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Author Note

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Abstract

Social anxiety disorder (SAD) often develops during teenager years, and it is important to conceptualize developmentally appropriate interventions. Exposure therapy framed from a perspective of acceptance and commitment therapy (ACT) shows promise for decreasing pathology and increasing wellbeing. This case illustrates the process through which exposure therapy was integrated with ACT to elicit meaningful outcomes in a case of SAD with a 16-year-old female. Treatment outcomes assessed included engagement in values-based activities as well as assessments of depression, social anxiety, separation anxiety, generalized anxiety, experiential avoidance, and contextually targeted school-based wellbeing. Intervention centered on learning ACT principles through relatable metaphors and experiential exercises and practicing them with values-guided social exposures. This integration resulted in increased engagement in socially meaningful experiences over time as well as associated changes in treatment outcomes. Treatment implications, guidelines, and recommendations are presented, including the need for skill-focused treatments, identifying deficits in psychological flexibility, and maintaining a compassionate yet growth-oriented course of treatment.

Keywords: acceptance and commitment therapy (ACT), social anxiety/social phobia, exposure therapy, adolescent

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Theoretical and Research Basis for Treatment

Social anxiety disorder (SAD) commonly begins during adolescence and has a 7% lifetime prevalence (Beesdo-Baum et al., 2012). While all anxiety disorders are characterized by anxiety and avoidance causing impairment across contexts, SAD is unique in its focus on embarrassment in front of others (American Psychiatric Association, 2022). SAD is specifically characterized by heightened reactivity that often facilitates problems in connecting with others, which can elicit struggles during adult years (Norton & Paulus, 2017; Tung & Brown, 2020). Treating this disorder during adolescence might increase chances of long-term connectedness and greater wellbeing. While traditional cognitive-behavior therapy (CBT) packages are usually considered the gold-standard treatment for SAD in adolescence (Hofmann & Smits, 2008), these interventions are not always productive, and other efficacious treatments are additionally available (Fang & Ding, 2023).

Research shows that an underlying treatment mechanism of adolescent SAD is increasing social confidence through practicing and engaging in meaningful social interaction, (Norton & Paulus, 2017; Olivares-Olivares et al., 2019). Fear often prevents clients from engaging in such experiences, so exposure therapy, utilized in many CBT packages, strategically exposes clients to feared stimuli until levels of fear dissipates, which then allows clients to freely engage in increased social interaction (Foa & Kozak, 1986). Research shows that treatments utilizing exposure usually outperform any treatments not utilizing exposure (Carpenter et al., 2018).

When examining the mechanism through which exposures work, early research proposed that engaging exposures until dissipation of stress occurred decreased the symptomology of

anxiety- and other fear-related disorders (Asnaani et al., 2016). However, current research argues that fear reduction aspect of exposure sessions does not predict desired clinical outcomes (Sewart & Craske, 2020). Questioning the function of exposures is thus important for delivering effective services. Intervention still necessitates building confidence in social settings, so utilizing exposures with a purpose of behaving more meaningfully in social interaction may be useful. This paper highlights such a focus from the perspective of acceptance and commitment therapy (ACT), an alternative intervention designed for helping clients live a valued, higher quality of life amidst anxiety.

ACT increases an individual's psychological flexibility, which Hayes et al. (2016) defined as "contacting the present moment as a conscious human being, fully and without needless defense—as it is and not what it says it is—and persisting with or changing behavior in the service of chosen values" (pp. 96-97). Psychology flexibility is characterized by six processes of change, which are present-moment awareness, cognitive defusion, acceptance, self-as-context, values, and committed action (Hayes, 2004; Ong & Eustis, 2023). Research shows that individuals reporting greater levels of psychological flexibility also report greater levels of wellbeing, life satisfaction, and treatment outcomes (Kashdan & Rottenberg, 2010). ACT targets behavioral processes that maintain socially anxious behavior through (1) cultivating awareness of experiences that motivate escape behaviors; (2) building increased acceptance, or willingness, to have unpleasant experiences; and (3) clarifying values that reinforce engagement in social experiences amidst fear (Smith et al., 2023).

Multiple meta-analyses have examined the effectiveness of ACT with the upshot demonstrating sufficient evidence that clinical treatments are effective for the treatment of anxiety disorders broadly and in similar comparison to outcomes from traditional CBT

treatments (Bluett et al., 2014; Hacker et al., 2016). Further evidence highlights the effectiveness of ACT self-help interventions on reducing anxiety broadly (e.g., Brown et al., 2016; Thompson et al., 2021). A recent meta-analytic review of 20 meta-analyses further validated the effectiveness of ACT for reducing anxiety symptoms with small to moderate effect sizes in reducing clinical pathology and increasing wellbeing (Gloster et al., 2020). A recent scoping review concluded ACT to demonstrate strong promise in reducing clinical pathology and increasing wellbeing of SAD, specifically, but the authors call for increased research in this area (Caletti et al., 2022).

Use of ACT with adolescent clinical populations, who are experiencing a critical period of development, may be especially effective due to the intervention's nature of building internal awareness and increasing the number of approach-guided, rather than avoidant, behaviors (Petersen et al., 2023). ACT may also teach functional behaviors to teens that might serve to benefit future functioning as an adult (Petersen et al., 2023). Moreover, ACT with adolescents can facilitate identity growth amidst changing contexts through use of minimal language and increased experiential exercises (Petersen et al., 2023). Rostami et al. (2014) showed that ACT facilitated a 60% reduction in social anxiety symptoms after 10 one-hour therapy sessions with students at school. Azadeh et al. (2016)'s randomized control trial further highlighted significant decreases in adolescent female social anxiety after ten 90-minute therapy sessions. A larger randomized control trial by Hancock et al. (2018) compared ACT to traditional CBT and waitlist conditions for treating youth anxiety broadly and showed superior outcomes to the waitlist and no differences between ACT and CBT with medium to large effect sizes across both therapies. Ivanova et al. (2016) also showed an online ACT intervention was effective at reducing SAD symptomatology and increasing wellbeing in adolescents (Ivanova et al., 2016). An ACT

intervention further demonstrated effectiveness in increasing adolescents' interpersonal skills post intervention (Bernal-Manrique et al., 2020).

The data suggests that ACT for treating SAD during adolescents is a worthwhile pursuit, yet critical research is lacking in this area. The lack of research is partly due to unexamined implementations of the intervention in traditional settings. The purpose of the current manuscript is to educate how ACT can be utilized in conjunction with exposures to treat adolescent SAD in relevant settings. We hope that this example can be shared with clinicians and researchers to spark creativity in the nature through which exposures and ACT interventions are implemented as well as provide a template for future research of ACT with youth.

Case Introduction

This is a case of an adolescent diagnosed with SAD who was treated at an outpatient clinic with ACT-based exposure therapy. We found changes in psychological flexibility that occurred in accordance with decreases in clinical symptoms and increases in context-specific, school-based wellbeing. Mary is a cisgender, White, 16-year-old female attending public high school in the western United States and living with her mother, father, and sibling. To prevent disclosure of the participant's identity, her name was changed to a pseudonym, which is in no way representative of her real name. Unnecessary details about her life have been additionally changed, and she and her parents consented to the publication of this case study. Mary attended all sessions and engaged therapy in meaningful, dedicated manner. Evaluation and treatment occurred when Mary was attending high school and presently experiencing related psychosocial and educational stress. Her parents were supportive throughout treatment. Aside from clinical struggles, Mary reported notable academic achievement, active involvement in school activities and having hobbies outside of school. Information for this study was collected from case notes,

clinical records, patient self-report weekly measures, therapist assessment, and therapist-supervisor consultation.

Presenting Complaints

Mary begun a new year of high school just prior to being seen in outpatient psychotherapy. She reported that her life became increasingly difficult following a recent move to a new school. This experience elicited struggles to make new friends and subsequent worry about her self-appearance and inability to make friends. Relatedly, she experienced mild suicide ideation, restlessness, and clinical levels of anxiety symptoms, especially debilitating thoughts of self-judgement, worry about being lonely, and anxiety of her incapability. Mary and her father expressed hope that the present treatment could provide helpful resources to decrease anxiety and make friends.

History

Mary reported experiencing notable anxiety since kindergarten. While medication mostly mitigated her experience, Mary's anxiety heightened to clinical concern after transferring from middle school to a different high school from where her friends would attend. She stated that this transition clearly caused the increase in anxiety. Prior to moving, Mary additionally reported dealing with interpersonal struggles caused by middle-school coaches, which negatively affected her self-image. Mary reported that she spent significant time criticizing her self-image, social abilities, and lack of friendships. Mary reported that these experiences were debilitating because she wished she could be more social, outgoing, and personal, but she refrained due to fear of being judged for her interactions. Mary reported that sometimes she felt so afraid of attending school that she refused to leave the house or get out of bed. Mary's father added that Mary's anxiety often increased to the point of becoming inconsolable. Mary related that she felt sorrow

for her anxiety causing grief to her family, and she sometimes thought it would be better to not be on the earth than to burden her family with worry. Mary affirmed that a healthy life without anxiety would include reaching out to peers and engaging in more social activities.

Assessment

An intake interview was conducted with Mary and her father by the clinician, in which Mary completed various screening forms, Mary and her father were interviewed together for 30 minutes, and Mary was interviewed alone for 30 minutes. On Mary's initial paperwork, she gave reports of anxiety, depression, and problems with school adjustment. Various brief rating forms were the utilized to screen for the presence of anxiety, depression, psychological flexibility, and school-based wellbeing (since most anxiety symptoms occurred within a school context).

Chorpita et al.'s (2000) Revised Children's Anxiety and Depression Scale - 47 – Child Version (RCADS) was administered to screen for various anxiety, OCD, and depressive disorders. The domains "Social Anxiety," "Separation Anxiety," and "Generalized Anxiety" were marked as clinically significant indicators of Mary's anxiety and later administered during weekly sessions to monitor levels of relevant anxiety. Kroenke et al.'s (2001) Patient Health Questionnaire (PHQ-9) was utilized to screen for depression severity. Given Mary's expressions of suicide intention, the PHQ was later administered during weekly sessions to monitor associated depression and suicide distress. Greco et al.'s (2008) Avoidance and Fusion Questionnaire for Youth – 8 (AFQY) was utilized to screen for psychological inflexibility. It was later administered during weekly sessions to monitor inflexibility over time and inform treatment planning. Renshaw et al.'s (2015) Student Subjective Wellbeing Questionnaire (SSWQ) was used to screen for initial levels of wellbeing at school. It was later administered during weekly sessions to monitor changes in wellbeing at school-related settings over time. Initial findings

from the RCADS, PHQ, AFQY, and SSWQ helped to focus the later diagnostic clinical interview, which was guided by the Diagnostic Interview for Anxiety, Mood, and OCD Related Neuropsychiatric Disorders (DIAMOND; Tolin et al., 2018).

Case Conceptualization

Mary reported during the DIAMOND interview that her biggest fear was feeling "dumb," "embarrassed," and "judged" in front of peers. Through discussion, Mary reported fear of feeling vulnerable in front of others and worry that they would perceive her lack of confidence. She also expressed many criticisms of herself including being ugly and awkward in social situations. These internal behaviors existed for over two years during her freshman and sophomore years at high school and withheld her from making friends and sometimes attending school. Given these reports, a DSM-5 diagnosis of social anxiety disorder was utilized to inform case conceptualization and treatment planning. Specifically, Mary reported (1) marked fear and anxiety about social situations in which she might be exposed to scrutiny by peers, (2) worries that her anxiety will show to peers and thus be negatively evaluated; (3) social situations with peers almost always provoke fear, (4) social situations were often avoided, (5) significant anxiety was persistent for more than two years, and (6) anxiety was often out of proportion to the context (American Psychiatric Association, 2022).

Evidence demonstrates a significant relationship between social anxiety and increased experiential avoidance, especially as measured by the AFQY (Shimoda et al., 2018). Kashdan et al. (2014) showed that social anxiety is caused by avoiding social situations that evoke feelings of vulnerability in front of others. These studies recommend that treating social anxiety disorder requires clients to contact and experience vulnerability with an attitude of acceptance and willingness to have vulnerability rather than behaving in ways to avoid feeling vulnerable

(Kashdan et al., 2014; Shimoda et al., 2018). ACT is effective at increasing willingness to experience anxiety-related exposure exercises, which is due to its didactic focus on acceptance, defusion, and values engagement (Levitt et al., 2004). An ACT model was utilized to increase defusion and acceptance of vulnerability while engaging in uncomfortable yet values-guided exposures. Learning acceptance over time could allow Mary to experience positive contingencies from new social behavior at school and gradually grow in confidence. It was predicted that experiential avoidance decreasing over time, per reports on the AFQY, would correlate with Mary developing willingness to experience vulnerability in front of peers. As this occurred, social behaviors and wellbeing at school would increase and relevant anxiety and depression would decrease.

Course of Treatment and Assessment of Progress

Goals

Mary and her father's initial treatment goals were to decrease feelings of depression and social anxiety. ACT recognizes that attempting to control and decrease feelings is less strategic than increasing functional behaviors (Hayes et al., 2016; Twohig et al., 2021), so further prompting allowed Mary to state behavioral goals including having more friends at school and engaging in desired social situations. The clinician, Mary, and Mary's father agreed that Mary would reach goals as she willingly and independently sought increased social experiences, reported values-based engagement at school, and expressed less need for support. While decreased anxiety and depression were not expressed as target goals, measures of such variables were utilized by the clinician to monitor fluctuations in distress and make treatment decisions. Intervention was deemed effective when Mary's functioning increased to levels that were deemed acceptable by her and her family.

Location, Schedule, and Duration of Treatment

Services were provided at the outpatient site in the form of confidential, one-on-one therapy sessions. Each session was held between Mary and the primary clinician for approximately 50 minutes. Mary was punctual and attentive to all sessions. Sessions were held on a weekly schedule for the intake and first 12 sessions, and a every other week schedule was held for the last three. The intake, 12 weekly intervention sessions, and 3 spaced sessions equaled 16 total sessions.

Roles and Responsibilities

Mary was responsible for showing up prepared to work with the clinician. Mary was responsible for showing up with ACT materials and exposure plans, ready to listen, and flexibly capable of adapting to situational contexts. Given that services were provided by an unlicensed graduate student, the graduate student's supervisor was responsible for signing clinical notes and providing necessary supervision. An office secretary was responsible for scheduling appointments, managing legal paperwork, and complying services according to HIPPA regulation. Mary's father was responsible for signing forms, paying for services, and supporting behavioral commitments as needed.

Procedures

ACT sessions were highly structured and didactic yet flexibly adapted to situational needs (Hayes et al., 2016). Mary filled out progress monitoring forms in the clinical waiting room prior to being seen for intervention. Mary then entered the therapy room, rapport was built, and the clinician followed up on past behavioral commitments. Individually tailored skills from Twohig et al. (2021) and Westrup (2014) were taught through use of relatable metaphors and experiential exercises. Targeted exposures and social-based role plays were provided in session

as means of practicing the skills, and client-chosen behavior commitments in accordance with in-session exposures were set for the upcoming week. Using this framework across all sessions, the details enacted as follows:

Session 1

The first meeting was an intake appointment in which Mary and Mary's father filled out forms and shared information with the clinician. Target goals were set and agreed upon by Mary and Mary's father. Due to reports of suicidal thoughts, Mary was briefly assessed for suicide ideation. Standard, legal protocol at the clinical site was used to structure the risk assessment and accordingly asked the level, severity, intent, and plan of her ideation. Mary was also asked about coping strategies, familial supports, and access to lethal objects, and risk assessment deemed her to be of minimal to low risk. This was shared with her father in session, and a brief safety plan was created that included coping mechanisms, supportive relationships, and crisis hotlines.

Sessions 2-5

Sessions focused on teaching acceptance, defusion, and present-moment awareness with intentions of allowing Mary to clarify values and recognize the futility of her avoidance strategies in controlling anxiety. This was first done using creative hopelessness, in which Mary was asked to list all the strategies she used to control or make her anxiety go away. Strategies listed included going home, not talking to people at school, and doing homework instead of hanging out. Like breaking a bone and choosing to take a brief pain medication or get a cast the clinician asked Mary how effective her strategies were at reducing anxiety in the long term. After thinking about it, Mary realized within herself that strategies did not work long term. The purpose of the creative hopelessness exercise was to help Mary recognize the futile nature of

avoiding feared social experiences and argued the necessity of approaching feared social experiences that aligned with values (Twohig et al., 2021).

Metaphors were then taught that helped Mary become aware of and open for anxiety and to especially turn toward social values during exposures. These metaphors including the beachball, mountain in the clouds, and funeral elegy exercises. The beachball metaphor, intended to teach principles of acceptance, allows clients to imagine they have an unwanted beachball that they attempt to hide under the water of a swimming pool. Spending effort in hiding the beachball refrains the individual from enjoying time in the pool with others. Clients are asked if they might let the beachball float openly for a moment while they play with their friends in the pool (Stoddard & Afari, 2014). Mountain in the clouds is an experiential exercise intended to teach awareness in which a client is likened unto a mountain that is unchanging and watching "clouds" of emotion and thoughts that pass by. These clouds are sometimes small and fluffy, and sometimes they are dark, ominous, and heavy. Whatever the clouds are that pass by, the client stands behind them as a steadfast, unchanging, and observant mountain (Stoddard & Afari, 2014). The funeral elegy is used to clarify values that the client wants to embody in their life through reciting desired qualities, such as courageous, fun, or compassionate, that they hope others would describe of them at the end of their life (Stoddard & Afari, 2014). Mary especially stated that participation in learning at school, connection with others one-on-one, and helping others feel seen and listened to were important values she wished to embody more extensively.

Passengers on the bus was also used to describe all processes of psychological flexibility together, in which Mary was likened unto a bus driver that chose where she wanted to drive her bus in life. As she drove, unwanted passengers such as fear, embarrassment, shame, and other negative internal experiences got on her bus and started yelling where she should turn. Although

the directions did not align with connecting to others, she chose to follow the directions none-the-less. Nevertheless, Mary is the bus driver who choose where she wants to drive, regardless of what the passengers say (Stoddard & Afari, 2014).

These metaphors were reinforced with experiential exercises such as mindful breathing, in which Mary closed her eyes, focused on her breathing, and labeled feelings as "sadness," "fear," and "excitement" as they emerged in her body (Twohig et al., 2021). She also practiced giving her anxiety a name, color, shape, texture, and location when bigger feelings of fear during exposures occurred. In this exercise, Mary described in her body where she felt her fear, what color the fear was, what shape the fear was, and what texture the fear was. Mary also gave her fear a name, such as "Dave" or "Gertrude the Fear." Merging practices together, Mary clarified that Dave mostly resided in her chest and stomach and without fail always emerged before facing an undesired social situation.

After these first few sessions, which were mostly didactic in nature, Mary was invited to practice principles between sessions through trying brief behavioral commitments of her own choosing that were manageable, values-based, and designed to foster small amounts of anxiety. Commitments included raising her hand in class and saying hi to students in the hallway. It is important to clarify that commitments were discussed and enacted to practice ACT skills at home and not just to face fears. (i.e., Mary was invited to raise her hand in class, which aligned with her value of classroom engagement, and likewise say hi to Gertrude the fear, emerging like a dark cloud around her mountain peak.) After a few sessions of initial practice, Mary and the clinician agreed after session 5 it was time to practice ACT skills with social exposures of greater difficulty during sessions.

Sessions 6-13

These sessions were the most important part of treatment given that they focused on practicing ACT processes with a variety of fear-evoking situations in-session that were designed to simulate feelings of embarrassment, vulnerability, and perceived judgment from strangers, which were the feelings that Mary avoided most often.

The process was first facilitated through listing a hierarchy of least- to most-feared social situations that Mary to practice values-guided interaction amidst increasing amounts of anxiety. Before engaging in exposure exercises, ACT metaphors and experiential exercises that had been practiced during Weeks 2-5 were reviewed, and Mary and the clinician planned for how they would navigate the exposure from a perspective of openness and in contact with one-on-one connection. Legal conversations surrounding confidentiality outside the therapy room were also held before engaging in exposures.

Mary listed that least difficult was asking strangers quick and routine questions such as asking for directions. Thus, practices began by inviting Mary to leave the therapy room and approach various receptionists across the clinical building to ask (first) important questions (such as when her next session was or how their day was going) and (second) silly/embarrassing questions (such as asking why they were making her pay for her therapy sessions). As she enacted these practices, Mary was consistently reminded and asked of the clinician how she was approaching her feelings, and the clinician consistently reminded her of metaphors and experiential exercises they had practiced earlier. Mary then listed more feared experiences such as approaching random strangers on the street. As such, Mary and the clinician spent time walking outside to interrupt strangers and ask them to remove headphones. Tapping into one-on-one connection, Mary would ask (first) important questions (such as wondering where a certain

building was) and (second) silly and embarrassing questions (such as asking if they thought she was attractive).

After building fluency in mid-tier fears such as those, Mary then proposed that her highest fears were leading and engaging in long conversations with strangers. Thus, after reviewing ACT concepts of awareness and openness to fear and letting values of connection drive the bus, Mary practiced (first) long conversations with the clinician in the therapy room (timed at five minutes or more), (second) long, meaningful conversations with secretaries across the clinical building (timed at five minutes or more) and then long, meaningful conversations with strangers outside around the building (timed at five minutes or more). Mary often wanted to shift her a nature into one of endurance through distress rather than acceptance of distress, so it was important that the clinician notice when these changes occurred and invite Mary to re-align with values of connection and listening to others through exercises such as reviewing mountain meditation or funeral elegy.

Mary mirrored this practice at home by practicing acceptance of anxiety while engaging in values-centered, feared experiences with peers at school. Commitments included one-on-one conversations with other students, answering questions in class, hanging out with new friends, inserting herself in groups of unfamiliar people, and trying new, difficult athletic strategies in front of her athletic team. Mary was invited to engage in these at-home exposures for the purpose of practicing ACT skills. (e.g., "Engage in a conversation with a stranger at school, and notice your desire to run away, hide, and push anxiety away while you talk, similar to how you might shove and hide an embarrassing beachball under the water while in a pool with your friends. What if, while you connect, you let the beachball float for a moment while you talk to the stranger?")

Sessions 14-16

After making progress with these ACT-guided exposures, sessions were moved to every other week, and ACT skills were generalized across new contexts. Briefer exposures were practiced in session, including practicing a lengthy speech while standing on a chair in front of the clinician and debating political topics with the clinician. The sessions were focused on allowing Mary to recognize new ways she could behave in accordance with values, accept internal experiences, and take initiative to achieve her goals. At-home commitments mirrored exposures in session, including giving a speech to her class and engaging during debate club (which she had signed up for amidst therapy sessions.) Session 16 included a summary of intervention skills, and the clinician allowed Mary to express ways she might integrate acceptance while engaging in further values-guided social situations.

Plan Evaluation

Mary was given the AFQY, RCADS, PHQ, and SSWQ via paper and pencil by a clinical office secretary in a waiting room before each session. After entering the therapy room, Mary reported if she enacted her behavioral commitment, how the experience went, and other social-related activities she willingly chose to do. These two forms of assessment (battery of rating forms and qualitative reports) matched treatment goals established during intake; specifically, levels of experiential avoidance decreased as ACT skills were learned (via the AFQY), levels of anxiety and depression further decreased (via the RCADS and PHQ), and levels of wellbeing at school increased as Mary fulfilled commitments. Most importantly, qualitative explanations allowed the clinician to understand the nature of Mary's experience each week and adapt interventions to facilitate the greatest amounts of behavior change at home.

The intervention was deemed effective when, over time, Mary qualitatively reported increased independence and initiative in social situations, engagement in values-based social experiences, increased connection at school, increased desire to attend school, decreased anxiety about judgment from others, decreased feelings of depression, and increased connection at school for a period of multiple weeks. Qualitative findings were validated from the progress monitoring forms. Decisions about service continuation occurred as Mary engaged in greater amounts of socially related behavior at school, expressed less need for therapy services, and demonstrated below-levels of clinical-related anxiety on the RCADS for multiple weeks.

Outcomes and Treatment Termination

At first, Mary reported significant difficulty and a lack of willingness to engage in any social situation that risked feeling vulnerable in front of others. Mary chose to stay at home rather than attend social events, she sat in the back of her classes, she did not raise her hand or interact with teachers, she did not talk to other people during lunch, after class, or after dance practice, and she came straight home from school. After the first few sessions, prior to in-session exposures, Mary began taking small amounts of initiative at home such as raising her hand in class or initiating a brief interaction at school, such as asking “did you understand the homework?” or “I like your shoes.”

Mary experienced stress when in-session exposures began occurring. When Mary first interacted with receptionists across the clinical site, she expressed feelings of embarrassment, self-judgment, and worry that she looked dumb. The “name your anxiety, give it a color, a texture, and a location” exercise as well as the “two trains” metaphor were particularly effective at increasing acceptance and willingness. The two trains metaphor was explained in that Mary was standing at a train stop hoping to reach her hometown in the further distance. She had two

trains to choose from, one was nice, clean, and comfortable whereas the other was gross, stinky, and broken down. As she sat in the comfortable train and waited for it to leave, she watched the broken-down train leave the station and arrive at the city. After watching this for several occurrences, she realizes that the comfortable train would never leave. Thus, getting where she wants to go in life necessitated riding on the uncomfortable train. Integrating these exercises while allowing Mary to choose her social exposures caused greater increase in acceptance and decreased distress over time. After she grasped them, Mary expressed her own interest in engaging increasingly difficult exposures such as, for example, asking strangers where the clinical site was (while standing right next to the clinical building), asking a large group of strangers where the bathroom was because she really needed to go, and asking chefs at a nearby café what type of butter they used in their cooking.

These in-session exposures translated to greater risk taking at school, as Mary reported making new friends, attending social activities, participating in class, joining new clubs, trying new athletic moves in front of her sports team, inserting herself in social groups, expressing opinions in debate, and giving class presentations. At the end of treatment, Mary reported that "my anxiety has never really gone away, but I'm learning to just set it aside, like in that beachball story. I'm realizing that it isn't as correct about others as I thought it was… Even if people are judging me, I don't really care anymore. I'd rather spend my time enjoying life instead of worry what others think of me." These qualitative descriptions and behavioral changes were validated with findings on the monitoring forms, including decreased anxiety, depression, and experiential avoidance as well as increased wellbeing at school. Progress monitoring graphs are presented at the end of this document.

Services ended as Mary expressed contentment with her new abilities to engage in social situations. During the final session, Mary expressed that she felt "much better" and was grateful for services. While also expressing worry that things would get bad again, Mary was informed that she can always come back if she felt future support was warranted. General population supports such as ACT for anxiety manuals, online self-help interventions, and mindfulness practices were also provided and recommended as useful resources she could use to practice on her own. No significant adaptations were made to treatment aside from shifting a weekly schedule to a biweekly schedule during weeks 14-16.

Complicating Factors

Mary underwent therapy sessions amidst a busy school year filled with obligations and pressures. Nevertheless, Mary consistently showed up for treatment and engaged therapy attentively. Mary's parents actively supported skills at home and encouraged Mary to engage in exposures. No variables to the clinician's awareness occurred that hindered the course of treatment.

Access and Barriers to Care

Mary showed up punctual and engaged to all sessions. She usually drove herself to the clinic, but her parents were readily available for transportation if need be.

Follow-up

Comparisons between initial and final treatment scores taken from the progress monitoring forms are presented in Table 1 at the end of this document. Results indicate that Mary reported clinical levels of experiential avoidance, and separation anxiety, total anxiety while also reporting near clinical levels of social anxiety. Mary also reported low to moderate levels of depression and "often" experiencing wellbeing at school. At the end of treatment, levels

of experiential avoidance, separation anxiety, total anxiety, and social anxiety decreased and maintained below clinical levels for a significant amount of time. While pre- and post- scores indicate minimal change in depression, visual analysis of the graph indicates meaningful decreased trend through duration of treatment, and results from the school-based wellbeing graph verify graduate trends in the upward, desired direction. As Mary engaged in intervention sessions over time, levels of anxiety and depression decreased in desired directions of levels of wellbeing at school increased in a qualitatively meaningful direction.

Treatment Implications of the Case

Most importantly, intervention necessitated opportunities to develop social skills through taking social risk and learning new boundaries on par with peers. Talk therapy focusing only on client-guided emotional processing, discussing relational struggles, or pondering ACT principles alone would likely miss key opportunities to build abilities necessary for meeting important developmental milestones. Developing psychological flexibility from learning ACT skills allowed Mary to notice and accept biological alerts such as fear, self-criticism and a desire to escape but ultimately disregard them in order to increase her ability to make thoughtful social decisions. Consistent practice in making social decisions and thus experiencing greater feelings of reward despite potential risks of experiencing social punishment elicited greater motivation to practice further social skills on her own, make friends, and develop confidence. These findings thus argue the necessity of skills-focused intervention that helped Mary change influential behaviors in her life. At the end of the day, it was not about teaching ACT, facing fears to reduce stress, or even to build a therapeutic relationship. In accordance with past research, the intention of sessions was *using* ACT in a therapeutic relationship to help Mary (1) approach a valued life and (2) realize a developmentally appropriate social identity.

Recommendations to Clinicians and Students

Treating SAD in adolescence using a framework of ACT requires a host of in-the-moment decisions that require flexibility and fluidity amidst effecting important, long-term outcomes. While it might be effective to manually teach all areas of the ACT hexaflex in preparation for engaging in fear-related exposures, a more efficient and client-centered approach assesses deficits in ACT processes and intervenes appropriately. For example, Mary often reported a strong sense of her values, was committed to engaging in difficult exposures, and was often aware of present-moment experiences and sensations. As such, treatment did not spend significant time clarifying values, building committed action, or practicing present-moment awareness. However, Mary often manifested significant fusion to unhelpful cognition and became notably unhappy when negative feelings appeared. Much time was therefore spent in teaching principles of defusion, acceptance, and openness, and metaphors such as the beachball and the sports commentator were practiced more frequently. (The sports commentator is described in Stoddard & Afari (2014): Thoughts in your head are like a sports commentator. You can listen to the commentator, or you can let the commentator talk in the background while you watch the game.)

Additionally, it was critical to build exposures slowly. Jumping into difficult social experiences too early and without basic fluency in psychological flexibility often led to diminished therapeutic alliance and confidence. Determining when to increase the difficulty of exposures came through watching responses to minor exposures and noticing the flexibility and openness that Mary manifested. Finally, it was important for the clinician to utilize role-plays in session prior to inviting Mary to engage in behavioral commitments at home. Mary often became

more flexible and willing to engage in at-home practices after being allowed to verbalize the situation in the safety of a confidential, trusting relationship with the therapist.

It was an immense pleasure to work with Mary. She hopes that this paper can be used to help other teens like her.

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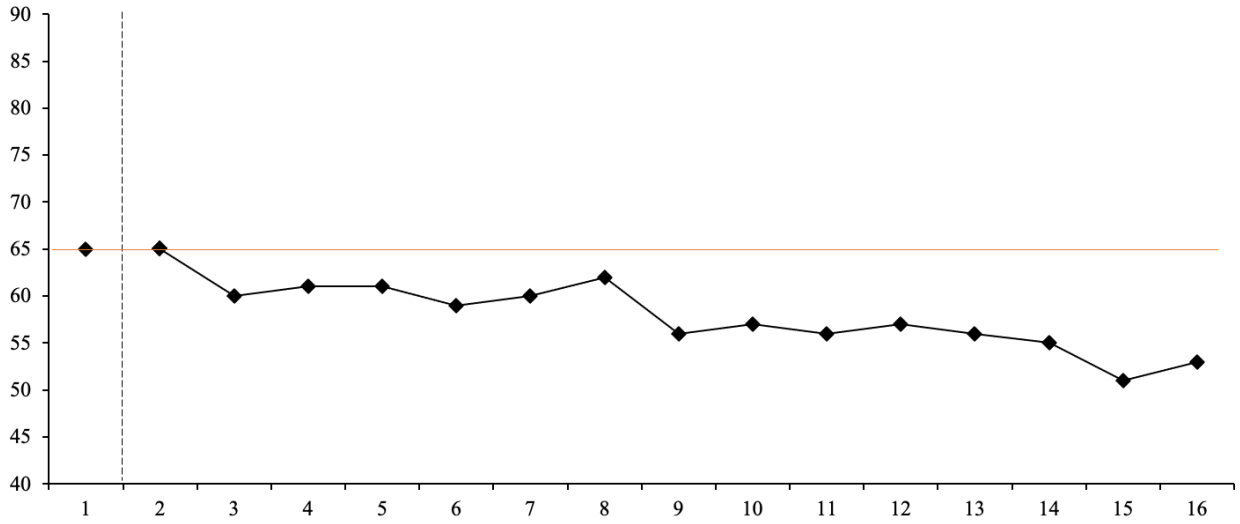
Figure 1

Progress monitoring of the RCADS: Total Anxiety



Note. The black dotted line indicates the separation between assessment and treatment phases.

The red line indicates clinical levels of anxiety distress.

Table 1

Pre- and post-treatment scores

Progress Form	Pre-Score	Post-Score	Percentage Change
Experiential Avoidance	20	14	30% Decrease
Social Anxiety	60	50	16.6% Decrease
Separation Anxiety	65	61	6.2% Decrease
Total Anxiety	65	53	18.5% Decrease
Depression	8	7	12.5% Decrease
School-Based Wellbeing	42	51	21.4% Increase

Note. For experiential avoidance, 8—18 = nonclinical and 19+ = clinical. For social anxiety, separation anxiety, and total anxiety, 40—64 = nonclinical and 65+ = clinical. For depression, 19—26 = severe clinical concern, 14—19 = clinical levels of depression, 9—14 = low to moderate levels of depression, 4—9 = minimal levels of depression, and 0—4 = no presence of depression. For school-based wellbeing, 16—25 = “rarely” experiencing wellbeing at school, 26—40 = “sometimes” experiencing wellbeing at school, 41—56 = “often” experiencing wellbeing at school, and 57—64 = “almost always” experiencing wellbeing at school.