Building Social Confidence: Practitioner Guide

THE TALKING THERAPIES UK PRACTITIONER GUIDES



Building Social Confidence: Practitioner Guide

Delivering the programme as guided self-help

A practitioner guide · 8 contacts · to accompany the workbook

TALKING THERAPIES UK

First edition · 2026

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

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First edition, 2026.

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

Revised and expanded edition, November 2026: the approach and its evidence, written practitioner notes and a worked example for every contact, the module's own teaching set out for the practitioner, and the answers to every sorting task and quiz.

Revision 9. This printing was set on 7 November 2026 from the programme as it stood that day.

A note on clinical responsibility. This guide supports qualified practitioners delivering guided self-help within their competence, their supervision and their organisation's policies. It does not replace clinical judgement, and its thresholds are guidance: where your service's policy differs, follow your service's policy.

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

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How to use this guide

This guide is for qualified practitioners who support clients through the Building Social Confidence programme as guided self-help: a short supported contact after each of its 8 modules, with the client working through the programme or its workbook in between.

Part 1 sets out the model the programme is built on, what the research shows, and who the programme is for. Part 2 covers what every contact needs: your part in guided self-help, how to structure a contact, how to review each kind of worksheet, what to do when the work is not being done, how to adapt the programme, the check-ins and when to step up, and risk. Read Parts 1 and 2 before you begin with a client.

Part 3 has a chapter for each contact, to read before that contact: what the client has read in the module, why the skill matters, the messages to reinforce, a plan, the questions to ask, a worked example with dialogue, how to review the week's worksheets with their answers, and what to do when the skill is hard, how to adapt it and its cautions. Part 4 covers ending the work, supervision, and the checklist.

The guide follows the programme as it stands on the platform, so its plans name the programme's own modules, teaching and worksheets, and it is set again whenever the programme changes.

What this guide covers

- The model the programme is built on, and what the research shows
- Who the programme suits, how to assess for it, and when it is not enough on its own
- Your part in guided self-help, and how to structure each contact
- For each of the 8 contacts: what the client has read, why it matters, a worked example with dialogue, a plan, and the worksheets with their answers
- What to do when a skill is hard to learn or use, how to adapt it, and its cautions
- Keeping the work going, adapting the programme, the check-ins and stepping up, and risk at every contact
- Ending well, supervision, and a checklist for delivering the programme as designed

PART 1

The approach and the evidence

The model the programme is built on, what the research shows, and who the programme is for.

In this part

- Chapter 1, The model behind the programme: social anxiety and its spectrum, the Clark and Wells cognitive model, why social anxiety persists, and how the eight modules are built
- Chapter 2, What the research shows: the evidence for CBT in social anxiety disorder, NICE's recommendations and where guided self-help fits, and the evidence for the programme's techniques

CHAPTER 1

The model behind the programme

What social anxiety is

Social anxiety is fear of being judged, evaluated or scrutinised by others. Its defining feature is not a dislike of people but a fear of how one will appear to them and what will follow if one appears badly: that others will see the anxiety, think less of the person, and reject them. It sits on a spectrum, from ordinary shyness, through self-consciousness that costs the person some opportunities, to social anxiety disorder, in which the fear is persistent, the avoidance is wide, and work, friendships and relationships are restricted. Module 1 describes the spectrum and the three domains of the problem, thinking, behaviour and body, and asks the client to set goals.

Social anxiety often begins in adolescence and is frequently long-standing by the time a person seeks help. Many clients have come to regard it as their personality ("I'm just a quiet person"). The programme does not ask anyone to become outgoing; it asks whether fear is making choices that the person would not otherwise make.

The Clark and Wells model

The programme is built on the cognitive model of social anxiety published by Clark and Wells (1995), one of the two models NICE names as the basis for individual CBT for social anxiety disorder. The model proposes that when a socially anxious person enters a feared situation, beliefs about the danger of being judged are activated, and the person shifts into processing themselves as a social object. Attention turns inwards, to monitoring their face, voice, hands and

words. From the feelings this monitoring detects, they build a vivid and distorted impression of how they appear, often as an image seen from an observer's point of view. To prevent the feared outcome, they use safety behaviours: rehearsing, avoiding eye contact, gripping a glass, staying at the edge of the group, drinking before they arrive. And the anxiety symptoms, blushing, trembling, a mind going blank, are experienced as visible and as proof of the danger.

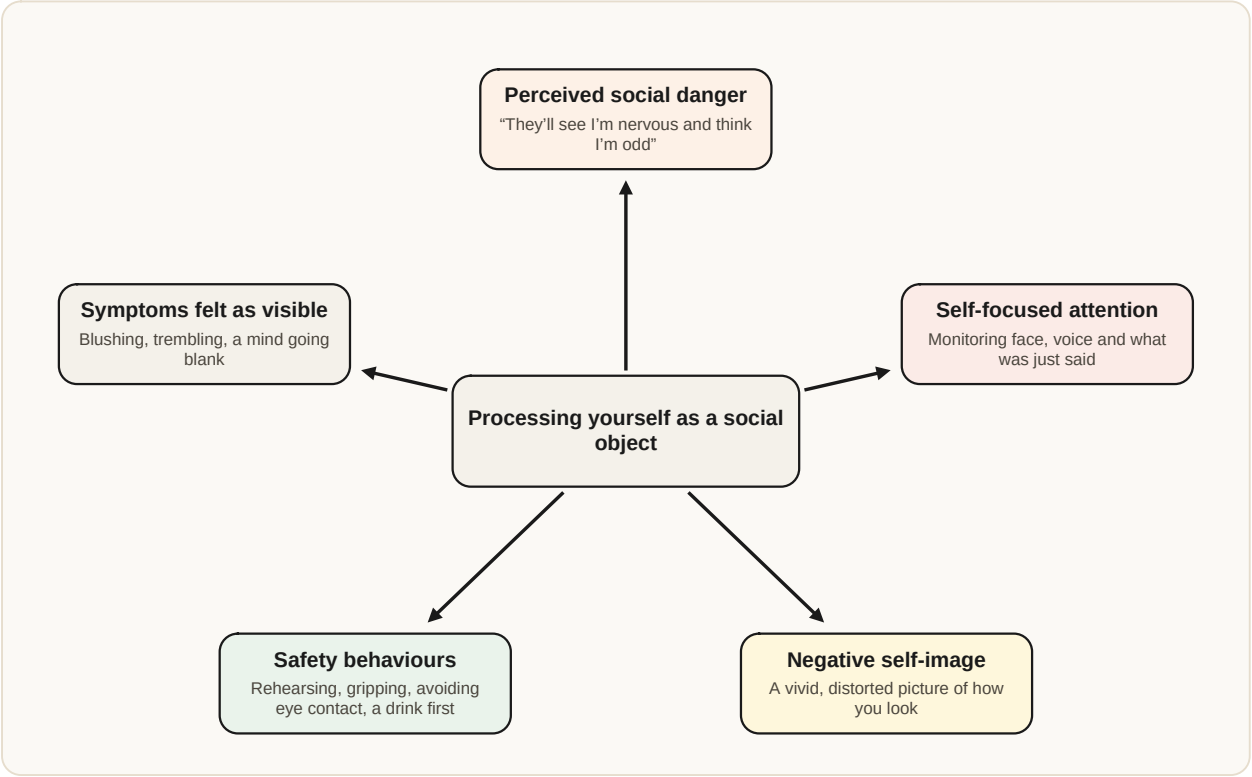


FIGURE 1.1 The Clark and Wells model of social anxiety
In a feared social situation, attention turns inward and the person builds an impression of how they appear from how they feel. That impression, the safety behaviours used to manage it, and the anxiety symptoms that are felt as visible all keep each other going, and all stop the person seeing what is actually happening around them.

The model explains why social anxiety persists despite years of social situations that turn out acceptably. Inward attention means the person does not see the evidence around them, such as people's friendly or neutral reactions. The self-image is built from feelings, not from information about how they look. The safety behaviours take the credit for the catastrophe not happening, and some of them make the feared outcome more likely: a person who rehearses their lines and avoids eye contact can come across as distant, which they then read as rejection. Wells and colleagues (1995) showed experimentally that exposure with safety behaviours dropped reduced anxiety and negative beliefs more than exposure with them kept.

Around the situation, two further processes complete the picture. Before a feared event, the person worries in detail about what will go wrong, which primes the predictions and the self-image. Afterwards, they replay the event, focusing on every perceived mistake, so that a conversation that went reasonably well is remembered as a humiliation. Brozovich and Heimberg (2008) reviewed the evidence that this post-event processing is common and persistent in social anxiety and that it maintains negative self-appraisals.

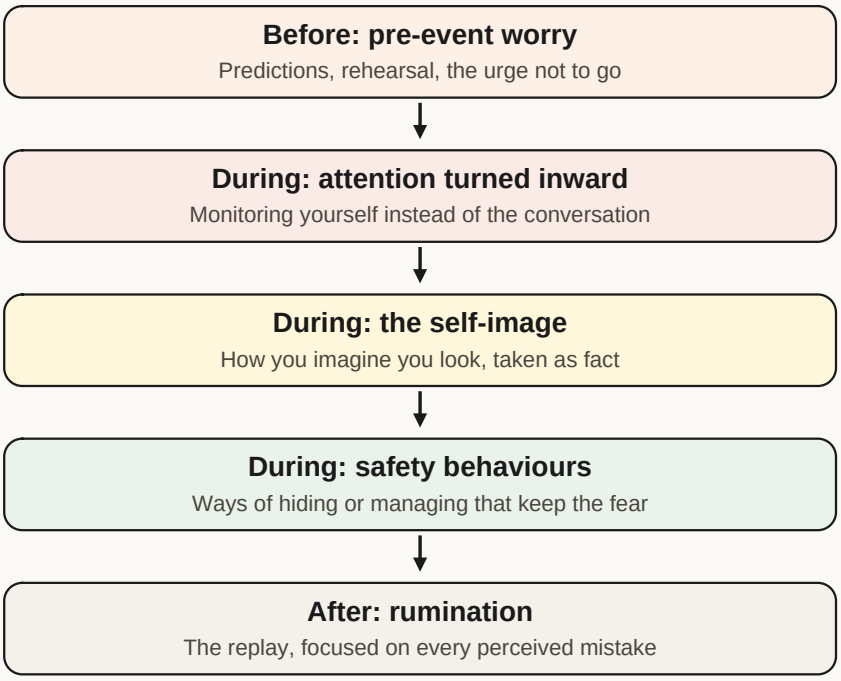


FIGURE 1.2 The five maintaining factors, before, during and after
Module 2 adds to the three factors inside the situation two that surround it. Pre-event worry primes the predictions and the self-image before the event; post-event rumination replays the event through the same distorted lens afterwards, so that even a situation that went well is remembered as a failure.

How the programme breaks the cycle

The modules work through the five factors in turn. Module 1 explains social anxiety and sets goals; module 2 maps the client's own version of the model from one situation. Module 3 trains attention outwards. Module 4 builds a full inventory of safety behaviours. Module 5 is the centre of the programme: behavioural experiments that compare inward and outward attention, and that drop safety behaviours one at a time. Module 6 updates the negative self-image with video feedback and surveys. Module 7 works on the worry before events and the replay after them, and module 8 consolidates the work.

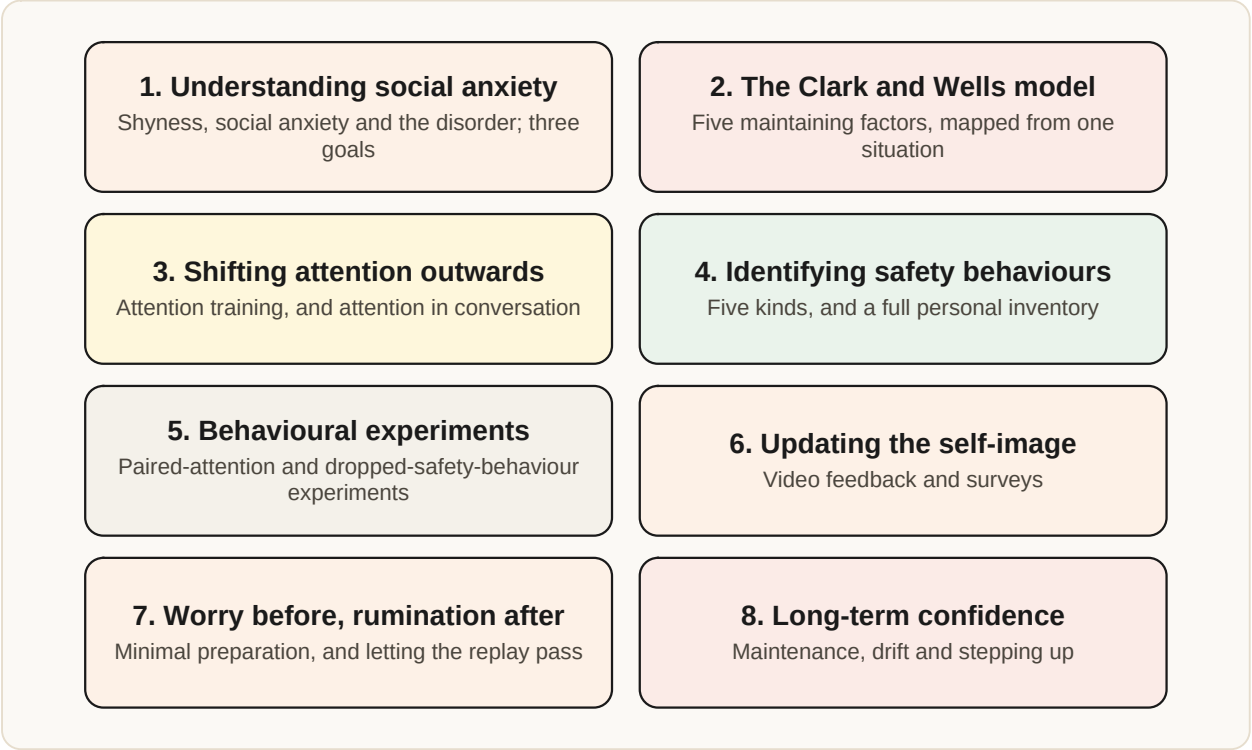


FIGURE 1.3 The eight modules and what each works on
Modules 1 and 2 explain social anxiety and map the client's own version of the model. Modules 3 to 6 work on the three factors inside social situations: attention, safety behaviours, and the self-image, with experiments at the centre. Module 7 works on the worry before and the replay after, and module 8 keeps the gains.

How the modules are built

Each module has an introduction, two to four teaching sections, a sorting exercise, a practical worksheet, a closing summary with practice for the week ahead, and a reflection, "Taking this forward", which asks what the client most wants to keep, when it will be hardest to use, and what exactly they will do then. The check-ins come in modules 1, 4 and 8: the PHQ-9 and the Work and Social Adjustment Scale in module 1, and the PHQ-9, GAD-7 and WSAS in modules 4 and 8. Take the GAD-7 at assessment, and the Social Phobia Inventory (Connor et al., 2000), seventeen items scored from 0 to 68, which NHS Talking Therapies services use to measure social anxiety and which is more sensitive than the GAD-7 to the change this programme aims for. The worked examples in this guide follow one composite client, Tomasz, through all eight contacts.

What the practitioner adds

The programme carries the teaching. The practitioner's part in social anxiety work has a particular feature: the contact is itself a social situation, and the client's social anxiety will be present in it. A client may rehearse what to say, avoid eye contact, give the answers they think the practitioner wants, or replay the contact afterwards. This is not an obstacle but an opportunity: the contact is a safe place to notice the model working, and later to run small experiments. The practitioner also helps the client design experiments that are genuinely informative, which in social anxiety means making predictions specific enough that the result can surprise them, and resisting the client's skill at explaining away a good outcome. Chapter 5 shows how a thirty-minute contact can keep its focus on what the client has done and learned.

CHAPTER 2

What the research shows

CBT for social anxiety disorder

Cognitive behavioural therapy is the most effective psychological treatment for social anxiety disorder. A network meta-analysis of psychological and pharmacological treatments for adults found individual CBT to have the largest effect of the psychological treatments compared with a waiting list, and concluded that it should be regarded as the best intervention for the initial treatment of social anxiety disorder; self-help, with or without support, was also more effective than a waiting list, with a somewhat smaller effect (Mayo-Wilson et al., 2014). Cognitive therapy based on the Clark and Wells model has performed particularly well in trials, including one in which it was more effective than exposure with applied relaxation, both of which were more effective than a waiting list (Clark et al., 2006).

Where guided self-help fits

The National Institute for Health and Care Excellence (2013) recommends individual CBT, based on the Clark and Wells model or the Heimberg model, as the first treatment for adults with social anxiety disorder, and CBT-based supported self-help for adults who decline individual CBT and wish to try another psychological intervention, with up to nine sessions of supported use of a self-help book over three to four months. This has a practical consequence for how the programme is offered. For a client with social anxiety disorder, individual CBT should be discussed first. The programme is a good choice for clients with milder social anxiety, for those who have been offered individual CBT and prefer supported self-help, for those waiting for individual therapy, and for those who find the prospect of face-to-face therapy too daunting to start with, which is common in social anxiety and is itself worth discussing. Record the discussion and the client's choice.

The techniques

Each of the programme's central techniques has direct evidence. Wells and colleagues (1995) found that dropping safety behaviours during exposure produced greater reductions in anxiety and in negative beliefs than exposure alone. Harvey and colleagues (2000) found that video feedback was more effective in correcting the distorted self-impression when it was preceded by cognitive preparation, predicting in detail how one would look and picturing it, and then watching as an observer would, which is how module 6 teaches it. Hackmann, Clark and McManus (2000) found that most people with social phobia reported recurrent negative self-images in social situations, often linked in theme to memories of unpleasant social events around the time the problem began, which is why module 6 asks the client to articulate their image precisely. And Brozovich and Heimberg (2008) reviewed the evidence on post-event processing that underpins module 7.

What the research does not show

No trial has tested this programme in its present form. The evidence above comes mainly from therapist-delivered CBT and from experimental studies of its components. The programme applies that evidence with care, and the stepping-up guidance in Part 2 and in module 8 is the safeguard for clients for whom it is not enough: those whose avoidance is severe, and those whose social anxiety is accompanied by depression, panic attacks, the use of alcohol or drugs to cope, or the effects of trauma.