

Contains Video <sup>1</sup>

## Seeing Is Believing: Using Video Feedback in Cognitive Therapy for Social Anxiety Disorder

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*Distorted negative self-images and impressions appear to play a key role in maintaining Social Anxiety Disorder (SAD). In previous research, McManus et al. (2009) found that video feedback can help people undergoing cognitive therapy for SAD (CT-SAD) to develop a more realistic impression of how they appear to others, and this was associated with significant improvement in their social anxiety. In this paper we first present new data from 47 patients that confirms the value of video feedback. Ninety-eighty percent of the patients indicated that they came across more favorably than they had predicted after viewing a video of their social interactions. Significant reductions in social anxiety were observed during the following week and these reductions were larger than those observed after control periods. Comparison with our earlier data (McManus et al., 2009) suggests we may have improved the effectiveness of video feedback by refining and developing our procedures over time. The second part of the paper outlines our current strategies for maximizing the impact of video feedback. The strategies have evolved in order to help patients with SAD overcome a range of processing biases that could otherwise make it difficult for them to spot discrepancies between their negative self-imagery and the way they appear on video.*

A recent network meta-analysis (Mayo-Wilson et al., 2014) has established that cognitive therapy for social anxiety disorder (CT-SAD) is an effective treatment that compares favorably with a range of other psychological and pharmacological interventions, including group CBT, exposure therapy, interpersonal psychotherapy, and psychodynamic psychotherapy. CT-SAD is based on the Clark and Wells (1995) cognitive model of SAD and involves a number of components: (1) developing a personalized cognitive model including the patient's negative thoughts, self-images, focus of attention, safety behaviors and anxiety symptoms; (2) an experiential exercise to demonstrate the adverse effects of self-focused attention and safety behaviors; (3) video and still photograph feedback to correct negative self-imagery; (4) training in externally focused attention; (5) behavioral experiments to test patients' negative beliefs by dropping safety behaviors and focusing attention

externally in social situations and also by purposefully displaying feared behaviors or signs of anxiety (decatrophizing); (5) surveys to discover other people's view of feared outcomes; (6) memory work (discrimination training and memory rescripting) to reduce the impact of early social trauma experiences. Video feedback is a key component of the treatment and is used throughout therapy. This present-focused technique aims to counteract the distorted negative self-images that characterize social anxiety disorder (Hackmann, Surawy, & Clark, 1998) by helping patients to obtain a more realistic view of how they appear to other people. In this paper we will first describe a study providing updated evidence for the effectiveness of video feedback. Following this we will present clinical guidelines detailing a range of procedures for the successful implementation of video feedback.

McManus et al. (2009) reported on the effects of video feedback in the context of a standard course of CT-SAD. In 94% of patients, video feedback was associated with an improved appraisal of their performance. Significant reductions in social anxiety were observed in the week following video feedback and these exceeded those observed in a control week. A number of other studies have also demonstrated positive effects of video feedback in both clinical and subclinical samples (Harvey, Clark, Ehlers & Rapee, 2000; Kim, Lundh & Harvey, 2002; Orr &

<sup>1</sup> Video patients/clients are portrayed by actors.

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Moscovitch, 2010; Parr & Cartwright-Hatton, 2009; Rapee & Hayman, 1996). However, two studies (Rodebaugh, 2004; Smits, Powers, Buxkamper, & Telch, 2006) failed to demonstrate beneficial effects of video feedback on social anxiety. In both studies, it appears that little time was devoted to preparing participants for viewing their videos and subsequent discussion of the viewing experience was also curtailed. These differences may help explain the negative findings. In an analogue study, Orr and Moscovitch (2010) found that detailed discussion following video viewing was essential in order to achieve substantial changes in both self-perception and subsequent social anxiety. The same authors (Orr & Moscovitch, 2013) also found video feedback to be less effective in socially anxious individuals who have additional concerns about their physical appearance. They propose that a preoccupation about physical appearance when viewing video may affect a patient's ability to perceive that they come across better socially than they predicted they would. This is one example of the processing biases that can potentially undermine the effectiveness of video feedback. Over the years, we have noticed that patients with social anxiety disorder have a range of processing biases that make it difficult for them to see the difference between their habitual negative self-perception and the way they appear on video. To overcome these processing biases, we have developed detailed procedures for setting up video recordings, for preparing patients to view the recordings, and for discussing what they have seen.

The processing biases that can interfere with video feedback fall into five broad categories. First, *reexperiencing feelings when watching the video*. Clark and Wells (1995) hypothesized that patients with social anxiety disorder misleadingly use their feelings to decide how they appear in social interactions. When subsequently watching a video of a social interaction, many patients appear to reexperience some of their original feelings and these can become confused with the video image. As a consequence, they may rate themselves as coming across more negatively than other people who do not reexperience their feelings from the original interaction might have rated them. To prevent this bias from interfering, it is necessary to help patients to observe themselves as though they are observing a stranger, ignoring their feelings and only focusing on what would be visible to anyone.

Second, *selectively searching for behaviors that could be interpreted negatively*. Patients with SAD have a general belief that they come across badly in social interactions. This can lead them to selectively search a video for any behavior that could conceivably be interpreted in a negative fashion. This can happen even if they were not particularly concerned about those behaviors during the interaction and they were not prominent in the negative self-image. To solve this problem, it is necessary to ask patients to make clear predictions in advance of watching

the video about any negative features that they believe were evident during the interaction.

Third, *discounting the accuracy of the video image*. If an anticipated negative feature (severe blushing, shaking, etc.) is not evident in the video, some patients may discount the accuracy of the video image, claiming that the camera is at fault (e.g., poor color rendition for blushing, or the shot was not zoomed in enough to pick up shaking). Therefore, it is necessary to carefully set up the recording so that patients are confident that features that they are concerned about will be visible if they occur. We call this procedure calibrating the video.

Fourth, *mistaking safety behaviors for social deficits*. Clark and Wells (1995) hypothesized that patients with SAD engage in a wide range of safety behaviors during social interactions in order to prevent their feared catastrophes from coming about. For example, individuals who are concerned that they may come across to others as uninteresting may say little. In addition, when they do speak, they may memorize what they have said and compare it with what they are about to say in order to check that it is sufficiently interesting. When watching the video, patients may see the observable side of these safety behaviors (appearing withdrawn and disengaged) and interpret this as an inherent social deficit. Asking patients whether they were intentionally holding back or doing other self-absorbing safety behaviors helps them realize that the apparent deficit in their social performance is the effect of a conscious strategy, which they can decide to drop in future.

Fifth, *reactivating habitual patterns of self-criticism*. During and after social interactions, patients with SAD are highly self-critical. When subsequently watching a video of the interaction, the self-critical commentary that accompanied or followed the interaction may be reactivated, making it difficult for patients to judge themselves objectively on the video. To address this, a number of techniques have been developed to reduce the reactivation of past memories and self-critical commentaries while viewing the video.

In the present paper, we first present data on the effectiveness of our current version of video feedback and compare it with the earlier version, whose effects were reported by McManus et al. (2009). Following this, we then describe in detail the clinical strategies that we now use to maximize the effects of video feedback. It is hoped that description of the strategies will help other clinicians to obtain optimal results when using video feedback.

### **Effectiveness of Current Version of Video Feedback**

Video feedback can be used in a variety of different ways during a course of CT-SAD. The first time that it is used is in Session 3. In the preceding session, patients engage in an experiential exercise in which they have a social interaction under two conditions: first, while focusing their attention on themselves, evaluating their performance, and engaging

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