BİLİŞSEL DAVRANIŞÇI PSİKOTERAPİ ve ARAŞTIRMALAR DERGİSİ
Journal of Cognitive-Behavioral Psychotherapy and Research

P-ISSN: 2146-9490 | E-ISSN: 2636-8765

ÖZGÜN MAKALE / ORIGINAL ARTICLE

https://doi.org/10.5455/JCBPR.98679

J Cogn Behav Psychother Res 2023; 12(1), 1-9

Therapeutic Efficacy of Video Feedback in Cognitive-Behavioral Psychotherapy of Social Anxiety Disorder

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Abstract

Social anxiety disorder affects the quality of life of individuals and their functionality in professional, academic, and social dimensions adversely. Cognitive therapy is an effective treatment for social anxiety disorder (CT-SAD). This study was performed to investigate the therapeutic efficacy of video feedback in CT-SAD. The CT-SAD was applied to individuals who constituted the sample of this study (n=13). The changes in the anxiety levels of individuals and the results of cognitive behavioral psychotherapy were evaluated using the evaluation questions in the CT-SAD protocol. In the 2nd session, two social interaction experiments, including self-focused attention, and safety behaviors, were performed. These two video recordings were watched in the 3rd session with the participants. According to the data of the two videos, participants rated themselves significantly less anxious, felt that their feared social outcomes occurred to a lesser extent, and they used safety behaviors less in the second video of their social interactions than in the first video. The effect size demonstrates that the "self-focused attention and safety behaviors experiment" was useful. In the self– focused attention experiment, it was found statistically significant that individuals focused more on themselves than on the outer focus. Individuals stated that safety behaviors were not effective in reducing anxiety; they did not feel anxiety symptoms when they gave focused on attention outside, and their performance was better. Safety behavior and self-focused attention have an impact on the development and continuation of social anxiety in certain situations. It can be suggested that video feedback is an effective method with a high level of evidence in changing the negative thoughts and images of individuals with social anxiety.

Keywords: cognitive therapy, social anxiety disorder, adolescent

Öz

Sosyal Anksiyete Bozukluğunun Bilişsel Davranışçı Psikoterapisinde Video Geribildiriminin Terapötik Etkinliği

Sosyal anksiyete bozukluğu bireylerin mesleki, akademik, sosyal boyutta işlevselliğini veyaşam kalitesini olumsuz yönde etkilemektedir. Bilişsel terapi, sosyal anksiyete bozukluğu için etkili bir tedavidir (BT-SAB). Bu çalışma, BT-SAB'da video geri bildiriminin terapötik etkinliğini araştırmak için yapılmıştır. Çalışmanın örneklemini oluşturan bireylere (n=13), BT-SAB protokolü uygulanmıştır. Bireylerin kaygı düzeylerinde meydana gelen değişim ve bilişsel davranışçı psikoterapinin sonuçları BT-SAB protokolünde kullanılan değerlendirme soruları kullanılarak değerlendirilmiştir. Çalışmaya katılan tüm bireylere psikoterapi sürecinin, 2. seansında kendine-odaklı dikkat ve güvenlik davranışları deneyini içeren iki sosyal etkileşim deneyi yapılmıştır. Bu iki deneyin video kaydı3. seansda katılımcılarla birlikte izlenmiştir. İki videonun verilerine göre, katılımcılar kendilerini önemli ölçüde daha az endişeli olarak değerlendirmişlerdir. Korktukları sosyal sonuçların daha az gerçekleştiğini ve sosyal etkileşimlerinin ikinci videosunda ilk videoya göre güvenlik davranışlarını daha az kullandıklarını belirtmişlerdir. Kendine-odaklı dikkat ve güvenlik davranışları deneyinin yararlı olduğunu gösteren etki büyüklüğü geniş düzey bulunmuştur. Kendine-odaklı dikkat deneyinde, bireylerin dış odağa göre kendilerine daha çok odaklandığı istatistiksel olarak anlamlı bulunmuştur. Bireyler güvenlik davranışlarının kaygının azaltılmasında etkili olmadığını, dikkat odağını dışarıya verdiklerinde kaygı belirtilerini hissetmediklerini ve performanslarının daha iyi olduğunu belirtmişlerdir. Belirli durumlarda sosyal kaygının oluşmasında ve devam etmesinde güvenlik davranışı yapmanın ve dikkati kendine odaklamanın etkisi bulunmaktadır. Video geribildirimin, sosyal kaygısı olan bireylerin olumsuz düşünce ve imajlarını değiştirmede kanıt düzeyi yüksek etkili bir yöntem olabilir.

Anahtar Kelimeler: bilişsel terapi, sosyal anksiyete bozukluğu, ergenlik

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Received / *Geliş:* July 17, 2021
Accepted / *Kabul:* September 18, 2022
Online published / *Çevrimiçi yayın:* October 16, 2022

Cite this article as: Eskiyurt, Y., Coşkun, N., Öğütlü, H., Türkçapar, H.M. (2023). Therapeutic Efficacy of Video Feedback in Cognitive-Behavioral Psychotherapy of Social Anxiety Disorder. J Cogn Behav Psychother Res; 12(1), 1-9. https://doi.org/10.5455/JCBPR.98679

INTRODUCTION

Social anxiety disorder (SAD) is defined as an extreme and persistent fear arising from one or more social situations in which disgrace or a sense of shame may occur. Anxiety stems from the fear of being examined and evaluated by others negatively, which may lead to a sense of shame, humiliation, and embarrassment (Clark and Beck, 2010; Hofmann and DiBartolo, 2010). Individuals with SAD either avoid these social situations that cause them anxiety or experience these situations by bearing significant distress (Leahy and Holland, 2009). Social anxiety disorder affects the quality of life of individuals and their functionality in professional, academic, and social dimensions adversely (Hofmann and DiBartolo, 2010). It has been suggested that 13% of people might experience distress in a period of their lives due to social anxiety (Kessler et al., 2012).

In the meta-analysis study performed by Mayo-Wilson et al. (2014), they aimed to reveal the most effective intervention method in the treatment of social anxiety disorder in adults and compare these interventions. The findings showed that individual cognitive– behavioral psychotherapy was more effective than placebos, and comparisons between psychological interventions demonstrated that individual cognitive-behavioral psychotherapy was more effective than psychodynamic psychotherapy and other psychological therapies (interpersonal therapies, mindfulness, and supportive therapies). The findings of a randomized controlled study by Clark et al. (2006) showed that cognitive therapy and exposure-applied relaxation methods were effective treatments for social anxiety. As a result of the comparison of the two methods, cognitive therapy seems to be superior to the exposure-applied relaxation method in social anxiety measurements. Stangier et al. (2011) divided individuals who were diagnosed with social anxiety disorder into three groups and compared the effectiveness of treatment in individual cognitive therapy, interpersonal psychotherapy, and wait-list groups in the short and long term. The findings of the study showed that cognitive therapy and interpersonal psychotherapy were effective treatments for social anxiety disorder. Both treatments were associated with the significantly greater improvement compared to the wait– list group. However, in the measurement results of the Liebowitz Social Anxiety Scale (LSAS), cognitive therapy was found significantly superior to interpersonal psychotherapy (Stangier et al., 2011).

Hoffmann defined several cognitive factors that maintain social anxiety disorder. These include high-perceived social standards, poorly defined social goals, heightened self– focused attention, negative self-perception, high estimated social costs, low perceived emotional control, perceived poor social skills, avoidance and use of safety behaviors, and post-event rumination (Hofmann, 2007). Another cognitive model proposed for social anxiety was presented in 1995 by Clark and Wells. The negative thoughts include assumptions about what will happen during a socially anxiety-provoking situation. The occurrence and visibility of physical symptoms, the thoughts about performance, and perceived reactions of the audience to these elements.

Suggested interventions for high-perceived social standards and poorly defined goals are discussed with the help of Socratic questioning. There isn't any specific research to examine the effectiveness of this approach. There is some other research that points out the importance of self-focused attention in social anxiety (Bögels and Lamers, 2002; Jakymin and Harris, 2012). In a controlled clinical trial 72% of the attention training group, compared to 11% of the control group, no longer met social anxiety disorder diagnosis and, after 4 months, maintained improvement (Schmidt et al., 2009). There are also internet delivered attention training programs but their effects are still a matter of debate (Kuckertz et al., 2014). In another study, the methods of imagery rescripting and video feedback were found to be effective to decrease social anxiety through modifying self-imagery (Ahn and Kwon, 2018). Negative self-perception or self-impression is included in all cognitive social anxiety models.

Video feedback, in this sense, is a behavioral experiment and a cognitive intervention. There are numerous studies showing the effectiveness of video feedback to decrease social anxiety (Warnock et al., 2017; Parr et al., 2009; Rodebaugh, 2004). Safety behaviors are known for maintaining dysfunctional beliefs in SAD (Clark and Wells, 1995). Exposure with dropping safety behavior was found to be effective to decrease social anxiety (Morgan and Raffle, 1999; Furukawa et al., 2009).

The cognitive model of social anxiety and the treatment program, which were established by Clark and Wells (1995), involved some elements. These elements included a) the development of a cognitive model involving negative thoughts, self-images, attention focus, safety behaviors, and anxiety symptoms specific to the individual who was diagnosed with SAD; b) the experiment to show the negative effects of self-focused attention and

safety behaviors; c) video feedback to change negative self-imagery; d) external focus training behavioral experiments to change the patient's negative beliefs; e) questionnaires administered to discover other people's views on feared outcomes; f) and memory work to reduce the impact of social trauma experiences. It has been suggested that video feedback is very effective in the therapy process. With video feedback, it is aimed at patients with social anxiety disorder to resist their negative self-images. Thanks to this technique, individuals have a more realistic view of how they look to other people. It has been determined in the previous studies that following the video feedback, patients' self-evaluation of their performance improved, and they developed a more realistic impression of how they looked to others (McManus et al., 2009; Warnock-Parkes et al., 2017). Moreover, it has been concluded that it is an effective method in reducing the symptoms of SAD and demonstrating the role of the patient's self-focused attention, safety behavior, s and negative self-impression on the continuation of SAD (McManus et al., 2009).

Previous studies have revealed that self-focused attention, safety behaviors experiment, and video feedback have therapeutic effects in the treatment of social anxiety. It is stated that patients with social anxiety disorder have processing bias, which makes it difficult for them to see the difference between their negative self-perceptions and the way they appear in the video. To overcome these processing biases, beholding video recordings and discussing what patients see is recommended as an effective method. This study was performed to investigate the effects of the "self-focused attention and safety behaviors experiment" and "video feedback", which were applied in accordance with the CT-SAD protocol in the sample of Turkey.

METHOD

Ethical approval was obtained from the Ankara Yildirim Beyazit University Clinical Research Ethics Committee (No: 12, Date: 15.03.2021). Informed consent was obtained from the participants before their participation in this study. Individual cognitive-behavioral psychotherapy was administered to the individuals who were included in this study in a single center between July 2019 and March 2020. The inclusion criteria of this study were defined as being the age of 18 or older, volunteering to participate in this study, having the clinical features of SAD, not having any diagnosis other than SAD, and not receiving any medication. All authors of this research article have received cognitive behavioral therapy (CBT) training and have been certified by ACT.

The CT-SAD protocol, which was developed by Clark et al. (2006), was applied to individuals who constituted the sample of this study (n=13). "Self-focused attention and safety behaviors experiment" was applied to all individuals, who were included in this study in the 2nd session of the psychotherapy process, and "video feedback" intervention was performed in the 3rd session.

In the 2nd session, two social interaction experiments, including self-focused attention and safety behaviors, were performed on the individuals who were included in this study. These two video recordings were watched in the 3rd session with the participants. In the 2nd session, individuals had two different conversations with a stranger they did not know. In the first conversation, the participants were asked to talk about doing safety behaviors and focusing all their attention on the negative self-image in their minds. In the second conversation, they were asked not to engage in safety behaviors and to pay as much attention to the content of the conversation as possible. In order for this conversation to be natural and similar to real life, the stranger who had a conversation with the individuals participating in the study was not informed about the symptoms of the individual. A different stooge was interviewed with each participant. The content of the conversation consists of daily topics such as the participant's educational life and social life. Each conversation took place between 3–5 minutes. After the first conversation was over, instructions were given on how to continue the second conversation after the participants' assumptions were evaluated. Following the self-focused attention and safety behaviors experiment was completed, the assessment queries, which are used in the CT-SAD protocol and were developed by Leigh and Clark (2018), were administered to the individuals for both sessions. In session 3, video feedback of the two social interactions was made to assist young people in comparing "the thoughts of individuals on what impression they make" with "what impression they made actually". The participants were re-assessed after watching the videos.

The results of individual cognitive-behavioral psychotherapy were assessed via administering the assessment queries, which were used in the CT-SAD protocol developed by LSAS, Leigh and Clark (2018), and the individuals' statements related to their symptoms.

Self-Perception: Before watching each video, individuals were asked assessment queries, which are used in the CT-SAD protocol developed by Leigh and Clark (2018). Some of these assessment queries involve the anxiety level of the individuals, the focus of attention, whether they have a self-image in their mind, to what extent they perform safety behavior, to what extent their social fears are realized, and anxiety symptoms. Scoring is between 0–100. For instance, 0 means not anxious at all, while 100 means the most anxious you have ever felt. Scoring was repeated after watching and discussing each video with the participants.

Liebowitz Social Anxiety Scale: The Turkish adaptation studies of the scale, which was developed by Liebowitz et al. (1987) to investigate the severity of anxiety and avoidance associated with social situations, were performed by Soykan, Ozguven, and Gencoz (2003). The scale consists of 24 items and has two dimensions, anxiety and avoidance. The total scale score ranges between 48 and 192. A higher score indicates that social anxiety and avoidance behavior become more severe. The test-retest reliability coefficient of the scale was r=0.97. The Cronbach Alpha coefficient of the social anxiety subscale was r=0.96, and the Cronbach Alpha coefficient of the social avoidance subscale was r=0.95. The Cronbach Alpha coefficient of the whole scale is 0.98. The Cronbach Alpha coefficient of the scale ranges between 0.92 and 0.81.

Statistical Analysis: The software of IBM SPSS Statistics, version 21.0, was used to assess the quantitative data in this study. Of the statistical methods, the Shapiro-Wilk test, number, percentage, mean, standard deviation, and dependent t-test were used. The results were considered statistically significant at $p<0.05$. Effect size measurements were utilized to assess the significance of the obtained results in practice. To systematically analyze the feelings and thoughts, which were stated by individuals about the problem, the data obtained from the voice recordings were transcribed. The frequency of data on the common themes of the participants is given as a percentage. To increase the validity of authenticity, some of the statements of the individuals who were included in this study were written directly and presented as the results of this research (Braun and Clarke, 2006).

RESULTS

Results of the Self-Focused Attention and Safety Behaviors Experiment Performed in the 2nd Session

In this study, of the 13 individuals who were diagnosed with Social Anxiety Disorder, 76.9% (n=10) were female and 23.1% (n=3) were male. The mean age of the individuals was 19.54±1.45, and the mean LSAS total score before psychotherapy was 107.62±14.80, while the LSAS anxiety sub-dimension was 55.23±7.48, and the LSAS avoidance sub-dimension was 52.38±8.01. During the video sessions made in the 2nd session, it was determined that 46.2% of the individuals experienced anxiety symptoms, such as sweating and tremors, 38.5% of them had blush on their face, and 23.1% of them experienced an increase in heart rate (see Table 2).

The mean scores of the individuals regarding their anxiety levels, the use of safety behaviors, and to what extent their social fears occurred in the 1st video session and 2nd video session in the 2nd session are presented in Table 1. It was determined that the difference between the scores obtained in the 1st video session and 2nd video session was statistically significant ($p<0.05$). The effect size demonstrates that the "Self-focused attention and safety behaviors experiment" was useful ($r>0.50$) (see Table 1).

In the 2nd session, the mean value of self-focused attention in the 1st video session was 1.69±0.94, while the mean value of focusing outside/on the content of the conversation was 1.31±1.25 in the 2nd video session. In the

Table 1: Comparison of participants' ratings of 2nd session, in the with and the without self-focus and safety behaviors conditions

		Self-focus and safety behaviorscondition		*Statistical analysis*	*Effect size Cohen's d*
Measure	*n*	*with*	*without*		
Mean score of feeling anxious (0–100)	13	61.15±6.30	46.15±7.29	t=4.416 p=0.001	2.20 r=0.74
Mean score of social fear belief (0–100)	13	61.15±6.25	45.77±7.06	t=2.507 p=0.028	2.30 r=0.75
Meanscore of safety behaviors (0–100)	13	77.31±5.38	37.31±8.85	t=4.774 p=0.001	5.46 r=0.93

*p<0.05

Table 2: Anxiety symptoms

Anxiety symptoms	*Presence of symptoms n (%)*	
Increased heart rate	23.1%	3
Sweating	46.2%	6
Tremors (in the hands)	46.2%	6
Blushing	38.5%	5
Hot flashes	15.4%	2
Dry throat	7.7%	1
Choking in the throat	7.7%	1
Body spasm	15.4%	2
Restlessness	15.4%	2
Stomache ache	7.7%	1

self-focused attention experiment, it was found statistically significant that individuals focused more on themselves than focusing on the outer focus (z=3.201, p=0.001). It can be said that the manipulation was successful. 61.5% of the individuals in the 1st video session and 30.8% in the 2nd video session stated that images related to their anxious appearance were passing through their minds. This difference was statistically significant (z=2.00, p=0.046). It was concluded that the experiment was successful in showing the negative effects of self-focus and safety behaviors.

Results of the Video Feedback Performed in the 3rd Session

In the video feedback performed in the 3rd session, all of the individuals stated that safety behaviors were not beneficial in lessening anxiety symptoms and that what they felt was different from what they saw. All of the individuals stated that they felt more comfortable in the 2nd video session and performed better than in the 1st video session. They concluded that when the anxiety level increased, the images that passed through their minds were not seen in the video, and their thoughts were irrational. They expressed that the symptoms they observed in themselves and/or the impressions they gave to the other party were different (see Table 3).

"In fact, the safety behavior didn't protect me; it just gave me away."

"My performance is better in the 2nd video session. It increases more when I focus on my physical symptoms."

"It's good to watch from outside. Because I notice that many things I felt are not actually like that. The image that comes alive in my mind and feelings are not seen in the video."

"When I pay attention to the outside, not to myself, the bad thoughts in my mind fade away. It is nice to see that the tremor of my hand based on my mind does not match the tremor that actually happens."

The individuals stated that taking a video and talking with the opposite sex during the sessions increased their anxiety, and they had difficulty continuing the conversation as nothing came to their minds to ask questions.

DISCUSSION

In this study, CBT intervention was performed on young individuals with social anxiety. The effects of the "self-focused attention and safety behaviors experiment" and "video feedback" were examined in accordance with the CT-SAD protocol. Following the self-focused attention and safety behaviors experiment, individuals stated that safety behaviors were not effective in reducing anxiety; they did not feel anxiety symptoms when they gave the focus on attention outside, and their performance was better. They learned that safety behavior and self-focused attention had an impact on the development and continuation of social anxiety in certain situations.

Safety behaviors are employed by individuals with social anxiety to prevent a feared outcome from occurring. Safety behaviors are reasonable if the feared outcomes are true. However, if the fear is not true, safety behavior could be a problem. One of the negative consequences of safety behaviors is that it prevents the individual from discovering that the feared outcome is unlikely to occur. Thanks to the video feedback, individuals with social anxiety are enabled to see their own behavior in the existing context (Clark and Wells, 1995; Leigh and Clark, 2018). McManus et al.'s (2009) findings suggest that safety behaviors have a non-helpful effect. It was determined that displaying self-focused attention and safety behaviors caused individuals with social anxiety to feel more anxious, consider their performance worse, think that they seemed more anxious, increase the likelihood of negative images, and think that social fears were more likely to occur. Warnock-Parkes et al. (2017) found that video feedback was considerably effective in changing negative self-perceptions, and social anxiety decreased significantly in the latter weeks of the therapy process. A similar protocol was also performed

Table 3: Video feedback

Numbers	*An image of how the client came across*	*A self-focus, image of myself*	*The stooge's feedback about the experiment*	*The client's feedback about the experiment*
1	Poor and worried impression	Ignorant-poor-loser-retarded	He/she looks like a calm, serene person. I thought he/she was a hesitant person because he/she didn't spontaneously ask questions. I may not have given him/her the opportunity, as I always asked questions. I noticed that he/she was strained, but as the session progressed, his/her appearance became more comfortable. He/she was tightening the veil in him/her hand. It drew my attention that he/she made eye contact. Facial blushing and foot tremors did not catch my attention.	"In fact, the safety behavior didn't protect me, it just gave me away." My feelings and things I saw were not the same, I was not anxious, actually. I don't look piteous in the videos. My thoughts are not real.
2	The impression of a cold and hard facial expression	A helpless and timid character who is incapable of expressing herself/himself	Quiet, inoffensive. He/she tightened himself/herself to be comfortable. Focusing and eye contact were good. I did not see himself/herself anxious. He/she was more comfortable in the 2nd video. I didn't feel anything negative about him/her.	Thoughts and facts are quite different things. I recognized by experiencing that the thoughts and facts are completely different. In fact, my thoughts were not real. I made a very different impression than I thought. If I let it flow, my stress symptoms subside. I felt much more comfortable when I let it flow. "My performance is better in the 2nd video. It increases more when I focus on my physical symptoms." The safety behaviors, which I did to hide my stress, made everything clearer. I noticed that I was in control. All the negative things I think about myself are actually not real. Most of them are not observed and noticed. The things I observe are not perceived that way from the other side.
3	He/she considers me as a person who is helpless and incapable of expressing himself and who can't say his name because of excitement	Head bowed-collapsed-fluttering-helpless. Embarrassed-ashamed	He/she always let me speak and ask questions. He/she talks a little slow. Nothing caught my attention about her/his appearance. Something like excitement, embarrassment didn't catch my attention. While chatting, I usually asked questions, so I think he/she is timid.	It was good to watch from outside. Because I notice that many things I felt are not actually like that. The image that comes alive in my mind and feelings are not seen in the video.
4	A quiet girl who doesn't speak, don't react.	Someone with trembling hands, trying to breathe, red ears, who is timid-crybaby.	He/she was more comfortable in the 2nd video. In the 1st video, he/she rotated the chair too much. He/she was willing to talk as the conversation progressed. He/she did well mostly. He/she asked a question in the 2nd video. Nothing negative caught my attention.	I was more comfortable when I focused on the outside. I have no problem when I focus on what I do. My anxiety increases when I think of "What does the other person think for me?Am I disgraced?" Safety behavior was not helping me, actually. I could notice this distinction in these two videos. When I pay attention to the outside, not to myself, the bad thoughts in my mind fade away. It is nice to see that the tremor of my hand based on my perception does not match the tremor that actually happens."
5	I gave an anxious impression.	Someone cold and timid.	He/she gave the impression of a good person. I would like to have such a friend as he/she gives candid responses to my questions. He/she has a self-confident posture. His/her tone is very gentle; he/she is afraid to speak. He/she left a positive impression on me.	It got better when I focused on the outside; it worked. I felt my hands weren't shaking. In the second video, I became more comfortable, I forgot the symptoms on my body. Safety behavior hasn't worked; it's not a pleasant sight to constantly pay attention to my body. Actually, everything was going on in my mind. It was not perceived that way from the outside.

Table 3 Continuation: Video feedback

Numbers	*An image of how the client came across*	*A self-focus, image of myself*	*The stooge's feedback about the experiment*	*The client's feedback about the experiment*
6	Unassured, quiet, unable to speak.	Introverted, collapsed Hunchbacked, strained.	He/she looks like a good person. Nothing negative caught my attention. As he/she said during the interview that he/she did not like to talk very much, I thought he/she was a quiet person. Regarding his/her external vision, I only noticed that he/she was wearing glasses.	What I felt was not the same as what was happening actually. It was not clear from the outside that I was strained.
7	I made a silly, funny, excited, humiliated impression.	Someone with a flushed face and tangled hands.	He/she seemed like a friendly person. Occasionally he/she glanced away. She/he left a positive impression on me; nothing caught my attention.	It is not what I imagined, what I pictured in my mind. I am quite self– critical. I am not blushed. I'm more comfortable in the second video. It wasn't as disgraceful as I had in mind. Safety behaviors have never relieved my anxiety. I haven't used my hands much and my speech is smooth. When viewed from the outside, I don't look like I imagined.
8	I made an uneasy impression.	He/she's a tight, shy person.	I understood from the content of his/her speech that he/she had a structure that avoided speaking in public. He/she spoke with a smile on his/her face. He/she played too much with his/her hands. He/she turned too much in the chair. He/she stretched his/her legs. His/her face was slightly red.	In the 1st video, I focused on myself by performing the safety behaviors; it is evident that I was anxious. It seems that when I focused on myself, my anxiety increased much more. I didn't listen to the conversation either. The safety behavior made my anxiety more obvious. I'm more comfortable in the second video.
9	Embarrassed, anxious, someone who doesn't want to talk.	A person who tightens his hands, with blushed face, and who is taciturn.	I got a very good aura from him/her. If we were in the same setting with him/her, we could talk to him/her well. He/she could be a little more audacious. He/she is a reliable person in his/her daily life.	I felt more comfortable in the 2nd video. Because I didn't think about myself. When I focused outside, I forgot that my hands were shaking and that I was embarrassed. Safety behaviors make me feel comfortable but don't conceal my anxiety. The safety behavior has not reached its goal. What I have thought and what I have seen are not the same.
10	A timid impression.	Someone hunched over, playing with his hands.	In general, I got a positive impression. I didn't feel anything negative. He/she is less talkative or a little shy compared to me. It might be because we met for the first time. Nothing special happened to my attention about his/her behavior.	I felt more comfortable in the 2nd video. I was more comfortable when I focused on the outside. I don't seem like in my own mind.
11	She may get bored from our conversation.	Someone with a shrunken body, shrunken face, and blushed face.	He/she was a bit excited and nervous. It is likely that he/ she was excited while chatting because he/she is of the opposite sex. I think he/she is a well-intentioned and kind person. I did not find his/her behavior disturbing.	What's happening in my mind is not the same as what's actually happening. It doesn't have a consistent side. I don't care too much about the thoughts in my mind anymore. The safety behavior did not serve my purpose to dampen my excitement.
12	I gave an anxious impression.	Blushed and timid, like a robot.	I gave the impression of a kind, nice person. I thought he/she had a cold personality in the 1st video, but he/she acted more candidly in the 2nd video. We laughed together. He/she continued the conversation.	I was more comfortable in the 2nd video. I am not like the image in my mind. When I focused on myself in the 1st video, I could not pay attention to the conversation and I was more anxious. However, in 2nd video, I focused on the conversation, and I was more comfortable. Actually, safety behavior did not protect me from getting excited.
13	A timid impression.	A person who does not make eye contact, strained, with a flushed face.	He/she looks like a gentleman with a decent character. He/she made me feel like a calm person. A good person. I think he/she needs to express himself/herself a little more and join the conversation.	I was more comfortable in the 2nd video. I saw that it was not what I felt. After watching the videos, I noticed that it wasn't like what I thought. I feel so good. Safety behavior gives away the things that I don't want.

in video feedback in Stangier et al.'s (2011) study. It was determined that individuals who received CBT had a significant reduction in social anxiety symptoms. The results of our study are consistent with the findings of the studies reviewed. Self-focused attention and safety behavior experiment and video feedback have a significant impact on the therapy processes of individuals with social anxiety.

Leigh and Clark (2016) applied the CT-SAD protocol in the treatment process of young individuals aged between 11 and 17 years. Significant improvements were observed in thoughts, beliefs, and safety behaviors related to social anxiety in the study. There has been an improvement in the functionality of individuals, such as classroom concentration, school attendance, and social participation. After the self-focused attention and safety behaviors experiment in the 2nd session, individuals discovered that their anxiety increased when they focused on themselves. The results of the study, in which the CT-SAD protocol was performed with different age groups, support the findings of our study. When individuals with SAD perform safety behaviors that have become habitual during social interaction and direct their attention focus to them, their anxiety levels increase further (Leigh and Clark, 2016).

In this study, the "self-focused attention and safety behaviors experiment" and "video feedback" experiment were performed on individuals with social anxiety as an element of the therapy processes. The obtained results are based on the statements of the individuals, and the small sample size is one of the limitations of this study. Other limitations of our study are that SCID assessment was not performed on the participants and the absence of a control group. Factors, such as video recording of experiments, and cultural and individual characteristics could impact the anxiety level of the individual during the experiment.

In this in-session experiment, self-focused safety behaviors were used as a therapeutic maneuver. At the end of the experiment, the individual's cognitions were tested through evidence review with video feedback. In our study, it was observed that the self-confidence and motivation of individuals with SAD increased after having video feedback during the psychotherapy process. Individuals with SAD had the opportunity to discover the effects of self-focused attention on daily life activities through the experiment. They learned from the video feedback how negative thoughts and images passing through their minds are reflected in external reality. They gained insight into the role of safety behaviors in maintaining anxiety. It was observed that the individuals attended the 4th session more willingly. The findings obtained in this study suggest performing the "Self-focused attention and safety behaviors experiment" and providing "video feedback" in the CBT protocol for SAD. There is a need for larger studies with children and adolescent patients investigating the significance of "video feedback" in the SAD-CBT protocol.

Ethical Standards and Informed Consent

Additional informed consent was obtained from all individuals for whom identifying information is included in this article.

Ethics Committee Approval: The study was approved by the Clinical Research Ethics Committee of Ankara Yıldırım Beyazıt University (date and number of approval: 15.03.2021 / 12).

Informed Consent: Informed consent was obtained from all individual participants included in the study.

Peer-review: Externally peer-reviewed.

Conflict of Interest: The authors declare no conflict of interest.

Financial Disclosure: No financial disclosure was received.

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