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Conducting Exposure-Based Groups via Telehealth for Adolescents and Young Adults With Social Anxiety Disorder

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The rapid spread of COVID-19 and subsequent social distancing measures posed unprecedented challenges in providing mental health care and a swift transition of services to telehealth platforms. Social distancing measures create unique concerns for young people with social anxiety disorder who already struggle with social connection and isolation; therefore, the continuation of care via telehealth platforms is especially important for this population. To date, there is little literature regarding use of telehealth groups for this population and the current commentary aims to fill in this gap in the literature while also providing general guidelines for telehealth groups. The commentary discusses the delivery of an exposure-based cognitive behavioral therapy group for adolescents and young adults via telehealth and provides considerations, challenges, and benefits of conducting a group through a telehealth platform. In conjunction with clinically relevant examples and in-depth exposure discussions, we aim to provide guidance for youth-focused practitioners who are considering conducting groups in a telehealth format for a range of presentations.

The COVID-19 pandemic is an unprecedented public health threat that has led to strict social isolation measures to decrease its rapid spread (World Health Organization [WHO], 2020). With an emphasis on social isolation, the COVID-19 pandemic presents a constellation of unique concerns for individuals with social anxiety disorder (SAD). SAD is a common and chronic mental illness that has serious personal, interpersonal, and economic costs (Aderka et al., 2012; Kessler et al., 2005; Ruscio et al., 2008). SAD is characterized by excessive fear of negative social evaluation that leads to physiological arousal and avoidance of social interactions and/or performance situations where negative evaluation may occur (American Psychiatric Association [APA], 2013). For adolescents, commonly feared situations include participating in class, speaking with new peers at lunch, placing an order at a restaurant, and musical or athletic performances (Burstein et al., 2011). For older teens and young adults with SAD, public speaking,

job interviews, assertiveness situations, and dating are often feared and avoided (Ruscio et al., 2008).

Cognitive behavior therapy (CBT) models have well established that avoidance plays a key role in the development and maintenance of SAD (Clark, 2005; Clark & Wells, 1995; Hofmann, 2007; Rapee & Heimberg, 1997), as it is through confronting feared scenarios that one learns that he or she can manage distress, that social fears (e.g., “Everyone will laugh at me”) may not be accurate, and/or that one can manage and recover from potentially negative experiences. Prolonged avoidance and lack of treatment can lead to significant functional impairment, including academic and occupational underachievement, limited social relationships, and long-term dependence on caregivers (Aderka et al., 2012). Therefore, the social distance necessary to reduce the spread of COVID-19 (e.g., not going to a party) can have significant deleterious effects for youth and young adults with SAD. Social distancing measures not only limit the frequency of social opportunities, but also increase the ease of avoiding social opportunities. With the increased ease of avoidance, individuals with SAD may not identify the need to pursue treatment and the exacerbating effects of

Keywords: telehealth; social anxiety; youth; exposure-based group; telehealth group

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prolonged avoidance may make the transition back to in-person interactions much more challenging.

Research supports the use of exposure-based CBT for reducing SAD symptoms in individual (Acarturk et al., 2009; Rodebaugh et al., 2004) and group (Heimberg et al., 1990; Heimberg et al., 1993) formats for both youth (Higa-McMillan et al., 2016; Herbert et al., 2009; Hollon & Beck, 2013) and young adults (Barkowski et al., 2016). Specifically, CBT for SAD targets behavioral, cognitive, and affective avoidance using exposure techniques (Clark, 2005). These techniques prompt the patient to repeatedly approach feared stimuli and, therefore, habituate to or learn to tolerate fear responses (Eckman & Shean, 1997) and/or disconfirm fear-based beliefs (i.e., inhibitory learning; Craske et al., 2014).

CBT has also been shown to be as effective for SAD in a group format (Heimberg et al., 1990; Heimberg et al., 1993) for adolescents (Herbert et al., 2009) and adults (Barkowski et al., 2016). A group format offers a cost- and time-effective option for both the provider and patients, while simultaneously providing additional opportunities for group cohesion (Yalom, 1995). Changes in group cohesion, or the “we-ness” or connection felt among group members (Yalom, 1995), has been shown to be associated with changes in treatment outcome measures (Taube-Schiff et al., 2007). More specifically, a significant relationship has been found between change in group cohesion (i.e., increase in group cohesion from the midpoint of group treatment to the endpoint of group treatment) and social anxiety and comorbid symptom reduction as well as improvements in functional impairment (Taube-Schiff et al., 2007). Groups are particularly beneficial for individuals with SAD because group-based exposure exercises, such as giving a presentation or engaging in small-talk with peers, offer an ecologically valid context for practicing and testing skills and allow for receiving and giving feedback with similar-aged peers.

While effective treatments for SAD exist, the pandemic has led to changes in the scope of treatment and a transition to telehealth platforms. Over the last two decades, telehealth platforms have been developed and utilized to provide evidence-based treatments for a broad spectrum of disorders (Gros et al., 2013) and have been shown to increase accessibility to providers and decrease associated costs with in-person treatment (e.g., transportation, missed work; Harvey & Gumpert, 2015; Trott & Blignault, 1998). Recent randomized controlled trials (RCTs) and meta-analyses have demonstrated that individual CBT delivered via telehealth is as effective in alleviating symptoms as in-person treatment for adults with depression

(Osenbach et al., 2013), PTSD (Yuen et al., 2015), eating disorders (Mitchell et al., 2008) and comorbid mood and anxiety disorders (Stubbings et al., 2013). For SAD specifically, RCTs of individual CBT via telehealth for adults have also demonstrated promising results, yet the research does not focus on synchronous (i.e., real-time) telehealth and exclusively includes stand-alone, self-help formats that incorporate cognitive restructuring and behavioral experiments for adults (Botella et al., 2010; McCall et al., 2018). The research on telehealth with youth is more limited. A small number of pilot studies have demonstrated the efficacy of individual CBT via telehealth in alleviating symptoms in trauma-related disorders (Stewart et al., 2017; Stewart et al., 2020) and comorbid anxiety and autism spectrum disorder (Hepburn et al., 2016). A pilot study conducted by Carpenter et al. (2018) found that family-based CBT via telehealth for children with anxiety disorders was effective in reducing anxiety symptoms and parental accommodation. In addition, a recent publication by Dueweke et al. (2020) provides resources and recommendations for engaging in individual trauma-focused CBT via telehealth with children and adolescents. To our knowledge, there is currently no published research or guidance on individual CBT via telehealth for SAD in youth or young adult populations.

Most research on telehealth treatment has either focused on individual therapy or general group therapy as a supportive healthcare service. In a 2012 systematic review on the feasibility, satisfaction, and outcomes of telehealth treatment using videoconferencing platforms, only 7 of the 42 empirical articles focused on a group therapy format (Backhaus et al., 2012), despite studies demonstrating group therapy effectiveness for a range of conditions, including depression and anxiety (Khatri et al., 2014), PTSD (Frueh et al., 2007; Morland et al., 2004), and comorbid anger and PTSD (Morland et al., 2010). In fact, the aforementioned 2012 review (Backhaus et al., 2012) suggested that telehealth psychotherapy treatment is comparable to in-person psychotherapy, while a subsequent 2019 systematic review confirmed that currently there is no evidence suggesting that either telehealth group-based treatment or in-person group-based treatment is superior to the other in terms of outcomes (Gentry et al., 2019). In addition to outcomes, it is important to consider group cohesion, a theorized primary mechanism of change in group therapy. A recent pilot study examined group experience and cohesion in a synchronous Dialectical Behavior Therapy (DBT) skills group for adults via telehealth, in comparison to an in-person format (Lopez et al., 2020). Results demonstrated significant differences in group cohesion, with telehealth

participants reporting feeling less connected to other group members. Still, the telehealth participants felt equally connected to the group leader and attendance was significantly better when compared to the in-person group. One paper by [Sansom-Daly et al. \(2015\)](#) recognized the ethical and clinical challenges in running a CBT group via telehealth for adolescents and young adults with cancer. Challenges centered on managing difficult conversations about cancer-related experiences and managing risk without face-to-face contact. While the authors do not present empirical data on the effects of the telehealth group on specific outcomes, they discuss that benefits of delivering the treatment outweighed the potential challenges and risks for a population considered vulnerable. The current commentary has similar aims and considers youth and young adults with SAD a vulnerable population during the COVID-19 pandemic.

To date, there is a clear gap in the literature on telehealth groups for SAD. There is a need for an empirical discussion of applying exposure-based CBT for SAD to a telehealth group format. The aim of the current commentary is not to present a novel treatment; instead, we aim to fill a gap in the literature and provide guidance for conducting these groups. We, along with many others, abruptly transitioned to a telehealth format and will discuss important considerations, challenges, and recommendations based on our experience. Given that now it is more important than ever to publish on providing accessible and evidence-based treatments, our goal is to provide clinical examples that will ultimately complement empirical studies for telehealth adaptations for SAD.

Overview of Telehealth Groups

Our clinic is a specialty anxiety clinic within a larger academic medical center located in an urban setting. Typical CBT groups for SAD in our clinic include 6–8 group members, 1 group leader who is a licensed clinical psychologist or social worker, and 1 co-leader who is typically a volunteer or trainee. Initial sessions (Sessions 1–3) include psychoeducation and an introduction to CBT, with emphasis on describing the CBT model and cognitive restructuring techniques. Subsequent sessions (Sessions 4–10) emphasize in vivo exposure, including exposures related to public speaking, assertiveness, informal conversation, and managing embarrassment. Due to the urgent need for telehealth group therapy, the group leaders adapted the typical group format to a telehealth platform. Engagement in exposures remained the focus of participation in the telehealth groups. Each exposure session consisted of briefly checking-in to review progress and homework completion, reviewing skills centered on the given

exposure for that session, engaging in the in-session group exposure, debriefing after the exposure, and assigning homework for the upcoming week.

Group leaders have conducted two telehealth social anxiety groups thus far: one 5-week (60-minute sessions per week) adolescent group with three group members (ages 15–18), and one 10-week (90-minute sessions per week) young adult group with six group members (ages 18–24). The teleconferencing service Zoom-Pro was utilized. As all high school group members had previously and recently engaged in group or individual CBT at the clinic, the group was shortened and solely focused on exposure.

General Considerations and Challenges

Many clinicians may be wary of offering telehealth social anxiety groups, particularly groups that emphasize engagement in exposure. Fear not! Below we outline important considerations and highlight potential solutions to typical challenges. Notably, the intake process and general structure of our telehealth groups remained generally consistent with our in-person groups; therefore, the focus will be on highlighting the specific considerations for a telehealth group that are distinct and unique.

Clinical Considerations

Assessment

An initial, important step of group treatment is to conduct an evaluation to determine the patient's needs and fit for group treatment. In accordance with the clinic's usual procedure, prior to participation, all members were evaluated via a 1-hour intake session. During the intake, members were evaluated to confirm a SAD diagnosis (i.e., via an abbreviated diagnostic interview using the Anxiety and Related Disorder Interview Schedule for DSM-5 [ADIS-5], adult [[Brown & Barlow, 2014](#)] and child [[Silverman & Albano, 1996](#)] Versions) and assessed for group fit (i.e., all members were within the same developmental range, members shared similar goals that could be targeted by group, members' comorbid diagnoses would not interfere with their own or others experience in group treatment). Ways in which the telehealth group would address goals were reviewed, including psychoeducation about anticipated exposure practices that could be completed via telehealth (e.g., one-on-one conversation, making phone calls, etc.). As is common when conducting in-person groups for social anxiety, some group members were initially hesitant to engage in group-based treatment due to concerns regarding potential embarrassment or discomfort. We recommend that clinicians use their typical clinical judgment

and skills to address these concerns as they would for in-person groups, while also normalizing and validating that engaging in group therapy via telehealth may initially feel awkward, strange, or uncomfortable. Clinicians should highlight the potential benefits of participating in the group (e.g., meeting people with similar struggles, particularly during a time of enhanced loneliness; opportunities to practice skills in a safe place, etc.) and, as one would with any novel exposure, encourage participation and small goal setting.

Additional considerations for group fit/appropriateness include frequent substance use that would interfere with engaging in group and tolerating exposures soberly and significant oppositional behavior or refusal to participate in group. An evaluation of the patient's ability to engage in appropriate behaviors without in-person redirection, support, and reinforcement should be conducted. Barring technical difficulties, group members are expected to remain on video for the entire duration of the group. Therefore, the group leaders must ensure the patient's ability to actively and appropriately engage with the telehealth platform. For example, is the patient likely to engage in inappropriate or disruptive behaviors such as changing the video background, remaining on mute, staying within the view of the camera, or recording the session? It is recommended that a discussion on this topic is included in the initial assessment to outline the expectations and requirements, as well as any possible issues with meeting these measures. If these issues do arise during treatment, the group leaders can manage the situation by individually chatting the patient to address the issue or initiating a breakout room to discuss the issue.

Risk

In the context of telehealth groups, the assessment and management of risk involves additional considerations. In our clinic, the assessor completed sections of the ADIS-5 to rule out symptomatology that would require additional intervention, specialized treatment, and/or would interfere with effective group participation, such as substance abuse, disruptive behavior or significant impulsivity, severe depression, and acute suicidality. Although these rule-outs are typical for in-person groups as well, they are especially important for telehealth groups given the lack of physical proximity for interventions (e.g., safety planning) if necessary. Prior to initiating a group via telehealth, clinicians should consider procedures for thorough assessment of risk, a clear threshold for risk exclusion, and procedures for handling risk concerns that arise during group. For both of our telehealth groups, we excluded individuals who presented with current and acute

suicidal ideation and plan. We also excluded individuals who were unwilling to provide an emergency contact and current address. To manage risk throughout the group, the group leaders were prepared with safety plans and contact/location information for the group members. Having multiple group leaders also allowed for separate check-ins or risk assessments to be conducted in breakout rooms while the group was still running.

Behavior

Just as for in-person groups, group leaders should begin the first group session with a review of expectations and engage group members in discussion of group rules and norms. Particular attention should be paid to those specific for telehealth, including staying on camera for the duration of the group, not changing background or name, sitting upright (i.e., to increase engagement and simulate an in-person group as much as possible), using names when speaking to someone, etc. It should be noted that for individuals with severe social anxiety, remaining visible on camera may be difficult. For these individuals, behavioral shaping strategies may be employed, such as encouraging them to gradually increase the length of time that their cameras are "on" or the length of time that their faces are visible on camera. Further, social anxiety is often associated with a behavioral expression of anxiety, such as closed-off body language, lack of eye contact, and fidgeting. These behaviors should remain treatment targets during telehealth groups, although it is noted that lack of eye contact is specifically difficult to target via telehealth. While group leaders found it more challenging at times to observe and target these behavioral indicators of anxiety, they addressed this limitation by openly discussing this challenge with group members and encouraging members to independently monitor their behavior. Group members were prompted to reflect on their own nonverbal behavior and that of fellow group members, with feedback frequently elicited. Group leaders also found it helpful to collaborate with members to set multiple goals for them prior to exposures.

Engagement and Cohesion

Given the importance of these variables in group-based treatments, it is critical to consider how to maintain or increase group engagement and cohesion despite the lack of physical proximity. Prior to the pandemic, our group leaders had never run exposure-based telehealth groups and elected to meet before each group to problem-solve how to increase engagement, stimulate attention, and facilitate interactions between the group members. For example, the group

leaders for the adolescent group designed “Icebreaker” and “Exposure” wheels on wheeldecide.com and shared their screen on Zoom to “spin the wheel.” The wheels included personal questions (e.g., What is your favorite type of music?) and small exposure challenges (e.g., lead Simon Says for the group), respectively. By incorporating the wheels, the leaders were able to engage the group members through a game-like activity that was also therapeutic.

For youth, we recommend incorporating reward systems (i.e., count points or award “stars”) to shape behaviors by using the whiteboard or chat feature from the platform. Figure 1 displays an example of how to use the whiteboard feature to reinforce behaviors by awarding group members with stars. Based on individual goals, stars can be awarded for answering questions, keeping the camera on, completing an exposure, providing positive feedback to peers, etc. The private chat feature can also be used for redirection and positive reinforcement throughout sessions. For example, group leaders often used the private chat feature to reinforce the teens for participating in particularly challenging exposures or for responding to a question (e.g., a simple, “Awesome job!”). The chat feature was also used to privately provide prompts or conversation ideas for a teen with severe social anxiety who struggled with initiating verbalizations. Group and/or individual rewards should be utilized in the same way as they would for in-person groups. Appropriate rewards via telehealth include time carved out to watch a preferred video or play a fun game. While use of food rewards (e.g., pizza party to celebrate group success) is more challenging, this remains possible by including parents in the plan.

It required extra effort to establish a sense of connection and cohesion among group members as it was difficult to engage in conversations, both casual

and formal, and these conversations are often what forges camaraderie among group members. Typical cues that often allow conversations to flow (e.g., eye contact, noticing when someone is finished speaking or is getting ready to speak, taking turns when speaking) were difficult to decipher, and when this is considered within the context of a conversation between individuals struggling with social anxiety, it is perhaps unsurprising that forming connections is difficult. A solution to this problem emerged in the form of extended check-in periods at the start of each session during both groups. Members were encouraged to share events from their weeks with each other, and given that the groups occurred during the pandemic, leaders always offered space for members to share their thoughts related to the ongoing crisis. Allowing space to process the current situation and remaining flexible to divert from typical protocol was both appropriate and assisted in forming cohesion among members. Additionally, group leaders found it helpful to use breakout rooms during this check-in period. One leader remained in a breakout room and met individually with a patient to review their homework from the week and goals for the session, while the other group leader remained in the main Zoom room and encouraged casual conversation among the group members. This offered members the opportunity to find commonalities among themselves, which helped to create more cohesion.

Logistical Considerations

Ancillary Treatment and Consent

As with the clinic’s in-person groups, all participants were asked to confirm continued contact with ancillary, individual providers and sign a consent form allowing

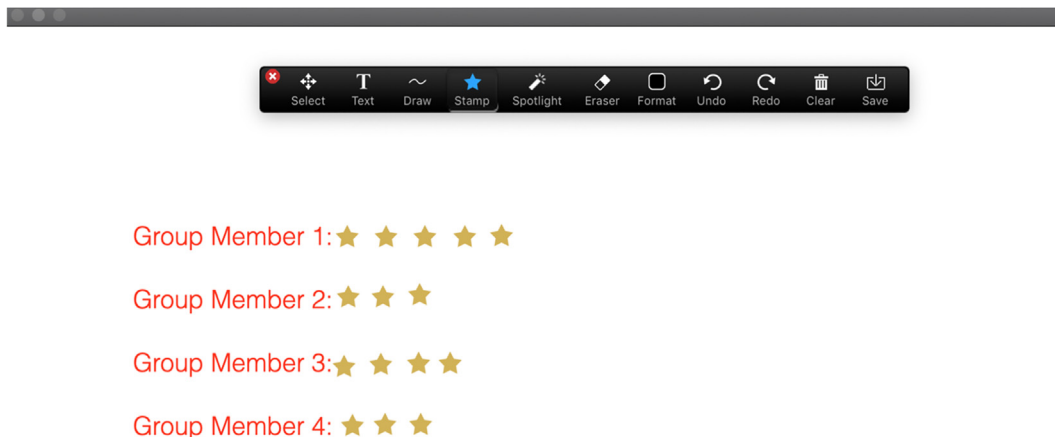


Figure 1. Example of Whiteboard Reward System. *Note.* Visual example of using whiteboard feature in Zoom to incorporate reward system during telehealth groups. The authors listed out group member names (removed here for confidentiality) and utilize the “stamp” option to add stars as rewards for each member.

communication with the individual provider before the start of the group. Ongoing treatment is required in our clinic to ensure that the individual provider is available to support the patient between group sessions and to help manage any risk that may transpire. Although we find this requirement is feasible in our setting, clinicians in alternative settings may consider if this is necessary or manageable given their population. Furthermore, others may only include this requirement for patients who are at higher risk rather than for all group members.

Additionally, an adapted consent form (Telehealth Terms and Conditions agreement) was created and required for each group member. The consent form provided participants with an overview of risks and benefits of engaging in a telehealth session and aspects of privacy and online etiquette, including mandatory use of headphones and a private, confidential space. Given HIPAA considerations, the consent form also included information affirming that recording sessions was strictly prohibited, as was sharing information about other group members.

Technological Considerations

Before the start of the group, members were instructed to confirm access to a device with reliable internet service and the ability to download Zoom. Group leaders may consider scheduling a “practice group” before its official start to individually or collectively troubleshoot any technological issues related to joining the group sessions. Additional considerations include if and how to utilize the platform’s features (i.e., enabling the waiting room, breakout room and/or chat feature) and whether or not members should stay muted or use headphones. There are a number of recommendations for technological considerations. First, we recommend enabling the waiting room so group leaders can ensure they are ready to start the group and can control who has access to the meeting. Second, we recommend asking participants to remain unmuted even when not speaking to enhance opportunities for spontaneous speech and leaving the decision to use headphones up to the group members. Last, it is recommended that group leaders control chat access on Zoom so that group members are only permitted to chat with the group leaders (i.e., hosts of the meeting). This removes the possibility of group members chatting each other while also maintaining the use of this feature for communication with group leaders.

As anticipated, maintaining strong and consistent Internet (WiFi) connection was challenging for both group leaders and group members at times. Often, weak connections resulted in the group member being unable to view and hear the rest of the group from their

location, but leaders and members were unable to see or hear the affected member. A solution to this problem was for the affected member to participate in the group visually through their typical system (i.e., computer) and for them to call into the meeting via telephone to participate verbally. Additional technological challenges encountered during sessions centered on members’ access to necessary technology and their skill levels using technology. A solution to consider for those without access to a device with a camera (i.e., computer, iPad, iPhone, Android) is to allow members to call into the Zoom meetings. This solution is not ideal but allows for greater access to treatment. For those with minimal skill level using technology, it may be helpful to host “practice groups” as suggested above. Group leaders may consider creating handouts with written or visual instructions for members that communicate how to engage with the Zoom platform. If clinics possess the benefit of having a leader and co-leader for the group, the co-leader may also be designated as a person who can assist members with technology challenges during group so as not to interrupt the experience of other members. The clinic group leaders found that this designation was particularly helpful.

Location

Prior to joining group, each member should confirm access to a quiet, private space for the entire duration of the group. Patients’ locations should be confirmed at the beginning of each session. Additionally, it is advised that group leaders gather parents’ and patients’ addresses and contact information in the event of unexpected absence or exit from the group or heightened risk that would require emergency services.

As it may be challenging for youth and young adults to find a private space away from family members also residing in the home, group leaders should take extra care to brainstorm location options with each group member prior to the start of group. Additionally, it is important for group leaders to acknowledge potential socioeconomic and family considerations in this brainstorming phase, as some group members may face additional complexities in finding a private space or being on camera with their environment in view. Group members should be supported in identifying a suitable space and discussing their need for a private space with parents and family members. Creative solutions to space and/or environment problems include use of apartment balconies or backyard space when weather permits, sound machines, use of a bathroom, if necessary, and use of Zoom backgrounds to conceal the environment. Although use of Zoom backgrounds

is generally discouraged to reduce distraction, this could be considered in unique circumstances, as long as the background is generally neutral and does not change frequently throughout the group.

Benefits

Increased Access

A commonly cited benefit of telehealth is the increased accessibility to treatment that may reduce barriers associated with in-person attendance (Gros et al., 2013). Telehealth offers the potential to solve troublesome access-to-treatment barriers due to transportation, distance, or scheduling conflicts. This is particularly beneficial for high school students and young adults given that their schedules can be very busy with school and extracurricular activities and that they may be reliant on parents or other caregivers for transportation. The SAD telehealth group offered members flexibility and the opportunity to attend group sessions that may have otherwise been difficult to attend. For example, one teen was previously unable to participate in our SAD group due to frequent soccer practice after school and the long commute between home and the clinic. The telehealth group offered a less time-consuming and more convenient option that allowed the teen to engage in the telehealth group after not being able to attend in-person groups in the past.

Enhanced Exposure Experience

A notable benefit of utilizing telehealth for an exposure-based group is the opportunity to engage in exposures that would otherwise be difficult or impossible to complete. The group members were participating in the sessions at home, which offered a more personal setting on which exposures could be based. For example, group leaders were able to challenge group members in a vulnerability exposure during which they were encouraged to share personal items from their room or home or play an instrument for the group. More details on vulnerability exposures are included in the examples below.

As mentioned, the telehealth platform's features were often utilized, and group leaders found that the use of breakout rooms and the chat allowed for important side conversations to seamlessly take place. The self-view feature provides constant and in-vivo self-feedback during presentations or conversations that would not be present during in-person exposures. This aspect allowed group members to not only receive immediate feedback on verbal and nonverbal skills from others, but also from themselves. For patients with appearance-related social anxiety, the self-view fea-

ture is a built-in exposure throughout the group. One of the exposure challenges for the Exposure Wheel was for the group member to place the phone or computer camera close to their faces for 10 seconds. Additionally, Zoom features were manipulated to target different manifestations of appearance related anxiety. Group members who disclosed anxiety related to observing themselves changed their setting to "speaker view" to get a larger view of their own "Zoom square." Group members who disclosed anxiety related to not monitoring their own appearance used Zoom features to hide their "Zoom square" from their view.

Practice With a Virtual Platform

An unforeseen benefit of a telehealth group was the opportunity to practice engaging with others over a videoconferencing platform that was required in almost all other social interactions during the COVID-19 pandemic quarantine. For example, exposures in the high school group focused on participating in Zoom classes and engaging in a conversation with another freshman at a virtual college orientation. This practice was further reinforced through exposure homework assignments, such as calling a friend via FaceTime to ask how they were doing during quarantine or to start a Houseparty (an app for group video calls). Since virtual communication is becoming increasingly common and is in fact required during quarantine, the telehealth group offered relevant practice for these types of interactions.

Telehealth Exposure Examples

Three examples of exposure activities conducted during sessions will be elaborated below. We highlight assertiveness, group conversation, and vulnerability exposures as these are three commonly feared situations for youth and young adults with SAD. We also provide noteworthy telehealth features associated with each exposure activity. For all telehealth exposures, members engaged in pre- and postprocessing of the task as a group. Preprocessing included obtaining members' Subjective Units of Distress scale (SUDS) ratings and having members consider features of their anticipatory anxiety regarding the exposure, including identifying feared expectations. Postprocessing included again obtaining members' SUDS ratings, discussing changes in SUDS or tolerance of high anxiety, and reviewing potential differences in actual versus feared outcomes or experiences. Group members were provided opportunities to elicit feedback from others during postprocessing as well (e.g., "Was I talking too fast during that presentation?" or "How was my volume?"). Pre- and postprocessing typically occurred as

a whole group, though occasionally breakout rooms were used for smaller groups to allow for more efficient processing when time was tight.

Assertiveness

The aim of the telehealth-based assertiveness exposure was to engage group members in simulated conversations that required them to exercise assertiveness to achieve a desired outcome while enduring associated anxiety. Group leaders briefly explained the concept of assertiveness and reviewed assertiveness skills. Members were prompted to discuss challenges associated with assertiveness and to individually share typical situations in which they struggled to assert themselves. Group leaders and members collaborated to design personalized one-on-one conversation situations for each member that required the use of assertiveness skills. Members then engaged in their individual exposures while other members and leaders observed and provided feedback on content of speech, body language, tone of voice, eye contact, etc. It should be noted that eye contact was operationalized as looking at the camera and/or screen and lack of eye contact was operationalized as looking down, around the room, etc. Examples of typical assertiveness exposures included asking a professor for an extension on an assignment, asking a boss for time off for vacation, and standing up to a peer who engaged in teasing behavior.

Noteworthy telehealth features of this exposure were the use of the screen-sharing tool, confederates, and breakout rooms. Group leaders utilized the screen-sharing feature of Zoom-Pro to provide visualization of the assertiveness skills reviewed (e.g., use of appropriate eye contact, posture, tone). This allowed the leaders to mimic the use of a typically used whiteboard or handouts and ensured that all members were following along properly and appropriately. Additionally, two confederates (i.e., other clinic staff members) were used as conversation partners for the exposure. The use of confederates allowed members to engage in conversations with novel individuals, thus increasing their anxiety during the exposure. While use of confederates was possible in our group, group leaders could also utilize members to engage in role-plays, which would be an exposure for both parties. Breakout rooms were used to divide members into two groups for actual engagement in the exposure. After collaborating as a group to design personalized conversations, two to four members were sent to a pre-assigned room. One to two leaders were present in each room and one confederate was placed in each room. The use of breakout rooms allowed all members the appropriate amount of

time to engage in at least one exposure conversation. Further, because the transition to/from the rooms occurred quickly (i.e., more quickly than transitioning to a new office or conference room), there was the added benefit of having more time during the session to design detailed personalized conversation situations and debrief after the exposure. Overall, members noted that the telehealth-based assertiveness exposure accurately mimicked real-life situations and effectively raised their anxiety.

Small-Talk Group Conversations

The aim of this exposure was to challenge group members to experience and endure typical social anxiety levels associated with group conversations, including engaging in small talk and joining and leaving group conversations. Group leaders first engaged members in discussing typical social challenges encountered in group settings (e.g., at parties, in a class, in the cafeteria, at work), such as knowing when and how much to contribute to the conversation, tolerating awkward silences, and showing appropriate interest in others. Group members also highlighted the particular difficulties of entering and leaving group conversations, as individuals with SAD can struggle (or perceive themselves to struggle) with effective use of these social skills. Less effective strategies for entering and leaving group conversations were identified, including standing nearby a group until invited to join, interrupting someone mid-sentence to join and share a thought, and walking away abruptly when unsure of how to exit. Group members were supported in brainstorming alternative, more effective strategies, including waiting for an appropriate moment to walk over and introduce themselves to a group and providing a brief reason for leaving and saying goodbye. The discussion highlights strategies that can be generalized to in-person settings. Other group conversation skills were reviewed, including balancing how many questions they ask with how many they answer, identifying social cues to shape how much to disclose about themselves, sharing appropriate information about themselves, and engaging in appropriate body language. Leaders and members were then divided into two groups, and all members practiced entering/leaving conversations and engaging in small talk with a group. Feedback was provided and discussed at the end of the group. A benefit of this type of exposure is that the skills acquired and practiced in this exposure can be easily applied to in-person interactions.

Noteworthy features of this exposure were the flexible use of confederates, breakout rooms, and the chat feature. Similar to the assertiveness exposure, confed-

erates joined the group conversations in an effort to raise members' anxiety due to the novelty of the confederates. Breakout rooms were again used for this exposure. Members were assigned to start in one of two breakout rooms, and each room represented a different group conversation. Thus, group members were able to "leave" one room to practice verbally leaving a group conversation and were able to "enter" another room to practice verbally entering a group conversation. The host (i.e., one group leader) of the session maintained the ability to send members to either room. Finally, group leaders and members utilized the private chat feature on Zoom. Group leaders messaged members private "secret mission" exposures that they were required to complete during the group conversations without the knowledge of others. Examples included asking someone a question, sharing their opinion, saying something that they knew was wrong, asking a "dumb" question, or altering their appearance in an embarrassing way. A challenge encountered during this exposure involved both the breakout room and chat feature. When the host sent a member to another room, they immediately disappeared without warning to the member, thus not allowing them to verbally leave the conversation. Group leaders solved this problem by privately chatting members to give them a warning that they would be sent to another room shortly, affording them time to practice verbally leaving the conversation appropriately. Overall, group members reported enjoying this exposure activity and reported that it effectively activated their anxiety and allowed for practice of relevant conversation skills.

Vulnerability

The vulnerability exposure session was designed to help group members practice managing the discomfort associated with sharing aspects of themselves with others that they typically keep hidden. Group leaders initially facilitated a discussion regarding the definition of vulnerability, the ways in which openness and vulnerability can enhance friendship quality and closeness, and the challenges associated with practicing vulnerability. Group leaders explained how the risk of rejection often feels amplified for people with social anxiety due to common cognitive distortions. Members were encouraged to share related experiences and discuss relevant challenges. Group leaders provided vulnerability exposure ideas (e.g., share something personal, dance to music, share a photo they find embarrassing, play an instrument, etc.) and collaborated with group members to design individualized exposures.

Noteworthy telehealth features of this exposure were the use of breakout rooms, the screen sharing tool, and the private chat function. Breakout rooms were utilized once again. One group leader met with participants one-on-one in a separate breakout room, while the other leaders engaged group members in homework review. This reserved more time for members to participate in the actual exposure, while allowing for individualization of goals prior to the exposure task. In general, the remote group setting enabled more seamless access to sharing tools as well as items for group members to share. One group member, who had previously identified difficulty accepting compliments, selected to share art he made and to subsequently request feedback from the group. He utilized the Zoom screen share function to share photos of his artwork. Group members were also able to make use of personal items in their own homes, such as musical instruments or items in their room, to enhance their vulnerability exposures. The Zoom private chat feature allowed group leaders to prompt members to complete goals during the exposure. Though the telehealth setting provided numerous benefits to this exposure session, as detailed above, it is possible that the comforting setting of group members' homes could have served to lessen members' anxiety. Overall, group members reported significant levels of anxiety and identified experiencing substantial physical symptoms of anxiety (e.g., sweating, heart racing). It may be inferred that group members are likely to generalize the gains obtained through vulnerability exposures since the topics discussed can be easily practiced and utilized in in-person interactions.

Generalization

It is noted that there are issues of generalization beyond the pandemic context. Throughout the treatment groups and exposure practices, discussions focused on how the skills and exposures can apply to in-person contexts. It is our recommendation to incorporate such strategies in telehealth groups to maximize generalization to nondigital settings. Although we acknowledge issues of context and generalization of engaging in exposures via telehealth, it is our belief that these gains are likely to be maintained upon return to in-person interaction.

Discussion

The COVID-19 pandemic represents an unprecedented public health threat for individuals across the world, especially for those with SAD, given that restrictions on social interactions and subsequent unintended avoidance can further fuel anxiety and

impairment. The recent and rapid switch to telehealth treatment allowed the authors to begin to examine a previously unexplored subject of telehealth exposure groups for SAD. Similar to Dueweke et al. (2020), we aimed to discuss general considerations, benefits, and challenges faced in utilizing telehealth. Additionally, we discuss specific exposure examples and outline specific skills learned and practiced that can be utilized in in-person interactions and nondigital settings.

Despite a lack of empirical evidence, the current commentary aimed to present recommendations in conjunction with clinically relevant details for adapting treatments to telehealth, specifically exposure-based group sessions for SAD. Providing this information to other clinicians is of the utmost importance during a period of swift change to telehealth in the mental health field. Although our paper is focused on SAD, we believe this content is broadly applicable for other CBT and/or exposure-based telehealth groups. Further efforts to study telehealth groups will ultimately enhance our ability to adapt and disseminate effective interventions.

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This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors. The authors declare that there are no conflicts of interest.

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Received: October 6, 2020

Accepted: April 3, 2021

Available online 30 April 2021