

CHAPTER 5

CLINICAL ASSESSMENT OF SOCIAL ANXIETY AND SOCIAL PHOBIA IN YOUTHS

The previous chapter covered the major research-based assessment techniques that have been used to evaluate youths with social anxiety and social phobia. In this chapter, general clinical assessment procedures for this population are discussed. The chapter is organized according to screening, formal evaluation, and consultation phases, and includes recommendations pertinent to each phase as well as important pre-treatment considerations. Ideas and a sample case are also presented for synthesizing assessment material to help determine treatment direction and techniques.

SCREENING

When initially screening a referral for potential social phobia, certain sets of questions may be considered to see whether a true problem exists and to help structure a possible formal evaluation. For example, *demographic information*, in particular the child's age, should be requested. Knowledge of age will help determine (1) whether the child's behavior problem is developmentally appropriate (e.g., a young preschooler versus an adolescent), (2) the child's general cognitive status and potential fit for cognitive therapy (e.g., limited versus advanced), and (3) function of the child's social anxiety. Regarding the latter, for example, many younger children display anxious behavior for negative reinforcement and attention, whereas many older children and adolescents display anxious behavior

for negative reinforcement and tangible rewards (e.g., being allowed to stay home and watch television). Information about gender may also be somewhat instructive, as girls tend to have more social anxiety than boys (see Chapter 2).

A second set of screening questions should obviously surround the *nature and form* of the anxiety-based behavior problem. In particular, brief questions may be asked about the problem's history, symptoms and associated problems, severity, and functional impairment. Knowing the history and duration of the problem may provide an early glimpse into how comprehensive treatment will need to be. For example, if the problem is very new, such as at the beginning of the school year, then treatment may not yet be necessary or may be brief as many initial social worries fade with habituation to new surroundings and peers. However, if the problem has persisted or lasted many weeks or longer, then more rigorous treatment is much more likely to be needed.

Knowing the breadth and severity of symptoms and associated problems may provide further information about the scope and urgency of treatment, particularly if a child's social anxiety is associated with severe depression, suicidal behavior, drug use, or school refusal behavior. Symptom-related questions may surround the physiological, cognitive, and behavioral response sets of social anxiety. In addition, asking these questions may help a clinician derive an early picture of whether social anxiety is the primary problem or one that is symptomatic of something larger such as depression or another disorder. For example, a child's anxiety about performing academically before others may be closely related to his or her learning disorder, such that alleviation of the learning disorder might naturally decrease the child's performance anxiety. Knowing whether social anxiety is the primary or a secondary problem will help a clinician better tailor his or her main assessment choices (e.g., measures of depression, achievement, drug use) during formal evaluation.

In related fashion, information should be obtained about what areas of the child's functioning are currently impaired. In many cases of childhood social phobia, school refusal behavior is a prominent issue that should be investigated at length. However, severe avoidance of different social and/or evaluative situations should certainly be probed as well. In essence, questions should be raised as to whether a child's social anxiety significantly interferes with his or her, or the family's, daily life functioning. Treatment is more warranted in cases where social or performance anxiety has led to extensive absenteeism or avoidance of key situations. However, therapy may be necessary as well for children who *do* attend social events or perform before others, but who do so with great dread and reduced quality of life.

In some screenings for social anxiety symptomatology, parents will focus more on a child's externalizing and disruptive behavior problems (e.g., noncompliance about school attendance, tests, and recitals) than on equally relevant internalizing behaviors. Clinicians should take care to cover *all* relevant behaviors and, if possible, contact others (e.g., teachers) who may have additional information. Furthermore, parents often seek treatment for their child's social anxiety following some crisis or otherwise difficult event, and may frantically portray the problem in the worst possible light. Clinicians in this situation may wish to model a calm approach, adopt a methodical questioning process, and convey that excessive social anxiety is a common difficulty that many children face and overcome.

A third important set of screening questions surrounds any *medical or familial variables* that may be affecting a child's social anxiety. For example, many youths with social anxiety have somatic complaints, and social anxiety with school refusal behavior is often associated with headaches, stomachaches, asthma, and gastrointestinal problems (see Chapter 2). In such cases, referral to a physician for medical assessment is recommended prior to formal evaluation. Neuropsychological testing may also be appropriate in some cases. In essence, clinicians should know whether a true organic basis exists for somatic complaints or whether significant attention-seeking and exaggeration may be occurring. In other cases, consultations with psychiatrists will be necessary to address possible pharmacotherapy and/or comorbid conditions such as severe depression or other anxiety disorders. Knowledge about recent family stressors and transitions (e.g., move to a new location) may also be instructive, as a child's social anxiety may spike during these times.

Formally evaluating a child's social anxiety is generally more warranted if the problem is developmentally inappropriate *and* has lasted at least several weeks, proliferated to many symptoms and associated problems, reached at least a moderate level of severity, or caused significant interference in a child's and/or family's daily life functioning. Scheduling the first session for formal evaluation will be more urgent for cases of social anxiety that also include pervasive avoidance, destructive behavior, or school absenteeism. In addition, formal evaluation of this population should focus on multiple methods, informants, and domains (March & Albano, 2002). Suggestions regarding the formal evaluation process for general clinical settings are discussed next.

FORMAL EVALUATION

Formally evaluating a youth with social anxiety/phobia would ideally include as many of the procedures discussed in Chapter 4 as possible.

Outside of research-based environments, however, this is often difficult to do. As such, suggestions are made here for tailoring research-based assessment procedures to general clinical settings. Of course, variations must be made depending on the dynamics and characteristics of a particular case.

INTERVIEW

A preferred method for assessing youths with social anxiety and social phobia is a structured interview with good psychometric strength, such as the Anxiety Disorders Interview Schedule for Children: DSM-IV: Child and Parent Versions (ADIS-C: DSM-IV: C/P) (Silverman & Albano, 1996) (see Chapter 4). Although highly comprehensive and useful, the ADIS-C: DSM-IV: C/P can take several hours to administer for complex cases. Even for less complex cases, administering just one interview version (child or parent) will usually take longer than a typical clinical session (March & Albano, 2002).

If time is limited and a particular case clearly involves social or performance anxiety, then a clinician may opt to administer only the ADIS-C: DSM-IV: C/P social phobia and other relevant sections. The social phobia sections have good reliability, though authors of psychometric studies of the ADIS-C: DSM-IV: C/P generally administered the entire measure. Still, using particular sections can provide important and quick information about child and parent perspectives of the problem, symptoms, ratings of fear, types of avoided situations, mediating factors, and degree of interference.

Although a structured interview is preferred, a general interview can still cover topics most pertinent to a case of childhood social phobia. In doing so, particular attention should be paid to developmental variables (Albano & Hayward, 2004; Morris, Hirshfeld-Becker, Henin, & Storch, 2004). Important interview topics thus include the following:

- relevant demographic characteristics and contact information
- symptomatology, including physiological, cognitive, and behavioral aspects of social and performance anxiety; this includes information for assigning a diagnosis of social phobia and ruling in or out closely associated problems such as generalized anxiety disorder and depression
- current effects of symptomatology on the child's and family's daily life functioning
- child's current life stressors and his or her ability and techniques for coping with these stressors in particular and with social and performance anxiety in general

- child's current status in various areas, including academic, social, intellectual, and mental functioning; this includes the child's level of performance and satisfaction in each area as well as detail about the child's interpersonal relationships, friendships, and social skills
- etiological factors such as family dynamics and applicable cognitive, social, traumatic, temperamental, and biological variables
- maintaining factors (e.g., negative reinforcement, attention-seeking, pursuit of tangible rewards) and antecedents and consequences pertinent to episodes of intense social and performance anxiety
- potential crisis issues such as extensive depression, destructive behavior, and school absenteeism
- history regarding the child's and/or family member's psychiatric/mental health diagnoses/treatment, development and delay of key milestones, transitions, academic performance, personality/temperament, and medical conditions
- child's current health status and medication usage
- family member perspectives of the child's social and performance anxiety
- family contextual issues such as marital status, finances, social support, and living situation, among others
- other contextual issues such as maltreatment, school violence/bullying, divorce, homelessness, unemployment, and distance from social events, among others
- relevant cultural variables, including differences in language, norms, problem-solving methods, and perspectives on social and performance anxiety
- reasons for seeking treatment at this time, informant variance, anticipated resistance or obstacles to treatment, and other important sources of information (e.g., peers, siblings, teachers, dating partners, grandparents and other relatives)
- relevant information for treatment, including practical issues (e.g., frequency of sessions) and family motivation, optimism, and expectations regarding treatment

CHILD SELF-REPORT QUESTIONNAIRES

As with interviews, information regarding child self-report measures has burgeoned tremendously in recent years (see Chapter 4). Given that many child anxiety researchers believe that youths are the best descriptors of their internal anxiety states, using self-report questionnaires for youths with social phobia seems indispensable. These measures are inexpensive and can be given quickly and without extensive technical expertise. The

self-report measures most pertinent to social anxiety/phobia and most empirically supported are the *Social Anxiety Scale for Children-Revised*, *Social Anxiety Scale for Adolescents*, and the *Social Phobia and Anxiety Inventory for Children* (SPAI-C). The use of at least one of these measures is strongly suggested during screening or formal evaluation, though each contains unique characteristics that may fit better with a particular case (see Chapter 4).

Other child self-report measures may also pertain to children with social anxiety or phobia, particularly those children with concurrent fear, depression, general anxiety, worry, or even externalizing behavior problems (see Chapter 4). Furthermore, cognitive assessment via questionnaires can be done to identify relevant self-statements, biases, self-consciousness, and self-focused attention that may be relevant to treatment.

PARENT AND TEACHER QUESTIONNAIRES

Parent-based questionnaires regarding a child's social and performance anxiety remain largely under development (see Chapter 4). However, using parent versions of the main child self-report measures for this population may be instructive and will, at a minimum, reveal any informant variance that may be important. Using measures to explore more general childhood behavior problems, such as the *Child Behavior Checklist* and *Teacher's Report Form* (Achenbach & Rescorla, 2001), are highly recommended as well. In addition, parent-based questionnaires that explore family functioning, such as the *Family Environment Scale* (Moos & Moos, 1986), are easy to administer and can provide important information about contributing family dynamics.

BEHAVIORAL OBSERVATIONS

Methods of observing youths with social and performance anxiety have been nicely designed in the literature, and include various role-play and problem-solving tasks as well as scenario and story presentations (see Chapter 4). Observed child behaviors are then usually coded along pre-determined categories. Although useful, these procedures are not always amenable to general clinical settings because of their time requirements and complexity. Still, certain behaviors can be closely observed in-session to identify baseline patterns of responding as well as possible treatment targets.

Behavioral observations of youths with social and performance anxiety can pragmatically consist of simple in-session role play and annotations about parent-child interactions and avoidance. Feasible in-session role plays, for example, include reading aloud or giving oral presentations before a small audience, test-taking (e.g., from sample tests sent from a

teacher), initiating and maintaining conversations with others, greeting and requesting help from others, and excusing oneself from a room. Of course, other social- and performance-based tasks may also apply to a particular case.

Brief naturalistic observations in community-based settings can also involve these tasks as well as others such as ordering food in a restaurant, interacting with peers at a large social gathering, and responding to spontaneous attention from others. In addition, a child may be asked to attend certain settings (e.g., classroom, cafeteria) when no one else is there. This helps confirm that the presence of others is indeed the main variable causing his or her avoidance (e.g., as opposed to noncompliance or specific phobia). Although formal coding of behavioral categories from all of these observations may not be feasible, obtaining regular anxiety ratings from a child before, during, and after each observation is highly recommended. In addition, thought-listing or think aloud procedures may be employed to assess a child's thoughts during the observations (see Chapter 4).

In-session parent-child interactions and child avoidance can also be observed. In particular, therapists should watch for instances of conflict, overprotectiveness, parental reinforcement of anxious or attention-seeking behavior, and other inappropriate parental responses (e.g., offering excessive tangible rewards for compliance). A common scenario, for example, is for a socially anxious child to refuse to speak with the therapist to try to force parental acquiescence (e.g., to leave the office) or some incentive for participation. Parental responses to child reluctance are quite instructive, and range the gamut from appropriate encouragement to hostility or vigorous defense of the child.

Other means of child avoidance should be monitored closely as well, including lack of eye contact, adherence to simple (e.g., yes/no) answers, pleas to end the interview prematurely, crying, defensiveness, and forms of resistance. Discrepancies between the child's verbal statements and his or her actions can be instructive as well, especially in cases where the child denies any social or performance anxiety. Observations of the child's general appearance, level of social skill, odd motor mannerisms, fidgeting or other overt signs of nervousness, posture, and physical proximity to parents may also be informative. If a child's social and performance anxiety is linked to school refusal behavior, then observations relevant to different functions are advised (see Kearney & Albano, 2000).

DAILY ASSESSMENT METHODS

Excellent ways of assessing anxiety and related variables that are highly amenable to most clinical settings are child and parent diaries or log-books. Although compliance can be problematic (see Chapter 4), recordings

from daily logbooks often improve an understanding of a child's episodes of social and performance anxiety, child and parent motivation in treatment, and informant variance among family members. A logbook could allow a child and parents to list episodes of the child's social and performance anxiety, antecedents and consequences to these episodes, coping strategies and cognitions pertinent to these episodes, anxiety and depression ratings (e.g., 0–10), and other behaviors or situations deemed important for treatment (e.g., child compliance to commands, progress on therapeutic homework assignments). Of course, simplified or more tailored logbooks can be administered as well depending on a child's cognitive status and particular needs.

In many cases, logbook compliance will have to be monitored regularly, and any problems addressed immediately. Educating family members about the importance of the logbooks, providing a rationale for their use, and training members to complete them are highly recommended. In cases where logbooks are not feasible, or where compliance remains highly problematic, then retrospective ratings and behavior descriptions for the past 2–3 days can be solicited during each treatment session or via telephone.

CONTACTING SCHOOL OFFICIALS

When assessing youths with social anxiety and social phobia, contact with various school officials is strongly suggested. School officials such as general and special education teachers, specialized (e.g., physical education) teachers, guidance counselors, deans and principals, school psychologists, nurses, librarians, and even bus drivers and other staff members are often rich sources of information about a child's avoidance, symptomatology, social status, and academic functioning. In addition, school records and other documentation, including daily report cards and weekly progress reports of behavior, can be quite valuable.

If a child with social phobia has even modest in-school avoidance and/or school refusal behavior, then information from school officials and records should be obtained about several pertinent variables. From school officials, important information may concern the child's social and performance and classroom behaviors/skills, peer status, others' attitudes toward the child, and previous school-based attempts to remediate the child's behavior (e.g., incentives, punishments). From school officials or records and documentation, important information may also concern attendance, school policy regarding absenteeism, course schedules, lay-out of the school, alternative school programs, missed assignments and tests, required make-up work, performance expectations and assigned

homework/external projects, past behavior problems, standardized test scores, and rating scale information.

The willingness of school officials to participate in various school-based adjustments and treatment plans (e.g., 504 plan, class schedule changes, gradual re-exposure to social/performance situations and classes) should be gauged and developed as well. Ongoing conflict between parents and school officials, or potential school-based obstacles to treatment, should also be explored and addressed as necessary. In many cases of childhood social phobia, a close working relationship between the therapist, parents, and school officials is crucial for successful treatment. As therapy progresses, consultation with school officials should continue in order to sustain rapport, eliminate new obstacles to treatment, obtain feedback about the effectiveness of the treatment plan, and ensure that parents are notified quickly of any problems. A rapprochement of parents and school officials should also be pursued as necessary to help prevent future relapse.

SYNTHESIZING ASSESSMENT INFORMATION

In cases of childhood social anxiety/phobia, clinicians should solicit information from various methods and informants about as many child and family behaviors as possible. In doing so, care should be taken with respect to issues of social desirability, informant variance, gender, and important developmental factors (see previous chapters) (Sweeney & Rapee, 2001). Synthesizing assessment information can be challenging, but a good strategy is to begin with interview and questionnaire information to develop initial hypotheses about the scope and nature of a child's presenting problems. Some of the most crucial hypotheses or questions that the clinician should bear in mind during this process include the following:

- Is the child's social phobia specific to certain situations or stimuli or more generalized in nature?
- What response sets, physiological, cognitive, and/or behavioral, are most problematic in this particular case?
- Does the child have primary social phobia or is the condition secondary to other mental disorders or behavior problems? If the child's social phobia is primary, does he or she have comorbid conditions that need to be addressed?
- Is the child's social phobia primarily anxiety-based or do concurrent social skills deficits also need to be addressed?
- Is the child's social phobia also associated with specific functions of behavior such as excessive attention-seeking or pursuit of tangible rewards from others?

- What external factors may be influencing the child's social phobia and are they relatively circumscribed or broad in scope?

As answers to these questions become clearer following interviews and questionnaires, behavioral observations may be done to confirm one's initial hypotheses. In cases involving significant informant variance, however, behavioral observations will be needed to help develop these hypotheses in the first place. Daily logbook information will also be helpful in this regard. A good conceptualization of the child's social phobia must precede treatment so that an appropriate strategy may be chosen. For example, a child with specific social phobia and substantial social skills deficits may require a more child-based behavioral approach, whereas another child with generalized social phobia, school refusal behavior, and associated functional elements may require an intense cognitive-behavioral approach that involves the child, parents, and school officials.

A clinician's hypotheses about a child's social anxiety may change during the course of treatment as new data become available and as the child's behavior is modified. Therefore, aspects of the formal evaluation process should never completely end, even during treatment. Furthermore, initial and ongoing consultation with family members about the clinician's hypotheses is critical, and this process is described next.

CONSULTATION

The consultation session generally involves summarizing extant assessment findings, providing treatment rationales, addressing pre-treatment considerations, and covering procedures regarding sessions and treatments. These areas are discussed next.

SUMMARIZING EXTANT ASSESSMENT FINDINGS

Summarizing extant assessment findings may be done by evaluating patterns of responses across individuals and across measures. A clinician may wish to concentrate on recurring themes that most people agreed on during formal assessment, such as pervasive avoidance, anxiety, physiological symptoms, and reduced quality of life. However, discrepancies across information sources are instructive as well and could be used as fodder for further investigation and education. For example, a child may report excessive anxiety and little avoidance, whereas a mother may complain of her child's excessive avoidance but not anxiety. A discussion of such discrepancies may help inform certain family members about the true nature of the child's problem, especially if such a discussion can be facilitated by third-party input (e.g., teachers, clinician).

Assessment findings regarding diagnoses, severe symptoms and behavior problems, function of social anxiety, and interference in daily life functioning should be emphasized. In addition, priorities should be assigned to the problems at hand, with higher priority given to severe anxiety and avoidance, depression, destructive behavior, and school absenteeism. During the summary process, which may be done separately with children and parents, feedback and questions should be solicited in case someone wishes to dispute the findings. In some cases, further assessment or a better synthesis of information is needed. In other cases, a family member will need evidence that their viewpoint is less than accurate.

During the consultation process, care should be taken not to assign blame to any one individual for the child's social anxiety problem, especially the child *per se*. In related fashion, because etiology in these cases is usually unclear, an extended discussion of causal factors with family members is rarely helpful. Instead, clinicians may wish to focus on the multifaceted nature of the child's symptoms and the various factors that can impinge upon them. For example, one could generally cover issues of temperament, cognitive bias, reinforced avoidance, family dynamics, problematic peer interactions, and other variables within the context of a manifold explanation of the child's social phobia. Of course, conspicuous etiological variables (e.g., traumatic events, excessive shyness) in a particular case should be discussed, especially if they are clearly and highly relevant to treatment. In general, though, emphasizing a collective responsibility for a child's social phobia will be consistent with the cooperative parent-child-school approach necessary for treatment.

PROVIDING A TREATMENT RATIONALE

Following a summary and discussion of assessment results, a treatment rationale may be given and tailored to the cognitive developmental status of the child. A treatment rationale may be given first in a general way and then more specifically. More generally, children and parents can be reminded of the difficulties they presently face and the child's current preferred method of coping with severe social anxiety (i.e., avoidance). One should point out that avoidance is a passable way of reducing anxiety in the short run but, in the long run, only leads to more problems (e.g., distress when around peers, loss of friends, panic when asked to perform, school absenteeism). Particular examples of the child's physiological and cognitive symptoms may be provided in this regard.

Following this preamble, the clinician may convey that he or she wishes to help the child learn a different way of coping with social and performance anxiety. In essence, new skills will be taught to help the child control negative feelings, change upsetting thoughts, and cope with

difficult situations in ways he or she has not done before. An important idea that should be stated at this point is that the child and parents must be prepared to work hard and give substantial effort for treatment to succeed. In essence, the therapist must convey that he or she will be a guide or teacher but that the “heavy lifting” aspects of therapy will have to be done by the child and parents.

A more specific treatment rationale may then be given. This surrounds the idea that treatment will generally involve remediation of the major physiological, cognitive, and behavioral aspects of social phobia via different techniques. For example, the child and parents can be informed that unpleasant physical symptoms will be addressed via somatic control exercises, self-reinforcement, and practice. In addition, aversive thoughts may be addressed via cognitive restructuring and other exercises as well as development of effective social skills and self-confidence. Furthermore, behavioral avoidance may be addressed by gradual exposure to anxiety-provoking social and performance situations and practice in real-life situations. Other, more overarching treatment procedures can be discussed as well, including psychoeducation, contingency management, reduction of family conflict and other obstacles, and treatment of comorbid conditions, among relevant others. During this process, clinicians should solicit questions from family members about suggested treatment procedures and obtain information about potential problems.

PRETREATMENT CONSIDERATIONS

Various factors can derail even the best laid plans for treating youths with social phobia. Significant impediments include extremely high levels of anxiety and avoidance, poor child or parent motivation, treatment non-compliance and willingness to sabotage treatment, refusal to speak to the therapist, inflexible personality traits, intense comorbid conditions such as depression, severe health or academic problems, rigid parenting strategies, lack of financial and other familial resources, highly dysfunctional family dynamics and communication/problem-solving skills, excessive parental psychopathology, marital conflict, poor cognitive developmental status, highly discrepant therapist-client cultural variables, poor cooperation from school officials, legal obligations (e.g., family court dates, school expulsions), and events that naturally exacerbate a child’s social or performance concerns (e.g., bullying or other forms of true victimization).

If any of these factors exist to a substantial degree, then treatment will have to be adjusted or the impediments will have to be addressed almost immediately. In many cases, these impediments will slow or stop treatment progress, mandate a broader treatment strategy, alter treatment goals (e.g.,

part-time, not full-time school attendance), or require a referral to another mental health professional. In addition, these cases will usually require extensive consultation with other professionals such as school officials, psychiatrists and pediatricians, social workers, legal case workers, and other mental health specialists.

GENERAL TREATMENT CONSIDERATIONS

The consultation session can also be used to lay the ground rules for future therapy. This includes scheduling future sessions, placing limits on a therapist's time, and reiterating the amount of work that will be needed between sessions. The average length of treatment from research-based protocols is often 8–16 sessions or weeks, and this can be given to family members as a general timeline. However, many cases take more time to resolve, and this should be conveyed as well. In addition, sessions may be held twice per week but should be held at least once per week to assess progress and maintain an even course of therapy. If substantial school refusal behavior is evident, then sessions should be held in late afternoon or evening so the child does not miss school for therapy appointments. Contingency plans for missed sessions should also be developed.

Many cases of childhood social phobia, especially those involving a mixture of behavior problems, can be quite intense in nature. Therefore, clinicians should advise clients of any limits on their time with respect to answering telephone calls, attending school-based or other meetings, extending specific session lengths, and conducting treatment procedures (e.g., exposures) outside of the office. These limitations will not preclude a clinician from conducting therapy with this population, but may slow treatment progress if all relevant techniques cannot be covered or if all exigencies cannot be addressed immediately. Finally, the consultation session should end with a reminder that a significant amount of work will be required of parents and children for treatment to be successful. This includes maintaining daily logbooks, practicing treatment techniques and new skills between sessions, and contacting school officials and other relevant persons as necessary. Reconveying this point throughout treatment is also recommended.

SAMPLE CASE: SCREENING, FORMAL EVALUATION, AND CONSULTATION

Alisha was a 12-year-old multiracial female referred for treatment by her parents and school guidance counselor. During the screening phase,

Alisha's mother (Mrs. A.) told the therapist that her daughter was struggling to maintain attendance at her new middle school. Although she did go to school, each day was marked by dawdling and reluctance, crying, shaking, and statements from Alisha that she did not like school and felt lonely there. Mrs. A. reported that Alisha did not appear to have other behavior problems except occasional bouts of sadness and lack of motivation to be with peers. Furthermore, Alisha was described as a typically shy child who always stayed close to two friends during elementary school. Upon entry to middle school, however, Alisha's contact with these friends had diminished greatly as she had a different class schedule and isolated herself more from social activities.

When asked about Alisha's current level of functioning, Mrs. A. said that her daughter rarely wished to attend social gatherings and usually stayed close to family members. She said further that Alisha's grades were very good and that her daughter enjoyed solitary activities like doing homework and watching television. Mrs. A. also reported the recent onset of physical symptoms in Alisha, including headaches and stomachaches, although no medical cause had been found. Both Mrs. A. and the school guidance counselor were concerned about Alisha's mood and the fact that she was becoming increasingly isolated from peers.

During formal evaluation, the therapist utilized sections of the ADIS-C: DSM-IV: C/P pertinent to social anxiety, social interaction, and depression. In addition, Alisha completed questionnaires regarding social anxiety (Social Anxiety Scale for Children-Revised), depression (Children's Depression Inventory), and general behavior problems (Youth Self-Report). Mr. and Mrs. A. completed the Child Behavior Checklist, and all parties completed relevant versions of the School Refusal Assessment Scale-Revised.

Information from these measures revealed that Alisha had a high level of social anxiety, particularly with respect to new social situations at school. In essence, she had great trepidation about new experiences with peers, although she tended to be less anxious once she knew a person better. Unfortunately, her avoidance of most social situations maintained her anxiety and precluded the development of more friendships. In addition, she had subclinical depression that was determined to be secondary to her social anxiety. Brief behavioral observations with different clinic personnel confirmed Alisha's anxiety and difficulty when meeting new people and her gradual ease once more social interactions were completed (e.g., with the therapist). Logbook information also revealed that Alisha's social anxiety was intense during school mornings but less so in the afternoons as she habituated to her surroundings.

Consultation with Alisha and her parents was designed to summarize assessment results, outline a potential treatment plan and its rationale, and assess potential obstacles. The therapist recommended an intense behavioral treatment program of role play and practice in new social situations, gradual enrollment in more extracurricular activities, class schedule adjustments so Alisha could spend lunch with her two close friends, and somatic control exercises to help Alisha manage her physical anxiety symptoms. All parties agreed that the treatment plan would be implemented by attending one formal treatment session per week, receiving one call from the therapist between sessions per week, and daily practice of skills learned in therapy. Logbook information during treatment revealed that Alisha's level of social anxiety in new situations and depression eased considerably over the next several weeks, and that her willingness to attend school and more diverse social activities did improve.