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Incorporating Parents and Peers In the Assessment and Treatment Of Childhood Anxiety

Tracy L. Morris and Laurie A. Greco

Anxiety disorders are the most prevalent mental health concerns among children. Unfortunately, relatively few children meeting diagnostic criteria for anxiety disorders are identified and referred to appropriate treatment providers. This may be due to several factors such as limits in children's understanding of their own emotional states (e.g., difficulty recognizing and communicating that they are feeling anxious), the inability of parents and teachers to detect mild to moderate levels of anxiety in children, and the oft-expressed notion that children will "grow out of it." In this contribution we will provide a general orientation to childhood anxiety and then discuss two areas of innovation in the assessment and treatment of anxiety in children: the incorporation of parents and peers.

Symptoms of anxiety may be classified into three broad categories: physiological, overt behavioral, and cognitive. Physiological symptoms include increased heart rate and respiration, muscle tension, abdominal pain, and nausea. It is quite common for young children to report that they don't feel well or have a stomachache under anxiety-provoking conditions. Overt behavioral symptoms of anxiety are generally easily observed by others. Such behaviors may include attempts at avoiding or escaping the situation (e.g., refusing to go to school), compulsive rituals (e.g., excessive handwashing), or motoric behaviors (nail biting, trembling hands). However, it is important to note that adults may incorrectly interpret avoidance behaviors as being a sign of disobedient or disruptive behavior on the part of the child rather than being due to anxiety. Cognitive symptoms of anxiety include unrealistic and catastrophic thinking ("None of the kids will ever like me"), excessive self-focus, and biased perceptions. All people experience some symptoms of anxiety in certain situations. However, when anxiety interferes with the child's social relationships and/or academic performance, or results in serious subjective distress, comprehensive assessment and intervention is warranted.

We will not attempt to present or discuss specifics regarding diagnostic criteria, but rather, as a refresher, a cursory description of each of the anxiety disorders of childhood is provided below (the reader is referred to Rabian & Silverman, 2000, for a more thorough review).

Diagnosis

Separation Anxiety Disorder
Generalized Anxiety Disorder
Social Anxiety Disorder
Obsessive-Compulsive Disorder
Posttraumatic Stress Disorder
Panic Disorder
Specific Phobia

Hallmark Feature

Anxiety in response to separation from caregiver
Pervasive anxiety and worry across multiple contexts
Anxiety in social interaction and performance situations
Obsessive thoughts and compulsive rituals
Anxiety and avoidance subsequent to traumatic experience
Anxiety attacks marked by intense physiological symptoms
Intense anxiety response in the presence of specific stimuli
(e.g., animals, heights, enclosed places)

ASSESSMENT

Comprehensive assessment incorporates multiple methods across multiple informants and contexts. Typical assessment methods include diagnostic interviews (e.g., Anxiety Disorders Interview Schedule for DSM-IV Child Version; Albano & Silverman, 1996), parent-report (e.g., Child Behavior Checklist; Achenbach, 1991), self-report (see list below), and behavioral observation. Clinicians generally rely almost exclusively 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 the relevant individuals who have access to the situations in which the problem behaviors occur (e.g., teachers may provide a wealth of data on the child's performance in school and interactions with peers). It is not uncommon to find inconsistencies in information provided by the parents, teacher, and child, and the bases for such discrepancies should be explored. Mash and Dozois (1996) noted several reasons why multiple informants may present discrepant information: (a) bias or error on the part of one of the informants, (b) variability in child behavior across situations observed by the informants, (c) lack of access to specific behavior (i.e., thoughts, feelings), (d) denial of the problem, or (e) active distortion of information in service of some goal.

For children over 8 years of age, self-report questionnaires are a common means of obtaining information on anxiety symptoms. Several widely used self-report measures of child anxiety are listed below:

- Fear Survey Schedule for Children-Revised (Ollendick, 1983)
- Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1978)
- Multidimensional Anxiety Scale for Children (March, 1997)
- Social Phobia and Anxiety Inventory for Children (Beidel, Turner, & Morris, 1998)
- Social Anxiety Scale for Children-Revised (La Greca & Stone, 1993)
- Trauma Symptom Checklist for Children (Briere, 1996)

Behavioral 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. However, with consideration and preparation, clinicians may set up situations in and around their office that provide the proper setting events in which the relevant behaviors may be displayed.

TREATMENT

Behavioral approaches to the treatment of childhood anxiety have received strong empirical support. Below we have listed common treatment strategies used to decrease anxiety and improve social functioning of anxious children. A thorough review of these treatment strategies is beyond the scope of this contribution. The reader is referred to March (1995) and Vasey and Dadds (2001) for more complete presentations of the topic. It should be noted, however, that treatment of childhood anxiety generally involves the use of several of these behavioral treatment strategies within an organized framework:

- Relaxation Training
- Exposure-Based Procedures
- Contingency Management
- Social Skills Training

Relaxation training may involve training in 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 one must attend to cognitive limits. It generally is most effective to present the relaxation skills in the form of a game - such as having children pretend they are a turtle, stretching out their neck and limbs and then pulling them back into the shell. Although relaxation training in itself is not considered sufficient for the treatment of most anxiety disorders, when practiced regularly relaxation has the effect of lowering children's overall level of arousal, enabling them to cope more effectively when in anxiety-producing situations.

Exposure-based approaches involve exposing children to the feared situation(s) in a sufficient manner to allow for habituation and extinction of anxious responding. Such approaches include systematic desensitization, graduated exposure, and flooding. The research literature suggests that exposure is a necessary component to the successful treatment of anxiety disorders. Systematic desensitization involves relaxation training and the development of a fear hierarchy. Once 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 via imagery or *in vivo/in situ*. With repeated pairings, individuals are able to progress up the hierarchy, rapidly extinguishing the fear response. Systematic desensitization is commonly used in the treatment of specific phobia (e.g., animals, heights). Graduated exposure is similar to systematic desensitization, but relaxation procedures are not invoked during the presentation of the feared objects or situations. 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 increasingly longer periods of time.

Contingency management involves specification of consequences for performing target behaviors. Contracts are devised explicitly stating what children are to do in order to receive certain levels of reinforcement (and often a response cost for failure to meet a given goal). This typically involves 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.

Many anxious children exhibit social skills deficits. Children with extreme anxiety often avoid social situations in which they may miss out on opportunities to learn age-appropriate skills. Most social skills training (SST) programs involve coaching, modeling, and social problem-solving components. Typical skills trained include joining in activities with peers, establishing and maintaining conversations, developing friendships, and communicating assertiveness.

DEVELOPMENTAL ISSUES

A common clinical assumption is that intervention tends to be more effective when implemented earlier, as opposed to later, in the individual's life span. It is generally held that behavior patterns are less well established in young children and are thus more responsive to change. No doubt, certain approaches will be demonstrated to be more effective within specific age periods than will others. Too often, efforts toward intervention with children have reflected mere downward extensions of work with adults.

PARENTAL INVOLVEMENT

An evaluation of the family context is essential for effective assessment and treatment. Research indicates that children of parents with anxiety disorders are at risk for the develop-

ment of anxiety disorders (Turner, Beidel, & Costello, 1987; Weissman et al., 1984). At present it is unclear whether genetic or family environment variables exert primary influence, however the data suggest that both variables are in play. Parents who are themselves anxious are more likely to model strategies of avoidance in an effort to reduce discomfort. They may inadvertently contribute to the development of anxiety in children by providing information that may promote heightened states of arousal and hypervigilance. In a study of the offspring of parents with anxiety disorders, Turner and Beidel (cited in Beidel & Turner, 1998) used a "risk room" procedure in which children were given access to a laboratory room furnished with playground equipment. Parents with anxiety disorders were observed to make significantly more comments to their children regarding the potential danger of the situation than were nonclinical control parents (e.g., "Be careful"; "Don't climb so high").

An innovative series of studies provides evidence 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 are parents of aggressive or nonclinical control children (Barrett, Rapee, et al., 1996; Dadds et al., 1996).

Recognizing the impact of anxiety on the family system, and the potential for family members to inadvertently participate in the maintenance of an anxiety disorder, efforts toward incorporating parents in treatment are becoming more common. For example, Family Anxiety Management (FAM; Heard, Dadds, & Conrad, 1992) is based on behavioral family intervention strategies found effective for the treatment of externalizing disorders in youth (Dadds & Sanders, 1992). Following each individual child session, children and their parents participate in a FAM session. Parents are trained in reinforcement strategies, with emphasis on differential reinforcement and selective inattention of anxious behavior. Contingency management strategies are utilized to enhance communication and problem-solving skills within the family. The inclusion of FAM sessions has been reported to significantly improve treatment outcome when compared with individual child treatment alone (Barrett, Dadds, & Rapee, 1996).

Toren et al. (2000) examined the effectiveness of a brief parent-child group treatment for childhood anxiety disorders. Twenty-four children (10 girls and 14 boys) aged 6 to 13 years (mean 9.6) and their parents (27 mothers, 13 fathers) attended 10 sessions through a community mental health center in Tel Aviv, Israel. Group sessions were conducted by two therapists each and were 80 minutes in duration. Session content included such topics as relaxation techniques, automatic self-talk, cognitive pitfalls, avoidant strategies, graded exposure, coping skills, and problem-solving techniques. Although parents participated in the treatment, parental symptoms of anxiety were not directly addressed. Following treatment, significant reductions were demonstrated in self-reported anxiety, and 70% of the children no longer met criteria for any current anxiety disorder. A 36-month follow-up was conducted with 22 children, in which 91% were found to be diagnosis free.

Spence, Donovan, and Brechman-Toussaint (2000) examined the effectiveness of an integrated cognitive-behavioral therapy (CBT) package with and without parental involvement for children and adolescents diagnosed with social phobia. Fifty children (aged 7-14 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. Groups of 6 to 8 children participated in 12 weekly sessions and 2 booster sessions (3 months and 6 months posttreatment). The parent involvement component was developed to teach parents to model and reinforce the social skills being taught in the CBT package, to ignore avoidance and socially anxious behavior, 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 practicing skills in another room. At a 12-month follow-up, 81% of children in the CBT-plus-parental-involvement group no longer met crite-

ria 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.

PEER INVOLVEMENT

Children's peer relationships provide important contexts for social, emotional, and interpersonal growth, and children who experience interpersonal difficulties with their peers are at substantial risk for developing various forms of psychopathology, including anxiety disorders. It is important, therefore, for researchers and clinicians to identify children's prominent socialization agents (e.g., parents, siblings, peers, teachers) and to solicit their active participation throughout the course of therapy. Recent attempts have been made to incorporate children's peers in the assessment and treatment of childhood anxiety disorders.

Children and adolescents belong to their own subcultures or "societies," often creating and adhering to their own social rules and norms. Children's peers, therefore, may serve as effective coping models and may be more equipped to offer informed judgments regarding "social etiquette rules" and nuances operating within the larger peer group. Furthermore, although cognitive-behavioral therapies have been successful in enhancing children's social competencies, it is possible for the peer group to reject prosocial attempts made by clients due to the stability of peer labeling and social status. One suggestion for promoting socially valid and meaningful change (e.g., enhanced social integration and peer-group acceptance) is to include important social networks in the treatment process.

Group and Dyadic Peer Relationships

It is important for clinicians to understand and assess children's adjustment within different types or "levels" of social relationships. At the group level, a child's *peer status* denotes his or her social standing within the peer group at large, whereas *friendship* often is conceptualized as a dyadic relationship requiring mutual and voluntary selection between two specific individuals. Although peer status and friendship are related phenomena that appear critical to children's social and emotional well-being, empirical findings suggest that they do not overlap completely and may serve different developmental functions (e.g., Vandell & Hembree, 1994). Thus, it is recommended that clinicians assess children's functioning at both the group and dyadic levels and, based on the assessment results, select appropriate target behaviors and include important socialization agents within relevant social domains. Prior to soliciting information and support from nontargeted children, it is essential for clinicians to obtain child assent and parental consent.

Assessing Peer Group Relations

Peer Status

A child's peer status typically is identified using sociometric procedures in which level of group acceptance is determined via nomination or rating methods. One variant of sociometrics involves having children nominate up to three classmates he or she "likes the most" and three classmates he or she "likes the least." Children then are assigned to one of five sociometric groups (i.e., popular, rejected, neglected, controversial, average) with categorization based on two dimensions: how much a child is liked or disliked by peers (social preference score) and the child's social visibility (social impact or peer influence score). In general, the five categories derived from the nomination procedure can be conceptualized in the following manner (see Coie, Dodge, & Coppotelli, 1982, for a detailed description):

- *Popular children* are accepted and well liked by their peers and receive high social preference and social visibility scores. Popular children tend to be well adjusted compared to their rejected and neglected classmates.
- *Rejected children* often are disliked actively by their peer group and receive low social preference and high social visibility scores. Peer-rejected children appear to be at highest risk for concurrent and future adjustment difficulties and psychopathology, including delinquency, substance use, conduct problems, aggression, anxiety, and depression.
- *Neglected children* are neither liked most nor actively disliked by their peers. These children receive low social preference and social visibility scores and tend to “fade into the woodwork” or go unnoticed by their peers. Data regarding neglected children have been inconsistent; however, there is evidence suggesting that peer-neglected children may be at risk for experiencing significant internalizing difficulties, such as anxiety and depression.
- *Controversial children* are both liked and disliked by a larger number of their peers, receiving moderate social preference but high social visibility scores. Relative to their rejected and neglected classmates, controversial children do not appear to be at high risk for future maladjustment.
- *Average children* have “moderate” social preference and visibility scores and often do not differ significantly from their popular and controversial peers in terms of adjustment.

By collecting sociometric data, researchers and clinicians obtain valuable information regarding the social dynamics operating within the larger peer group. Additionally, such procedures can function effectively as screening tools that aid professionals in identifying children with interpersonal difficulties who are at risk for future psychopathology. When considering the relative merits of sociometric procedures, it is important to note that adverse effects on subsequent peer relations have not been found. Children, for example, have not reported hurt feelings or increased levels of loneliness following their participation in sociometric research (e.g., Bell-Dolan, Foster, & Sikora, 1989; A. M. Iverson, Barton, & G. L. Iverson, 1997).

Although a thorough review is beyond the scope of this contribution, other forms of peer-report methods can be used to evaluate children’s social acceptance or peer group status. Two examples include sociometric rating procedures and the Revised Class Play (Matsen, Morrison, & Pelligrini, 1985). Sociometric rating procedures involve asking children to rate their classmates on various dimensions of liking and acceptance using a Likert-type scale (e.g., “On a scale from 1 to 5, rate how much you like to play with Linda”). Finally, using the Revised Class Play (RCP), children are asked to assign their peers to various roles (usually positive and negative roles) in an imaginary play. Children might, for example, be asked to cast their classmates as characters who are too bossy, smart, athletic, or very shy. The RCP provides descriptive information and can be used in conjunction with, or as an alternative to, nomination and rating procedures.

Assessing Dyadic Friendships

When assessing the impact of friendship on children’s psychosocial and emotional development, it is important to consider three interrelated dimensions: (a) *having a friend* (e.g., whether or not children have a mutual, dyadic relationship), (b) *the identity of one’s friends* (e.g., important personal and social characteristics of children’s friends), and (c) *friendship quality* (e.g., levels of perceived closeness, social support, and conflict within a friendship). Common methods used to evaluate each of these dimensions are described briefly.

Having Friends

Simple nomination procedures can be used to determine whether or not children have at least one mutual friendship. Most friendship nomination procedures require children to list three to five of their closest friends. Children often are asked to name classmates or same-grade peers who attend their school to allow for the identification of *mutual* friendships (e.g., Johnny nominates Shane, and Shane nominates Johnny). Herein lies a primary distinction between peer status and friendship: children's social or peer status reflects unilateral liking and group acceptance, whereas reciprocity often is considered a quintessential feature of friendship.

Friend Identity

A second dimension of friendship assessment involves evaluating the personal and social characteristics of children's friends. This is an important dimension for clinicians to consider, particularly given the increasing role of social influence and peer pressure throughout childhood and adolescence. One way to ascertain pertinent characteristics of children's close friends is via clinical interviews with targeted clientele. Another method involves administering self-report questionnaires to children's mutual friends to obtain first-hand data regarding their behavior and personality characteristics.

Friendship Quality

Many relationship variables, including companionship, intimacy, conflict, and security, are reflective of friendship quality and can be assessed using questionnaires or interview procedures. Friendship quality most often is assessed using paper-and-pencil measures, such as the Friendship Quality Questionnaire (FQQ; Parker & Asher, 1993), the Network of Relationships Inventory (NRI; Furman & Buhrmester, 1985), or the Friendship Qualities Scale (FQS; Bukowski, Boivin, & Hoza, 1994). Such measures can be administered both to the client and, when possible, to the client's close friend(s). Additionally, qualitative aspects of a child's close friendships can be assessed via clinical interviews. The Friendship Interview (Berndt & Perry, 1986) is one example of a semistructured interview that provides descriptive information regarding the quantity and quality of children's close friendships. Finally, behavioral observations of children's interactions with friends can provide clinicians with valuable data regarding friendship quality, helping clinicians to formulate a treatment plan that includes training in relevant friendship-making and maintenance skills.

Romantic Relationships

The formation and maintenance of romantic relationships becomes increasingly important as children approach adolescence. Clinicians working with older children and adolescents, therefore, should consider evaluating their client's involvement and functioning with a romantic partner. This may be especially important when working with anxious clients, given that elevated levels of anxiety, particularly social anxiety, hinder the development of close, intimate bonds. Self-report questionnaires assessing involvement and perceived support in romantic relationships include the Social Support Scale for Children and Adolescents (HSSS-A; Harter, 1985) and the Behavioral Systems Questionnaire (BSQ; Furman & Wehner, 1994). Both measures focus more generally on perceived social support but have subscales reflecting adolescents' perceptions regarding romantic relationships.

Including Peers to Enhance Group Acceptance

Following a comprehensive evaluation, it is important to integrate assessment results and subsequently to select socially valid target behavior(s) and establish meaningful treatment goals. If an anxious client is exhibiting significant impairments in peer relationships (at the

group and/or dyadic levels), clinicians should consider integrating children's important peer networks into the treatment process. The association between long-term maladjustment (e.g., elevated anxiety) and negative peer experiences supports the need to target children's peer relationships in the treatment of anxiety disorders. Additionally, including peers in the treatment process is expected to facilitate the generalization and maintenance of treatment gains. Peer-mediated and peer-pairing interventions are empirically investigated approaches used to enhance children's peer status or *group* acceptance. Both types of interventions are described below.

Peer-Mediated Interventions

Although both peer pairing and peer mediation provide opportunities for clients to engage in joint-task activities with their nonanxious peers, there are differences between the two approaches. In peer-mediated or "peer-helper" interventions, anxious children's peers serve as behavior-change agents and are trained to initiate, model, and reinforce the desired behavior. More specifically, nonanxious peers can be trained to (a) initiate and maintain interactions with clients, (b) react appropriately to negative behavior, and (c) help structure dyadic play activities. Additional examples of training foci and inclusion of peers in treatment sessions are presented below.

<u>Focus of Training Sessions</u>	<u>Description/Examples</u>
Social skills	Peers are trained in the use of important social skills and are instructed to use skills when interacting with the targeted clientele; peers model appropriate use of skills, serve as role-play partners, and are instructed to initiate and maintain interactions with their anxious age-mates.
Problem solving	Clients and peers undergo problem-solving and communication training together; peers serve as partners with whom clients can role-play, engage in real-life discussions/disputes, and practice conflict resolution.
Assertiveness/coping	Peer helpers and clients undergo assertiveness training and learn effective coping skills; peer helpers receive additional training and learn to reinforce appropriate (e.g., approach) behavior and extinguish anxious responding (e.g., escape, avoidance). Peers serve as "confederates" by inciting conflict, forcing clients to apply skills to achieve resolution.

Peer-Pairing Interventions

Peer-pairing interventions involve strategically matching clients with well-liked and/or skilled peers and instructing them to engage in various activities together. For example, a socially anxious and withdrawn child might be paired with a popular, socially adept "buddy." This peer pair could be asked to sit together, play with one another during recess, and be assigned to work together on an upcoming classroom project. In general, peer-pairing techniques are less time-consuming than peer-mediated interventions because nonanxious peers do not undergo specialized training prior to or during participation in the program. Outcome data suggest that both types of interventions lead to improved sociometric status, increased rates of positive interactions, and decreased rates of solitary behavior (e.g., Morris, Messer, & Gross, 1995).

Including Peers to Enhance Friendship

Peer-mediated and peer-pairing interventions appear to be a logical extension of traditional child-focused therapies, with improvements in peer-group acceptance perhaps best illustrating their social validity and incremental utility. Although increased social acceptance has long been regarded as socially meaningful, outcome variables and criteria used to define treatment success often focus more on the *quantity*, rather than the *quality*, of children's peer relationships. In light of evidence supporting the buffering effect of close, supportive friendships, researchers and clinicians perhaps should place a stronger emphasis on enhancing the quality of children's mutual relationships. For instance, it may be beneficial to incorporate training in friendship-making skills and social contingencies related to the formation, deepening, and maintenance of close friendships.

Social Effectiveness Therapy for Children

Social Effectiveness Therapy for Children (SET-C; Beidel, Turner, & Morris, 2000) is a manualized behavioral intervention that incorporates both peer-generalization and friendship-making components. SET-C is a 12-week, multicomponent program developed specifically to treat children diagnosed with Social Anxiety Disorder (SAD). In sum, SET-C includes (a) a one-session educational component, (b) weekly individual exposure sessions (60 min.), (c) weekly SST group sessions (60 min.), and (d) peer-generalization activities (90 min.). The educational component involves providing children and their parents information about SAD and SET-C. Individual sessions involve *in vivo* exposure exercises constructed to address each child's unique pattern of social fears, and the SST sessions (conducted in small groups of 4-6 children) focus on conversational and friendship-making skills. Finally, to address a significant limitation of most treatment programs, peer generalization is conducted on a weekly basis and includes up to 90 minutes of unstructured group activities (e.g., pizza parties, bowling, skating). Similar to peer-pairing approaches, nonanxious "peer facilitators" are recruited to participate in the treatment on a voluntary basis and asked to initiate and maintain interactions with the other (socially anxious) children. Examples of friendship-relevant topics covered in SET-C are presented below:

<u>Sample Topics</u>	<u>Suggestions</u>
Meeting potential friends	Client generates list of places and activities that might facilitate meeting potential friends (e.g., school, churches, after-school activities, summer programs, organized athletic events, coffee houses)
Inviting others to join activities	Address importance of recognizing and responding appropriately to social cues (e.g., is the other person interested in a joint activity?); begin by suggesting a relatively small activity (e.g., roller blading rather than a camping trip); use open-ended invitations (e.g., maybe we should go roller blading <i>sometime</i>); role-play responding to positive, negative, and neutral reactions
Maintaining friendships	Discuss importance of fostering relationships; encourage clients to interact regularly with friends but to guard against being too domineering or possessive (e.g., importance of "sharing" friends)

SUMMARY AND RECOMMENDATIONS

We strongly encourage inclusion of parents and peers in the treatment process for children presenting with anxiety disorders. The more elements of the natural environment that may be incorporated the greater the likelihood of facilitating skill acquisitions, maintenance, and generalization. The inclusion of parents and peers in traditional child-focused interventions is timely given research documenting the relation between childhood anxiety, parent-child interaction, and negative peer experiences. If the clinician is able to step outside the usual bounds of outpatient therapy, the ability to improve children's lives is greatly enhanced.

CONTRIBUTORS

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