This present chapter discusses the relationship between social anxiety and socialization among adolescents. In particular, the text addresses the associations among social anxiety disorder, social development, and social experiences during adolescence. Treatment implications among adolescents are highlighted in the context of a case study.
Social anxiety disorder is a condition characterized by abnormal fears of social situations and is one of the most prevalent psychological problems among adolescents (American Psychiatric Association [APA], 2000). The disorder typically emerges in adolescence, with average age of onset between 12 and 16 years of age (Rapee & Spence, 2004; Schneier, Johnson, Hornig, & Liebowitz, 1992; Silverman et al., 1999; Strauss & Last, 1993). Without treatment, social anxiety typically runs a chronic course (APA, 2000; Turner & Beidel, 1989; Wittchen, Stein, & Kessler, 1999).

The terms social anxiety disorder, social phobia, and social anxiety are often used interchangeably in research literature, even though they may have different connotations. Social anxiety disorder and social phobia refer to clinically significant features that meet specific diagnostic criteria set forth by the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM-IV) (APA, 2000) and are defined as a “marked and persistent fear of one or more social or performance situations” (APA). The term social anxiety typically serves as a more general term for which the presentation of social anxiety may not meet diagnostic criteria for social anxiety disorder/social phobia, though fear of social situations and interference with daily functioning are still present. For the sake of conciseness, this chapter will refer to these phenomena as “social anxiety disorder” from this point forward (unless specified). Social anxiety disorder is categorized into two subgroups, generalized and non-generalized. Social anxiety disorder is specified as generalized when an individual’s fears occur during most social situations (APA), whereas non-generalized (also known as performance-based, circumscribed, or specific social anxiety) denotes a fear of a single performance situation and some, but not most, social situations (APA). Music performance anxiety and reading aloud in front of a class are examples of these non-generalized, specific situations. The debate over the usefulness of these subgroups has raised questions as to whether social anxiety disorder can be understood as a continuum with different levels of severity and presentation or as a categorical perspective of either meeting criteria or not (Bögels et al., 2010; Marmorstein, 2006). Another controversial topic within the conceptualization of social anxiety is the potential classification of non-generalized (performance-based) social anxiety as a specific phobia rather than simply a subtype (Bögels et al., 2010).

Within the child and adolescent population, studies have suggested that 1% meet diagnostic criteria for social anxiety disorder at any time for males and females (Beidel, Turner, & Morris, 1999; Kashani & Orvaschel, 1990). However, this percentage may underestimate the true prevalence.
of the disorder because many studies are based on revised diagnostic criteria system of social anxiety disorder that specifically excludes public speaking from the diagnostic category. Speaking or reading in front of a group is one of the most common social fears in adolescents, with percentages of adolescents with social anxiety disorder endorsing this specific fear as high as 90% (Beidel et al., 1999). Subclinical rates (i.e., symptoms that fall short of meeting diagnostic criteria) of social anxiety disorder are significantly elevated. For example, one study found 22% of 8-year-olds, 46% of 12-year-olds, and 56% of 17-year-olds reported fears associated with social situations (Kashani & Orvaschel, 1990). Adolescence is a time of social comparison and beliefs that others are evaluating oneself (Piaget, 1958). During adolescence, self-awareness and self-consciousness continue to develop, and shyness and withdrawal often begin to be perceived as more problematic by peers (Hymel, Rubin, Rowden, & Le Mare, 1990). As youth with social anxiety disorder continue to develop cognitively, they begin to increase their abilities to see others’ perspectives and compare themselves with others, potentially increasing any preexisting social evaluative fears (Morris, Hirshfeld-Becker, Henin, & Storch, 2004). Avoidance of social interactions and anxious behaviors during social and school situations may adversely affect overall social functioning and development, and negative experiences may increase anxiety regarding future social interactions (Inderbitzen, Walters, & Bukowski, 1997; Rubin & Burgess, 2001). Thus, difficulties with socialization may serve as both a cause and a consequence of social anxiety disorder.

Beyond socialization difficulties, youth with social anxiety are likely to experience difficulties in academic and future occupational functioning, making this disorder a frequent impairment into and throughout adulthood. For example, children and adolescents with social anxiety often have poor academic performance that is coupled with difficulty attending school (Beidel & Turner, 2007; Kingery, Erdley, Marshall, Whitaker, & Reuter, 2010; Mychailyshyn, Mendez, & Kendall, 2010; Seipp, 1991). Symptoms of anxiety in childhood have been found to significantly predict poorer standardized achievement scores (Ialongo, Edelsohn, Wertherman-Larsson, Crockett, & Keliam, 1995), and teachers subjectively rate children with social anxiety children lower in academic performance than their peers (Strauss, Frame, & Forehand, 1987).

Additionally, academic problems associated with social anxiety often persist into adulthood, with approximately 90% of college students with social anxiety reporting academic difficulties such as poor grades, infrequent class participation, and avoidance of classes with public speaking requirements, and decisions to not attend graduate school (Turner, Beidel, Borden, Stanley, & Jacob, 1991). Beyond academics, individuals with social anxiety also tend to have problems in other realms (e.g., occupational, addiction) that persist into adulthood. The small body of literature exploring the relationship between social anxiety and occupational functioning suggests that individuals with social anxiety exhibit occupational difficulties, including problems obtaining employment, accepting job offers, and receiving promotions (Stein, Torgud, & Walker, 2000). Furthermore, adults with social anxiety are significantly less likely to initiate conversations and engage in interactions with coworkers and report greater hardships in work relationships (Yeganeh, 2006).

The complex relationship between socialization and social anxiety symptoms has implications for understanding the manifestation of social anxiety disorder, as well as the development of appropriate and effective interventions for youth presenting with its symptoms. This chapter will provide a brief overview of social anxiety disorder among adolescents. Next, we will discuss the relationships among social anxiety disorder, social development, and social experiences during adolescence. Finally, we will conclude with a discussion of the implications for treatment of this disorder among adolescents and the presentation of a case study to illustrate these concepts.

Physical, Cognitive, and Behavioral Symptoms

Symptoms of clinical and subclinical adolescent social anxiety disorder are usually classified into three categories: physical/somatic, cognitive, and
behavioral. However, the boundary between
clinical and subclinical presentations of social
anxiety has been controversial in recent literature.
The DSM-III-R and DSM-IV do not provide clear
guidelines for distinguishing between clinical and
subclinical presentations of social anxiety (Stein,
1995), often making diagnostic decisions difficult.
Social anxiety is prevalent in the general popu-
lation (Stein & Walker, 1994), and those with sub-
clinical levels of social anxiety close to the
diagnostic cutoff often present with equal levels
of disability (Stein, 1995). Thus, due to the lack of
specific diagnostic thresholds, clinicians are often
forced to make a full diagnosis of social anxiety
disorder based on other subjective factors. Some
researchers have attempted to clarify the clinical
versus subclinical distinction by viewing anxiety
in children and adolescents on a continually
changing trajectory over time (Weems, 2008;
Weems & Stickle, 2005). One way to view this
trajectory is to redefine how we diagnose social
anxiety disorder according to the DSM-IV
(Weems & Stickle). By casting what these col-
leagues refer to as a wider “nomological net,”
children experiencing social anxiety could have
clinical diagnoses based both on symptoms and
mechanisms of anxiety. This would allow for
more precise classification of types of social
anxiety among adolescents without a strict two-
dimensional view of a child having either clinical
or subclinical social anxiety. This view suggests
that most youth have varying levels of anxiety
throughout their development, which is likely to
fluctuate in severity and impairment based on
continually changing biological, social, environ-
mental, and other factors (Weems, 2008). In other
words, while some core characteristics of social
anxiety may remain stable and continuous for
anxious adolescents, other symptoms are likely to
fluctuate in clinical severity across time. The clin-
ical versus subclinical debate is likely to persist as
researchers continue to more accurately define
social anxiety among adolescents. Regardless,
symptom presentation among youth with social
anxiety disorder has important implications for
case conceptualization and treatment, as the vari-
ous types of symptoms may affect the social func-
tioning of adolescents in different ways.

Social anxiety disorder can include a wide
variety of somatic symptoms, including nausea,
sweating, heart palpitations, choking, fainting,
headaches, stomachaches, and panic attacks
(Beidel et al., 1999; Beidel, Christ, & Long,
1991). Adolescents who experience somatic
symptoms of anxiety may interpret threat in
social situations (thus, linking with cognitive
symptoms) or may perceive that they are sick and
therefore leave/avoid the social situation (thus,
linking with behavioral symptoms).

Cognitive symptoms of social anxiety disorder
include expecting to perform poorly, negative
appraisal of personal performance, negative
self-talk, social pessimism, perceived low social
acceptance and self-worth, increased levels of
loneliness, low expectations for social perfor-
mancc, and overall, more negative thoughts and
less positive thoughts (Alfano, Beidel, & Turner,
2006; Erath, Flanagan, & Bierman, 2007).

Table 12.1 contains a review of various empirical
studies investigating the cognitive domains asso-
ciated with social anxiety disorder.

Finally, behavioral symptoms can be classified
into three subcategories: social, school, and other
behaviors. Social behavioral symptoms of social
anxiety disorder include avoiding age-appropriate
social behaviors, such as dating and partying;
fear or avoidance of situations where scrutiny
from others may occur; social withdrawal; social
isolation; fewer friendships; and social impairment
(Bögels et al., 2010; Ginsburg et al., 1998; La
Greca & Lopez, 1998; Sutker & Adams, 2001;
Vernberg, Abwender, Ewell, & Beery, 1992).

School behaviors of social anxiety disorder
include withdrawal, school refusal, and decreased
participation in physical, team-based, and com-
petitive activities (Beidel & Turner, 2007; Bögels
et al., 2010; Van Roy, Kristensen, Groholt, &
Clench-Aas, 2009). Other behavioral signs of
social anxiety disorder include crying, selective
mutism, stuttering, limited eye contact, nail
biting, and mumbling (Albano, DiLillo, Heimberg, & Barlow, 1995; Beidel & Turner,
1998; Ollendick & Ingman, 2001).

Although symptom presentation will likely
vary by adolescent, each of the physical, cognitive,
and behavioral symptoms may affect the social
### Table 12.1  Recent empirical literature concerning cognitive symptoms for social anxiety in children and adolescents

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample size (N)</th>
<th>Participants</th>
<th>Objectives</th>
<th>Key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alfano et al. (2006)</td>
<td>80</td>
<td>Children ages 7–11 and adolescents ages 12–16</td>
<td>To examine different cognitive phenomena in children and adolescents who exhibit socially phobic tendencies</td>
<td>Socially anxious children and adolescents were more likely to expect to perform poorly and evaluate their performance as more inferior compared to the control groups. Socially phobic adolescents engaged in negative self-talk in social interactions</td>
</tr>
<tr>
<td>Beidel, Turner, and Morris (1991)</td>
<td>72</td>
<td>Children ages 7–14</td>
<td>To depict the clinical syndrome of socially anxious children</td>
<td>Socially phobic children reported extreme loneliness. Compared to the control group, socially phobic children rated higher on neuroticism and lower on extroversion</td>
</tr>
<tr>
<td>Chansky and Kendall (1997)</td>
<td>78</td>
<td>Children ages 9–15</td>
<td>To examine the link between social anxiety and negative social experiences</td>
<td>The anxiety disorder group perceived themselves as less socially competent compared to the control group and had negative expectations about being accepted by peers</td>
</tr>
<tr>
<td>Crick and Ladd (1993)</td>
<td>338</td>
<td>Children in third grade (M_{age} = 9.5) and fifth grade (M_{age} = 11.4)</td>
<td>Assessment of sociometric status in relation to loneliness, social anxiety, social avoidance, and attribution for social outcomes</td>
<td>Rejected children exhibit higher levels of social distress and loneliness than any other status group. Rejected children were more likely to view peers as the cause for their social difficulties compared to other status groups</td>
</tr>
<tr>
<td>Erath et al. (2007)</td>
<td>84</td>
<td>Adolescents in sixth and seventh grades</td>
<td>Evaluate social anxiety with negative social performance, maladaptive coping skills, and social skill deficits</td>
<td>Socially anxious adolescents exhibited less prosocial behavior and more social withdrawal compared to the control group. The socially anxious adolescents were associated with negative expectations in social performance</td>
</tr>
<tr>
<td>Ginsburg, La Greca, and Silverman (1998)</td>
<td>154</td>
<td>Children ages 6–11</td>
<td>Examine the relationship between social anxiety and children’s emotional and social functioning</td>
<td>Highly socially anxious children reported low perceived social acceptance and global self-worth. They also reported more negative interactions with peers compared to lower socially anxious children</td>
</tr>
<tr>
<td>La Greca and Lopez (1998)</td>
<td>250</td>
<td>Adolescents in 10th through 12th grades</td>
<td>Measure social anxiety in relation with social support, perceived competence, and best friendships</td>
<td>Highly socially anxious adolescents perceived low general peer acceptance and felt less romantically attractive to others</td>
</tr>
<tr>
<td>Spence, Donovan, and Brechman-Toussaint (1999)</td>
<td>54</td>
<td>Children ages 7–14</td>
<td>Measure social anxiety in relation to self-talk, self-evaluation of performance, and outcome expectancies</td>
<td>Socially phobic children had higher levels of negative cognitions in social tasks, anticipated negative outcomes in social tasks, and evaluated their own performance more negatively as compared to the control group</td>
</tr>
<tr>
<td>Stopa and Clark (1993)</td>
<td>36</td>
<td>Adults</td>
<td>Measure social anxiety in relation to self-talk, self-evaluation to performance, and actual performance</td>
<td>Socially phobic participants reported more negative self-evaluative thoughts and had more negative thoughts on behaviors in social situations as compared to the control groups</td>
</tr>
</tbody>
</table>
functioning of the individual (Langley, Bergman, McCracken, & Piacentini, 2004). The impact of social anxiety disorder on the social functioning and peer interactions in adolescence will be presented in detail in the following section.

### Social Anxiety and Socialization

Peers play a critical role in influencing the development of self-concept, health behaviors and norms, feelings of belongingness in school, psychosocial adjustment, and social and risk-taking behaviors during adolescence through interactions, friendships, and romantic relationships (for a review of relevant studies, please see Table 12.2). In fact, imaging studies show that areas of the brain associated with social cognitions and processing continue to develop during adolescence and thus may be shaped, in part, by social experiences (Sebastian, Viding, Williams, & Blakemore, 2010). Thus, engagement in positive peer friendships, social activities, and romantic relationships is critical for psychosocial adjustment and healthy transition into adulthood (Simon, Aikins, & Prinstein, 2008; Waldrip, Malcolm, & Jensen-Campbell, 2008).

Youth with social anxiety disorder may not experience the same quality or quantity of positive interactions with peers. That is, the somatic, cognitive, and behavioral symptoms may affect the frequency by which the adolescent interacts with peers, as well as place the individual at risk for future negative interactions with peers. An understanding of the complex interplay of social experiences, socialization, and social anxiety is critical to developing treatment strategies for adolescents with social anxiety disorder.

The relationship between social anxiety and withdrawal can be conceptualized as cyclical in nature (Inderbitzen et al., 1997; Rubin & Burgess, 2001). Behavioral symptoms of social anxiety disorder involve avoiding social situations, leading to a lack of peer interaction that limits opportunities for adolescents to develop and practice important social skills. Unfortunately, because socially anxious youth often have limited opportunities to develop and practice social skills with peers, their skills are likely to continue to lag behind their peers across development, limiting the experience of the benefits friendships can provide (Kingery et al., 2010; Siegel, LaGreca, & Harrison, 2009). These deficits in social skills may place the adolescents at risk for being targets of bullying and other forms of peer victimization. Additionally, as overt signs of anxiety become more severe, adolescents experience increased risk for peer victimization (Ollendick & Hirshfeld-Becker, 2002; Siegel et al., 2009; Storch, Brassard, & Masia-Warner, 2003). Finally, negative social interactions may lead to increased social anxiety, lower expectations of social situation performance, and lower self-esteem (Rubin & Burgess, 2001). Figure 12.1 presents a proposed model depicting the cyclical nature of the relationships among social anxiety, social development, and social experiences. Each component of the model is described in detail in the following section.

### Decreased Interactions with Peers

One early correlate with social anxiety that tends to be stable across time (often extending into adolescence) is behavioral inhibition (a pattern of withdrawal, avoidance, fear of the unfamiliar, and sympathetic nervous system hyperarousal; Morris et al., 2004). Children with behavioral inhibition tend to approach early school years (e.g., preschool, kindergarten) with reserve, reticence, and quiet watching behavior, particularly when they are with unfamiliar peers (Hirshfeld-Becker, 2010; Hirshfeld-Becker et al., 2008; Kagan, Reznick, & Gibbons, 1989). Although these children are likely unable to articulate fears of social evaluation, they at the least tend to demonstrate debilitating fears of adults and other children that prohibit them from talking to new adults or peers, developing peer relationships, and going to places where new friends might be made (Morris et al., 2004). As early years are important in socialization, the presence of behavioral inhibition (an early risk factor for social anxiety; Biederman et al., 2001; Hirshfeld-Becker et al., 2008; Morris et al., 2004) could be at least
<table>
<thead>
<tr>
<th>Study</th>
<th>Sample size (N)</th>
<th>Participants</th>
<th>Objectives</th>
<th>Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brendgen, Lamarche, Wanner, and Vitaro (2010)</td>
<td>201</td>
<td>Children ages 11–13</td>
<td>Examine how friendship experiences (i.e., having no friends, having nondepressed friends, and having depressed friends) relate to depressed mood trajectories in early adolescents</td>
<td>Friendless youth demonstrated a more elevated trajectory of depressed mood than youth who had reciprocated relationships with nondepressed friends. Friendless youth demonstrated a lower trajectory of depressed mood than youth who had depressed friends.</td>
</tr>
<tr>
<td>Mackey and La Greca (2008)</td>
<td>236</td>
<td>Females ages 13–18</td>
<td>Examine a model linking girls’ peer crowd affiliations (e.g., Jocks, Populars) with weight concerns, perceived peer weight norms, and weight control behaviors</td>
<td>Girls’ level of identification with certain peer crowds was associated with girls’ self-reported concern and perceived peer concern with weight. Girls’ own concern and peer norms were independently related to girls’ weight control behaviors.</td>
</tr>
<tr>
<td>Masten, Juvonen, and Spatzier (2009)</td>
<td>364</td>
<td>Children in fourth, sixth, and eighth grades</td>
<td>Examine associations among school-based behaviors, perceptions of peer group norms for these behaviors, and inferences of parent values about these behaviors during adolescent onset (when parents and peers compete for influence)</td>
<td>Perceived parent values predicted academic and social behaviors at each grade level. Peer group norms predicted social behavior for all grades, but academic behavior was predicted by peers only for older students.</td>
</tr>
<tr>
<td>McIsaac, Connolly, McKenney, Pepler, and Craig (2008)</td>
<td>174</td>
<td>Adolescent couples ages 15–18</td>
<td>Explore associations between conflict negotiation and the expression of autonomy in adolescent romantic partners</td>
<td>Expressions of autonomy were associated with behavior of the self and behavior of the romantic partner. For facilitative and restrictive conflict responses, female autonomy was uniquely associated with her behavior; male autonomy reflected contributions from himself and his girlfriend.</td>
</tr>
<tr>
<td>Simon et al. (2008)</td>
<td>78</td>
<td>Children in sixth to eighth grades</td>
<td>Compare characteristics of participants’ friends to those of potential romantic partners, Examine how degree of similarity within friend and romantic dyads explains the importance of general and relationship-specific peer selection criteria</td>
<td>Romantic partners’ popularity, symptoms of depression, relational aggression, and relational victimization significantly predicted changes in functioning in these areas over time. Of these, only popularity and depressive symptoms were important to partner selection.</td>
</tr>
<tr>
<td>Vaquera (2009)</td>
<td>90,000</td>
<td>Adolescents in the 7th–8th grades</td>
<td>Explore relationships between friendship formation (e.g., having best friend at same school), school engagement, and belonging among White and Hispanic students</td>
<td>Hispanic students were more likely to be friendless than White counterparts, and Hispanics were also less likely to form friends in school. Both Hispanic and White youth who reported having a best friend also reported lower engagement problems and a higher sense of school belonging. However, only students whose best friend attended their same school reported higher levels of school belonging, suggesting that school belonging is only promoted by friendships within the school.</td>
</tr>
<tr>
<td>Waldrip et al. (2008)</td>
<td>238</td>
<td>Adolescents in the fifth to eighth grades</td>
<td>Examine unique contributions of peer acceptance, friendship, and victimization to adjustment</td>
<td>Adolescents who had less peer acceptance, fewer friends, and lower friendship quality had greater teacher-reported maladjustment. Friendship quality buffered against adjustment problems when peer acceptance and number of friends were low.</td>
</tr>
</tbody>
</table>
one preexisting trait that leads to socialization problems and social skills deficits in early childhood years. Socialization problems, which may persist into adolescence, may include decreased likelihood of forming friendships that are important to overall development. However, it is important to note that behavioral inhibition does not necessarily lead to social anxiety and that social anxiety, negative appraisals, and social evaluative fears are not always preceded by behavioral inhibition (Morris et al.). Regardless, any behavioral manifestations of social anxiety (e.g., extreme shyness, fear, withdrawal) are likely to interfere with normal social development in both childhood and adolescence. In fact, social skills deficits and negative social appraisals have often been cited as important childhood traits related to social anxiety disorder (Barrett, 2000; Hudson & Rapee, 2000; Ollendick & Hirshfeld-Becker, 2002).

During the adolescent years, behavioral symptoms of avoidance are often characteristic of youth with social anxiety disorder. These symptoms may include decreased classroom performance (e.g., avoiding speaking in class), refusing to attend school, and avoidance of participation in physical, team-based, and competitive activities (Beidel, Turner, & Young, 2006; Bögels et al., 2010; Van Roy et al., 2009). Additional social behavior symptoms include avoiding age-appropriate social behaviors such as dating and partying, fear or avoidance of situations where scrutiny from others can occur, social withdraw, social isolation, fewer friendships, and social impairment (Beidel et al., 2006; Bögels et al., 2010; Ginsburg et al., 1998; Ginsburg & Grover, 2005; La Greca & Lopez, 1998; Sutker & Adams, 2001; Vernberg et al., 1992). Decreased involvement in peer activities and avoidance of social interactions can inhibit friendship formation. Indeed, adolescent females with social anxiety disorder report having fewer best friends and having friendships that are lower in intimacy, companionship, and emotional support (La Greca & Lopez, 1998; Vernberg et al., 1992).

**Social Functioning Deficits**

Adolescents who are isolated from engaging in social activities show several difficulties with social development due to the lack of contact with peers, as they have fewer opportunities for corrective socialization experiences (Rubin & Stewart, 1996). Socially anxious children and adolescents demonstrate a range of social skills deficits, such as withdrawal and shyness and inappropriate assertiveness and aggression (Inderbitzen-Nolan, Anderson, & Johnson, 2007; Strauss, Lease, Kazdin, & Dulcan, 1989). Furthermore, longitudinal studies have demonstrated that adolescents with social skills deficits experience increased psychosocial problems (including social anxiety) when encountering new stress in their environments (Segrin & Flora, 2000), such as negative peer interactions (e.g., bullying).

**Negative Peer Interactions**

Behavioral and cognitive symptoms of social anxiety disorder and corresponding deficits in social functioning place adolescents at risk for negative peer interactions, such as peer victimization (e.g., bullying) and peer rejection (Grills & Ollendick, 2002; Inderbitzen et al., 1997;
La Greca & Lopez, 1998; Storch & Masia-Warner, 2004). Specifically, social avoidance and withdrawal, coupled with decreased friendships and deficits in social skills, make children with social anxiety disorder salient targets for aggressive peers. The link between social anxiety disorder and peer victimization may be particularly salient in the middle-school years when peer victimization is most prevalent (Nansel et al., 2001). During the early adolescent years especially, unskilled and withdrawn behavior is likely to invite harassment by peers who view youth with social anxiety as easy targets (Egan & Perry, 1998; Grills & Ollendick, 2002).

Adolescents who are repeatedly victimized by peers tend to report increased symptoms of social anxiety in adolescence and young adulthood (Dempsey & Storch, 2008; Grills & Ollendick, 2002; La Greca & Harrison, 2005; Siegel et al., 2009; Slee, 1994; Storch, Masia-Warner, Dent, Roberti, & Fisher, 2004; Storch, Nock, Masia-Warner, & Barlas, 2003), including fear of negative evaluation (a cognitive symptom of social anxiety; Slee, 1994; Storch, Brassard, et al., 2003; Storch & Masia-Warner, 2004).

### Negative Expectations Regarding Peer Interactions

Negative peer experiences in the form of peer victimization and peer rejection may place adolescents at risk for the emergence or exacerbation of symptoms of social anxiety disorder. The mechanism for this link may be the cognitions of the adolescent. For example, negative peer experiences may result in reduced expectations regarding success in future peer interactions, decreased self-efficacy for social relating, and increased fear of negative evaluations (Flanagan, Erath, & Bierman, 2008; Grills & Ollendick, 2002; Inderbitzen et al., 1997). Additionally, peer rejection experienced by adolescents who relocated to a new school led to greater fears of negative evaluation and subsequent social avoidance (Vernberg et al., 1992). Thus, adolescents with social anxiety disorder and a history of negative social experiences may experience disruptions in healthy social processing, such as perceiving threat in social situations that most would interpret as benign and decreased perceptions of self-efficacy.

### Treatment Approaches

Because there are several components to the proposed cyclical model linking social anxiety, social development, and peer interactions, treatment approaches for social anxiety disorder and socialization difficulties need to be directed to various parts of the relationship. Treatment approaches should incorporate strategies that directly target cognitive and behavioral symptoms of social anxiety, as well as behaviors and strategies to promote socialization and coping with negative peer experiences.

Cognitive-behavioral therapy approaches incorporate the multiple components into a comprehensive treatment plan for adolescents with social anxiety disorder. In addition, cognitive-behavioral interventions that include social skills training, exposure, and cognitive restructuring, such as the Stand Up, Speak Out program (Albano & DiBartolo, 2007), have been promising for implementation for youth with social anxiety disorder and a history of peer victimization at reducing symptoms of social anxiety and improving social interaction skills (Berry & Hunt, 2009; Chu & Harrison, 2007; Herbert et al., 2009).

Figure 12.2 provides a summary of the various treatment strategies that should be included in comprehensive cognitive-behavioral interventions and depicts how they related to the proposed model of social anxiety disorder, socialization, and social experiences. Each strategy will be reviewed in the following section.

### Exposure and Friendship Promotion

Treatment of socially anxious adolescents that experience negative social experiences has showed promising results when the treatment involves the identification and/or development of a social support system (La Greca & Harrison, 2005).
Exposure to opportunities in which successful, positive peer interactions are likely (e.g., activities that involve prosocial peers and shared interests) will encourage the development of friendships with same-age peers and challenge the veracity of maladaptive and irrational beliefs (see section on “Cognitive Restructuring”). Thus, encouraging adolescents with social anxiety to identify target peers or activities in which successful peer interactions are likely is a critical component in the treatment of social anxiety disorder. This should include exposing adolescents to activities for which they previously exhibited avoidance behaviors and are likely to be successful with appropriate support and training (Chu & Harrison, 2007).

In addition to providing opportunities for positive interactions with peers via exposure, therapists should also work with adolescents with social anxiety disorder to develop close friendships, as the presence of close friendships may help reduce symptoms of social anxiety and provide a buffer against future negative peer interactions (Hall-Lande, Eisenberg, Christenson, & Neumark-Sztainer, 2007; La Greca & Lopez, 1998). In support of this idea, affiliation with a peer crowd, no matter the status, is associated with reduced symptoms of social anxiety in adolescence (La Greca & Harrison, 2005). That is, peer crowd affiliation and corresponding peer acceptance may provide adolescents with opportunities to develop companionship, which in turn will inhibit social anxiety disorder manifestation (La Greca & Harrison).

Additionally, close friendships serve as a buffer for adolescents who are exposed to repeated experiences of peer victimization and may actually decrease the likelihood that victimization will happen in the future (Bowker, Spencer, & Salvy, 2010; Davidson & Demaray, 2007; Hodges, Boivin, Vitaro, & Bukowski, 1999; Pellegrini, Bartini, & Brooks, 1999). As socially anxious youth are particularly at risk for being targets of aggressive peers, factors found to build resilience among victims of bullying and peer victimization may be especially important to include in a comprehensive treatment approach.

In support of this, one research study indicated that adolescents with social anxiety who had close friendships were less likely to experience loneliness and peer victimization than those without close friendships (Erath, Flanagan, Bierman, & Tu, 2010). Additionally, adolescents with additional friendships (secondary friendships) also reported greater self-efficacy related to interacting with peers.
Social Skills Instruction

Simply presenting adolescents with opportunities for positive social interactions and friendship development may be insufficient for some adolescents with social anxiety disorder, as they may not have the social skills to facilitate positive interactions (Strauss et al., 1989). Existing social skills deficits may inhibit success in such interactions without adequate preparation. Therefore, a critical component of cognitive-behavioral treatment for many adolescents with this disorder is social skills training and rehearsal (Spence, Donovan, & Brechman-Toussaint, 2000). In non-clinical populations, social skills training leads to decreased symptoms of social anxiety and increased self-esteem (Bijstra & Jackson, 1998), though social skills instruction alone is not sufficient for monumental or lasting change. In fact, interventions including exposure are often noted as critical for the treatment of social anxiety disorder (Chu & Harrison, 2007; La Greca & Harrison, 2005).

Development of Coping Strategies

In addition to promoting positive, successful interactions with peers and developing close friendships, therapist should work with adolescents with social anxiety disorder to develop healthy coping with feelings of anxiety and negative peer interactions, such as bullying. Adolescents with social anxiety disorder are more likely to exhibit other comorbid psychosocial problems, such as alcohol and drug use (Amies, Gelder, & Shaw, 1983; DeWit, MacDonald, & Offord, 1999) and depression (Sterba et al., 2010). In addition, adolescents who are exposed to negative peer experiences are more likely to experience negative psychosocial outcomes (including depression and anxiety) when they employ maladaptive coping strategies (Hampel, Manhal, & Hayer, 2009), whereas adolescents who display problem-solving-oriented coping styles are less likely to experience psychosocial problems associated with bullying (Baldry & Farrington, 2005).

Cognitive Restructuring

A final critical component of cognitive-behavioral treatment strategies for adolescence with social anxiety disorder is cognitive restructuring to reduce negative cognitions associated with social anxiety (e.g., fear of negative evaluation, low self-efficacy, and social competence). In a meta-analysis examining the effectiveness of cognitive-behavioral therapy for adolescents with social anxiety disorder, Chu and Harrison (2007) noted that treatment should include modifications of maladaptive thinking and attitudes, identifying thinking errors, Socratic questioning, and developing coping thoughts. Therapists may work with adolescents to challenge automatic and irrational perceptions of social situations as threatening and to instead use self-talk to train themselves to use more adaptive cognitions.

Illustrative Case Study

The problem of social anxiety disorder as it relates to socialization is clearly complex, and treatment must be multifaceted to address multiple issues in the relationship. The following case study describes an adolescent who presented for therapy with one of the authors. Care has been taken to alter details of the case to protect the anonymity of the individual.

Lauren was a 16-year-old student who moved to a new school at the start of her 11th grade year. Her mother referred her for therapy midway through the school year due to difficult interactions Lauren was experiencing with her peers, including social exclusion, rumor spreading, teasing, and mild physical aggression (e.g., pushing her in the hallways). Her mother noted concerns that Lauren begged and cried most mornings (particularly on Mondays) to be excused from school. Lauren’s mother allowed her to stay home approximately once per week.

During the first few therapy sessions, it quickly became apparent that Lauren had a history of social isolation. She had only one close friend who had lived in a different city from her for several years. Lauren saw her best friend approximately...
once each summer and talked to her intermittently via email. She was not involved in any clubs, sports, or group activities, though did regularly attend private violin lessons and attended a 1-week music camp two summers before with her best friend.

When moving to the new school, Lauren initially received invitations from peers to join them on social activities. However, Lauren told her mother she did not want to go to such activities because she did not really know the other girls and would feel awkward because she did not know what they would talk about. After several declines, the invitations stopped and bullying at school began. Lauren’s peers reportedly teased her about her clothes and hairstyle, called her names, did not talk with her at lunch, and threw bits of paper at her during class.

Lauren revealed that she hated to attend school because she expected that her peers would tease her. During class, she did not speak for fear that she would say something wrong that would target her for further bullying. Lunch was particularly difficult for Lauren. Her school had assigned seating at lunch, and Lauren did not talk to her peers sitting near her. She reported feeling so upset at lunch that she would do or say something wrong that she often did not eat and would ask to go to the nurse’s office due to nausea. Prior to presenting for therapy, Lauren’s distress had become so severe that she was showing signs of depression, including frequent crying, loss of interest in playing her violin, and indicating suicidal ideation.

Lauren exhibited a number of symptoms of social anxiety that were functionally related to her difficulties with social interactions. Behavioral symptoms of Lauren’s social anxiety included a clear pattern of withdrawal and avoidance of social interactions, indicative of a generalized subtype of social anxiety disorder. Although it was not possible to determine whether social skills deficits preceded the social avoidance, it was evident that Lauren lacked certain social skills necessary for successful peer interaction (e.g., not accepting social interactions because she did not know what to talk about with peers). Furthermore, her difficulty interacting with peers increased her avoidance of social situations, as evidenced by her refusal to accept social invitations, and prevented her from forming friendships with her fellow students. Thus, instead of befriending her, students at school selected Lauren as a target for bullying. Her ability to cope with the bullying was diminished, as she did not have a strong social support network and her existing coping strategies were insufficient for handling the high level of stress. Finally, the bullying contributed to an exacerbation of her social anxiety symptoms, as she felt even more fearful that she would behave in a way that would cause her to be negatively evaluated, thus leading to heightened behavioral avoidance.

Therapy for Lauren was multifaceted and targeted multiple domains of functioning. First, the therapist provided Lauren with psychoeducation about social anxiety and the types of strategies that would be implemented in therapy, including exposure and cognitive restructuring. Next, the therapist worked with Lauren to review social approach strategies and conversation topics for peer interactions and rehearse these skills with her. Lauren worked with the therapist to identify social settings in which she could implement these strategies and success would be likely. Lauren identified one peer who sat near her at lunch who did not engage in bullying and who had originally attempted to befriend Lauren when she first attended the school. Following successful interactions with this peer (including attending the peer’s birthday party), Lauren, the therapist, and Lauren’s parents agreed to identify group activities in which Lauren could interact in a structured setting with peers with shared interests. Lauren agreed to join the school orchestra to play the violin (no auditions were necessary). During this time, Lauren’s mother began to resist supporting Lauren’s behavioral avoidance by not excusing her from school and collaborating with the school nurse to limit the amount of time Lauren was allowed to stay in the clinic.

Cognitive monitoring and restructuring was used during each exposure activity. Strategies for cognitive restructuring included using scripted self-statements prior to engaging in peer interactions and directly challenging maladaptive and
irrational beliefs related to fear of negative evaluations, social competence, and self-efficacy. For example, self-statements included “I am a nice person and a good artist and have interesting things to talk about.” She also mentally reminded herself that only a minority of students in her class were mean and engaged in bullying behavior and many students had actually been friendly toward her.

Although bullying behavior did decrease per Lauren’s report over the course of the school year and as Lauren began to form friendships (though not yet close friendships) with individuals in the orchestra, Lauren and the therapist identified appropriate coping strategies for when she was bullied. These included removing herself from the situation, using self-talk to remind herself of her positive attributes and positive peer interactions, and engaging in enjoyable activities to avoid rumination over the events.

Lauren participated in weekly therapy sessions and completed therapy assignments when not in sessions over the course of approximately 5 months. At discharge, Lauren continued to experience anxiety related to novel social situations and interacting in large groups of peers, though her avoidance of such situations had significantly decreased. Lauren had formed friendships with two peers, with whom she spent time outside of school, and she had regular, positive interactions with students in the orchestra. She reported that the bullying had decreased, as she spent more time with her friends in school, and her depressive symptoms (avoidance of playing the violin, frequent crying, and suicidal ideation) were no longer present.

Conclusions and Future Directions

In conclusion, symptoms of social anxiety disorder can negatively affect the socialization of adolescents by limiting opportunities to engage in positive interactions with peers and placing individuals at risk for being targets of peer victimization and rejection. In turn, negative experiences with peers may exacerbate symptoms of social anxiety by confirming maladaptive cognitions, such as fear of negative evaluation and low social competence, and leading to an increase in social withdrawal and avoidance of social interactions. In this chapter, we proposed a conceptual model of social anxiety disorder, socialization, and social experiences to explain these relationships. Although relationships among individual components have been reported, research has not yet been conducted to empirically support the model in its entirety. Future research should examine the appropriateness of the proposed model for explaining the link between social anxiety disorder and socialization in adolescence. In addition, although cognitive-behavioral treatment approaches that target the various components of the model exist, randomized control trials need to continue to be implemented to assess the efficacy of comprehensive cognitive-behavioral therapy with adolescents with social anxiety.

References


E.A. Voelkel et al.


## Author Queries

**Chapter No.: 12  0001871292**

<table>
<thead>
<tr>
<th>Queries</th>
<th>Details Required</th>
<th>Author’s Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>AU1</td>
<td>“Beidel, Turner, and Morris (1991)” is cited in text but not given in the reference list. Please provide details in the list or delete the citation from the text.</td>
<td>![Chat Symbol]</td>
</tr>
<tr>
<td>AU2</td>
<td>“Beidel &amp; Turner, 1998” is cited in text but not given in the reference list. Please provide details in the list or delete the citation from the text.</td>
<td>![Chat Symbol]</td>
</tr>
<tr>
<td>AU3</td>
<td>References “Alfano et al. 2002; Oetting and Donnermeyer 1998; Turner et al. 1986” are not cited in text. Please provide reference citations.</td>
<td>![Chat Symbol]</td>
</tr>
</tbody>
</table>