would like.
What did you say	"I would like to get a day off on next week Thursday. I arranged my work in a way that no problems will occur".
How responded the other person	"Okay, you have my permission. Are you going to enjoy yourself?"
Did you fulfill your criteria	I am satisfied with my request: I was clear and to the point in what I would like to get.
Describe your positive self-statement	"I am glad that I did my request, I finally do have my day off, and my boss was interested in my plans ".
Would you like to change something	There is no need to change things; I fulfilled my criteria. I will repeat this behavior.

The homework assignments are accompanied with written examples derived from homework reports of past group members.

6.5.2 Identifying impeding demands or "deadlocks"

The next step will be that group members learn to identify and readjust their impeding demands. If demands are set higher than the actual performance can be, it is likely that one will not be satisfied and that the demands should be readjusted. We refer to the non-correspondence between demand and performance with the term ‘deadlocks’. The distinction between demands, activities and evaluation should help to give the participants insight into why they discontinued to perform some activities. The group members should read the text with respect to ‘deadlocks’ in the brochure "Demands, activities and evaluation" (Appendix 3, sections IV and V; see Box 28). In addition, they have to write down an example of such a deadlock describing which demand they did set for themselves, which kind of deadlock was applied and how the demands might be readjusted (Box 28).

In the next session first the read text of the brochure will be discussed. In addition, we ask a group member to read aloud his/her report of a deadlock. In discussing the text, we get attention to the four kinds of deadlocks mentioned in the text. To help the participants to identify these deadlocks in their own behavior, we suggest trying jointly to find examples of each of them. The homework assignment to identify and change a deadlock is given twice.

Box 28. Peter’s homework assignment: ‘deadlocks’

Please read the sections IV and V from the brochure ‘Demands, activities and evaluation’.
Please describe an example of the activity in which you applied one of the ‘deadlocks’ Note that it should concern an activity in which you discovered to have set one of the deadlocks (too high, ambiguous etc.); it does not mean that you should intentionally apply such a deadlock.
Please note the following points:

Describe your activity.	Improve my physical condition.
Which demand did you set?	Each day jogging for half an hour.
Note your performance level until now.	At the most, I jogged half an hour in two weeks.
How did you perform after setting the demand?	In the first week, I jogged three successive days and then stopped jogging because I was too tired.
Which deadlock did you apply?	My performance criterion was too high.
What should you do to prevent from discontinuing your activity?	Set a much lower demand, for instance, jogging the first week half an hour on Wednesday.

Points of interest for self-reinforcement. Identifying demands, specifying performance criteria, and readjusting adequate and impeding demands is difficult and a trying cognitive activity. We suggest that the participants not only read the brochure “Demands, activities and evaluation”, but also extensively discuss it within the sessions. In doing this, we first will give the room for questions, then we ask the group to summarize the content in own words and finally we ask every group member what they learned from reading it. It is important to transpose and apply the content into daily life situations with the help of homework assignments. Examples derived from homework from past

participants will be helpful in performing the assignments of this part of the treatment (see also Box 28).

We do not recommend to deal with the content of the brochure in homework assignments only. Use time within the sessions for elaboration and explanation. For example, in a group discussion everybody tells an example of an adequate criterion, a vague one, too high one, and so on. This might be preceded by an own example of the therapist.

6.6 Problem solving strategy

Purpose. With the successive application of self-monitoring, graded practice, self-evaluation and self-reinforcement the participants learn a so-called problem solving strategy. Obviously, the use of such a strategy is not restricted to change social behaviors. It is also aimed to teach the group members the skills needed for the solution of present and future problem situations.

Procedure. The separate parts of the self-control strategy finally should be integrated in the program. Every participant will make such a program for a certain activity and subsequently executes his/her program. Again the brochure "Demands, activities and evaluation" will be used. First the participants get the homework assignment to read the text concerning how to make programs (section VI). In addition, we ask them to make such a program for a relatively simple non-social activity, such as reading or walking (Box 29).

Box 29. Peter's report of homework assignment: a program for a non-social activity

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Please read section VI of the brochure 'Demands, activities and evaluation'.
Next please make a program for the activity you would like to improve, to diminish or extend.
Start with a simple activity such as reading, walking and so on.
Just make the program: first you should mainly learn to divide an activity in steps and make a program for it.

1.	*Describe the activity*	Improve my physical shape by running
2	*Division of the activity into steps.*	Twice a week a quarter of an hour Three times a week a quarter of an hour Twice a week a quarter of an hour and once half an hour Once a week a quarter of an hour and twice half an hour ……. Three times a week half an hour, three quarters and one hour respectively
3.	*My final goal*	Three times a week running one hour on fixed days
4.	*At this moment*	I run once in two weeks half an hour
5.	*My first demand*:	Once a week a quarter of an hour
6.	*I perform the activity*:	at the first Saturday a quarter of an hour
7.	*I compare point 5 with 6*	I fulfilled my criterion. I will continue with point 8.
8.	*My second demand:*	Twice a week a quarter of an hour (at Saturday and Sunday) and so on.

In the next session, the text of the brochure is discussed in the group. In addition, one participant will read his/her report of the program for a non-social activity. The therapist should be alert that this program successively consists of a description of the activity, a division of the activity in steps, a realistic and final goal, the actual performance level of the activity and finally a demand with specific criteria that are tailored to the actual performance level.

The participants should make this homework assignment with respect to the program for a non-social activity at least twice. The next step will be that the participants make a program for a social response that was already rehearsed within the session (Box 30). This program should be ready before they will practice the concerning response in their daily life situation. This program should be used as a guideline in daily life and should contain also a description of the performance of the first step, the evaluation of this step, the next step in the case of a positive result, a readjusted first step in the case of a negative result, the next step and so on, until the final goal will be achieved.

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Box 30. Mary's program for a social response.

Please list 6 situations for positive self-statements.
Note to whom you would like to express a positive self-statement and about what subject.
Make a rank order of these situations to the level of discomfort. Next make a program with the help of the brochure " Demands, activities and evaluation" and use your rank order of situations as the steps of your program.

1. *The activity I would like to improve*	Expressing a positive self-statement.
2. *Division of the activity in steps*	To my mother about my new suit. To my sister about my new suit. To the neighbor about my embroidery (showing it to her). To Jean about my help in constructing his new floor. To my colleague about the new showroom of our assortment To the preacher about my love for telling stories to children. Bring my strengths to the fore in a selection procedure.
3. *My final goal is*	To express positive self-statements about all kinds of subjects to friends and acquaintances.
4. *At this moment*	I seldom express a positive self-statement. However, I do give compliments to other persons.
5. *My first step*	Will be to express a positive statement about my new suit, to my mother, Monday, in my living room.
6. My demand :	Saying "I": being positive and to the point about myself .
7. *Performance:*	Who: my mother. Where: at home in my living room. About what: the new suit I am wearing. I said: "I am pleased with my new suit. It fits me well and I like the colors. I had eye contact and looked to my suit. My mother replied by saying: "Yes, I agree. It fits you very well.
7. *Evaluation:*	I fulfilled my criteria and I am satisfied about doing this. I don't see any need to change things.
8. *My second step is*:	To my sister about the same suit (she is somewhat more critical).
9. *My demand and performance criteria:*	Saying "I"; having eye contact, talking loudly and clearly.
And so on	

The next step participants make a program for a social response before it will be rehearsed within the session. They bring this program to the session and rehearsal takes place with the situations of this program. Finally, in the last session of the treatment the homework assignments include making programs for social responses that won't be rehearsed anymore within the treatment.

Points of interest. Making programs with the help of the brochure "Demands, activities and evaluation" asks a lot of the participants. The therapist should be aware of the differential cognitive capacities of the patients. Some group members are soon able to make well-elaborated programs. With others, it only should be achieved that they are able to set their final goal, to divide the activity in steps and to adjust their first step onto their actual performance level. Anyway, our experience is that also low educated participants could learn to apply the principles, whether or not this is achieved with some help of therapist and group members. Please explain that acquiring the principles is the main goal and not making excellent programs.

In all steps of learning to make programs, we provide written examples that are derived from homework reports of previous participants. Also in this part of the self-management phase it is possible to deal with this part of the SST in homework assignments and homework discussion only. However, some session time for further elaboration explanation might be necessary. In this case, the use of examples from the therapist as well as other group members may be helpful.
In Box 31, we give an example of a session plan in the self-management phase. In addition, we give the complete set of homework assignments in Box 32.

Box 31. A session plan in the self-management phase (>15th session)

During the *homework discussion,* one of the group members reads aloud his/her program for the response and reports of one of his/her practice situations of the concerning response. The homework discussion continues conform the previously described procedure.

The *theme* of the session will be (in this particular case) ' positive self-statements.'
In the session, all possible goals for doing positive self-statements are listed.
The same procedure will be executed with respect to the performance criteria.
In this phase of the SST, the modeling by the therapist may be skipped. The alternative is to generate several reactions with the help of the criteria; after this procedure every group member takes his/her turn in rehearsing the response.

The *homework assignment* is to re-evaluate the program for positive self-statements that was made before the session and to readjust eventually or extend it. In addition, group members are assigned to practice situations from this program and make reports from this practice

The *session evaluation* will take place as usual.

Box 32. Homework assignments of the self-management phase (session > 15th session)

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1. Re-evaluate your program for 'positive self-statements': if needed, add practice situations to your rank order. Please apply doing a positive self-statement in the two easiest situations of your rank. Describe the situations afterwards with the help of the following cues: (see also Box 27).

2. Mark your practice as well as avoidance on the self-monitoring forms. Please deliver one of the forms next session and save a copy for yourself.

3. Continue practicing the responses we already dealt with in the therapy. Describe each practice situation. If you like, you can deliver the described situations.

4. The response to be rehearsed in the next session will be ‘responding to a compliment’
- Please list possible goals for responding to a compliment.
- Next, list the criteria you would like to fulfill in responding to a compliment.
- In addition, make a rank order of 6 situations for responding to a compliment.
- Finally, make a program for this response with the support of the brochure ‘Demands, activities and evaluation’.

6.7 Fading out

In the last sessions of the treatment, the therapist diminishes his interventions more and more with the aim to demand an increasing responsibility from the group members. The session frequency is reduced from weekly to monthly as well as the amount of direction and structure by the therapist. This period of three months is for the participants transition to independent working at their goals.

Procedure. In the last weekly session (the 17th), the treatment should be evaluated with respect to what has been learned (see Chapter 7, Evaluation). Furthermore, intentions with respect to how to proceed in the next month until the next session should be formulated. The intentions should refer to the content as well as to the procedure of this planned progress. During the first period of about one month participants continue the self-monitoring, and they weekly have to deliver their self-monitoring forms and will get new forms. Reports of practiced situations might be delivered. The therapist will provide the feedback in written form.

In the first monthly (18th) session, the group members report their experiences with respect their social behavior of the passed weeks. This report consists of their successes, their failures and solutions while they also make concrete plans for their practicing for the next period. Next, the response ‘giving criticism’ will be dealt with in this session with help of verbal rehearsal instead of behavior rehearsal (see 5.4).

In the second period of about one month the group members have to complete the self-monitoring forms for only one part of the day, for example, the morning, afternoon or evening, The forms should be delivered weekly, and new forms will be sent (mail or internet). Reports of practice situations could be delivered, but no more feedback is given.

The second monthly (19th) session consists of the same parts as the 18th session. However, in this session responding to criticism will be dealt with only by verbal rehearsal. In between this session and the last session, the group members make their own choice in whether they complete the self-monitoring forms. At this point in time, no forms will be delivered, or new forms sent. The last session (20th) will be dedicated to the evaluation of the last three months.

Points of interest. This follow-up period often is very confronting and taxing for most participants with respect to their self-control. Especially in the first month it appears rather difficult to continue

practicing in a planned and structured way. Both the stimulation as well as the structure of the weekly sessions is lacking. Many participants experience that the first monthly session brings them again to their goals of the therapy. We suggest that the therapist will help the participants to take into account the experiences, successes as well as failures of the first period of fading out when planning the coming time. A pitfall for therapists is to take too much control, thus preventing the group members to take their own responsibility for their plans and goals.

7.Evaluation

Evaluation is a must for every treatment. Several procedures may be used to evaluate effects of treatment such as standardized measures, a short scale or an oral evaluation. First we will discuss the measurement of the effects of an SST, and next the use of written and oral evaluation as part of the treatment process.

7.1 Treatment effects

In order to establish the effects of the SST, we use the Inventory of Interpersonal Situations (IIS; Discomfort as well as Frequency Scales). The ISS should be completed by the participants at three moments, namely before the start of the SST (pretest), in the week of the 17th session (posttest), and in the week before the 20th session (3 months after the 17th session: follow-up test). For instruments to measure other aspects of social behavior see Chapter 2.

The interpretation and feedback with respect to any differences between pretest and posttest or follow-up test need special attention by the therapist. Since one of the main goals of the treatment is to teach the participants to observe themselves and others better, it might be expected that the items will be rated from another perspective than at pretest. In addition, it could also be expected that the therapy has changed the quality of the response with the result that the frequency of a performance might get another meaning than before the treatment. Finally, because the SST is directed on changing social skills and discomfort in social situations, reduction of avoidance behavior in social situations might initially result in a slight increase of the score on the Discomfort scale. However, it has to be expected that at follow-up in comparison with posttest the scores on the Discomfort scale will decline together with an increase of the scores on the Frequency Scale.

7.2 Evaluation of individual participation

Next to the evaluation of the treatment effect with respect to social anxiety and social competence we think it a matter of importance that participants take their time to realize what they have learned and what they plan to do with this experience after the treatment. By this evaluation, at posttest as well as follow-up test, our aim is to stimulate the participants to continue with their learning process. This kind of process evaluation provides the therapist with information about how participants evaluate the general approach as well as the procedures used in the SST. In order to bring some structure in this evaluation, we use short evaluation scales. The items of these scales have to be judged by the participants with help of

five point Likert scales with respect to own efforts, the effects in terms of treatment goals, the relevance of instruction- and information brochures, the frequency and duration of the sessions and the contribution of the various treatment components into behavior change (see Box 33 and 34)

Box 33. Evaluation scales for use at post and follow-up

Please rate for each of the statements how they apply to you by circling one of the numbers from '1=applies not at all' to '5=applies very much to me'.

Posttest:

1. I actively participated in this therapy.
2. I learned a lot by practicing responses.
3. I have learned to perceive better what other persons are saying and doing.
4. By what I have learned in therapy, my social interactions with others persons have been substantially improved .
5. I have learned to make programs and to practice social skills independently.
6. I am better aware of my goals in social interactions.
7. I have learned to set adequate performance criteria and as a consequence to be more satisfied.
8. I have learned to express more directly to others my wishes and meanings.
9. I am now able to decide what I would like to change in my behavior.
10. I am confident that I will succeed in independently continuing with what I have learned in the SST.
11. I make more first moves in social interactions than before treatment.
12. I do experience less discomfort in social situations.
13. The used information brochures are clear and to the point.
14. I was sufficiently informed at the start of the treatment about the general approach of the treatment.
15. The responses that are rehearsed in the SST played a crucial role in my problems in social interactions.
16. There is enough time reserved for practice within the sessions.
17. I am satisfied with the amount of rehearsal within the sessions.
18. It helped me a lot to choose a specific target behavior every week and every session.

Follow-up:

1. I still benefit from practicing the responses within the treatment.
2. I am confident that I will succeed in independently continuing with what I have learned in the SST.
3. I have learned to make programs and to practice new social skills independently.
4. I do avoid fewer situations now than at the end of the weekly sessions.
5. I am more aware of how people solve their problems in social interactions.
6. I am still working with programs that I have made during treatment.
7. I still shoe more initiative in social interactions.
8. I do experience less discomfort in social interactions.
9. I am now more able to decide what I would like to change.
10. I made new programs to practice responses that were not dealt with within the sessions.
11. If I did set my demands too high. I am able to re-adjust them into adequate ones.
12. Before starting practicing a new social skill, I think about the goals for that situation.

Procedure. In both evaluation sessions (17th and 20th session) oral evaluation in the group will be made with the help of the ratings of the two short evaluation scales. For this reason, the ratings for each item of all group members are put on a whiteboard or flip-over. The group members are invited to explain their ratings. This explanation is meant to clarify but not to justify their ratings. There is no need to discuss all items. Next, the therapist asks each participant to tell explicitly what he/she has learned from the treatment and how he/she will

continue his or her practicing. Group members participate by giving each other positive feedback and proposals about how to proceed. The therapist supports this with his/her feedback. In this way, the last session of group evaluation is a constructive and pleasant ending of the treatment.

Box 34. Rating list with respect to the progress of the social responses used at posttest and at follow-up test

Please rate for each of the following responses the amount of progress you've made by circling the respective number (from '1= I am at the beginning' to'5= I achieved my final goal')

1. Expressing positive self-statements
2. Giving compliments
3. Responding to a compliment
4. Refusing a request
5. Responding to a refusal
6. Giving criticism
7. Responding to criticism
8. Initiating a conversation
9. Inviting someone
10. Ending a social interaction
11. Expressing your opinion
12. Standing up for your rights
13. Asking for information
14. Doing a request
15. Making an offer
16. Responding to an offer

7.3 Final remarks

It is obvious that many variations of this SST treatment are possible, even within the limits of the chosen therapy setting. Although this description of the treatment started from group therapy with one or two therapists, we know from own experiences that the treatment model is feasible for individual treatment too. One of the advantages of individual SST is that the choice and sequence of the social responses could be completely tailored to the patient. However, the pitfall of an individual SST may be that the therapist will take over the function of the treatment group in the sense that his contribution to the learning process of the patient may be too large in relation to that of the patient. Finally, it should be noted that some procedures have to be adapted for use in an individual format.

Another variation is the format of an open group instead of a closed group as described. It should be noted that an open group format with irregular influx and outflux of participants demands extra skills from the therapist, for example, in maintaining a systematic treatment plan. This problem may be dealt with in different ways: by using separate treatment modules, by structuring the influx of participants according fixed time schedules and by mobilizing more experienced participants to help in the introduction of new participants.

When planning an SST for another kind of population we recommend first to assess which social skills and situations are important and what their meaning is. For example, the response ‘doing a request’ may have a slightly different meaning for physically handicapped persons than for psychiatric patients. In addition, therapist have to be aware in case of patients with various ethnicity that social responses are mediated by cultural values and characteristics. Illustrative of this are the different levels of social anxiety and performance of social skills observed between Eastern and Western societies (e.g. Dam-Baggen, Kraaimaat & Elal, 2003; Kraaimaat, Dam-Baggen, Veeninga et al., 2013). Next, it may be necessary to change the procedure of some parts of the SST. For example, perceiving social interactions with patients with psychotic features, learning to discriminate social situations with mentally retarded persons or persons with autism spectrum disorders (e.g. Kurtz & Mueser, 2008; White, Albano, Johnson et al., 2010). Finally, shorter versions of the SST may be more feasible. For example, when practice of social skills may be confined to a smaller number of social skills. With populations that do need a complete treatment, but for whom 20 weekly sessions are too overloading, the treatment may be divided into several modules that are subsequently passed through over a longer period.

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Appendix 1.

Treatment contract

In this treatment you are working on problems in dealing with others, by expanding and improving your social behavior. A step-by-step and systematic approach are important prerequisites for treatment success. That is the reason that you successively train and practice various social skills over several consequent meetings.
Also, as a participant, you must have clear objectives and be motivated to work on changing your behavior (what you think, do and feel). Changing your behavior costs much time and effort. It requires a lot of energy, time and active attitude. We, therefore, expect that you participate actively, take initiatives and adhere to agreements. With this mindset, you increase your chances of a successful outcome.
What do we expect from you? Please read the following rules and guidelines, which you must keep as a participant of the treatment.

1. Aim of treatment is that you can stand up for yourself, reach your goals and improve your interaction with others. You achieve this goal by practicing the following skills:
- to express your own opinions;
- to act with confidence;
- to come up for your rights without being aggressive;
- to give and receive criticisms;
- to initiate and maintain a conversation;
- to give and receive compliments.

Another purpose is to reach a better fit of your thoughts with concrete facts and events. Also in line with this is matching your expectations and demands on what you can accomplish at that point in time.
2 In this social skills training, we are dealing *only* with your 'interaction with others'. The treatment of other concerns is outside the scope of this group therapy.

3 The treatment takes place in a group with about six to eight participants and is guided by an experienced and registered therapist.

4 Treatment consists of 20 sessions, and each session takes one and a half hours. Seventeen sessions take place weekly. The last three sessions take place monthly, and the specific dates of these last three sessions will be agreed upon between therapist and participants.

5 You agree to take part in *all* meetings. If you cannot meet this requirement for very urgent reasons, you contact and notify our secretary until about half an hour before the start of the meeting.

6 Before the meeting you wait in the waiting room until the therapist picks you up.

7. Participants as well as therapist commit to appear just in time for the meeting.

8 You agree to read and study the issued written materials, answer questions and perform requested tasks.

9 Tasks are designed to practice during the week the topics you learned in the last session. You agree to perform this so-called homework and to make written reports of your homework before the next session.

10 Before and at the end of the treatment questionnaires are presented to you to evaluate the results of the treatment.

11 Participants agree to deal confidentially with all the personal information of the other participants obtained during the sessions.

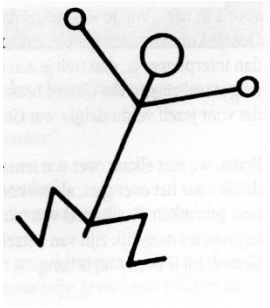
12 The sessions are video recorded and recordings of each session are kept up until the next meeting.

13 You agree to notify the therapist if you contact other therapists or if changes in your personal circumstances take place.

Appendix 2

Observing

This treatment is aimed at improving the way you interact with others. If you want to change the way in which you deal with others, you need to be first of all aware of your own behavior. In other words, you need to observe your doings and sayings. By looking and listen to yourself, makes it easier to assess what you want to change and improve in your behavior. In addition, in interacting with others, it is also important to observe what others are doing. This brochure is about the act of observing.



What is it to observe?

Observation is a description of what you hear and see

For example, someone who looks at the above drawing might say that the person of this figure is happy. What he or she really sees or observes, is a hodgepodge of lines and circles, which is similar to a person with legs apart and diagonally up straight arms. Someone who says: "This is a happy person" is interpreting. This means that he does not describe what he actually sees, when he look at the drawing, but what he infers of thinks to see.

*Interpreting is to describe situations, persons and events as how one thinks that they are; that is to say one draws **conclusions** from what one actually sees and hears.*

A few examples of observations and interpretations

Observation	*Interpretation*
Joe has his mouth pinched together and said not a word to his supervisor.	Joe is angry at his supervisor.
Maria moves frequently from the left to the right in her chair.	Maria is nervous.
Fred got an A for his exam.	Fred is doing everything well.
Frank goes whistling through the apartment.	Frank is cheerful.
Ellen shouts at her child.	Ellen is a bad parent.
Rita started crying when the dentist entered the waiting room.	Rita is a neurotic.

Some of the examples described here will probably raise questions with you. For example 'Joe is angry at his supervisor'; you can see this clearly on his face! The answer to this is that you actually don't know if Joe is angry at his supervisor. Perhaps he is afraid him. What you can probably see, is that he pinches his mouth together and is silent. Thus: You cannot see that Joe is angry. If you say that he is angry, you interpret or draw conclusions from what you see. Of course, you may think that Joe is angry at his supervisor. But this does not clarify Joe's feelings (angry of afraid?) and you might be wrong in your reactions. A rather concrete description of what someone is doing, makes it is also evident to other persons what he or she was doing (observations). Also, the disadvantage of an interpretation is that various meanings and consequent actions are possible. Acting upon the one that is not relevant leads to misunderstandings.

Observation in situations in which you are emotionally involved

We have discussed so far only examples, where the actions of other people were observed. If you participate in a situation, and feel unsecure, anxious, angry or disappointed, then it is even more difficult to observe. Let us consider what Carl said about attending a birthday party: "Listen. I was at a birthday party, and nobody noticed me. I was quite on myself" It is clear that by saying 'nobody noticed me' Carl does not describes what he saw and heard. It is unlikely that no one has noticed him. In this case, Carl made an interpretation. Let us go further and question what happened? "Well, I can tell you, I felt really bad. I came in and congratulated the guy who gave the birthday party. I looked around and saw about 30 people in a room decorated with garlands. These people stood together in small groups and talked. I stood there quite alone and looked at the ground. I went after five minutes without saying

something to anybody". The latter is a report of Carl's observations. You may perhaps have noticed now that his report contains statements such as "I have felt really bad" (observation of his emotion). This shows how Carl has felt at the moment. Your own feelings are observations also.

Observations are: descriptions of what one sees, hears and feels itself.

Some examples of observations which relate to what you feel:
-"I was very insecure during the examination".
-"I am sick".
-"Last night I was very angry at my father".
-"I'm very irritated by the child's yelling".
In examples above, the feeling is named (such as insecure, sick, angry), and it is indicated clearly that it is me ("I") and when (during the examination, last night).

In the next example, Thomas describes what he experienced while shopping. Thomas' statements are both observations and interpretations. Only the observations are printed in italics:
' It was a disaster in the supermarket. *The woman behind me has triggered me with her shopping cart*. I can't stand just that. *I was irritated. I came in touch to the man who stood in front of me. He turned around and said: "You are in a hurry?"* I blacked out. *I left quickly. And I found that the other supermarkets had already closed.* Such things happen to me again and again. That is what upsets me'.

Tasks

We give some examples of someone's reported experiences. Try to identify the observations and underline them.
1. I can say it again and again: that secretary will never learn it. Always the same errors in her letters. I went to her, and she did not even look up from her computer. I said 'hello'. Even then she did not look up. I repeated my 'hello' and after some time she asked: "what's the matter?" I was furious. I showed her the letter and the misspellings and asked her what that was about. She said, "if you are not satisfied I write another one". The whole affair makes me pissed.'

2. Yesterday I met the girl next door in front of our house. She always behaves as if I do not exist. I thought: "Give it a try". And said: "Good evening". She looked up and quickly looked the other way. She finds me not interesting enough.'

3. It is always the same. Before I realize it a huge pile of work that has to be completed. He obviously wants to annoy me. He comes out to me and asks if I have time to type just a few letters. Of course, I will be fired, if I'm not doing it. He obviously thinks that I work too slowly. I can see it on his face.

4. Nobody likes me. Yesterday I got a letter from my mother. She writes nothing else than: "Eat you well enough?", "Learn you well enough?", "Did you write your aunt?". Always being negative. As if there is nothing else in the world. The last 14 days I was every night quite alone, and don't think that anyone comes up with the idea, to visit me. In any case, I've seen nobody the last 14 days.'

Appendix 3

Demands, activities and evaluation

You start with a new activity or start improving an already running activity. But after a few times practice you cease doing so. Self regrets prevail. "I‘m no good at all"; "I'm a sissy"; "I lack motivation"; "I’m apt for nothing", and so on. Despite your good intentions and investments, you do not reach your ultimate goal and give up. What happened? In the following text, we will try to give you some answers.

I *Activities and their consequences*

What we undertake, postpone or avoid is largely determined by its consequences. In case we reach a pleasant or desired result with an activity then we are inclined to undertake this activity also in the future. However, an activity with an unpleasant, embarrassing or unwanted outcome will be undertaken less frequently. As a general rule, one can say that activities are influenced by their consequences.

An important consequence of our activities is the appraisal of others or ourselves. Evaluation by ourselves or others has a high influence on the frequency in which our activities will take place. Often we are not aware of the impact of our assessment of our own activities. In the case of mostly negative appraisal of our activities, we have a tendency to stop, while we continue activities in the event of mostly positive evaluation.

II *How is the evaluation of activities accomplished?*

Our appraisal is never isolated, but always related with the demands we have to meet from ourselves and with the actual course of the activity. In the case of evaluation, we compare the actual course of activity with our demands. This can result in a negative appraisal *or* a positive one. We achieve a:

-negative evaluation, if the performance of the activity is less good than requested;
-positive evaluation, if the performance of the activity matches the demand;
-positive evaluation, if the performance of the activity is better than the demand.

The general rule for the more frequent or better the performance of an activity is: "Make sure that its execution leads to positive results". A mistake often made is that people make too high demands when they start with an activity. If that is the case, they may be certain to achieve a

negative evaluation. For instance, someone who smokes an average of 20 cigarettes a day and demands to quit smoking quickly, disappoints him of herself. Even if he or she should smoke only 10 cigarettes in the first days after his decision, failure prevails.

III *Self-statements*

An evaluation is frequently accompanied with comments about ourselves. We define an account that we make in case of a too high demand of ourselves, a negative self-statement. Some examples of negative self-statements:

"I cannot stop smoking (or drinking, stuttering, etc.)

"I forget the meaning of this word always ".

"My English pronunciation is terrible".

A problem with negative self-statements is that they are exaggerations often. Most of the time they are too general and a too negative report of an activity. In this way, the features of the activity that did correspond with someone's demands will also be evaluated negatively. So is the statement: "My French pronunciation is terrible" definitely too generally formulated. Without questioning, there are words, which can be spoken correctly. The use of words such as ' always', 'never', 'any', 'all' or 'something', is characteristic of too general formulations of self-statements. Some examples of widespread negative self-statements:

"There must be *something* wrong with me"

"Why can I *never* act spontaneously?"

"Nobody likes me".

"I will *never* understand mathematics".

"I *always* say stupid things".

With negative self-statements, we achieve the opposite of what we actually want: we want to undertake activities or to improve them, but the result is that we stop.

IV *What happens if we stop at an early stage with an activity?*

If you cease with an activity before you have reached the ultimate goal, you have applied the rule of failure or a deadlock.

(a) You did not match your demands with how you can perform the activity. The demands you have set are much higher than the actual performance of the activity. Create lower demands, specify the criteria of your performance, and try to meet the final target in several and small steps.

(b) You have increased your demands during the execution of the activity. In the final evaluation, you feel down trodden: you are dissatisfied with your performance, because your specific requirements were too high.

(c) You exercise the same activity several times, but each time you make the same demand:

- In case of a too high demand, you give up the activity;
- When the demand was initially matched (i.e. not higher as the way the activity is run) you cease the activity, because you have reached this requirement. However, your end goal may not be achieved.

(d) You have not described your demand in concrete terms (i.e. specific criteria) so that the actual execution of the activity cannot be compared with your demand. This may lead to an under- or overestimation of the result. To tackle this obstacle, make a description of the activity to be performed in such a concrete and step-by-step way that anyone who reads it knows what he or she must do.

V *Examples of the application of failure rules or deadlocks*

Mrs. Brown feels very tense when she is on the street. At this time, she can walk up and down her home for about five minutes more or less at ease. If she remains longer than five minutes on the street, she panics and goes back into the house. In the first exercise, her demand is to walk a quarter of an hour up and down the street. The course of her exercise looks like this:

Exercise	*Demand*	*Performance(time)*	*Evaluation*
5 Min.			
1. Exercise	15 minutes	7 min.	negative
2. Exercise	15 min.	8 min.	negative
3. Exercise	15 minutes	5 min.	negative
4. Exercise			

Mrs. Brown gives up. She says to herself: "I panicked again, I'm not able to perform an exercise as simple as this"

Task:

- Write down what failure rule Mrs. Brown applied.
- Change her demands for the first and second exercise.

Pete stutters when he calls on others. Sometimes he stutters as much as that he breaks the connection. He does not succeed in speaking on the phone like others. To practice Pete decides to inquire by phone about the price of a new laptop. His ultimate goal is to stutter

only once per phone call. He examines how often he stutters before he formulates his first demand. He stutters 20 times during the tryout conversation. His exercises are as follows:

Exercise	*Demand*	*Performance*	*Evaluation*
20 stutters			
1. Exercise	20 stutters	19 stutters	positive
2. Exercise	18 stutters	14 stutters	positive
3. Exercise	15 stutters	10 stutters	positive
4. Exercise	7 stutters	12 stutters	negative
5. Exercise	7 stutters	13 stutters	negative
6. Exercise	0 stutters	17 stutters	negative
7. Exercise			

Pete stops practicing, and he is very disappointed and feels tense.

Task:

- Write down the failure rules or deadlocks Pete applied and when he did so .
- If necessary, adjust the demands for Pete.

In the following part, we present a different approach than that of Mrs. Brown or Pete with more chances for success.

VI *Rules or guidelines for an increase or improvement of activities*

This approach is aimed at matching your demands with your activities and counteracting general and negative self-statements. Work step by step in the listed order!

1 Make a description of the activity you want to improve (what, how often, time, etc.)

2 Divided the activity in steps or components.

3 Write down how the activity should look like in the end. (what is your final result?)

4 What is your current performance? Examine this in everyday life and make a detailed report.

5 Set your first demand not higher than your current performance. Write this demand down for your first exercise. Be specific and concrete. If necessary, transpose your demands as specific criteria (e.g. In such a way that a person who reads your demand can perform the activity).

6 Perform the activity.

7 Compare the execution of the activity with your demand. If the execution of the activity is lower/lesser than the demand go back to rule 5.

8 Prepare a new step by providing a new demand. Set your demand slightly higher than the actual performance of your activity. Write this down for your second practice situation.
9 Repeat the rules 6, 7 and 8, until you have reached your final goal.

You can increase the effectiveness of the above approach by a positive self-statement if the performance of the activity is equal to or better than your demand. Some examples of such statements that express a positive appraisal are:
- "I did well."
- "Well done."
- "This goes well."
- "Excellent!"

An example of the application of the aforementioned rules:

Elisabeth has just married and lives recently in a new area in the city. She is still fully employed. Elizabeth finds it very difficult to ask a request, and she avoids doing so whenever possible.
1 Description of the activity namely 'asking a request'. This includes:
- the person you would like to ask something; from easy to difficult, respectively her husband, their neighbors, her colleagues and officials;
- the nature of the request; she finds it difficult to do a request that costs the other person extra time or energy.

2 Division of the activity in intermediate steps (the person and the nature of the request are taken in account in these steps):
- ask her husband to bring the laundry to the cleaning shop
- ask their neighbor Carl to lend her a book;
- request their neighbor Renate when she goes to the store to bring vegetables for her;
- during the break of an English course asking another participant for an explanation of the meaning of a particular sentence;
- asking a colleague for a ride to the station;
- asking a shopkeeper to attend her heavy bag while she is shopping;
- etc.

3 Her ultimate goal is after three months practice: in relevant occasions, to ask a request to known as well as unknown persons, even if these requests costs the other person additional time or energy.
4 At the present time, Elisabeth almost never asked a request. If she does it, she speaks hesitantly and avoids eye contact.
5 Her first step is to ask her husband for help with some household activity (e.g. bringing laundry to the cleaning lady, take the kids to school, etc.). Her demands are to speak loud and clearly and to keep eye contact (she writes these criteria down).
6 She performs this activity. She says to her husband: "Dick, could you take the laundry to the cleaning shop for me?" She speaks loud and clearly and looks at him.
7 Elisabeth compares her performance with her demand. She did ask her husband to take the laundry to the cleaning shop, and she spoke clearly and kept eye contact (i.e. specific criteria). She is satisfied and says to herself ‘ well done’.
8 Next she writes down the demands for her second request: ask their neighbor Carl to lend her a book (voice, eye contact, what she wants to ask, etc.).
9 She rehearses the rules 6, 7 and 8, until she reaches her ultimate goal.

Appendix 4:

Examples of goals, criteria and general practice situations

Refusing a request

Description

Distinguish between a partial and a complete refusal of a request. A partial refusal is: "I want to do it not immediately, but later on", "I can do this part for you, but the whole thing is too much for me". A pitfall is to avoid refusing the original request and to offer an alternative choice that one also does not want to do.

Goals

- do what I want for myself
- to prevent being engaged in activities that I don't want to do
- to prevent that I take too much work and overload myself
- to request the other party to seek other solutions
- to prevent that I give the impression of being accessible for frequent and inappropriate requests
- to avoid that I do something against my will
- to prevent that people take advantage of me
- to achieve that others take my interests and needs into account
- to make explicit that I refuse this current request and not him or her as a person

Criteria

- I refuse loudly and clearly and start with saying "No"
- The refusal is direct and I state that "I" am the person that refuses the request
- The refusal is specific and I indicate explicitly *what* I refuse
- I refuse without any excuses, I do not need any justifications
- I take care that my non-verbal behavior meets with the situation

Situations

1 A friend asks me to lent her a particular book, which I would rather not borrow. I refuse.

2 A roommate asked me to take over some of her housework, for instance to clean the kitchen. I'm busy with something else and suggest doing this later.

3 A friend invites me to go to the cinema/shopping. I'm not interested and say "no maybe another time".

4 I stand in line in front of the ticket office and someone behind me asks to leave my place to him. I say that this is out of the question.
5 A friend asked for confidential and sensitive information about a common friend. I refuse to give her the information.

Standing up for your rights

Description

To lead others to comply with an implicit or explicit agreement. Some examples of implicit agreements: ‘do not to interrupt others’ and 'you have to return what you borrowed'. An example of an explicit agreement is: perform a job conform your contract.

Goals

- get that what you are entitled to
- to enforce others to adhere to agreements
- to give myself a pleasant feeling
- to make others clear where I stand for
- to clarify that I would like that he or she returns things that belong to me
- to achieve that the other person be aware of my rights
- to make others make clear what I find annoying
- to achieve my own goals
- to prevent that I will be exploited

Criteria

- specify *when* I want that something is happening
- be direct: say that *I* want something
- be short and to the point, say what you want
- bring my request as a request and not as a command, for example: "I would like to..." rather than: "Do this or do that!"
- keep eye contact
- address the other
- speak clearly and understandably

Situations

1 I bought a tool. At home, I discover a manufacturing defect, and I go to back to the shop.
2 You are standing with many people in a row waiting for being served, for example, at the bakery. Someone who comes after you is being waited on first.

3 The coffee I ordered in a restaurant is served. However, there is no sugar substitute included. I ask the waitress to bring me a sugar substitute.
4 I borrowed an acquaintance some months ago a book that I wanted to read for myself. She is rather late in returning it. I ask her to return the book.
5 Someone explains me something at my work. I did not exactly understand what was meant and asked for further explanation.
6 Someone has promised me to do a little work for me but has at this point in time not done so. I ask him when he may do it.

Expressing an opinion

Description

Say what one thinks of something. Expressing an opinion differs from giving a criticism. By giving a criticism, you express a feeling of being impeded or harassed.

Goals

- make your point clear
- challenge the position of the other
- show that I have a point of view
- to show that I know only a little and that I'm not an expert
- to give the other the opportunity to present his point of view
- to advance the relationship with the other
- to convince the other of something
- to start a discussion
- to achieve that others take my opinion into account

Criteria

-make it clear that it is my point of view, by saying: "I find...!", "I agree with you", "I'm not your opinion", "I think", "I am of the opinion of", etc.
- be concrete and specific, say what you mean
- listen to the other and finally summarize what is said
- do not interrupt the other person
- keep eye contact
- all other non-verbal behaviors that facilitate the expression of your opinion (e.g. talk loud and clear, address the other, be warm)

Situations

1 I sit together with friends, and one of them expresses his opinion on a current topic. I do not share his opinion and state my vision without being asked.

2 Someone asks for my opinion about something that I have seen or read. I don't know what he thinks of it.

4 I notice at the reaction of the other that he is very impressed by something. I am not his opinion and say this.

5 Someone tells me enthusiastic about his plan and asks me for my opinion. I will not moderate his enthusiasm, but say that I find this not so interesting.

Positive self-evaluation

Description

It concerns situations in which you express your satisfaction, joy or pleasure of an attained goal, about something you have done or made (Note the difference with the 'showing off'.)

Goals

- cause yourself a pleasant feeling
- to reward myself and perform the activity more frequently in the future
- share this pleasant feeling with others
- to stimulate others to make me a compliment
- to demonstrate that I am content with myself

Criteria

- what I say about myself is positive
- be direct, that is to say *I* find something
- be specific and clear that you are talking about yourself
- be short and to the point
- attune your non-verbal behavior at what you say

Receiving a compliment

Description

It is important to accept the recognition of the other and finally agree with him or her.

Goals

- show my positive feelings about the other’s recognition
- demonstrate that this gives me a pleasant feeling

-to stimulate the other to express his appreciation in the future
- to ensure a pleasant feeling in the other
- to show that I appreciate the other's compliment
- - to give the other person the occasion to express his or her positive opinion, even though I do not share this

Criteria

- to be positive and clear what I say. About the compliment as well as that I agree with what the other says.
- be direct: say "I"
- be clear with regard to which, what and whom you are talking, namely about yourself.
- be short and assertive
- attune your non-verbal behavior at what you say

To criticize

Description

To express your feeling of being hindered or harassed, together with a request for positive change. (Note: the other person must be able to change his or her behavior). A criticism includes more than the mere utterance of a request: express a feeling of irritation or displeasure about something and follow that by a request for change. A criticism differs from the expressing of opinion in that it deals with the behavior of the other person that hampers you.

Goals

- to give the other person feedback about what he or she is doing with the aim of changing his or her annoying behavior
- to express my feelings of being hindered
- to show the other on the consequences of his actions
- to offer the other person alternatives for his or her behavior
- to express my feelings, rather than to bottle it up in me
- to clarify the other person how far I go
- to prevent being misused

Criteria

- There must be a clear statement of a sense of dissatisfaction.
- A criticism is a statement, quite different from saying sorry

- A criticism must be expressed direct and to the point: say that it hindered or annoyed *me*
- What you say is addressed to the other, say, "You", "Your" or "You".
- Be short and warm.
- Be specific and restrict yourself to the current situation, do not expand or generalize your criticism to other situations
- Criticisms may be accompanied by a request for a positive change

Appendix 5

The Inventory of Interpersonal Situations (ISS)

The ISS is based on an interactive concept of social anxiety and provides scores for both a Discomfort scale (emotional aspect) and a Frequency scale (behavioral aspect). Each scale comprises a separate explanation and instruction, and the same list of 35 items formulated as responses to specific social situations (see Figure 1). Both scales comprise the following 5 subscales: giving criticism, expressing opinions, giving compliments, initiating contact, and positive self-evaluation. The subscales comprise the following items: *Subscale 1.* Giving criticism: items 2, 8, 10, 21, 25, 31 and 33; *Subscale 2.* Expressing opinions: items 14, 16, 20, 30, 32 and 34; *Subscale 3.* Giving compliments: items 9, 17, 23 and 24; *Subscale 4.* Initiating contacts: items 1, 12, 13, 15 and 29; and *Subscale 5.* Positive self-evaluation: items 4, 26, 27 and 28.

The reliability and validity of the ISS were investigated in several adult and non-psychiatric samples. The scales and subscales for Discomfort and Frequency showed stability over time and high internal consistency. The conceptual structure was shown to be rather invariant across socially anxious and non-socially anxious groups. The ISS scales were able to discriminate between socially anxious and non-socially anxious samples, and showed significant relationships with independent measures of social anxiety. In addition, the ISS scales demonstrated high predictive validity for overt behavior in social situations (Dam-Baggen & Kraaimaat, 1999).

The level of anxiety/discomfort and frequency of performing the response is rated with 5-point Likert scales. The scores on the 35 items are counted up which can result in a minimum score of 35 and a maximum score of 175 for the two main scales. The ISS can be individually as well as group administered. The inventory is applicable to persons from about 16 years, takes about 20 minutes to complete, and has no time limit for completion. The instructions and items have been formulated in such a way that one can complete the questionnaire without further explanation (see Figure 1).

The scores on the Discomfort scale and Frequency scale serve as an indication of the extent of problems in dealing with others. In the clinical practice, the question can be answered with the scores if someone come into account for the treatment of social anxiety. However, the scale scores give no information on what type of treatment would be appropriate, because this depends on the mechanisms that underlie the subject’s emotional

and behavioral aspect of their social anxiety and social incompetence (see 2.2). A comparison of pre- and post-treatment scores on the ISS provides information about the effectiveness of the treatment.

Scale and subscale values were calculated for socially anxious patients (N = 461), a heterogeneous group of psychiatric patients (N = 729), "normal" subjects (N = 580) and students (N = 425) (see Table 1). Note that the Discomfort and Frequency scales are related: r = -.62 for the socially anxious patients, r =-.49 for the heterogeneous group of psychiatric patients, r =.43 for normal people and r = -.46 for the students.

Several cross-cultural studies with the ISS were undertaken (Kraaimaat, Vanrijckghem & Dam-Baggen, 2002; Dam-Baggen, Kraaimaat & Elal, 2003; Kraaimaat, Dam-Baggen, Veeninga et al., 2012). The Dutch manual and inventory (IOA) are available at Harcourt Publishers (www.harcourt.nl).

For research purposes, the ISS is available in Bahasa Indonesia, English, German, French, Spanish, Turkish and Italian (www.floriskraaimaat.nl).

Table 1. Means and standard deviations (within parenthesis) of the scales and subscales of discomfort and frequency for social anxious psychiatric patients (N = 461), a heterogeneous group of psychiatric patients (N = 729), and normal subjects (N = 580) and students (N = 425).

	Social anxious psychiatric patients		Heterogeneous psychiatric patients		Normal subjects		Students	
Discomfort	100.0	(26.1)	91.8	(27.8)	70.5	(17.8)	70.9	(16.4)
Criticism	24.6	(6.3)	22.0	(7.4)	19.0	(5.2)	18.3	(4.6)
Opinion	18.9	(5.9)	16.6	(6.3)	12.6	(4.0)	12.2	(3.9)
Compliments	7.4	(3.4)	8.1	(4.0)	5.3	(2.2)	5.4	(2.3)
Initiating contacts	14.5	(4.7)	12.9	(5.0)	9.6	(3.3.)	10.3	(2.9)
Self-evaluation	10.6	(4.0)	10.0	(4.0)	7.7	(2.7)	8.2	(2.8)
Frequency	94.2	(16.9)	97.4	(20.7)	111.3	(15.8)	111.3	(13.3)
Criticism	14.7	(4.3)	15.8	(5.3)	18.3	(4.6)	17.9	(3.9)
Opinion	14.8	(3.9)	15.9	(4.7)	18.9	(3.5)	19.3	(3.4)
Compliments	14.9	(3.0)	15.0	(3.3)	16.2	(2.7)	16.3	(2.3)
Initiating contacts	13.2	(3.5)	14.0	(4.0)	15.8	(3.1)	15.9	(2.6)
Self-evaluation	10.5	(2.9)	10.9	(3.5)	11.7	(3.0)	11.5	(2.8)

Figure 1

INVENTORY of INTERPERSONAL SITUATIONS

I.I.S.

Name: _____

Date of birth: _____

Sex: male/female

Achieved level of education: _____

Date: _____

Part 1. Discomfort

This inventory consists of a number of interpersonal situations. Please indicate the degree of DISCOMFORT you would experience in each of these situations. Use the following answer key:

1. no discomfort
2. a little discomfort
3. a fair amount of discomfort
4. much discomfort
5. very much discomfort

For example:
If you feel a FAIR amount of discomfort when you join a conversation of a small group of people, then circle figure 3 as follows:

1. Joining a conversation of a small group of people 1 2 3 4 5

Please complete the following inventory. Take your time when you work from one situation to the next. There are no right or wrong answers; it is rather your opinion that matters.

1.	Joining a conversation of a small group of people	1	2	3	4	5
2.	Telling a friend that he/she is doing something that bothers you	1	2	3	4	5
3.	Resisting pressure to accept an offer (for example at the door, in the street)	1	2	3	4	5
4.	Accepting a compliment for something you did	1	2	3	4	5
5.	Asking a friend to help you with something	1	2	3	4	5
6.	Requesting the return of something you have lent to someone	1	2	3	4	5
7.	Turning down a request to lend someone money	1	2	3	4	5
8.	Refusing a request from an authority figure (e.g. employer, superior, teacher)	1	2	3	4	5
9.	Telling someone that you are pleased with what he/she did for you	1	2	3	4	5
10.	Asking someone to stop bothering you in a public place (theater, subway)	1	2	3	4	5
11.	Keeping eye contact during a conversation	1	2	3	4	5
12.	Asking for information (at a window or booth)	1	2	3	4	5
13.	Initiating a conversation with an attractive male or female	1	2	3	4	5
14.	Expressing an opinion that differs from that of the person with whom you are talking	1	2	3	4	5
15.	Initiating a conversation with a stranger	1	2	3	4	5
16.	Expressing an opinion that differs from that of those around you	1	2	3	4	5
17.	Complimenting someone for a job well done	1	2	3	4	5
18.	Returning a defective item (for example, in a store or restaurant)	1	2	3	4	5
19.	Asking for a further explanation about something you did not understand	1	2	3	4	5
20.	Expressing your opinion in a conversation with a group of unfamiliar people	1	2	3	4	5
21.	Telling someone that he/she offended you	1	2	3	4	5
22.	Refusing a request from a person you like	1	2	3	4	5
23.	Expressing your appreciation for a present	1	2	3	4	5
24.	Telling someone that he/she is good looking	1	2	3	4	5
25.	Discussing why someone seems to avoid you	1	2	3	4	5
26.	Telling someone that you like it that he or she appreciates you	1	2	3	4	5
27.	Agreeing with a compliment about your looks	1	2	3	4	5
28.	Telling someone that you are pleased with something you did	1	2	3	4	5

29.	Introducing yourself to someone	1 2 3 4 5
30.	Expressing your opinion of life	1 2 3 4 5
31.	Telling someone you no longer want to see him/her	1 2 3 4 5
32.	Insisting that someone contributes his/her share	1 2 3 4 5
33.	Telling someone that the way he/she is talking disturbs you	1 2 3 4 5
34.	Expressing your opinion to an authority figure (e.g. employer, superior, teacher)	1 2 3 4 5
35.	Asking a friend to go out with you	1 2 3 4 5

Please check if you marked all situations

Part 2. Frequency of occurrence

In this part, you will find the same 35 interpersonal situations as described in section 1. This time you are to indicate HOW OFTEN you behave as described in the situations. Use the following answers:

1. I never do
2. I seldom do
3. I sometimes do
4. I often do
5. I always do

For example:
If you NEVER are joining a conversation of a small group of people, you circle number 1 as follows:

1. Joining a conversation of a small group of people 1 2 3 4 5

One by one you complete the list of interpersonal situations, taking your time. Again there are no right or wrong answers; it only matters what you think you would do.
Take your time to complete part 2.