Tools for Treating Social Anxiety Disorder Among Latinos

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Social anxiety disorder (SAD), formally known as social phobia, is mainly characterized by fear or anxiety of being negatively judged and evaluated by others and presenting intense crying, fear, and tremors when having a conversation, meeting with strangers in social events (e.g., eating or drinking), and speaking in public. SAD in children is characterized by problems speaking in public, asking for help at school or shops, and attending parties or events where they meet people of their same age (McEvoy, Rapee & Heimberg, 2016; Spence & Rapee, 2016). The prevalence of SAD among Latinos is similar to the global population, though epidemiological data in Spanish-speaking countries remain unclear. Research on treatment adaptation of empirically based treatments for social anxiety is still in progress. Based on the characteristics of the Latino population with social anxiety, this chapter will provide:

- An account of social anxiety and its epidemiology in the Latino population
- Cultural considerations when delivering treatment
- A description of the gold standard treatment for SAD: session vignettes and Spanish-adapted work sheets

Understanding SAD

Different models establish that social anxiety (SA) is impacted by biological markers and genetic factors (Bandelow et al. 2016); however, evidence suggests that SAD is also regulated by sociocultural factors and epigenetic processes that affect the way in which the environment influences on the development and adaptation of the individual to different contexts (Brockveld, Perini, & Rapee, 2014; Hofmann, & Hinton, 2014; Paniagua, 2014). These findings led to significant changes in the current classification of mental disorders (DSM-5), such as the inclusion of cultural factors and the establishment and maintenance of different psychological disorders, including SAD (Carter, Mitchell, & Sbrocco, 2012; La Roche, Fuentes, & Hinton, 2015; Woody, Miao, & Kellman-McFarlane, 2015). Cross-cultural studies indicate that cultures promoting interaction and support among members evidence lower levels of SA (Prina, Ferri, Guerra, Brayne, & Prince, 2011; Woody et al., 2015). For

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example, Latino culture is characterized by promoting closeness, friendship, and relationships among group members, leading to lower indicators of SAD compared to American and European groups (Benuto, & O'Donohue, 2015; Camacho et al., 2015; Polo, Alegría, Chen, & Blanco, 2011). In comparison, social anxiety indexes are higher in Anglo-Saxon countries where autonomy, personal achievements, and respect for the community are paramount (Woody et al., 2015).

The DSM-5 agreed that SAD is circumstantially determined; hence, they excluded the generalized subtype from its classification. Social anxiety is a specialized disorder, that is, individuals feel anxiety when speaking to a specific audience rather than a general public (Hofmann & Di Bartolo, 2014). This highlights the importance of environmental and cultural variables when diagnosing and treating social anxiety.

Epidemiology and Comorbidity

Epidemiological studies report that at least 13% of the global population has presented SAD symptoms once in their lifetime (Baxter, Scott, Vos, & Whiteford, 2013; Spence & Rapee, 2016). In the USA, 12% of the population has experienced SA at some point, and a prevalence rate of 0.4% and 6.8% is reported (Prina et al., 2011). Prevalence of SAD in Latin America is less clear. SAD prevalence during the first 12 months is 1.7% for Mexican, 6.4% for Chileans, and 1.2% for Colombians (Encuesta Nacional de Salud Mental, 2015; Hofmann, & Di Bartolo, 2014). The report of SA symptoms is slightly different between Latino females and males. In this population, SAD is more frequent when individuals interact with people of the opposite sex, receive criticism, and speak to authorities (e.g., professors, bosses, etc.) (Caballo et al., 2014). One difficulty in establishing epidemiological data in Latinos is the absence of instruments that accurately assess the characteristics of SA in this population; most investigations have adapted instruments designed with White American samples. Additionally, questionnaires developed with Latinos still lacking of strong validity and reliability (Antona, Delgado, García & Estrada, 2012; Brockveld et al., 2014; Caballo et al., 2014; Camacho et al. 2015).

The average age of onset for SAD is 11 years old for European Americans, while 13 years old is the average age of onset for Latinos living in America (Polo et al., 2011). However, the data for the onset of SAD symptoms in Latin America remains muddled. The DSM-5 reports that the prevalence in children and teens is similar to adults, between 2.3% and 7% (APA, 2013). Polo et al. (2011) found that in Latinos born in the USA, SAD commonly co-occurs with several psychological disorders, such as depression (48.7%), generalized anxiety (19.1%), panic disorder (16%), alcohol abuse (30.4%), drug addiction (11.3%), behavioral disorder (25.1%), and bulimia (7.1%). Interestingly, as time spent in the USA increases, so do rates of comorbidity with agoraphobia (48.6%) and post-traumatic stress disorder (22.8%).

Longitudinal studies have found that the presence of behaviors characteristic of SAD in adolescence increases the risk of depression in adulthood (Polo et al. 2011). Additionally, SAD symptoms increase the risk of alcohol consumption, marijuana use, and alcohol dependence during adulthood, especially in women (Spence & Rapee, 2016). Although data on the prevalence of SAD at the global level are relatively similar, it has been found that in the USA, 8.2% of Latin Americans present SAD compared to 12.6% of European Americans and 8.6% of African Americans. No gender differences have been identified between males and females in the Latino population living in the USA (Polo et al., 2011). Epidemiological data also show that the presence of SAD symptoms in Latinos living in the USA ranged from 18 to 34 years old. Additionally, married and employed people have higher risk to develop SAD.

Cultural Considerations

Therapists working with Latinos need to take into account certain cultural variables in order to treat SAD. Studies with the Latino population have

demonstrated that religious beliefs are an important part of Latino culture and can directly impact the client's perceptions about their psychological problems (Carter et al., 2012; Prina et al., 2011). *Familismo*, a value that embraces cooperation, closeness, respect for authority, and the importance of family bonds (Vega, 1990), is another key factor that supports therapeutic success; particularity, it plays an important role in overcoming family difficulties. Therapist-client relationships might be benefitted by sharing personal information with the client when appropriate, as well as shaking hands, or occasionally accepting hugs, as a sample of closeness and interest in the relationship. Although the APA code of ethics does not allow accepting gifts as part of the therapeutic process, given the characteristics of the Latino population, it is important to explain to clients that gifts can only be accepted in special occasions whether they want to share something with the therapist, such as Christmas or birthdays (Carter et al., 2012; Paniagua, 2014).

Some additional considerations when working with Latinos include:

1. Maintain a professional distance during the first session; however, as the sessions progress, it is recommended to increase the level of "closeness" with the client.
2. Talk, when necessary, about spiritual aspects that the client believes lead to emotional problems.
3. Provide any suggestion of behavioral change as long as they do not compete against cultural values (e.g., *machismo*, *familismo*)
4. Close the first session with some suggestions about the intervention, allowing the client to have the opportunity to make some changes in their current behavior and environment (Paniagua, 2014).

In general, it is desirable to accomplish some of these recommendations during the session by being mindfully respectful of clients' cultural values throughout therapy. Although protocols in evidence-based therapies for SAD have not been directly validated and adapted for Latinos, it would be useful to adopt a language as close as possible to the EBT language (Camacho et al., 2015; Hofmann & Hinton, 2014).

Empirical-Based Treatments for SAD in Latinos

Exposure-based therapy for social anxiety and cognitive behavioral therapy for social anxiety (CBT-SA) have gained the most empirical support in the treatment of SAD (Deacon & Abramowitz, 2004; Chambless & Ollendick, 2001; McMain, Newman, Segal, & DeRubeis, 2015). Moreno, Méndez, and Sánchez (2000) carried out a meta-analysis comparing both behavioral and cognitive behavioral treatments (CBT, skills training, exposure, and Ellis cognitive restructuring), including studies conducted in English- and Spanish-speaking countries. They found that CBT was the highest clinically significant intervention; however, CBT was not significantly different from other treatments. Recently, Labrador and Ballesteros (2011) extended the analysis of the previous study; they found that 64.1% of clients treated with CBT in Spain achieve their therapeutic goals.

Some researchers have adapted the CBT-SA manual developed for US population to the characteristics of Hispanos and Latinos. Olivares and García-López (2001) adapted the Protocol for Intervention in Adolescents with Social Phobia to treat adult population in Spain and young adults in Mexico (Antona et al., 2012). The treatment is composed of 12 sessions consisting of social skills training, cognitive restructuring, and exposure to social situations that trigger fearful responses. Additionally, CBT for social anxiety has shown positive effects in the treatment of children in Mexico (Gil-Bernal & Hernández-Guzmán, 2009) and college students with public speaking anxiety in Colombia (Kalil, 2012), Chile, and Brazil (Brockveld et al. 2014). The four therapeutic elements of the CBT-SA protocol that have been successfully utilized with both US population and Latinos include (1) psychoeducation, (2) cognitive restructuring, (3) exposure, and (4) relapse prevention (McMain et al., 2015; Hofmann & Otto, 2008). The duration of CBT-SA

varies between 12 and 16 sessions depending on the format utilized, with the individual modality requiring 1 h sessions and the groups 2.5 hours sessions. Group intervention can offer advantages over the individual, especially in the exposure process. One of the key elements of success in the group format is that the audience provides direct feedback in every session. At the end of each session, therapists assign homework that helps clients to master and generalize the new skills.

In the next section, each one of the components of the CBT-SA will be presented using a hypothetical case.

Andres' Case

Andres is a 22-year-old man who is worried about his academic performance. Specifically, he thinks that he will fail most of his courses since he could not meet the criteria required in the classes. He mentions that his academic performance is being affected by his difficulties in discussing his opinions with others (classmates and teachers) and doing public presentations. Andres says that this problem began after watching some classmates criticizing and mocking another peer, while she was doing a presentation during their first year in college. Currently, when he is assigned group presentations or must express his opinions to others, Andres thinks that he is going to crumble and get exposed. In such circumstances, he either asks others to complete his presentation or prefers to stay quiet during class. When he has been forced to do the presentation or talk to the group alone, he exhibits high arousal (he blushes, shakes, sweats excessively, and his heart rate increases); he thinks he is doing it wrong and that others will mock him when he finishes. Andres also speaks rapidly, stutters, or walks out of the room. As a result, he has stopped attending classes in which he is required to speak in public or to do group assignments.

Cognitive Behavioral Therapy for Social Anxiety: Treatment Description

Psychoeducation

At this stage, the therapist presents and discusses the rationale of the SAD model and the factors that maintain it. The first session covers the description of the model and the core elements of CBT-SA (Hofmann & Otto, 2008). Therapists should explain the *social phobia model* (Clark & Wells, 1995). It illustrates that the central element of the SA is the desire of the person to produce a positive impression of him- or herself onto others, which leads to social situations that trigger distorted perceptions about themselves and the world. The individual, thus, assumes that the audience (others) is dangerous. Such perceptions make people anticipate that their performance will be unacceptable to the public or that their behavior may cause them to lose their status. This leads to behavioral symptoms (i.e., avoidance of social situations), somatic symptoms (i.e., redness, trembling), and automatic thoughts (AT) (i.e., I'm inept; they're going to laugh at me). These symptoms provide a feedback loop to the perception of danger and reaffirm anxiety in social situations (Folleto A).

The Role of Avoidance and Escape in Social Anxiety Maintenance

Therapists need to address with the client the role of avoidance and escape in the maintenance of SA. Describing the function of avoidance and escaping is fundamental for decreasing anxiety responses and subsequently becomes the central issue during the exposure phase. It is important to describe to the client how the behaviors associated with SA are part of the avoidance/escape cycle. This vicious cycle usually prevents clients from contacting anxiety-provoking situations and immediately stops the occurrence of nega-

tive thoughts about these events. Contrary to expectations, avoidance responses increase over time generating even greater psychological distress (Folleto B).

Therapists need to explain to the client the importance of scheduling and performing exposure exercises consistently in order to break down the avoidance/escape cycle that produces SA. Therapists should inform the client that all responses associated with avoidance increase momentarily after the first exposure session; however, upon continuous exposure, these responses decrease over time in their frequency and duration (Hofmann, & Di Bartolo, 2014). During this phase, it is important that the therapist continues the exposure exercises, while anxious responses increase. Rather than reducing anxiety symptoms, an abrupt interruption during the exposure leads to counterproductive effects. That is, the frequency, duration, and severity of the anxious response could escalate (more details about the exposure procedure are found below).

Let's review this phase through Andres' case:

Terapeuta	Imagina que tu profesor te pide después de clase que expongas un tema en la siguiente sesión. ¿Qué tipo de respuestas tendrías ante tal petición? (*pedir descripción específica de las respuestas de ansiedad*).
Cliente	Le digo que tengo un viaje de trabajo importante, o el día anterior le digo que estoy muy enfermo.
Terapeuta	Exacto, el malestar sería intenso y para ello actualmente llevas a cabo una serie de estrategias para disminuir la ansiedad, como: dar excusas, dejar de asistir a clase… (*permitir que el cliente de otros ejemplos*). A esto le llamamos evitación. Estas conductas te permiten salir de la situación ansiosa y sentir un alivio inmediato. La evitación es muy poderosa y genera bienestar a corto plazo, y por tanto vuelves a engancharte en ella cada vez que una situación social que te genera ansiedad se presenta. Sin embargo, la evitación también tiene consecuencias a largo plazo, como generar mayor ansiedad, y limita de manera dramática tu interacción con otros. Por ejemplo, tu has comenzado a evitar situaciones sociales que son importantes para ti como la asistencia a clases, esto te genera alivio inmediato al aliviar tu ansiedad, el problema es que la evitación se puede volver la única manera que encuentres para manejar tu ansiedad y puede comenzar a extenderse a más situaciones en tu vida social.
Cliente	Si, entiendo, eso es lo que he hecho desde que empecé a sentirme ansioso
Terapeuta	Parte de lo que haremos en la intervención es interrumpir este ciclo invasivo de la evitación para que la ansiedad disminuya, y así vuelvas a involucrarte en las actividades que has venido dejando progresivamente. Esto se logra a través de la exposición. Esta estrategia permitirá que te pongas en contacto con las situaciones que te producen temor hasta reducir la ansiedad de manera que sientas que tienes dominio sobre lo que está pasando a tu alrededor.

Cognitive Restructuring

An important part of the CBT-SA is challenging clients' cognitions. Cognitive restructuring is guided by three principles: (a) people's responses and emotions are caused by the interpretations they have of the world; (b) interpretations are often biased, leading to cognitive distortions; and (c) CBT focuses on identifying these distortions and reinterpreting them in terms of objective facts. It is important to begin the cognitive restructuring phase, describing what the automatic thoughts (AT) and core beliefs are. This process will allow the client to make sense of the connection between their thoughts and anxiety:

> Ahora que vamos a iniciar el proceso de reestructuración cognitiva es importante que entendamos cómo los pensamientos distorsionados afectan la forma en que sentimos, pensamos y actuamos. Los pensamientos ansiosos son automáticos, sesgados y usualmente ilógicos. Interpretamos constantemente lo que está pasando basado en nuestras creencias nucleares acerca del mundo, nosotros mismos, y el futuro. Al tratarse de un proceso automático, no somos conscientes de lo que hacemos, pero los pensamientos tienen el poder de producir emociones positivas o negativas, como la ansiedad.

Recording AT is a fundamental step to establish the characteristics of clients' distortions and their "triggers" (first three columns of the thought record; Folleto C). Therapist should assist the client in identifying the automatic thoughts that maintain the problematic behaviors (i.e., all-or-nothing, overgeneralization, filtering, mind reading, magnification or minimization, emotional reasoning, "should" statement) by explaining the thought record in session. Frequently, clients struggle with keeping track of the occurrences of AT. It is highly recommended the therapist describe to the client that completing the thought record allows them to identify the causes of the SA, which will be targeted in session. In such cases where the client does not complete the thought record, the therapist should explore those factors that are interfering with its completion. The therapist might ask the client if they had problems identifying automatic thoughts, whether they set up specific times throughout the week to fill the thought record, or if external or personal events interfered with this activity.

With the purpose of initiating the process of restructuring AT and core beliefs, the therapist needs to examine along with the client the thought record (Folleto C). During cognitive restructuring sessions, the therapist formulates some questions about the social situations that triggered the AT. The goal is to reevaluate client thoughts by identifying the extent to which AT accurately describe "reality" and how they affect his/her performance in social circumstances. The therapist can modify AT through the following strategies:

1. Using Socratic dialogue (client reaches a conclusion based on the evidence)
2. Searching of evidence (contrasting thinking and objective reality)
3. Examining the advantages and disadvantages of AT
4. Designing behavioral experiments, acting "as if ..." (creating hypothetical scenarios of appropriate behavior during anxious situations)
5. Formulating alternative beliefs, using imagery techniques (i.e., creating images that modify thinking)
6. Using metaphors, asking others about their thoughts and beliefs, examining the origin of beliefs in childhood (Beck, 2011)

Subsequently, it is important that the therapist and client evaluate the level of believability of the AT and if these are useful to achieve his/her expectancies. At the end of each session, the therapist and client set up a behavioral experiment, which will allow challenging client's AT in his/her natural environment.

Cognitive restructuring ends when the client has learned to identify his automatic thoughts and core beliefs and how to modify them to produce accurate thoughts about social circumstances.

Exposure

Exposure is an essential part in the treatment of social anxiety. This phase must take between six and eight sessions, involving an ongoing and consistent practice in and out of the therapeutic setting. Exposure exercises require the cooperation of different individuals, who function as an audience to evoke anxious situations and to provide genuine feedback after client performance. The therapist must video record the client's performance in therapy to facilitate his/her practice at home, which allows him/her to generalize the effects of in-session exposure. Clients must accomplish two tasks: (a) completing exposure exercises in the natural environment and (b) watching the videos of the exposure exercises

performed in session. Here is an example of how to present the *exposure* to the client:

> Ahora que iniciaremos las sesiones de exposición es importante recordar el rol de la evitación y la extinción en el proceso de mantenimiento y cambio respectivamente. Como habíamos discutido, la evitación perpetua los patrones problemáticos en las situaciones sociales. El papel fundamental de la exposición es romper dichos patrones de manera que puedas volverte un experto enfrentando tales situaciones. Para ello es importante la práctica dentro y fuera de nuestra sesión. Al comportarte de forma diferente en la sesión, puedes empezar a aprender que la ansiedad cambia cuando te expones a situaciones temidas, aunque inicialmente haya un aparente incremento del temor. Por lo tanto, es importante que practiques estas estrategias afuera, para que puedas aprender que dichos cambios no sólo ocurren cuando lo intentamos en sesión, sino cuando lo realizas de manera similar en el ambiente natural. Es importante recordar que dejar de actuar en las situaciones sociales en las que experimentas ansiedad es otra forma de evitación, y no podemos darle la oportunidad a la ansiedad de tomar fuerza nuevamente.

Exposure exercises must be designed and adapted to the specific needs of the client. It is important that he/she understands what the expected outcome of this process is (Hofmann & Otto, 2008). The objectives of the exposure sessions are:

(a) Being aware that any social situation could be anxious provoking
(b) Attaining small goals, though the performance is not perfect
(c) Observing social situations, independently of expectations and judgments
(d) Being prepared to deal with destructive biases that may occur before, during, and after social interactions
(e) Predicting optimal levels of social performance in anxious-provoking circumstances
(f) Adapting clients' responses to the changes that may occur in those situations

Once exposure objectives are established, the therapist and client assess the different situations in which the client experiences SA. The exposure activities planner template (Hoja de Actividades para Planear la Exposición, in Spanish; Folleto D), developed by Hofmann and Otto (2008, p. 193), is a useful tool to identify the characteristics of client anxious-provoking situations. The exposure activities planner contains a series of questions that provide specific descriptions of social circumstances and behaviors that will be targeted within the exposure phase.

A hierarchy of fear and avoidance responses should be used to monitor the changes in the avoidance/escaping cycle and emotion of the client during the exposure phase (Folleto E). This hierarchy assesses the Subjective Units of Distress Scale (SUDS), which measures the degree of distress caused by anxious situations. At the beginning of each exposure session, it is necessary to administer this scale to evaluate the current subjective level of fear and avoidance produced by anxious events. In order to decrease response reactivity by the client during the first session, it is important that the therapist selects an event that the client has rated at an intermediate level on the scale. In doing this, the therapist facilitates contact with a fearful social situation that is not comfortable but won't produce damage or treatment dropout.

Starting the second session, the client should be exposed to situations that have been rated as highly anxious (SUDS > 6). The client and therapist will agree on the minimal accepted criteria to compare the progress against (e.g., 0–10), and this score will serve as a criterion for the success of the exposure phase. During these sessions, the client should report when the SUDS decreases, so that the therapist can monitor the effects of the intervention (Folleto E). The client's scores will also help the audience provide accurate feedback when the client achieves the goals proposed for each exercise.

Clients should evaluate their fear to the anxious-provoking events (SUDS 0–10) before and after their performance. They should do a brief presentation to the therapist and audience of no more than 30 s about the symptoms of anxiety, what happened during the anxious situations, and the place where they occur. The assessment of the exposure performance (Formato para evaluar la ejecución del cliente durante las sesiones de la exposición; Folleto F) allows the therapist and

audience to rate the client's performance during the exposure session. It is required that the therapist trains the audience how to provide accurate and genuine feedback once the client finishes his/her presentation. Upon completing the presentation, it is important that the audience applaud and reinforce the client performance. When a member of the audience provides negative feedback, the therapist needs to paraphrase his/her feedback into a constructive comment, turning it into a beneficial statement. This shift needs to be supported by other members of the group. For example:

> Cuando estabas presentando mantuviste contacto visual con nosotros, eso me produjo confianza sobre lo que estabas hablando (retroalimentación positiva). No obstante, algunas veces bajabas mucho la voz y no se oía claramente lo que decías (retroalimentación negativa). Dado que es un tema muy interesante, es posible que la próxima vez trates de hablar un poco más alto, con ello podría entender mejor el punto central de tu discurso (parafraseo para mejorar la siguiente presentación).

At the end of the feedback, the therapist hands over the video recording of the session to the client so he/she can watch it at home. The therapist should provide a brief description to the client about the topic he/she will present in the next session and encourage him/her to practice in front of the mirror daily. It is recommended to encourage clients to record (audio or video) the home rehearsals to provide feedback of her/his performance during the next session. Exposure sessions follow the same format during the remaining sessions.

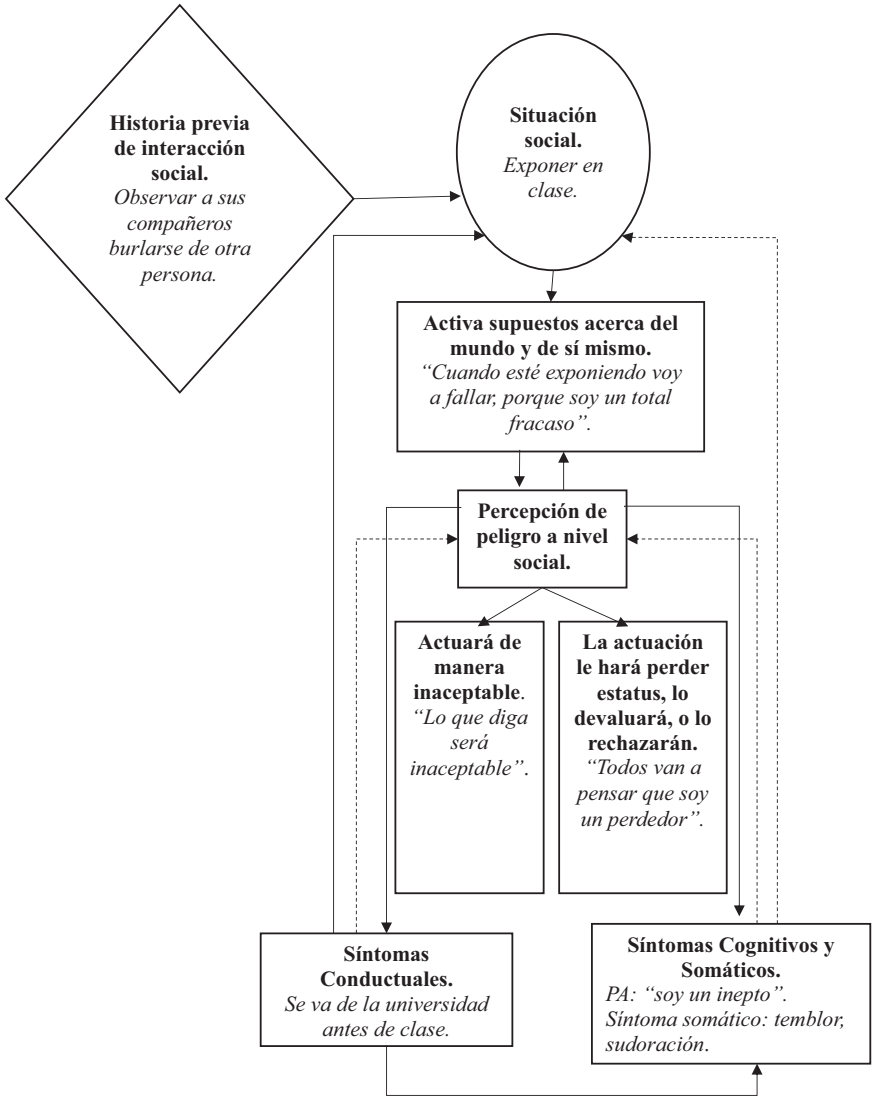
Last sessions are focused on conducting the exposure session in a natural environment such as restaurant, coffee shop, library, etc. At the end of this phase, the client should report SUDS before and after every exposure exercise. Before starting exposure, the client is encouraged to answer these questions: (a) What will be the average and maximum level of anxiety when exposed to the anxious situation? (b) What will be the result of the situation (how will others react to his/her performance)? and (c) How long will these consequences last? (Hofmann & Otto, 2008).

Relapse Prevention

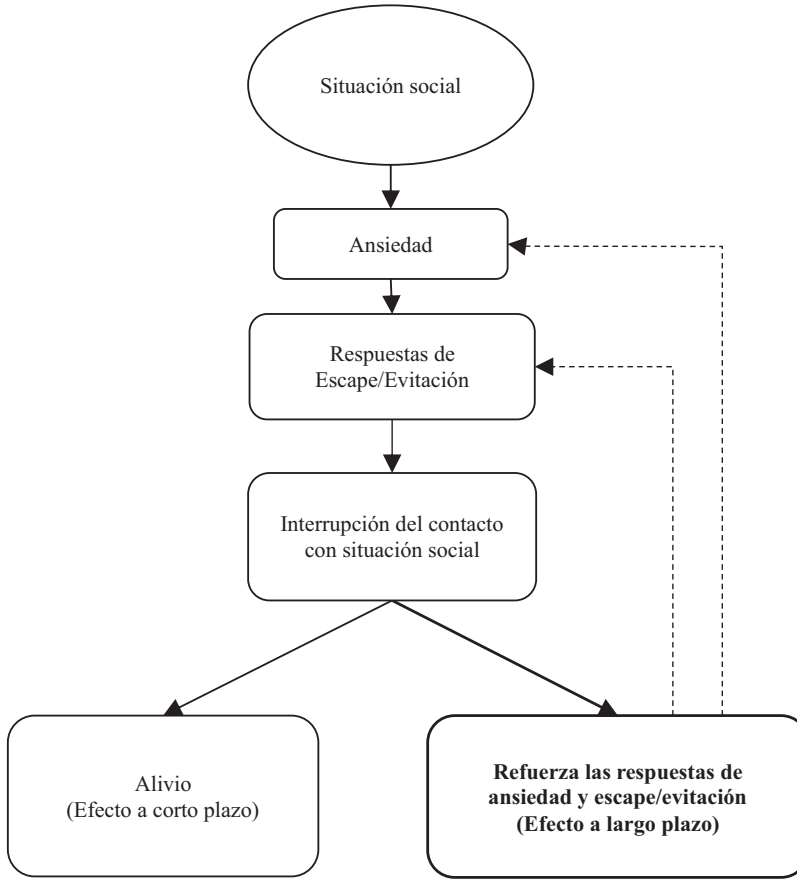
As in many psychological interventions, it is important that the therapist and the client discuss what conditions are associated with social anxiety, how to identify them, and what to do in such circumstances to prevent relapse.

Therapist should familiarize clients with relapse language. Clients need to identify events that provoke anxiety symptoms and the skills to cope with them successfully. They should learn to detect a lapse before it turns into a relapse (returning to baseline levels, prior to intervention). For this purpose, therapists and clients need to examine possible circumstances in which anxiety occurs and how to address the automatic thoughts, core beliefs, and avoidance behaviors associated with such events. It is necessary to state that lapses are an opportunity, not a failing, to re-implement the skills learned during the treatment (Folleto G).

Folleto A: Modelo de Fobia Social en el Caso de Andrés



Folleto B: Efecto de los patrones de evitación/escape en el mantenimiento de la Ansiedad Social.



Folleto C: Autorregistro de Pensamientos Automáticos

Situación ¿Qué estaba haciendo cuando me sentía ansioso?, ¿Donde estaba?, ¿Con quien estaba?	**Pensamiento Automático ¿Qué pensó inmediatamente antes de que se sintiera ansioso?**	**Emoción o Sentimiento Valore la intensidad de su emoción (0-10) Describa los síntomas fisiológicos**	**Desafiar el Pensamiento Automático ¿Cuál es la evidencia? ¿Cuál es la evidencia que la peor consecuencia ocurra?**	**Pensamiento Alternativo**
Ejemplo *Reunirse con otras personas*	*"No soy suficiente", "Soy un tonto"*	*Temblor Sudoración (5)*	*No hay evidencia: Las personas nunca mencionaron que era un tonto o insuficiente.*	*"Soy capaz de interactuar con otros"*

Folleto D: Hoja de Actividades para Planear la Exposición

Hofmann & Otto (2008)

¿Cuáles son las situaciones que mejor caracterizan los miedos de humillación o vergüenza del cliente? ¿Estas son interacciones uno a uno, pequeños grupos, o grandes grupos; informales o formales, estructurados o no-estructurados; de trabajo o sociales; en relación con un rema especifico; etc.?

Pregunta: Descríbame algunos de los escenarios sociales que más teme.

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¿Cuáles son los miedos relacionados con la humillación? ¿Estos miedos se centran en errores sociales, la aparición de síntomas, creencias de incompetencia, etc.?

Pregunta: Muchas veces, los individuos con ansiedad social temen cometer ciertos errores sociales. ¿Puede decirme algunas de las cosas que teme puedan pasar en una situación social?

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¿Los miedos de tipo social dependen fuertemente de la aparición de síntomas (tasa cardiaca, sudoración, enrojecimiento, resequedad de la garganta, etc.)?

Pregunta: ¿hay algunos síntomas que intensifiquen el miedo a sentirse avergonzado(a) cuando están presentes (tasa cardiaca, sudoración, enrojecimiento, resequedad de la garganta, etc.)? ¿Por qué estos síntomas resultan tan molestos?

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¿Cuáles son las claves de seguridad que usa el cliente?

Pregunta: ¿cuáles son esas cosas que suele hacer para sentir menos ansiedad en las situaciones sociales?

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¿Cuáles son las formas en las que le paciente elimina las actuaciones adecuadas o en las que se auto-critica después de su ejecución social?

Pregunta: ¿Qué suele decirse a sí mismo(a) después de experimentar una situación social?

Pregunta: ¿Cómo llenaría las siguientes afirmaciones?

No puedo creer que haya hecho… (en la situación social), Yo siempre…

Lo eche a perder. Soy todo (a) un…

Yo debería haber…

Pregunta: y ¿cuándo se prepare para la siguiente situación social, cuales son las cosas que le preocupan o sobre las que quiere prestar atención?

Folleto E: Escala de Ansiedad Social (SA) y Jerarquía de Miedo y Evitación

La escala de la AS	Situaciones sociales	Antes de situación de ansiedad		Después de situación de ansiedad	
		Miedo (0-100)	Evitación (0-100)	Miedo (0-100)	Evitación (0-100)
	Mi peor miedo:				
	Mi 2o. peor miedo:				
	Mi 3er. peor miedo:				
	Mi 4o. peor miedo:				
	Mi 5o. peor miedo:				
	Mi 6o. peor miedo:				
	Mi 7o. peor miedo:				
	Mi 8o. peor miedo:				
	Mi 9o. peor miedo:				
	Mi 10o. peor miedo:				

Folleto F: Formato para evaluar la ejecución del cliente durante las sesiones de exposición

Metas a alcanzar con la exposición		
Parámetros de logro		
	Antes de la exposición	**Después de la exposición**
Nivel de ansiedad (0-10)		
Descripción síntomas de los síntomas de ansiedad		
Descripción sí mismo en la situación		
Descripción el ambiente		
Descripción el discurso		

Ejemplo en el caso de Andrés

Metas a alcanzar con la exposición	*Expresar mi acuerdo con las políticas de vacunación como estrategia de prevención de enfermedades*	
Parámetros de logro	*Hablar durante 3-minutos sobre las ventajas de la vacunación en el país, mencionando los progresos y metas para el futuro de los programas de vacunación.*	
	Antes de la exposición	**Después de la exposición**
Nivel de ansiedad (0-10)	*8*	*4*
Descripción síntomas de los síntomas de ansiedad	*Sudoración*	*Sudoración*
Descripción sí mismo en la situación	*Soy incapaz*	*Soy capaz*
Descripción el ambiente	*Las personas afuera están en silencio, están esperando por mí.*	*Las personas están aplaudiendo y sonriendo ante lo que dije. Las personas dijeron que el tema fue claramente expuesto.*
Descripción el discurso	*Este contiene los pros de la vacunación, los avances hechos en los últimos años y que se necesita hacer*	*Mencione los puntos programados, sobre la importancia de la vacunación y lo que se requiere para lograr mayor cobertura.*

Folleto G: Plan para el manejo de caídas y recaídas

Situaciones asociadas a la ansiedad social		
	Habilidades para cambiar los patrones de evitación	**Habilidades para reestructurar los pensamientos y supuestos problemáticos**
Pensamientos y expectativas asociadas a la ansiedad social		
Conductas de evitación asociadas a la ansiedad social		

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