

ABSTRACT

Title of Dissertation: BASIC PSYCHOMETRIC PROPERTIES OF THE
CHILD SOCIAL FUNCTIONING INVENTORY (CSFI)

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To date, interventions for childhood social phobia have examined outcome primarily in terms of symptomatic reduction or efficacy. Although more emphasis is being placed on reporting clinically relevant outcome, few studies have provided a systematic assessment of treatment effectiveness, perhaps due to a lack of an appropriate assessment inventory. The current study presents the initial psychometric characteristics of the Child Social Functioning Inventory (CSFI), a self-report inventory designed to assess social functioning of preadolescent children. The CSFI contains 24 items with a 6-factor structure. The results indicate that the CSFI has good internal consistency and adequate test-retest reliability. In addition, assessment of the construct validity, including concurrent, convergent, and discriminant validity suggest that the CSFI is a valid inventory of social functioning for children ages 10 or above. Implications for assessment and treatment outcome are discussed.

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FUNCTIONING INVENTORY (CSFI)

by

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A. SPECIFIC AIMS

1. To determine the feasibility of assessing children's social functioning with the use of a simple self-report measure of social activities
2. To establish the reliability, including internal consistency and test-retest reliability of the Child Social Functioning Inventory (CSFI)
3. To establish construct validity (concurrent, convergent and discriminant) of the CSFI

B. BACKGROUND

1. Introduction

Although ADHD and disruptive behavioral disorders are the most common referral source for child mental health, anxiety disorders are the most common psychiatric disorders affecting children and adolescents (Albano, Chorpita, & Barlow, 1996; Albano, Detweiler, & Logsdon-Conradson, 1999; Schneier, 1997). If left untreated, children with anxiety disorders usually suffer from pervasive and enduring functional impairment across several domains. School avoidance, decreased interpersonal relationships with peers, and social withdrawal are fundamental problems often associated with childhood anxiety disorders (Beidel & Morris, 1995; Francis & Radka, 1995; Velting & Albano, 2001). However, fearful reactions in children are quite common and usually considered a part of normal development. Therefore, when attempting to study childhood anxiety disorders, questions regarding the developmental appropriateness of fears are raised. A challenging distinction for researchers and clinicians alike is to differentiate anxiety

disorders from “normal” childhood fears. At what point are childhood fears considered pathological?

This question has received increased attention in the last few years (Albano, DiBartolo, Heimberg, & Barlow, 1995; Francis & Radka, 1995; King, Murphy & Heyne, 1997) and recent studies have greatly increased knowledge about fears in subclinically anxious and normal children (Gullone, 2000; Muris, Merckelbach, Mayor, & Prins, 2000). Specifically, “normal” children and adolescents report a large number of fears. However, these fears tend to be transient and cause little to no disruption in daily functioning (Gullone, 2000). For example, in a study of 290 children ages 8-13 years, only 22.8% reported fears of a pathological level (Muris et al., 2000). In addition, the pattern of fear changes with age. Overall fears decrease in prevalence and intensity as age increases, and the content of fears change from immediate and concrete (e.g., fear of small animals and loud noises) in young children to anticipatory and abstract (e.g., fear of criticism and failure) in adolescence (Gullone, 2000). Despite this increased knowledge of developmental phases, there remains limited consensus with respect to distinguishing normal developmental fears from anxiety disorders (Albano et al., 1995; Kashdan & Herbert, 2001; Rapee, 1995).

Social phobia, for instance, is one of the most debilitating childhood anxiety disorders, but research regarding this disorder has remained rather sparse partly due to its developmental complexities (Albano et al., 1996; Beidel, Turner, & Morris, 1999; King et al., 1997), including the belief that social fears (i.e., shyness) are common among children. Thus, one explanation for the lack of attention in this area is that social fear is

“normal” (Beidel & Morris, 1995; King et al., 1997). Other reasons include minimal knowledge of what composes normal anxiety reactions (Albano et al., 1996), and beliefs that these children are merely shy and will outgrow their fears (Beidel & Morris, 1995; Kashdan & Herbert, 2001; Rapee, 1995).

Following the publication of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV, American Psychological Association, 1994) there has been increased interest in the study of childhood social phobia. A number of recent studies have provided information about its clinical presentation (Beidel & Morris, 1995; Beidel et al., 1999; Francis & Radka, 1995; King et al., 1997; Spence, Donovan, & Brechman-Toussaint, 1999) and elucidation of its psychopathology has led to the development of psychosocial interventions. Further research has focused on testing the efficacy of these treatments (Albano et al., 1999; Beidel, Turner, & Morris, 2000; Francis & Ollendick, 1990). Specifically, several studies have reported improvements on self-report measures for socially phobic children from pretreatment to posttreatment (Albano et al., 1995; Beidel et al., 2000); a measure of treatment efficacy. However, unlike studies on adults, which have reported treatment outcome effects with the use of an index of improvement (Jacobson & Truax, 1991; Turner, Beidel, Long, Turner, & Townsley, 1993; Turner, Beidel, & Wolff, 1994), basic questions about the clinical utility or effectiveness (as opposed to efficacy) of these interventions remain. In other words, how do we know that children with social phobia are truly getting better? What does statistical improvement from pre-treatment to post-treatment on symptomatic measures tell us about children’s overall improvement in social functioning? In order to determine

answers to these questions, measures and measurement strategies other than symptom assessment are necessary.

2. Clinical Picture

Social phobia is defined as “a marked and persistent fear of one or more situations (the social phobic situations) in which the person is exposed to possible scrutiny by others and fears that he or she may act in a way that will be humiliating or embarrassing (American Psychiatric Association, 1994, p.416). However, children and adolescents may fail to recognize this fear as unreasonable. Diagnostic criteria denote that anxiety exhibited by children must be present in peer settings, not just in interactions with adults. If fear causes interference with functioning or creates significant distress for at least six months, a diagnosis of social phobia is made. Also, children with social phobia must show the capacity for social relationships with familiar people. This distinction is necessary in order to differentiate them from children with pervasive developmental disorders. See Table 1 for full diagnostic criteria.

Children with social phobia have more severe trait anxiety, less confidence in their cognitive abilities, and strong tendencies towards rigid temperamental styles (Beidel, 1991). These children also report significantly more loneliness, fearfulness, and depression on self-report measures than normal controls. In more recent studies, socially phobic children had significantly higher levels of depression, more severe fears of criticism and failure, and higher distress ratings during socially oriented behavioral tasks than children without a disorder (Beidel & Morris, 1995). Youth suffering from social anxiety also report having less supportive friendships and a lower degree of acceptance by their peers than youth without social anxiety (Velting & Albano, 2001).

Socially phobic children usually exhibit significant anxiety when placed in situations where they might have to interact with others (Beidel & Morris, 1995; Spence, et al., 1999), particularly when persons are unfamiliar (American Psychiatric Association, 1994). Some children express their anxiety outwardly by stuttering, biting their nails, mumbling, or engaging in poor eye contact (Albano, et al., 1995). Other children experience somatic symptoms such as headaches, stomachaches, heart palpitations, blushing, or nausea (Beidel & Turner, 1998). Younger children may simply manifest their anxiety through crying, temper tantrums, or shrinking from social situations all together (American Psychiatric Association, 1994). This anxiety transcends age, as it can be seen with both unfamiliar adult and peer interactions. In most cases, distress is so severe that children may seek to withdraw from or avoid interaction with strangers. In examining daily reports of socially phobic children, over 25% reported avoiding distressing events by hiding their eyes, refusing to follow directions, or playing sick (Beidel, et al., 1999). Because of these acts of avoidance, these children are typically described by parents and teachers as unassertive or withdrawn and by their peers as shy (Francis & Radka, 1995).

A defining feature of social phobia is that fear and anxiety exist across many settings. For example, daily diary data of socially anxious youth revealed that these children experienced distress when speaking formally in front of a group (88%), eating in front of others (39%), going to parties (28%), writing in front of others (27%), using public restrooms (24%), speaking to authority figures (21%), and speaking informally with others (13%). Generally, these distressful events occurred approximately every other day and at a significantly higher frequency than their occurrence among normal

peers (Beidel & Morris, 1995). As a result of experiencing such widespread anxiety, socially anxious youth typically have few friends, significantly fewer social skills, and participate in fewer extracurricular activities than children with no psychiatric disorder (Beidel et al., 1999). In addition, the severe anxiety experienced by these children often interferes with peer status (Bierman & McCauley, 1987; Carlson, Lahey, & Neeper, 1984), the ability to make and maintain friendships (Inderbitzen, Walters, & Bukowski, 1997), and school performance (Albano et al., 1995; King, et al., 1997). Essentially, the fear and anxiety across multiple settings can cause significant impairment in socio-emotional growth (Albano et al., 1995).

3. Epidemiology

Currently, most social phobia prevalence data are based on adult samples. According to the National Comorbidity Survey (NCS: Kessler et al., 1994) social phobia is the third most common psychiatric disorder following depression and alcohol dependence (Juster & Heimberg, 1995). The survey was conducted with over 8,000 US citizens in which the 12-month prevalence rate and lifetime prevalence rate for social phobia were reported as 7.9% and 13.3%, respectively.

Very little information thus far exists with respect to the prevalence of social phobia in children and adolescents. Among the minimal epidemiological data, prevalence rates between 1% and 2% have been reported. A longitudinal study in New Zealand found a 1.0% prevalence rate for childhood social phobia (Anderson, Williams, McGee, & Silva, 1987). Two cross sectional epidemiological studies (Kashani & Orvaschel, 1990; Kashani, Orvaschel, Rosenberg, & Reid, 1989) reported a prevalence

rate of 1.1% for social phobia in children. One percent of general pediatric patients (Costello, 1989) and 1.1% of 8 - 12 years and 17 year olds (Kashani & Orvaschel, 1990) were documented with social phobia. However, because these studies were conducted prior to the DSM-IV, current prevalence rates may be higher based on the new diagnostic criteria. For example, one study (Kendall & Warman, 1996) reported DSM-IV rates of diagnosed social phobia with children ages 9-12 to be approximately equal to DSM-III-R rates of social phobia and avoidant disorder combined. Specifically, based on parent and child diagnostic interviews, 17 of 40 children (43%) were diagnosed with avoidant disorder or social phobia using DSM-III-R criteria, and 16 of these same 40 children (40%) were diagnosed with social phobia using DSM-IV criteria (Kendall & Warman, 1996).

The mean age of onset for social phobia is around the mid to late teens (Juster & Heimberg, 1995; Rapee, 1995). Schneier, Johnson, Hornig, Liebowitz, and Weissman (1992) reported the average age of onset at 15.5 years, using data from 4 of the NIMH Epidemiological Catchment area sites. Interestingly, those data were positively skewed and bimodal with one peak at 5 years and the other at 13 years. These findings suggest that the median age of onset is a better estimate (Rapee, 1995). Adult retrospective data also place the average age of onset for social phobia around midadolescence (Beidel et al., 1995). However, several studies have reported younger-aged children with social phobia. Strauss and Last (1993) placed onset at 12.3 years. Beidel and Turner (1988) found children as young as 8 years with social phobia. These findings suggest that the onset of social phobia may occur at any time throughout childhood and adolescence.

4. Functional impairment

When anxiety in social settings is unremitting, it can have a significant effect on adjustment and development, thus leading to a diagnosis of social phobia. In addition to performance situations, socially phobic children tend to fear and sometimes avoid situations where they might have to interact with others, particularly with unfamiliar people (Beidel & Morris, 1995; Spence et al., 1999). For many of these children, fear and anxiety are persistent across many situations and cause significant impairment in social emotional growth, including problems with establishing friendships and academic performance (Albano et al., 1995).

An important developmental milestone for children is academic achievement. However, socially phobic children sometimes refuse to go to school as a means of escaping anxiety (Albano et al., 1995) and, as a result, school avoidance is one of the greatest potential threats to socially anxious children's development of normal social functioning (Francis & Radka, 1995). To further complicate the situation, youth with social anxiety are often overlooked or neglected in the classroom and at home. In the classroom, socially anxious children tend to remain quiet and invisible, so as not to draw attention to themselves. Their teachers and parents generally perceive them as "shy" and do not realize that they could be suffering from an anxiety disorder (Kashdan & Herbert, 2001). It is usually not until the children's anxiety is so severe that avoidance prevails and school refusal behavior is exhibited that school personnel and parents take notice. In addition there is a relationship between school refusal behavior and social anxiety as one study (Last & Strauss, 1990) conducted with 63 school-refusing children, reported that 30% of the sample presented with social phobia. Children who do not attend school miss

achieving vital developmental milestones (e.g., the acquisition of social skills, exposure to social interactions and extracurricular activities and establishment of peer groups). Therefore, socially anxious children's overall social emotional development may be greatly impaired by school avoidance.

Perhaps because of their limited socialization, children with social phobia have been noted to develop unusual interests for their age. For instance, Albano et al. (1995) observed that most social phobic children pursue solitary hobbies such as chess and video games and atypical interests such as stamp and coin collecting. These activities may be the result of children's inadequate exposure to mainstream stimuli and minimal social reinforcement from their peers (Helper, 1990). Thus, because socially phobic children avoid social interaction, they are more likely than their peers to develop a pervasive disruption of overall social functioning and therefore, engage in a limited range of normal activities (Francis, 1990).

Peer neglect experienced by children has been shown to account for several problems associated with childhood social phobia. Restricted peer interaction leads to impairment in the development of interpersonal relationships and sociometric status; thus resulting in heightened anxiety and possible ineffective interaction in social situations (Bierman & McCauley, 1987; Carlson et al., 1984; Foster, Inderbitzen, & Nangle, 1993). Furthermore, children who are neglected by their peers endorse more social anxiety than normal controls (Beidel & Morris, 1995; Inderbitzen, et al., 1997) and children with anxiety disorders are more likely to experience peer neglect than children with other psychiatric disorders or normal controls (Inderbitzen et al., 1997; LaGreca & Lopez, 1998).

Social skill deficits, which are characteristic of social anxiety and social phobia, also often are associated with the experience of peer isolation (Bierman & McCauley, 1987; Carlson et al., 1984; Foster et al., 1993; Spence et al., 1999). Rapee (1995) asserts that the onset of social phobia is most likely to occur during the period where children are presented with the importance of peer approval. Specifically, it has been argued that self-consciousness and concerns about negative evaluation from others develop in children around the time that they become more aware of themselves as social objects (Buss, 1980). Usually, this time occurs when increased importance is placed on belonging to a peer group and “fitting in” (Foster et al., 1993; Velting & Albano, 2001). However, it should be noted that this explanation alone cannot account for the development of social phobia, as the diagnosis present in children as young as age 8 (Beidel & Turner, 1988).

In addition, social phobia has been hypothesized to emerge from normal anxiety that is inflated by social pressures faced in early adolescence (Velting & Albano, 2001). Specifically, children at this age are regularly faced with social evaluative tasks such as answering questions in class, working in groups, and participating in music and athletic performances (Beidel et al., 1995). Furthermore, during preadolescence the onus of arranging social activities is no longer on the parent, but rather on the child him/herself, thus adding the role of initiating social activity to the list of social evaluative tasks (Velting & Albano, 2001). However it is during preadolescence that youth begin to show more individualized preferences for types of social activities and in many cases will form groups of friendships around the activities in which they participate most frequently (Foster et al., 1993). For the adolescent with social anxiety who experiences great distress in social activities or avoids them all together, there is limited exposure to the normal

development of forming these friendship groups, thus exacerbating the differences in social functioning between youth with and without social anxiety (Ferrell, Beidel, & Turner, 2002). Specifically, because of their pervasive social fears, socially anxious youth are unable to achieve this developmental milestone and professional intervention often is necessary.

5. Treatment Options

Currently, only four treatment protocols exist designed specifically to address childhood social phobia. Cognitive-Behavioral Group Treatment Program for Adolescents (CBGT-A; Albano, Marten, & Holt, 1991), Social Skills Training (SST; Spence, Donovan, & Brechman-Toussaint, 2000), Social Effectiveness Therapy for Children (SET-C; Beidel, Turner, & Morris, 2000), and Skills for Academic and Social Success (SASS; Masia, Klein, Storch, & Corda, 2001) are the only treatments with empirical evidence of efficacy with children and/or adolescents with social phobia.

Results of CBGT-A (Albano et al., 1991; Hayward et al., 2000), SET-C (Beidel et al., 2000), SST (Spence, et al., 2000), and SASS (Masia et a., 2001) in the treatment of childhood social phobia have been positive. CBGT-A (Albano et al., 1991) consists of two 8-week components: 1) cognitive restructuring and social skills training and 2) behavioral exposure. Five adolescents (ages 13-16) diagnosed with social phobia generalized type were examined at 3-month posttreatment and 1-year follow-up. Efficacy of CBGT-A was determined through examination of symptomatology across self-reports and ratings of severity by independent diagnosticians. According to independent rater evaluations at 3-month follow-up, 4 of the 5 adolescents, remitted to

subclinical levels. At 1-year follow up, all but one adolescent was free from any disorder and the remaining subject had achieved subclinical levels of anxiety. On self-report measures, decrease in social anxiety symptoms was reported. The mean number of negative self-focused thoughts also decreased suggesting that subject's perceptions of physiologically arousing situations changed from anxious and inward thoughts to nonanxious and nonthreatening (Albano et al., 1995). More recently, Hayward et al. (2000) compared 12 socially phobic adolescent females in a CBGTA group to a waitlist control group of 23 socially phobic female adolescents. At posttreatment, 45% of the girls in the CBGTA group no longer met diagnostic criteria for social phobia, in comparison to only 5% of girls in the waitlist control group. However, at 1-year follow-up the group differences were no longer present with respect to severity of the disorder or absence of the disorder.

SET-C (Beidel et al., 2000) is a 12-week intervention for children ages 8 to 12 years that consists of social skills training, behavioral exposure, and peer generalization activities. Treatment outcome was assessed with self-report instruments of anxiety symptomatology, behavioral observation of social skill and performance, and independent clinician ratings of diagnostic severity. Results of this controlled trial (Beidel, et al., 2000) with socially phobic children ($N=67$) indicate significant improvement following behavioral treatment. Specifically, improvement in social phobic fear, general anxiety and distress, social skill performance, and functioning in daily social encounters was statistically significant. Clinical significance of these results was reported with respect to pretreatment – posttreatment change on the SPAIC and

independent evaluation ratings of overall functioning. Six-month follow-up suggests maintenance of treatment gains.

SST (Spence, et al., 2000) consists of 12-week group sessions and 2 booster sessions at 3 and 6 month posttreatment for children ages 7 to 14. The group sessions are centered on social skills training, cognitive restructuring, and relaxation training. The original treatment protocol included parent training, but outcome data suggested no differences between children in conditions with and without parental involvement (Spence, 2000). Efficacy of SST was determined with the use of self-report measurement of symptoms, direct observation of social competence and skill, and independent rater evaluation of diagnostic severity. SST yielded significant decreases in symptomatology and increased social skill and social competence for children in the treatment condition ($N=19$) versus those in waitlist control ($N=14$).

SASS (Masia et al., 2001) consists of 14 weekly group sessions for adolescents that take place within a school setting. The SASS was designed to incorporate social skill training and exposure sessions modeled after SET-C; cognitive restructuring and relapse prevention skills modeled after Rapee's book *Overcoming Shyness and Social Phobia*; and overall pragmatic group construction modeled after CBGT-A. Six adolescents (ages 14-17 years) diagnosed with social phobia were assigned to SASS condition in a pilot study; therefore no control condition was used. Efficacy of the SASS intervention was assessed with the use of self-report inventories and independent evaluator ratings of severity. At postintervention, 50% of the adolescents no longer met diagnostic criteria and all six had significantly decreased clinician rated severity scores.

6. Defining Efficacy and Effectiveness

Throughout the treatment outcome literature there is a lack of standardization regarding operational definitions of efficacy and effectiveness. For example, the terms clinical utility, clinical significance, clinical relevance, treatment efficacy, and treatment effectiveness are often used interchangeably to describe the effects of treatment (Foster & Mash, 1999). However, each term has its own unique definition. Therefore, before further discussing the assessment of treatment outcome, it is important to delineate the differences among these terms.

For the purpose of this paper, only two terms, treatment efficacy and treatment effectiveness will be discussed. A treatment is deemed efficacious if marked changes in decreased symptomatology are reported. Specifically, efficacy is defined as symptomatic reduction associated with the treatment (Kendall, 1999; Seligman, 1995). The majority of outcome studies refer solely to a treatment's efficacy. In contrast, effectiveness refers to the treatment's ability to show improvement in an individual's overall functioning (Mintz, Drake, & Crits-Christoph, 1996). More specifically, treatment effectiveness is defined as the impact of treatment on marked symptomatic improvement in relation to differences in their daily functioning (Jacobson, Roberts, Berns, & McGlinchey, 1999; Kendall, 1999). While these two terms may seem rather dissimilar, it is important to note that treatment effectiveness hinges on the measurement of treatment efficacy.

When measuring treatment effectiveness, the efficacy of the treatment should be examined as well. Drawing the conclusion that a treatment is effective would be questionable without reporting changes in symptomatology (efficacy). As stated by Jacobson and Christensen (1996, p. 1031), the purpose of the effectiveness study is to

“...establish the generalizability, feasibility, and cost-effectiveness of a treatment, given the establishment of efficacy.” Therefore treatment effectiveness is best defined as the treatment’s ability to show efficacy as well as improvement in daily functioning (Bobes, 1998).

7. Current Trends in the Assessment of Treatment Outcome

The gold standard of treatment outcome research has been the assessment and identification of efficacious interventions (Norquist, 2002). Generally, the clinical trial has served as the traditional assessment tool of a treatment’s efficacy because it provides a systematic method of observing change from pretreatment to posttreatment (Eddy, Dishion, & Stoolmiller, 1998). Due to its precise and tightly controlled nature, researchers have a certain degree of confidence that differences between two treatment groups are not due to chance, but rather the effect of the treatment (Jacobson & Truax, 1991).

The majority of treatment outcome research has defined “change” as the difference between pre and posttreatment ratings of patient symptomatology (Eddy et al., 1998). As defined previously, this is a measure of treatment efficacy that fails to capture other important facets of change such as differences in daily functioning and quality of life (Weisz & Hawley, 1998). Reliance on symptomatic reduction from pretreatment to posttreatment as the best indicator of treatment outcome is perilous. A treatment may demonstrate efficacy in a clinical trial, but have minimal or no effect on the patient’s level of functioning (Lonigan, Elbert, & Johnson, 1998). Essentially, symptom reduction does not equate change in functioning. Therefore, researchers have begun to report

clinically relevant data (e.g., absence of diagnosis at posttreatment, degree of difference between patients and a normative sample) alongside the report of efficacy data.

While solely reporting symptomatic reduction is no longer the cornerstone of treatment outcome research, it should be noted that an important contribution of efficacy research has been the development of empirically validated measures designed to assess symptoms relevant to the specific disorder under treatment (c.f., Social Phobia and Anxiety Inventory for Children, SPAI-C; Beidel et al., 1995 and the Social Anxiety Scale for Children-Revised, SASC-R; La Greca & Stone, 1993; The Liebowitz Social Anxiety Scale for Children and Adolescents, LASAS-CA; Masia-Warner et al., 2003). The area of effectiveness research; however, pales in comparison, as currently there are only a few empirically derived measures of effectiveness and these are primarily designed for adult samples (e.g., The Social Phobia Endstate Functioning Index, SPEFI; Turner et al., 1989; The Index of Social Phobia Improvement, ISPI; Turner, Beidel, Dancu, & Stanley, 1994). Therefore, there is a necessity for the development of standardized instruments designed specifically to assess treatment effectiveness.

With a demand from managed care for treatments that work and an emphasis within the field to develop a systematic means of assessing treatment efficacy (Task Force on the Promotion and Dissemination of Psychological Procedures, Division of Clinical Psychology, American Psychological Association, 1995), there has been a shift in the data provided within the treatment outcome literature. Currently, treatment outcome studies have moved beyond reporting simple pre-posttreatment symptomatic differences, to including at least some data on clinically relevant change. In addition, NIMH has supported this strive towards expanding the frontier of treatment outcome

research by publicly recognizing that while traditional randomized controlled clinical trials are important, they are just the beginning of the treatment outcome assessment process. New focus on effectiveness research, which involves not only establishing efficacy but also providing evidence of cost effectiveness, feasibility of transfer of services, and impact on patients' quality of life is now a necessity (Norquist et al., 2002).

Specific to child outcome studies, most have continued to focus on the amelioration of symptoms and diagnostic features, rather than emphasizing how treatment may have affected children's daily functioning in areas such as school, peer relationships, and home life (Weisz & Hawley, 1998; Kazdin & Kendall, 1998). Kazdin and Kendall (1998) suggested that childhood researchers should look to assess several different outcome variables when discussing treatment outcome including the following criteria below.

Criteria to Evaluate Treatment Outcome

1. Child Functioning
 - a. Symptoms
 - b. Impairment
 - c. Prosocial Competence
 - d. Academic functioning
 - e. Peer relationships/social functioning
 2. Parent and Family Functioning
 - a. Dysfunction (e.g., symptoms)
 - b. Contextual influences (e.g., stress, quality of life)
 - c. Conditions that promote adaptation (e.g., family support, quantity and quality time)
 3. Social Impact Measures
 - a. Consequences on systems (e.g., school activities, attendance, truancy)
 - b. Service use (e.g., reduction in special services or needed services)
 - c. Monetary costs and gains (e.g., on or off social assistance, costs for services)
-

In summary, the importance of accounting for statistical change in patients' behavior or symptomatology following treatment remains; however, it should no longer be considered the only outcome criterion. Although efficacy data provide valuable

information about symptom reduction, they lack the ability to address questions that form the basis of effectiveness research (Howard, Moras, Brill, Martinovich, & Lutz, 1996). For example, how do we measure if a person is truly better? How do we know that our treatments have an impact in a setting outside of the laboratory (e.g. home, school, work)? As suggested by Kazdin and Kendall (1998), there is a need for broader criteria for the evaluation of treatment outcome. By including more domains such as the patient's level of functioning to the outcome assessment evaluation, perhaps some of these questions can be addressed.

8. Assessment of social functioning

As stated above, one way to address the assessment of treatment effectiveness is to examine more outcome variables rather than just symptomatic change, including child functioning and social impact measures. For the purpose of this study, children's normal social functioning is defined as the characteristic behaviors and activities in which non-socially anxious children participate. However, few data currently exist that examine and quantify social behaviors of preadolescent children. Several studies have reported on the social behavior of children. However these studies focus on social skills (Foster et al., 1993; Matson, Rotatori, & Helsel, 1983), peer interaction (Bierman, & McCauley, 1987; Carlson, Lahey, & Neeper, 1983; Helper, 1990) or social competence (Cavell & Kelly, 1992; Spence et al., 2002) rather than on actual social activities.

To date, only 2 studies (Rosenthal, Muram, Arheart, & Bryant, 1994; Henker, Whalen, Jamner, & Delfino, 2002) have examined type of activity as a measure of social functioning and both used a teenage sample. Specifically, the Leisure Interests Checklist for Teenagers (LIC-T; Rosenthal et al., 1994) was generated for use within the clinical

setting to aid in the assessment and treatment of atypical teenagers. Two thousand and three teenagers rated 74 items on a Likert scale according to amount of interest for the activity. Six factors (feminine, masculine, social, education, amusements, and belonging) were delineated. Group mean differences between males and females indicated a significant gender effect on feminine, social, education, amusement, and belonging factors. For further discussion of these factors see Rosenthal et al. (1994). In a second part of the study (Rosenthal et al., 1994) scores of pregnant teenage females were compared to normal control adolescents. Significant differences were found on social interest with normal control adolescents producing higher scores. Preliminary use of the LIC-T suggests that the scale can be used to determine differences between normal and atypical teenagers. However, authors noted that due to sampling complications, no normative data were collected for such a comparison.

Henker et al., (2002) measured anxiety levels, affect, and activity among a community sample of adolescents with the use of an electronic diary. The 150 youth were given personal data assistants (PDAs) to record their activity and mood throughout the day for two 4 consecutive day periods. The PDAs were preset to remind participants to record their entries every 30 minutes during waking hours. Group comparisons (high anxious vs. low anxious) were made with the use of scores from the Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978). Results indicated that teenagers with higher anxiety levels were less likely to spend time in entertaining activities with peers and more likely to spend time in achievement-oriented activities. In addition, these highly anxious adolescents were 20% more likely to be alone than with friends.

In sum, these studies suggest that examining type of activity, as a measure of social functioning is feasible. Furthermore, the data suggest that these assessment strategies have some validity inasmuch as they appear capable of differentiating between disordered and normal control groups. Thus, they appear to be a sensitive measure of clinical states and therefore may have some validity for a treatment outcome study. However, currently there is no scale to determine normal social functioning among preadolescents.

C. PRELIMINARY STUDIES

Currently, only two studies (Spence et al., 2002; Ferrell et al., 2002) within the childhood literature have addressed the assessment of treatment effectiveness for childhood anxiety disorders with the development of standardized inventories. The Child and Adolescent Social Adaptive Functioning Scale (CASAFS, Spence et al., 2002) was designed to measure children's social functioning as defined by the degree to which they fulfilled various roles in their life. Specifically, the 24-item self-report was given to 1,478 adolescents ages 12-14 years from Catholic high schools in Australia. The inventory contains four subscales, which assess children's functioning and adaptation in school performance, peer relationships, family relationships, and home duties/self-care. The CASAFS was found to be a reliable and valid measure of functioning and adaptation of adolescents within the community (see assessment measures section for specific psychometrics). In addition, the CASAFS was found to be easy and quick to administer, with no problems reported with respect to adolescents' comprehension and completion of the measure. The CASAFS however, has not been used for assessment or treatment

outcome with a clinical sample, therefore the utility of using this as an effectiveness measure is unknown at this time.

A second measure of childhood treatment effectiveness is the Child Social Functioning Inventory (CSFI; Ferrell et al., 2002), which was designed to assess children's social functioning with respect to frequency of participation in social activities. Specifically, 153 children between the ages of 8-12 years from elementary schools in Fairfax County, Virginia and 355 members of the American Psychological Association (APA) who specialize in the assessment and treatment of children participated in a study to derive the items for the inventory. Specifically, the clinicians identified items for the inventory from a predetermined list of activities that they perceived to be relevant to children's social functioning. The children completed a 14-day daily diary in which they endorsed participation in the social activities from the same list presented to the clinicians. Through an item reduction strategy (see Ferrell et al., 2002 for details), the items on which agreement was found between clinicians and children were chosen for the final inventory. The 28 items of the CSFI reflect participation in group activities, performance-related activities, prosocial classroom behavior, and engaging in peer social outings. Differences in activity level between children with high and low anxiety were reported. In addition, the CSFI format was found to be useful and appropriate in the assessment of social activities for children ages 10-12 years. However, there appeared to be problems with respect to accurate reporting and comprehension of the items with the 8-9 year olds. For example, children in this age range tended to check off the item "maintained a conversation" but would not check off "participated in a conversation" as well. This pattern was not observed among the older children.

Following the scale's construction, the CSFI was changed to a Likert scale format to facilitate ease of reporting. This change in format was in part due to concerns regarding the accuracy of daily monitoring. For example, it was unclear whether children truly completed their diaries everyday or at the end of the week. In addition, switching to a rating scale format would allow for more flexibility over the period of assessment. For example, children's social functioning could be assessed over a longer period of time than would be feasible with a daily diary (e.g. 2 month time frame rather than a 2 week time frame). Specifically, it would be difficult to examine children's social functioning using daily frequency counts over a 2-month period. Given these potential problems, the CSFI was adapted to support a rating scale format. However, no studies to date have been conducted with this format. Therefore, validation and replication studies are needed to address the inventory's psychometric properties.

D. PURPOSE / RATIONALE

Currently, there is no standard measure of treatment effectiveness for childhood social phobia. Many outcome studies allude to variables deemed representative of clinically relevant changes; however, these assertions are usually based on non-empirically validated measures. Therefore, there is a need for the development of reliable treatment effectiveness measures to assess psychotherapeutic outcome. The current study addresses this need by establishing the basic psychometric properties (reliability and construct validity) of the Child Social Functioning Inventory (CSFI; Ferrell et al., 2002), an empirically derived, normatively based inventory designed to measure treatment effectiveness in childhood social phobia.

E. METHOD

1. Participants

One hundred and forty-seven children between the ages of 8-12 years participated in the study. Given a prior study (Ferrell et al., 2002) that elucidated developmental differences with respect to social functioning, children were divided into 2 groups, an 8-9 year old group ($N=39$) and a 10-12 year old group ($N=108$) for the purpose of data analysis. In the overall sample, 57% of the children were White, 25% African American, 8% Latino, 5% Middle Eastern, 2% Asian, and 3% other (refer to table 2 for demographic characteristics by age group). All children were enrolled in regular classrooms and were of normal intelligence.

2. Assessment Measures

Child Reports:

The Child Social Functioning Inventory (CSFI). The CSFI (Ferrell et al., 2002) is a 28-item, empirically derived self-report inventory designed to assess children's level of social functioning as it pertains to their involvement in social activities with their peers. Using a 4-point Likert Scale of 0-*Not at all* to 3-*Daily*, Children endorse how often they participated in certain social activities over the course of a 2-month period. A total score will be derived in which higher scores are indicative of better social participation. The CSFI was used to assess children's level of participation in social activities. As described previously, a developmental analysis during the initial construction of the CSFI yielded a subscale of 6 items for children ages 8-9 years. Specifically, the first 6 items of the CSFI

are considered relevant for the evaluation of social functioning in younger children.

Possible total score range for the CSFI is 0 – 84 for the 10-12 year old group and 0 – 18 for the 8-9 year old group. A copy of the CSFI is contained in Appendix A.

The Social Phobia and Anxiety Inventory for Children (SPAI-C). The SPAI-C (Beidel et al, 1995) is a 26-item empirically derived self-report instrument that measures potentially fearful social situations. Physiological, cognitive, and behavioral aspects of social phobia are also assessed with the use of a 3-point Likert scale. The SPAI-C has high internal consistency ($\alpha = 0.95$) and good test-retest reliability ($r = .86$). The SPAI-C significantly correlates with the Child Behavior Checklist (CBCL) Internalizing scale, $r = .45, p < .001$. A cutoff score of 18 or higher successfully differentiates non-socially anxious children from socially anxious children with an overall classification accuracy of 83% (sensitivity = .80) (Beidel et al., 1996). The SPAI-C was used to classify children either as socially anxious (SA) or non-socially anxious (NSA) for the purpose of determining discriminate validity of the CSFI. Refer to Appendix B for a copy of the SPAI-C.

The Child and Adolescent Social and Adaptive Functioning Scale (CASAFS).

The CASAFS (Spence et al., 2000) assess the social functioning of children and adolescents as it pertains to how well they fulfill their life roles. The CASAFS measures four specific domains including school performance, peer relationships, family relationships, and home duties with the use of a 4-point Likert Scale. Price et al. (2002) have reported good internal consistency ($\alpha = 0.81$) and moderate test-retest reliability ($r = .58$) of the CASAFS. The CASAFS was administered to the children to determine

the concurrent validity of the CSFI, as it was used to assess children's level of social and adaptive functioning. A copy of the CASAFS is contained in Appendix C.

The Fear Survey Schedule for Children- Revised (FSSC-R). The FSSC-R (Ollendick, 1983) assesses children's level of distress in 80 potentially fearful situations. The FSSC-R contains five factors including fear of failure and criticism, fear of the unknown, fear of injury and small animals, fear of danger and death, and medical fears. Good internal consistency ($\alpha = 0.95$) and adequate test-retest reliability ($r = .55$) have been reported for the FSSC-R (Ollendick, 1983). The FSSC-R was used to assess children's overall fears and to determine the discriminant validity of the CSFI. Refer to Appendix D for a copy of the FSSC-R.

The Perceived Competence Scale for Children (PCSC). The PCSC (Harter, 1979) is a 28-item scale designed to measure children's overall competence. The PCSC is divided into 4 subscales, including cognitive, social, physical, and general. The subscales have adequate internal consistency ranging from (.73 - .83). The PCSC was used to assess children's social competence to evaluate the concurrent validity of the CSFI. Refer to appendix E for a copy of the PCSC.

Parental report:

The Child Behavior Checklist (CBCL). The CBCL (Achenbach, 1991) is a 118-item scale that measures children's behavioral and social competence. The items constitute two broad-band scales; the Internalizing Scale, which measures anxiety and depression, and the Externalizing Scale, which measures aggressive, antisocial, and uncontrollable "acting out" behavior. In addition, the two broad-band scales can be further divided into narrow-band scales that measure more specific behaviors (e.g.,

delinquency, aggression). The CBCL also contains 3 competency scales, including school, activities, and social, which examine the degree to how well children perform in each. For example, the social competency scale looks at the number of friends that a child has and the amount of time that he/she spends with children on a weekly basis. The CBCL has established norms and high test-retest reliability ($r = .97$). The CBCL was administered to parents to ascertain overt types of psychopathology and competency in the sample. A copy of the CBCL is contained in Appendix F.

3. Procedure

a. Subject Recruitment

Children were recruited from 2 elementary schools, one in Fairfax County, VA and one in Edgewater Park, NJ. A letter, drafted by the principal investigator (PI) and the school's administration, was sent home to parents of children grades 3-6. The letter described the purpose and requirement of the study as well as informed the parents of when the PI would be present at the school for data collection. The letters were sent home via the children's weekly folders (the schools sent home information for parents every Friday or Wednesday via the weekly folders). A consent form was attached to the letter so that all interested parties could complete it and return it to the school. All consent forms were returned to the main office and collected by the PI within 2 weeks of the forms being sent home.

b. Data Collection

Irrespective of the school setting, all materials were collected using the same procedures. Once the consent forms were sent home, the PI visited the school twice a

week for 2 weeks to remind children to return their forms and to inform them of the beginning of the study. Following this 2-week period, data collection began. Small group administration was used whereby children were placed into groups of 4-8 individuals according to their age group (8-9 year old group or 10-12 year old group). Children were given a set of inventories to complete (refer to Appendices A-E) that were counterbalanced to account for order effects, as well as to decrease their proclivity to share responses.

Administration took approximately 30–45 minutes depending on the age group. During the small group administration, the PI read the instructions aloud to the children and answered questions when necessary. Following the completion of the inventories, children were given a packet of questionnaires to take home to the parents to complete. Children were provided with 2 dates upon which the PI would return to the school to collect the parent forms and compensate them for participating. Two dates were chosen within a 3-week to 4-week period in order to provide children with a chance to return their forms by the 2nd date, should they forget on the 1st date. Compensation was given on an individual basis in a private room at the school. The private room was used so that children who did not participate in the study would not feel excluded. Also at the time of compensation, children ($N= 44$) who were randomly selected to participate in the CSFI test-retest study were given the CSFI an additional time.

F. RESULTS

a. Reliability

To assess the internal consistency of the CSFI, Chronbach's alpha (α) was calculated using 39 subjects from the 8-9 year old group and 105 subjects from the 10-12

year old group. The resulting alpha coefficients were .72 and .85, respectively. The CSFI was readministered to 44 children (thirteen 8-9 year olds and thirty-one 10-12 year olds) 3 weeks following the initial administration. These subsamples were not significantly different from the larger sample with respect to demographic variables. Using a Pearson Product Moment correlation, the stability of the CSFI over a 3-week time period was $r = .65, p < .05$ for the 8-9 year olds and $r = .57, p < .01$ for the 10-12 year olds.

b. Factor Structure

A factor analysis was conducted on the data from the 10-12 year old age group only. Data from the 8-9 year old group were not included due to the small number of items (6) that would be included in the analysis. Given that there were no a priori considerations regarding the potential number of factors that would be identified, an exploratory factor analysis was conducted using a principal components analysis with a varimax rotation. Factors with eigenvalues greater than one were retained. Only items with factor loadings greater than .40 were included as part of a factor (See Table 3).

A 6-factor solution appeared to be the best fit, as the overall variance explained was 59%. Factor 1, *Attending Group Activities*, accounted for 24% of the variance and had an eigenvalue of 5.8. Most of the items on this factor involve interactions with others in a group setting such as parties. The second factor, *Prosocial School Behaviors*, accounted for 10% of the overall variance with an eigenvalue of 2.4. Items on this factor consist of behaviors relating to positive and outgoing classroom behavior. Factor 3, *Initiating Peer Interactions*, includes items that involve inviting friends to activities and accounted for 8% of the variance with an eigenvalue of 1.8. Most of the items on factor 4, *Participation in Camp Activities or Lessons*, involve attending a day camp or taking

lessons. This factor accounted for 6% of the variance and had an eigenvalue of 1.5.

Factor 5, *Socializing with Peers*, accounted for 6% of the variance with an eigenvalue of 1.4 and includes items referring to participation in activities that foster friendships. The final factor, *Conversational Skill*, accounted for 5% of the variance with an eigenvalue of 1.2 and consists of items that involve the use of social skills needed to engage in conversation. Four of the original 29 items on the CSFI did not load on any of the above factors. These items were “give an oral presentation,” “attend church,” “play with other children at recess,” and “join in a conversation.” It should be noted that the elimination of these items did not change the overall alpha coefficient of the inventory. No significant differences between NSA and SA children were identified on these four items.

c. Validity

Concurrent validity with other measures of social functioning

To determine the concurrent validity of the CSFI, the original 147 children (39 from the 8-9 year old group and 108 from the 10-12 year old group) completed the CASAFS as well as the CSFI. It was hypothesized that there would be a moderately positive correlation between the total scores of the CSFI and the CASAFS considering that both self-reports purport to measure social functioning. The results yielded significant relationships between the CASAFS total score and the CSFI total score for the 8-9 year old group ($r = .65, p < .01$) and the 10-12 year old group ($r = .49, p < .01$), as well as between the CASAFS *peer relationship* subscale and the CSFI total score (8-9 year old group: $r = .38, p < .05$; 10-12 year old group: $r = .56, p < .01$). Furthermore, the CSFI factors were correlated with the subscales of the CASAFS. A significant

association was identified between the *school performance* CASAFS subscale and CSFI *prosocial school behaviors* factor ($r = .30, p < .01$). The correlations between the CASAFS *peer relationships* subscale and the CSFI *initiating peer interactions* ($r = .47, p < .01$), *participation in camp activities/lessons* ($r = .22, p < .05$), *conversational skill* ($r = .32, p < .01$), and *attending group activities* ($r = .5, p < .01$) factors yielded significant relationships.

Children also completed the PCSC along with the CSFI, as another measure of concurrent validity. Again, a moderate and positive relationship was expected given that children who participate frequently in social activities, as measured by the CSFI, would likely have higher social competence, as measured by the PCSC. A significant relationship was identified between the total scores of the 2 inventories for the 10-12 year olds ($N=108$), $r = .24, p < .05$, but not for the 8-9 year olds ($r = .12, p > .05$). When examining the PCSC subscales and the CSFI factors, the following significant associations were revealed: the CSFI *prosocial school behaviors* factor and the PCSC *social competence* subscale ($r = .30, p < .01$) and the CSFI *socializing with peers* factor and the PCSC *social competence* subscale ($r = .24, p < .05$).

To further examine the concurrent validity of the CSFI, parents' perception of their children's social competence was measured by the CBCL competency scales and correlated with CSFI total scores. It was hypothesized that a moderate relationship would be established between the CBCL competency scales and the CSFI, as they both purport to assess social activity. However, no significant relationships were found between the CBCL competency scales and the CSFI for either age group. Specifically, the correlations between the CBCL and CSFI for the 8-9 year old group ($N=37$) yielded the following: the

CBCL *activities* competency scale and the CSFI, $r = .10, p > .05$, and the CBCL *social* competency scale and the CSFI, $r = .05, p > .05$. Again, no significant relationships were identified between the CBCL competency scales and the CSFI for the 10-12 year old group ($N=80$): the CBCL *activities* competency scale and the CSFI, $r = -.06, p > .05$, and the CBCL *social* competency scale and the CSFI, $r = .06, p > .05$. In addition, no significant correlations were identified between the CSFI factors and the CBCL competency scales.

Convergent validity with measures of social anxiety

To assess the convergent validity of the CSFI, 147 children (the initial sample) completed the SPAI-C and the CSFI. A negative correlation between the two measures was hypothesized given that those with high social anxiety should have lower levels of social activity. Results indicated a significant inverse relationship between the total scores of the inventories for the 10-12 year old group, $r = -.36, p < .05$. In addition, significant inverse relationships were identified between the CSFI *prosocial school behaviors* factor ($r = -.27, p < .01$), the *initiating peer interactions* factor ($r = -.31, p < .01$), the *socializing with peers* factor ($r = -.30, p < .01$), the *attending group activities* factor ($r = -.25, p < .05$) and the SPAI-C. However, a non-significant association was found between the total scores of the measures for the 8-9 year old group, $r = -.02, p > .05$.

To further establish the convergent validity of the CSFI, a subsample of parents completed the CBCL and their scores on the internalizing scale were correlated with children's scores on the CSFI. The internalizing subscale of the CBCL was expected to

correlate inversely with the CSFI, as the internalizing subscale of the CBCL is indicative of problems with anxiety and social withdrawal. No significant relationships between the total scores were found for either the 8-9 year old group ($N=37$), $r = -.21, p > .05$, or the 10-12 year old group ($N=80$), $r = -.17, p > .05$. However, a significant and inverse association was revealed between the *socializing with peers* CSFI factor and the CBCL *internalizing* subscale ($r = -.23, p < .05$).

Discriminant Validity

As a measure of discriminant validity, the CSFI total score was correlated with the factor scores from the FSSC-R. It was hypothesized that there would be a significantly higher correlation between the CSFI and the fear of *failure/criticism* subscale of the FSSC-R than between the CSFI and the *medical fears* subscale of the FSSC-R. This hypothesis was based on the idea that medical fears would not restrict children's social functioning, whereas fear of failure/criticism is an essential component of social anxiety and therefore more likely to affect one's social functioning. No significant relationships were identified between the CSFI and FSSC-R. Specifically, for the 8-9 year old group, the results yielded the following: CSFI and FSSC-R *fear of failure/criticism* subscale, $r = .04, p > .05$; CSFI and FSSC-R *medical fears*, $r = .16, p > .05$. Results for the 10-12 year old group indicated non-significant associations between the CSFI and the FSSC-R *fear of failure/criticism* subscale, $r = -.02, p > .05$ and the CSFI and the FSSC-R *medical fears* subscale, $r = -.06, p > .05$. Furthermore no significant correlations were yielded between the CSFI factors and the FSSC-R *medical fears* subscale or FSSC-R *fear of failure/criticism* subscale.

To determine the ability of the CSFI to differentiate children with high social anxiety from those with minimal social distress, two groups, socially anxious (SA) and non-socially anxious (NSA), were established using the SPAI-C cutoff scores of 14 or below and 20 or above. The selection of these specific scores was based on data from the original SPAI- C construction paper (Beidel et al., 1995), whereby the cutoff score of 20 reduced the false positive rate (incorrectly identifying normal control children as socially anxious) below 20% and the cutoff score of 14 reduced the false negative rate (incorrectly identifying socially anxious as normal control children) below 17%. CSFI mean total scores from the non-socially anxious group were compared to mean total scores from the socially anxious group. Results from univariate analyses indicated significant mean differences between the groups for the 10-12 year old group ($N=108$), $F = 5.29, p < .05, \eta^2 = .05$; however, no significant differences between the NSA and SA groups were identified for the 8-9 year olds ($N=39$), $F = .04, p > .05$. Refer to table 4 for means and standard deviations of the groups. In addition, for the 10-12 year old group, differences between the NSA and SA children were examined among the CSFI factors using univariate analyses. Significant differences were yielded between the groups on the *prosocial school behaviors* factor ($F = 5.29, p < .05, \eta^2 = .05$); the *initiating peer interactions* factor ($F = 8.22, p < .01, \eta^2 = .07$); and the *socializing with peers* factor ($F = 4.52, p < .05, \eta^2 = .04$).

To further evaluate the ability of the CSFI to predict group membership, a discriminant function analysis was conducted using a jackknife classification. Results revealed accurate classification of (86%) of NSA and (88%) of SA children in the 10-12

year old group and (71%) of the NSA and (47%) of the SA children in the 8-9 year old group.

Parent-child Agreement

Parent and child scores on the CSFI were correlated (Pearson's Correlation Coefficient) to determine the agreement of children's participation in social events. The results indicated a nonsignificant relationship between parent and child scores in the 8-9 year old group ($N=37$) ($r = .26, p > .05$). However results for the 10-12 year old group ($N=80$), yielded a moderate and significant correlation ($r = .50, p < .01$).

G. DISCUSSION

The purpose of this study was to describe the initial psychometric characteristics of an inventory designed to examine treatment effectiveness of childhood social phobia. The CSFI is a 24-item empirically derived inventory, which assesses children's frequency of participation in social activities, including children's social skill, classroom behavior, and social interaction with peers in unstructured environments. The development of a standardized self-report inventory of this nature is an important step towards examining treatment outcome for socially anxious children in a manner that incorporates more than just symptomatic reduction.

The CSFI has good internal consistency and adequate test-retest reliability for children ages 10 and above, indicating that it is a reliable inventory of children's social functioning. As described previously, developmental differences were identified between 8-9 year olds and 10-12 year olds during the initial development of the CSFI and the

same pattern emerged in this study with respect to the validity of the scale. Specifically, the validity of the CSFI supports its utility among the 10-12 year old group, but not for the 8-9 year old group.

The construct validity of the CSFI was evaluated under several methods including: (1) identifying the factor structure of the CSFI (2) correlating the CSFI total score and factor scores with other inventories of social functioning, (3) assessing the agreement between parents and children on the CSFI, (4) correlating the CSFI with measures of social anxiety, and (5) determining the ability of the CSFI to differentiate between NSA and SA children. Overall support for the construct validity of the CSFI was moderate to good for the 10-12 year old group, but weak for the 8-9 year olds. The factor analysis conducted on the 10-12 year old data revealed a 6-factor solution that accounted for 59% of the variance. *Attending group activities*, the largest factor, consists of items that reflect several widespread unstructured social situations, such as spending the night at a friend's house, attending parties or dances, and hanging out at places like the mall. These particular types of activities are often most distressful for children and adolescents with social phobia (Beidel & Morris, 1995); however, they also make up the largest portion of a child or adolescent's leisure time (Larson, 2001). In contrast, the remaining 5 factors refer to behaviors that are much more specific in nature. For example, the second factor, *prosocial school behavior*, represents more specific performance-based behavior, such as responding to questions in class and participating verbally, which are additional areas of difficulty for socially anxious youth (Beidel & Morris, 1995).

When examining the overall relationship between the CSFI total scores and other inventories purporting to measure social functioning or social competence, small to

moderate relationships were identified for both age groups, irrespective of the different definitions used to define the construct. The CASAFS and PCSC inventories, which were used to determine the concurrent validity of the CSFI, assess children's competence/performance in areas, including home, family, and peer relationships. But they do not quantify time spent participating in these social activities, as the CSFI does. However, when the factor scores from the CSFI were correlated with the subscales from both the CASAFS and the PCSC, a pattern emerged whereby stronger associations were identified between the more specifically defined subscales. For example, moderate correlations were revealed among the CASAFS *peer relationships* subscale and the CSFI *attending group activities* subscale, as both subscales include items that involve general unstructured activities with peers.

As another indicator of construct validity, parents' perception of their children's social competence, as measured by the CBCL, was compared to CSFI total scores and CSFI factor scores. No significant correlations were revealed for either age group, suggesting perhaps a discrepancy between parents' perceptions of their children's social activity and children's report of their own social participation. There are several potential hypotheses for why there does not appear to be a relationship between the CSFI and the CBCL competency scales. First, the competency scales of the CBCL are broader indices of social activity, as they were designed to examine the number of friends and activities that a child engages in, rather than to identify the frequency in which a child participates in peer-related activities. Second, given that the CBCL competency scales measure general social behavior, it is likely that the correlations among the CSFI factors were truncated by the specific nature of the items within each factor. Specifically, it is

reasonable to conclude that the number of friends and activities, as represented by the CBCL competency scales, would not be highly associated with the amount of time spent answering questions in class or hanging out with friends at the mall, as assessed by the CSFI. Furthermore, parent's perceptions of their child's level of participation in social activities (as measured by the CSFI parent version) significantly correlated with children's self-report on the CSFI (for the 10-12 year olds only); therefore, suggesting that the nonsignificant relationships between the CSFI and CBCL are most likely not due to differences in perception between parents and children.

Further examination of the construct validity of the CSFI, yielded no significant relationship between the CSFI total score and the internalizing scale of the CBCL for either age group. Again, this finding is most likely due to the fact that the internalizing scale is a broad measure of psychopathology that includes difficulties associated with depression, somatization, and overall anxiety concerns, whereas the CSFI includes both general social behaviors and areas of difficulty specifically defined for children with social anxiety. Additional support for this hypothesis is revealed when examining the relationship between the CSFI factors and the CBCL internalizing scale. A significant inverse relationship was identified between the CSFI *socializing with peers* factor and the CBCL internalizing scale, which suggests that the feelings of social withdrawal, isolation, and anxiety are more closely associated with lower participation in activities such as playing games with other children and making new friends (as identified by items on this factor), than with an overall global score of social functioning.

Further support for the convergent validity of the CSFI was established for the 10-12 year old group when correlating the CSFI total score and factor scores with the

SPAI-C. Specifically, the data show that children with high levels of social anxiety symptoms are likely to exhibit lower scores on the CSFI, therefore indicating a lesser degree of participation in social activities. This pattern remained consistent among both the general and basic items of social behavior, as well as with the more specific behaviors on the CSFI. In addition, these findings are consistent with clinical reports throughout the literature that allude to difficulties with restricted peer relationships and interaction in unstructured social activity for children and adolescents with social phobia (Velting & Albano, 2001). No significant relationships were revealed to support the convergent validity of the CSFI for the 8-9 year olds.

The discriminant validity of the CSFI was partially supported for the 10-12 year olds, but not well supported for the 8-9 year old group. Specifically, the CSFI total score significantly differentiated NSA children from SA children in the 10-12 year old group. Additionally, mean differences between the NSA and SA groups were also identified among 3 (*prosocial school behavior, initiating peer interactions, and socializing with peers*) of the 6 factors on the CSFI. Interestingly, no significant differences were revealed between the NSA and SA groups on *attending group activities*, the largest factor of the CSFI that accounts for the greatest percentage of the variance. However, the lack of significant findings on this factor could be explained by the generalized nature of items. Specifically, although no empirical evidence has been provided thus far, the current factor structure of the CSFI lends support to the idea of subtyping for childhood social phobia. Reflective of the adult social phobia literature, several researchers (Hofmann et al., 1999; Wittchen et al., 1999) suggest that children also might be categorized according to the specific vs. generalized subtype. Within the DSM-IV those with social phobia can

be specified as “generalized” or “non-generalized” according to the extent of their individual fears. Adults with the generalized social phobia subtype often report performance fears that occur in most social situations that correspond most closely with items on the *attending group activities* factor. Individuals with a generalized social phobia diagnosis might report minimal engagement in social activities across all 6 factors. In contrast, children with the non-generalized subtype may not be different from normal control children on factors such as *attending group activities*, but rather on the more specifically defined factors such as *prosocial school* behavior. For those children, examining items on this particular factor may be a more appropriate and valid assessment of treatment effectiveness in contrast to using the entire scale.

Although significant differences between the NSA and SA groups were identified with the total score and factor scores of the CSFI, it should be noted that the small effect sizes associated with the univariate analyses render these differences statistically significant, but not necessarily clinically relevant. However, a discriminant analysis revealed an overall classification rate of 87% for children in the 10-12 year old group. Although no significant differences were identified between the NSA and SA scores on the CSFI for the 8-9 year olds, the discriminant analysis indicated an overall classification rate of 62% for this age group.

In summary, the CSFI has good reliability and initial validity data support the construct validity of the inventory, including concurrent, convergent, and discriminant validity for children in the 10-12 year old age group. However, the CSFI was not a good indicator of social functioning for the 8-9 year olds. One hypothesis for this finding is that children at this age may not be reliable when it comes to recording their social

participation. When using self-report measures with younger children, there is a general question regarding the extent to which they are capable and willing to report about their social behaviors and problems (Harter & Whitesell, 1989; Kazdin, 2000; Marsh, 1986). Several studies have alluded to the fact that with children under the age of 10, parental report may be a better source of information regarding children's functioning (c.f. Chambers, 2002; Marsh, 1986). Given the lack of empirical evidence for the utility of the CSFI with the 8-9 year olds, at this time the inventory is best suited for use with children ages 10 and older. Further development of the CSFI is necessary for use with younger children. For example, the parent version of the CSFI may be a more appropriate strategy for the assessment of social functioning among the 8-9 year olds.

This study provides initial psychometric data for the CSFI, however the examination of construct validity is an ongoing process. Therefore, future studies will be needed with additional samples to further support and replicate the findings. In addition, a community sample was used for the evaluation of the psychometrics in this study, which can provide the possibility of greater generalizability. However, the absence of a diagnostic sample makes it difficult to determine how the CSFI will be most useful with a diagnosed sample of socially phobic youth. Specifically, it is unknown at this time whether the CSFI will be useful as an ideographic assessment tool or treatment outcome measure or both. In order to determine the answer to these questions, the CSFI will need to be further validated with diagnosed groups including children with social phobia and other anxiety disorders.

The CSFI is the first self-report inventory designed to address the lack of standardization with respect to assessment of treatment effectiveness for childhood social

phobia. More recently there has been a push towards examining more than symptomatic reduction as an indicator of treatment outcome, however determining clinically relevant change following treatment remains rather subjective and differs from study to study. Specifically, in examining the current treatments of childhood social phobia, clinically relevant outcomes have been determined by the absence of diagnosis, decreased ratings of severity according to clinician report, or decreased scores on global rating scales. The development of a normative social functioning measure that can be used to objectively assess changes in impairment will ultimately help to streamline advances in the assessment of treatment effectiveness for childhood social phobia.

Although the CSFI is a reliable and valid inventory of children's social functioning, it is only one step in the assessment of this construct. Specifically, a thorough assessment procedure is one that incorporates a multi-method approach, including self-report, clinician ratings, and observation. The CSFI provides a self-report inventory of social functioning, but other assessment modalities such as parent and teacher ratings and direct observation should be considered as well. In addition, the CSFI has large-scale implications whereby it can be useful in the assessment of other childhood disorders that include difficulty with social functioning. For example, children who suffer with depression, other anxiety disorders, externalizing disorders such as ADHD and conduct disorder, often exhibit impairment in "normal" social functioning. However, to date there is no known literature that quantifies "normal" social behavior of children. This is where the CSFI becomes an important contribution, as it was designed to assess common social activities and the frequency with which children participate in these activities. An inventory of this nature may help to standardize the assessment of treatment

effectiveness for any childhood disorder where impairment in social functioning is a component of the disorder.

Table 1. DSM-IV Diagnostic Criteria for Social Phobia

- A. A marked or persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. Note: In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer setting, not just in interactions with adults
- B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed panic attack. Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.
- C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent.
- D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.
- E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having phobia.
- F. In individuals under age 18 years, the duration is at least 6 months.
- G. The fear or avoidance is not due to the direct physiological effects of a substance (eg., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic disorder with or without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).
- H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear of Stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa.

Specify if:

Generalized: if the fears include most social situations (also consider the additional diagnosis of Avoidant Personality Disorder)

Table 2. Demographic Characteristics of the Sample by Age Group

	8-9 Years	10-12 Years	Total
Girls	23	62	85
Boys	16	46	62
Total	39	108	147
# NSA	24	83	107
# SA	15	25	40
% White	59	57	57

NSA = Non-socially anxious, SA= Socially anxious

Table 3. Factor Loadings of the Child Social Functioning Inventory (CSFI)

Item Content	Factor Loading
Factor 1 – Attending Group Activities	
Invite a friend out to play	.426
Go to a dance or party	.717
Throw a party	.764
Do volunteer work	.582
Call a friend	.399
Spend the night at a friend’s house	.761
Hangout with friends at places such as the mall	.655
Factor 2 – Prosocial School Behaviors	
Participate in class	.690
Participate in group work	.505
Start a conversation	.668
Maintain a conversation	.554
Respond to questions in class	.743
Factor 3 – Initiating Peer Interactions	
Invite a friend out to an outing	.684
Go over to a friend’s house to play	.590
Stand up for oneself against a bully	.726
Factor 4 – Participation in Camp Activities/ Lessons	
Attend a day or sports camp	.708
Go away to a sleep camp	.652
Take lessons (e.g., dance, karate, music, etc.)	.629
Attend a club/group meeting	.743

Factor 5 – Socializing with Peers

Play games with other children	.578
Participate in competitive sports	.578
Make a new friend	.408

Factor 6 – Conversational Skill

Answer the phone	.802
Talk with others at a party	.677

* Items not included in the factor structure: give an oral presentation, attend church, play with children at recess, and join in a conversation

Table 4. Descriptive Statistics of the Child Social Functioning Inventory (CSFI)

	8-9 years	10-12 years
Group		
NSA	12.92 (4.05)	54.87 (11.37)
SA	12.67 (3.31)	49.00 (10.52)

NSA = Non-socially anxious, SA = Socially anxious

Appendix A. The Child Social Functioning Inventory

Name: _____ Date: _____

Age: _____ Gender: _____

Race/Ethnicity: _____ ID#: _____

The Child Social Functioning Inventory (CSFI)

Children are involved in social activities throughout their day, whether at school or at home. Social activities are those that require interaction with around other people. For example, playing computer games alone would not be a social activity, but playing computer games with friends would be a social activity. Think about how often you do each of these social activities listed below. Circle the number that shows how often you did the activity over the past 2 months.

	Not at all / rarely 0	1-2 times per month 1	Weekly 2	Daily 3
1. Answer the phone	0	1	2	3
2. Participate verbally in class	0	1	2	3
3. Participate in group work	0	1	2	3
4. Participate in a competitive sport (e.g., soccer, football)	0	1	2	3
5. Play games with other children (e.g., Monopoly)	0	1	2	3
6. Invite a friend out to play	0	1	2	3
If you're 9 or younger stop here 				
7. Go to a dance or party	0	1	2	3
8. Throw a party	0	1	2	3
9. Talk with others at a party	0	1	2	3
10. Start a conversation	0	1	2	3

Not at all / rarely	1-2 times per month	Weekly	Daily	
0	1	2	3	3

11. Give an oral presentation at school, church, or other places	0	1	2	3
12. Make a new friend	0	1	2	3
13. Maintain a conversation	0	1	2	3
14. Go to a day or sports camp	0	1	2	3
15. Go to a sleep away camp	0	1	2	3
16. Take lessons (e.g., musical instrument, karate, dance)	0	1	2	3
17. Attend church	0	1	2	3
18. Invite a friend to an outing	0	1	2	3
19. Go over to a friend's house	0	1	2	3
20. Stand up for yourself against a bully	0	1	2	3
21. Do volunteer work	0	1	2	3
22. Call a friend	0	1	2	3
23. Spend the night at a friend's house	0	1	2	3
24. Hangout with friends at places like the mall	0	1	2	3
25. Play with other children during recess	0	1	2	3
26. Attend a club or team meeting	0	1	2	3
27. Respond to questions in class	0	1	2	3
28. Join in on a conversation	0	1	2	3

Total Score: _____

Appendix B. The Social Phobia and Anxiety Inventory (SPAI-C)

Name: _____

Age: _____

Date: _____

Sex: _____

Dx: _____

SPAI-C

Below are some places of activities that sometimes make boys and girls feel nervous or scared. All of these activities are called social situations because they involve being with other people. Social situations include playing outside with other boys and girls, playing a sport while others are watching, being in a play or recital, going to a party or a meeting, playing at the playground or just being around other boys and girls at school.

Think about yourself and circle the number that shows how often you would feel nervous or scared when doing this.

	Never or Hardly Ever	Sometimes	Most of the time or Always		
	0	1	2		
1)	I feel scared when I have to join in a social situation with a large group of boys and girls (more than 6).	0	1	2	
2)	I feel scared when I am with other boys and girls or adults and I become the center of attention (they all look at me).	0	1	2	
3)	I feel scared when I am with other boys and girls or adults and I have to do something while they watch me (read aloud, play a game, play a sport).	0	1	2	
4)	I feel scared when I have to speak or read in front of a group of people.	0	1	2	
5)	I feel scared when answering questions in class or at meeting (scouts, soccer team) even when I know the answer.	0	1	2	
6)	I feel scared at parties, dances, school, or anyplace where there will be more than two other people that I go home early.	0	1	2	

Never or Hardly Ever	Sometimes	Most of the time or Always		
0	1	2		
7)	I feel scared when I meet new kids.	0	1	2
8)	I am too scared to ask questions in class.	0	1	2
9)	I feel scared when I am in the school cafeteria with: boys or girls my age that I know	0	1	2
	boys or girls my age that I don't know	0	1	2
	adults	0	1	2
10)	If somebody starts arguing with me, I feel scared and do not know what to do if that person is: a boy or girl my age that I know	0	1	2
	a boy or girl my age that I don't know	0	1	2
	an adult	0	1	2
11)	If somebody asks me to do something that I don't want to do, I feel scared and don't know what to say if that person is: a boy or girl my age that I know	0	1	2
	a boy or girl my age that I don't know	0	1	2
	an adult	0	1	2
12)	I feel scared and don't know what to do when in an embarrassing situation with: (Embarrassed means that your face gets hot and red). a boy or girl my age that I know	0	1	2
	a boy or girl my age that I don't know	0	1	2
	an adult	0	1	2

Never or Hardly Ever	Sometimes	Most of the time or Always		
0	1			
		0	1	2
13)	If somebody says something that I think is wrong or bad, I feel scared saying what I think if that person is:			
	a boy or girl my age that I know	0	1	2
	a boy or girl my age that I don't know	0	1	2
	an adult	0	1	2
14)	I feel scared when I start to talk to:			
	a boy or girl my age that I know	0	1	2
	a boy or girl my age that I don't know	0	1	2
	an adult	0	1	2
15)	I feel scared if I have to talk for longer than a few minutes with:			
	a boy or girl my age that I know	0	1	2
	a boy or girl my age that I don't know	0	1	2
	an adult	0	1	2
16)	I feels scared when speaking (giving a book report, reading in front of the class) in front of:			
	a boy or girl my age that I know	0	1	2
	a boy or girl my age that I don't know	0	1	2
	an adult	0	1	2

Never or Hardly Ever	Sometimes	Most of the time or Always		
0	1	2		
17)	I feel scared when I am in a school play, choir, music or dance recital in front of:			
	a boy or girl my age that I know	0	1	2
	a boy or girl my age that I don't know	0	1	2
	an adult	0	1	2
18)	I feel scared when I am ignored or made fun of by:			
	a boy or girl my age that I know	0	1	2
	a boy or girl my age that I don't know	0	1	2
	an adult	0	1	2
19)	I try to avoid social situations (parties, school, playing with others) where there are:			
	a boy or girl my age that I know	0	1	2
	a boy or girl my age that I don't know	0	1	2
	an adult	0	1	2
20)	I leave social situations (parties, school, playing with others) where there are:			
	a boy or girl my age that I know	0	1	2
	a boy or girl my age that I don't know	0	1	2
	an adult	0	1	2

Never or Hardly Ever	Sometimes	Most of the time or Always		
0	1	0	1	2
21)	Before going to a party or going someplace with others, I think about what might go wrong. I think:			
	Will I make a mistake and look stupid?	0	1	2
	What if nobody talks to me?	0	1	2
	What if somebody talks to me and I can't think of what to say?	0	1	2
	What if they see how scared I am?	0	1	2
22)	My voice leaves me or sounds funny when I am talking to others.			
23)	I usually do not speak to anyone until they speak to me			
24)	When I am with other people, I think scary thoughts. Sometimes I think:			
	If I goof up, I will really feel bad.	0	1	2
	What are they thinking of me?	0	1	2
	Whatever I say will sound stupid.	0	1	2
25)	<u>Before</u> I go someplace (a party, school, soccer game or any place where I will be with others):			
	I feel sweaty	0	1	2
	I feel like I have to go to the bathroom	0	1	2
	My heart beats fast	0	1	2
	I get a headache or stomachache	0	1	2
	My stomach feels funny	0	1	2

Never or Hardly Ever	Sometimes	Most of the time or Always
0	1	2

26) When I am someplace (a party, school, soccer game, or any place where I will be with others):

I feel sweaty	0	1	2
I shake	0	1	2
I feel like I have to go to the bathroom	0	1	2
My heart beats fast	0	1	2
I have a headache or stomachache	0	1	2

Appendix C. The Child and Adolescent Social and Adaptive Functioning Scale (CASAFS)

SOCIAL SCALE

Below is a list of items that describe people. Please **circle** the number for each item that best describes you. If the item '**NEVER**' describes you circle the '**1**', if it '**SOMETIMES**' describes you circle the '**2**', if it '**OFTEN**' describes you circle the '**3**' and if it '**ALWAYS**' describes you circle the '**4**'. Some of the family questions may not apply to everyone, so if this is the case for you, please circle the '**DOES NOT APPLY**' response.

	Never	Some-times	Often	Always	
1. I get good marks in Maths/Arithmetic	1	2	3	4	
2. I go out to places with my friends	1	2	3	4	
3. I have a good relationship with my mother	1	2	3	4	Does Not Apply To Me
4. I help around the house	1	2	3	4	
5. I get good marks in Science	1	2	3	4	
6. I have friends of the opposite sex	1	2	3	4	
7. I have a good relationship with my father	1	2	3	4	Does Not Apply To Me
8. I keep my room and belongings tidy	1	2	3	4	
9. I get good marks in Social Science and/or History	1	2	3	4	
10. I go to parties or school dances	1	2	3	4	
11. I get along well with brother(s)/ sister(s) (if you have any)	1	2	3	4	Does Not Apply To Me
12. I keep my clothes clean and tidy	1	2	3	4	
13. I get good marks in reading/writing/English	1	2	3	4	
14. I have at least one or two special friends	1	2	3	4	

PLEASE TURN THE PAGE TO ANSWER MORE QUESTIONS

	Never	Some-times	Often	Always
15. I get along well with my relatives	1	2	3	4
16. I shower and keep myself clean	1	2	3	4
17. I have trouble with my school work	1	2	3	4
18. I spend most of my spare time alone	1	2	3	4
19. I have fights with my parent(s)	1	2	3	4
20. I help with the cooking at home	1	2	3	4
21. I am successful at my school work	1	2	3	4
22. I have difficulty making friends	1	2	3	4
23. I have an adult who I can talk to if I have a problem	1	2	3	4
24. I help with the clearing up after meals	1	2	3	4

PLEASE CHECK THAT YOU HAVE ANSWERED EACH QUESTION

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Appendix D. The Fear Survey Schedule for Children – Revised (FSSC-R)

FSSC-R

A number of statements which boys and girls use to describe the fears they have are given below. Read each fear carefully and circle the words that describe your fear. There are no right or wrong answers. Remember, find the words which best describe how much fear you have.

1. Giving an oral report	not at all	a little	a lot
2. Riding in a car	not at all	a little	a lot
3. Getting punished by mom	not at all	a little	a lot
4. Lizards	not at all	a little	a lot
5. Looking foolish	not at all	a little	a lot
6. Ghosts or spooky things	not at all	a little	a lot
7. Sharp objects	not at all	a little	a lot
8. Having to go to the hospital	not at all	a little	a lot
9. Death or dead people	not at all	a little	a lot
10. Getting lost in a strange place	not at all	a little	a lot
11. Snakes	not at all	a little	a lot
12. Talking on the telephone	not at all	a little	a lot
13. Rollercoaster or carnival rides	not at all	a little	a lot
14. Getting sick at school	not at all	a little	a lot
15. Being sent to the principal	not at all	a little	a lot
16. Riding on the train	not at all	a little	a lot
17. Being left at home with a sitter	not at all	a little	a lot
18. Bears or wolves	not at all	a little	a lot
19. Meeting someone for the first time	not at all	a little	a lot

20. Bombing attacks-being invaded	not at all	a little	a lot
21. Getting a shot from the doctor	not at all	a little	a lot
22. Going to the dentist	not at all	a little	a lot
23. High places	not at all	a little	a lot
24. Being teased	not at all	a little	a lot
25. Spiders	not at all	a little	a lot
26. A burglar breaking into our home	not at all	a little	a lot
27. Flying in a plane	not at all	a little	a lot
28. Being called on by the teacher	not at all	a little	a lot
29. Getting poor grades	not at all	a little	a lot
30. Bats or birds	not at all	a little	a lot
31. My parents criticizing me	not at all	a little	a lot
32. Guns	not at all	a little	a lot
33. Being in a fight	not at all	a little	a lot
34. Fire-getting burned	not at all	a little	a lot
35. Getting a cut or injury	not at all	a little	a lot
36. Being in a crowd	not at all	a little	a lot
37. Thunderstorms	not at all	a little	a lot
38. Having to eat foods I don't like	not at all	a little	a lot
39. Cats	not at all	a little	a lot
40. Failing a test	not at all	a little	a lot
41. Being hit by a car or truck	not at all	a little	a lot
42. Having to go to school	not at all	a little	a lot
43. Playing rough games	not at all	a little	a lot
44. Having my parents argue	not at all	a little	a lot
45. Dark rooms or closets	not at all	a little	a lot
46. Having to put on a recital	not at all	a little	a lot

47. Ants or beetles	not at all	a little	a lot
48. Being criticized by others	not at all	a little	a lot
49. Strange looking people	not at all	a little	a lot
50. The sight of blood	not at all	a little	a lot
51. Going to the doctor	not at all	a little	a lot
52. Strange or mean looking dogs	not at all	a little	a lot
53. Cemeteries	not at all	a little	a lot
54. Getting a report card	not at all	a little	a lot
55. Getting a haircut	not at all	a little	a lot
56. Deep water or the ocean	not at all	a little	a lot
57. Nightmares	not at all	a little	a lot
58. Falling from high places	not at all	a little	a lot
59. Getting a shock from electricity	not at all	a little	a lot
60. Going to bed in the dark	not at all	a little	a lot
61. Getting car sick	not at all	a little	a lot
62. Being alone	not at all	a little	a lot
63. Having to wear clothes different from others	not at all	a little	a lot
64. Getting punished by my father	not at all	a little	a lot
65. Having to stay after school	not at all	a little	a lot
66. Making mistakes	not at all	a little	a lot
67. Mystery movie	not at all	a little	a lot
68. Loud sirens	not at all	a little	a lot
69. Doing something new	not at all	a little	a lot
70. Germs or getting a serious illness	not at all	a little	a lot

71. Closed places	not at all	a little	a lot
72. Earthquakes	not at all	a little	a lot
73. Russia	not at all	a little	a lot
74. Elevators	not at all	a little	a lot
75. Dark places	not at all	a little	a lot
76. Not being able to breathe	not at all	a little	a lot
77. Getting a bee sting	not at all	a little	a lot
78. Worms or snails	not at all	a little	a lot
79. Rats or mice	not at all	a little	a lot
80. Taking a test	not at all	a little	a lot

Appendix E. The Perceived Competence Scale for Children (PCSC)

What I Am Like

NAME _____ BOY OR GIRL _____ AGE _____ BIRTHDAY _____ CLASS OR GROUP _____
(circle which)

SAMPLE SENTENCES

	REALLY TRUE <small>for me</small>	SORT OF TRUE <small>for me</small>		BUT		SORT OF TRUE <small>for me</small>	REALLY TRUE <small>for me</small>
a.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids would rather play outdoors in their spare time		Other kids would rather watch T.V.	<input type="checkbox"/>	<input type="checkbox"/>
b.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids never worry about anything		Other kids sometimes worry about certain things.	<input type="checkbox"/>	<input type="checkbox"/>
1.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids feel that they are very good at their school work		Other kids worry about whether they can do the school work assigned to them.	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids find it hard to make friends		For other kids it's pretty easy.	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids do very well at all kinds of sports		Others don't feel that they are very good when it comes to sports.	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids feel that there are alot of things about themselves that they would change if they could		Other kids would like to stay pretty much the same.	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids feel like they are just as smart as other kids their age		Other kids aren't so sure and wonder if they are as smart.	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids have alot of friends		Other kids don't have very many friends.	<input type="checkbox"/>	<input type="checkbox"/>

	REALLY TRUE for me	SORT OF TRUE for me		BUT		SORT OF TRUE for me	REALLY TRUE for me
7.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids wish they could be alot better at sports		Other kids feel they are good enough.	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are pretty sure of themselves		Other kids are not very sure of themselves.	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are pretty slow in finishing their school work		Other kids can do their school work quickly.	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids don't think they are a very important member of their class		Other kids think they are pretty important to their classmates.	<input type="checkbox"/>	<input type="checkbox"/>
11.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids think they could do well at just about any new outdoor activity they haven't tried before		Other kids are afraid they might not do well at outdoor things they haven't ever tried.	<input type="checkbox"/>	<input type="checkbox"/>
12.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids feel good about the way they act		Other kids wish they acted differently.	<input type="checkbox"/>	<input type="checkbox"/>
13.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids often forget what they learn		Other kids can remember things easily.	<input type="checkbox"/>	<input type="checkbox"/>
14.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are always doing things with alot of kids		Other kids usually do things by themselves.	<input type="checkbox"/>	<input type="checkbox"/>
15.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids feel that they are better than others their age at sports		Other kids don't feel they can play as well.	<input type="checkbox"/>	<input type="checkbox"/>
16.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids think that maybe they are not a very good person		Other kids are pretty sure that they are a good person.	<input type="checkbox"/>	<input type="checkbox"/>

	REALLY TRUE for me	SORT OF TRUE for me		BUT		SORT OF TRUE for me	REALLY TRUE for me
17.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids like school because they do well in class		Other kids don't like school because they aren't doing very well.	<input type="checkbox"/>	<input type="checkbox"/>
18.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids wish that more kids liked them		Others feel that most kids do like them.	<input type="checkbox"/>	<input type="checkbox"/>
19.	<input type="checkbox"/>	<input type="checkbox"/>	In games and sports some kids usually watch instead of play		Other kids usually play rather than just watch.	<input type="checkbox"/>	<input type="checkbox"/>
20.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are very happy being the way they are		Other kids wish they were different.	<input type="checkbox"/>	<input type="checkbox"/>
21.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids wish it was easier to understand what they read		Other kids don't have any trouble understanding what they read.	<input type="checkbox"/>	<input type="checkbox"/>
22.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are popular with others their age		Other kids are not very popular.	<input type="checkbox"/>	<input type="checkbox"/>
23.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids don't do well at new outdoor games		Other kids are good at new games right away.	<input type="checkbox"/>	<input type="checkbox"/>
24.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids aren't very happy with the way they do alot of things		Other kids think the way they do things is fine.	<input type="checkbox"/>	<input type="checkbox"/>
25.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids have trouble figuring out the answers in school		Other kids almost always can figure out the answers.	<input type="checkbox"/>	<input type="checkbox"/>
26.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are really easy to like		Other kids are kind of hard to like.	<input type="checkbox"/>	<input type="checkbox"/>

	REALLY TRUE for me	SORT OF TRUE for me				SORT OF TRUE for me	REALLY TRUE for me
27.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are among the last to be chosen for games	BUT	Other kids are usually picked first.	<input type="checkbox"/>	<input type="checkbox"/>
28.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are usually sure that what they are doing is the right thing	BUT	Other kids aren't so sure whether or not they are doing the right thing.	<input type="checkbox"/>	<input type="checkbox"/>

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Appendix F. The Child Behavior Checklist



Please print **CHILD BEHAVIOR CHECKLIST FOR AGES 6-18**

For office use only
ID # _____

CHILD'S FULL NAME First _____ Middle _____ Last _____			PARENTS' USUAL TYPE OF WORK, even if not working now. (Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, (a)the operator, shoe salesman, army sergeant.)			
CHILD'S GENDER <input type="checkbox"/> Boy <input type="checkbox"/> Girl	CHILD'S AGE _____	CHILD'S ETHNIC GROUP OR RACE _____	FATHER'S TYPE OF WORK _____		MOTHER'S TYPE OF WORK _____	
TODAY'S DATE Mo _____ Date _____ Year _____		CHILD'S BIRTHDATE Mo _____ Date _____ Year _____	THIS FORM FILLED OUT BY: (print your full name) _____			
GRADE IN SCHOOL _____	Please fill out this form to reflect your view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the space provided on page 2. Be sure to answer all items.			Your gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
NOT ATTENDING SCHOOL <input type="checkbox"/>				Your relation to the child: <input type="checkbox"/> Biological Parent <input type="checkbox"/> Step Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other (specify) _____		

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc. <input type="checkbox"/> None	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	a. _____	_____	_____	_____	_____	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. _____	_____	_____	_____	_____	_____	_____	_____	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. _____	_____	_____	_____	_____	_____	_____	_____	

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, computers, singing, etc. (Do <i>not</i> include listening to radio or TV.) <input type="checkbox"/> None	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	a. _____	_____	_____	_____	_____	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. _____	_____	_____	_____	_____	_____	_____	_____	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. _____	_____	_____	_____	_____	_____	_____	_____	

III. Please list any organizations, clubs, teams, or groups your child belongs to. <input type="checkbox"/> None	Compared to others of the same age, how active is he/she in each?			
	Less Active	Average	More Active	Don't Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	a. _____	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. _____	_____	_____	_____	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. _____	_____	_____	_____	

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.) <input type="checkbox"/> None	Compared to others of the same age, how well does he/she carry them out?			
	Below Average	Average	Above Average	Don't Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	a. _____	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. _____	_____	_____	_____	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. _____	_____	_____	_____	

Be sure you answered all items. Then see other side.

Please print. Be sure to answer all items.

- V. 1. About how many close friends does your child have? (Do not include brothers & sisters)
 None 1 2 or 3 4 or more
2. About how many times a week does your child do things with any friends outside of regular school hours?
(Do not include brothers & sisters) Less than 1 1 or 2 3 or more

- Vi. Compared to others of his/her age, how well does your child:
- | | Worse | Average | Better | |
|-----------------------------------------------|--------------------------|--------------------------|--------------------------|-----------------------------------------------------|
| a. Get along with his/her brothers & sisters? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Has no brothers or sisters |
| b. Get along with other kids? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| c. Behave with his/her parents? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| d. Play and work alone? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

- Vii. 1. Performance in academic subjects. Does not attend school because _____

Check a box for each subject that child takes		Failing	Below Average	Average	Above Average
Other academic subjects—for example: computer courses, foreign language, business. Do not include gym, shop, driver's ed., or other nonacademic subjects.	a. Reading, English, or Language Arts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. History or Social Studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Arithmetic or Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Science	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	g. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Does your child receive special education or remedial services or attend a special class or special school?
 No Yes—kind of services, class, or school: _____

3. Has your child repeated any grades? No Yes—grades and reasons: _____

4. Has your child had any academic or other problems in school? No Yes—please describe: _____

When did these problems start? _____

Have these problems ended? No Yes—when? _____

- Does your child have any illness or disability (either physical or mental)? No Yes—please describe: _____

What concerns you most about your child?

Please describe the best things about your child.

Please print. Be sure to answer all items.

Below is a list of items that describe children and youths. For each item that describes your child *now or within the past 6 months*, please circle the **2** if the item is **very true or often true** of your child. Circle the **1** if the item is **somewhat or sometimes true** of your child. If the item is **not true** of your child, circle the **0**. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know)			1 = Somewhat or Sometimes True			2 = Very True or Often True		
0	1	2	1. Acts too young for his/her age	0	1	2	32. Feels he/she has to be perfect	
0	1	2	2. Drinks alcohol without parents' approval (describe): _____	0	1	2	33. Feels or complains that no one loves him/her	
0	1	2	3. Argues a lot	0	1	2	34. Feels others are out to get him/her	
0	1	2	4. Fails to finish things he/she starts	0	1	2	35. Feels worthless or inferior	
0	1	2	5. There is very little he/she enjoys	0	1	2	36. Gets hurt a lot, accident-prone	
0	1	2	6. Bowel movements outside toilet	0	1	2	37. Gets in many fights	
0	1	2	7. Bragging, boasting	0	1	2	38. Gets teased a lot	
0	1	2	8. Can't concentrate, can't pay attention for long	0	1	2	39. Hangs around with others who get in trouble	
0	1	2	9. Can't get his/her mind off certain thoughts; obsessions (describe): _____	0	1	2	40. Hears sound or voices that aren't there (describe): _____	
0	1	2	10. Can't sit still, restless, or hyperactive	0	1	2	41. Impulsive or acts without thinking	
0	1	2	11. Clings to adults or too dependent	0	1	2	42. Would rather be alone than with others	
0	1	2	12. Complains of loneliness	0	1	2	43. Lying or cheating	
0	1	2	13. Confused or seems to be in a fog	0	1	2	44. Bites fingernails	
0	1	2	14. Cries a lot	0	1	2	45. Nervous, highstrung, or tense	
0	1	2	15. Cruel to animals	0	1	2	46. Nervous movements or twitching (describe): _____	
0	1	2	16. Cruelty, bullying, or meanness to others	0	1	2	47. Nightmares	
0	1	2	17. Daydreams or gets lost in his/her thoughts	0	1	2	48. Not liked by other kids	
0	1	2	18. Deliberately harms self or attempts suicide	0	1	2	49. Constipated, doesn't move bowels	
0	1	2	19. Demands a lot of attention	0	1	2	50. Too fearful or anxious	
0	1	2	20. Destroys his/her own things	0	1	2	51. Feels dizzy or lightheaded	
0	1	2	21. Destroys things belonging to his/her family or others	0	1	2	52. Feels too guilty	
0	1	2	22. Disobedient at home	0	1	2	53. Overeating	
0	1	2	23. Disobedient at school	0	1	2	54. Overtired without good reason	
0	1	2	24. Doesn't eat well	0	1	2	55. Overweight	
0	1	2	25. Doesn't get along with other kids	56. Physical problems <i>without known medical cause</i> :				
0	1	2	26. Doesn't seem to feel guilty after misbehaving	0	1	2	a. Aches or pains (<i>not</i> stomach or headaches)	
0	1	2	27. Easily jealous	0	1	2	b. Headaches	
0	1	2	28. Breaks rules at home, school, or elsewhere	0	1	2	c. Nausea, feels sick	
0	1	2	29. Fears certain animals, situations, or places, other than school (describe): _____	0	1	2	d. Problems with eyes (<i>not</i> if corrected by glasses) (describe): _____	
0	1	2	30. Fears going to school	0	1	2	e. Rashes or other skin problems	
0	1	2	31. Fears he/she might think or do something bad	0	1	2	f. Stomachaches	
				0	1	2	g. Vomiting, throwing up	
				0	1	2	h. Other (describe): _____	

PAGE 3 Be sure you answered all items. Then see other side.

Please print. Be sure to answer all items.

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0	1	2	57. Physically attacks people	0	1	2	84. Strange behavior (describe): _____
0	1	2	58. Picks nose, skin, or other parts of body (describe): _____	0	1	2	85. Strange ideas (describe): _____
0	1	2	59. Plays with own sex parts in public	0	1	2	86. Stubborn, sullen, or irritable
0	1	2	60. Plays with own sex parts too much	0	1	2	87. Sudden changes in mood or feelings
0	1	2	61. Poor school work	0	1	2	88. Sulks a lot
0	1	2	62. Poorly coordinated or clumsy	0	1	2	89. Suspicious
0	1	2	63. Prefers being with older kids	0	1	2	90. Swearing or obscene language
0	1	2	64. Prefers being with younger kids	0	1	2	91. Talks about killing self
0	1	2	65. Refuses to talk	0	1	2	92. Talks or walks in sleep (describe): _____
0	1	2	66. Repeats certain acts over and over; compulsions (describe): _____	0	1	2	93. Talks too much
0	1	2	67. Runs away from home	0	1	2	94. Teases a lot
0	1	2	68. Screams a lot	0	1	2	95. Temper tantrums or hot temper
0	1	2	69. Secretive, keeps things to self	0	1	2	96. Thinks about sex too much
0	1	2	70. Sees things that aren't there (describe): _____	0	1	2	97. Threatens people
0	1	2	71. Self-conscious or easily embarrassed	0	1	2	98. Thumb-sucking
0	1	2	72. Sets fires	0	1	2	99. Smokes, chews, or sniffs tobacco
0	1	2	73. Sexual problems (describe): _____	0	1	2	100. Trouble sleeping (describe): _____
0	1	2	74. Showing off or clowning	0	1	2	101. Truancy, skips school
0	1	2	75. Too shy or timid	0	1	2	102. Underactive, slow moving, or lacks energy
0	1	2	76. Sleeps less than most kids	0	1	2	103. Unhappy, sad, or depressed
0	1	2	77. Sleeps more than most kids during day and/or night (describe): _____	0	1	2	104. Unusually loud
0	1	2	78. Inattentive or easily distracted	0	1	2	105. Uses drugs for nonmedical purposes (<i>don't</i> include alcohol or tobacco) (describe): _____
0	1	2	79. Speech problem (describe): _____	0	1	2	106. Vandalism
0	1	2	80. Stares blankly	0	1	2	107. Wets self during the day
0	1	2	81. Steals at home	0	1	2	108. Wets the bed
0	1	2	82. Steals outside the home	0	1	2	109. Whining
0	1	2	83. Stores up too many things he/she doesn't need (describe): _____	0	1	2	110. Wishes to be of opposite sex
				0	1	2	111. Withdrawn, doesn't get involved with others
				0	1	2	112. Worries
				0	1	2	113. Please write in any problems your child has that were not listed above:
				0	1	2	_____
				0	1	2	_____
				0	1	2	_____

PAGE 1

Please be sure you answered all items.

References

- Achenbach, T.M. (1991). *Integrative Guide for the 1991 CBCL/4-18, YSR, and TRF Profiles*. Burlington, VT: University of Vermont Department of Psychiatry.
- Albano, A.M., Chorpita, B.F., & Barlow, D.H. (1996). Childhood anxiety disorders. In E.J. Mash (Ed.). *Child psychopathology*. (pp. 196-241). New York: The Guilford Press.
- Albano, A.M., Detweiler, M.F., & Logsdon-Conradsen, S. (1999). Cognitive-behavioral interventions with socially phobic children. In Russ, S.W. & Ollendick, T.H. (Eds.). *Handbook of psychotherapies with children and families* (pp. 255-280). New York: Plenum Publishers.
- Albano, A.M., DiBartolo, P.M., Heimberg, R.G., & Barlow, D.H. (1995). Children and adolescents: Assessment and treatment. In R.G. Heimberg, M.R. Liebowitz, et al. (Eds.). *Social Phobia: Diagnosis, assessment, and treatment* (pp. 387-425). New York: The Guilford Press.
- Albano, A.M., Marten, P.A., & Holt, C.S. (1991). *A Therapist's manual for cognitive-behavioral group therapy for adolescent social phobia*. Unpublished manuscript, State University of New York, Albany.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (4th ed.)* Washington, DC: Author.
- Anderson, J.C., Williams, S., McGee, R., & Silva, P.A. (1987). DSM-III disorders in preadolescent children. *Archives of General Psychiatry*, 44, 69-76.
- Beidel, D.C. (1991). Social phobia and overanxious disorder in school-age children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 30,

545-552.

- Beidel, D.C., & Morris, T.L. (1995). Social phobia. In J. March, et al. (Eds.). *Anxiety disorders in children and adolescents*. (pp.181-211). New York: The Guilford Press.
- Beidel, D.C., & Turner, S.M. (1998). *Shy children, phobic adults: Nature and treatment of social phobia*. Washington, DC: American Psychological Association.
- Beidel, D.C., Turner, S.M., & Morris, T.L. (1995). A new inventory to assess childhood social anxiety and phobia: The Social Phobia and Anxiety Inventory for Children. *Psychological Assessment*, 7, 73-79.
- Beidel, D.C., Turner, S.M., & Morris, T.L. (1996). *Social Effectiveness Training for Children: A treatment manual*. Unpublished manuscript, Medical University of Charleston, South Carolina.
- Beidel, D.C., Turner, S.M., & Morris, T.L. (1999). Psychopathology of childhood social phobia. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 643-650.
- Beidel, D.C., Turner, S.M., & Morris, T.L. (2000). Behavioral Treatment of childhood social Phobia. *Journal of Consulting and Clinical Psychology*, 68(16), 1072-1080.
- Bierman, K.L., & McCauley, E. (1987). Children's descriptions of their peer interactions: Useful information for clinical child assessment. *Journal of Clinical Child Psychology*, 16, 9-18.
- Bobes, J. (1998). How is recovery from social anxiety disorder defined? *Journal of*

- Clinical Psychiatry*, 67, (suppl 17) 12-16.
- Buss, A.H. (1980). *Self-consciousness and social anxiety*. San Francisco: Freeman.
- Carlson, C.L., Lahey, B.B., & Neeper, R. (1984). Peer assessment of the social behavior of accepted, rejected, and neglected children. *Journal of Abnormal Child Psychology*, 12, 187-198.
- Cavell, T.A., & Kelly, M.L. (1992). The measure of adolescent social performance: Development and initial validation. *Journal of Clinical Child Psychology*, 21(2), 107-115.
- Chambers, C.T. (2002). Developmental differences in children's use of rating scales. *Journal of Pediatric Psychology*, 27(1), 27-36.
- Costello, E.J. (1989). Child psychiatric disorders and their correlates: A primary care pediatric sample. *Journal of the American Academy of Child and Adolescent Psychiatry*, 28, 851-855.
- Eddy, J.M., Dishion, T.J., & Stoolmiller, M. (1998). The analysis of intervention change in children and families: Methodological and conceptual issues embedded in intervention studies. *Journal of Abnormal Child Psychology*, 26(1), 53-70.
- Ferrell, C.B., Beidel, D.C., & Turner, S.M. (2002). A scale to determine treatment effectiveness of childhood social phobia: The Child Social Functioning Inventory (CSFI). Unpublished manuscript.
- Foster, S.L., & Mash, E.J. (1999). Assessing social validity in clinical treatment research: Issues and procedures. *Journal of Consulting and Clinical Psychology*, 67, 300-319.
- Foster, S.L., Inderbitzen, H.M., & Nangle, D.W. (1993). Assessing acceptance and

- social skills with peers in childhood. Current issues. *Journal of Abnormal Child Psychology*, 17(3), 233-243.
- Francis, G. (1990). Social phobia in childhood. In M. Hersen, C. Last, et al. (Eds.). *Handbook of child and adult psychopathology: A longitudinal perspective*. (pp. 163-168). New York: Pergamon Press, Inc.
- Francis, G., & Ollendick, T.H. (1990). Behavioral treatment of social anxiety. In Feindler, E.L., Kalfus, G.R., et al. (Eds.). *Adolescent behavior therapy handbook. Springer series on behavior therapy and behavioral medicine* (pp. 127-145). New York: Springer Publishing Co, Inc.
- Francis, G. & Radka, D.F. (1995). Quality of life in anxiety disorders. In H.Katschnig, H.Freeman, & N. Sartorius (Eds.). *Quality of life in mental disorders*. (pp. 149-163). New York: Wiley & Sons.
- Gullone, E. (2000). The development of normal fear: A century of research. *Clinical Psychology Review*, 20(4), 429-451.
- Harter, S., & Whitesell, N. R. (1989). Developmental changes in children's understanding of single, multiple, and blended emotion concepts. In C. Saarni & P. L. Harris (Eds.), *Children's understanding of emotion* (pp. 81 -116). Cambridge: Cambridge University Press.
- Helper, J.B. (1990). Social behavior patterns and interactions of elementary school children. *Social Work in Education*, 12, 104-118.
- Hofmann, S., Newman, M., Ehlers, A., & Roth, W. (1995). Psychophysiological differences between subgroups of social phobia. *Journal of Abnormal Psychology*, 104, 224-231.

- Howard, K.I., Moras, K., Brill, P.L., Martinovich, Z., & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist, 51*, 1059-1064.
- Inderbitzen, H.M., Walters, K.S., & Bukowski, A.L. (1997). The role of social anxiety in adolescent peer relations: Differences among sociometric status groups and rejected subgroups. *Journal of Clinical Child Psychology, 26*(4), 338-348.
- Jacobson, N.S., & Christensen, A. (1996). Studying the effectiveness of psychotherapy. *American Psychologist, 51*, 1031-1039.
- Jacobson, N.S., Roberts, L.J., Berns, S.B., & McGlinchey, J.B. (1999). Methods for defining and determining the clinical significance of treatment effects: Description, application, and alternatives. *Journal of Consulting and Clinical Psychology, 67*, 300-307.
- Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to Defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*, 12-19.
- Juster, H.R. & Heimberg, R.G. (1995). Social phobia longitudinal course and long-term outcome of cognitive-behavioral treatment. *Psychiatric Clinics of North America, 18*, 821-842.
- Kashani, J.H., & Orvaschel, H. (1990). A community study of anxiety in children and adolescents. *American Journal of Psychiatry, 147*, 313-318.
- Kashani, J.H., Overaschel, H., Rosenberg, T.K., & Reid, J.C. (1989). Psychopathology in community sample of children and adolescents: A developmental perspective. *Journal of the American Academy of Child and*

Adolescent Psychiatry, 28, 701-706.

- Kashdan, T.B. & Herbert, J.D. (2001). Social anxiety disorder in childhood and adolescence: Current status and future direction. *Clinical Child and Family Psychology Review*, 4(1), 37-61.
- Kazdin, A.E. (2000). *Psychotherapy for Children and Adolescents*. (pp. 45-47). New York: Oxford University Press.
- Kazdin, A.E., & Kendall, P.C. (1998). Current progress and future plans for developing effective treatments: Comments and perspectives. *Journal of Clinical Child Psychology*, 27(2), 217-226.
- Kendall, P. C. (1999). Clinical significance. *Journal of Consulting and Clinical Psychology*, 67, 283-284.
- Kendall, P. & Warman, M. (1996). Anxiety disorders in youth: Diagnostic consistency across DSM-III-R and DSM-IV. *Journal of Anxiety Disorders*, 10, 453-463.
- Kessler, R.C., McGonagle, K.A., Zhao, S., Nelson, C.B., Hughes, M., Eshelman, S., Wittchen, H.U., & Dendler, K.S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry*, 51, 8-19.
- King, N., Murphy, G.C., & Heyne. (1997). The nature and treatment of social phobia in youth. *Counseling psychology quarterly*, 10, 377-387.
- LaGreca, A.M., & Lopez, N. (1998). Social anxiety among adolescents: Linkages with peer relations and friendships. *Journal of Abnormal Child Psychology*, 26, 83-94.

- LaGreca, A.M., & Stone, W.L. (1993). Social Anxiety Scale for Children – Revised: Factor structure and concurrent validity. *Journal of Clinical Child Psychology*, 72, 17-27.
- Last, C.G., & Strauss, C.C. (1990). School refusal in anxiety-disordered children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 29, 31-35.
- Lonigan, C.J., Elbert, J.C., & Johnson, S.B. (1998). Empirically supported psychological interventions for children: an overview. *Journal of Clinical Child Psychology*, 27(2), 138-145.
- Marsh, H. W. (1986). Negative item bias in ratings scales for preadolescent children: A cognitive-developmental phenomenon. *Developmental Psychology*, 22, 37 -49.
- Masia, C.M., Klein, R.G., Storch, E.A., & Corda, B. (2001). School-based behavioral treatment for social anxiety disorder in adolescents: Results of a pilot study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40(7), 780-786.
- Masia-Warner, C.M., Storch, E.A., Pincus, D.B., Klein, R.G., Heimberg, R.G., & Liebowitz, M.R. (2003). The liebowitz social anxiety scale for children and adolescents: An initial psychometric investigation. *The Journal of the American Academy of Child and Adolescent Psychiatry*, 42(9), 1076-85.
- Matson, J.L., Rotatori, A.F., Helsel, W.J. (1983). Development of a rating scale to measure social skills in children: The matson evaluation of social skills with youngsters (MESSY). *Behaviour Research and Therapy*, 21, 335-340.

- Mintz, J., Drake, R.E., Crits-Christoph, P. (1996). Efficacy and effectiveness of psychotherapy: Two paradigms, one science. *American Psychologist*, 51, 1084-1085.
- Muris, P., Merckelbach, H., Mayor, B., & Prins, E. (2000). How serious are common childhood fears? *Behavior Research and Therapy*, 38, 217-228.
- Norquist, G.S. (2002). Role of outcome measurement in psychiatry. In W.M. IsHak, T. Burt (Eds.). *Outcome measurement in psychiatry: A critical review*. Washington, DC: American Psychiatric Publishing, Inc., 8-13.
- Ollendick, T.H. (1983). Reliability and validity of the Revised Fear Survey Schedule for Children (FSSC-R). *Behaviour Research and Therapy*, 21, 685-692.
- Rapee, R.M. (1995). Descriptive psychopathology of social phobia. In R.G. Heimberg, M.R. Liebowitz, et al. (Eds.). *Social Phobia: Diagnosis, assessment, and treatment* (pp. 41-66). New York: The Guilford Press.
- Rosenthal, T.L., Muram, D., Arheart, K.L., & Bryant, E.S. (1994). A brief leisure interests checklist for teenagers: Initial results. *Journal of Sex Education and Therapy*, 20, 30-40.
- Reyonlds, C.R., & Richmond, B.O. (1978). What I think and feel: A revised measure of children's manifest anxiety. *Journal of Abnormal Child Psychology*, 6, 271-280.
- Schneier, F.R. (1997). Quality of life in anxiety disorders. In H. Katschnig, H. Freeman, & N. Sartorius (Eds.). *Quality of life in mental disorders* (pp.149-163).
- Schneier, F.R., Johnson, J., Hornig, C.D., Liebowitz, M.R., & Weissman, M.M (1992). Social phobia: Comorbidity and morbidity in an epidemiologic

- sample. *Archives of General Psychiatry*, 49, 282-288.
- Seligman, M.P. (1995). The effectiveness of psychotherapy: The consumer report study. *American Psychologist*, 50, 965-974.
- Spence, S.H., Donovan, C., & Brechman-Toussaint, M. (2000). The treatment of childhood social phobia: The effectiveness of social skills training-based cognitive-behavioral intervention with and without parental involvement. *Journal of Child Psychology and Psychiatry*, 41(6), 713-726.
- Spence, S.H., Donovan, C., & Brechman-Toussaint, M. (1999). Social skills, social outcomes, and cognitive features of childhood social phobia. *Journal of Abnormal Psychology*, 108, 211-221.
- Strauss, C.C., & Last, C.G. (1993). Social and simple phobias in children. *Journal of Anxiety Disorder*, 7, 141-152.
- Turner, S.M., Beidel, D.C., Dancu, C.V., & Stanley, M.A. (1989). An empirically derived inventory to measure social fears and anxiety: The social phobia and anxiety inventory. *Psychological Assessment*, 1, 35-40.
- Turner, S.M., Beidel, D.C., Long, P.J., Turner, M.W., & Townsley, R.M. (1993). A composite measure to determine the functional status of treated social phobics: The social phobia endstate functioning index. *Behavior Therapy*, 24, 265-275.
- Turner, S.M., Beidel, D.C., & Wolff, P.L. (1994). A composite to determine improvement following treatment for social phobia: The index of social phobia improvement. *Behaviour Research & Therapy*, 32, 471-476.
- Velting, O.N., & Albano, A.M. (2001). Current trends in the understanding and

treatment of social phobia in youth. *Journal of Child Psychology and Psychiatry*, 42(1), 127-140.

Weisz, J.R., & Hawley, K.M. (1998). Finding, evaluating, refining, and applying empirically supported treatments for children and adolescents. *Journal of Clinical Child Psychology*, 27(2), 206-216.

Wittchen, H., Stein, M., & Kessler, R. (1999). Social fears and social phobia in a community sample of adolescents and young adults: Prevalence, risk factors, and comorbidity. *Psychological Medicine*, 29, 309-323.