
CHAPTER 2

Social phobia in children: clinical considerations

TRACY L MORRIS, LAURIE A GRECO

Michael is a 9-year-old boy who dreads informal interactions with his peers. He experiences dizziness and a pounding heart prior to lunch time at school and fears he might say or do something embarrassing in front of the other children. To avoid appearing socially inept Michael pretends to be sick during his lunch period. Rather than eating and socializing with his peers, Michael spends the hour lying down in the nurse's office.

Amy is a 16 year old who admits to having been shy her entire life. As an infant and toddler, she clung to her mother and was slow to warm up in the presence of unfamiliar children and adults. During preschool, Amy frequently played alone while quietly watching her more sociable peers. This pattern of shyness and inhibition intensified throughout elementary and middle school, reaching debilitating levels when Amy entered high school. Amy currently is refusing to attend school because she cannot bear the thought of giving an oral presentation in her English class. Amy is terrified of making a mistake and humiliating herself in front of her classmates.

What is social phobia?

The cases above paint a picture of a relatively common and often long-lasting disorder affecting between 2% and 13% of the US population (lifetime prevalence estimates vary greatly due to methodological differences across studies). Social phobia, also known as social anxiety disorder (SAD) is defined in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as a 'marked and persistent fear of one or more social or performance situations in which the person is

exposed to unfamiliar people or to possibly scrutiny by others' (American Psychiatric Association (APA), 1994, p. 416). Social anxiety and 'fear of negative evaluation' have been regarded as hallmark features of social phobia. Individuals with this diagnosis fear they will say or do something embarrassing in the presence of others and as a result they avoid anxiety-inducing situations or endure them with extreme distress.

Children diagnosed with social phobia must demonstrate the capacity for age-appropriate social relationships (for example, with family members) and experience anxiety-related symptoms in the presence of other children (symptoms must extend beyond interactions with adults). The peak age of onset for social phobia is in adolescence, perhaps due to the heightened importance of peers during this time period.

Researchers and clinicians have identified behavioural, cognitive, and somatic symptoms characterizing childhood social phobia. Escape and avoidance behaviours, such as those demonstrated by Amy and Michael, are particularly salient. Responses such as 'freezing', clinging, and tantrums also may be observed, particularly when children are unable to avoid the feared situation. Maladaptive cognitions, such as self-deprecating beliefs or intense fear of negative evaluation, are common. Children and adolescents with social phobia, for example, may perceive themselves as socially inept and interpret even the most benign social events (such as birthday parties) as threatening. Finally, children and adolescents with social phobia often experience intense physiological responses, including heart palpitations, trembling, sweating and blushing. In Michael's case, anticipation of unstructured social encounters during lunchtime elicited bodily sensations such as a 'pounding heart' and dizziness.

Is social anxiety 'normal'?

Some level of social anxiety may be both universal and adaptive (for example, Menzies and Harris, 2001). Many of us, for example, can recall instances of heightened anxiety in social situations (such as first dates) and performance situations (such as public speaking) without ever meeting criteria for social phobia. Similarly, childhood shyness is a relatively common phenomenon that some children simply outgrow. How, then, do clinicians distinguish between normal and adaptive versus clinically relevant social anxiety?

Generally speaking, individuals must demonstrate impaired functioning and/or experience significant levels of distress to receive a diagnosis of social phobia. In the opening scenarios, Michael seeks refuge in the nurse's office to avoid unstructured peer interactions and Amy avoids giv-

ing a speech by refusing to attend school. Both cases reflect instances of functional impairment with the potential for severe consequences, including peer relationship difficulties and decreased academic functioning. Thus, both Michael and Amy appear to be potential candidates for receiving a diagnosis of social phobia.

Developmental course

The mean age of onset for social phobia typically has been reported as from early- to mid-adolescence (Turner and Beidel, 1989). However, most adults with social phobia will report having been extremely 'shy' most all of their lives. Retrospective investigations (Stemberger et al., 1995) indicate that the developmental pattern of social phobia often reflects an early onset and progressive generalization of social fear. It is quite common for adults to report long intervals (over 20 years on average) between the reported onset of social anxiety and initial attempts to seek treatment. Such findings suggest a high degree of stability for social phobia in the absence of intervention.

Comorbidity

Social phobia is a highly comorbid disorder. The most common comorbid conditions include other anxiety disorders (particularly generalized anxiety disorder) and depression. Children who meet criteria for multiple anxiety disorders often show earlier onset, longer chronicity, and higher intensity of their anxiety symptoms than those meeting criteria for a single anxiety disorder. When multiple forms of anxiety are present, the clinician should a longer course of treatment in which exposure is implemented across multiple contexts. The presence of depression also complicates the picture. When depressive symptoms are severe it is generally necessary to treat those as a primary target before implementing treatment for social anxiety. Pharmacological treatments often are useful adjuncts in such cases.

Social phobia as a risk factor

A number of negative and long-lasting conditions have been linked with childhood social phobia. There is evidence to suggest that early social anxiety may increase an individual's risk for certain conditions. For example, Stein, Tancer, Gelernter, Vittone and Uhde (1990) found that depression began after the onset of social phobia in the majority of cases. Children experiencing clinical levels of social anxiety also tend to have fewer close friendships and are less accepted by their peer group com-

pared with their sociable classmates. Restriction of social activities in an effort to avoid or reduce feelings of social anxiety impedes the development of interpersonal relationships (Schneier et al., 1992) and may adversely impact academic and occupational functioning (Turner et al., 1986). As social withdrawal increases and functioning becomes more impaired, depression becomes more likely.

Social anxiety also may increase risk for substance abuse. Page and Andrews (1996) reported a 27% rate of alcohol problems for adults with social phobia, representing risk ratios three (males) to five (females) times those of the ECA population estimates. Individuals who experience high levels of social anxiety may use alcohol in an attempt to lower inhibition and general physiological arousal. Social phobia has been found to precede alcohol abuse in the majority comorbid cases (Kushner, Sher and Beitman, 1990).

Further research is necessary to elucidate patterns of risk associated with social anxiety. However, at this point it seems clear that high levels of social anxiety do little to promote wellbeing and may seriously reduce an individual's quality of life. In light of such adverse consequences, the early identification and subsequent treatment of children and adolescents at risk for social phobia appears a worthy pursuit.

How does social phobia develop?

As with nearly every childhood disorder, social phobia presumably results from the complex interaction between environmental and biological influences. Due to the nature of this chapter, we provide only a cursory summary of general findings within both domains, placing relative emphasis on the potential role of family factors. For more thorough coverage of social phobia etiology, we refer the reader to Morris (2001) and Hudson and Rapee (2000).

Genetic and biological factors

There is considerable evidence supporting the role of genetic and temperamental factors in the origin of social phobia. Family studies, for example, suggest that social phobia is relatively more common among first-degree relatives, with monozygotic twins evincing the highest concordance rates. In short, it appears that a genetic predisposition towards anxiousness may put individuals at risk for anxiety disorders, including social phobia. Thus, when biologically vulnerable individuals encounter stressful environmental conditions, they are more prone to develop an anxiety disorder.

Behavioural inhibition is a biologically based temperament style characterized by fear of novel stimuli, such as unfamiliar people, objects, and events. Behaviourally inhibited children may be withdrawn and overly cautious in their interactions, putting them at increased risk of pervasive social difficulties. As illustrated in Amy's case, it is possible for behaviourally inhibited toddlers to become shy children. In the absence of intervention, these children may go on to develop debilitating levels of social and evaluative fears characteristic of social phobia. Indeed, temperament research points to a link between behavioural inhibition and social-evaluative concerns in both children and adults (Turner and Beidel, 1998).

Environmental influences

Behavioural theories have emphasized the potential role of conditioning, modelling and information transfer in the development of social phobia. The *conditioning* of fears can occur through direct or indirect (vicarious) exposure to a traumatic situation or event. *Modelling* involves 'learning by example,' such as when children imitate avoidance behaviour demonstrated by a socially anxious parent. Finally, *information transfer* refers to the verbal or nonverbal transmission of information regarding social situations. Parents, for example, may directly or indirectly communicate information regarding the 'dangerousness' of social situations (for example 'if you make a mistake when reading aloud, you will get a bad grade and children will laugh at you').

In general, direct and vicarious conditioning appear to trigger more circumscribed or situation-specific fears, such as anxiety experienced exclusively during oral presentations. Conversely, individuals experiencing more generalized and pervasive social anxiety often have a long history of shyness, with its chronicity and severity influenced by environmental factors. Due to the tremendous amount of learning that occurs in the home, we turn next to parental influences related to the development of social phobia.

Parental influence

It is crucial to assess the family environment when considering environmental factors that may be involved in the development or maintenance of social phobia. Three central avenues have been identified as playing an important role in the formation of social fears:

- children's restricted exposure to social situations;
- parental modelling of social and evaluative concerns; and
- parent child-rearing style (see Masia and Morris, 1998 for review).

Restricted exposure

Early on, children rely on parents for initiating and maintaining their social contacts. Parents who fail to set up 'play dates' and who do not make social arrangements restrict their child's exposure to important peer experiences. By doing so, parents may place their child at risk for later social difficulties, including social anxiety. Such parental restriction may be unintentional; however, some findings indicate that parents of socially anxious adults discouraged family sociability and sought to isolate them as they were growing up.

Modelling

In ambiguous and novel situations, children may use their parents' verbal and nonverbal behaviour as cues or guides for appropriate responding. Parents of socially anxious children tend to be overly concerned with the opinions of others and may experience their own social evaluative fears. Moreover, such parents may interpret social situations as threatening and demonstrate avoidance and reticent behaviour in the presence of their children. By modelling such behaviour, parents may be inadvertently encouraging their children's social fears. Children, for example, may imitate their parents' avoidance and distress-related behaviour when confronted with similar social situations. Conversely, parents who model positive behaviour during social discourse may encourage their children to behave accordingly.

Parenting style

Certain types of parenting styles may contribute the formation and intensification of social phobia and related difficulties. Some anxiety research has focused on the potential role of parental rejection and overprotection/control. Although definitions may vary, *rejection* refers to low affection and warmth, often co-occurring with parental negativity and/or indifference. Parental *overprotection* refers to over-controlling and intrusive behaviour, in which parents may exhibit excessive vigilance and prohibit age-appropriate levels of autonomy. A growing body of literature suggests that overprotective and rejecting parenting may put children at risk for current or future internalizing symptoms, including social anxiety and depression (see, for example., Dadds and Barrett, 1996; Greco and Morris, 2001). Our studies focusing on parent-child interactions, for example, suggest that both mothers and fathers of socially anxious children demonstrate controlling behaviour (such as physical takeovers) and rejecting behaviour (such as criticisms) during joint tasks (Greco and Morris, 2001; Spaulding and Morris, 1997).

In summary, the complex interaction between biological and environmental factors likely lead to the formation and maintenance of childhood social phobia. Due to the chapter aims, we focused primarily on environmental and parental influences. We would like to stress, however, that no single factor (such as parenting style) *causes* social phobia. It is more likely to be the case that multiple factors interact with one another, with certain factors ameliorating or exacerbating the effects of others. Much research is needed to help us gain a more thorough understanding of the various pathways to social phobia.

Assessment of social phobia

As with any disorder, a careful assessment includes the use of multiple methods (for example, self-report and behavioural observations). When working with children and families, it is important to solicit information from multiple sources, such as parents, teachers, and peers. We also recommend careful evaluation of children's cognitive, behavioural, and somatic responses in a variety of social contexts, such as home and school. Using a multi-method, multi-modal approach will allow for a thorough description of the presenting problem, which can be used to guide case conceptualization and treatment planning. Schniering, Hudson and Rapee (2000) provide a thorough review of diagnostic issues and assessment methods for childhood anxiety disorders. Below we emphasize measures developed (in whole or in part) to assess social social anxiety and social phobia.

Structured interview

The Anxiety Disorders Interview Schedule for DSM-IV Child Version (ADIS-C) (Silverman and Albano, 1996) is a semi-structured interview developed to assist with the differential diagnoses of DSM-IV anxiety disorders. Even though the ADIS-C focuses primarily on childhood anxiety disorders, interview questions are included to screen for affective and externalizing disorders as well. The child and parent(s) are interviewed separately and the resulting information combined to determine diagnostic status.

The ADIS-C includes items assessing children's cognitive, behavioural, and physiological responses across a range of potentially anxiety-provoking situations (for example, interacting with peers, being separate from a parent). To assess clinical significance, intensity ratings are obtained to indicate the extent to which particular fears interfere with daily functioning. The social phobia section on the ADIS-C asks the child

and parent(s) to provide fear, avoidance, and interference ratings across 13 social and performance situations. We would advise taking the time to administer the full interview prior to initiating treatment as it can be quite useful in differential diagnosis and in obtaining relevant targets for treatment planning.

Self-report measures

Self-report questionnaires are a common means of obtaining information on anxiety symptoms among children over 8 years of age. The two most widely used (and psychometrically sound) measures of social anxiety in children are the SPAI-C and the SASC-R.

Social Phobia and Anxiety Inventory for Children (SPAI-C)

The SPAI-C (Beidel, Turner and Morris, 1995, 1998) is an empirically derived self-report measure developed to assess the frequency and range of social fears experienced by children and adolescents (8–14 years) in multiple social settings, such as home and school. The SPAI-C consists of 26 items evaluating cognitions (for example, 'what if I make a mistake and look stupid'), behaviour (for example, avoiding social situations), and somatic responses (for example, 'feel sweaty', 'heartbeat fast') across a range of potentially fear-inducing situations (such as school plays or parties). The measure has demonstrated excellent internal consistency and high test-retest reliability across two-week and 10-month intervals.

Beidel, Turner, Hamlin and Morris (2000) provide data on the external and discriminative validity of the SPAI-C among 254 children aged eight to 14 years. Behavioural validation was examined through read-aloud and role-play tasks. Independent observers' ratings of the children's anxiety and effectiveness in the behavioural tasks and the children's ratings of their own distress were significantly associated with SPAI-C scores. More importantly, the measure successfully discriminated not only between children with social phobia and normal controls, but also between children with social phobia and children with other anxiety disorders. This is quite notable given that other anxiety assessment instruments generally have failed to differentiate among children of varying diagnostic groups.

Social Anxiety Scale for Children-Revised (SASC-R)

The SASC-R (La Greca and Stone, 1993) is a 22-item measure of social anxiety that focuses on both subjective experiences and behavioural consequences (such as avoidance or withdrawal) associated with social anxiety. The SASC-R is comprised of three factors: Fear of Negative Evaluation (FNE), and two subscales reflecting Social Avoidance and

Distress (SAD) with new or unfamiliar peers (SAD-New) and more generalized social avoidance and distress (SAD-G). Scores on the SASC-R and SASC-A (adolescent version) have been associated with peer relationship difficulties, such as peer rejection and neglect, and low self-esteem (for example, La Greca and Stone, 1993). The measure has been shown to have good reliability and validity.

Morris and Masia (1998) examined the association of the SPAI-C and the SASC-R among 277 grade-school children. A moderate association was found indicating that the two measures do not assess identical constructs. One consideration is that the SPAI-C was developed specifically to assess the construct of social phobia as defined in the DSM-IV whereas the

SASC-R was designed to assess the general construct of social anxiety.

Parent report

In most settings clinicians rely heavily on information provided by parents (and often to a lesser extent on information provided directly by the child) when conducting an assessment and formulating a treatment plan. However, parents should not be considered the gold standard for all information about their children. Information should be obtained from pertinent individuals present in situations in which the problem behaviours occur (for example, teachers provide valuable data on the child's academic performance and interactions with peers). It is common to find inconsistencies in information provided by the parents, children, and teachers – the bases for such discrepancies should be explored as they may provide important contextual information for treatment planning.

Behavioural observation

Behavioural observation is an important component of the assessment of anxiety. Ideally, the child will be observed in the natural setting in which the anxiety manifests. For example, in the case of social phobia, it may be particularly useful to observe the child during school recess periods. However, with consideration and preparation, clinicians may set up situations in and around their offices that provide the proper setting events in which the relevant behaviours may be displayed for example, reading aloud, delivering a speech).

Treatment of social phobia

Behavioural approaches to the treatment of childhood anxiety have garnered strong empirical support. A thorough review of behavioural

treatment strategies is beyond the scope of this chapter (see March, 1995 and Vasey and Dadds, 2001 for more complete coverage). Below, we present an overview of the most common strategies used to decrease anxiety and improve social functioning of anxious children. Comprehensive treatment of childhood anxiety generally involves the use of several of these treatment strategies within an organized framework.

Relaxation

Procedures to promote relaxation may involve training progressive tensing and relaxing of each of the major muscle groups, use of pleasant imagery, or a combination of both. When working with very young children the clinician must be mindful of cognitive limitations. It is generally most effective to present the relaxation skills in the form of a game – such as having the child pretend he were a turtle, stretching out his neck and limbs, and then pulling them back into the shell. Although relaxation training in itself is not considered sufficient for the treatment of social phobia, when practised regularly relaxation may be useful in lowering the child's overall level of arousal.

Exposure

Exposure-based approaches involve exposing the child to the feared situation(s) in a sufficient manner to allow for habituation and extinction of anxious responding. Such approaches systematic desensitization, graduated exposure, and flooding. The empirical literature suggests that exposure is a necessary component to the successful treatment of all anxiety disorders including social phobia.

Systematic desensitization

This approach involves training in relaxation and the development of a fear hierarchy. Once the children are able to learn to put themselves in a relaxed state, items from the fear hierarchy are presented (from least to most anxiety producing). These pairings may be presented through imagery or in live in the clinic or natural setting. With repeated pairings, the child is able to remain in the presence of successively more salient fear stimuli for progressively longer periods of time.

Graduated exposure

This approach is similar to systematic desensitization, however relaxation procedures are not implemented during the presentation of the feared stimuli. Most clinicians prefer to use a graduated exposure approach when working with children (rather than sustained flooding), working slowly

through a hierarchy, gradually exposing children to more challenging situations for increasing periods of time. No evidence is available to suggest that the inclusion of relaxation training (as in systematic desensitization) is a necessary component or even adds incrementally to the success of exposure in the treatment of social phobia. However, when working with an extremely fearful child the clinician may find that the process of relaxation training helps establish rapport and, as such, may foster more cooperation among children during subsequent exposure work.

Contingency management

Contingency management strategies are used one way or another in the treatment of most childhood disorders. This approach involves stipulation of consequences for performing target behaviours. Contracts are formulated that explicitly state what the child is to do in order to receive certain levels of reinforcement (and often a response cost for failure to meet a given goal). This generally requires training parents and/or teachers to administer consequences, although some adolescents may be able to self-contract. Contingency management is a useful adjunct to exposure-based strategies in that it facilitates completion of homework assignments specified in the treatment plan.

Social skills training

Many anxious children exhibit social skills deficits. This of course is particularly the case with social phobia. These children often avoid social situations in which they may miss out on opportunities to learn age-appropriate skills. Most social skills training (SST) programmes involve coaching, modelling, and social problem solving components. Typical skills trained include joining in activities with peers, establishing and maintaining conversations, developing friendships, and communicating assertiveness.

Multicomponent treatment programmes

Social effectiveness therapy for children

Beidel, Turner and Morris (2000) provide the first published study of a controlled trial of behavioural treatment for social phobia in preadolescent children. Fifty children (ages eight to 12) were randomized to social effectiveness therapy for children (SET-C) or an active treatment for improving test taking and study skills. Each programme lasted 12 weeks and the programmes were equivalent in terms of therapist-participant contact. Components of the SET-C programme included parent education, social skills training, peer generalization, and graduated *in vivo*

exposure. One group social skills training session and one individual graduated *in vivo* exposure session was held each week. Instruction, modelling, behaviour rehearsal, feedback, and social reinforcement were used to teach and reinforce appropriate social behaviour. Topic areas included nonverbal social skills, initiating and maintaining conversations, joining groups of children, friendship establishment and maintenance, positive assertion, and negative assertion. A unique and essential component of SET-C is the use of formalized peer interaction experiences to assist in the generalization of social skills to situations outside the clinic. 'Normal' child volunteers were recruited from the community to serve as peer facilitators in the peer generalization experiences (developmentally appropriate group recreational activities – for example, roller skating).

Following treatment, children receiving SET-C demonstrated statistically and clinically significant improvements across various domains (for example, decreased levels of social and general anxiety, increased social skill and performance ratings, and more adaptive functioning in daily situations). These improvements were maintained 6 months post-treatment. Notably, 67% of children who participated in the SET-C programme no longer met diagnostic criteria for social phobia after treatment compared to only 5% of those receiving the active control treatment.

Cognitive-behavioural group treatment for adolescents

Albano and Barlow (1996) developed a cognitive-behavioural group treatment for adolescents diagnosed with social phobia. Cognitive-behavioural group treatment for adolescents (CBGT-A) is a modified version of CBGT for adults (see Heimberg, Dodge, Hope, Kennedy and Zollo, 1990). More specifically, the adolescent version of CBGT is a 16-week programme that includes psychoeducation, exposure-based activities (for example, structured snack time, role-plays), and a variety of skill-building techniques (for example, SST, social problem solving, cognitive restructuring).

To date, two pilot studies have examined the short-term efficacy of CBGT-A (Albano, Marten, Holt, Heimberg and Barlow, 1995; Hayward et al., 2000). Albano et al. reported 3- and 12-month followup data for five adolescents; four were completely diagnosis free at both followup evaluations, and the fifth improved to the point of only expressing subclinical levels of social anxiety. In a subsequent investigation, Hayward and colleagues randomly assigned 35 female adolescents ($M = 15.8$ years) diagnosed with social phobia to a treatment ($n = 12$) or control ($n = 23$) group. Similar to findings reported by Albano et al., significantly fewer teens participating in CBGT-A met diagnostic criteria

for social phobia post-treatment. Notably, however, there were no diagnostic differences between the treated and untreated groups at 1-year follow-up, highlighting the need to investigate further the long-term efficacy of CBGT-A.

Inclusion of parents

Consideration of the family context is essential for effective assessment and treatment of social anxiety. Parents who experience high levels of anxiety are more likely to model strategies of avoidance in an effort to reduce discomfort and inadvertently may contribute to the development of anxiety in children by providing information that may promote heightened states of arousal and hypervigilance.

Dadds and his colleagues have conducted a series of studies demonstrating that parents of anxious children are more likely to model threat interpretations to ambiguous cues and to provide and reinforce avoidant solutions in response to hypothetical social scenarios than parents of aggressive or nonclinical control children (Barrett, Rapee, Dadds and Ryan, 1996; Dadds, Barrett and Rapee, 1996). Given the role of parents in potentially maintaining anxious behaviour, efforts toward incorporating parents in treatment are becoming more common.

Spence, Donovan, and Brechman-Toussaint (2000) investigated the effectiveness of an integrated cognitive-behavioural treatment (CBT) package with and without parental involvement for children and adolescents diagnosed with social phobia. Fifty children (aged seven to 14 years) were randomly assigned to CBT, CBT plus parent training, or a wait-list control condition. The CBT package included SST, relaxation training, positive self-instruction, cognitive challenge, and graded exposure. The programme included 12 weekly small group sessions and two booster sessions (3 months and 6 months post treatment). The parent involvement component was designed to help parents learn to model and reinforce the social skills taught in the CBT package; to ignore avoidance and socially anxious behaviour; to encourage child participation in social activities; and to reinforce homework completion. Parents observed the children's group sessions behind a one-way mirror and participated in a 30-minute weekly training session while their children were practising skills in another room. At a 12-month follow-up 81% of children in the CBT plus parental involvement group no longer met criteria for social phobia (in contrast to 53% of children in the CBT only group). Results of these studies provide preliminary data supporting the incorporation of parents in the treatment of childhood anxiety disorders.

Conclusions

Social phobia tends to be an early onset, chronic and comorbid disorder. Early identification and treatment may help to spare children from a lifetime of distress. The last decade has witnessed advances in our understanding of etiological factors as well as the development of psychometrically sound self-report measures, and empirically supported treatments. We strongly encourage clinicians to include parents in the treatment of children presenting social phobia. Exposure-based approaches appear to be crucial for successful remediation of social fears. Clinicians should give strong consideration to observing children in natural settings (for example, at school) and designing opportunities for exposure in the natural environment. The more elements of the natural environment that may be incorporated the greater likelihood of facilitating skill acquisitions, maintenance, and generalization.

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