Chapter 9

TREATING YOUTHS WITH SOCIAL ANXIETY AND SOCIAL PHOBIA

EXPOSURE-BASED PRACTICES

The previous two chapters covered the primary techniques designed to facilitate the most critical psychological treatment element for youths with social anxiety and social phobia: *exposure-based practices*. By the time a child reaches this point in therapy, he or she should be proficient at monitoring anxiety-based symptoms, managing aversive physical feelings, identifying and modifying irrational thoughts (if applicable), and practicing social and assertiveness skills with ease (at least within a comfortable therapeutic environment). In addition, parents should be proficient in contingency management procedures, and all relevant family members should clearly understand the rationale and nature of treatment. Proficiency at other skills, such as communication or contract development, may also be necessary by this point. Insufficient development of any of these key skills may seriously impair the effectiveness of exposure-based practices. Therefore, an in-depth evaluation of treatment progress, necessary refinement of skills, and careful minimization of treatment obstacles are recommended at this time.

The purpose of this chapter is to describe the primary aspects of exposure-based practices for youths with social anxiety and social phobia. Exposure in this context essentially refers to confronting social and/or evaluative stimuli that a child fears, or is otherwise distressed by, and that

a child avoids or escapes. In doing so, the child is expected to practice the skills described previously to manage anxiety. In this chapter, the potential mechanisms of action, forms, and steps regarding exposure-based practices are described. Individual and group exposure therapy is also discussed, and obstacles to exposure treatment are covered throughout. An extension of the sample case from Chapter 7 (Julianna) is provided as well.

MECHANISMS OF ACTION OF EXPOSURE

The mechanisms of action traditionally thought to underlie exposure primarily include habituation, extinction, and reciprocal inhibition. In the context of phobia treatment, *habituation* refers to a weakened fear/anxiety response to a stimulus when that stimulus is presented repeatedly (Mackintosh, 1987). For example, a person's physiological arousal around dogs may decrease as he or she frequently comes into contact with dogs. In related fashion, *extinction* in this context refers to a weakened fear/anxiety response to a stimulus when that stimulus is linked to a lack of aversive consequences (Mowrer, 1960). For example, a person's fear of dogs may decrease when his or her fear is no longer associated with negative outcomes when around dogs for an extended period of time. *Reciprocal inhibition* refers to a weakened fear/anxiety response to a stimulus when some antagonistic response is learned and practiced during the response (Wolpe, 1990). For example, a person's fear of dogs may decrease as he or she practices relaxation training in the presence of dogs.

These and other explanations for exposure mechanisms of action remain popular, but have been criticized on several grounds, including the prominent fact that many people experience fear even with repeated exposures to a stimulus (Craske, 1999). Newer mechanism of action theories surround a person's *beliefs* that a certain stimulus is dangerous, that anxious responses to the stimulus will persist and increase indefinitely, and that horrible outcomes will occur when faced with the stimulus (see also Chapter 3). Successful exposure thus provides *new* information that is incompatible with these perceptions and expectancies: the stimulus is not dangerous, anxiety reactions are time-limited and manageable, and horrible outcomes will not occur.

Exposure may provide some short-term anxiety reduction via habituation. In the long run, however, successful exposure treatment may require the development of more *realistic* perceptions or expectancies and beneficial emotional processing that facilitates a return to normal functioning (Bouchard, Mendlowitz, Coles, & Franklin, 2004; Foa & Kozak, 1986; Rachman, 1980). *Perceived self-efficacy*, or a confident understanding

that one can successfully cope with a feared stimulus, is likely crucial for successful exposure treatment as well (Bandura, 1977). Exposure for treating social phobia, therefore, may concentrate on habituation, development of new associations between social/evaluative stimuli and positive or realistic expectancies/outcomes, constructive emotional processing, and a heightened sense of self-efficacy in social/evaluative situations.

FORMS OF EXPOSURE

Mechanisms of action of exposure are quite varied, and so are its forms. These forms primarily include spaced versus massed, assisted versus independent, and imaginal versus in vivo exposure. *Spaced exposure* refers to periodically confronting a feared stimulus along a graded hierarchy, whereas *massed exposure* or flooding refers to confronting a feared stimulus at a high intensity level for one extended period of time (e.g., Marshall, 1985). Massed exposure is less time-consuming, of course, but not always the best choice for young children, those with extreme anxiety, those with chronic anxiety problems, or those with anxieties about social/evaluative situations (Kearney & Albano, 2000). Therefore, spaced exposure is emphasized in this chapter.

Assisted or *modeled exposure* refers to having a child confront a stimulus with someone else. Typically, the other person is a therapist, parent, older relative, or friend. Assisted exposure allows children to receive support and feedback from someone they trust and to observe an effective model who manages a difficult situation with calm and aplomb (Ritter, 1968). Assisted exposures are generally recommended in the early sessions of exposure-based treatment for children. Assisted *interoceptive* exposure, where one confronts anxiety-provoking *internal* stimuli, may be helpful for some youths as well.

Effective treatment in the long run, however, will likely require more *independent exposures*, or having children practice exposures by themselves. This method accelerates the child's edification that various social/evaluative stimuli are not dangerous, that anxiety reactions can be controlled, that aversive outcomes are not always present, and that avoidance is unnecessary for fear reduction. In addition, this method requires children to practice behaviors that facilitate a return to normal functioning, such as going to school or speaking with peers. In addition, perceived self-efficacy is likely enhanced most during successful independent exposures.

Finally, *imaginal exposure* refers to confronting a stimulus through visual imagery, perhaps as a child discusses his or her fear/anxiety or as a

therapist reads an anxiety-provoking story or hypothetical scenario (e.g., Bornstein & Knapp, 1981). Imaginal exposure is typically conducted in-session, directed closely by a therapist, and designed as a prelude to in vivo exposure. *In vivo exposure* refers to confronting an actual stimulus either in-session or in external settings (e.g., Stableford, 1979). Successful exposure treatment, particularly for youths with social phobia, will almost necessarily have to include some degree of in vivo exposure (Garcia-Lopez, Olivares, Turner, et al., 2002).

STEPS OF EXPOSURE

When conducting exposure-based treatment for youths with social anxiety and social phobia, several general steps are typically employed, with some variation. Major steps include psychoeducation about exposure, development of an anxiety/avoidance hierarchy and rating scale, imaginal exposure, assisted or modeled in vivo exposure, and independent in vivo exposure. These steps are described in turn.

Psychoeducation About Exposure

Although a general treatment description and rationale was likely presented early in therapy, providing a new and more detailed summary regarding exposure-based practices is highly recommended at this point. This is because the "heavy lifting" part of therapy is about to begin and will require considerable effort from the child and his or her parents. A complete understanding of why a child must now enter and stay in difficult situations to confront feared/anxious stimuli will facilitate motivation and compliance to do so.

The technical mechanisms of action regarding exposure can be eschewed in favor of an approach that draws an analogy to skills that the child has already developed. Most children, by the time they enter therapy, have developed basic skills such as riding a bicycle, swimming in a pool, playing a simple song on a musical instrument, or even skiing down a small hill. A discussion with the child about these skills can begin with a description of how he or she performed during the initial stages of learning. Most children report that they fell down frequently, made constant mistakes, and experienced a sense of frustration. Follow-up questioning by the therapist, however, can lead a child to describe the process by which he or she eventually became proficient at the skill. Most of the time, of course, this involved extensive practice, support and feedback from others, and modeling of others prior to independent functioning.

As the child discusses several of these examples, an analogy can be drawn to exposure-based practices. The therapist may convey that managing one's anxiety in different situations is a skill not unlike others mentioned by the child. In fact, the therapist can remind the child that he or she has already learned different skills (e.g., somatic control, cognitive, social) to manage such anxiety, but must now put these skills to use in the "real world." However, just like riding a bicycle, the child will necessarily feel awkward and frustrated in the beginning. Therefore, the therapist and the child's parents will provide substantial support and feedback during early exposure sessions. However, just as the child eventually tried to ride a bicycle independently of others, so too will he or she have to practice managing anxiety alone in key social and evaluative situations.

Questions can be addressed at this point, and the child should understand that exposure will be a gradual process that will proceed at a regular but not overwhelming pace. However, the therapist should also convey that the child will be nudged forward on occasion and will be expected to eventually manage even difficult situations more independently over time. In addition, the therapist can remind the child and parents of the final goals of therapy and indicate that the final steps are now approaching. Expected improvements in the child's/family's quality of life (e.g., more friends, less fear and conflict, full-time school attendance) should be emphasized as well. Extensive rapport, encouragement, and contact with the child at this time are strongly recommended.

Develop an Anxiety/Avoidance Hierarchy and Rating Scale

Following this psychoeducation process, the therapist and child can work together to develop an anxiety/avoidance hierarchy and accompanying rating scale. An *anxiety/avoidance hierarchy* is a list of key social and evaluative situations that range from least to most anxiety-provoking in nature. Items for the hierarchy, which will serve as *targets for the exposures*, can be derived from the child's formal assessment material, daily logbooks, recent verbal statements and areas of avoidance, or a child's endorsement of a list of many hypothetical social and evaluative situations (see Chapter 2 for examples). The hierarchy, the form of which may change several times during therapy, may initially consist of about 5–20 items with a preferred number of about 10.

The child must understand that each item is one that he or she will eventually confront in various forms, including independently. However, many children often need reassurance that their most feared items will not be encountered immediately. Although such reassurance can be given, the

child should be reminded that all situations will be confronted in time. Questions about the hierarchy may then be addressed, and any necessary modifications can be made.

To help organize these items, children can employ a rating scale that is developmentally appropriate for them. A common rating scale is 0–10 where 0 = none, 2 = mild, 4 = moderate, 6 = intense, 8 = severe, and 10 = extreme anxiety or avoidance. A thermometer-type scale for younger children may also be helpful. Condensed scales (e.g., 1–3 or 1–5) may also be used but tend to restrict the number of clearly defined hierarchy items. Extended scales (e.g., 0–100) are likely better for adolescents than children. The rating scale used for the hierarchy is often similar to that used for the child's daily logbooks.

Youths are then asked to rate their anxiety level for each item on the hierarchy as well as their level of avoidance, or how often they avoid or wish to avoid a given situation. The therapist then draws the hierarchy along various columns and presents the final version to the youth and his or her parents for review and confirmation of accuracy. An example of an anxiety/avoidance hierarchy for Julianna, the case discussed in previous chapters and later in this chapter, is presented in Table 9.1.

The anxiety/avoidance hierarchy may need extensive modification throughout treatment. Many children, for example, progress well along a hierarchy until one particular item leads to strong resistance. For example, a child may successfully engage in many exposures outside of session and school, but balk when school attendance is required. In these cases, items can be subdivided into smaller steps. For example, some children respond better to a part-time school attendance schedule before proceeding to hierarchy items that require formal performance before others in school. In still other cases, children have multiple facets of social phobia that demand more than one hierarchy. Some, for example, have great difficulties interacting with others *and* performing before others. In this situation, dual hierarchies may be developed to address each element.

Imaginal Exposures

Once the hierarchy or hierarchies have been developed, the formal exposure process may begin. As mentioned earlier, *imaginal exposure* is often a prelude to later in vivo exercises. Imaginal exposure is largely a therapist-child interaction, though others can be present as appropriate. To conduct imaginal exposures, the therapist prepares various scenarios that are closely linked to the hierarchy items. The process begins by having the child listen to a scenario closely linked to a low-level hierarchy item. Imaginal exposure is not generally recommended for youths under

age 10 years, although imagery training procedures may be helpful for some of these children (Beidel & Turner, 1998).

The scenario chosen by the therapist should be brief but also graphic, detailed, and comprehensive. Worst-case scenarios regarding a particular hierarchy item are emphasized as well so a child fully processes all possible sources and consequences of anxiety. If necessary, however, the therapist may also include statements of the child's ability to effectively cope and manage anxiety and remain in the situation. The goal of imaginal exposure is to have a child listen to an entire anxiety scene and fully process the scene without stopping. An example of an imaginal scene from Julianna's hierarchy follows:

> You are sitting in the school cafeteria for lunch, and the room is crowded with noisy, talkative, and even disruptive students. You were not able to get a seat close to the exit, so you have to sit about three rows away from the exit. You wanted to be alone but instead had to squeeze between two other people. As you try to eat your lunch and read your book, you start to feel nervous about what others are doing and how they might disrupt your lunch. For example, your stomach begins to tighten, you feel a bit sweaty and dizzy, and your heart is beating faster. You start to think about all the bad things that could happen in this situation, including other people watching you and making comments, laughing at the way you are sitting and bowing your head, preventing you from reading your book, and making you feel humiliated, nauseous, and tempted to throw up in the cafeteria. You just want the whole period to end, so you start to eat a little too quickly. As you do, a couple of kids bump into you as they are getting to their seat and the people next to you give you dirty looks. You are feeling really nervous now, and the cafeteria food is greasy and makes your stomach churn. The people around you snicker and you suddenly feel very queasy and sick. You get up quickly to leave but trip over the seat and fall down. By now, everyone is laughing loudly and you become so dizzy that you have trouble standing up. Instead, your stomach heaves and you begin to vomit all over the floor and on people's backpacks. Now, everyone is screaming and yelling at you to leave, which only makes you more nauseous. You feel like you just can't get away from the situation, and start to feel sick again.

Imaginal exposure may begin with somatic control exercises to relax the child and to set the stage for practicing these exercises prior to real-life anxiety-provoking situations. Audiotaping the process is a good idea so the child can practice the imaginal exposures at home. The therapist also explains that the child may raise a hand if his or her anxiety level rises above a certain point on the rating scale previously developed. If the child raises a hand during the exposure, then the therapist temporary halts the description and helps the child lower arousal via somatic control exercises, other relevant therapy skills, and/or thoughts about more pleasant scenes.

Therapists must use good clinical judgment when deciding what anxiety level would halt an exposure, but a rating of 3+ on a 1–5 scale or 6+ on a 0–10 scale may be useful. Once a child's anxiety abates, the therapist can resume describing the imaginal scene. Throughout the scene, the therapist may periodically (e.g., every 30 seconds) ask for anxiety ratings from the youth. This helps the therapist and child later process the exposure, and hopefully provides the youth with evidence that longer endurance in an anxiety-provoking scenario results in greater anxiety reduction. If this is not the case, then easier scenarios may be necessary. If the child does endure the entire scenario, then somatic control exercises may be used to end the session on a relaxing note. Of course, extensive encouragement and praise should be employed throughout this process.

As therapy progresses, the child confronts more difficult, complicated, or anxiety-provoking scenarios that are linked to higher-ranking hierarchy items. In addition, the child can be asked to tolerate increasingly higher levels of anxiety before raising a hand and stopping the procedure. Homework assignments to practice these exposures at home must also be emphasized. Many children progress through imaginal exposures with only occasional difficulty, but others require more time. At least one scenario per session should be completed, but more may be done as feasible and appropriate.

Assisted/Modeled In Vivo Exposures

Once a child has mastered imaginal exposures, then controlled in-session in vivo exposures may be done with the help of a therapist and relevant others such as parents. For younger children, "relevant others" may also include their favorite superheroes who team with them to "attack" anxiety (i.e., *emotive imagery*) (Lazarus & Abramovitz, 1962). As with imaginal exposure, assisted or modeled exposures are initially conducted for easier hierarchy items and later more difficult ones. In my experience, such in-session exposures are often closely linked as well with social skills training goals (see Chapter 8).

Assisted or modeled in vivo exposures may be conducted in stages. Initially, a child may be asked to simply observe a therapist or relevant others perform a task and successfully practice skills to manage anxiety. The next stage requires the child and relevant others to practice the task *together*. Common tasks include introducing oneself, initiating and maintaining a conversation, being assertive, joining a group, entering a room full of people, speaking on the telephone, listening to others, and performing in some way before others (e.g., making an oral presentation, eating, playing a musical instrument). As a child progresses through these team-oriented exposures, he or she may be asked to do so more independently, but with

considerable support, feedback, and praise from trusted others. The child is also reminded to use appropriate social and anxiety management skills during these tasks as necessary and appropriate.

Out-of-office assisted/modeled exposures may also be conducted, and often include the therapist and the child attending different places and practicing together various tasks and social and anxiety management skills. Task examples include asking others for directions, handling mistakes when purchasing something, and striking up conversations with strangers. In these early exposures, the child often relies heavily on the therapist or others for support, guidance, and feedback. The child may stop the exposure if anxiety is excessive, but therapists should encourage a child to remain in the situation and practice appropriate skills for as long as possible. Finally, including same-age peers may also be helpful during this process, which makes group therapy often advantageous in this regard. Whatever the format, however, assisted/modeled exposures are usually closely supervised and controlled so that the child likely experiences success.

Homework assignments in this regard are also assigned. Typically, parents are asked to engage in exposures with their child that mimic those conducted in-session. Critical to this process, however, is the parents' understanding that the child should not be rescued from the exposure prematurely. Instead, parents should demonstrate to the child (as the therapist did) how to handle the anxiety-provoking situation *without* protecting the child from anxiety. In fact, parents may need to be reminded that the child's experience of anxiety is necessary for exposure to work. If helpful, parents can be reminded as well of the original rationale and mechanism of action for exposure.

Interoceptive exposure may also be integrated with assisted/modeled exposures. Interoceptive exposure refers to confronting fearful *internal* stimuli such as heart palpitations, dizziness, and shortness of breath (Craske et al., 2000). In this procedure, a person is exposed to internal stimuli in-session and then asked to lower arousal via somatic control exercises. Exposure examples include running up a flight of stairs to increase heart rate, spinning in a swivel chair to induce dizziness, and breathing through a coffee straw to produce shortness of breath. In each case, the person learns that the symptoms are not dangerous and that they can be controlled. While not used extensively for anxious children, interoceptive conditioning may be particularly useful for adolescents with clearly defined panic attacks in social and/or evaluative situations.

In general, assisted or modeled exposures are especially useful for children who are younger, cannot tolerate a faster therapy pace, and/or have extreme levels of anxiety. In addition, assisted/modeled exposures are

usually a good prelude to independent in vivo exposures or as a "bridge" between imaginal and independent in vivo exposures. The exposures are also useful for very difficult hierarchy items that a child strongly resists confronting. As with imaginal exposure, however, assisted/modeled exposures may need to be subdivided as necessary for a child to proceed systematically.

Independent In Vivo Exposures

Once a child has successfully navigated through various assisted or modeled exposures, more *independent in vivo exposures* are conducted. This step involves having the child independently confront various anxiety-provoking social and evaluative tasks from his or her hierarchy. In many cases, independent in vivo exposures are first aligned with assisted or modeled exposures. For example, a child may ask a stranger for directions without help from the therapist, who is still several steps away. However, *later* independent in vivo exposures will necessarily involve *contrived* tasks that cannot or should not include a therapist's presence (e.g., oral presentation in a school classroom; eating in the cafeteria) and *non-contrived* tasks that develop without warning (e.g., accidentally bumping into someone in a hallway; spontaneous conversations with peers).

As with previous exposures, independent in vivo exposures must involve active practice of social and anxiety management skills. Because a child must practice these skills *and* confront a situation independently, initial exposures should involve ones that have a very high probability of success (i.e., little desire for escape). In this way, the child's motivation and perceived self-efficacy are enhanced. Movement up different treatment hierarchies can then proceed. In addition, all appropriate efforts during exposures should be amply rewarded by others, although the child should be encouraged to engage in substantial *self-reinforcement* as well upon a successful exposure. Children should also be encouraged to linger in an exposure even several minutes *after* anxiety has completely abated to ensure its effectiveness and to build self-efficacy. Extensive practice and repetition of exposures is also recommended for complete emotional processing.

As a child engages in independent exposures, he or she should supply ratings of anxiety and desired avoidance every 30–60 seconds. This information is then shared with the therapist to process whether anxiety is truly declining during the exposure. If so, the child is praised and shown again that remaining in a difficult situation and handling it appropriately will lower anxiety and is a better approach than avoidance or escape. However, problems may occur. Some children, for example, report declining anxiety levels to simply escape a given situation. Conversely, some children

report *increasing* levels of anxiety or *spikes* of anxiety at intermittent times of the exposure. Here, the child either is not ready for exposure treatment, in which case previous techniques should be reemphasized, or the child is not ready for that particular hierarchy item. If the latter is so, then designing a slightly less challenging exposure may be in order. Once a child masters this less challenging exposure, however, he or she is expected to proceed as before.

Between-session homework assignments are obviously crucial for independent in vivo exposures, and should involve as many situations as possible to ensure generalization of treatment effects. As treatment progresses, increasingly difficult and complicated tasks are assigned. In general, at least one exposure task per session can be completed, although more can be addressed as appropriate. In addition, near the end of therapy, a child may be asked to respond to hypothetical anxiety-provoking scenarios to evaluate his or her anxiety management skills and to anticipate any future problems.

For all exposure-based practices, but especially independent in vivo exposures, *safety signals and subtle avoidance behaviors must be eliminated*. Some youths, for example, will attend school as long as their best friend is with them. Tasks to eliminate this safety signal might thus involve attending classes without that friend and developing new friendships. Recall from Julianna's case that one of her subtle avoidance behaviors was sitting near an exit in case she felt nauseous. A good exposure here might thus include sitting in the middle of the cafeteria surrounded by others. All *distractions* that a child uses for subtle avoidance must be identified and eliminated during exposure treatment as well to enhance full emotional processing. Distraction examples include switching scenes during imaginal exposure or repeating irrelevant words silently to oneself during in vivo exposure.

INDIVIDUAL VERSUS GROUP EXPOSURE

Exposure-based practices may be conducted in individual or group format. A clear advantage of group therapy, of course, is that similar-aged peers are readily available for formal and informal (e.g., break time) exposures. As mentioned in Chapter 6, the process of *double exposures*, whereby youths with social phobia participate in exposures designed for other youths with social phobia (Albano & Barlow, 1996), is a key group treatment ingredient for this population. A potential risk of group-based exposure therapy, however, is that some members will not progress at the same rate as their groupmates and will feel even more isolated as a result.

In addition, for some children, particularly those with more severe or comorbid symptomatology such as depression/suicidality or school refusal behavior, individual exposure therapy may be more appropriate. However, successful therapy in this regard will still require comprehensive exposures that involve many social interactions and performances before others.

SAMPLE CASE: JULIANNA

Julianna had progressed well during her early stages of therapy, but was clearly very nervous about the upcoming exposure-based practices. As a result, her therapist devoted one entire session to psychoeducation and addressing Julianna's concerns. Her main concern was having to progress quickly, which she felt would happen given that her parents were pressuring her daily to resume full-time school attendance. The therapist secured an agreement from Julianna's parents and school guidance counselor, however, that a measured exposure regimen would be satisfactory. Still, Julianna was reminded that she was expected to fully complete the exposures at a systematic and adequate pace.

Julianna and her therapist then designed *two* anxiety/avoidance hierarchies. The first (see Table 9.1) involved the primary social/evaluative activities that made Julianna most anxious, and these were arranged from least to most anxiety- and avoidance-provoking in nature. Interestingly, Julianna's ratings did not completely match with what she had said during

TABLE 9.1. Julianna's Initial Anxiety and Avoidance Hierarchy

Situations or places that scare me	Anxiety rating	Avoidance rating
Eating lunch in the school cafeteria	9	9
Playing sports in physical education class	9	8
Starting conversations with others	9	8
Calling someone unknown on the telephone	8	8
Oral presentations before others in class	8	7
Taking tests in class	8	7
Walking along a crowded hallway at school	7	6
Walking into class	7	5
Walking into the school building	7	5
Maintaining conversations with others	5	5
Going to assemblies at school	4	4
Riding the school bus to and from school	3	3
Calling someone known on the telephone	2	2
Answering the door at home	2	1
Speaking to extended relatives at home	1	1

the earlier assessment, which often happens among youths. For example, eating in the cafeteria was now rated worse than playing sports in physical education class. In addition, Julianna added some items such as starting conversations with others and calling someone unknown on the telephone. Also interesting was the fact that *maintaining* conversations with others was rated as less anxiety- and avoidance-provoking than *starting* conversations with others. As the therapist later discovered, however, this was primarily due to a subtle avoidance behavior on Julianna's part.

Exposure treatment began imaginally, but Julianna handled various scenarios with ease. Treatment then shifted quickly to assisted/modeled exposures that initially intersected with her social skills training. For example, Julianna was asked to repeat in-session what she had learned earlier, especially with respect to using good eye contact and voice volume when speaking with or to others. Once this mini-review was complete, the therapist enlisted a few clinic staff members to listen to Julianna's oral presentations. With practice, she was gradually able to handle more people in the room as well as people who were instructed to behave somewhat rudely during her presentation.

Julianna was also expected to have conversations with same-age peers who were presented by the therapist to speak with her. The therapist noted two interesting facts. First, Julianna had enormous difficulty making small talk to initiate a conversation, so considerable practice was placed on this skill as well as proper introductions, smiling, and anxiety control when doing so. Second, the therapist saw that Julianna maintained her conversations with others by simply asking questions about the other person and deflecting attention away from herself. This subtle avoidance behavior was identified for Julianna, who did not realize what she was doing, and she was instructed to engage in more conversation about herself or a neutral topic.

In-session assisted/modeled exposures also required Julianna to walk into the clinic alone, walk in clinic hallways when other people were present, and walk into a room full of people who then looked at her. Julianna was also asked to call clinic staff members on the telephone. Throughout these exposures, the therapist gently guided Julianna to practice whatever skill was most appropriate for that situation. Often this involved subtle control of physical anxiety symptoms and extensive cognitive restructuring to stay in a certain situation. Outside the office, Julianna and her therapist also engaged in exposures that involved riding a bus, playing a pick-up basketball game at a local playground, and sitting in a large crowd (to simulate assemblies).

Julianna's second anxiety/avoidance hierarchy involved number of classes attended at school, and this overlapped with the beginning of

independent in vivo exposures. Julianna was asked to pick three school classes that were easiest for her to attend. She did so and successfully attended those classes. In doing so, Julianna practiced many of the tasks on her hierarchy, such as walking into school and class. Each subsequent week, Julianna was told to add one class to her schedule. Not surprisingly, she chose those classes that involved little chance of having to perform before others. Physical education and English classes and lunchtime were the last to be added.

Working closely with the teachers, the therapist established methods for gradually reintroducing Julianna to these latter classes. During physical education class, for example, Julianna initially observed games that were being played, then participated in one-on-one games, and later participated in larger groups. During English class, Julianna was permitted to conduct makeup oral presentations before the teacher only, but was later expected to present orally before her peers. During lunchtime, Julianna was asked to sit one row closer to the middle of the cafeteria per week until she could sit without anxiety in the center of the room. During each exposure, Julianna practiced her anxiety management and social skills and provided anxiety ratings for the therapist. Although several exposures were less than successful, Julianna eventually experienced a general decline in her anxiety in these situations. Her sense of self-efficacy and mood improved greatly as well.

When full-time school attendance was achieved, Julianna wanted to end the therapy program. However, the therapist pointed out that long-term treatment effectiveness would depend heavily on Julianna's ability to develop and maintain some close friendships. Therefore, she was given a list of extracurricular activities and asked to choose at least three to join. With some reluctance, Julianna chose a choir group, a swim club, and a tutoring program where she could help peers with homework. Although her swim club attendance was problematic, she did faithfully attend the other groups and develop a few close friends as a result.