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A NEW MULTIDIMENSIONAL INTERVENTION FOR SOCIAL ANXIETY: THE MISA PROGRAM

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Abstract

This article presents a new treatment program for social anxiety, specifically for social anxiety disorder (social phobia) and avoidance personality disorder. Its name, *Multidimensional Intervention for Social Anxiety* (MISA), indicates that it revolves around the five dimensions that our research team found working on social anxiety with participants from 20 countries for more than 15 years, namely (1) interaction with strangers, (2) interaction with the opposite sex, (3) assertive expression of annoyance, disgust, or displeasure, (4) embarrassment or criticism, and (5) speaking in public/interaction with persons of authority. It incorporates both traditional techniques of cognitive behavioral therapy and strategies of third-generation therapies. The MISA program is applied in a group format through 15 treatment sessions of 2.5 hours each, plus one booster session, and pre/post-treatment and follow-up assessment sessions. We believe that it is currently the best treatment program available for social anxiety and in the coming months we will be able to substantiate this claim.

KEY WORDS: *MISA Program, multidimensional intervention, social anxiety, social phobia.*

Resumen

Se presenta un nuevo programa de tratamiento para la ansiedad social, específicamente para el trastorno de ansiedad social (fobia social) y el trastorno de personalidad por evitación. Su nombre, *Intervención multidimensional para la ansiedad social* (IMAS), indica que gira alrededor de las cinco dimensiones que nuestro equipo de investigación encontró trabajando en ansiedad social con 20 países durante más de 15 años, como son: 1) Interacción con desconocidos, 2) Interacción con el sexo opuesto, 3) Expresión asertiva de molestia, desagrado o enfado, 4) Quedar en evidencia/Hacer el ridículo, y 5) Hablar en público/Interacción con personas de autoridad. Incorpora tanto técnicas tradicionales de la terapia cognitivo conductual como estrategias de las terapias de tercera generación. El programa IMAS se aplica en formato grupal a lo largo de 15 sesiones de tratamiento de 2,5 horas cada una, más una sesión de apoyo y las sesiones de evaluación pre/postratamiento y seguimiento. Creemos que en estos momentos constituye el mejor programa de tratamiento para la ansiedad social y en los próximos meses estaremos en disposición de demostrar esta afirmación.

PALABRAS CLAVE: *programa IMAS, intervención multidimensional, ansiedad social, fobia social.*

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Introduction

Social anxiety is a widespread problem today. Its clinical expression is included in classification systems with the name of social anxiety disorder (SAD) or social phobia. The Diagnostic and Statistical Manual of mental disorders (DSM-5) (APA, 2013) defines it as "marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others" (p. 202). In this definition, the APA includes three types of situations feared by an individual with SAD: social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech). In general, the individual has to do something while he knows that others will be watching him and, to some extent, evaluating his behavior. The distinguishing characteristic of people with SAD is the fear of being judged by others, that is, fear regarding the prospect of being observed and evaluated by other people, and, particularly, when expressing anxiety when carrying out certain activities in the presence of others, which will be embarrassing or humiliating. These activities may include eating, drinking, writing, signing, using public toilets, working or traveling on public transport, walking in front of others or simply being observed. During these activities the concern is that people realize that they are anxious, that they blush, tremble or show any other physical sign of anxiety, that they see them fainting or that they look sick, which can lead to a negative evaluation (Caballo, Salazar, García-López, and Arias, 2014). This highlights the social nature of the disorder, because subjects with this disorder have no difficulties when they perform the same tasks in private. "Behavior deteriorates only when others are watching" (Barlow, 2002, p. 456). However, this fear of being negatively evaluated also appears markedly when they interact (or there is a possibility of doing so) with other people. In those cases, their fears are related to the opinion they fear the other has formed regarding them. Their expectation is that others will think they are incompetent, clumsy, inefficient, not valid, etc.

The prevalence of SAD seems to vary considerably between countries (e.g., from 0.6% in Spain to 7% in the United States) (Kessler & Üstün, 2008), although it is possible that the percentage of individuals with social phobia is underestimated. The reasons given by some authors (e.g., Heimberg, 1990, Heimberg, Dodge, & Becker, 1987) for this underestimation are the following. First, individuals with social phobia may avoid treatment because of the idea that talking openly about themselves may trigger the fear of being observed. Second, those subjects may consider that their problems cannot be solved, that they are shy of character ("that's who I am") and that they cannot change ("that's how I've always been"). Third, people with social phobia can go to treatment due to depression, alcoholism and other substance uses rather than primarily for SAD. Boyd et al. (1990) believe that the low percentage of subjects with social phobia receiving treatment could be due to the avoidance of physicians or psychologists as another issue of the characteristic interpersonal avoidance in subjects with SAD. Individuals with this disorder may be especially reluctant to discuss their emotional

difficulties with a therapist, due to their social concerns. Another possibility is that social phobia is not as disturbing as other psychological disorders with may be comorbid of SAD (e.g., major depressive disorder, obsessive-compulsive disorder, substance use disorder). Thus, individuals may decide to accept it as chronic and cope with it on their own instead of facing the challenges that SAD entails and learning new more authentic ways of living their lives.

Although at the treatment level there have been significant advances, (*Society of Clinical Psychology, APA, Division 12*, 2018), the evolution of SAD as a psychological construct since its first uses in the clinical setting (Janet, 1903, 1909) and its current assessment are not so clear. Thus, for example, the latest version of the DSM classification system (DSM-5) eliminated the generalized social phobia subtype ("fear of most social situations") and included a new one, the social phobia subtype of only performance ("when fear is limited to speaking or acting in public"). We think that this change is not based on empirical data and even disregards data provided by large studies with Spanish, Portuguese, and Latin American population (Caballo *et al*., 2012, 2015; Caballo, Salazar, Arias, *et al*., 2010; Caballo, Salazar, Irurtia, *et al*., 2010; Caballo, Salazar, Nobre-Sandoval, *et al*., 2017; Caballo, Salazar, Robles, Irurtia, & Equipo de Investigación CISO-A Mexico, 2016; Salazar, Caballo, Arias, & Equipo de Investigación CISO-A Chile, 2018; Salazar, Caballo, Arias, & Equipo de Investigación CISO-A Colombia, 2016), what constitutes a setback in the concept of SAD. At this moment, and if we paid attention to the DSM-5, there would be no diagnostic differences between a subject who fears only one type of social situations (unless they were situations of "speaking or acting in public") and one that fears most of social situations, when, at the clinical level, the differences are significant. Furthermore, it is not clear why "speaking or acting in public" constitutes a special type of social situation and no other kinds of situations such as "interaction with strangers" or "fear of embarrassment" are implicated. Our research on social anxiety over 15 years with more than 50,000 non-clinical participants and over 1,000 patients in 20 countries do not show special characteristics regarding the type of situations that have to do with speaking or acting in public (Caballo *et al*., 2012, 2015; Caballo, Salazar, Arias, *et al*., 2010; Caballo, Salazar, Irurtia, *et al*., 2010). Thus, we doubt that this change introduced in the DSM-5 constitutes some advance in the understanding of the SAD.

On the other hand, there is a significant overlap between the diagnosis of SAD and that of avoidant personality disorder (APD). The removal of the generalized subtype in the DSM-5 (APA, 2013) does not help this differentiation either, given that within the term SAD it is included from the fear of a social situation to the fear of most social situations and this generalized fear is what characterizes the APD. "It seems illogical to have two different nosological categories that show the same phenomenology and respond more or less to the same treatments, particularly in the absence of clear data on the differences in their etiology or in their course" (Bellack & Hersen, 1990, pp. 240-241). Both individuals with APD and those with SAD are very concerned about the perceptions that others have of them, they excessively desire the acceptance of others, suffer a social or work impairment because of their social fears and are very

concerned that others will discover their deficiencies. As Widiger (1992) pointed out, "a person who meets the criteria of generalized social phobia and APD does not suffer from two comorbid mental disorders, but simply a disorder that meets the criteria of two different diagnoses" (p. 341).

Another controversial issue is that in the area of the assessment of social anxiety, our research has established five basic dimensions:1) Interactions with strangers, 2) Interactions with the opposite sex, 3) Assertive expression of annoyance, disgust, or displeasure, 4) Criticism and embarrassment, and 5) Speaking in public/Talking with people in authority. All these dimensions should always be considered when assessing that construct, but they are never included all of them in the questionnaires assessing social anxiety, such as the *Liebowitz Social Anxiety Scale* (LSAS; Liebowitz, 1987), the *Social Phobia and Anxiety Inventory* (SPAI; Turner, Beidel, Dancu, & Stanley, 1989), the Social Phobia Inventory (SPIN; Connor *et al*., 2000), the *Social Interaction Anxiety Scale* (SIAS; Mattick & Clarke, 1998), the *Social Phobia Scale* (SPS; Mattick & Clarke, 1998) or the *Brief Social Phobia Scale* (BSPS; Davidson *et al*., 1991). So, only two of those dimensions, *Interactions with strangers* and *Speaking in public*, emerge as consistent dimensions in the most commonly used questionnaires around the world (SPAI, LSAS, SPIN, SIAS, SPS, and BPS). However, the *Interactions with the opposite sex* (or "interaction with people that attract me") dimension was not identified in the factor structure of any such measures. This seems surprising given the importance of this problem in the lives of individuals with social anxiety/phobia. These questionnaires include very few items, if any, addressing anxiety in social interaction with the opposite sex. For instance, the SPS and the SPIN do not include any such items and the SIAS and the LSAS only include a single item that assesses this problem. The SPAI, on the other hand, includes 17 of its 96 items. However, these 17 items are really sub-items grouped in each item with three other sub-items (fear of strangers, people with authority, and people in general) to give the average score of 17 "higher" level items. We understand that this is a limitation of the scoring procedure of the SPAI (Caballo, Salazar, Irurtia, *et al*., 2010).

Another dimension that appears with little frequency in the traditional questionnaires assessing social anxiety is the *Assertive expression of annoyance, disgust, or displeasure*. The SPIN, SPAI and SPS do not include any items on this issue and the SIAS contains only one item. Only the LSAS includes some items on assertiveness. Again, this is a surprising finding given the importance of assertiveness problems in social anxiety (Caballo, Salazar, Irurtia, *et al*., 2010).

Finally, the *Criticism and embarrassment* facet tends to be represented in excess in the existing questionnaires, although they generally differ in the names that they call this dimension. Although the fear of being observed is a major concern among individuals with social anxiety, the measures seem to overemphasize this issue while omitting other problem areas. For example, most of the SPS and SPIN items deal with the fear of embarrassing situations (Caballo, Salazar, Irurtia, *et al*., 2010).

There are also certain social situations included in most of the self-report instruments seen above that may not apply to Spain and the Latin American

countries. For example, "drinking in public" does not seem to be a typical concern among socially anxious people in those countries. People from Latin American countries spend an important part of their leisure time outside their homes at night, sitting outside or in bars, drinking in public. Therefore, drinking in public is rarely a problem, even among socially phobic individuals. A major problem in these cultures is not having friends with whom to participate in this activity. We do not believe that items such as drinking in public reflect a representative behavior of socially anxious people in Spanish and Portuguese speaking countries. Similar concerns can be raised with some other elements, such as the use of public toilets. We have the impression that "paruresis" (inability to urinate in a public bathroom) is not a major problem in Spanish and Latin American cultures.

Taking into account all the previous problems, our team developed the Social Anxiety Questionnaire for adults (SAQ) where some unrepresentative items are excluded and the five dimensions pointed above are included (Caballo *et al*., 2012, 2015; Caballo, Salazar, Arias, *et al*., 2010; Caballo, Salazar, Irurtia, *et al*., 2010). Results obtained with this questionnaire, validated in Spain, Portugal and most of the Latin American countries (e.g., Caballo *et al*., 2012, 2015, 2016; Caballo, Salazar, Arias, *et al*., 2010; Caballo, Salazar, Irurtia, *et al*., 2010; Caballo, Salazar, Nobre-Sandoval, *et al*., 2017; Salazar *et al.,* 2016, 2018), are the basis for the development of a new *Multidimensional Intervention for Social Anxiety*, the MISA program. The rest of the article will be dedicated to the description of this new cognitive behavioral program for the treatment of social anxiety.

Development of the Multidimensional Intervention for Social Anxiety (MISA program)

First steps

The idea of developing a new treatment program for social anxiety arose from the problems encountered throughout our research of more than 15 years on the assessment of social anxiety, problems that we have already described in the previous section and that can be found in deeper detail in the published works on the SAQ.

On the other hand, although there are several cognitive behavioral procedures empirically validated for the treatment of SAD (*Society of Clinical Psychology, APA, Division 12*, 2018) there are controversies about whether some of these strategies are necessary for the effective treatment of SAD, such as relaxation or social skills training. On the other hand, the irruption of procedures from third-generation therapies, such as acceptance and commitment therapy (ACT), mindfulness or dialectical behavior therapy (DBT) could add new techniques for the treatment of SAD.

Taking into account our experience in the treatment of social anxiety with cognitive behavioral techniques (e.g., Caballo, Bas, & Andrés, 1998), we decided to use this experience and try to incorporate the strategies of third generation therapies that could be more useful for intervention with social anxiety. After reviewing in depth the procedures of acceptance and commitment therapy,

mindfulness and dialectical behavior therapy and the empirical evidence supporting these procedures, we considered some of them of special relevance for its application in patients with social anxiety.

Development of the MISA program

Based on the findings found in our research with 20 countries, we placed the five dimensions defining the SAD (or social phobia) as the central axis of the new treatment program. We also took into account the social situations that best define each of the five dimensions, not only those that describe the items forming the "Social Anxiety Questionnaire for adults" but also those that could not be included in each of those dimensions (factors), but that clearly loaded onto the described dimensions. We thought that many of these situations could serve as exposure elements for homework. For instance, the situation "being asked to be quiet or to stop making noise in a library" was not selected among the items included in the dimension of *Criticism or embarrassment*, but clearly loaded on it (its loading in the factor was not one of the highest, but always loaded on that same factor). That situation could be part of the homework when working in the former dimension. That is, it could be a shame-attacking situation, so that patients could be scheduled to go to a library and speak out loud until they are asked to quiet down.

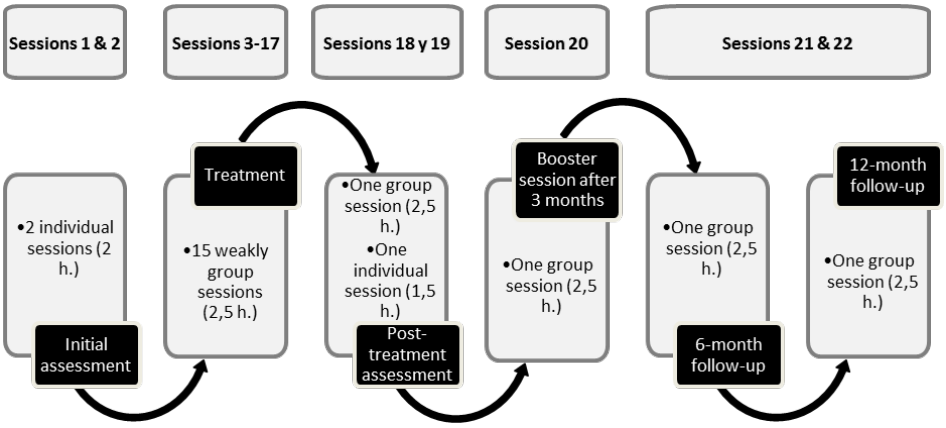
We devote two sessions to each of the five basic dimensions of social anxiety. But before addressing these dimensions, patients should learn the basic strategies that will allow them to approach social situations from a different and more functional perspective and with much more security. To do this, the first five sessions (not counting the assessments) are devoted to psychoeducation on social anxiety and, above all, to learn strategies to cope with social situations in a different way than they have done so far. With this goal in mind, we incorporated the establishment of life values, acceptance of emotions and bodily sensations, opposite action to change emotions, mindfulness and defusion from thoughts into the MISA program. The term *defusion* is a little confusing (even for English speakers). We could have used the words "detaching" or "distancing". Other authors use the term "decentering" (e.g., Eftekhari, 2017) and even some "spiritual" perspectives also handle the concept of detaching from our own thoughts (Tolle, 1997). This author also uses the concept of the here and now, pretty similar to the concept of mindfulness.

In addition to these "new" strategies for the treatment of social anxiety, we maintained some of the classic techniques that have already proved effective for SAD, such as social skills training (SST) and exposure, as well as some elements from cognitive restructuring (particularly the identification of dysfunctional thoughts) and progressive muscle relaxation (adapted to achieve the goal of fully attending to bodily sensations).

Key elements of the program

In this section, we will briefly address some of the key elements of the MISA program (Caballo, Salazar, & Garrido, 2018; Caballo, Salazar, Garrido, Irurtia, & Hofmann, 2018). We will describe them in the order in which they are applied throughout the program (figure 1).

Figure 1
General structure of the Multidimensional Intervention for Social Anxiety (MISA program)



1. *Pre/post-treatment and follow-up assessment*. The first contact (first session) with the potential patient is done through the "Clinical Semi-structured Interview for Social Anxiety" (CSISA; Salazar & Caballo, 2018) included in the therapist's guide. The CSISA is composed by 11 sections: 1) general data, 2) description of the physical appearance of the patient, 3) behavioral observation of the patient during the interview, 4) self report of current problems and / or difficulties, 5) description by the patient of the problems and / or current difficulties related to social anxiety, 6) effects of social anxiety on the daily functioning of the person, 7) motivation for treatment, 8) description by the patient of the goals and expectations regarding treatment, 9) evaluation of social anxiety by dimensions, 10) other psychological or medical problems, and 11) medications, alcohol and other drugs. The main objective of the interview is to obtain exhaustive information about the patient and his social anxiety, both at the global level and the five basic dimensions of social anxiety and to see to what extent such anxiety produces interference and distress in his life. In addition, it is a diagnostic interview, since it tries to find out if the patient meets the diagnostic criteria for the SAD according to the DSM-5 (APA, 2013). Once the interview is finished, the potential patient takes to fill in at home a series of questionnaires including the "Social Anxiety Questionnaire for adults" (SAQ) (Caballo, Salazar, Irurtia, *et al*., 2010), the "Social Skills Questionnaire" (SOSAQ) (Caballo, Salazar, & Equipo de Investigación CISO-A España, 2017) (both included in the therapist's book), as well as other self-report questionnaires that involve worry, depression, and alcoholism. In

the second session these questionnaires are reviewed, their responses are compared with the data obtained through the CSISA and it is verified that the patient meets the criteria for the SAD.

Immediately after having finished the treatment sessions, two more post-treatment evaluation sessions are implemented. Session 18 is carried out as a group and evaluates the personal progress that has taken place in each patient, the MISA program is also evaluated and personal work is planned for the next three months, until the booster session. Patients fill out the same questionnaires that were given at pre-treatment. Session 19 is an individual assessment session through the CSISA to find out if each patient continues to meet the diagnostic criteria for SAD (social phobia). Session 20, the booster session, is carried out 3 months after the end of the last treatment session (session 17) to check the progress that patients may have been made during this time and help solve the most important difficulties that they have had since the end of treatment. Sessions 21 (at six months) and 22 (at 12 months) constitute follow-up sessions in which, by means of the same questionnaires used in the pre and post-treatment stages, possible benefits obtained with the MISA program are evaluated to see if they are maintained, improved or worsened.

2. *Psychoeducation.* Psychoeducation is used to brief patients on a series of aspects related to SAD and relationships with other people. The therapist makes a clear, straightforward and systematic presentation of the scientific aspects of the subject being addressed in the session, using the educational material in the Patient's workbook and other sources (e.g., videos, pamphlets, testimonies, comic strips, etc.). At the same time, the aim is to actively help the patient understand and assimilate the information presented by using exercises, activities, discussions and, in general, any group strategy. Active listening is encouraged among patients at this stage, with them also asking questions out loud, making comments or giving examples. Psychoeducation is one of the program's main components as it allows a patient to compare the information provided by the therapist and other group members with that garnered from other sources (e.g., what they have read for themselves, testimonies from other people suffering from anxiety, internet searches, previous therapists, and other health professionals). The amount of information available nowadays may also heighten the patient's confusion, so the therapist needs to be ready to clarify any doubts they may have, their concerns, debunk myths or errors in their knowledge and use scientific reasoning to help them understand key information.

3. *Life values.* The identification of personal life values constitutes one of the key aspects raised by the MISA program. Life values, following the approach of ACT, represent what people want their lives to be, what really matters to them, and the pillars that support their existence; in short, what gives their lives meaning and purpose. Living a worthwhile life is acting according to

what one values. Values encourage people to tackle the obstacles that arise in their everyday struggles and dignify their lives. Values are chosen freely and this choice does not require explanations, justifications, evaluations or judgments. Values are not at the service of thoughts, they remain separate from them and can be upheld over an entire lifetime, regardless of the problems and circumstances someone is forced to confront. In the case of subjects with SAD, the values help particularly the implementation of exposure exercises, as they are increasingly aware of how avoidance and, in general, safety behaviors take them away from their vital purposes.

4. *Acceptance training*. Acceptance, following ACT, means coming to terms with the reality that we experience fear and anxiety, which means being ready to accept feelings, emotions, sensations, memories, and thoughts of anxiety for what they are, without trying to avoid or escape from those experiences and the circumstances that may have prompted them. To accept an emotion or feeling, we first have to detect its presence, and this is where acceptance and mindfulness overlap. What's more, acceptance is implicit in mindfulness. Acceptance does not mean passive resignation, but instead that a space is created in which patients can experience their thoughts and emotions instead of resorting to the automatic, habitual, ways of responding (Forsyth & Eyfert, 2016). Readiness and acceptance mean adopting a pleasant and caring view of ourselves, our past and our aspirations, whereby we will find it easier to be aware of our own experiences, in the same way we hold a fragile object in our hands to look at it closely and dispassionately (Hayes & Smith, 2005).

5. *Mindfulness training*. Mindfulness training involves teaching patients to direct and focus their attention on what they are experiencing in the present, to live it fully, consciously, without judging and with acceptance. It involves learning to observe, describe, and actively participate in their life experiences without judging them and fully focusing on them. There are two types of mindfulness:
   a. One that favors concentration, *focusing one's attention* on a specific place or object.
   b. One that involves fully realization, without prejudices, of internal and external experiences.

   Both kinds of mindfulness feed off each other and both are used in our program. The patients are thus taught to observe both external stimuli and events, that is, sounds, sights, and smells, and internal ones, that is, feelings. In this way, patients learn to focus their attention on specific aspects of their environment, both internal and external ones, without the judgments and evaluations prompted by language (Stoddard & Afari, 2014). In the case of SAD, we focus on helping patients learn to fully attend to the relevant aspects of social situations.

6. *Defusion from dysfunctional thoughts.* It is clear that our thoughts have a major impact on our behavior and on how we feel and we invest a great deal of time, effort and energy in responding to them. We may have spent (and still do) a large part of our lives struggling with thoughts that cause us distress. Those who suffer SAD are trapped by their negative anticipations about social events, the automatic negative thoughts during the situation and their ruminations on their performance when they have gone through the feared situation. The defusion strategy encourages a patient to become an external observer of their own thoughts, looking *at* their thoughts and not *from* them. Thoughts are then seen for what they are, a series of words and images, whereby they are taken into consideration in terms of their functionality instead of what they mean; in other words, the extent to which they are useful rather than whether they are true or not. When the thoughts are about oneself, this defusing may help to distinguish between the person having the thought (the real me) and the verbal categories applied to oneself though the thought (the other me). In this case, it is not a question of struggling with thoughts, but rather accepting them as separate entities far removed from who the individual actually is. This procedure is similar to the one undertaken in the ACT (Hayes y Smith, 2005; Hayes, Strosahl, & Wilson, 2012) although in the MISA program the application of defusion is preceded by the identification of dysfunctional thoughts, in the style of traditional cognitive restructuring from cognitive behavior therapy (CBT). However, even if patients initially identify dysfunctional thoughts,, they often do not try to change those thoughts for more functional ones. Defusion addresses this issue This procedure is a key element in the MISA program, although detaching from thoughts is not an exclusive feature of ACT. Many other authors, from other perspectives, some even of mystical orientation, speak of the utility of this distancing from one's thoughts. Thus, for example, Eckhart Tolle, a "spiritual guide" without formal studies in Psychology, considered by some as the most popular spiritual author in the United States and by others as the most influential person in the world at the spiritual level (surprising, isn't true?), says that the mind is a superb instrument if used correctly. However, if used inappropriately, it becomes very destructive. "To put it more precisely, it is not so much that you use the mind wrongly, but you usually do not use it at all but it uses you. That's the problem. You believe that you are your mind. That is the deception. The instrument has seized you" (Tolle, 1997). More recently, and from empirical research, there is also talk of "decentering" as the process of observing one's thoughts from a distance imposed by oneself (that is, in the third person) and without judging them (Eftekhari, 2017).

7. *Social skills training.* Social skills training (SST) allows acting out certain social situations within a controlled setting, such as group therapy, with a view to learning and practicing certain social behaviors that patients can then implement in their daily lives. These skills could be in the repertoires of patients with SAD, but after years of avoidance and disuse of those skills

they need to re-trust their ability to implement them, so this component is also a key element of the MISA program. We then use behavior rehearsal and role-playing involving much of what we have seen in the preceding sections, such as mindfulness, cognitive restructuring and defusing from thoughts. The steps for this new behavior rehearsal procedure would be, in its brief format, the following:

a. Roleplay the original situation by the patient.
b. Identify dysfunctional cognitions before and during roleplay.
c. Identify experimented emotions and physical sensations.
d. Identify the basic human assertive rights involved in the situation.
e. Identify an appropriate target for the new patient's behavior.
f. Suggestions of improvement by the therapist and the group.
g. Roleplay by the patient of the selected behavior, performing it with defusion, acceptance, and mindfulness.
h. Evaluation of the effectiveness of the response, first of all by the patient and then by the therapist and the group.
i. Repeat f, g, and h until the appropriate behavior is achieved.

8. *Exposure.* Exposure is a key element to approach social anxiety. This technique is used to help a patient cope with feared social situations, once the basic competencies have been worked on for undertaking appropriate social behaviors, defusion from anxiety-causing thoughts and the acceptance of feelings and emotions. Exposure takes place both during the sessions, in the form of behavioral rehearsals, and between them, through homework, and may involve imagination, in simulated situations or directly in real situations. It may be staggered in increasingly more complex situations or through immediate exposure to the most feared situation. As with specific phobias, exposure tends to be a necessary strategy, although compared to these phobias it is not usually enough. For some patients, the actual exposure before the treatment group may be one of the fears to be overcome. Defusion from thoughts, acceptance of feelings and emotions and mindfulness may make a significant contribution to the patients' exposure.

9. *Homework.* Homework assignments are tasks or exercises that patients have to carry out in their everyday lives, between each session, to incorporate into real life what they have learned at the clinic. These assignments are an essential part of the MISA program and its success depends largely on the tasks patients carry out when they are not with the therapist. Each session in the program normally starts and ends with a discussion of homework, and assignments are specifically designed to achieve the therapy's goals. As the program advances, a part of each session is used to prepare the patients for the next round of homework, with the tasks' difficulty gradually being increased as the treatment progresses. The following should be taken into account regarding homework tasks:

a. Some of them are designed and agreed with the patients, while many others are specified in the Patient's workbook.
b. They should have detailed instructions, as in the case of those specified in the Patient's workbook. Patients must be able to understand them.
c. Tasks should have a high probability of success, especially the initial ones. Successes may considerably increase patients' motivation and engagement regarding treatment.

Group format vs. individual format for the MISA program

The format chosen for the IMAS program is a group format due to the advantages that this format has when dealing with social interaction problems. Some advantages are the following:

a. The group provides a pre-established social situation in which the patients can rehearse with each other. A group caters for the different kinds of people required for roleplaying and for providing a broader range of feedback.
b. A group provides its members with a series of people to meet and with whom they can practice what they have just learned in the clinical session. In addition, it provides a supportive setting in which the patients, finding themselves in a group made up of people in similar situation to their own, feel less intimidated.
c. The social situations covered by the roleplay in the group have the advantage of being real rather than simulated, as tends to be the case in individual sessions, with more chances of the new behavior being generalized to other social situations.
d. The group format makes a more efficient use of the therapist's time, which also means a lower financial outlay for the patient.

However, the MISA program could also be applied in an individual format, only adapting the exercises of the sessions to this format. In addition, this modality of format may be the only acceptable when the patient has excessive anxiety that would make it extremely difficult to adapt to the group. For this type of people it would be useful to start the training individually and, once the level of anxiety has decreased, introduce them in the group format. At other times, there may not be enough patients to form a group, so individual training is necessary. In any case, be it the individual or group format, the participant needs to follow the patient's workbook, since he / she will have to follow many of the exercises of the workbook, fill in homework that is included in it and read additional information on matters addressed in therapy. The therapist's guide is also a requisite for the psychologist who will lead the group. This has the advantage of providing a structured guide session by session, step by step, including all the materials the therapist needs to conduct the group from the first session to the last. The publication of the program for both patients and therapist allows greater control over the development of the program and a more uniform application than if it were based on workshops or courses.

The size of the groups may vary, although a suitable group format would be between six and eight members. It is convenient that the group includes a balanced distribution of patients of both sexes. Regarding the age of the

participants, there are no restrictions regarding the upper limit, but they must be 18 years of age or older. It is likely that the composition of the group with respect to this variable depends on the availability of the patients who apply for the intervention group.

Sessions diary

The MISA program consists of 15 treatment sessions, once a week, for 2.5 hours each. In addition to these sessions, we added two screening sessions for the selection of patients (pre-treatment), in order to test that they meet the criteria for SAD or social phobia and do not have any serious comorbid disorder, such as a psychotic disorder, a bipolar disorder, a borderline personality disorder, or a substance use disorder. Once the program is over, two more sessions of post-treatment assessment, similar to those at the pre-treatment, will take place, that is, application of the CSISA ECSAS and the self-report measures. After three months a booster session is held in order to reinforce progress, clarify doubts and help with difficulties. Finally, at 6 and 12 months there will be new assessment sessions applying the same questionnaires of the pre / post-treatment stages.

Of the 15 treatment sessions, the first five are devoted to learning key strategies of the program that will form the basis for addressing different kinds of social situations. In these first sessions, patients will be given clear and systematic information about SAD, its impact on the lives of people who suffer from it (something that patients usually recognize in themselves), and the new options that they will have with the MISA program to address once and for all, in a systematic and effective way, the problem of social anxiety that causes so much distress in their lives. In these first sessions different exercises are practiced for learning the key strategies noted above. We can remember briefly some of them:

1. *Identification of life values*. It is one of the first issues that patients are taught. We even have a "Life Values Questionnaire" (included in the patient's workbook) that participants fill in at home after the first treatment session.
2. *Acceptance of bodily sensations*. A series of exercises are practiced so that patients learn to be aware of a whole series of bodily sensations without doing anything to change them. It will help them to accept their anxiety symptoms when they occur in the situations they fear and to focus on more relevant and useful aspects to function properly in the situation.
3. *Mindfulness*. Mindfulness is one of the key strategies in the application of the MISA program. Accompanied by defusion, it is used to address the feared social situations from a different perspective. Patients no longer approach these situations by paying attention to their thoughts, but doing so to the elements present in the social situation.
4. *Defusion from thoughts*. Defusion is another key procedure of the program. Turning patients into observers of their thoughts and distancing from them is an essential element of the intervention. Together with mindfulness, it helps patients to approach social situations from a different perspective and with greater self-confidence.

5. *Social skills training* (SST). This strategy, used since the 70s as part of CBT, has proven to be effective for the treatment of SAD (social phobia). Social skills and anxiety are two areas with a close relationship (e.g., Caballo, Salazar, & CISO-A Spain, 2018) and the increase of the former usually reduces the last. In the MISA program, behavioral rehearsal (SST) is accompanied by acceptance, mindfulness, and defusion so that the patient feels more confident and with more strategies when exposed to feared social situations in real life (homework).
6. *Exposure*. This procedure is another of the classic treatment techniques of CBT and has also been shown to be effective for the treatment of SAD. In the MISA program, the exposure is reinforced by all the previous strategies, so that the possibility that it is effective increases notably.

Training based on the five dimensions of social anxiety

From the eighth session of the program (the sixth treatment session) begin to address the basic dimensions of social anxiety. Two sessions are devoted to each of these dimensions. The order and the basic content of the 10 sessions devoted to these dimensions are the following:

1. DIMENSION 1. INTERACTIONS WITH STRANGERS (sessions 8 and 9). This dimension offers information about the initiation, maintenance and termination of conversations to face the interaction with unknown or little known people. These elements are also very useful for people with SAD who want to resume the interaction with persons who were previously part of their usual environment and with whom they have lost contact due to the disorder. It is one of the most basic skills and, therefore, is the first dimension with which the program begins. It addresses the fears related to looking uninteresting, boring, clumsy, causing distress or discomfort to the other, or that others view the person negatively. The literature on social skills includes numerous aids to adequately manage social interactions, from the beginning to the end. For example, we have a whole series of techniques that help to maintain conversations, such as: a) open-ended questions, b) free information, c) self-disclosures, d) active listening, or e) managing silences. Also, work with the non-verbal behaviors involved in such interactions is essential. Patients are also asked to think about possible places and activities to meet people, including new technologies (e.g., social networks), as well as activities that friends do together. In session 8 the behavior rehearsal is introduced with the topic interaction with strangers. The "Multimodal self-monitoring form" for exposure is also used for the first time, self-monitoring that will be widely used throughout the entire program. Needless to say, it continues to practice and refine the skills of mindfulness and defusion.
2. DIMENSION 2. INTERACTIONS WITH THE OPPOSITE SEX (sessions 10 and 11). This kind of dimension can be considered at a broader level as "interaction with people that attract us". This dimension shares with the previous one the skills of initiating, maintaining and ending interactions with people that attract us, so the skills practiced in these two sessions are very useful for this dimension. We

must keep in mind that in this dimension are also shared fears of being unattractive or uninteresting to the other person, looking bored, clumsy or stupid, to be rejected by others, that things do not go as expected, or being embarrassed because we like the other person (and the other person does not like us) or that we are nervous. It continues to include situations to meet subjectively attractive people, including social networks. Apart from these skills, the response classes of making and accepting compliments and expressing liking, love, and affection are also practiced. It insists a little more on the behavioral rehearsal of situations that are difficult for patients, always incorporating the strategies of the acceptance of bodily sensations, mindfulness, and defusion.

3. DIMENSION 3. ASSERTIVE EXPRESSION OF ANNOYANCE, DISGUST, OR DISPLEASURE (sessions 12 and 13). This dimension unfolds on the terrain of assertiveness. It focuses on behavior classes such as the expression of negative feelings, asking someone to change their behavior and the skills to make and reject requests. This dimension is undoubtedly one of the fundamental issues related to social anxiety according to our research, and that is why we work with fears of disapproval, anger, rejection or abandonment by others, that the other person become offended, that the relationship is damaged, that they think "I'm not a good person" or that "I'm not so nice" (being criticized), or doing something people would not want others doing to them. Among the techniques practiced within this dimension are the use of "I" and the DESC script (Bower and Bower 1976), helping patients to be at the same level as other people in terms of assertive rights. For this same reason, we train techniques for the defense of one's rights, such as broken record and fogging. Apart from continuing to train patients in acceptance of bodily sensations, mindfulness and defusion, "opposite action to the urge" is introduced in session 12, a strategy derived from dialectical behavior therapy (Linehan, 2015).
4. DIMENSION 4. CRITICISM AND EMBARRASSMENT (sessions 14 and 15). The situations included in this dimension are especially feared by people with social anxiety. In fact, the fear of negative evaluation is one of the central fears, perhaps the essence, of SAD. This fear usually includes concepts such as making a fool of himself, embarrassing oneself or being humiliated and that is why the idea of "wanting to please everyone" is addressed. Fear of criticism or embarrassment can be one of the big obstacles when it comes to meeting people, participating in activities or having jobs that could be highly reinforcing for a person. Exercises that are carried out in these sessions, as part of the confrontation of the fear of embarrassment, would involve carrying out ridiculous behaviors and that the rest of the group will observe while doing it. On the other hand, as part of this dimension, strategies for coping with criticism are included. Garner (1981) proposes to address the criticism in a constructive way following two steps: 1) ask for details, and 2) agree with the criticism. This second point raises two options: a) agree with the truth, and b) agree with the critic's right to an opinion. Specific strategies are used such as negative assertion, negative inquiry, and separating subjects. In addition, work continues in these sessions with the review of life values and the

strengthening of strategies of mindfulness, acceptance of embarrassment feelings, and defusion.

5. DIMENSION 5. SPEAKING IN PUBLIC/TALKING WITH PEOPLE IN AUTHORITY (sessions 16 and 17). The last two sessions of the MISA program are dedicated to people losing the fear of speaking in public and relating to people of authority. These fears include those related to looking incompetent, making mistakes, saying or doing things that are not interesting, realizing that they are very nervous (due to physical symptoms), giving a bad image or that others take a negative impression of them, and feeling disappointed with themselves (for "not doing it as they "should" -in content and form-"). Although "speaking in public" is part of the only subtype of SAD that diagnoses the nosological system of the DSM-5 (APA, 2013), we do not believe that this dimension presents special challenges different from the other dimensions of social anxiety previously discussed. This fifth dimension has certain connotations of embarrassment, so that the previous sessions devoted to the fourth dimension can facilitate coping with the fears related to public speaking. Exercises carried out in these last two sessions include the performance of a presentation to the rest of the group, taking into account the verbal and non-verbal components that it implies. It is not about forming experienced speakers, but that people lose the fear of speaking before a group and, as generalization and homework tasks, to a larger group. In these last two sessions, the consolidation of personal values, the practice of full attention to social situations, the acceptance of bodily sensations and the defusion from dysfunctional thoughts continue to be practiced. As we mentioned earlier, the development of the multidimensional intervention for social anxiety (MISA) program revolves around the five dimensions found empirically throughout our research on social anxiety. But we consider that not only these five dimensions characterize the program, but also the incorporation of both classical and third generation cognitive behavioral strategies. We believe that the MISA program is a powerful intervention for the treatment of social anxiety problems, but belief is not enough when we are talking about scientific psychology. We must empirically verify the efficacy of the program and thus apply it in clinical populations. And that is precisely what we are trying to implement in different places.

Applying the program in Spain and Latin America

The program is designed for, but not limited to, application in Spain, Portugal and all the Ibero-American countries. However, the current version of the program and the one in the press (in Portuguese) makes the Ibero-American area particularly favorable to the current application of the program. In addition, advantages such as sharing language, common cultural elements, manual nature of the program, and that there is a book for the therapist and a workbook for the patient allow the intervention to be followed with enough fidelity by therapists and patients of various Spanish and Portuguese speaking countries. We are currently preparing the application of the MISA program in several countries. Our first contacts seem to be on the right track, bearing in mind that the application of

the program involves the acquisition of the patient's workbook by the people who will follow the group treatment and who are sent efficiently from Spain by the publisher, Piramide. Additionally, the questionnaires for the pre/post-treatment assessment and follow-up are also sent by e-mail for greater uniformity at the time of the assessment, they are reviewed by the therapists of each country and we are informed if they have to adapt any term to the idiosyncrasy of the country and the start of the groups is planned jointly. The MISA program is one of the few interventions developed from the empirical work with many Spanish and Portuguese speaking countries and it could be applied not just in Latin America but in any region of the world.

Discussion

The goal of this work was to present the characteristics of a new multidimensional intervention for social anxiety, the MISA program. The MISA program offers those who suffer from this disorder the opportunity to confront in a different way the central fears of the disorder and have a more authentic life by teaching them not to avoid social situations and actively engage in their life experiences. For this, the MISA program proposes to work from the identification of one's deepest values, through the detaching from thoughts that make one unhappy to the full attention of life experiences (including the physical and subjective manifestations of their emotions).

Until now, the therapy of choice for the treatment of SAD is cognitive behavior therapy (CBT), having obtained empirical evidence of the effectiveness of techniques such as exposure, cognitive restructuring, relaxation and social skills training (*Society of Clinical Psychology, APA, Division 12*, 2018). On the other hand, acceptance and commitment therapy (ACT), included within the cognitive behavioral orientation, accumulates evidence that it is also a valid option for the treatment of SAD (García-Pérez & Valdivia-Salas, 2018). These authors analyzed eight studies (published between 2005 and 2016) that used ACT for the treatment of SAD and found that, in the five studies that compared ACT with CBT, their results were equally effective. But what would happen if we combined CBT strategies with ACT procedures in a new program? Would this be as effective as the application of CBT or ACT separately?

The MISA program is a new program that incorporates both traditional CBT techniques and strategies of third-generation therapies, especially, but not exclusively, acceptance and commitment therapy. It is aimed at people with SAD or social phobia, avoidance personality disorder or simply with significant social anxiety in situations that are important in the lives of individuals. Although the program has not created any new treatment techniques, and at this point it is difficult for any intervention to present a really new strategy, it has been proposed as a novel program, based on findings obtained by our own research, which has incorporated into a compact and systematic treatment package, classic and recent cognitive behavioral strategies. Why do we believe that the MISA program can be equal or more effective than CBT and ACT separately? We will discuss it in the next paragraphs.

First, the incorporation of education in life values, from ACT, which would be the ultimate motivation for people to carry out their actions and design the paths through which their lives should go. The obstacles and difficulties that the subjects with social anxiety find in their new way to overcome their problem can be softened if they have values that guide their lives and that are above the results of their behaviors in the short and medium term.

Secondly, being one of the points that most discussion can generate, is whether it is more appropriate cognitive restructuring, Beck or Ellis type, than the defusion from thoughts, ACT type. A first phase, the identification of dysfunctional thoughts, it seems that it could be common to both and even question the dysfunctionality of such thoughts. What sets them apart is what comes next. Should we replace negative thoughts with others that are more rational or adjusted to reality, with the entire debate process that this leads to? What we have found in previous research (Caballo & Buela, 1989) as well as in a review of the literature on the subject (Caballo, 1997) is that socially appropriate behavior is characterized by the absence of negative self-verbalizations, but not necessarily by the presence of positive ones. Maybe the whole process that involves a cognitive restructuring exercise to change negative thoughts by rational ones is unnecessary. What we have to work on is detaching from negative thoughts. The insistence on debating these kinds of thoughts, looking for more rational alternatives and replacing them with those alternatives, supposes a lot of time and energy, and perhaps it would be better to use these efforts in defusing (distancing) from those thoughts. If these thoughts do not help, if they are dysfunctional, continuing to insist on them, even if it is to change them, makes people with social anxiety keep in constant contact with thoughts that make their lives bitter. Additionally, with the practice of defusion it will happen that people will understand that their thoughts are transient events, with a beginning and an end, and that they will not be maintained, as long as they do not become the center of their lives. Usually, what happens to people with SAD is that they are so focused on such thoughts that they cannot see anything beyond them and, therefore, their emotions (anxiety, distress, shame, nervousness) in social situations will not stop, being difficult to behave appropriately.

Third, mindfulness can be very useful to help in the process of distancing from dysfunctional thoughts. If we get people with social anxiety to defuse from negative thoughts, they will have to do something once they have detached from them. And what they can do is pay full attention to what they have before their eyes, to the social situation they are living, to the behavior of other people involved in the situation. This not only helps them distance themselves from their dysfunctional thoughts, but also helps them experience the situation with more intensity and realism, attending to the external signals that will provide them with information to act in a more socially appropriate way. Fully attending to the present moment, to the social situation, using their skills to observe and describe (leaving aside that "judging mind" that they have cultivated for years), implies less dedication to making (negative) anticipations and ruminating ("crushing themselves") about past events.

Fourth, the acceptance of bodily sensations typical of social anxiety can help subjects with this problem not to be frightened and not react negatively to their internal symptoms when they feel anxiety. Generally, people with SAD interpret their symptoms as a sign of their incompetence to handle themselves appropriately in social situations and this increases the intensity of their emotions with the consequent need to flee from situations. Palpitations, tremors, flushing, muscle tension, stomach discomfort and hyperventilation are all typical symptoms of social anxiety. By training patients in the recognition and acceptance of their bodily sensations with exposure exercises, they learn to accept them as normal physical responses (whose presence is expected and even necessary to offer an adequate response to a situation) and will help them to lend more attention to what happens on the outside (and use mindfulness) than to what goes on inside.

Fifth, social skills training (SST), commonly used by CBT, is significantly modified when practiced in the therapy session (and then generalized to real life as homework). Acceptance of bodily sensations, mindfulness, and are incorporated into the behavior rehearsal of SST. This proposal gives a very different perspective to the way in which behavior rehearsal is acted. Approaching this rehearsal through the acceptance of possible feelings of anxiety that can occur at that moment, distancing oneself from dysfunctional thoughts that will surely appear in the mind of the person who is going to perform the behavior rehearsal and fully attending to the behavior that is going to be rehearsed, constitutes a very different perspective, even if the situation to be roleplayed is the same. This new type of behavior rehearsal in the therapy sessions will provide patients very powerful strategies for applying what they have learned in the clinic to real life, offering a very different alternative to how patients have been doing so far or, rather, how patients used to avoid social situations. Armed with these new strategies, the possibility of a negative result decreases markedly. The new strategies provide them with enough security to face social situations more effectively.

Finally, the MISA program maintains exposure in real life as a basic strategy to overcome social anxiety. But exposure is now accompanied, as was the case with behavior rehearsal, by acceptance, mindfulness, and defusion. Exposing oneself now is much less aversive. Distancing oneself from dysfunctional thoughts and fully attending to the situation to which they are exposed provides a very different perspective to the person with social anxiety. Now they will be attending to all the environmental stimuli (including the behaviors of the other people involved in the situation), they will not react to their physical sensations as they did before while at the same time they detach themselves from their dysfunctional thoughts. A whole declaration of intentions to address in a different way the dreaded social situations.

In conclusion, we believe that the MISA program, including a set of procedures, of both traditional CBT and so-called third-generation therapies, can be extremely effective for people with a diagnosis of SAD (social phobia) or avoidant personality disorder. It can also benefit those people who, although they do not have one of these diagnoses, suffer from high anxiety in certain types of social situations.

On the other hand, the MISA program, with slight tweaks, can also be effective for other disorders other than SAD, such as borderline personality disorder. Our incursion into this disorder using a good part of the procedures composing the MISA program seems to be working. However, this is a clinical perspective, far from an empirical research work that, it is possible, we will propose in the future. It could also work for people with depression, obsessive-compulsive disorder or generalized anxiety disorder. However, beliefs do not necessarily imply realities. The application of the MISA program in the treatment of social anxiety and other psychological problems will tell us if this program is effective and to what extent.

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