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Social anxiety disorder– case study

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Introduction

This study focuses on the analysis of a clinical case involving Social Anxiety, specifically performance anxiety with comorbidity with Attention Deficit Hyperactivity Disorder, of the inattentive type. After investigating the most pertinent aspects of the case, using a structured clinical history model and with reference to specific assessments, intervention strategies are outlined using theoretical support and, finally, its evolution is monitored. This case was chosen because it was followed up during advanced postgraduate specialization in cognitive-behavioural psychotherapy in childhood and adolescence, and the lessons learned during this training were crucial to good therapeutic progress. It therefore seemed to me to be the ideal case to report and demonstrate the effectiveness of these therapies.

The following is a brief introduction to the two psychopathologies present in this case

Anxiety is a biological defense mechanism whose main objective is to defend the body against dangers, be they physical (e.g. being hit by a car), social (e.g. defending a master's thesis) or emotional (e.g. being dumped by your boyfriend). The cognitive component is fundamental to assessing the danger of the situation and the body's ability to respond.

When faced with a dangerous situation, there is a response with 4 components: cognitive (my assessment of the situation, i.e. thoughts that come to mind); physiological (e.g. hyperventilation, sweating, trembling); emotional (the emotion is always in line with the assessment of the situation); and behavioral (flight, fight, paralysis). In this way, anxiety is a state of psychological distress associated with the expectation of an unforeseen event that is perceived as unpleasant or dangerous. Fear, on the other hand, is related to an object and a specific situation, after a specific experience of unpleasant exposure, or by learning. Fear and anxiety represent normal reactions to danger, and both show typical fluctuations at each age (Couto, Alto & Soares, 2015).

These fluctuations usually occur with increased anxiety about separation or strange situations in early childhood, followed by fear of being physically hurt at school age. In adolescence, anxieties related to competence, abstract threats and social situations arise (Couto, Alto & Soares, 2015). Social Anxiety Disorder (SAD) is a generalized and persistent fear of situations in which the individual feels socially exposed and can be evaluated/criticized (Couto, Alto & Soares, 2015). It is a frequent disorder in childhood and adolescence, with an estimated prevalence of approximately 5% (Couto, Alto & Soares, 2015). Social phobia is characterized by physical symptoms such as increased heart rate, flushing, dizziness, abdominal pain and trembling, which can lead to episodes of panic when associated with the feared situation (Couto, Alto & Soares, 2015). Children and adolescents with Social Phobia have a high level of emotional reactivity, which can range from behavioral inhibition and social isolation to irritability and generalized anxiety (Couto, Alto & Soares, 2015). I've attached the diagnostic criteria according to the DSM-5 (Manual of Social Disorders Mental) (APA, 2013).

With regard to ADHD, it can be defined as a persistent disorder of psychological development, characterized by high levels of inattention and/or hyperactivity and impulsive behaviour, of a more severe and frequent intensity than that usually observed in individuals with a similar level of development and with an impact at a social, academic or professional level (APA, 2013). It is a disorder of the central nervous system that presents a diverse symptomatic picture and significantly interferes with children's social, family and academic life and, consequently, their normal development.[1]

It is a neurobehavioural disorder characterized by persistent patterns and inappropriate levels of inattention and/or hyperactivity-impulsivity, and is the most frequent disorder in school-age children.[1] Children with ADHD find it difficult to remain in activities that are not stimulating or interesting and find it easier to direct their attention to irrelevant stimuli that they have been advised to ignore.[2] They have limited ability to persist in a task, aggravated by a motivational problem and difficulty staying in activities that are not immediately rewarding.[2] It is a disorder that can manifest itself early in childhood and whose symptoms are: hyperactivity, impulsivity and/or inattention.[2] I enclose the diagnostic criteria according to the DSM-5 (Manual of Mental Disorders) (APA, 2013).

There are 3 subtypes of ADHD: **Combined presentation**: when criteria A1 (inattention) and A2 (hyperactivity-impulsivity) have been met during the last 6 months. **Predominantly inattentive presentation**: if criteria A1 (inattention) but not A2 (hyperactivity-impulsivity) **have** been met during the last 6 months. **Presentation predominantly** of **hyperactivity-impulsivity**: if criterion A2 (hyperactivity-impulsivity) but not A1 (inattention) has been met during the last 6 months (APA, 2013).

Case description

Summary of the child's/adolescent's medical history; reason for consultation

The subject of this case study (referred to as MJ.) is a ten-year-old child in the fifth grade. She is an only child and lives with her parents and maternal grandmother. MJ. started at APSIZ in October 2023, with a weekly psychology session lasting 60 minutes.

The mother sought psychological support at APSIZ for intervention with the aim of promoting her daughter's concentration and reducing anxiogenic behavior. Initially, the parent's request focused on screening for Attention Deficit Hyperactivity Disorder (ADHD) and adapting academic strategies. The descriptions given during the clinical interview procedure raise the hypothesis of an anxiety condition, a diagnosis which will be later explored. Her mother describes MJ as a shy child, reserved and with few words. She likes to have friends, but she doesn't get on with *just* anyone, *she* avoids conflict and tries to please them so *that they* play with *her* "*she might ask me to pick her up from school*, *just so she can give a ride to a friend*". The mother also mentions that during primary school there was a situation of *bullying* in which one of the girls put MJ aside and also forced the rest of the group to *stay* away from her, "*it was another difficult phase, but we managed to overcome it by inviting two girls to come over more often"*. The relationship with the 3rd and 4th grade teacher was also the best, the mother describes that "*MJ was afraid of her, she spoke very loudly and MJ got scared. She asked me to find someone to study with her, she didn't want to get bad marks so the teacher wouldn't get angry. That's when I found a tutor, because I didn't have much time (...) but everything was done on the sly, MJ didn't want anyone at school* to *get suspicious*."

Outside of school, she gets on well with everyone in her family, but she also tries to please, she hates to see anyone cry, "*she gets very upset*". She attends English classes, which in an individual context she shared that she only went because her mother liked *it* "*it's boring, but mom likes it and says it's important*" and swimming.

She was a much-loved daughter who was always cherished by all the family members. Until the age of six, she didn't attend any school and was left in the care of her maternal grandmother. When she entered primary school, according to her mother, she adapted a little too quickly, often picking her up to have lunch together "*she would ask me, please, claiming that she missed me and her grandmother*" (...) "*but she really liked learning, as soon as she got home she would go and do her homework straight away and would often ask the girls to stay at home and play with her*". Her mother describes the third year as the most difficult, as her maternal grandfather died of cancer "*It was a very difficult process, MJ accompanied everything and she loved her grandfather very much. She talks about him every day and after that I had to take over the company, which was two losses for her, because I had no time for my daughter*".

Over the course of the consultations, there is a request for individual intervention with the aim of behavioral and emotional regulation, as well as outlining strategies for the family context.

Identification and description of the child's/adolescent's/parent's current problems/symptoms/disturbance

The request for follow-up, as mentioned above, came at the beginning of October, identifying the start of secondary school and the change of school as triggering factors for concentration difficulties, combined with anxiogenic behaviors.

Her mother describes symptoms such as excessive fear of failure "*MJ doesn't sleep! Since she changed schools she says she has no friends and is afraid of everything. Now that the tests are about to start she's even worse, she only sleeps with her grandmother and hardly eats because she gets a stomach ache. (...) I pick her up every day at lunchtime to eat at home and call her every break. I'm afraid I'll talk to the principal and she'll take her aside. I don't know what else I can do."*

Alongside this information, the mother added that MJ has had a home tutor since the 4th grade, who is with her every day to help her study and do her homework, since the mother has been less available since the 3rd grade, due to the fact that her paternal grandfather died and the mother had to take over the family business, a gas station that is just below the house where they live and which requires a lot of time. Her father, on the other hand, has never been very present when it comes to learning, he also has his own business (car sales) which also requires a lot of hours and sometimes trips abroad. On the other hand, her mother describes that MJ's behavior has always been complicated, "*I always had to be on top of her, she was unmotivated, she got distracted by anything and if she doesn't have someone by her side she doesn't finish her homework, then she cries and says she can't do it. She's going to fail the year."*

Impact

MJ's symptoms seem not only to be affecting her directly, but also her family dynamics. In relation to herself, she shows increasingly isolated behavior in relation to her peers, there is an increased lack of appetite, which in turn can have physical health consequences, as well as altered sleep regulation, which also contributes to her lack of concentration and mood swings. As far as family dynamics are concerned, in a clinical interview, the mother shared that some arguments are starting to break out between the couple about how they should raise the child, the father says that the mother is too permissive and the mother can't find any other strategies to help her daughter, feeling guilty about the whole situation.

Characteristics of the child/adolescent and their level of development

MJ. has always been a very sheltered child, but also a stimulated one. Because of her family's business, she has always been exposed to the public, and has even done some "customer service". She seems to be a curious child who likes to learn, but tasks that involve a lot of time at the table make her tired and bored, and she ends up giving up. No health problems have been reported to date. However, it should be noted that during the monitoring period, in March 2023, MJ was hospitalized for a week due to pneumonia, and was not monitored during that month.

Protective factors: description of the resources and skills of the child/adolescent, the family and the context

MJ. appears to be an intelligent, curious and dedicated child, which contributes to a good therapeutic prognosis. The family, despite having some difficulties with time management, shows concern and wants to be involved in the therapeutic process, looking for strategies and sharing the results and doubts that arise.

Multimodal standardized formal assessment: brief description of the assessment measures used, results obtained and interpretation according to normative values. Diagnostic hypothesis, if applicable

The initial hypothesis of ADHD seems plausible, given the clinical interview with the child's mother. According to the DSM-5 in Hyperactivity Disorder and Attention Deficit Disorder **314.01** (F90.2), of moderate severity, a child can be expected to manifest their distraction through behaviors of "wandering off task, lack of persistence..." (APA, 2014, p.71). However, this diagnosis does not seem to be enough due to the exhibits that are presented, leading to the suspicion of comorbidity with Social Anxiety Disorder, specifically Performance Disorder - **300.23 (F40.10)**, which according to the

DSM-V, their automatic thoughts tend to reflect a general pessimism, in the form of negative thoughts. These thoughts are reflected in inattention, excessive fear of failure and avoidance of evaluative situations.

The following instruments were used to assess the hypothesis of ADHD:

I. Test D2;

II. WISC-III;

III. Toulouse Piéron Dam Test - 2 signals

D2 Attention test

The D2 Attention Test assesses the ability to concentrate and pay attention, analyzing information processing capacity, efficiency and consistency of performance. In general, the results suggest that MJ. has a lower than average concentration/attention capacity for his age group. His overall performance (TC-E) as well as his ability to concentrate (IC) are much lower than those of the subjects in his age group, with a score of **177 (2nd percentile)** and **61 (3rd percentile)** respectively. MJ. was unable to perform the task effectively **(TA= 65, percentile 1), not demonstrating** good information processing skills. It should also be noted that their **performance is inconsistent**, with a variability index of **26** (**5th percentile**). However, the percentile assigned to the percentage of errors parameter is **normative**, being in the 65th percentile, i.e. despite not having the expected performance, he performs the task with few errors.

The results obtained suggest that MJ has an **attention/ concentration capacity below** the average expected for his age group.

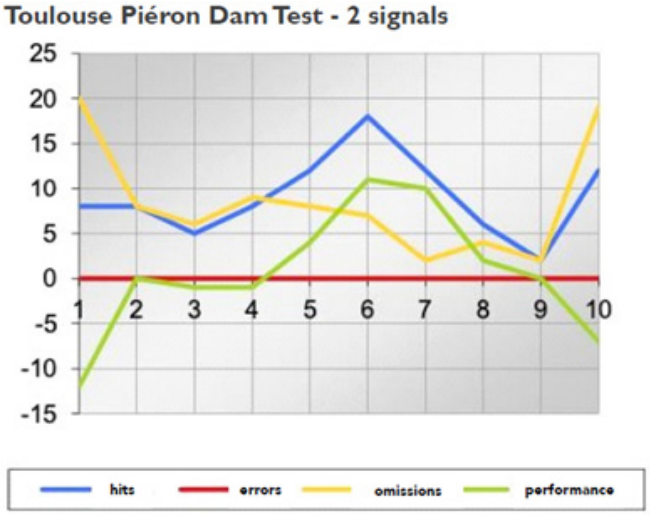
Wechsler intelligence scale for children (WISC -III)

In order to obtain their cognitive profile, the Weschler Intelligence Scale III (WISC-III) was used. This scale assesses the cognitive skills of children and adolescents. With a chronological age of 10 years, 6 months and 10 days, MJ obtained a Full Scale IQ of **107** (**average level**), a Verbal IQ of **113** (**upper average level**) and an Achievement IQ of **99** (**average level**). With regard to the results of the Factor Indices, he obtained a **higher average level** in the Verbal Comprehension Index (**VCI=116**) and an **average level** in the Perceptual Organization Index (**IOP=98**).

In the verbal tests, MJ obtained a homogeneous profile, but with values always within and above the expected average for your age group. The *Comprehension* test scored the highest, being above average, showing a good ability to express their experiences, knowledge of social rules and mental flexibility. The *Arithmetic* test scored the lowest, but still within the average range, there were some difficulties with attention and auditory, working and immediate memory. In the achievement tests, Benedita's profile is also heterogeneous, with values above and below the average expected for her age group.

The *Cubes* test is the one in which achieves the highest score, demonstrating an ability to solve non-verbal problems and a good performance in executive functions. In the *Arrangement of Pictures* subtest, he obtained the lowest score, which shows that he did not do a good perceptual analysis, also revealing inattention and impulsiveness.

Looking at their performance results, they are consistent, there are few discrepancies between the verbal and achievement factors, so it is possible to see a **homogeneous profile**. The difference between the Verbal IQ and the Achievement IQ is 14 points, (113-99=14), which shows that their Verbal abilities are slightly higher than those for Achievement, but with slightly different values.



The Toulouse Piéron test assesses perceptual aptitude and the ability to attention of the subjects, through a routine task that requires concentration and resistance to monotony. Composed of a sheet of the task is to identify the same figures as the three models given. The results show a slow rate of achievement (total number of correct answers 91 - cut-off point 80-100) and a very high level of concentration.

dispersed (93.4 - cut-off point >15).

The following instruments were used to assess the hypothesis of Social Anxiety Disorder:

I. Family drawing

II. Children's Apperception Test (CAT)

III. SPAI-C - Social Phobia and Anxiety Inventory for Children (Beidel et al., 1995)

Family drawing

In the projective family drawing tests, MJ portrays herself as smiling, which seems to show that she is a happy child. Her drawings are full of color and detail. She portrays herself appropriately in the middle of the family, flanked on the right by her mother and on the left by her father and maternal grandmother. She appears to have a good individual and family self-concept, with appropriate close emotional relationships with her close family members.

Children's apperception Test - CAT

A projective test in which 10 images of real-life situations with animal figures are presented and the child is asked to build a story around them. MJ. showed a good understanding of the stimulus situations presented, recognizing the problems and positive and negative emotions portrayed in them. Nevertheless, in some of the images, it was evident that themes related to loss, abandonment and fear of the unknown emerged, situations for which MJ shows little ability to analyze and resolve. MJ is able to identify and recognize the negative feelings related to the situations, but has difficulty understanding the reasons for them and, consequently, finding strategies to appease them.

SPAI-C - social phobia and anxiety inventory for children (Beidel et al., 1995)

The SPAI-C (Social Phobia and Anxiety Inventory for Children) is a self-report inventory developed by Beidel and collaborators in 1995. This instrument consists of 26 items and is used to assess social phobia and anxiety in children aged 8 to 14. MJ scored a total of 22 points, thus falling within the possible category of Social Anxiety Disorder.

Hypotheses about the mechanisms that contribute to the development and maintenance of the problem according to the cognitive model behavioral (cognitions, emotions and behaviors)

MJ has negative cognitions about herself, denigrates herself and believes that her peers see her as weak and insufficient. Thoughts such as "*I'll never have a best friend; I'll fail the year; the EV teacher hates me; I can't go to that place at school because there are older people there and they can make fun of me*", mark the child's discourse, translating into permanent unease and a constant search for strategies to avoid any situation that she considers embarrassing. In this way, MJ avoids any kind of conflict, even if it's not directly with herself, so that she doesn't have to be assertive, which can lead to *her* colleagues "*thinking she's rude and ill-mannered*". This constant search to be someone perfect, accepted and interesting leaves MJ worn out, with feelings of inferiority, often triggering emotions such as sadness and frustration about herself.

Precipitants: situations that aggravated the difficulties

There are at least three situations that may have contributed to the worsening of her difficulties**:** 1) the *bullying* she experienced during the third year of school; 2) the death of her maternal grandfather, which her mother mentions several times, demonstrating a very early mourning process and which, at the same time, triggered a series of changes in the family dynamic; 3) the most recent change of cycle and school, which forced MJ to leave her comfort zone, explore a new place and socialize with new people, especially new classmates.

Origins of the mechanisms: risk factors more distant or closer to the child/adolescent, family, context

MJ's family dynamic seems to be the biggest risk factor for therapeutic progress. MJ doesn't always show up for her appointments because her mother doesn't have time to bring her, or she is asked to change the format of her appointment so that she can have a teleconsultation. This inconsistency not only interferes directly with the therapeutic process, but also makes MJ more anxious. On the other hand, the mother also shows various symptoms of anxiety, very self-critical speech and easy crying.

Factors that can make intervention difficult: the child's level of development, more practical obstacles, level of preparation for change

In view of MJ's medical history, it is considered that the under-protection of MJ's mother and grandmother could be a strong factor hindering the intervention, and that psychoeducation and parental guidance are crucial in order to achieve a successful intervention therapeutic intervention. On the other hand, MJ's already crystallized behaviors and negative automatic thoughts about himself are also indicative of difficulties and will need to be addressed.

Operationalization of problems that will be the target of intervention/objectives of the intervention: centered on the child/adolescent and/or the parents

Taking into account the results obtained during the MJ evaluation, the following recommendations are suggested:

It is recommended that MJ. benefit from a global intervention plan whose goals should include:

I. Psychoeducation on the psychopathologies presented to both the child and the parents;

II. Socio-emotional promotion, so that they can identify and understand their emotions;

III. Cognitive restructuring, both to obtain a more realistic picture of the situation and to reduce negative automatic thoughts;

IV. Problem-solving training, so that they can acquire more skills to resolve certain situations, especially social ones;

V. Parental guidance so that parents are more confident about the parenting strategies to use and at the same time more consistent in the way they act.

VI. Promoting attention/concentration, as well as study techniques and methods so that you can get the most out of your cognitive level and avoid academic demotivation.

Treatment plan: identification of the manualized treatment selected if applicable, description of the therapeutic process with objectives per session and conclusion with evaluation of the therapeutic process

Although MJ. was diagnosed with PDHA and Social Anxiety Disorder, specific to performance, the symptomatology presented in the latter overlaps with the former, creating greater unease in her daily functioning intervention will focus mainly on Social Anxiety Disorder, specific to performance. There are various models that can be used to outline an intervention plan for Social Anxiety Disorder. The Clark & Wells model[3] stands out. Within this model we find the following objectives: formulation and construction of an ideosyncratic model; obtaining realistic information about their image through behavioral experiences, video-feedback with cognitive preparation; exposure/behavioral experiences (cutting out safety behaviors and using strategies to change the focus of attention); cognitive strategies; cutting out anticipatory and post-situational processing; working on dysfunctional beliefs and assumptions. It should also be noted that some studies already point to the effectiveness of the ACT model and intervention in social phobia (Block & Wulpert, 2000; Dalrymple & Herbert, 2007; Kocovski, et al., 2009; Ossman et al., 2006). Finally, and no longer as an individual intervention, it was suggested that MJ be included in a mindfulness group for children, both to put into practice, in a group context, some of the strategies worked on in individual sessions, and to reinforce mindfulness skills. Attached is the group program, based on the book *Happy Meditation* by Valérie Marchand Annex.

Annexes

- **Social Anxiety Disorder Diagnostic Criteria:**
- Marked fear or anxiety of one or more social situations in which the individual is exposed to the possible scrutiny of others. Examples include social interactions (such as a conversation,

meeting strangers), being observed (such as eating or drinking) and in performance situations (such as public speaking).

- **Note**: in children, anxiety must be present with peers and not just during interactions with adults.
- The individual fears behaving or showing symptoms of anxiety that could be evaluated negatively (i.e. that would be humiliating or embarrassing; that would lead to rejection or offense from others).
- Social situations almost always provoke fear or anxiety.
- **Note**: in children, fear and anxiety can be expressed by crying, tantrums, immobility, clinging to others, withdrawal or inability to speak in social situations.
- Social situations are avoided or faced with intense fear or anxiety.
- The fear or anxiety is disproportionate to the real danger posed by the social situation and the socio-cultural context.
- The fear, anxiety or avoidance is persistent, typically lasting 6 months or more.
- Fear, anxiety or avoidance cause clinically significant malaise or a deficit in social, school, occupational or other important areas of functioning.
- Fear, anxiety and avoidance are not attributable to the physiological effects of a substance (e.g. drug of abuse, medication) or other medical condition.
- Fear, anxiety or avoidance are not better explained by symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder or autism spectrum disorder.
- If another medical condition (e.g. Parkinson's disease, obesity, disfigurement caused by burns or injuries) is present, the fear, anxiety or avoidance is clearly unrelated or excessive.
- Specify whether: Performance only (if the fear is restricted to public speaking or performance situations.
- **Attention Deficit Hyperactivity Disorder Diagnostic Criteria:**
- A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, characterized by (1) and/or (2)
- **Inattention**: 6 (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and has a direct negative impact on social and academic/occupational activities.
- **Note**: Symptoms are not just a manifestation of oppositional behavior, defiance, hostility or failure to understand tasks or instructions. For older adolescents and adults, at least 5 symptoms are required.
- Often fails to pay attention to detail or makes careless mistakes in schoolwork, work or other activities (e.g. neglects or misses details, work is inaccurate).
- They often have trouble keeping their attention when performing tasks or activities (for example, they have trouble staying focused during lessons, conversations or prolonged reading).
- They often don't seem to listen when they are spoken to directly (for example, they seem to be thinking about something else, even in the absence of an obvious distraction).
- They often don't follow instructions and don't finish schoolwork, assignments or workplace duties (for example, they start tasks but quickly lose concentration and are easily sidetracked).
- They often have difficulties organizing tasks and activities (e.g. difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy and disorganized work; poor time management; failure to meet deadlines).
- Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (e.g. schoolwork or home; for older teenagers and adults, preparing reports, completing forms, revising long texts).
- Often loses objects needed for tasks or activities (e.g. school materials, pencils, books, tools, wallets, keys, documents, glasses, cell phones).
- They are often easily distracted by extraneous stimuli (for older adolescents and adults, this can include unrelated thoughts).
- Frequently forgetting daily activities (for example, doing chores, running errands; for older teenagers and adults, returning calls, paying bills, keeping appointments).
- **Hyperactivity and impulsivity**: 6 (or more) of the following symptoms have persisted for at least 6 months at a level that is inconsistent with developmental level and has a direct negative impact on social and academic/occupational activities.
- **Note**: Symptoms are not just a manifestation of oppositional behavior, defiance, hostility or failure to understand tasks or instructions. For older adolescents and adults, at least 5 symptoms are required.
- He often shakes or taps his hands or feet or fidgets when sitting down.
- He often gets up in situations where he is expected to sit down (for example, he gets up from his seat in the classroom, in the office or other workplace or other situations that require him to remain seated).
- Often runs or jumps in situations where it is inappropriate to do so. (Note: in adolescents or adults it may be limited to feeling restless).
- They are often unable to play or engage in leisure activities.
- He is often "on the move", acting as if he is "on a motor" (for example, he feels uncomfortable or is unable to sit still for long periods, such as in restaurants, meetings; he may be experienced by others as being impatient or having difficulty keeping up).
- He often talks too much.
- They often rush into answers before the questions are finished (for example, they complete people's sentences; they can't wait for their turn in the conversation).
- They often have difficulty waiting their turn (for example, while waiting in a queue).
- Often interrupts or interferes in other people's activities (for example, intrudes on conversations, games or activities; may start using other people's things without asking or receiving permission; for teenagers and adults, may intrude or take control of what others are doing).

- Several of the symptoms of inattention or hyperactivity-impulsivity appeared before the age of 12.
- Several of the symptoms of inattention or hyperactivity-impulsivity are present in 2 or more contexts (for example: home, school or work; with friends or family; in other activities).
- There is clear evidence that symptoms interfere with or reduce the quality of social, academic or occupational functioning.
- The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g. mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

In this way, a therapeutic intervention plan was created with the following objectives: 1) psychoeducation for the parents and for MJ; 2) self-monitoring of thoughts so that MJ becomes more aware of her thoughts and a cognitive dysfusion begins; 3) externalization using various strategies so that she can regulate her physical sensations when she experiences an anxiety crisis (such as relaxation): muscular, respiratory and imaginary relaxation); cognitive restructuring; 4) Systematic desensitization - initially with conversation training and the application of relaxation strategies in the office, later outside the office, specifically in the nearby café. The preparation of the therapy sessions was also based on the *Skillful Cat* manual by P. Kendall (2011), using some of the proposed activities several times.

Some of the sessions that took place with MJ are detailed below. However, it should also be noted that at the end of each appointment, the last 15 minutes were dedicated to sharing information with her mother (who had always accompanied MJ to therapy). In these 15 minutes, the activities of the session and the tasks that were to be carried out at home were explained, and it was often MJ who showed an interest in sharing what she had learned with her mother. Whenever necessary, an individual conversation was also held with the mother after the consultation in order to provide specific suggestions for the parents, such as: reducing phone calls and messages during school time; encouraging MJ to attend activities outside of school with her classmates and in contexts other than her home; actively listening to MJ's doubts/fears..., but without showing signs of concern; reinforcing/encouraging MJ to sleep alone - for this topic in particular, some specific strategies were provided, such as: staying with MJ in her room until she fell asleep, leaving an object in MJ's room that identified that her parents had been to see her during the night, the possibility of leaving a light on, leaving bedroom doors open and creating a moment for two before bed (using relaxation cards and the gratitude notebook); finally, the importance of avoiding arguments between parents in front of MJ was also discussed.

Date Objective da Resources used session

09/11/2023 Psychoeducation (first part of the session with MJ and the second part with the family).

Explanation of what PAS is through Clark & Wells' ideosyncratic model, exemplifying with the cognitions and beliefs, behaviors and emotions described by MJ. and the family. In the second part of the session, MJ tried to do most of the psychoeducation in order to confirm that he had understood what had been explained to him earlier.

How does fear make itself felt in my body	How does fear make me feel?	What does fear make me think?	What does fear make me do?
- stomach ache; - difficulty breathing	- distressed; - scared	the mother may have a car accident and die on the way to work	cry, bite my clothes, stamp my feet on the floor, don't play with my classmates

16/11/2023 Socio-emotional promotion: recognizing emotions

Using the story and game of the Colour Monster, identify and recognize their emotions.

23/11/2023 How our body reacts to emotions

Specifically exploring the emotion of fear and understanding what it causes in our bodies.
Resources for the book "Sometimes I worry".
Role-play: comparison of robot body vs rag doll (using the *Skilled Cat* notebook)
Initiation of relaxation strategies - suggested breathing techniques.

30/11/2023 Relaxation strategies

Creating a box with various relaxation techniques "Emotional First Aid Kit" that you can use whenever you feel worried.
Examples of materials: calm down jar, notebook for writing down your thoughts and checking their validity, breathing reminders.
Analysis of the notebook of your thoughts and training of the muscle relaxation cards (orange, cat, turtle, chewing gum, fly, elephant, mud and breathing)
Suggestion to use these cards every day before going to bed.

07/12/2023 Relaxation strategies

Table Continued...

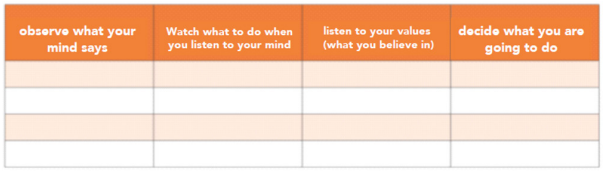
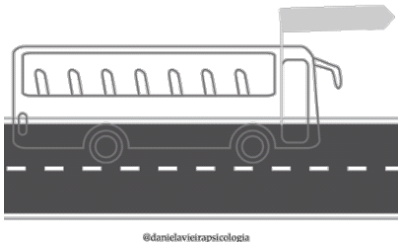
14/12/2023	Sleeping alone	 Taking advantage of the Christmas vacations, a points system was introduced to encourage MJ to sleep alone. In addition to the goal of sleeping alone, the points system included other tasks that were easy for MJ to solve so that she would feel motivated to reach the final goal 
21/12/2023	Identifying fears	Using the resource: ladder of fear - session 16 of the *Skilled Cat* Workbook
28/12/2023	Monitoring thoughts	After understanding how his emotions worked, MJ worked on identifying his thoughts. The self-monitoring chart was used, which was also taken home as a homework assignment. (At this point the "Emotional First Aid Kit" booklet is no longer used) The EV teacher doesn't like me I don't go to class I have to go to class to be a good student I go to class Using the "bus of life" dynamic, MJ. identified which thoughts were most frequent and an obstacle to his goals.
04/01/2024	Identifying your negative automatic thoughts	
11/01/2024	Alternatives to thoughts	Using session 6 of the *Skilled Cat* notebook. The idea that different thoughts lead us to different actions/reactions.
18/01/2024	Realistic information about your image	MJ was first asked to create a portrait of herself with descriptions of how she saw herself. Then, using footage, reading messages she exchanged with her friends and bringing descriptions of the people close to her, a "picture" was created of what she really looks like.
25/01/2024	Realistic information about your image	Using the book "Monster Love" by Rachel Bright and the board game I created based on this story. In this game there are role-play challenges about ways of acting and integrating, accepting ourselves as we are After identifying the triggers that set off MJ's anxiety, several alternatives to her thoughts were worked on
01/02/2024	Working on dysfunctional beliefs	
08/02/2024	Problem-solving training problems	Various problem-solving and acceptance activities were carried out using board games mistakes that are common to everyone.
15/02/2024	Identifying achievements	Creation of a gratitude diary. Together, they created a book in which MJ wrote down her gratitude every day. achievements and the things she was grateful for.
22/02/2024	Problem-solving training problems	Various problem-solving and acceptance activities were carried out using board games. mistakes that are common to everyone.

Table Continued...

29/02/2024	Behavioral experience	Step by step, the stages of going to a new place, a café, were defined. • what could I ask for? • what to say? • how to behave? • what to talk about with your friends while you're there? • how would you react if you started to feel anxious? This plan was written and trained in role-play, in the office.
04/04/2024	Experience behavioral	Going to the neighboring café, putting into practice all the learning.
11/04/2024	Behavioral experience	Training for the Portuguese presentation. MJ was going to have a Portuguese presentation that he practiced in session and recorded. Afterwards, he watched the recording, identified some flaws and together we laughed at them, increasing the feeling of acceptance and devaluing the small ones errors.
18/04/2024	Identifying your values	Creating a list of future goals you would like to achieve. Identifying any obstacles that may arise and how they can be overcome.
02/05/2024	Compassionate me	After a short meditation, "Close your eyes and concentrate on your breathing, breathe slowly. Start by feeling where you are sitting, where your feet are touching, where your hands are touching, what do you feel in your body? Now I want you to think of a place that is very beautiful and special to you, it can be real, like a garden, a beach, a forest or a place in your house, or it can be imaginary, you can imagine yourself on another planet, in a rocket ship or even in a cartoon. Notice several details it's a safe place. While you play in that place Someone very special, very intelligent, someone who loves you very much is approaching you. It could be someone from your family, a friend, an animal or a cartoon, but it's someone very important. This person brings you a message and says in your ear, "You are very strong and brave. That day you managed to do that difficult task, you were always able to do it! It's normal to be afraid, we all are, sometimes we fail too, but that's okay. The important thing is to believe that you can do it. Now say goodbye to that person with a tight hug. Start moving your body slowly and when you want you can open your eyes" Drawing of a being that welcomes her.

Discussion/Conclusion/Reflection on work and learning

The strategies used in the intervention with MJ. showed excellent results, and I'll highlight the most important ones below: 1) MJ started sleeping on her own; 2) her descriptions of tachycardia, lack of appetite and feeling constantly tired visibly decreased; 3) MJ stopped having tutoring at home and started going to an ATL with other children from school (in one of the sessions MJ shared that she didn't want to go to an ATL, because there might be boys from school there and they would think she was "dumb"); 4) she started taking the bus to and from school; 5) she started eating lunch at school; 6) she stopped being around the girls she didn't like; 7) she goes to all the school's facilities; 8) she practically stopped calling her mother at break times; 9) she left the English extracurricular activity, which she went to "just because her mother wants her to"; and 10) her academic results improved.

MJ. was also referred to a child psychiatrist for a psychopharmacological intervention. The child psychiatrist corroborated the diagnosis of Social Anxiety Disorder, specific to performance with comorbidity in Attention Deficit Hyperactivity Disorder, of the predominantly inattentive type; however, no medication was prescribed, since the child psychiatrist considered that the attention deficit was partly due to the ruminative thoughts she had, which stemmed from the social anxiety disorder. With regard to the social anxiety disorder, he considered that the psychological monitoring plan should be maintained and if there was no progress, which there wasn't, he would move on to the pharmacological part. It should be noted that throughout the process, despite the mother repeatedly mentioning the difficulty she felt MJ had in mourning her grandfather, MJ. always approached the subject naturally. However, the mother was referred for psychotherapy in order to find strategies to cope better with this loss. Without a doubt, attending this specialization course was crucial to achieving such good results with MJ and in such a short space of time.[4–8]

Acknowledgments

None.

Conflicts of interest

The author declares there is no conflict of interest.

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