Chapter to appear in L.S. Greenberg & R. Goldman (eds.), *Clinical Handbook of Emotion-Focused Therapy.* Washington, DC: APA. Author submitted version, 2016. This is not the version of record.

Social Anxiety

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Social Anxiety (SA) is a common, debilitating anxiety difficulty characterized by persistent fear of social interactions or situations in which a person might be scrutinized or judged by others (American Psychiatric Association, 2013). People with SA are typically not only terrified of public speaking but of talking or just being seen in a range of social or interpersonal situations, including close personal relationships (Stravinsky, 2007); they also experience significant distress as they anticipate interactions with other people and later ruminate over them. It is the third most prevalent psychological difficulty, after depression and substance abuse, affecting up to 12% of the population during their lifetime (Kessler et al., 2005). SA is often comorbid with other psychiatric diagnoses, such as Major Depression, other anxiety difficulties, and substance misuse. It is also associated with impaired ability to form and maintain good interpersonal relationships, leading lonelinessa and isolation (Alden & Taylor, 2004). In addition, there is an increased risk of suicidal ideation and suicide attempts (Cox, Direnfeld, Swinson & Norton, 1994).

At present, the treatment guidelines (e.g., National Collaborating Centre for Mental Health, 2013; Society of Clinical Psychology, 2016) recommend various forms of CBT as front line evidence-based treatments for SA, such as the Clark and Wells individual model (Clark et al., 2006) and Heimberg's group therapy model (Hope, Heimberg & Turk, 2010). While these approaches have been shown to be effective (Acarturk, Cuijpers, van Straten, & de Graaf, 2009; Mayo-Wilson et al., 2014), a substiantial number of clients do not respond well to CBT or remain symptomatic to some degree at the end of therapy (Davidson et al, 2004, Moscovitch, 2009). Although there is little current literature on other therapies for SA, there is clearly a need for non-CBT alternatives, including EFT.

Theory of Dysfunction

In EFT terms, SA involves a set of maladaptive emotion schemes developed as a result of being chronically and traumatically shamed or bullied, usually during the developmental periods of childhood or adolescence. These experiences lead to the development of primary and secondary emotion processes in which interpersonal interactions come to be perceived as dangerous situations in which the person will be revealed as socially defective, thus cuing first shame (a primary maladaptive emotion) and then anxiety about this shame (a secondary reactive emotion), further complicated by patterns of emotion dysregulation (both under- and over-regulation). The complexity and multiplicity of the different emotion processes helps to explain why full-blown social anxiety is so debilitating and so challenging to treat. In Figure 1 we summarize our current understanding of the most common proceses involved in severe social anxiety. These can be divided into *sources*, *primary processes*, and *secondary processes*.

Sources. We propose what is essentially a *social degradation* model of the origins of social anxiety (cf. Garfinkel, 1956). During childhood or adolescence, the person (who may or may not have been born with an introverted or shy temperament) experiences a period of social or interpersonal mistreatment. This can take the form of some sort of repeated public humiliation in the form of bullying, or it can involve various forms of interpersonal trauma, that is, physical, sexual or emotional abuse (Kuo, Goldin, Werner, Heimberg & Gross, 2011).

This degradation takes place in the *absence of interpersonal support*, including love, validation, protection and so on, which amplifies the effects of the degradation. Often, supposedly helpful others instead act as witnesses to the person's supposed transgressions, reinforcing the degradation. This combination of social degradation and lack of support results in *traumatic emotional pain*, which typically involves shame, but also commonly fear or sadness. In the original situation, shame can be understood as an immediate primary adaptive emotional response to the degradation, consistent with the person accepting it as an accurate representation of who they are. Thus, the person not only experiences chronic interpersonal humiliation but must go through this on their own, as if they were some sort of social pariah, or had even been banished from their social unit, resulting in deep and long-lasting psychological pain.

Primary Emotion Processes. The enduring results of this social degradation process are several, and include first of all a deep, generalized sense of shame. One part of the person might protest angrily against the way they have been mistreated and about their ruined self-identity, but at another, deeper level, they accept that they are radically and irrevocably defective. Over time, this comes to be symbolized as a *shame-ridden defective self*, which is experienced as the deepest truth about who they are. Each person with social anxiety symbolizes his or her defect in their own idiosyncratic way: "stupid," "rubbish," "spacey," "not nice to look at," "unfit for human company," and perhaps most commonly, "having nothing to contribute" – to conversation, to a relationship, or to other people generally.

Along with this, there is a complementary self-organization, in the form of a *harsh internal critic*, which continually reinforces the sense of defectiveness. This angry, self-judging aspect is an internalization of the bullies or abusive others who have mistreated the person in the past. In fact, it is this internal voice that repeatedly recites the symbolized defect ("You are awkward and socially inept"; "You're so inarticulate you can't put a coherent sentence together"). Thus, the previous degradation by others now continues as self-degradation and self-shaming, and the person returns again and again to memories of the previous mistreatment, which serve as further evidence in support of self-defectiveness. At the same time the emotional pain of the mistreatment becomes congealed around defectiveness and shame, and the person loses touch with the broader aspects of that pain, such as fear/fragility and isolation/sadness. The result is a one-dimensional experience of self as socially defective.

Secondary Emotion Processes. The shame-ridden defective self-organization leads to a set of secondary emotional processes, which together constitute the clinical presentation of social anxiety: a socially vulnerable self that experiences secondary reactive fear/anxiety about others; a hypervigilant coach/critic/guard aspect that generates anxiety even in the absence of others; and a dysregulated panicky/disengaged experiencer who engages in behavioral avoidance by physically removing themselves from the situation or in experiential avoidance by freezing, shutting down or even dissociating.

To elaborate: In response to their chronic maladaptive feelings of shame about being deeply defective, the person develops *secondary reactive fear or anxiety* that others will see their defectiveness and shame them again. Thus, they repeatedly see certain types of social situations as dangerous and to experience themselves as generally vulnerable to being exposed as defective to others. Nevertheless, this is not necessarily clinical social anxiety.

In addition, in order to cope with chronic feelings of shame, the person develops a hypervigilant *coach/critic/guard* (CCG) aspect of self, whose role is to continually look out and warn the person about social dangers in order to prevent further degradation. This part of the self is organized around an emotion scheme of fear/distrust, and powerfully motivates the person to engage in various activities to try to keep themselves safe: Most obviously, when in an immediate social situation, such as an informal social gathering or if they have to speak up

in a more structured situation such as a class or meeting, people with social anxiety actively scan for signs of impending negative judgement, especially facial expressions like frowns or contempt. In addition, prior to entering situations, they try to anticipate and prepare possible threats, often mentally composing scripts of what they will say. Furthermore, after a social encounter they typically replay social interactions over and over to analyze and critique their performance. All of these activities are intended to help the person deal more effectively with social situations; however, their actual effect is to generate more and more fear or anxiety of others, which thus reinforces the person's conscious sense of vulnerability and implicit feeling of shameful defectiveness.

By enhancing and prolonging the person's social anxiety, the hypervigilance of the coach/critic/guard aspect leads to a chronic state of moderate anxiety, vulnerable to *emotion dysregulation*, in the form of overwhelming states of anxiety ("anxiety attacks" or "panic attacks"). These underregulated states in turn motivate the person to overregulate their distress through behavioural or experiential avoidance, as the person either flees the situation or shuts themselves down emotionally. In EFT terms, the latter is a self-interruption, but can be extreme enough at times for the person to enter a quasi-dissociated state in which they experience mental confusion or fuzziness. These dysregulated states underscore the person's sense of defectiveness and associated shame. Finally, the person becomes desperately miserable with this social isolation, finding it constricting or even imprisoning.

Evidence for the Effectiveness of EFT for Social Anxiety

In addition to a set of systematic case studies (MacLeod & Elliott, 2012; MacLeod, Elliott & Rodgers, 2012; Shahar, 2014), there are now two studies of the outcome of EFT for social anxiety. First, Shahar et al. (2016) have recently reported the results of a multiple baseline design with 12 clients who were offered up to 28 sessions; they randomized clients to wait four, eight or 12 weeks between intake and beginning therapy. Of the 11 completers, seven no longer met criteria for SA at the end of treatment. On the Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987) scores did not change during baseline, but showed very large and statistically significant improvements during treatment (Cohen's d = 3.14), and remained improved during follow-up.

Second, Elliott and colleagues (Elliott, 2013, Elliott, Rodgers & Stephen, 2014) compared EFT to Person-Centered Therapy (PCT) in a sample of 53 clients with moderate to severe SA, who were offered up to 20 sessions. The first phase of the study focused on treatment development, with unsystematic assignment of clients to treatments; in the second phase, clients were assigned randomly to treatments. Across both phases of the study, effect sizes on the Social Phobia Inventory (SPIN; Connor et al., 2000) were 1.75 for EFT vs. 1.01 for PCT; for the Personal Questionnaire (Elliott et al., 2016) effect sizes were 2.22 for EFT compared with 1.05 for PCT. These differences were statistically significant and clinically important. In addition, the effect sizes obtained for both EFT and PCT were quite large and superior to effects on the SPIN found in comparable studies of CBT and medication (Antony et al, 2006; Connor et al, 2000; Taube-Schiff et al, 2007).

While not definitive, these two studies provide clear evidence supporting the further development and testing of EFT as a promising evidence-based treatment for social anxiety, with large benefits for clients.

Change Processes in EFT for Social Anxiety (EFT-SA)

As we see it, the key change process in EFT-SA is accessing and activating shame so that it can be restructured within a secure, accepting, validating therapy relationship. Clients are helped to access their sense that they are defective, worthless, or inferior, then to deepen it to their core pain (eg., deep brokenness or isolation), so that it can be transformed by

experiencing and expressing adaptive emotions, such as self-soothing/compassion, assertive/protective anger, and connecting sadness (Greenberg 2010). These adaptive emotions strengthen socially anxious individuals and help them to connect with important needs that have been missing in their lives, thus encouraging them to reestablish relationships and fulfill authentic life goals and values. In working with clients with moderate to severe social anxiety we have found a common change process (see Table 1).

Phase I: Making contact and beginning to explore social anxiety. Several things happen in the intial phase of EFT-SA. First, a strong and genuinely caring and empathic therapeutic relationship needs to be developed with the client, creating a secure emotional bond that is essential for the rest of the work. This can be challenging because clients with SA are generally quite interpersonally vigilant. In fact, for clients whose social anxiety centers on unstructured social situations, *alliance formation* often turns out to be a key part of the work, and may require therapists to be more active and to provide more information and structure than they are used to offering.

Second, it is useful to begin, even in the first session, by helping the client to *explore and symbolize their experience of social anxiety*. Every client's experience of social anxiety is different, so the therapist helps the client elaborate their unique SA emotion scheme. This includes: (a) How the SA feels in their body (bodily-expressive emotion scheme elements); (b) what situations it refers to and that trigger it (situation/perceptual elements); (c) the meanings they attach to their SA, what they tell themselves about it, and how they symbolize their social defects (symbolic/conceptual elements); and (d) how they cope with their SA and what it tells them to do (action tendencies).

Third, therapist and client begin to construct a *narrative* of where the SA fits into the person's life, including the story of how it originated or developed over time, and the life projects that are currently being compromised by it. Through this early narrative work, the therapist also hears the major task markers presented by the client and begins to develop a collaborative case formulation with the client.

Phase II: Initial work with presenting secondary anxiety processes. From this point forward, the change process in EFT-SA involves a step-by-step deconstruction of the client's social anxiety, working backwards through the etiological processes depicted in Figure 1. In other words, the therapist begins with the client's presentation of fear/anxiety in interpersonal and other social situations. The therapist asks the client to unfold of a specific example of a social situation in which the person was afraid, which leads quickly into work on their *anxiety split process*, that is, the process by which a coach/critic/guarding (CCG) part of themselves generates and heightens their fear of others.

An important feature of EFT-SA is the need to help clients manage of within-session *episodes of emotion dysregulation*, which commonly occur when they begin working with anxiety splits. As noted in the etiology discussion earlier, the CCG aspect at times overwhelms the vulnerable self-experiencer, which leads to in-session anxiety episodes, to which clients respond with experiential or behavioral avoidance, including emotionally shutting down, experiencing mild dissociation, or even leaving the session. If mishandled through therapist passivity or lack of strong empathic affirmation these will become relational ruptures. On the other hand, if the therapist is able to actively and sensitively work with the client, these can become therapeutic opportunities, in that they help the client experience directly how they generate their social anxiety. Phase II is completed when the CCG itself softens into anxiety, revealing a protective but often childlike quality of vulnerability.

Phase III: Deepening: Working with primary shame processes. Phase III opens with the client beginning to face their core defectiveness, which the secondary processes explored in Phase II had been interrupting. The therapist helps the client explore the specific nature of

the danger that CCG has been trying to protect the person from. This leads to an exploration of the underlying primary maladaptive shame, and specifically the sense that they are fundamentally defective as a human being. This level of shame brings clients to a deeply vulnerable state, which is very difficult for them to stay with; thus, it requires close tracking and actively communicated empathic affirmation to hold the client emotionally. The therapist's genuinely unconditional positive regard and active prizing of the client is essential here, as is continuing to work with the client's immediate or delayed secondary reactions to their primary shame. This work takes courage and active engagement on the part of both client and therapist, supported by chair work, focusing and emotion regulation efforts.

Once therapist and client are able to help the client stay with their primary shame, the next step is helping the client look at the deeper self-critical split by which they shame themselves through harsh self-criticism and self-contempt. Regardless of the developmental origins of the SA, the person continues to treat self in the here and now as defective and broken. Thus, the therapist helps the client to work with their harsh internal critic and its introjected, self-directed anger and contempt. This helps them experience directly how their sense of defectiveness, like their fear of others, is an internal, self-generated process.

Phase IV: Emotional Change: Working with and repairing the sources of social anxiety. Sometimes working with the deeper anxiety and self-critical splits is enough to generate emotional transformation through mobilizing protective anger, connecting sadness or self-compassion. In other instances, the work moves on to the developmental sources of the SA. If it is not already obvious where the harsh internal critic voice and its introjected anger and contempt have come from in the person's life, all it takes at this point is a bit of focusing by the client for them to contact episodic memories of repeated experiences of social or interpersonal degradation from others, generally in the form of bullying or abuse. At this point in therapy it become apparent that the client's social anxiety is really a form of complex trauma (Paivio & Pascual-Leone, 2010), and client and therapist begin working in earnest on this *unfinished business* from unresolved relationships and in particular unexpressed feelings and unmet needs left over from these relationships.

In this, client and therapist follow the standard deepening process in working with unfinished business, helping the client move from secondary protest and complaint about their mistreatment to their *core traumatic pain*, or what hurts the most, about the degrading experiences they went through. Following Timulak (2015), we have found that this core pain most commonly takes one of several forms: First, there can be intense feelings of *fragility or exposure*, which points to a generalized maladaptive existential fear of shattering or dying. Second, what hurts the most can be a sense of having been fundamentally *violated or injured* by degrading treatment by others, leaving the person full of shame and self-disgust ("damaged goods"). However, in our experience a third form of core pain is most often present: a deep sense of having been *abandoned or rejected* by others, as if their defectiveness was so great as to cause the person to be entirely cast out of or shunned by their social unit, leaving them stuck in a deep sense of emptiness, loneliness and disconnection.

Once the client accesses their core pain, the next step is to enter into *transformative self-soothing* (Goldman & Fox, 2010; Sutherland, Peräkylä & Elliott, 2014). In this process, the therapist accepts the core pain and helps the client identify what it needs, which in turn activates an appropriate, primary adaptive emotion in the client. Thus, fragility or exposure needs protection and safety, which points to *self-compassion*, as if re-parenting oneself as a frightened child. Alternatively, violation helps the person activate *protective anger,* which helps the person to reassign the fault for the degradation and make better boundaries in current relationships. In addition, abandonment/isolation transforms into *connecting sadness*, which motivates the person to seek others in the face of their fears. These adaptive emotions as resources help clients address their core pain.

Phase V: Consolidation and ending. These new, emerging emotions form the basis of new, more useful self-organisations, leading to far-reaching changes in emotion schemes for self and others, behavior change and more fulfilling interactions with others. However, addressing the traumatic pain and the primary processes of shame and harsh self-criticism do not automatically lead to change in the secondary processes of social anxiety. Rather, there needs to be a process of working back out to the Coach/Critic/Guard anxiety split process, which has over time become a stable self-organization in its own right. Thus, we have found that it is important to support a process of helping the client to consolidate the more fundamental changes and to translate these into their current life functioning. Among other things, the therapist helps the client to use their new adaptive emotions of connecting sadness to motivate themselves to seek social situations in which to learn for the first time to really be themselves. Similarly, the client's self-compassion and even protective anger can help them to better meet the challenges of being in relationship with others, where disappointments are inevitable and boundaries are sometimes very important.

In this process of consolidation, which may last several months, the focus of the therapeutic work shifts to helping the client carry forward their internal emotional changes into their life. At the same time, client and therapist may agree to meet less often, gradually tapering the frequency of session, as they prepare for and process the end of therapy, and deal with any set-backs or emergent situations in the client's life.

Intervention Strategies and Case example

In this section we describe in more detail the various tasks and interventions that are commonly used to facilitate these and other change processes. We will demonstrate these tasks and interventions using a case example from Shahar et al.'s (2016) study.

Client Description. The client was a 28 year-old man whom we will refer to as "Daniel," currently studying abroad in Israel. He was originally from Brazil and had been raised only by his mother. At the age of 8 his mother married another man, a European, and Daniel and his mother moved to Europe, which Daniel experienced as a traumatic loss of his extended family and protective natural environment. Daniel described his mother as emotionally unstable and paranoid, with frequent anger outbursts, and even psychotic symptoms. As he grew up, Daniel experienced various degrading events, but the one that he recalled as most painful was being forced to move from an international elementary school to a religious Jewish school. Having been popular in the international school, he now felt different, inferior, and excluded in the religious school, yet his attempts to convince his mother to let him go back to the international school failed. When he began therapy, Daniel was in a serious romantic relationship but suffered from severe levels of social anxiety symptoms (Leinowitz Social Anxiety Scale scores of 78).

Interventions in Phase I. The most important goal at the beginning of therapy, in addition to unfolding the narrative and exploring the current social anxiety, is to help clients feel safe, validated, and understood. Therapists use a variety of validating empathic responses that reflect their genuine warmth and care for the client. Therapists allow themselves to taste the client's suffering and vulnerability, and to be touched by them. For example, in the first session Daniel talked about his first night at the new house after they moved to Europe. He could not fall asleep and called his mother, but his new stepdad thought that "8-year-olds should fall asleep on their own" and forced his mother to leave him alone, which left him feeling terrified. His therapist responded: "Yes, just being there alone in the room, just 8 years old, in a new country, new house, new family, away from everything that's safe and familiar, feeling so alone and terrified." For socially anxious clients, who usually feel prone to judgment, a therapeutic relationship that is based on validation can be highly soothing, affect-regulating and provides a corrective emotional experience.

Interventions in Phase II. Around the third session the marker for the anxiety split (e.g., the split in which the CCG generates anxiety around social situations) is often clearly present, and the emotional bond between the therapist and the client is strong enough to begin deeper emotional processing work. Working on the split using a two-chair dialogue task can now be suggested after a rationale for doing such work is provided. In the third session, as Daniel described a job situation in which he was anxious because he felt judged by his boss, the therapist invited him to work on this using the chairs:

Therapist: So it seems like one part of you stresses you out in these situations, calling you stupid and lazy, telling you that your boss thinks you can't spell right, whereas another part is left feeling anxious and tense… it's in the body right? Feeling sweaty I think you mentioned. Is that right?

Daniel: Yes (nodding his head). I feel like I can't talk because it might come off as… as stupid or something.

Therapist: Right, it sounds like it's so hard to function with this voice in your head that keeps warning and frightening you that things will go wrong, that others will look down on you.

Daniel: (Nods in agreement.)

Therapist: So I suggest we try something to work with that voice, OK? Can you come over here (pointing to an empty chair located in front of the client's chair)? (Daniel agrees and moves to the empty chair which directly faces his usual chair.) See if you can see yourself there (creating contact). How do you stress him out in this situation? Let's actually try to do it.

Daniel: (Looking at the therapist.) I tell him that he's no good.

Therapist: Yeah, so tell him: "You're no good!"

Daniel: (Facing the empty chair.) You're no good, and you must show him that you're competent and make the right impression.

As shown above, after initiating the task and creating contact (e.g., making sure the two sides talk to each other rather than through the therapist), the therapist coaches the CCG (catastrophizer) to express the anxiety-eliciting messages. In this step it is important to help the CCG be as specific as possible in order to see how anxiety is generated in social situations and even to directly generate it in the session. After the client in the CCG chair expresses the most anxiety-provoking messages, the therapist asks him to switch chairs in order to explore the bodily felt feelings in response to the CCG's attacks.

Therapist: Ok, come over here (pointing to the client's original chair).

Daniel: (Switches to the other chair.)

Therapist: So, look inside…what happens inside as you hear this? Tell him how he makes you tense.

Daniel: These things that you tell me, they make me anxious.

Therapist: Like…it's hard to breath…and…it's like…"I am so scared"?

Daniel: I can't find words in such places so I don't have much to say.

Therapist: Just like being paralyzed. So tense and anxious that you can't speak.

Daniel: Yeah, and I often start to sweat a little, and I am afraid that others can see that.

Therapist: Ok, come over here.

Daniel: (Moves back to the CCG's chair.)

Therapist: How do you make him sweat?

Daniel: (using a contemptous tone) Look at you, you have nothing to say, so now he thinks you're stupid and will fire you.

The therapist helps Daniel explore the bodily-felt tension and anxiety in response to the CCG's messages. The therapist uses a variety of empathic conjectures to help Daniel deepen the process and actually experience the tension <u>in the session</u>. As mentioned before,

some clients become dysregulated in this stage and experience intense anxiety or panic in the session. It is important to help them breathe and regulate the anxiety. Such moments of therapist-client dyadic regulation can be healing because so often these clients have been alone in this process. Other clients, however, like Daniel, are overregulated and do not feel much anxiety in the session. With them, the focus is more often on the anxiety they experience in specific out-of-session situations. Focusing is useful here to help deepen the experience of the bodily experience of the anxiety (in this case sweating), as is coaching the CCG to describe how it elicits that response. This further intensifies the criticism and clarifies the anxiety generating process.

Interventions at Phase III. The primary goal of this stage is to differentiate the secondary anxiety into deeper, primary maladaptive shame and defectiveness in the experiencing chair and finally to facilitate the emergence of primary adaptive anger and sadness (Greenberg, 2010). By experiencing and expressing adaptive emotions, the self is strengthened and feels more motivated to break free from limiting avoidant processes. At the same time, the protective nature of the CCG becomes apparent and the CCG softens into anxiety. In the fifth session Daniel described another social situation in which he was anxious, and the therapist again suggested that they work on this using the chairs:

Therapist: So come over here (Daniel moves to the CCG chair). How do you make yourself self-conscious?

Daniel: You're going to make a mistake, you're going to look bad, you'll even look ugly if you eat like that, if you drink you might spill something, I don't know…you look bad in front of other people when you eat.

Therapist: Right, so you need to be careful…

Daniel: Yeah, you need to be careful with everything that you're doing, every step you do, so that someone would not see that you can't spell and make fun of you,

Therapist: And that's going to be so painful.

Daniel: Exactly, so I always push you to be more, to be better.

Therapist: Right, so tell him, you need to be more, I expect you…

Daniel: I expect you to be better, to achieve, to be perfect.

Therapist: Otherwise…

Daniel: Otherwise everyone will see that you're not good (begins to tear up).

Therapist: Ok, can you change? (Daniel moves to the experiencing chair.) So he is sort of watching all the time, making sure you don't make mistakes. What's happening inside now?

Daniel: (On the verge of having tears but trying hard not to cry.) It's hard… It's hard to be supervised like that, and to be told not to do this and not to do that, and you're telling me…I mean, it's hard to be myself (becoming sadder).

Therapist: Mmm, so he is the supervisor. Tell him, I can't be myself…

Daniel: I can't be myself and I have to pretend all the time. I feel handicapped.

Therapist: Yeah, so this is so sad right? Tell him what's most missing for you.

Daniel: I miss being free with other people. (Turning to the therapist.) You know, without this anxiety I am actually pretty fun to be with... and I'm interesting.

Therapist: I'm sure. And you miss this part of you so much! I imagine, you know, it's so sad to lose that part of you.

In this segment, as the function of the CCG becomes more apparent (e.g., to watch and to supervise the self in order to be perfect and to avoid being exposed as defective), Daniel becomes more connected with the loss that comes with having to constantly pretend. In this case adaptive sadness appears before the client experiences deep shame.

Later in the session:

Therapist: So come over here, I want you to be the supervisor. Watch him, watch everything he does.
Daniel: (Moves to the CCG chair.) You need to be better, you need to make sure your spelling is correct.
Therapist: And I am watching you. All the time. To make sure…
Daniel: To make sure you don't screw up. So they don't find out who you really are.
Therapist: What's wrong with him?
Daniel: He is no good. He has problems.
Therapist: What are his problems?
Daniel: I don't know, there is something wrong with you. You're not like everyone, you are not as good. You're just…fucked up.
Therapist: And if they find out this truth…
Daniel: They'll reject you. No one will want to be with you.
Therapist: Ok, change (Daniel moves to experiencer chair). What's it like inside now as you hear this?
Daniel: (Displays shame: Looking down, shouldiers slumped, silent.)
Therapist: (after a few seconds) So hurt, so painful. It's tough to hear…it's so degrading.
Daniel: Yeah, I just feel inferior, like I'm not worth shit.
Therapist: Yeah, I imagine this is the hardest feeling. Feeling so worthless. Just wanting to hide somewhere (= action tendency of shame).
Daniel: Right. I don't want to be here.
Therapist: To disappear somehow.
Daniel: (Nods.) Yeah, it hurts because I don't feel like I'm enough and I need to be someone else that I'm not (voice indicates emerging resentment).
Therapist: (Supporting expression of assertive anger:) Right, it's like, "I lose my own sense of self and I'm tired of it." Tell him how you feel about that.
Daniel: I'm tired of always having to prove myself, to show that I'm not weak.
Therapist: So talk to your supervisor. What do you resent?
Daniel: I resent the fact that you make me pretend and work so hard to be someone that I am not.
Therapist: Right, so I need you to…
Daniel: I need you to stop doing that and let me be myself. I need you to encourage me, to tell me I am ok, that I'm just… good enough.
Therapist: OK, Change.
Daniel: (Moves to CCG chair.) I can't encourage you. I can't act as if everything is ok, and then… and then you'll think everything is ok, that you're fine, and you'll make mistakes.
Therapist: And then…
Daniel: You'll be exposed for the fake that you are.
Therapist: And then…
Daniel: I don't know…it's going to be so humiliating.
Therapist: Right, so my job is..
Daniel: To make sure that doesn't happen. That it never happens!
Therapist: Yes, it's so scary…this possibility, this feeling of being humiliated. Can you tell him about this anxiety?
Daniel: Yeah, I'm afraid of this feeling. I can't let it happen.
Therapist: Right, so this is the anxiety that drives you. Tell him some more about what you're afraid of. What are you most afraid of?
Daniel: That people will look down on you and think that you're less than… and they will see this little vulnerable boy.

Therapist: Right, so that's the part I don't want you to…
Daniel: Yeah, I don't want anyone to see that part. You're strong, no one should see that weak part.

In this segment, as the CCG expresses the most degrading comments, the shame scheme is activated and processed, even if for a few seconds, in the experiencing-self chair. Usually at this point an adaptive emotion scheme – sadness or anger – begins to emerge and it is most crucial for the therapist to pay attention to nonverbal signs (posture or voice quality) of that scheme and to support its emergence. As Daniel experiences shame, he begins to feel resentment for "having to be someone else that I'm not" and the therapist supports him in expressing the anger and its needs. As the client accesses shame in a context of a safe and validating relationship, sadness and anger naturally emerge as an antidote for shame without the therapist having to pull for them. These primary adaptive emotions lead to expressing basic needs that are important to Daniel's well-being, and are likely to promote emotional and behavioral changes. In addition, accessing shame and subsequent adaptive anger leads to an important dialgue, in which the protective function of the CCG is expressed (i.e. to prevent humiliation) and the CCG softens into anxiety.

Interventions at Phase IV. At the beginning of this stage, the source of the social anxiety and self-directed anger and contempt are usually already clear. For Daniel, the sources of the social anxiety involved, first, the fear that others will see him as like his unstable/weak/vulnerable mother, and, second, prior experiences of being rejected and feeling not worthy of love. In particular, he remembers the first night at his new home in Europe when he couldn't fall asleep but was abondoned by his mother and forced to remain alone. Also, being "moved like a doll from place to place" contributed to feeling "like nothing for no one".

In session 17 during two-chair work, accessing shame in the experiencing chair led to episodic memories of being rejected and to working through the pain:

Therapist: (To the experiencing self): So tell him how you feel when he doubts you.
Daniel: When he doubts me I feel so lost (begins to cry). I feel like this boy that wasn't accepted when I was little.
Therapist: Yeah, be that little boy…
Daniel: No one acepted me, my mom didn't accept me, my mom wasn't there for me, and my dad… I didn't have a dad (cries). I was just this boy that everyone leaves on the side and just.. just not worth anything.
Therapist: Yeah… this boy, he suffered so much, he was abandoned…
Daniel: I feel like when I am getting doubted, when I am getting judged, I feel like this boy that is worthless, he is so worthless that everyone leaves him (sobs).
Therapist: Yeah… I must be so worthless if you left me like that.
Daniel: Like I am not worth the love, the hugging, the attention (sobs).
Therapist: It's ok, breathe… because this is the most painful feeling…because this is the core wound right? When this little boy felt so abondoned and started to ask: "How come you left me, am I that worthless?"
Daniel: Yes and when I am judged I feel so alone… I feel like again this little boy… When I was a little boy I had no one not even a friend.. not even my mom hugged me that night. It's like you're not worth your mother, you're not worth your grandmother, you're worth being alone there.
Therapist: That's all you're worth… Try and see your mom here and be that little boy.
Daniel: I am so angry at you! Why couldn't you… She wasn't sensitive to me.
Therapist: I needed you…
Daniel: I needed you to be there for me and…like…I was only 8!
Therapist: Right right, tell her.

Daniel: I was only 8 (sobs)! And you were pushing me to sleep alone and screaming at me. I needed you to be there for me and hug me and tell me things are going to be fine.
Therapist: I needed you to be by my side and show me that I am important to you.
Daniel: Yeah show me that I am worth…that I am your son that I am more important than this boyfriend that you just met. Therapist: I needed you to soothe me and calm me down.
Daniel: Yeah, I felt like I'm not worth the hug, I'm not worth the comfort

The therapist and the client continue to process the deep pain and its associated needs until at a later point the therapist initiates a self-soothing process:

Therapist: So can you come over here? And this is Daniel now ok? Can you see this little boy?
Daniel: (Sobs…)
Therapist: Yeah this is so hard… I know… See if you can see the 8-year-old you there. Can you see him?
Daniel: Yeah.
Therapist: Can you give him what he needs?
Daniel: Yes.
Therapist: See what it feels like?
Daniel: Everything is fine...you know when you were so alone, I think it was pretty hard for mom.
Therapist: With her new boyfriend you mean?
Daniel: Yeah, she was very confused, she didn't know what she was doing.
Therapist: Right, tell him, this is very important.
Daniel: It's not that she judged you, she was confused and she also took a big step.
Therapist: So it's like…it wasn't your fault?
Daniel: Right, it wasn't your fault, it didn't mean that you are worthless.
Therapist: Right, tell him that again, because I think he really needs to hear that.
Daniel: You are not worthless and it wasn't your fault.
Therapist: What do you feel toward him right now?
Daniel: I am thinking like I am the protecting part right now and I need to make him understand.
Therapist: So tell him, I need you to understand…
Daniel: This was a difficult situation, you were alone and removed from your grandmother, who was really your mom (his grandmother raised him), but it didn't mean that you are worthless.
Therapist: What do you actually feel inside when you look at him and tell him these things? See the 8-year-old…
Daniel: I feel like… I feel sorry for him, I am sad for him.
Therapist: So it's this warm feeling I guess… What do you want to do with this feeling?
Daniel: I want to comfort him… and tell him everything's fine.
Therapist: So tell him. Comfort him. Be his mother that he never had.
Daniel: It's ok… I am here for you. We'll go through this together. I'm here (turning to the therapist). This is what I needed. It's so simple. I just needed her to help me through.

At the beginning of this segment, in the context of dialoging with the CCG, Daniel accessed the episodic memory of the first night in Europe and the feeling of not being worthy of his mother's love and attention. This was a marker for empty-chair work with her, and it was important for him to experience this shame in the context of the relationship with her, where the shame scheme was originally created. This naturally led to expressing basic needs

for comfort from her and an experiential understanding that it wasn't his fault. The therapist then initiated the self-soothing process so that Daniel could experience providing this comfort to himself and actually experience the feeling of being comforted. In session 21, this process was further deepened using imaginal restructuring, in which Daniel was guided in imagery to go back to the religious school and provide comfort and soothing and guidance to the little boy who was alone and having a hard time adjusting. These experiences are essential, as they fulfil his previous unmet needs, thus transforming and correcting, or reconsolidating (Lane, Ryan, Nadel, & Greenberg, 2015) the shame emotion scheme into a compassion emotion scheme, resulting in more confidence

Interventions at Phase V: In this stage the therapist and the client go back to the dialogue with the CCG in order to consolidate the change and help the experiencing self make plans to confront and overcome the entrenched avoidant processes, reclaim the right to connect with others in a meaningful way, and to be authentically present in social situations. For example, in session 24, in a dialgue with the CCG, Daniel in the experiencing chair says:

Daniel: I am seeing him in the other chair and I have this sense that I am calmer than him. he's anxious to be more, more, more…and stressed, but when I am sitting here I feel calm and more confident.
Therapist: So what does he need from you?
Daniel: To hear that it's OK, we are fine now.
Therapist: Yeah, tell him, see if you can help him to calm down.
Daniel: You don't need to run around anymore. You don't need to be anxious anymore, you don't need to run for something that is not there.
Therapist: And I don't need you to push me to run around…
Daniel: Yeah I don't need that.
Therapist: But I see, it's so sad…
Daniel: (Turning to the therapist.) You know it's funny because before little Daniel was sitting here (in the experiencing chair) but now he's there.
Therapist: Yes, he is the scared one… So try telling him, I am not the little boy anymore.
Daniel: Yeah I am not the little boy anymore. The little boy is confident now and I grew up.

Conclusion

In this chapter, we have laid out our approach to applying EFT to clients presenting with social anxiety (EFT-AS), a debilitating fear of other people. It is our view that this approach is promising in two ways: To begin with, it provides an alternative to a common but difficult-to-treat psychological difficulty that up until now has been almost exclusively the province of CBT; this is important because in our experience many clients have either had previous unsuccessful courses of CBT for SA or prefer a less directive, more relational approach. In addition, it is our view that EFT-AS can help EFT practitioners extend their practice to a new, challenging and complex client population, helping therapists to develop additional skills for working effectively with all their clients: First, we can improve how we work with clients who are deeply shame-ridden and display high levels of interpersonal vigilance in sessions, putting us under a microscope. Second, we can learn how better to meet clients who are likely to be phobic of unstructured social situations of which therapy is an exemplar and who therefore demand that we become more process guiding – even though they may turn out to be allergic to chair work. Third, we can develop a wider, more flexible approach to working with clients who easily become emotionally dysregulated in sessions, including panic attacks in sessions. Fourth, we can add compassionate self-soothing to the set of therapeutic tasks we are able to offer clients. Meeting and learning from these

challenges over the past ten years has made us both better EFT therapists, and we are grateful to our clients for bringing these challenges to us.

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Table 1. **Phased Change Process Model for EFT-SA**

Phase I: Making contact and beginning to explore social anxiety

(a) Alliance Formation

(b) Empathic exploration/focusing for accessing, deepening, and symbolizing experience of social anxiety (emotion scheme work)

(c) Narrative work for developing a coherent account of the social anxiety in the person's life

Phase II: Initial work with presenting secondary anxiety processes:

(a) Systematic Unfolding of social anxiety episodes, leads into two chair work on anxiety splits (secondary reactive anxiety/fear)

(b) Emotion regulation work

Phase III: Deepening: Working with primary shame processes:

• Two chair work (with Focusing) on deeper self-critical split: defective self vs. harsh critic (primary maladaptive shame/fear)

Phase IV: Emotional Change: Working with and repairing the sources of social anxiety

(a) Empty Chair work with developmentally significant degradation experiences, leads into core pain, unmet needs, leads into:

(b) Compassionate self-soothing (primary adaptive emotions: connecting sadness, protective anger, exploratory curiosity) (Repeated as needed within and across sessions)

Phase V: Consolidation and ending

• Tapering off frequency of therapy; helping client carry forward changes in their life; preparing for and processing end of therapy

Figure 1. **EFT Model of Social Anxiety**