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## Treating Social Anxiety in an Era of Social Distancing: Adapting Exposure Therapy for Youth During COVID-19

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*The novel coronavirus (COVID-19) pandemic has caused widespread disruption to our traditional way of life and mental health therapy has not been spared. A combination of increased anxiety, diminished social opportunities, and the shift to telehealth service provision presents particular challenges for the treatment of social anxiety in youth, which relies heavily on exposures to social situations with peers, adults, or other feared social stimuli. The objective of this commentary is to provide guidance to clinicians working with youth with social anxiety on how to maintain ethical, evidence-informed provision of exposure therapy in light of these unusual circumstances. We first present an overview of how COVID-19 may uniquely impact youth with social anxiety and highlight the importance of continuing to provide exposure-based treatments during this time. We then discuss guiding principles for delivering exposure therapy during COVID-19. We focus on providing practical examples of how common social anxiety exposures can be adapted and delivered successfully through telehealth while abiding by COVID-19 social distancing guidelines. Finally, we discuss key recommendations to assist clinicians in moving treatment forward while considering changing safety guidelines pertaining to COVID-19.*

THE novel coronavirus (COVID-19) pandemic has brought swift and unparalleled changes to the landscape of mental health care. Individuals globally are encouraged to maintain physical distance from others to minimize contagion risk ([World Health Organization, 2020](#)). While therapy has moved to telehealth platforms to prevent interruptions in mental health care, emerging evidence suggests youth are at risk for heightened anxiety and psychological distress in the wake of COVID-19 ([Golberstein et al., 2020](#); [Liang et al., 2020](#); [Loades et al., 2020](#)). This is likely to be compounded with the evolving recommendations for safe learning during the 2020–2021 academic year and reductions in social opportunities for many youth. A combination of increased anxiety, diminished social opportunities, and the shift to telehealth service provision presents particular challenges for the treatment of social anxiety disorder (SAD) in youth, which

relies heavily on exposures to social situations with peers, adults, or other feared social stimuli.

SAD, a persistent fear of social situations due to the potential for negative evaluation or embarrassment, is the most common anxiety disorder nationally ([Kessler et al., 2005](#)), with typical onset during late childhood or adolescence ([Grant et al., 2005](#); [Knappe et al., 2015](#)). Untreated, SAD is persistent and associated with significant functional impairment, as well as the onset of depression and additional comorbid psychiatric conditions ([Beidel et al., 2019](#); [Beidel & Turner, 2006](#)). SAD symptoms are maintained via avoidance or limited engagement with feared stimuli and heightened attention to threat (e.g., negative evaluations and judgements); maladaptive anxiety is perpetuated through the absence of corrective learning about the true threat level of the situation and one's ability to tolerate discomfort ([Rapee & Heimberg, 1997](#)).

Cognitive-behavioral therapy (CBT), the leading psychosocial treatment with efficacy and effectiveness data supporting its use with youth with SAD ([HigamcMillan et al., 2016](#); [Radtke et al., 2020](#)), places heavy

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emphasis on the use of exposure therapy (“exposure”; [Banneyer et al., 2018](#)). Exposure consists of therapist-guided support for youth to engage with feared stimuli, reduce maladaptive avoidance behaviors, enhance ability to tolerate fearful situations, promote new learning of social safety, and enhance self-efficacy in navigating social situations. Through repeated and novel exposures, individuals learn new information about the feared stimulus (e.g., it is not truly dangerous, they can tolerate the anxiety it provokes, avoidance is not the only coping response to anxiety), which helps them overcome problematic avoidance and related impairment ([Abramowitz, 2013](#); [Craske et al., 2014](#)). Exposure for youth with SAD often includes facilitating social interactions both during and between therapy sessions to provide youth with opportunities to engage in practice; when needed, exposure practice may also incorporate skills coaching for those youth who also exhibit social skill deficits.

Physical distancing recommendations and reliance on telehealth pose unique difficulties for conducting effective exposures for SAD. We first present a brief overview of how COVID-19 and its sequelae may uniquely impact youth with SAD and discuss the importance of continuing to deliver exposure therapy. Second, we discuss key considerations for clinicians working with youth with SAD to support continued delivery of exposure-based treatments. We also provide concrete examples to illustrate how exposures can be adapted to optimize their success via telehealth while adhering to public health recommendations. We conclude by discussing considerations for continuing treatment with youth with SAD in the near and long-term future. Of note, our primary focus is on implications for exposure treatment delivery, process, and content; readers are referred elsewhere for guidance related to ethical and effective teletherapy practices more generally ([Chenneville & Schwartz-Mette, 2020](#); [Comer et al., 2014](#); [Helping Give Away Psychological Science/Telepsychology, 2020](#); [Seager van Dyk et al., 2020](#)).

### Unique Challenges for Social Anxiety

Without creative intervention, adherence to public health guidelines to prevent and control the spread of COVID-19 may exacerbate youth social anxiety and loneliness ([Ellis et al., 2020](#)). “Social distancing,” the recommendation that individuals maintain a distance of at least 6 feet (2 meters) from others and limit group interactions ([Centers for Disease Control and Prevention, 2020](#)), has led to decreased social interactions, increased screen time, and reduced physical activity ([Ellis et al., 2020](#)). Youth with SAD may be particularly attuned to the social behavior of others and hypercritical of their own social performance relative

to others ([Spence & Rapee, 2016](#)). As social norms related to human interaction shift during COVID-19 (e.g., with mask wearing), youth with SAD may also experience new anxiety triggers. For example, a shift to online schooling may present a host of new social scenarios that youth may feel unequipped to navigate.

Some youth may experience short-term *reductions* in social anxiety symptoms due to the removal of anxiety-provoking social stimuli (e.g., sitting in the lunchroom, joining a club or group, ordering at a restaurant). While such youth may face lower anxiety in the short term, they may be at risk for exacerbated symptoms later, such as when onsite schooling or traditional socializing resumes. In some cases, individuals and families may be hesitant to seek help or assessment for SAD symptoms, due to lowered impairment during the pandemic.

Telehealth also presents unique challenges for treating youth with SAD. There are many natural social contexts and skills in the therapy environment that can be anxiety provoking for youth with SAD (e.g., checking in for their appointment, interacting with others in waiting rooms, partaking in natural and spontaneous conversations) that provide organic opportunities for social practice. These may be difficult to replicate over video platforms. The novelty of telehealth may also be anxiety provoking for youth with SAD, which presents challenges for treatment engagement.

### Need for Continued Exposure Delivery

Exposure is one of the key treatment ingredients leading to symptom improvement for SAD. SAD exposures work to teach individuals that they can face their core fears related to embarrassment and judgment, and tolerate the discomfort that comes from the anxiety rather than just avoiding it. Fortunately, extant literature supports the potential effectiveness of exposure delivery via telehealth. In adults, CBT for anxiety was similarly effective both in vivo and virtually ([Khatri et al., 2014](#)). While there is limited research on telehealth efficacy for SAD specifically, there is evidence that youth with anxiety disorders respond positively via telehealth ([Carpenter et al., 2018](#); [Sequeira et al., 2020](#)). In fact, there may be higher generalizability of the effects of exposure over telehealth, where in-session practice is conducted in the youth’s ecological environment ([Cooper-Vince et al., 2016](#)).

Continuing to conduct exposures for youth with SAD is critical to prevent any erosion of gains (for youth in treatment prior to March 2020) or worsening of symptoms. Decreased social contact naturally results in fewer opportunities for social practice; creating these opportunities via exposure is critical. Not only is exposure necessary for maintaining gains, it helps

youth adjust to the ever-changing social landscape due to COVID-19 (e.g., distanced social interactions, virtual learning, online peer interactions). By continuing exposures, youth with SAD can navigate this new social landscape with clinician support.

Additionally, while lifestyles have changed dramatically over the past few months, this situation is temporary. Social restrictions will eventually end, requiring youth to socially reengage. Continuing to conduct exposures will ensure that youth gain sufficient practice tolerating social uncertainty and “flexing their brave muscles” to be ready to resume normal social interactions when the pandemic has ended.

### **Key Considerations for Exposure Treatment During COVID-19**

Therapists now face the challenge of how to ethically encourage safe social interactions to help clients maintain gains and build new mastery, while also adhering to changing health guidelines. While not exhaustive, we posit a series of considerations for clinicians to support their exposure delivery for SAD during COVID-19.

#### **Assessing Social Anxiety and Monitoring Treatment Progress**

While there has been a rapid publication of measures to index COVID-19-related anxiety (e.g., [Ehrenreich-May, 2020](#); [Taylor et al., 2020](#)), there is limited guidance for if or how we should adapt traditional youth anxiety measures to assess symptoms that may be *exacerbated* by COVID-19 (e.g., enhanced anxiety about being around others due to contagion worry) or *suppressed* by COVID-19 (e.g., reductions in anxiety due to limited need or opportunity to interact with feared social stimuli). Established SAD measures rely on youth to report on their experiences for a recent time period (e.g., the past 3 months; [Birmaher et al., 1997](#)), which, at this point, encompass only a post-COVID window. One option for new clients may be to assess a youth’s anxiety symptoms, distress, and impairment in the 3 months preceding the shelter-in-place issuance in March, 2020, *and* anxiety in the most recent 3 months. Alternatively, clinicians can assess both current impairment versus impairment if “COVID-19 went away tomorrow,” and future fears regarding social interactions (e.g., “I’m afraid to go back to school” or “I’m afraid to see my friends in person”). Second, there may be enhanced utility for using more idiographic assessment tools (e.g., the Top Problems Assessment; [Weisz et al., 2011](#)) to delineate core domains in which social anxiety may be impairing (e.g., difficulty partici-

pating in online class, difficulty engaging with friends via video chat).

Assessing common comorbidities remains critical, especially those that impact social skills (e.g., attention-deficit/hyperactivity disorder [ADHD], autism spectrum disorder). The presence of such comorbidities should inform treatment planning, such as including a focus on social skill practice in addition to exposure. While numerous supports can be attempted to scaffold youth attention (see [Seager van Dyk et al., 2020](#)), youth who continue to struggle to sustain attention via telehealth due to attention difficulties or screen fatigue may also need to be considered for priority return to in-person visits. It is also critical to assess nonanxiety comorbidities on an ongoing basis. Depression in particular may rise during COVID-19 and may require priority treatment ([Loades et al., 2020](#)).

#### **Framing Exposures**

Providing psychoeducation about exposure to increase youth and caregiver buy-in is critical across the board; it may be doubly so during this time of limited social opportunity. Youth experiencing anxiety reductions due to reduced social stimuli may be less motivated or even resistant to continue practicing difficult social exposures in the absence of ongoing impairment. Specific psychoeducation to youth and caregivers about how SAD symptoms may differ due to COVID-19 may bolster motivation and treatment engagement. Another strategy to maintain treatment engagement and motivation is to frame the rationale for continuing exposures as preventing atrophy of “social/brave muscles,” or the clinical gains already made ([Westra, 2004](#)). In addition, motivational interviewing strategies can be helpful for eliciting key areas of clinical impairment (e.g., showing one’s face on video chats, speaking in online classes), where a client is most motivated to see change ([Rollnick & Allison, 2004](#); [Westra & Dozois, 2006](#)).

#### **Setting Up Exposure Practice**

Setting up feasible and manageable exposures is always of importance but may be especially critical over telehealth. It may be more challenging to create a controlled environment over telehealth in which to conduct social exposures; flexibility is key. Having caregivers help limit distractions and set up a quiet therapy space may be one strategy to help ensure that youth with SAD are engaged in the exposure, especially for younger children. It may be helpful for clinicians to collaborate with caregivers to set clear expectations

early in the treatment process; depending on the age and attention span of the child, clinicians and caregivers may consider framing the treatment hour as similar to when the child does online school (i.e., as “work time” rather than play time). Related, clinicians might flexibly shorten the amount of exposure practice if a youth seems to be experiencing screen fatigue. However, it is important to be mindful of caregiver burden and stress, with many caregivers essentially working three full-time jobs (day job, caregiver, and home-school teacher) simultaneously. Clinicians must attend to caregiver stress, and support caregivers in accessing any necessary resources for their own mental health and well-being (Brown et al., 2020; Schleider et al., 2015). Once expectations are established, caregiver burden may be reduced for future sessions. There is also limited evidence regarding the trajectory of youth mental health symptoms during COVID-19 and treatment gains may be harder to measure. Clinicians should set flexible expectations regarding symptom reduction and treatment gains for clients to help mitigate frustration about treatment progress.

### Adapting Traditional Social Exposures

While some traditional SAD exposures may not be feasible in the current climate, many traditional exposures can be easily adapted to address the same core issues over telehealth while ensuring compliance with CDC guidance. Table 1 provides an overview of a representative sample of 35 unique social exposures from an online exposure repository (Becker-Haimes, n.d.). In Table 1, we demonstrate which exposures can be delivered without modifications, identify exposures in need of adaptation, and suggest adaptations that address the same underlying exposure goal. As youth become more familiar with exposure over teletherapy, different exposures can be layered (e.g., completing multiple exposures in a row), or varied to facilitate new safety learning and promote distress tolerance, consistent with leading exposure theory (Craske et al., 2014). Readers are referred to Peterman et al. (2015) for more general guidance on exposure practice with youth.

### Navigating New Social Situations

There are opportunities for novel exposures to support youth in navigating a changed social landscape. With respect to school, there may be a need to focus on exposure practice related to engaging in an online class environment, supporting those youth who have the opportunity to retransition to on-campus schooling, or engage in novel social opportunities virtually.

Youth with SAD may experience greater difficulty connecting with peers, may struggle to ask for help or ask questions in the online medium, and may take advantage of options for anonymity in class (e.g., by keeping their video off).

Youth with SAD may experience additional discomfort when navigating peer interactions, social gatherings, and extracurricular activities, since social distancing provisions may change how these social environments are navigated (e.g., online school clubs). Creating targeted exposures will be crucial to help youth with SAD practice increasing their comfort in these novel social situations. Additionally, youth and their families are likely to vary in their accepted level of risk with respect to socializing with others and this may result in social discomfort for youth with SAD, particularly around navigating peer pressure regarding violation of social distancing protocols. Exposure work may benefit from incorporating assertiveness training and helping youth practice advocating for themselves in such situations. Finally, the growing ubiquity of masks may also heighten anxiety for youth with SAD by making it more difficult to pick up on subtle facial cues or increasing perceptions of threat in social interactions (e.g., youth with SAD may view individuals with masks as less trustworthy due to the potential for illness; Olivera-La Rosa et al., 2020).

These challenges point to ripe opportunities for exposure practice to support youth and increase their comfort in these anxiety-provoking situations. Examples might include a graduated practice of leaving a video camera on for a therapy session or other online class or social activity, practicing tolerating videos of others “staring” at him or her, “forgetting” to mute oneself on a call, “accidentally” sharing his or her screen during an online social engagement, going out for a walk in an “uncool” mask (e.g., a juvenile print), interacting with peers or adults wearing masks, and joining new virtual clubs or pursuing other new online (and safe) social forums. For youth with “mask anxiety,” exposure practice with a variety of masked individuals in a range of social situations may bolster self-efficacy for socializing while masked, since there is evidence that masks do not impede delivery of social cues (Roberson et al., 2012).

Finally, there is always the possibility youth may need to be tested for COVID-19, which may be a stressful event. An exposure framework for approaching COVID-19 testing may help youth cope with the associated distress. Targeted exposures may focus on reporting symptoms, asking for help/testing, or practicing imaginal exposures of getting tested or telling friends and family about having to be tested.

Table 1

Social Anxiety Exposures (“Brave Challenges”) From [www.bravepracticeforkids.com](http://www.bravepracticeforkids.com) and Possible Modifications for COVID-19 Therapy Provision

<i>Original exposure</i>	<i>Suggested modifications<sup>2</sup></i>
<b>Goal of exposure<sup>1</sup>: Practice tolerating embarrassment or “bothering” someone else</b>	
Pick out a silly hat and run some errands.	Ensure errands are necessary (e.g., at grocery store); wear a hat during an online call or while taking a socially distanced walk; wear a “silly mask” instead of a silly hat. Complete over video or phone with family or friends.
Pick out a few silly tongue twisters, find three people to read them to (quickly).	
Watch videos of people doing embarrassing things or being embarrassed.	Share screen over telehealth platform to watch together.
Drop a giant bag of coins in a hallway, lobby, or waiting area and then pick them all up (Bonus if there are others around).	Drop bag of coins outside of a building, rather than inside.
Read a poem to a stranger; make it harder by making three mistakes on purpose.	Bring in novel people (e.g., fellow clinicians) onto the telehealth session to facilitate practice; send a text message containing mistakes to a friend or acquaintance.
Sing “Happy Birthday” as loud as you can in the middle of the lobby.	Sing “Happy Birthday” as loud as you can outside in a semipublic space while maintaining social distance.
Open a closed door in the clinic without knocking.	FaceTime someone without scheduling a time to chat in advance.
Pick a tasty snack and practice eating in front of someone you would normally avoid eating in front of.	Encourage a “lunch playdate” where youth eat over Zoom or a socially distanced picnic outside with a peer or family member.
Push on a pull door repeatedly.	None needed (can encourage hand sanitizer or use of a glove if a public space).
Answer a question incorrectly in class.	Potentially none needed; play a difficult trivia game virtually with clinician or with family.
Eat your snack in front of the clinic staff.	Eat a snack in front of clinician during telehealth session.
Do something embarrassing in front of peers at school (e.g., trip and fall, drop books on floor).	Send silly selfie to a peer via Snapchat; do something embarrassing during a video call.
<b>Goal of exposure: Practice asking something of someone or “bothering” someone else</b>	
Send a text to a friend (Bonus: Immediately text to say it was an accident).	None needed.
Wear glasses on your head and ask someone if they have seen your glasses (or phone).	Practice doing so with a mask and maintaining social distance.
Prepare a 1-minute presentation on a topic of your choice to give to a few people.	Present over video or in front of family (or both).
Sit with people you do not know well in the cafeteria.	Will vary based on school restrictions. Can encourage outdoor picnics with peers when feasible.
Ask the teacher for help after class	Ask the teacher for help over video platform.
Call a friend to invite him or her for a playdate.	Call a friend for a socially distant playdate or a video playdate.
Order a cup of coffee or small object from a store—make it harder by telling the store clerk your order is incorrect or you want to return for something else.	Encourage ordering at a location with some type of outdoor location to maximize safety (while wearing a mask); instead of returning can add an item or ask for water.
Go to a local bookstore with a help desk and ask for a book recommendation.	Call a restaurant and ask for a recommendation on what to order; call a library and ask for an e-book recommendation.
Place an order for takeout by phone and say you changed your mind and do not want it anymore (Bonus: Add or change an item you ordered!).	None needed.

(continued on next page)

Table 1 (continued)

<b>Goal of exposure: Practice asking something of someone or “bothering” someone else</b>	
Ask for help (e.g., the time, a pen, directions) at the clinic front desk.	Call clinic to ask about appointment details (e.g., time, delivery method) (Bonus points if silly question).
<b>Goal of the exposure: Practice tolerating social uncertainty</b>	
Pick random topics out of an envelope and speak about them for 1 minute to three or four people.	Bring in novel people (e.g., fellow clinicians) onto the telehealth session to facilitate practice.
Ask someone a hard question they probably will not know like “How many miles are between Las Vegas and the North Pole?”	Bring in novel people (e.g., fellow clinicians) onto the telehealth session to facilitate practice or ask friends of their parents over the phone.
For older youth—post a picture on social media that might not be perfect or cool.	None needed.
Start a conversation with someone new; make eye contact with peers in a hallway.	Send a text message to an acquaintance; for increased difficulty, FaceTime an acquaintance.
Attend an anxiety-provoking social event.	“Attend” a group video chat or a virtual social activity (e.g., youth group meeting; Bonus if you arrange the group video chat).
<b>Goal of exposure: General social practice and skills opportunity</b>	
Go to a location with lots of people and tell 5–10 strangers you are doing a survey about their favorite ice cream flavor.	Bring in novel people (e.g., fellow clinicians) onto the telehealth session to facilitate practice or utilize friends of parents over the phone.
Ask someone in your building for directions to the train station.	Ask someone in a grocery store where the bread is located (while wearing a mask); call a store and ask about hours or COVID-19 protocols.
Say hello to someone new with eye contact.	Encourage practice outdoors with a mask on, making eye contact; encourage having video turned on for classroom activities.
Engage a new person in a conversation—practice on starting and continuing and exiting.	Have conversations with novel people (e.g., fellow clinicians) in teletherapy; arrange phone calls with unfamiliar friends of a caregiver to practice conversation.
Have a neutral conversation with a stranger in the elevator or grocery store line.	Practice neutral conversations in other contexts: ordering food on the phone, calling a store to ask about hours, scheduling an appointment.
Order by yourself in a restaurant.	Be in charge of ordering takeout for the family over the phone (not through an app) or call and ask what is on the menu.
Join age-appropriate clubs and organizations (e.g., sports teams, art class).	Join virtual clubs, or engage in virtual classes (e.g., dance, yoga, Karate, art).
Have one-on-one or small-group playdates.	Connect with other kids virtually, or in an outdoor space. With appropriate consent, facilitate connecting several socially anxious clients of similar age.

<sup>1</sup> There is overlap in which exposures fall under which category, as exposures may be able to target more than one core fear simultaneously. Categories are presented as a guide for the types of modifications that might be made considering the primary goal of the exposure.

<sup>2</sup> Allowing clients to use safety behaviors initially and then repeat the same exposures while gradually pulling back safety behavior use can be one strategy for titrating the intensity of the exposure.

## Safety Behaviors

Safety behaviors (i.e., anxiety-reduction behaviors unrelated to objective safety that prevent the client from fully engaging in exposure; Morrison & Heimberg, 2013) are common to SAD (e.g., avoiding

eye contact, speaking softly, fidgeting/clenching fists, only engaging if a caregiver is present, only engaging if a safety object is present). Monitoring and reducing safety behavior use via telehealth (e.g., increased fidgeting, looking away or turning off the camera) remains important, although may be more difficult.

Varying camera angles to capture body language may be critical for assessing safety behaviors to effectively redirect attention to the exposure.

### Optimizing Collateral Support

Caregivers play a vital role in conducting out-of-session exposure practice by helping to guide exposure practice at home and provide rewards and encouragement. The virtual platform affords unique advantages by facilitating a clinician's ability to observe and provide live coaching to caregivers during exposure practice ("bug-in-the-ear" coaching using headphones) in the youth's ecological setting; skills learned can be utilized in other out-of-session practice (Frederick et al., 2020). Clinicians can also model and coach caregivers to label their own emotions and verbally model effective coping. Additionally, virtual platforms can facilitate including teachers in exposure practice, obviating traditional challenges of travel, and coordinating schedules with teachers.

### Clinician Anxiety and Bandwidth

A clinician's own anxiety may interfere with effective delivery of exposure therapy. While exposure is one of the most effective treatments for SAD, many clinicians hold reservations about utilizing exposures, even in traditional treatment (Deacon et al., 2013; Gunter & Whittal, 2010; Lokers, 2020), and exposure is underutilized compared to other interventions, like relaxation (Becker-Haimes et al., 2017). Clinician anxiety about exposure (e.g., fear of harming patients, exacerbating symptoms) is also a major barrier to exposure use (Farrell et al., 2013; Olatunji et al., 2009). Utilizing a virtual platform may result in even higher anxiety for clinicians due to decreased proximity to the client. Clinicians may be hesitant to push clients to address fears that are higher on the hierarchy for fear of not being able to effectively complete the exposure without pushback or rejection from the client. Additionally, clinicians may be struggling with their own COVID-19-related anxiety (e.g., clinicians who are hesitant to order takeout themselves out of fear of COVID-19 risk may avoid recommending it as an exposure). It may be necessary for clinicians to check their own "anxiety temperature" related to COVID-19 risk and socialization to ensure that exposures are conducted in the best interest of the youth. More than ever, seeking peer consultation to gain support in delivering the best possible treatment for SAD is recommended. Furthermore, clinicians may need to take extra steps to ensure that they are attending to their own emotional well-being to avoid burnout and optimize their ability

to support the youth they treat (see TRAILS, 2020a, 2020b, for clinician-targeted resources for clinician well-being during COVID-19).

### Key Considerations for the Future

The COVID-19 pandemic has introduced an array of challenges and uncertainties for treating youth with SAD. However, it also provides an opportunity for therapists to practice adaptability and responsiveness. The shift to teletherapy provides opportunities for modeling flexibility and emotion regulation as therapists learn to use a variety of new platforms (that our younger clients may feel much more comfortable with). Managing this embarrassment, leaning into the challenges, and creatively identifying unique and relevant exposures that elicit the same core fears as the more "tried-and-true" social exposures, are essential skills to the successful treatment of social anxiety in youth.

As of this writing, the contours of the 2020–2021 school year and beyond remain unknown. Much will depend on local spread/containment of the virus; guidelines and restrictions are changing quickly as COVID-19 case counts rise and fall regionally. These changes will affect youth with SAD dramatically. Therapists and clients alike will need to remain flexible in the face of uncertainty and changing guidelines. Navigating uncertainty can be challenging for everyone, but especially so for youth with SAD (Boelen et al., 2010; Hearn et al., 2017). Thus, it may be relevant to also incorporate exposures related to uncertainty and to emphasize the importance of flexibility within the treatment for social anxiety. This will support clients to master social anxiety triggers and prepare them to adapt to inevitable changes in the short term and unpredictable changes in the long term.

Adaptability and flexibility will continue to be relevant to clinicians as we eventually consider a return to a version of normal. When in-person schooling and social opportunities resume, many youth (even those not previously struggling with social anxiety) may experience increases in social anxiety symptoms. The virtual environment necessitates some degree of involuntary avoidance (e.g., not having the opportunity to sit in the cafeteria). While exposure for SAD can and must continue in the interim, therapists should anticipate possible upticks in social anxiety symptoms, both among their clients and the general population upon the resumption of normal social expectations. While preventing this increase completely is likely impossible, proactively planning exposures to triggers from the pre-COVID era may be needed. For example, clinicians might develop a plan with a client to have them sit in the cafeteria beginning on their first day of school, whenever that resumes.



This planning could be followed by imaginal exposures related to this stimulus. Proactive exposures, coupled with discussions of adapting to uncertainty, can set socially anxious youth up for success upon the resumption of the new normal.

## Conclusions

The impact of COVID-19 will persist. Clinicians working with youth with SAD should continue to emphasize the use of exposure in their clinical practice, regardless of treatment medium, although adaptations may be needed. Ultimately, the investments therapists make now, both related to adapting and administering exposure, and shifting to teletherapy platforms, will pay dividends in the future. While COVID-19 specific anxiety will eventually pass, teletherapy will likely persist as a common treatment format; strategies that clinicians master now can hopefully be used to support youth with SAD for decades to come. More immediately, the challenging but necessary adjustments to treatment will benefit youth with SAD as they navigate an unpredictable social landscape. Although a pandemic may not be the easiest time for clinicians to adapt in such a dramatic fashion, we believe it will be well worth it.

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