

# Transitioning From In-Person to Telehealth Cognitive-Behavioral Therapy for Social Anxiety Disorder During the COVID-19 Pandemic: A Case Study in Flexibility in an Adverse Context

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## Abstract

Social anxiety disorder (SAD) is a condition in which people consistently and persistently experience significant fear and/or anxiety about one or more social situations in which they may be scrutinized and negatively evaluated. SAD has historically been found to respond well to cognitive-behavioral therapy (CBT) delivered both in-person and via telehealth; however, comparatively little information is available regarding response to treatment in the context of Coronavirus Disease 2019 (COVID-19) pandemic social and physical distancing guidelines, which have affected the way in which behavioral health services are delivered, as well as opportunities for interpersonal interactions which are either spontaneous or assigned as exposures. The current case study describes “Jennifer” (a pseudonym), a college student with a primary diagnosis of SAD, who was treated with primarily CBT interventions for 18 individual sessions over the course of approximately 6 months, which included treatment with a psychologist and a graduate student, implemented both in-person and via telehealth, both before and during the COVID-19 pandemic. Jennifer responded well to treatment, as evidenced by her self-report and decreases in symptom measure scores, engaged in CBT adapted to pandemic restrictions, and was able to utilize strategies learned during SAD treatment to address generalized anxiety and pandemic-related

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concerns. This case study demonstrates the feasibility of transitioning SAD care between providers and formats, as well as the robustness and flexibility of CBT strategies in the face of significant change, stress, and limitations of the external environment.

### Keywords

COVID-19, social anxiety, social phobia, telehealth

## I Theoretical and Research Basis for Treatment

Social anxiety disorder (SAD) is a condition in which people consistently and persistently experience significant fear and/or anxiety about at least one social situation in which they may be scrutinized and negatively evaluated, to the extent that it is out of proportion to the danger of the situation as it would be experienced by the average person in the same sociocultural context ([American Psychiatric Association \[APA, 2013\]](#)). Comorbidity of other disorders with SAD is common, with varying impact; for example, while an additional anxiety disorder may not significantly impact SAD treatment outcome, an additional mood disorder may result in higher SAD symptomatology both before and after treatment ([Gordon et al., 2014](#); [Rowa et al., 2014](#)).

Cognitive-behavioral therapy (CBT) is an evidence-based treatment for SAD which addresses processes that maintain social anxiety, such as self-focused attention and safety-seeking behaviors ([National Institute for Health and Care Excellence \[NICE\], 2013](#)). CBT is recommended for SAD in clinical practice guidelines from [NICE \(2013\)](#) and the [Anxiety and Depression Association of America \(ADAA, 2015\)](#). CBT for SAD commonly includes assessment of historical factors, places, people, activities, cognitions, and physiological symptoms which prompt social anxiety, and interventions such as psychoeducation, cognitive restructuring, planned social experiences, and specific exposures to facilitate new learning and habituation ([ADAA, 2015](#); [Gordon et al., 2014](#); [NICE, 2013](#); [Rowa et al., 2014](#)).

A meta-analysis by [Mayo-Wilson et al. \(2014\)](#) examining different treatment modalities for SAD indicated that interventions based in CBT yielded large effects, with individual CBT being the best initial treatment recommendation, with further note that the benefits gained tended to be maintained after termination, or even increased over time. [Gordon et al. \(2014\)](#) highlighted that individual therapy permits greater flexibility to address specific individual client concerns, and to adjust logistics such as frequency and duration of treatment. With regard to individual differences, [Gordon et al. \(2014\)](#) also noted that clients with optimistic expectations for treatment, and who adhere to practice assignments, tend to experience better outcomes, and that individuals with social anxiety limited to specific situations tend to experience more functional benefit, compared to those with generalized social anxiety.

The socioenvironmental context within which social anxiety and SAD treatment occurred shifted at the end of 2019 and the beginning of 2020, with the discovery of Coronavirus Disease 2019 (COVID-19), later deemed a pandemic due to its major population impact spanning multiple countries ([Centers for Disease Control, 2020](#)). In conjunction with this public health concern, multiple geographical areas (e.g., states, counties) served by the clinic in which data for this study were collected issued “stay-at-home”-type guidelines. Examples included restrictions on movement except for obtaining household necessities and medical care or traveling to a job considered essential, maintaining a physical distance of six feet from others, and restrictions on the number of attendees at, and duration of, public gatherings. Many individuals transitioned to working or attending school from their homes, began wearing shields or masks covering the lower half of their faces in public, and initiated health care via telehealth platforms. Public health

guidelines, and rapid behavioral changes which were accordingly required, impacted the population as a whole (including behavioral health providers as well as clients), and presented challenges in maintaining continuity of care, as well as the way in which CBT was typically provided for SAD. Articles published toward the start of the pandemic suggested that social anxiety, interpersonal isolation, and loneliness would be of particular concern, in light of restrictions such as social distancing and staying at home (Casale & Flett, 2020; Edisan, 2020; Inchausti et al., 2020; Tull et al., 2020). Research from initial stages of the pandemic also suggested that mental health care of individuals with pre-existing mental health concerns would be a priority, as such individuals experienced higher levels of depression and anxiety after the declaration of the pandemic (Alonzi et al., 2020).

Telehealth is a service modality which was acceptable to clients both before and during the COVID-19 pandemic, and which permitted continuity of care and social distancing (Barney et al., 2020; Inchausti et al., 2020). In their review of studies of CBT delivered via televideo, Nelson and Duncan (2015) reported comparable therapeutic outcomes between face-to-face and televideo interventions for social phobia, as well as for depression, PTSD, and OCD, and significant benefit from televideo interventions for a range of diagnoses and treatment targets, (e.g., substance abuse, quality of life associated with cancer, and geriatric insomnia). Nelson and Duncan (2015) reported that therapeutic alliance and client satisfaction also appeared comparable between modalities. Specific to SAD, a number of research studies have found significant improvement with CBT delivered via distanced methods (e.g., videoconferencing and internet-based). Pelletier (2002) evaluated outcomes from a treatment which incorporated cognitive restructuring and exposure to address public speaking anxiety, for five participants diagnosed with social phobia; all participants were satisfied with the treatment, three participants no longer met criteria for social phobia at post-treatment and 3 month follow-up, and four participants had a moderate or high end-state status at 3 month follow-up. Yuen et al. (2013) evaluated outcomes from a protocol incorporating exposure and acceptance-based strategies, with 20 participants diagnosed with generalized SAD having completed treatment; the majority of participants were satisfied with the treatment and their therapists, 54% of participants did not meet criteria for SAD following the treatment, and there were improvements in symptoms and functioning following treatment and at 3 months follow-up. A research team based in Sweden also examined outcomes for participants with social phobia who engaged in a largely self-directed, internet-delivered program, with additional opportunities for support, such as group exposures, email from therapists, and an online discussion group; CBT strategies used included challenging automatic thoughts, behavioral experiments, and social skills training (Andersson et al., 2006; Carlbring et al., 2009; Hedman et al., 2011). An initial randomized controlled trial found post-treatment improvement on symptom and quality of life measures, and follow-up studies found sustained improvement in social anxiety at 30 months and at 5 years post-treatment (Andersson et al., 2006; Carlbring et al., 2009; Hedman et al., 2011).

As research is still nascent regarding response to treatment in the context of the COVID-19 pandemic, our objective is to provide a real-world example of a case which was transitioned from in-person to telehealth-only mental health care during the pandemic, and lessons learned by the providers and the clinic during this rapid transition in service modality.

## 2 Case Introduction

This case study was approved by the University of Missouri–Kansas City Institutional Review Board. The pseudonym “Jennifer” is used to maintain the anonymity of the participant, from whom a HIPAA waiver was obtained permitting the use of limited medical information for the purposes of writeup as a case study. Jennifer was a woman of White descent in her 20s, who was attending college and planned to attend graduate school. At the outset of therapy, she lived with

roommates in an apartment near her college, but later moved back to her family home due to the onset of the COVID-19 pandemic. The therapists were a licensed psychologist and a graduate student in a clinical psychology doctoral program, with the student supervised by the licensed psychologist who completed the assessment and led the initial treatment sessions, and also by the licensed psychologist serving as the director of the treatment center.

### 3 Presenting Complaints

Jennifer presented with a chief complaint of long-standing, consistent anxiety and fear of embarrassment or “sounding dumb” in interpersonal situations, with high awareness of accompanying physiological symptoms (e.g., sweating, muscle tension, elevated heart rate, and shortness of breath). Compensatory behaviors included covering her mouth while speaking, researching conversation topics ahead of time, “overanalyzing” her social performance before and after interactions, avoiding attention (even positive attention), avoiding phone calls, and making excuses to get out of social commitments.

### 4 History

Jennifer reported some difficulty making friends as a child, and that since early grade school, others had thought of her as awkward and shy (with the client noting this feedback was not presented to her in an unkind way). She reported currently having at least five close friends. She reported a history of mild asthma, but generally good physical health, sleep, and appetite. She reported having reached most developmental milestones on time/within normal limits. Jennifer also reported taking medication for attention-deficit/hyperactivity disorder (ADHD).

### 5 Assessment

As was typical for the anxiety specialty center where this case was seen, Jennifer was administered a general clinical interview which included review of patient history, prompts from the Mini-International Neuropsychiatric Interview English Version 7.0.2 for DSM-5 (M.I.N.I.; [Sheehan, 2016](#)), and an electronic battery of adjunctive measures, which were re-administered over time to assess progress; three of these measures pertinent to the chief complaint are presented in further detail below. Electronic measures were administered at three points: pre-treatment (between Session 1 and Session 2), mid-point (between Session 12 and Session 13), and post-treatment (after Session 18).

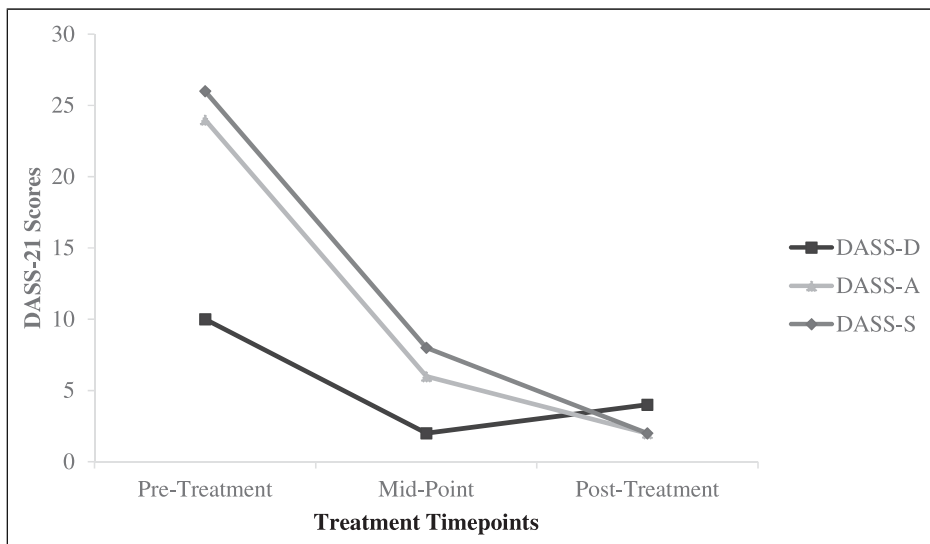
#### *Clinical Interview and Adjunctive Measures*

M.I.N.I. ([Sheehan, 2016](#)). The M.I.N.I. is an interview which screens for epidemiologically common disorders ([Sheehan et al., 1998](#)). The original M.I.N.I. demonstrated good reliability and validity, as well as high rates of agreement between diagnoses made by general practitioners and by expert psychiatrists ([Sheehan et al., 1998](#)), and has been updated over time to align with changes in diagnostic criteria. In response to M.I.N.I. prompts, Jennifer perceived that her social anxiety was excessive, distressing, and interfered with functioning in multiple life domains. She denied change in medication or substance use, physical health, or other emotional/behavioral health problem immediately prior to the onset of social anxiety symptoms. The primary diagnosis was established as SAD. Jennifer also reported further symptoms meeting full criteria for generalized anxiety disorder (GAD).

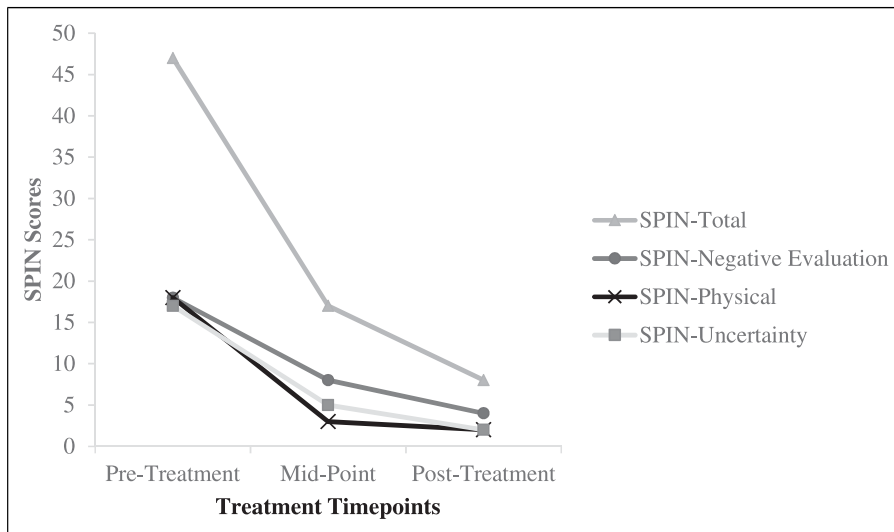
Depression, Anxiety, Stress Scale - 21 Items (DASS-21; Lovibond & Lovibond, 1995a, 1995b). SAD can impact different areas of functioning, such as mood and stress. The DASS-21 is a self-report measure with three subscales related to depressive symptoms, anxious arousal and the subjective experience of anxiety, and general tension/arousal and emotional reactivity (e.g., being easily agitated). Antony et al. (1998) confirmed the three-factor structure of the DASS-21, and found that the subscales exhibited good discriminant validity, and good to excellent reliability. Changes in DASS-21 scores over the course of treatment are presented in Figure 1. Pre-treatment DASS-21 scores indicated mildly elevated depression, extremely severe anxiety, and severe stress. By mid-point, all subscales dropped below the clinical thresholds. At post-treatment, Jennifer's anxiety and stress subscale scores continued to decrease, while the depression subscale increased slightly but was still below the clinical threshold.

Social Phobia Inventory (SPIN; Connor et al., 2000). The SPIN is a 17-item self-report scale which is generally used as a screener for social anxiety symptoms, but has also been shown to capture treatment response. Three subscale scores measure fear of negative evaluation, fear of physical symptoms, and fear of uncertainty in social situations. The scale as a whole exhibits excellent reliability, with the reliability of subscales ranging from good to excellent. Changes in SPIN scores over time are presented in Figure 2. Jennifer's pre-treatment total SPIN score was above the cut-off score of 19 suggested by Connor et al. (2000) as marking clinically significant social anxiety; her total SPIN score decreased below this cut-off score by the mid-point of treatment, and continued to decrease post-treatment. Her subscale scores related to fear of negative evaluation, fear of physical symptoms, and uncertainty also decreased from baseline through mid-point, and continued to decrease at mid-point and post-treatment.

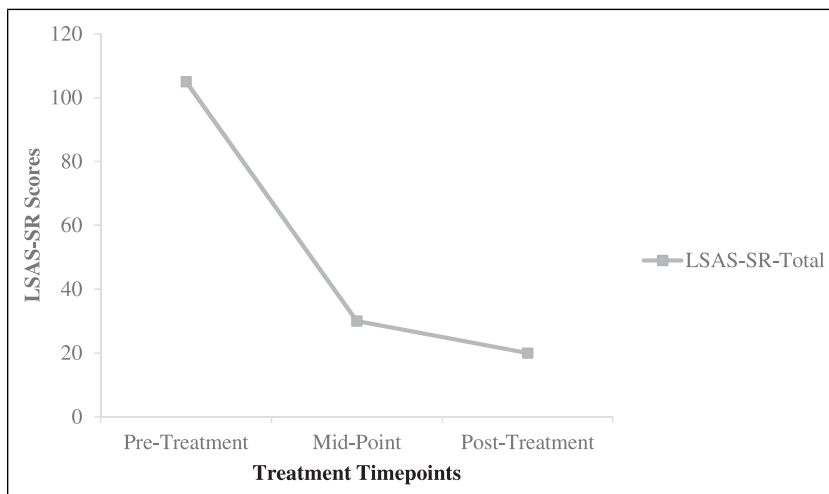
Liebowitz Social Anxiety Scale - Self-Report (LSAS-SR; Baker et al., 2002). The LSAS-SR is a 24-item self-report measure assessing fear and avoidance of a variety of social situations. Baker et al. (2002) found that this instrument generally had good psychometric properties, including good test-retest reliability for the total score, and was sensitive to the effects of treatment. Changes



**Figure 1.** DASS-21 Subscale Scores Across Treatment. Note: DASS = Depression, Anxiety, Stress Scale—21 Items. DASS-D = Depression subscale scores. DASS-A = Anxiety subscale scores. DASS-S = Stress subscale scores.



**Figure 2.** SPIN-Total and Subscale Scores Across Treatment. Note: SPIN = Social Phobia Inventory. Suggested clinical cut-off score is 19 for SPIN-Total score. SPIN-Negative Evaluation = Fear of negative evaluation subscale scores. SPIN-Physical = Fear of physical symptoms subscale scores. SPIN-Uncertainty = Fear of uncertainty in social situations subscale scores.



**Figure 3.** LSAS-SR Total Scores Across Treatment. Note: LSAS-SR = Liebowitz Social Anxiety Scale—Self-Report. Suggested clinical cut-off score is 47 for LSAS-SR Total score.

in the LSAS-SR total score over time are presented in [Figure 3](#). Jennifer's pre-treatment LSAS-SR total score was above the clinical cut-off of 47 suggested by [Rytwinski et al. \(2009\)](#), and indicated highly probable social anxiety. At mid-point, Jennifer's score still indicated probable social anxiety, but was below the clinical cut-off, and her post-treatment score was further decreased from mid-point.

## 6 Case Conceptualization

Following a model suggested by [Clark and Wells \(1995\)](#), as cited in [Wong et al., 2014](#), Jennifer's experience of unhelpful social anxiety is conceptualized as follows. Examples of feared situations included speaking in class, small talk, greeting others, and asking for help in a store, with her concerns including that others would think of her as incompetent or as wasting others' time, or would try to sell her things she did not need. Her concerns seemed to be confirmed by physiological reactivity (e.g., feeling warm), and feeling "horrified" at her own performance. To ward off negative outcomes, Jennifer engaged in behavioral avoidance, wearing "safe" colors which she perceived would not show sweat, or asking multiple questions (e.g., in order to not be "wasting" someone's time by asking for a meeting to address a single topic). Anxiety remained high due to unhelpful or avoidant behaviors interfering with corrective learning (e.g., that negative evaluation might not be catastrophic), practice of more helpful behaviors (e.g., assertively declining to purchase an unwanted item), and experience of habituation. She overestimated the extent to which she would be negatively evaluated, as well as the likelihood of negative evaluation occurring at all, and also experienced anticipatory anxiety before interpersonal interactions, which led to increased inward-focused attention and potential actual deficits in social situations (e.g., due to not attending to conversations). The result of these dysfunctional processes was the maintenance of unhelpful beliefs and avoidance of social situations in which she might be evaluated, which was a particular problem for Jennifer as she anticipated being evaluated while interviewing for graduate school in the near future.

## 7 Course of Treatment and Assessment of Progress

In total, the client was seen for 18 sessions, with the first and second sessions primarily focused on assessment, and with the remaining 16 sessions utilizing a variety of interventions consistent with the model of SAD authored by [Clark and Wells \(1995\)](#), as cited in [Wong et al., 2014](#). These included identifying unhelpful avoidant or safety behaviors and designing exposures to find out what would happen if she ceased these behaviors, as well as raising awareness of patterns of thinking and unhelpful negative cognitions related to social anxiety, and learning to challenge and change such cognitions ([Wong et al., 2014](#)).

As progress was made and different needs emerged over time, other interventions were incorporated into the client's individualized course of treatment, including psychoeducation, training in mindfulness and assertiveness skills, sleep hygiene, relapse prevention, and attending an online support group for young adults with a history of anxiety and related conditions. [Table 1](#) includes examples of interventions and intervention targets.

### *Psychologist-Led Sessions*

At the first and second sessions, diagnoses were discussed, and psychoeducation was presented regarding CBT as an evidence-based intervention for SAD. Jennifer perceived this information as applicable to her experience, and agreed to initiate CBT. A thought tracking worksheet was introduced as a preliminary assignment to raise Jennifer's awareness of interactions among activating events, thoughts, emotions, and behaviors, as well as to provide the treatment team with further information about her personal experience of specific symptoms.

At Session 3, Jennifer returned her worksheet, on which she identified activating events associated with negative predictions (e.g., that others would consider her stupid), negative emotions/urges (e.g., reluctance to socially engage), physiological reactivity (e.g., muscle tension), and difficulty articulating her thoughts to others. This session also included preparatory

**Table 1.** Examples of interventions and intervention targets.

Interventions/intervention targets	Treatment exposures	Treatment strategies
Negative cognitions: “They think you’re weird.” “I may have said something stupid, or it may not have made sense . . . [the provider] may think I don’t know what I am talking about, or that I am incompetent.” “Good luck trying to get a job there won’t be one for you.”	In-vivo: Asking clinic staff members a question Greeting strangers Interrupting a conversation to present her point of view Imaginal: Writing and reading aloud a script acknowledging feared outcomes from a conversation just completed	Psychoeducation Cognitive-behavioral model Reassurance seeking Cognitive restructuring Exposures Mindful noticing and accepting of thoughts Guided imagery Using assertive “I” statements
Unhelpful behaviors: Wearing dark clothing to avoid visible sweat stains Reassurance seeking Asking unnecessary questions in email, due to perceiving that sending an email for just one question would be a waste of the professor’s time	Interoceptive: Holding breath as long as possible, twice in a row Combined: Deliberately wetting her face and underarms before having a conversation with clinic staff members	

work for introducing exposures for SAD, which entailed gradually and systemically facing feared stimuli while removing safety behaviors. Types of exposures used included *in-vivo*, in which Jennifer engaged in “real life” or analog social situations, *interoceptive*, which involved intentionally bringing on feared or avoided physiological sensations, and *imaginal*, in which feared thoughts were deliberately brought up in the client’s imagination, for example, by way of writing and reading aloud a “worst case” outcome for an anxiety-provoking social scenario. Potential exposure items and associated anticipated Subjective Units of Distress (SUDS) levels were identified for Jennifer and were added to a hierarchy. Examples of exposure items identified over the course of therapy included asking a question in class (anticipated SUDS of 9/10, where 10 represented the highest distress), and sending an email to a professor without checking for errors (anticipated SUDS of 7/10). During Session 3, Jennifer also reflected that she had a difficult time recognizing her emotions, with psychoeducation regarding emotions thus presented at the next session. At Session 4, Jennifer was also given her first exposure assignments to engage in social situations and collect data to support or disconfirm her feared predictions (e.g., that someone would say something “snarky” to her).

At Sessions 5 and 6, the client reported consistent completion of exposure homework, and having generally experienced habituation (indicated by decrease in SUDS) within exposures, though not always across exposures. Potentially problematic patterns in thinking, such as “mind reading” and hindsight bias, were noted, with the client demonstrating ability to generate alternate balanced thoughts, such as the idea that others may not be as concerned about her performance as she thought. She also began identifying “safety behaviors,” or pre-emptive behaviors designed to



mitigate feared outcomes, such as asking multiple questions in meetings with authority figures to avoid “wasting” their time. Exposures were specifically designed to exclude safety behaviors (e.g., asking a staff psychologist, who also taught at the university level, only a single question about her class). During processing of the exposure, it was noted that while Jennifer expressed a hope for objective feedback regarding her social skills, asking for feedback seemed to serve the less helpful purpose of obtaining reassurance that she had not poorly performed; Jennifer expressed understanding of reasons to withhold such feedback.

At Session 7, the client inquired about general relaxation skills to manage symptoms of physiological distress, such as hyperventilation. It was reviewed that, while relaxation techniques may be helpful to address physical tension which accompanies generalized anxiety, they would not be recommended during a hyperventilation exposure, as they would interfere with experiencing her breath returning to a normal rate without having to take any specific action upon it. Jennifer was amenable to delaying introduction of relaxation skills; interoceptive exposures were instead introduced to challenge the use of safety behaviors. After holding her breath as long as possible and then releasing it, twice in a row, Jennifer spontaneously noted that she was in fact able to speak after holding her breath. Interoceptive exposures were later combined with social exposures (e.g., hyperventilating before a conversation).

During review of homework at Session 8, it was observed that the client made strong negative self-statements which seemed to interfere with her sense of benefit from exposures; for example, that if she was dissatisfied with what she had said, her statements must have been “stupid.” Thus, Socratic questioning was introduced, which is a technique in which the therapist asks the client questions to uncover potential errors in logic and identify evidence for or against a particular thought, allowing the client to come to a more helpful conclusion. This session marked transition of care to the graduate student therapist, initiated in part to assist with managing costs.

### *Graduate Student-Led Sessions*

The ninth through eighteenth sessions were provided by the graduate student as the primary therapist. Supervision involved review of session videos made using an in-room camera, and in-person and telesupervision meetings between the supervisors and the student therapist.

Session 9 marked Jennifer’s first report of a successful use of an alternative thought in a real-life social situation, and better awareness of positive emotions. She reported that, upon reflecting on the outcome of a practice assignment cognitive restructuring worksheet, she had greater motivation to initiate social outings besides those specifically assigned for therapy. She demonstrated increased ability to generate balanced and helpful alternate thoughts (e.g., “No matter what, there is always ambiguity”). Jennifer also noted greater awareness of running/racing thoughts as a result of completing the worksheet, and was uncertain as to whether this might be due to anxiety or to a change in ADHD medication; while medication management was deferred to the client’s existing prescribing provider, the client was offered and accepted the option of practicing mindfulness and guided imagery during therapy, in order to notice and accept thoughts and allow them to pass, rather than ruminating on them. Mindfulness refers to the practice of non-judgmentally noticing one’s experiences (internal or external), while guided imagery, such as the therapist encouraging the client to picture their experiences as leaves on a moving stream, is meant to allow a client to experientially engage in this process. The difference between helpful feedback and unhelpful reassurance was again explored, with further psychoeducation on reassurance seeking offered at Session 10. Jennifer reported greater awareness of reassurance seeking and safety behaviors outside of session, and that she was wasting less time by rationally countering her anxious thoughts on her own and resisting urges to seek reassurance. At this session, an in-vivo small talk exposure with the therapist was combined with an imaginal script regarding the client’s anxious

thoughts, feared outcomes, ways in which she could resist seeking reassurance, and also the risks of not seeking reassurance (e.g., that she would never know if what she said made sense). Jennifer reported that she learned from this exposure that ruminating on social interactions was not worth it, as she ultimately could not go back and change anything.

At Session 11, Jennifer reported having encountered a barrier to her practice assignment completion, due to an anticipated classroom interaction having been cancelled, and having overcome this barrier by proactively taking a leadership position in a group in which she would engage in conversations to help others with their English language skills. She reported decreased rumination after social interactions, and greater awareness of the conversational difficulties or mistakes experienced by others whom she had assumed to be “normal.” Given her outstanding progress in therapy, she was offered the challenge of doing a more anxiety-provoking social exposure that would ban her typical safety behavior of wearing clothes in “safe” colors that would not show sweat. She accepted this challenge and at Session 12 wore an “unsafe” clothing item during unstructured small talk with two clinic staff members. Afterwards, Jennifer reported she had entirely forgotten about sweating, and she was pleased with how she handled a silent moment and the unexpected departure from the room of one staff member. Jennifer also decided that she would try interrupting others in real-life conversations, and potentially doing interoceptive exposures prior to such conversations.

After mid-point assessment between Sessions 12 and 13, Jennifer was excited and happy to receive feedback reflecting improvement, which she found helpful in conceptualizing how much she had achieved from therapy. SUDS for exposure hierarchy items were re-rated, with many ratings being lower compared to baseline, and with the client also perceiving that she had underestimated her social abilities. She was amenable to engaging in exposures of increasing difficulty and complexity. As Jennifer identified that she regularly experienced “should” cognitive distortions (reflecting internalized rules or beliefs) related to her ability to understand the mechanics of conversations, it was discussed that one cannot always plan for how a conversation will turn out, and a cognitive intervention addressing “should” statements was interwoven into the processing of her in-session exposure. In order to further assist Jennifer in working towards valued life goals, it was planned to do a mock graduate school interview at the next session. Jennifer was encouraged to attend the clinic’s support group for young adults to interact with new people; however, she was not able to attend due to a conflicting commitment.

It was after Session 13 that public health measures to respond to the COVID-19 pandemic were initiated on a statewide level, within Jennifer’s college, and within the clinic; these included “stay-at-home” orders which took effect during the period when the client and therapist were working toward termination of ongoing therapy. In consideration of the public health emergency, the clinic made the decision to immediately transition all services to a telehealth format in order to support the immediate physical safety and well-being of clients, as well as to maintain continuity of care and therapeutic progress for established clients. Such changes in format were also taking place across other outpatient and specialty treatment settings at the time (e.g., [Reeves et al., 2021](#)). Telehealth services had already been available at this particular clinic prior to the onset of the COVID-19 pandemic (although generally used only when distance precluded clients from coming to the clinic, and generally not utilized for all sessions). Thus, prior to the start of the pandemic, supervising psychologists were already familiar with the delivery and the technology involved with these services, and all graduate students training at the clinic were also familiar with the previously established telehealth services as part of their orientation to the practicum. In addition, any issues as they arose with telehealth were discussed during supervision and at staff meetings, both pre-pandemic and during the pandemic. Repeatable symptom measures had already been administered in an electronic format prior to the onset of the pandemic, and continued to be administered in an electronic format afterwards; Jennifer’s initial ability and willingness to

electronically complete these measures during the period of in-person services suggested that she would be able to continue doing so during all telehealth services. In line with ethical guidelines suggesting that psychologists engage in ongoing maintenance and enhancement of their understanding of the technologies and considerations involved with telepsychology ([Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013](#)), supervising psychologists engaged in peer consultation, as well as continuing education, with regard to provision of telehealth services and telesupervision. The student therapist also reviewed relevant ethical standards and professional guidelines, attended relevant webinars, and had the opportunity to observe fully licensed clinicians conducting telehealth services, by sitting in on or co-facilitating sessions. As the pandemic continued, the student therapist continued to consult with supervising psychologists about ways to most effectively engage clients in telehealth services.

Also in line with ethical guidelines regarding telepsychology, clients were provided with information regarding risks involved with electronic communications and services. This occurred both during initial informed consent for in-person services, and during the later COVID-19 pandemic-related transition to telehealth services. In conjunction with the transition to telehealth services, established clients were contacted by email and were informed that, effective immediately, all services would be transitioned to a HIPAA-compliant telehealth service. It should be acknowledged that for established clients in this clinic who had a strong preference to continue their current course of therapy with this clinic, rather than to interrupt services or transition care, there was no option other than telehealth. With that caveat noted, Jennifer did agree to transition sessions to a telehealth format. Jennifer's case had multiple characteristics suggestive of appropriateness for telehealth, including the client's aforementioned agreement to continue therapy via telehealth rather than to terminate therapy, that telehealth visits were follow-up visits for already known and diagnosed concerns and with an existing therapist with whom Jennifer already had good rapport, Jennifer's previously evidenced willingness and ability to access and use technology for tasks such as completing symptom measures and communicating with the clinic via email, her ability to engage in telehealth in a private space using additional measures to support privacy (e.g., in-ear headphones with an integrated microphone), and no evidence of ongoing crisis or imminent risk for harm to herself or to others ([Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013](#); [Nelson & Duncan, 2015](#); [Reeves et al., 2021](#)).

At Session 14, supervision of the student therapist transitioned to telesupervision, with recordings of sessions being made and stored in a secure, HIPAA-compliant manner which allowed remote review by the licensed supervising psychologists. Therapy materials and practice assignments were electronically sent to the client. These materials were also made available online in a HIPAA-compliant manner which allowed the therapist and the client to view and work on worksheets in real-time during sessions, and which allowed the client to complete homework which could be stored and asynchronously viewed and commented on by the therapist between sessions. Additionally, support groups were converted to a televideo format, and were attended by the client for support and social interaction during the "stay-at-home" orders.

### *Sessions after the start of geographic area public health responses to COVID-19 pandemic*

At Session 14, Jennifer reported that pandemic-related restrictions had been a barrier to practice assignment completion, and that she had experienced an exacerbation of generalized anxiety symptoms, as well as an onset of sleep difficulties. Topics of generalized anxiety included pessimism about being able to get a job during the summer and the prospect of going to graduate school, and transitioning to online classes, because "it does not feel real." While she was not

bothered by the idea of people seeing her on camera during online classes, she reported uncertainty about not knowing whether to look at the person speaking on the screen, or at the camera, and thus, it was discussed that exposures could be built around video chatting. Jennifer's worries about school and job prospects were addressed in the session using a cognitive restructuring worksheet, with the client concluding that "You're not the only human that is dealing with this, believe it or not most of the world is in the same position," and "It is possible that I don't get into graduate school or don't get a job, but I did the best I could." Transition of the clinic's support groups to an online format resolved the obstacle of Jennifer not having adequate travel time to reach the clinic by the start time of the group. She reported that did not realize how valuable the group would be until she had finally attended, and perceived that anticipatory anxiety led to her not taking advantage of many past opportunities for social engagement. She reported that she would attend this support group again in the future.

At the next session, Jennifer reported that she had started video chatting and calling friends, which went better than she expected; she perceived that typically she would have spent time with them in person, and she felt uncomfortable and "weird" about being on their computer screens. While she was not able to identify what specifically seemed uncomfortable and "weird" about such interactions, she found that this discomfort nevertheless passed on its own over the course of social engagement. Jennifer reported having listened to a podcast about how to handle news about COVID-19, which she enjoyed, and which normalized her own struggles for managing the risk of contracting or spreading COVID-19. Jennifer also reported stress from having moved back to her family home rather than remaining near campus in her apartment. Emotional regulation strategies, as well as practical strategies (e.g., doing homework with earplugs to reduce distraction) for coping with these changes, were discussed. Jennifer noted that her family was experiencing more anxiety related to the pandemic than she was, and reflected that, after engaging in therapy, she currently had more tools and skills for addressing anxiety than they did. As the client both reported and demonstrated good understanding of the rationale for exposures and social anxiety-specific interventions, relaxation skills (which might have been contraindicated for social exposures) and assertiveness skills (which had previously not been introduced as a deliberate choice in order to allow the client to discover whether her existing social skills were better than she realized) were introduced and practiced at this session to assist with managing more generalized worries. Despite new stressors and changes in life circumstances, Jennifer had maintained therapeutic gains, and plans were made to move toward termination of ongoing individual therapy, with plans for future re-entry into in-person school to be incorporated into therapy goals and her relapse prevention plan.

At Session 16, Jennifer continued to demonstrate ability to spontaneously use skills learned from therapy, identified that focusing on one thing at a time had been a particularly helpful coping skill which also facilitated her realization that if she could focus on one thing, she could also "sit down for 30 minutes and do homework," and recognized catastrophizing (e.g., assuming that outcomes of feared situations would definitely be terrible and beyond her ability to manage) as an unhelpful pattern in her thinking. The next session was scheduled for 2 weeks out, rather than the usual weekly session, in preparation for termination. Jennifer presented to Session 17 reporting continued independent use of skills and of the online support group, and having acclimated to online meetings. The graduate student therapist noted that, although Jennifer "does not love Zoom meetings, she is able to do them and not avoid them." Jennifer anticipated being able to use these skills after the more acute crisis aspects of the pandemic had passed. She reported being more aware of how much fun she used to have in social situations, with opportunities for social interactions (e.g., classes and walks with friends) unfortunately now being less available to her during quarantine and pandemic conditions. A relapse prevention plan was collaboratively created to identify remaining/ongoing goals, behaviors which were now "banned" (e.g., reassurance seeking), and signs that anxiety symptoms might be increasing (e.g., sweating and redness above

and beyond what she typically experienced in her daily activities), which might indicate the need to increase practice of therapy skills and/or schedule a follow-up or booster therapy session. The final session was scheduled 1 month out in order to allow for independent practice of skills, but also to plan for the prospect of needing additional support.

Jennifer presented to the final session of therapy 1 month later, reporting that use of her relapse prevention plan had been going well, and that she had added new items onto the plan as needs arose (e.g., encouraging herself to think positively about treatment gains and to keep a writing log). She reported increased motivation since the start of pandemic measures to leave her home for social interaction, and greater enjoyment of her free time, rather than worrying and dreading upcoming responsibilities. In light of Jennifer's excellent insight, understanding of relapse prevention, awareness of when she might benefit from returning for additional therapy, and maintenance of therapeutic gains, the ongoing course of individual therapy was terminated as planned, by mutual agreement between Jennifer and the graduate student therapist.

### ***Complicating Factors***

Multiple complicating factors were present during this case. These included comorbid diagnoses of GAD and of ADHD (the latter addressed with medication managed outside of the therapy clinic), the larger context of the pandemic, including the impact of social distancing measures on key treatment targets such as interpersonal interaction and concerns about physical appearance, and rapid transition to treatment via telehealth as necessitated by the public health emergency situation. Initial focus on SAD, with treatment expanded to other concerns over time, is consistent with recommendations by [Rowa et al. \(2014\)](#) to prioritize the most significant problem when comorbidity exists, or to utilize a transdiagnostic approach. In their review of SAD research, [Rowa et al. \(2014\)](#) further noted that concurrent medication management is common during CBT for SAD, and that anxiety disorder comorbidity is unlikely to affect the outcome of CBT for SAD. At times when a particular treatment approach might have been indicated for one diagnosis, but conflicted with the treatment approach for SAD, the rationale and recommendation for the session interventions targeted towards SAD were discussed with Jennifer, and the way forward was collaboratively agreed upon. For example, relaxation techniques have been found effective in GAD treatment (e.g., [Hayes-Skelton & Roemer, 2013](#)), but conflicted with the expected mechanism of change for exposures for SAD, and were also not expected to significantly improve exposure outcomes ([Rowa et al., 2014](#)). Thus, relaxation strategies were not introduced until after significant progress was made on SAD symptoms, and the client had identified GAD as having shifted to a higher priority for treatment.

## **8 Access and Barriers to Care**

Relatively few barriers to care were present during this case. Jennifer had consistent access to an adequate internet connection and the needed technology equipment during the shift to telehealth services. Jennifer also had adequate resources to pay for treatment. However, as therapy could be appropriately provided by a student under supervision at a lower price rate, sessions were transitioned to the graduate student in order to assist with managing costs. This clinic was already electronically collecting treatment data and providing telehealth services prior to the pandemic, and thus, significant additional effort was not required to set up telehealth logistics and infrastructure, or secured methods for electronic communication/document sharing.

## 9 Follow-Up

Results from symptom measures completed after Session 18 supported the qualitative observation of significant improvement since baseline, as well as continued improvement since the previous assessment timepoint, which had been before the onset of local COVID-19 pandemic measures. One additional follow-up appointment was scheduled for 6 months from the final session, to coincide with the client's anticipated return to in-person college classes.

## 10 Treatment Implications of the Case

Jennifer had already made significant progress with her SAD symptoms before initiation of stay-at-home guidance and regulations related to the COVID-19 pandemic. However, CBT via telehealth, with HIPAA-compliant adaptations, continued to be useful to Jennifer in addressing new stressors and generalized anxiety which became more distressing after the start of the pandemic and the initiation of pandemic-related public health guidance and regulations. Jennifer's symptom measure scores primarily decreased between baseline and mid-treatment, with a continued but more gradual decrease between mid-treatment and post-treatment. It would not have been unexpected that the majority of client progress would have occurred by the two-thirds mark in the course CBT, whether in-person or via telehealth; however, it remains a possibility that the transition to CBT via telehealth, or COVID-19 pandemic stressors, affected the potential trajectory of progress. However, we would note that, at least in this case, gains were sustained and further improvement did occur even in light of factors such as comorbidity of other diagnoses and a significant change in life circumstances.

While this course of therapy did not follow a manualized format, it did draw on evidence-based principles, and had the flexibility to spontaneously address idiosyncratic concerns which were not necessarily related to the primary diagnosis addressed (e.g., racing thoughts, generalized anxiety) as well as unexpected situational circumstances (e.g., overall stress of a global pandemic, shift to online classes, and initiation of social distancing measures). For Jennifer, the generally successful resolution of social anxiety did not resolve her overall generalized anxiety. However, it was found that the skills learned and progress made in the context of SAD treatment did assist with other concerns she experienced, such as normative worry with the onset of the COVID-19 pandemic, and about her future after college.

This case demonstrates the potential for good outcomes from CBT for SAD even in the context of COVID-19 pandemic conditions. Although the course of treatment followed in this case may have been similar to a planned course of telehealth CBT prior to the pandemic (e.g., incorporating initial in-person sessions and exposures with remote sessions and virtual exposures), telehealth was in fact not planned well in advance and was an abrupt shift in delivery method, which thus required rapid flexibility and openness to novel experiences by the providers as well as the client, including choosing a format that might not have been first choice under typical circumstances, and addressing acute stressors as they arose. This course of treatment also differed from pre-pandemic telehealth CBT by virtue of the fact that even in-person exposures done on Jennifer's own needed to account for the loss of typical access to others she had regularly seen in person. For example, Jennifer previously would use classes or walks with friends for social exposure opportunities, but once the pandemic started she did not have such options anymore. Over the course of the COVID-19 pandemic, our clinic therapists have needed to consider whether or how to carry out the go-to types of social exposures often used in CBT, such as physically approaching strangers to ask questions, due to the globally shared experience of uncertainty in learning how to physically and socially navigate the world in these pandemic circumstances. In addition, new therapy topics that arose included the impact of the pandemic on Jennifer's family, Jennifer's reflection that what she

had learned in therapy allowed her to more constructively cope, and the specific consideration of social cues and behaviors during online meetings and classes. For example, Jennifer addressed the dilemma of whether to look at the screen or the camera during online classes, and online meetings meant that Jennifer would rarely be seen from the shoulders down in class, which would eliminate her fears of people noticing underarm sweat. It was also noted that, as SAD resolved and in response to new stressors, different symptoms emerged as the primary concern, which represented both exacerbation of previous symptoms (e.g., generalized anxiety) and new symptoms (e.g., sleep difficulties). Unexpectedly, the change in treatment delivery format and circumstances due to the COVID-19 pandemic also provided Jennifer the opportunity to benefit from attending the support group, because she did not have to physically travel to the clinic.

Having a solid base of CBT already completed during in-person treatment laid the groundwork for continuing strong CBT after the abrupt shift to telehealth, as well as for Jennifer maintaining treatment gains and sustaining her trajectory of improvement over time. If it had been the case that Jennifer would have significantly benefitted from more social exposures following the transition to telehealth, these might have been arranged in an online format (e.g., having another staff member virtually join the session for a mock graduate school interview), or designed in a way compatible with social distancing measures (e.g., asking a grocery store employee for assistance from an appropriate distance and while wearing a face mask). It could be argued that such exposures would not fully capture the variables present during in-person interactions (e.g., odors and full body view). However, it has been the case for over a year at this point in time that online meetings and classes, and distanced interactions, are commonplace due to the pandemic, and may continue to be so for an indeterminate time into the future. It is thus to our benefit to create and utilize exposures that will promote success in these conditions, and to have a good understanding of what works in reducing anxiety in such interactions, whether or not we regain ample opportunities for in-person contact during the course of therapy. As this case also demonstrates therapy for SAD which was successfully done by a student over telehealth, and supervised via televideo, it could also be argued that changes in service delivery method and providers presented Jennifer with a wide variety of factors in social interactions, which could assist in generalization of skills. While the timeframe of this case did not include significant loosening of public health measures after their onset, based on Jennifer's success with in-person exposures prior to the pandemic, and her own initiative in seeking out additional in-person interactions (e.g., joining the English conversational group), it seems likely that she would be able to challenge anxiety-related obstacles and to succeed in navigating in-person interactions as the opportunities arise. Indeed, Jennifer commented after the onset of the pandemic that she now recognized how much fun she used to have interacting with others, and that anxiety prevented her from taking advantage of previously available occasions for social engagement. It is possible that she may eagerly rise to such occasions in the future.

Limitations of generalizability from this case study include that treatment took place in an outpatient clinic which was primarily self-pay, and with relatively few barriers to care. We hope to have provided useful information from a real-life course of treatment as an addition to the body of emerging research from the era of the evolving COVID-19 pandemic. Additional case studies and research with community and clinical samples as the pandemic continues to evolve will assist in determining whether treatment outcomes for Jennifer may be generalizable to other young adults with pre-existing mental health conditions during the pandemic.

## **11 Recommendations to Clinicians and Students**

Our recommendations are to utilize creativity in providing therapy under new and stressful circumstances. We may consider the intent of best practices from the evidence base, such as providing opportunities for new learning and approaching anxiety-provoking situations, while

carrying these practices out in unexpected circumstances or with limited or different resources. It is possible to provide CBT for SAD with effective results even with limitations on face-to-face therapy and ability to engage in in-person social exposures. The onset of a major life stressor does not necessarily preclude treatment or lead to a setback in progress; additional interventions can be incorporated into treatment as necessary. In addition, when comorbidity is present, we may expand our case conceptualization to consider multiple explanations for symptoms (e.g., racing thoughts may be precipitated by ADHD, ADHD medications, or anxiety) and multiple interventions (e.g., relaxation) which may be indicated for one treatment target but also compete with a different treatment target.

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