Chapter 7

TREATING YOUTHS WITH SOCIAL ANXIETY AND SOCIAL PHOBIA

LAYING THE GROUNDWORK

The previous chapter contained a brief overview of treatment components that are commonly used to address youths with social anxiety and social phobia. In this chapter as well as in Chapters 8 and 9, treatment procedures for use in general clinical settings are described in more depth. This chapter will concentrate on initial procedures designed to lay the groundwork for the more intense procedures discussed in Chapters 8 and 9. These initial procedures include psychoeducation, somatic control exercises, contingency management, and contingency contracting. Obstacles to treatment as well as homework assignments will also be discussed throughout. A sample case of a youth with social phobia and concurrent depression and school refusal behavior is provided as well.

Some caveats before proceeding. First, the procedures discussed in this book are covered in a way that implies their use more so for individuals than groups. However, many advantages exist for conducting group therapy for youths with social phobia, including increased social interaction, double exposures, and cost-effectiveness (see Chapter 6). Therefore, suggestions will be made intermittently for using these procedures in group settings. Second, the procedures do not necessarily apply to any particular case. Indeed, good clinical judgment is needed when selecting the course, pace, and techniques of therapy for a given child. In related

fashion, treatment techniques must be modified and applied with sensitivity to a child's mental condition, developmental status, unique characteristics such as culture, and family and other variables (see Chapter 5). Finally, the procedures are not described like a treatment manual, and descriptions are made with the assumption that the reader has a good background with respect to general psychotherapy practice with youths.

PSYCHOEDUCATION

Psychoeducation for this population generally refers to informing a child and his or her family members about the nature of social anxiety and its response components: physiological, cognitive, and behavioral. In addition, children and family members are educated about how anxiety is triggered and maintained. In doing so, a rationale may be conveyed for the treatment techniques that are to be used. Impairment from social anxiety in the form of skills deficits, peer rejection, or other problems, as well as inappropriate coping strategies such as avoidance, can also be illustrated to punctuate the need for treatment and how quality of life can be improved. Psychoeducation may be tailored to the specific characteristics of a child by relying on past and present self-monitoring and other assessment information.

Psychoeducation is often described in the literature as a child-based technique, though I find it helpful to include parents in the process. The technique begins by describing separately the components of social anxiety and providing examples from a child's own experiences. In many cases, children can provide their own examples but, in other cases, the therapist must provide considerable help. On a large sheet of paper or a writing board, the therapist may draw three circles that contain one heading each: "What I feel," "What I think," and "What I do." The circles do not overlap.

The first circle contains physical feelings that the child experiences in anxious social and/or performance-based situations. The child may reiterate his or her own physical feelings from formal assessment, the therapist may prompt these responses from the child and parents, or the therapist may provide a list of physical feelings commonly experienced by youths with social anxiety (see Chapter 2) and ask the child to endorse those that he or she usually experiences. The therapist then writes the responses in the "What I feel" circle.

The second circle contains the child's thoughts during anxious social and/or performance-based situations. The child may reiterate these thoughts from assessment or the therapist may prompt the thoughts in some way. The thoughts are then written in the "What I think" circle. The third circle contains the child's actual physical behaviors during anxious

social and/or performance-based situations. These behaviors most often include forms of avoidance as well as others such as excessive reassurance-seeking, oppositional, or noncompliant behaviors. Each circle can then be reviewed for completeness.

The therapist then explores with the child the specific *sequence* of anxiety that occurs in different anxiety-provoking situations. For example, a child may say that she experiences substantial stomach cramps at school immediately before going to the cafeteria for lunch. These cramps may then be followed by worries or thoughts about vomiting in the cafeteria and resultant embarrassment. Subsequent behaviors might then include obvious ones such as hiding in the bathroom during lunch or more subtle ones such as eating near the exit in case nausea becomes severe. Although an anxiety sequence is often similar across situations for a given child, this is not always so. Therefore, all major anxiety-provoking situations should be probed to identify the various sequences of physical feelings, thoughts, and behaviors that are evident.

As a child's anxiety sequences are identified, the therapist can outline how the child's anxiety is typically triggered and maintained. For many children, aversive physical feelings or troublesome thoughts are key triggers, but other children may avoid first and worry later. These sequences may change over time, however, which makes the use of self-monitoring quite important. Children and parents (if applicable) can monitor and rate a child's physical feelings, thoughts, and behaviors in anxiety-provoking situations to further illustrate these patterns, identify changes over time, and chart treatment progress.

Psychoeducation may also be done when providing rationales and goals for treatment. Because treatment procedures will target the major response components to anxiety, treatment rationales may be structured similarly. For example, physical feelings of anxiety could be managed via somatic control exercises, anxious thoughts could be modified via cognitive therapy, and avoidant behaviors could be eliminated via exposure-based practices. Each set of treatment techniques, and relevant others, can be explored in depth and divided into phases. For example, initial phases of treatment will likely concentrate on anxiety management techniques for aversive feelings and thoughts. Later phases of treatment will likely concentrate on using these anxiety management techniques to successfully engage in exposure-based practices to reduce avoidance.

Furthermore, specific goals for the child can be identified at this point. Examples include a substantial reduction in physical feelings and problematic thoughts (i.e., successful anxiety management), elimination of avoidant behaviors, development of social skills, and ancillary goals such as reduced family conflict or child noncompliance. Questions regarding proposed techniques should be answered fully to help prevent

misconceptions, skepticism, and noncompliance regarding treatment. Family members should also be warned that the general therapy plan may change over time to adapt to new information, problematic behaviors, and obstacles.

One key obstacle that may arise during this process is a lack of problematic thoughts during anxiety-provoking situations. This may be due to a child's limited cognitive developmental status, but other reasons include a diffuse anxiety response (e.g., "I just feel bad"), true lack of problematic thoughts, or noncompliance. In this case, extensive self-monitoring with help from others may be necessary but, in other cases, problematic thoughts simply do not apply. If thoughts do not seem overly relevant to treatment, then an emphasis can be placed on addressing aversive physical feelings and avoidant and other misbehaviors.

Psychoeducation can be easily adapted for use in individual and group therapy. In group situations, however, extra care should be taken to ensure that all members fully understand the anxiety and treatment components. Pulling children aside during breaks to ensure this may be desirable. In addition, psychoeducation may be conducted in conjunction with "ground rules" to be set for a group, including attendance, homework assignments, group participation, and confidentiality (Albano, Marten, & Holt, 1991).

Finally, psychoeducation should not be viewed as a one-time procedure, but one to be reintroduced throughout treatment to remind individuals of the "big picture" and goals of therapy. In related fashion, I have found psychoeducation to be useful for building and maintaining rapport, offering encouragement, enhancing motivation, and easing tension. As a therapist calmly conveys the structure of anxiety and its treatment, clients are often eased by the knowledge that this is a common and fixable problem. Psychoeducation usually takes one session to complete, but can be condensed or extended as necessary.

SOMATIC CONTROL EXERCISES

Somatic control exercises are typically employed to help a child manage aversive physical feelings associated with his or her social and/or performance anxiety. Although different forms of somatic control exercises exist, the most common for anxious children include relaxation training and breathing retraining. *Relaxation training* comes in several forms as well, and a child and his or her family members should provide input about which methods have been tried in the past. A popular form of relaxation training is a *tension-release method* involving different muscle groups. In this method, a child sits in a comfortable chair before a therapist who slowly

TABLE 7.1. Relaxation Training Script (from Ollendick & Cerny, 1981)

Hands and arms

Make a fist with your left hand. Squeeze it hard. Feel the tightness in your hand and arm as you squeeze. Now let your hand go and relax. See how much better your hand and arm feel when they are relaxed. Once again, make a fist with your left hand and squeeze hard. Good. Now relax and let your hand go. (Repeat the process for the right hand and arm).

Arms and shoulders

Stretch your arms out in front of you. Raise them up high over your head. Way back. Feel the pull in your shoulders. Stretch higher. Now just let your arms drop back to your side. Okay, let's stretch again. Stretch your arms out in front of you. Raise them over your head. Pull them back, way back. Pull hard. Now let them drop quickly. Good. Notice how your shoulders feel more relaxed. This time let's have a great big stretch. Try to touch the ceiling. Stretch your arms out in front of you. Raise them way up over your head. Push them way, way back. Notice the tension and pull in your arms and shoulders. Hold tight, now. Great. Let them drop very quickly and feel how good it is to be relaxed. It feels good and warm and lazy.

Shoulders and neck

Try to pull your shoulders up to your ears and push your head down into your shoulders. Hold in tight. Okay, now relax and feel the warmth. Again, pull your shoulders up to your ears and push your head down into your shoulders. Do it tightly. Okay, you can relax now. Bring your head out and let your shoulders relax. Notice how much better it feels to be relaxed than to be all tight. One more time now. Push your head down and your shoulders way up to your ears. Hold it. Feel the tenseness in your neck and shoulders. Okay. You can relax now and feel comfortable. You feel good.

Jaw

Put your teeth together real hard. Let your neck muscles help you. Now relax. Just let your jaw hang loose. Notice how good it feels just to let your jaw drop. Okay, bite down hard. That's good. Now relax again. Just let your jaw drop. It feels so good just to let go. Okay, one more time. Bite down. Hard as you can. Harder. Oh, you really are working hard. Good. Now relax. Try to relax your whole body. Let yourself get as loose as you can.

Face and nose

Wrinkle up your nose. Make as many wrinkles in your nose as you can. Scrunch up your nose real hard. Good. Now relax your nose. Now wrinkle up your nose again. Wrinkle it up hard. Hold it just as tight as you can. Okay. You can relax your face. Notice that when you scrunch up your nose your cheeks and your mouth and your forehead all help you and they get tight, too. So when you relax your nose, your whole face relaxes too, and that feels good. Now make lots of wrinkles on your forehead. Hold it tight, now. Okay, you can let go. Now you can just relax. Let your face go smooth. No wrinkles anywhere. Your face feels nice and smooth and relaxed.

Stomach

Now tighten up your stomach muscles real tight. Make your stomach real hard. Don't move. Hold it. You can relax now. Let your stomach go soft. Let it be as relaxed as you can. That feels so much better. Okay, again. Tighten your stomach real hard. Good. You can relax now. Settle down, get comfortable and relax. Notice the difference between a tight stomach and a relaxed one. That's how we want to feel. Nice and loose and relaxed. Okay. Once more. Tighten up. Tighten hard. Good. Now you can relax completely. You feel nice and relaxed.

(*Continued*)

TABLE 7.1. (*Continued*)

This time, try to pull your stomach in. Try to squeeze it against your backbone. Try to be as skinny as you can. Now relax. You don't have to be skinny now. Just relax and feel your stomach being warm and loose. Okay, squeeze in your stomach again. Make it touch your backbone. Get it real small and tight. Get as skinny as you can. Hold tight now. You can relax now. Settle back and let your stomach come back out where it belongs. You can feel really good now. You've done fine.

Legs and feet

Push your toes down on the floor real hard. You'll probably need your legs to help you push. Push down, spread your toes apart. Now relax your feet. Let your toes go loose and feel how nice that is. It feels good to be relaxed. Okay. Now push your toes down. Let your leg muscles help you put your feet down. Push your feet. Hard. Okay. Relax your feet, relax your legs, relax your toes. It feels so good to be relaxed. No tenseness anywhere. You kind of feel warm and tingly.

Conclusion

Stay as relaxed as you can. Let your whole body go limp and feel all your muscles relaxed. In a few minutes it will be the end of the relaxation exercise. Today is a good day. You've worked hard in here and it feels good to work hard. Okay, shake your arms. Now shake your legs. Move your head around. Open your eyes slowly (if they were closed). Very good. You've done a good job. You're going to be a super relaxer.

(Used with permission).

reads a relaxation training script. The session may be audiotaped so the child can practice the technique at home. A popular relaxation script from Ollendick and Cerny (1981) is in Table 7.1.

The tension-release method requires a child to tense a specific muscle group, maintain the tension for 5–10 seconds, and release quickly. As the therapist proceeds through different muscle groups, the child is encouraged to note the difference between a tense muscle and a relaxed one. Important muscle groups are covered, but special attention should be paid to groups (e.g., face, stomach) identified as most problematic for that child in anxiety-provoking social and/or performance situations. The child may then be asked to practice the relaxation technique at least twice per day and in situations of intense anxiety.

Breathing retraining may also be used to enhance relaxation, and is particularly useful for youths who hyperventilate during anxiety-provoking situations. A sample breathing retraining script from Kearney and Albano (2000) is in Table 7.2. The child is asked to inhale slowly through his or her nose and exhale slowly through his or her mouth. Having a child push a finger into his or her diaphragm is recommended to ensure the accuracy of the technique. Counting and imagery may also be used to enhance the technique or make it more palatable for younger children.

TABLE 7.2. *Breathing Retraining Script* (from Kearney & Albano, 2000)

Ask the child to imagine going on a hot air balloon ride. As long as the hot air balloon has fuel supplied by the child's breathing, destinations are unlimited. Ask the child to breathe in through his or her nose and out through his or her mouth with a SSSSSSSSS. . . . . sound. You may encourage this process through imagery (e.g., having a picture of a hot air balloon nearby). If necessary, have the child count to himself or herself slowly when breathing out.

Example:

Imagine going on a ride in a hot air balloon. Your breathing will give the balloon its power. As long as you breathe deeply, the balloon can go anywhere. Breathe in through your nose like this (demonstrate). Breathe slowly and deeply. Try to breathe in a lot of air. Now breathe out slowly through your mouth, making a hissing sound like this (demonstrate). If you want, you can count to yourself when you breathe in and out.

(Used with permission).

Somatic control exercises are particularly useful if a child experiences severe physical symptoms when anxious. However, these exercises per se may not provide much benefit. Indeed, in my experience, many children with social phobia discount the procedures or fail to use them because the procedures are less than helpful. However, other children do find the procedures quite useful, especially in conjunction with cognitive or other treatment procedures. If a child is noncompliant about using somatic control exercises, then a therapist should consider the possibility that the procedures are irrelevant.

CONTINGENCY MANAGEMENT

The procedures discussed so far are largely child-based in nature, but parents can be involved in treatment as well. *Contingency management* procedures, for example, are especially useful for treating children with social anxiety or social phobia, and often include the following:

- Establishing incentives for completing therapeutic homework assignments
- Establishing disincentives for failing to complete assignments or for related behavior problems
- Ignoring or otherwise extinguishing inappropriate behaviors
- Establishing set routines in the morning, evening, and weekends to encourage naturally occurring social interactions and performances before others
- Modifying parent commands to make them more succinct and effective

Incentives

As a child is asked to execute somatic control exercises, practice cognitive techniques, develop social and coping skills, and participate in exposure-based assignments, the therapist and parents can design an *incentive* package to help the child engage in these procedures. Often the most useful incentives are attention-based, such as extra time with parents or the comfort of family time without pressures to interact with outside family members. However, other youths respond better to tangible rewards, so these could be offered as well. Of course, incentives would be given only *after* the child has successfully completed specific therapeutic homework assignments. For example, a child may be required to order ice cream in a public place and then be allowed to eat the ice cream (tangible reward) with his or her family members (attention-based reward).

In children with social anxiety and social phobia, rewards are often linked as well to *shaping processes* such as gradual increases in school attendance, ongoing steps in anxiety management skills, and progressive exposures to feared stimuli. A progressive reward system can be implemented, for example, in accordance with successive classes a child adds to his school schedule or with each social skill that becomes proficient. Positive reinforcement is usually a preferred consequence for anxious children. This is so because a child's anxiety may have been ignored, stigmatized, ridiculed, or otherwise punished for some time with little benefit. In addition, encouraging approach behaviors is often more agreeable to parents than using threats.

Disincentives

Failure to complete therapeutic homework assignments may also be met with *disincentives*, though care and restraint should be employed. If a child is noncompliant with respect to a therapeutic homework assignment, then the therapist should *first* explore whether the assignment was simply too difficult for the child and whether other (e.g., school-based) obstacles were present. If the child could have completed the assignment but still did not, then mild punishment in the form of early bedtime or expression of disappointment may be used. Harsher punishments are not generally recommended for this population, though may be necessary when severe behavior problems (e.g., school refusal behavior) are comorbid with a child's social phobia.

For younger children, a *token economy with response cost* may be a desirable way of meting out incentives and disincentives. This involves a formal system of giving a child tokens (or tangible markers such as stickers) or

points for appropriate behavior (Kerr & Nelson, 2002). For example, a child may earn a token or certain number of points for demonstrating a predetermined socially acceptable behavior. At a later point, perhaps at the end of that day or week, the child may exchange his or her tokens/points for tangible rewards that increase in value the more tokens/points are accrued. Token economies are generally more effective with a response cost component, or loss of some tokens/points for inappropriate behaviors such as disruptiveness, noncompliance, or avoidance (Gelfand & Hartmann, 1984). Token economies for problematic behaviors may be implemented at home, but are often amenable to school classrooms as well.

Extinction

Relatedly, parents may be taught to engage in *extinction*, or withholding attention or tangible rewards from children who act inappropriately. Such acts include, among others, unnecessary avoidance, noncompliance, temper tantrums, whining, crying, pouting, refusing to move, dirty looks, withdrawal, mean-spirited statements, complaints about treatment, or other regressive or disruptive behaviors to force parental acquiescence. *Time-out* may be an effective form of extinction for younger children. For older children and adolescents, parents should generally ignore and "work through" minor inappropriate behaviors and strictly adhere to commands to their children to engage in appropriate behaviors. More severe inappropriate behaviors may be met with formal punishments.

Extinction is particularly useful for *excessive reassurance-seeking behavior*, or a constant barrage of questions or statements to parents to alleviate distress or avoid obligation (e.g., "Are you sure it will be okay?" "What if X happens?" "Do I have to?"). Often these questions or statements surround social- and performance-based events, school and therapy attendance, and whether parents will be at a certain place and time to retrieve or "rescue" a child (e.g., "Be sure to be there at 3:15 *exactly*, Mom"). In these cases, shaping is generally recommended. For example, parents are allowed to answer the child's first question (e.g., "Do I *have* to go?") in a succinct, calm, and therapy-relevant way (e.g., "Yes, you *are* going to the birthday party"). Subsequent questions or related statements can then be ignored for a certain time period (e.g., one hour) and then answered once again.

Routines

Another common contingency management practice for this population is to develop set *routines* for a family that increase natural occurrences of social interaction and performances before others. Many cases of

childhood social phobia involve family members who have reinforced a child's avoidant behavior for long periods of time. Therefore, parents must often learn to pay attention to, and reward, even minor child behaviors that are approach-oriented and more socially appropriate in nature.

In the morning, for example, children may be asked to engage in a set routine as they prepare for school, which includes conversations with others at the breakfast table, greetings to a school bus driver or peers when arriving at school, and questions to and conversations with others about the upcoming day. During the evening and weekends, youths may be asked to answer the telephone or door, greet others in casual settings, ask someone for help or directions, call an acquaintence or friend regarding homework or a social gathering, order food in a restaurant, perform somehow (e.g., play a musical instrument) before relatives or others, or be assertive when necessary. Compliance to these day-to-day expectations should be rewarded as well. Structuring routines is also a key aspect of treating many youths with social phobia with concurrent school refusal behavior.

Commands

Contingency management procedures for this population may also involve modifying parent *commands* toward greater brevity and effectiveness. Many parents who are frustrated with their child's behavior use commands that are dominated by criticism, lectures, vague statements, and blame. If so for a youth with social phobia, then parents can be educated about the negative effects of such commands on their relationship with their child, prospects for compliance, and eventual resolution of avoidant behaviors. Instead, parents may be taught to provide brief, clear commands to which a child may or may not respond. Appropriate responses are then rewarded and inappropriate responses or avoidance are then punished if desirable. Parent commands and statements may also be altered to encourage appropriate social behaviors in a child, guide a child gently through an assigned exposure, remind a child of different techniques that are useful in anxiety-provoking situations, and offer suitable comfort and support during therapy.

During the course of therapy, parents should continually engage in an active contingency management process to enhance other therapeutic techniques and to address noncompliant behaviors. Obstacles to such treatment include inconsistent application of the procedures, marital discord, fears about "pushing" a child in therapy, and resistance to change in what is sometimes perceived as a "child-only" problem. In these cases, working closely with parents, if even by telephone, is highly recommended. Reiterating treatment rationales and goals may be necessary as well. In

other cases, especially those where the parents have social phobia or other psychopathology themselves, concurrent or referred treatment may be necessary.

CONTINGENCY CONTRACTING

Another commonly used technique for youths with social phobia is *contingency contracting*. Contingency contracting refers essentially to written contracts between parents and a child regarding commitment to the therapy process, therapeutic homework assignments, and related issues such as chores and other responsibilities (e.g., curfew). Contracts may apply most to adolescent cases of social phobia or cases where contingency management procedures are not fully applicable.

The development of contracts often coincides with communication and problem-solving skills training. The general goal of these treatments is to improve a family's ability to define problems, negotiate solutions to these problems, and evaluate the effectiveness of the solutions. Contracts are initially developed in-session under the direction of the therapist, who usually serves as mediator. The first contract involves a general statement whereby all parties commit to the therapy process. In addition, this contract may include simple requirements such as completing an initial therapeutic homework assignment (e.g., practicing somatic control exercises) and accompanying incentives and disincentives for compliance or noncompliance, respectively.

Subsequent contracts may address compliance to more detailed therapeutic procedures as well as behavior problems other than social phobia (especially school refusal behavior). As therapy progresses, family members can hold meetings at home to design and implement contracts more independently. In addition, a therapist can blend contracts with communication skills training and other methods of problem-solving training. Family members can, for example, practice conversational skills as they develop a contract.

Common obstacles to contracts include insufficient strength of incentives and disincentives, noncompliance, and disingenuous agreement to a contract. The latter may result from a desire to avoid or escape the problem resolution process, or may result from one party pressuring another to sign a contract. I recommend contacting each party soon after a contract has been developed to reconfirm everyone's commitment to it and to assess for desired changes. Contracts may also have to be tweaked or simplified with respect to type and strength of responsibilities and consequences.

SAMPLE CASE: JULIANNA

A sample case is provided here and throughout Chapters 8 and 9 to further illustrate treatment procedures. Julianna was a 13-year-old multiracial (Hispanic and Caucasian) female referred to a university-based clinic for youths with general behavior problems. Her parents and school counselor had referred her based on recent problems at school. Specifically, Julianna had a two-year history of sporadic school absences as well as recently declining grades. In fact, Julianna was in danger of not passing eighth grade.

A therapist met individually with Julianna and her parents. Julianna reportedly felt unwell at her middle school and constantly pressured by all of the demands there. In particular, she was overwhelmed by the presence of new peers and diverse academic assignments. Julianna skipped school and classes on days when she had to participate in large group settings such as basketball games in physical education class, assemblies, and oral presentations during English class. In addition, she dreaded tests, eating in the cafeteria, walking down a hallway and into class, and riding the school bus. Her anxiety in these situations was so intense that she rarely enjoyed herself at school and was considering dropping out altogether. She also felt sad and tearful, had no friends, and wanted to stay home with her parents and younger siblings.

Julianna's parents largely echoed their daughter's report but also provided a more historical view of her problems. Julianna was described as a shy child who often wanted to stay close to home. She did have some friends in elementary school but did not initiate extensive contact with them. Instead, she usually waited for others to invite her to parties or to other social gatherings. Her parents also reported that Julianna was traditionally a good student at school and generally preferred solitary activities such as playing the piano or family activities such as trips.

Unfortunately, many of Julianna's earlier friends moved to other schools, leaving her quite isolated in middle school. Over the course of seventh grade and much of the current academic year, Julianna became more agitated, withdrawn, and depressed. In fact, Julianna's recent mood had worsened in recent weeks to the point where she was crying often and had even talked about hurting herself so she would not have to attend school. Julianna's school counselor confirmed these reports and said that Julianna would often try to stay in the counselor's office during key times such as lunch.

In addition to these general interviews, assessment consisted of (1) child self-report questionnaires surrounding depression, general and social anxiety, school refusal behavior, and self-esteem, (2) parent- and teacher-based measures of general internalizing and externalizing

behavior problems, and (3) ADIS-IV: C/P sections regarding social phobia and depression. School counselor observations and self-monitoring of mood were utilized as well. The therapist, after reviewing all relevant information, concluded that Julianna primarily met criteria for social phobia and had subclinical depression. Both problems were closely related to her school refusal behavior, which was found to be largely maintained by a desire to escape aversive social and/or evaluative situations.

The first formal treatment session included consultation and psychoeducation. Julianna and her parents were given a summary of the assessment findings, and all agreed that the general clinical picture portrayed by the therapist was accurate. The therapist then discussed the nature of social anxiety and the impairments that Julianna experienced as a result (e.g., declining grades, poor mood, social isolation). In addition, the therapist noted that Julianna's social skills were good but not excellent, as she bowed her head when speaking to others and often could not be heard audibly.

The psychoeducation process also focused on Julianna's sequences of symptoms in anxiety-provoking situations. Julianna's most anxiety-provoking situations were entering school and class, eating at lunchtime, performing on tests and other academic assignments before others, and playing sports during physical education class. Although the sequence of anxiety symptoms sometimes changed, Julianna said she often experienced nervousness in her stomach, shaking, trembling, and headaches during these times. These physical symptoms usually triggered thoughts about possible consequences, including vomiting and failure and subsequent ridicule and humiliation. Julianna would then engage in *overt* avoidance such as skipping class or *covert* avoidance such as going to her counselor's office, participating on the fringes during physical education and other classes, and bowing her head in the hallway at school to avoid eye contact with others.

The therapist explained how the proposed treatment regimen would target each of these anxiety responses. Julianna and her parents agreed that the treatment regimen seemed reasonable. Julianna was asked to continue to record various aspects of her anxious episodes, including details of physical symptoms, troublesome thoughts, and all types of avoidant behaviors. Julianna's parents were also encouraged to reinforce Julianna for completing her self-monitoring and the upcoming somatic control exercises. During the next session, Julianna engaged in relaxation training and breathing retraining and was instructed to practice these techniques at least twice per day and during anxiety-provoking times at school. Finally, an initial written contract was designed to provide reinforcements for appropriate school attendance with the provision that Julianna could go to the counselor's office when feeling overwhelmed.