© Journal of the Indian Academy of Applied Psychology
January 2026, Vol.52, No. 1, 118-128

Application of the Clark and Wells Cognitive Model in the Treatment of Social Anxiety Disorder: A Case Study of an Indian Adult

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Social anxiety disorder is characterized by an intense fear or anxiety in social situations where the individual anticipates being scrutinized or negatively evaluated by others. In the present case study, the Clark and Wells cognitive model was employed to conceptualize the case, provide psychoeducation, and guide the intervention. The client, a 31-year-old Indian male, presented to a psychiatric facility with complaints of social inadequacy, hand tremors, excessive sweating, stammering during public speaking, and heightened nervousness when interacting with individuals of the opposite sex. The clinical material derived from the client's experiences was analyzed to identify the dysfunctional assumptions activated in social contexts, which elicited perceived social threat and, consequently, the emergence of safety behaviours along with somatic and cognitive symptoms. The individual's self was ultimately processed as a social object, thereby reinforcing the perception of social danger and maintaining the cycle of anxiety.

Keywords: Clark and Wells model, case formulation, social anxiety disorder, cognitive-behavioural therapy

Social Anxiety Disorder

Social Anxiety Disorder (SAD) is characterized by marked and persistent fear or anxiety that arises in one or more social situations where the individual may be subject to possible scrutiny by others, such as engaging in conversation, being observed while performing everyday activities, or speaking in public. Individuals with this disorder experience excessive concern that they may behave in a manner, or display visible signs of anxiety, that could invite negative evaluation, humiliation, embarrassment, rejection, or offense. The fear is typically disproportionate to the actual threat posed by the social situation or the cultural context, and the anxiety response tends to occur immediately upon exposure. Such situations are either consistently avoided or endured with significant distress, often leading to functional impairment in personal, social, educational, or occupational domains, or necessitating considerable additional effort to maintain functioning. Symptoms generally persist for an extended duration, typically six months or longer, and cannot be explained by substance use, a medical condition, or another mental disorder. In some cases, individuals may initially report physical symptoms such as blushing, sweating, trembling, or poor eye contact before recognizing their underlying fear of negative evaluation (American Psychiatric Association, 2022; World Health Organization, 2019).

Prevalence of SAD in India

Population-based epidemiological data indicate that SAD is present but relatively uncommon at the national level in India. The National Mental Health Survey of India (NMHS; Gururaj et al., 2016) reported a current (one-month) prevalence of SAD of approximately 0.47%, based on structured diagnostic interviews administered to a

nationally representative adult sample. The survey also documented substantial functional impairment among affected individuals and a treatment gap exceeding 80%. Associated risk factors include male gender, unemployment and living in urban areas (Suhas et al., 2023).

In contrast, institutional and convenience-sample studies among adolescents and young adults have reported considerably higher prevalence rates of social anxiety symptoms. A cross-sectional study among Indian university students identified social phobia in 31.3% and social anxiety in 15.3% of participants using the Social Interaction Anxiety Scale (SIAS), with significant correlations observed between social anxiety and internet addiction (Jaiswal et al., 2020). Similarly, a study of undergraduate medical students in East Delhi found probable social phobia in 12.6% and probable social anxiety in 5.9% (Preeti & Das, 2019). Another investigation among pharmacy students documented elevated symptom levels, with 47.7% reporting moderate to high social anxiety, with greater prevalence amongst females than males in the age group 21-25 years (Gupta et al., 2025). These findings underscore wide variability in prevalence estimates across samples.

Methodological heterogeneity explains most of this variation. Representative surveys employing structured diagnostic instruments, such as the ones utilized during NMHS (Gururaj et al., 2016), yield lower prevalence figures, while studies using screening tools like the SIAS tend to overestimate probable cases due to symptom-based scoring and non-clinical samples. Differences in sampling frames, i.e., community versus campus populations further limit direct comparison (Jaiswal et al., 2020; Suhas et al., 2023).

Age also appears to be a determining factor, with adolescent and young adult populations showing a higher concentration of symptoms, consistent with the developmental trajectory of SAD. Student-based studies have highlighted correlates such as academic stress, performance anxiety, body image concerns, social media use, and family conflicts, all of which may contribute to symptom expression (Gupta et al., 2025; Jaiswal et al., 2020; Preeti & Das, 2019). Several reports have also documented a robust association between social anxiety symptoms and excessive social media use (Jaiswal et al., 2020; Gupta et al., 2025), suggesting that socially anxious individuals may rely on online interaction to avoid in-person social scrutiny (Hutchins et al., 2021).

Cognitive-behavioural therapy for SAD

Several empirically supported interventions have been developed for the treatment of SAD, including cognitive-behavioural therapy (CBT), exposure-based treatments, and social skills training (Rodebaugh et al., 2004). Among these, CBT has demonstrated particular efficacy and remains one of the most widely applied approaches to treat SAD (Kindred et al., 2022). CBT primarily focuses on identifying and modifying irrational thought patterns by examining automatic negative thoughts and dysfunctional beliefs. Automatic thoughts are stereotyped, exaggerated cognitive responses to stressors that elicit immediate emotional reactions, most commonly anxiety or low mood, and contribute to diminished self-esteem. Dysfunctional beliefs and attitudes, in contrast, shape the individual's interpretation of social situations and often involve cognitive distortions such as selective abstraction, dichotomous thinking, and catastrophising (Beck, 2021). Within the context of SAD, therapeutic efforts aim to systematically teach an alternative cognitive framework for understanding social interactions, performance, and perceived social risk. Interventions typically involve

guiding clients to evaluate their assumptions and expectations about social situations and to critically assess the perceived consequences of imperfect performance through logical analysis and structured behavioural experiments (Clark, 2001). The effectiveness of CBT in alleviating the symptoms of social anxiety has been well established and consistently supported across numerous empirical studies (Guo et al., 2020; Leichsenring et al., 2013).

Case Formulation

A case formulation is broadly conceptualized as a hypothesis that explains the origins, precipitating factors, and maintaining influences of an individual's psychological, interpersonal, and behavioural difficulties. Its central purpose is to integrate rather than merely summarize descriptive information about the client. Functionally, it serves as a blueprint for guiding treatment, a benchmark for monitoring change, and a framework that enhances the therapist's understanding of and empathy toward the client. A formulation represents a collaborative and theory-informed understanding of the client's presenting problems, situated within their biological, psychological, and social contexts. It links clusters of co-occurring symptoms to an underlying diagnosis and informs the development of a coherent and individualized treatment plan (Eells et al., 1998).

The purpose of the present case study is to illustrate the conceptualization of SAD using the Clark and Wells model (Clark, 2001) in an Indian context, with the aim of developing an individualized treatment plan focused on psychoeducation and the alleviation of symptoms.

Case Presentation

The following case was presented at a mental health clinic in New Delhi, India. Written and verbal informed consent was obtained from the client prior to including him in the present case study.

Mr. A.K. is a 31-year-old unmarried male who had been functioning well until approximately 15 years of age. During 10th grade, he experienced a romantic rejection that elicited intense feelings of embarrassment and shame. In the same period, he was subjected to bullying by his classmates, which contributed to a growing sense of inadequacy and led to a marked decline in self-esteem and self-confidence. These experiences were accompanied by a deterioration in academic performance and reduced classroom participation. He began to feel increasingly uncomfortable in situations that required public speaking, and reported heightened self-consciousness when being observed by others.

During such instances, he would experience pronounced physiological symptoms, including hand tremors, palpitations, dizziness, breathlessness, and stammering, often accompanied by 'mind going blank' and apprehension that others perceived him as "stupid" or "incompetent." Over time, he withdrew socially, avoiding interactions with peers and family members due to fears of being perceived as awkward or clumsy. Despite desiring social contact, he often remained at home to avoid potential embarrassment. In group settings, he would attempt to cope by excusing himself from the situation, such as going to the restroom, or mentally rehearsing potential responses.

During his college years, he reported significant anxiety when interacting with female peers, frequently experiencing profuse sweating and feeling blank mentally in such situations. These symptoms persisted into adulthood, substantially interfering with his social and occupational functioning. The client sought psychiatric consultation in April 2021 due to the chronic and debilitating nature of his anxiety.

Clark and Wells Model of Social Anxiety

Clark and Wells proposed a cognitive model for conceptualizing social anxiety by examining the cognitive processes that occur when an individual with social anxiety enters a feared social situation. Upon entering such a situation, certain maladaptive assumptions are automatically activated, typically involving beliefs about one's perceived social incompetence. These distorted assumptions give rise to a perception of social danger, which in turn generates three key consequences. First, the individual begins to process the self as a social object, viewing themselves from the perspective of others. Second, this perceived threat elicits a range of somatic and cognitive symptoms, such as physiological arousal and self-focused attention. Third, the individual engages in safety behaviours intended to reduce subjective distress, primarily through avoidance or concealment. However, the use of safety behaviours, along with the persistence of somatic and cognitive symptoms, maintains self-focused processing and further reinforces the perception of social danger. Consequently, the model describes a self-perpetuating cycle in which maladaptive cognitions, physiological arousal, and behavioural avoidance continuously interact to sustain and exacerbate social anxiety (Clark, 2001).

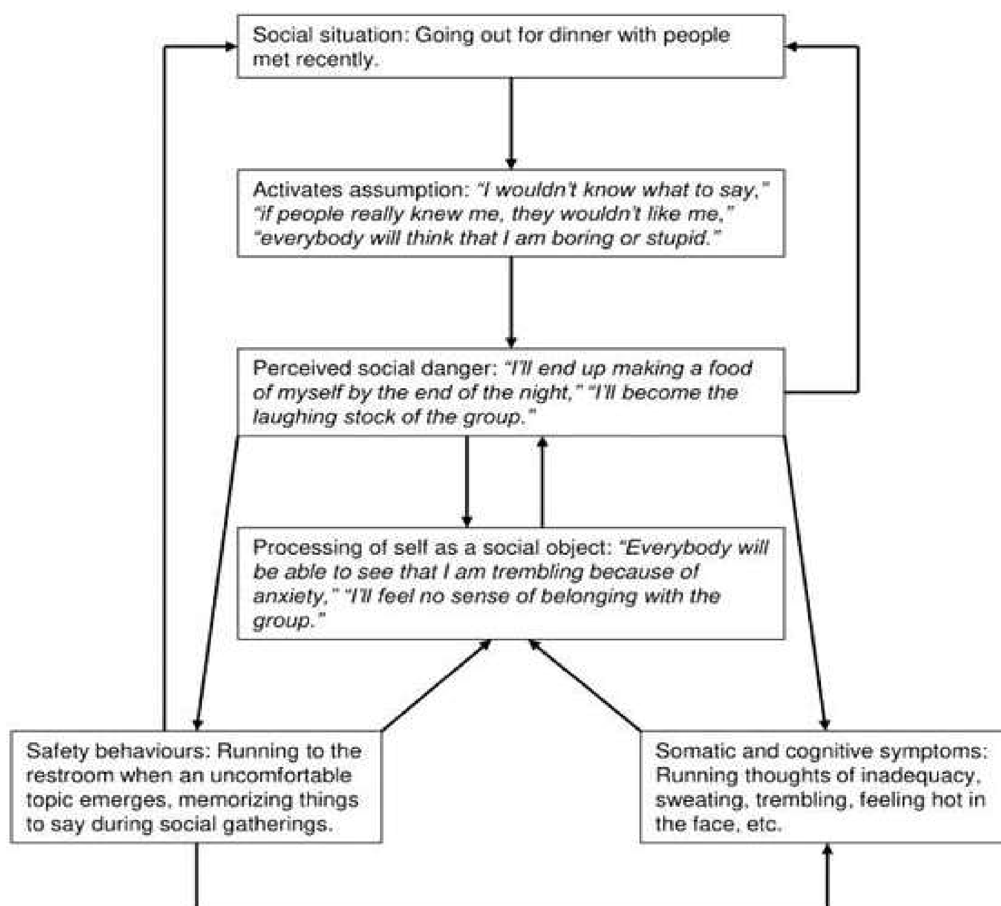

Figure 1. *Clark and Wells Model of Social Anxiety*

As illustrated in Figure 1, the Clark and Wells model of social anxiety was employed to formulate Mr. A.K.'s case. A social situation, such as going out for dinner with acquaintances, activates maladaptive assumptions such as, *"I would not know what to say."* This underlying belief leads to a perception of social danger, characterized by cognitions such as, *"I will end up making a fool of myself by the end of the night."* The perception of social threat manifests in three interrelated ways. First, the client engages in safety behaviours such as temporarily removing himself from the setting by going to the washroom when an uncomfortable topic arises to mitigate distress. Second, he begins to process himself as a social object, with thoughts such as, *"Since I will become the laughing stock of the group, I will feel no sense of belonging."* Third, he experiences physiological and cognitive symptoms, including rapid heart rate, intrusive self-critical thoughts, and a sense of inadequacy.

These processes are mutually reinforcing: safety behaviours and anxiety symptoms heighten self-focused attention and the belief that others can perceive his anxiety, which further intensifies the perception of social danger and fear of negative evaluation. Consequently, the client becomes trapped in a self-perpetuating cycle in which maladaptive cognitions, physiological arousal, and avoidance behaviours continuously sustain and reinforce one another. Unless interrupted, each subsequent social encounter is likely to reactivate the same pattern of cognitive, behavioural, and emotional responses.

The diagrammatic formulation of Mr. A.K.'s case informed the development of a structured treatment plan based on the principles of CBT. The intervention included the following components:

- *Psychoeducation*, aimed at enhancing the client's understanding of the cognitive and behavioural mechanisms underlying social anxiety;
- *Identification of negative automatic thoughts* that arise in social situations and contribute to heightened anxiety;
- *Recognition of maintaining factors*, including safety behaviours and self-focused attention, that perpetuate the anxiety cycle;
- *Evaluation of cognitive accuracy*, through logical examination of maladaptive beliefs and their evidentiary basis;
- *Design and implementation of behavioural experiments*, intended to test and challenge dysfunctional cognitions in real-life contexts; and
- *Use of role-plays and behavioural rehearsals*, to facilitate skill acquisition, corrective experiences, and increased confidence in social interactions.

Treatment Plan

Prior to the commencement of psychotherapy, informed consent was obtained from the client. Following the presentation of the case formulation, the client was provided with a brief orientation to the therapeutic process and the principles of CBT. Treatment goals were then collaboratively developed to ensure a shared understanding of the objectives to be addressed during sessions. At the outset of therapy, the Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987) was administered to assess the severity of the client's symptoms. The client obtained a total score of 71, indicative of marked social anxiety.

Psychoeducation

The initial phase of therapy focused on psychoeducation regarding SAD. The client

was provided with information about the broad range of symptoms associated with the disorder, its prevalence, and the potential etiological factors contributing to its development and maintenance. The previously discussed case formulation was then presented to facilitate the client's understanding of how cognitive, physiological, and behavioural components interact to trigger and sustain social anxiety. Particular emphasis was placed on elucidating the role of safety behaviours in perpetuating anxiety and preventing corrective learning. The client was also introduced to the concepts of negative automatic thoughts and cognitive distortions, with discussion centred on how these distorted patterns of thinking can lead to erroneous conclusions and reinforce maladaptive beliefs.

Identification and Verification of Faulty Cognitions

The case formulation proved instrumental in identifying the negative automatic thoughts that emerged in social situations. Each of these cognitions was systematically examined through logical evaluation to determine their validity. This process revealed that the client maintained excessively high standards for his own social performance (e.g., *"I must always have something interesting to say"*), tended to catastrophize minor social imperfections (e.g., *"If I stammer during my speech, people will think I am stupid"*), and endorsed pervasive, unconditional negative beliefs about himself (e.g., *"If people really knew me, they wouldn't like me"*).

Further exploration indicated that, in social contexts, the client habitually shifted his attention toward detailed self-monitoring, resulting in an exaggerated negative self-impression. He appeared to equate the internal experience of anxiety with its outward visibility, assuming that physiological signs, such as hand tremors during a speech were highly conspicuous to others. In reality, these signs were either minimally noticeable or entirely unobserved by others. This process reflected a self-as-object perspective, wherein the client perceived himself as if viewed through the imagined gaze of others. Consequently, his internal fears and apprehensions were projected onto this self-image, reinforcing his belief that his anxiety was both visible and socially discrediting.

Cognitive examination further revealed that the client's information processing in social situations was negatively biased. He selectively attended to, and recalled, social cues interpreted as disapproval, while overlooking or minimizing signs of acceptance. Many of the cues he perceived as negative were in fact ambiguous but were interpreted unfavourably (e.g., *"My friend yawned while speaking to me; I must be boring him"*). This hypervigilance to potential rejection contributed to persistent negative self-evaluation. Post-event rumination was also prominent, as the client frequently replayed social encounters, scrutinizing his performance and speculating about how others had perceived him. These retrospective evaluations were dominated by his negative self-image, thereby distorting the recollection of the interaction as more adverse than it likely was.

To explore the client's cognitive definitions of social adequacy, he was asked to articulate what he meant by being "socially awkward," identify the characteristics he associated with such behaviour, and describe how these might manifest in social settings (as presented in Table 1). Subsequently, he was encouraged to evaluate the extent to which he personally embodied these attributes during interpersonal interactions.

Table 1. Client's Conceptualization of "Socially Awkward" Behaviour and Self-Perceived Attributes

"Socially Awkward" Behaviour, as Defined by the Client	Attributes Identified in Self
• Being unable to read the room and behaving according to the situation • Talking too much or continuing to talk when others have clearly lost interest. • Odd body movements: moving the arms around a lot, or not moving them at all. • Bad table manners: chewing with an open mouth, spilling drinks or food, etc. • Not mixing up/interacting with others, sitting all by yourself completely alone and not talking to anyone.	• Not mixing up/interacting with others, sitting all by yourself completely alone and not talking to anyone.

This exercise was instrumental in demonstrating that the client's assumption that his behaviour in social settings could be categorically labelled as "awkward" was not entirely accurate. Upon examination, it became evident that he did not exhibit most of the behaviours he himself identified as characteristic of social awkwardness. To deepen this insight, the client was asked to evaluate the specific behaviours he believed reflected awkwardness such as *"not mixing or interacting with others, sitting alone, and refraining from initiating conversation"* and to rate the extent to which he had observed these behaviours in both himself and others within social contexts.

Through this reflective exercise, the client recognized that similar behaviours were not uncommon among others; for instance, he recalled observing several individuals at social gatherings sitting quietly and browsing their phones without perceiving them as socially inept. This observation prompted him to reconsider the validity of his self-appraisal. He acknowledged that, although he tends to keep to himself at social events and generally speaks only when approached, it is plausible that others do not interpret his reserved demeanour negatively. Supporting this revised perspective, the client noted that aside from one close friend, no one had ever remarked that he appeared nervous, clumsy, or that his hand tremor was noticeable.

Evaluating the Efficacy of Safety Behaviours through Role-Plays

To assess the maintaining factors of social anxiety, the client was first asked to identify his negative thoughts related to feared social outcomes and their perceived consequences. Once these fears were articulated, a comprehensive list of safety behaviours was compiled. This step was crucial, as safety behaviours often serve to maintain maladaptive cognitions by preventing opportunities to test and disconfirm erroneous assumptions. To empirically examine this mechanism, structured role-play exercises were conducted under two contrasting conditions. In the first condition, the client was instructed to engage in his usual safety behaviours such as mentally rehearsing conversation topics, closely monitoring his speech, and engaging in self-scrutiny. In the second condition, he was encouraged to refrain from using safety behaviours and to instead direct his full attention toward the conversational partner and the ongoing interaction.

Following the role-plays, the client was invited to compare the two conditions across several dimensions, including perceived anxiety intensity, perceived outward appearance of anxiety, and overall performance quality. He concluded that the use of safety behaviours heightened his subjective anxiety and that he had been inferring how anxious he *appeared* to others based on how anxious he *felt*. This realization facilitated a distinction between subjective emotional experience and objective social performance. Notably, the client also reported that he found the interaction in the second condition more enjoyable and engaging, as he was able to attend more fully to the content and flow of the conversation. In contrast, during the first condition, his focus on impression management and the suppression of physiological symptoms (e.g., hand tremors) detracted from his ability to participate naturally and effectively in the social exchange.

Role-Plays and Rehearsals

In addition to the techniques described above, role-play exercises were incorporated as a key component of the intervention. These included simulated interactions with salespersons and tele-callers, enacted by the therapist, to help the client practice and generalize adaptive social responses. The client also rehearsed upcoming office presentations and was asked to rate both his subjective anxiety and perceived performance following each attempt. A gradual and consistent improvement was observed in his performance ratings over time, indicating increased confidence and reduced anticipatory anxiety.

To optimize the effectiveness of role-plays and behavioural rehearsals, a fear hierarchy was collaboratively developed prior to the exercises. This hierarchy consisted of a graded list of social situations that the client either feared or avoided, arranged in ascending order according to the level of discomfort each situation elicited. An additional column was included to quantify the intensity of anxiety or avoidance associated with each situation, using a 0-10 rating scale, where 0 denoted no anxiety or avoidance and 10 represented extremely high levels of anxiety or avoidance (as illustrated in Table 2).

Table 2. Fear Hierarchy of Social Situations

Feared/Avoided Situations	Anxiety/ Avoidance (0 to 10)
Asking strangers on the street for the time or asking for directions.	5
Respectfully informing a tele-caller, *"I am not interested in this advertisement."*	7
Saying 'no' to a salesperson after selecting an item to purchase (saying, *"I changed my mind"* without apologizing).	8
Having a conversation with a stranger or going to a new place.	10
Answering a question or making a 2-minute speech in public.	10

Beginning with the least anxiety/ avoidance-provoking situation identified in the hierarchy, role-plays and behavioural rehearsals were conducted repeatedly until the client was able to perform each scenario with minimal subjective distress. Only then was the next, slightly more challenging situation introduced. This graduated and systematic approach ensured that exposure to increasingly anxiety-provoking situations occurred in a controlled and manageable manner. It also minimized the likelihood of the client feeling overwhelmed or overstimulated, thereby fostering a steady sense of mastery and confidence as treatment progressed.

Behavioural Experiments

The rationale for incorporating behavioural experiments extended beyond

the mere practice and implementation of skills acquired through role-plays and rehearsals. These exercises also aimed to help the client develop a more accurate perception of how he appears to others in social contexts. Additionally, behavioural experiments served the critical function of testing the client's predictions regarding perceived social threats and evaluating their validity.

To facilitate this process, the client was provided with a structured handout that outlined key components of each experiment. He was instructed to document the feared situation, his prediction (i.e., what he expected would occur and his degree of certainty regarding this outcome), the behavioural test (i.e., the actions taken to examine his prediction), the actual outcome, and the insights or conclusions drawn from the experience. These exercises were designed to encourage empirical testing of maladaptive assumptions and to promote cognitive restructuring through direct experiential learning.

The client was encouraged to conduct these behavioural experiments regularly across varied social contexts. Through consistent practice, he reported a gradual increase in self-efficacy and social confidence. Specifically, he noted improvements in his ability to place orders independently at restaurants, initiate conversations with acquaintances, and engage in brief interactions with strangers such as asking pedestrians for directions or the time. With the client's consent, selected excerpts from his reflective diary documenting these experiments are presented in Table 3.

Table 3. Handout for Documenting Behavioural Experiments: Excerpts from the Client's Notes

Situation	Prediction (What exactly did you think would happen? How would you know?) (Rate belief 0-100%)	Experiment (What did you do to test the prediction?)	Outcome (What actually happened? Was the prediction correct?)	What I learnt? 1. Balanced view? (Rate belief 0-100%) 2. How likely is what you predicted to happen in the future (Rate 0-100%)?
Interacting with a waiter at a restaurant.	I will forget my order and then I'll begin to stammer. This has happened many times before. (80%)	I placed my order despite how anxious I felt.	I didn't forget my order much. and when I did,I began to read from the menu. My prediction was partially correct, but I could handle the situation.	1. It did not go as planned, but it wasn't as bad as I thought it would be. 2. It may happen in the future, but I think I will be able to manage (70%).
Initiating a conversation with a distant relative at a social gathering.	It may look odd, my behaviour can be weird, and I may say something silly (95%).	I spoke with him briefly and we discussed our jobs and daily life.	I was anxious initially, but it felt like a normal conversation. He hugged me and seemed pleased to see me.	1. My predictions were all wrong. It was a pleasant conversation. 2. What I predicted may happen with unfamiliar people (75%) but less likely with family (30%).

Outcome of Therapy

The LSAS (Liebowitz, 1987) was re-administered at the conclusion of treatment. The client obtained a total score of 44, reflecting a 27-point reduction from the baseline assessment. This score falls within the range indicative of mild social anxiety. Correspondingly, the client reported a noticeable decrease in subjective anxiety during social interactions and demonstrated improved functioning across both professional and personal domains.

Conclusion

In conclusion, case conceptualization guided by Clark and Wells' cognitive model of social anxiety (Clark, 2001) facilitated positive therapeutic outcomes through enhanced client insight and self-awareness. The model provided a coherent framework for psychoeducation, enabling the client to understand the mechanisms underlying the onset and maintenance of social anxiety within interpersonal contexts. Through exploration of negative automatic thoughts, perceived social threat, self-focused attention, somatic and cognitive symptoms, and safety behaviours, the client developed greater awareness of the cognitive-behavioural processes sustaining his anxiety. This understanding allowed him to identify both precipitating and perpetuating factors contributing to his distress. Building on this conceptual foundation, therapeutic interventions focused on examining maladaptive cognitions from a more rational perspective, eliminating safety behaviours, and employing behavioural experiments, role-plays, and rehearsals to challenge dysfunctional assumptions. Collectively, these techniques promoted cognitive restructuring, which corresponded with a marked reduction in social anxiety symptoms and improvement in overall social functioning.

In the Indian context, where stigma surrounding mental illness and limited access to specialized psychotherapy pose significant challenges, the study highlights the adaptability and cost-effectiveness of cognitive-behavioural interventions, especially in the absence of resources for more sophisticated techniques (such as obtaining video feedback of client behaviour). It also illustrates the importance of culturally sensitive psychoeducation that addresses collectivistic norms and social performance expectations prevalent in Indian society. The positive outcomes observed reinforce the need for greater integration of cognitive models like Clark and Wells into routine clinical practice, community-based mental health programs, and professional training curricula in India to improve treatment accessibility and outcomes for socially anxious individuals.

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