Building Social Confidence

THE TALKING THERAPIES UK SELF-HELP SERIES



Building Social Confidence

An eight-module CBT programme for social anxiety, working with the cognitive patterns that maintain it and building the experiences that allow social confidence to develop

A self-help workbook · 8 modules · about 8 weeks

TALKING THERAPIES UK

First edition · 2026

Published by Talking Therapies UK, talkingtherapies.co.uk.

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First edition, 2026.

This workbook accompanies the Building Social Confidence programme on the Talking Therapies UK self-help platform. Its text is drawn from the programme and is kept current with it: whenever the programme changes, the workbook is set again.

Revision 7. This printing was set on 7 November 2026 from the programme as it stood that day.

A note on using this workbook. It offers self-help based on established psychological approaches for difficulties of mild to moderate severity. It is not a substitute for assessment or treatment by a qualified professional and is not designed for use in a crisis. The examples in it are fictional; no real person appears in them. If you are worried about your safety, or your difficulties are getting worse, the page headed “When self-help is not enough” says where to turn.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

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How to use this workbook

Social anxiety, in its chronic form, is one of the most common and most underestimated anxiety conditions. The felt experience is of being permanently on display, of every social situation carrying the risk of exposure, of having to manage how you come across rather than simply being. The pattern often dates back to adolescence or earlier and has typically been treated by the person as a personality trait ('I am shy', 'I am introverted') rather than as a treatable cognitive-behavioural pattern with a well-mapped maintenance cycle. This eight-module programme works with social anxiety using the Clark-Wells cognitive model developed at the Oxford Cognitive Therapy Centre by David Clark and Adrian Wells, which is the gold-standard CBT approach to social anxiety disorder. The model has strong randomised controlled trial evidence, is the framework used in NHS Talking Therapies, and is the basis of the protocols used in international guidelines for social anxiety treatment. The model and the methods are well-tested; the format is self-directed rather than therapist-led. Understanding social anxiety. The first conceptual move is recognising that social anxiety is not the same as ordinary shyness or introversion. Shyness is a temperamental disposition that is comfortable in its own skin and selective about social engagement; introversion is a preference for lower-stimulation social environments. Social anxiety is something quite different: a sense of social situations as threatening, an attentional shift to monitoring how you come across, and a set of cognitive and behavioural patterns that maintain the threat-sense rather than letting it settle through experience. The cognitive model. When social anxiety fires, three things happen in quick succession. First, attention shifts inward, away from the actual social situation and onto a self-monitoring stance: how do I look, how do I sound, what are they thinking of me. Second, a negative self-image arrives in the mind, often visual or felt rather than verbal: a picture of yourself as awkward, exposed, judged, that feels more real than the actual social moment. Third, safety behaviours kick in: the small things you do to manage the anxiety in the moment, such as avoiding eye contact, rehearsing what you will say, gripping your drink, leaving early. The safety behaviours feel protective but they keep the cycle going by preventing you from discovering that the predicted catastrophe is not arriving. Self-focused attention. The first substantive piece of work is shifting attention outward, away from the self-monitoring stance and into the actual social situation. Attention is trainable, and the cognitive modules teach the specific techniques for redirecting attention to external focus in real time. The shift is small in description and substantial in effect: people who learn to redirect attention often report that social interactions feel quite different even before the underlying beliefs have changed. The negative self-image. The image of yourself that arrives in socially anxious moments is typically not what other people are actually seeing. It is a distorted self-picture, often dating back to the original onset of the social anxiety, that the system keeps offering up as if it were a live snapshot. The cognitive work surfaces the image, examines what is actually in it, and gradually updates it with more accurate evidence about how you actually come across in social situations. Behavioural experiments and dropping safety behaviours. The behavioural work centres on structured experiments in which you enter social situations without the usual safety behaviours and gather evidence about what actually happens. The experiments are calibrated carefully, starting with situations that test specific predictions and gradually working up. The point is not to expose yourself to anxiety for its own sake; it is to discover,

through actual experience, that the catastrophes predicted by the social anxiety system do not arrive. Pre-event worry and post-event rumination. Social anxiety extends beyond the social moment itself. Before social situations, the system runs ahead with anticipatory worry; after them, it runs a post-event review that picks over every imperfect moment and stores the experience as evidence of the predicted catastrophe. The cognitive modules work explicitly with these patterns, since the social anxiety system feeds on the pre- and post-event processing as much as on the events themselves. The maintenance plan. The closing module is a personalised maintenance plan: the early warning signs that social anxiety patterns are reasserting themselves, the specific strategies that work for you at each level of intensity, and the conditions under which stepping up to therapist-led care is the right move. Who this is for and what it is not. The programme is suitable for adults experiencing social anxiety at NHS Talking Therapies Step 2 equivalent: social situations carry persistent worry, the worry is interfering with relationships or work, but there is enough capacity to engage with the structured exercises and the graded social exposure work. If social anxiety has become severely impairing, if there is substantial agoraphobia, if there is a co-occurring panic disorder requiring its own treatment, or if there is a substantial trauma history, individual therapy with a CBT-accredited therapist is more appropriate. If you are in crisis, please contact Samaritans on 116 123, text SHOUT to 85258, or NHS 111 option 2.

This workbook is the written form of the Building Social Confidence programme on the Talking Therapies UK self-help platform. It follows the programme module by module: each part of the book is one module, and each chapter is one piece of the module's teaching, set in the order the programme presents it.

Read the chapters of a part in order, then turn to the worksheets that follow them. The worksheets are the part of the work that changes things, so give them the time they ask for and come back to them as the weeks go on. You may copy or print the worksheets for your own use, as often as you need.

Most people work through one module a week, which takes the whole programme about 8 weeks. Go at the pace that suits you: a module done properly is worth more than two done quickly.

The check-in questionnaires let you see how things are changing. Complete each one when you reach it, note the date and your total, and compare it with the last.

When self-help is not enough

- If you are in danger now, or have seriously harmed yourself, call 999 or go to your nearest accident and emergency department.
- If you need help urgently but it is not an emergency, call NHS 111 or contact your GP surgery.
- Samaritans are there day and night, every day of the year: call 116 123 free from any phone.
- If you would rather not talk, text SHOUT to 85258 for free, confidential support at any hour.
- If your difficulties are getting worse as you work through this book, or you find yourself thinking about ending your life, stop and speak to your GP or a mental health professional. A workbook can be a good start, and some difficulties need more help than a book can give.

What this workbook will help you to do

By the end of this module you will:

- Understand social anxiety as a specific cognitive-behavioural picture rather than as a personality flaw or simple shyness
- Know the spectrum of social anxiety from mild self-consciousness to clinically significant social anxiety disorder
- Recognise the cognitive, behavioural, and physiological features of social anxiety
- Have set three goals for what this programme should change
- Understand the Clark-Wells cognitive model of social anxiety in working detail
- Know the three central maintaining factors and the two contextual factors
- Be able to map your own version of the model from a recent social situation
- Understand why social anxiety does not just resolve on its own without intervention
- Understand why self-focused attention is one of the central maintaining factors in social anxiety

PART 1

Understanding Social Anxiety

What social anxiety is, how it differs from ordinary shyness, and why the chronic version is one of the most treatable conditions in the anxiety family

CHAPTER 1

Welcome to the programme

This is an eight-module programme for people whose lives are being shaped by social anxiety. The condition is one of the most common in the anxiety family, with around 12% of adults meeting the diagnostic criteria at some point in their lives, and many more carrying social-anxiety patterns that fall short of the formal diagnosis but still substantially affect how they live. The picture is recognisable: the parties not attended, the meetings dreaded, the conversations rehearsed in advance, the post-event replays at three in the morning, the careful management of how you come across, the felt sense of being permanently on display.

The framework in this programme is the Clark-Wells cognitive model of social anxiety, developed by David Clark and Adrian Wells in the 1990s and refined extensively since. The model has stronger evidence than any other approach to social anxiety; randomised controlled trials consistently show large effect sizes and durable gains, and the model is the basis of the CBT-for-social-anxiety protocols used in NHS Talking Therapies, the IAPT programmes, and the equivalent services internationally. The approach is more demanding than generic anxiety advice but considerably more effective.

The good news, and it is genuinely good news, is that social anxiety is one of the most treatable conditions in the anxiety family. The cognitive-behavioural picture has clear maintaining factors that can be identified and changed. The interventions in this programme are not subtle; they ask you to do specific things that the social-anxiety pattern has been telling you not to do, and the doing produces direct evidence that the predictions of catastrophe were wrong. The change can be substantial within eight weeks for people who do the work consistently.

A note about what the programme is not. It is a self-directed Step 2 programme appropriate for social anxiety that is interfering with daily life but has not become severely impairing. If your social anxiety has reached the point of agoraphobia (you cannot leave the house, attend appointments, or do basic activities), if it is bound up with severe depression, if there are panic attacks at the thought of social situations, or if alcohol or other substances have become part of how you manage social situations, individual therapy is more appropriate. The final module covers the step-up criteria; for now, the point is that the programme is right for the socially anxious person who is functioning but tired of the felt cost.

CHAPTER 2

What social anxiety actually is

Social anxiety is the specific kind of anxiety that activates in situations involving the perceived evaluation of others. The defining feature is the fear of being judged, evaluated, or scrutinised. The fear is not of social situations per se; it is of how you will appear in those situations, and of the consequences of appearing badly.

This distinguishes social anxiety from other kinds of anxiety. In agoraphobia, the fear is of being trapped or unable to escape; the social aspect is incidental. In generalised anxiety, the worry spreads across many domains; social situations are one of many. In panic disorder, the fear is of the panic itself; the social element is secondary. Social anxiety is specifically about evaluation, and the cognitive content centres on what others might think of you.

The spectrum

Social anxiety exists on a continuous spectrum.

Ordinary self-consciousness. Almost everyone feels some self-consciousness in particular situations: giving a speech to a large audience, attending an event where they know nobody, being scrutinised in a job interview. The self-consciousness is proportionate to the situation, does not generalise to most social interactions, and resolves once the specific situation passes. This is normal and is not what the programme is about.

Trait shyness. Some people are temperamentally shy. They prefer smaller groups, take longer to warm up to new people, prefer depth over breadth in friendships. Shyness is a personality trait and is not pathological; many shy people have rich social lives that suit them and feel no need to change. The programme is not about reducing shyness as a trait.

Mild social anxiety. Some self-consciousness extends beyond the situations that would activate it in everyone, but does not severely constrain life. The person attends most social situations they want to, has friends and connections, but experiences anxiety in many ordinary social interactions and feels the cost. This is the level at which the programme can be transformative.

Moderate social anxiety. The anxiety constrains life more substantially. Some social situations are routinely avoided. Others are attended but at significant cost. There is post-event replay, pre-event dread, a sense of having to perform a normal-self rather than simply be one. Quality of life is affected. The programme is well-suited to this level; substantial change is realistic in eight weeks.

Social anxiety disorder. The clinical condition. The anxiety is severe enough that everyday social situations are routinely avoided or endured with substantial distress. Career, relationships, and quality of life are affected. The diagnosis requires the anxiety to have been present for at least six months and to cause significant impairment. The programme is part of the picture for this level but may need to be combined with individual therapy; the final module covers the step-up criteria.

Severe social anxiety disorder. The condition has reached the level of substantial avoidance of most social situations. The person may have left work, withdrawn from relationships, become

substantially housebound. Self-help alone is unlikely to be sufficient; individual therapy and possibly medication is the appropriate response.

Why it matters where on the spectrum you are

The programme is calibrated for mild-to-moderate social anxiety. Most clients in NHS Talking Therapies-equivalent services fall into this range, and the techniques in this programme are the same techniques that would be used in individual treatment for that range. People with severe social anxiety disorder benefit from the framework but typically need clinician-led care alongside; the self-help format is too demanding to do alone when the avoidance is comprehensive enough that most of the suggested behavioural exercises feel impossible.

A useful self-assessment: in a typical week, how many social situations do you avoid that you would, in some sense, have wanted to attend? How much mental energy goes into managing how you come across? How often does the post-event replay run? How constrained does your life feel by the social anxiety? The honest answers locate you on the spectrum and indicate what kind of work the programme will need to do.

Hannah, thirty-one, senior data analyst, moderate social anxiety since university. The Tuesday morning team meeting is the regular event she dreads most.

She wakes at 5:42 instead of 6:30. The first conscious thought is the meeting. She runs through the agenda items in her head and tries to anticipate which one will require her to speak. She mentally rehearses two possible things she might say about the quarterly numbers; she rehearses them as if each were a small audition.

At 8:55 she arrives at the office. She has chosen her blouse with reference to what she wore at the last team meeting (she had felt fine in it, so she has chosen it again, on the theory that the blouse is part of what allowed her to feel fine). She has applied makeup that hides the small patch of redness that appears on her neck when she becomes anxious. She has rehearsed three sentences she might use as opening remarks if her manager asks for her view.

At 9:03 the meeting begins. The agenda is largely operational. Hannah's role is to present the quarterly figures, which she does competently for four minutes. She sits down. She is aware of her face being warm and of her hand having shaken slightly while she clicked the slide forward. She becomes aware of these things because she is monitoring herself; she does not know whether anyone else has noticed them.

At 9:11 her manager asks her view on a strategic question. Hannah feels the room's attention turn to her. The sentences she had rehearsed do not fit the question. She speaks for thirty seconds. She is aware as she speaks of her voice sounding slightly thinner than usual, of the warmth in her face, of the second of pause she took before starting. She finishes. Her manager nods and moves on.

At 9:30 the meeting ends. Hannah's colleagues file out. Her colleague Ravi says "thanks, that was useful". She walks to her desk and immediately begins the replay. Did I sound stupid when I paused? Was the pause too long? Did my voice sound shaky? Did Ravi say "useful" warmly or politely? Was Ravi's "useful" sarcastic? Did everyone notice my face?

The actual view from outside, which Hannah cannot access, is that the meeting was a routine

team meeting in which one of the analysts presented her numbers clearly and gave a competent off-the-cuff strategic answer. No one noticed her hand. No one noticed her face. No one was thinking about her thirty seconds after the meeting ended. Ravi's "thanks, that was useful" was sincere.

Hannah will spend perhaps forty minutes today replaying the meeting in her head. Tonight she will wake at 3am and replay it again. Tomorrow at 9am she will notice she has been thinking about the meeting and tell herself to stop. By Thursday it will have largely faded. On Sunday evening, the dread for the next Tuesday meeting will begin to assemble.

The programme works on each of these mechanisms: the pre-event preparation, the self-focused attention during the event, the safety behaviours (the chosen blouse, the makeup, the rehearsed sentences), the post-event rumination, the prospective dread. Each module dismantles one of them.