9-1995

Relationship among Adolescent Reports of Social Anxiety, Anxiety, and Depressive Symptoms

Heidi M. Inderbitzen

University of Nebraska-Lincoln

Debra A. Hope

University of Nebraska-Lincoln, dhope1@unl.edu

Follow this and additional works at: <https://digitalcommons.unl.edu/psychfacpub>

Part of the [Psychology Commons](#)

Inderbitzen, Heidi M. and Hope, Debra A., "Relationship among Adolescent Reports of Social Anxiety, Anxiety, and Depressive Symptoms" (1995). *Faculty Publications, Department of Psychology*. 870.

<https://digitalcommons.unl.edu/psychfacpub/870>

This Article is brought to you for free and open access by the Psychology, Department of at DigitalCommons@University of Nebraska - Lincoln. It has been accepted for inclusion in Faculty Publications, Department of Psychology by an authorized administrator of DigitalCommons@University of Nebraska - Lincoln.

Published in *Journal of Anxiety Disorders* 9:5 (September-October, 1995), pp. 385–396;
doi: 10.1016/0887-6185(95)00019-K
Copyright © 1995 Elsevier Science Ltd. Used by permission.
Published online April 20, 2000.

Relationship among Adolescent Reports of Social Anxiety, Anxiety, and Depressive Symptoms

Heidi M. Inderbitzen and Debra A. Hope

University of Nebraska–Lincoln, Lincoln, Nebraska, USA

Corresponding author – Heidi M. Inderbitzen, Department of Psychology, University of Nebraska–Lincoln, 209 Burnett Hall, Lincoln, NE 68588-0308

Abstract

The present study examines the relationship among self-reported symptoms of social anxiety, anxiety, and depression in the context of Clark and Watson's tripartite theory of anxiety and depression for a sample of adolescents. Four hundred and twenty-eight 10th-grade students completed three measures: the Social Anxiety Scale for Children–Revised, the Revised Children's Manifest Anxiety Scale, and the Children's Depression Inventory. Results suggest that symptoms of social anxiety are distinct from symptoms of depression and unspecified anxiety. In addition, results indicate that in comparison to males, adolescent females report higher levels of social anxiety, anxiety, and depressive symptoms. Conceptual and methodological implications are discussed.

Recent controversy in the area of child and adolescent internalizing disorders exists regarding the distinction between anxiety and depression. Specifically, while some researchers believe that anxiety and depression are two distinct constructs, others maintain that the two are part of one global construct labeled *negative affectivity* (Finch, Lipovsky, & Casat, 1989; Malcarne & Ingram, 1994; Ollendick & Yule, 1990; Tannenbaum, Forehand, & Thomas, 1992). Much support for a single, internalizing construct comes from studies yielding significant correlations between measures (typically self-report) of anxiety and depression symptoms among clinical and nonclinical populations (e.g., $r_s = .57-.70$; Garber, Weiss, &

Shanley, 1993; Hodges, 1990; Ollendick & Yule, 1990; Tannenbaum et al., 1992; also see Malcarne & Ingram, 1994 for a review).

In reviewing similar results in the adult literature, Clark and Watson (1991) proposed a tripartite theory to explain similarities and differences in anxiety and depression symptoms. Specifically, these researchers suggest that internalizing disorders share a common core factor composed of general distress symptoms (i.e., negative affectivity) as well as symptoms specific to either anxiety or depression. Symptoms specific to anxiety would include physiological arousal and autonomic involvement, while symptoms specific to depression would include anhedonia and hopelessness (i.e., symptoms associated with low positive affectivity; Somoza, Steer, Beck, & Clark, 1994). Furthermore, Clark and Watson (1991) suggest that this common core of general distress or negative affectivity is typically what is assessed in self-report measures of anxiety and depression. Thus, the failure to discriminate between anxiety and depression when using self-report inventories may be due to the overlap in content of these measures (Malcarne & Ingram, 1994; Strauss, Last, Hersen, & Kazdin, 1988).

A better understanding of the relationship between anxiety and depression may thus be achieved by using Clark and Watson's (1991) tripartite theory to guide selection of measures and interpretation of results. For example, Jolly and Dykman (1994) found that self-reported cognitions in adolescent psychiatric inpatients with internalizing disorders separated into factors consistent with the tripartite theory (i.e., anxiety-specific cognitions, depression-specific cognitions, and general cognitions) and could be used to discriminate between depression and anxiety disorders. Other researchers have provided evidence for the distinction between depression and anxiety when anxiety measures assess specific types of anxiety. For example, Ollendick and Yule (1990) found that depression and fear were distinct constructs as measured by the Child Depression Inventory and the Fear Survey Schedule for Children-Revised. In addition, La Greca (1989) provided some preliminary data suggesting the distinction between social anxiety and depressive symptoms in a sample of elementary school-aged children.

The primary purpose of the present study was to evaluate the tripartite theory of internalizing disorders by examining the relationship between self-reported symptoms of depression, unspecified anxiety, and a specific type of anxiety—social anxiety. It was hypothesized that the depression and unspecified anxiety measures would be significantly related as both measures were likely to be constituted primarily of general distress symptoms. On the other hand, it was hypothesized that the social anxiety measure, in comparison to the unspecified anxiety measure, would not be as strongly related to the depression measure due to its more specific symptom content. Finally, due to their common anxiety symptom components, it was believed that the social anxiety and unspecified anxiety measures would be more closely related than the social anxiety and depression measures. If found, these hypothesized results would provide further evidence of Clark and Watson's tripartite theory of internalizing disorders.

Social anxiety was selected as the measure of a specific type of anxiety due to its neglected status in the literature and its importance for adolescents. Although investigations of childhood and adolescent anxiety have flourished in recent years, minimal research has focused on social phobia or social anxiety symptoms in children or adolescents. Instead,

most of the research has been restricted to separation anxiety or overanxious disorder. Yet, social phobics comprise 9–15% of children referred to an anxiety disorders clinic (Last, Strauss, & Francis, 1987; Strauss & Francis, 1989) and 20% of children identified as test anxious (Beidel & Turner, 1988). Furthermore, half of adult social phobics report the onset of their symptoms by age 12, with 17% reporting the presence of social anxiety symptoms for as long as they could remember (Bourdon et. al, 1988). Thus, taken together, the research suggests that many children may be experiencing problems associated with symptoms of social anxiety.

Furthermore, it appears that adolescence is a time when individuals may be most susceptible to social anxiety. Theorists suggest that adolescence is marked by an increase in self-consciousness and sensitivity to self-presentational concerns that often result in social anxiety (Buss, 1986; Elkind, 1980). Furthermore, Abe and Suzuki (1986) investigated the prevalence of specific anxiety symptoms for individuals aged 9 through 60 and found that “fear of blushing” and “fear of being looked at” (both thought of as characteristic of social anxiety) reached a maximum prevalence rate in the midteens.

One impediment to the study of social anxiety in children and adolescents, however, has been the absence of a psychometrically sound assessment instrument. Although several measures have been developed to assess social anxiety and avoidance in adults (e.g., Fear of Negative Evaluation and Social Avoidance and Distress scales; Watson & Friend, 1969) the validity of these instruments with child and/or adolescent populations has not yet been established (Albano, Marten, Heimberg, & Barlow; in press). Only one measure specific to child and adolescent social anxiety symptoms, the Social Anxiety Scale for Children–Revised by La Greca and colleagues, had been published when the present study was conducted (La Greca, Dandes, Wick, Shaw, & Stone, 1988; La Greca, 1989, 1991). Thus far, however, the research utilizing this instrument has involved elementary school–aged children only. Thus, given the importance of social anxiety symptoms in adolescence as discussed above, a second purpose of the present study was to provide data regarding the Social Anxiety Scale for Children–Revised (SASC-R) for a sample of adolescents.

A third purpose of the present study was to examine gender differences. Previous research has demonstrated significant gender differences in the incidence, prevalence, and presentation of clinical symptoms in childhood and adolescence. Specifically, girls appear to have higher rates of internalizing disorders throughout the life span, whereas boys appear to have higher rates of externalizing disorders (see Kavanagh & Hops, 1994 and for a review). Researchers have hypothesized that such differences are due to variations in gender socialization. For example, girls are positively reinforced for being affectionate, tender, and dependent while boys are encouraged to be dominant and independent (e.g., Hetherington, Cox, & Cox, 1978; Huston, 1983). Thus, it is possible that girls learn through modeling and verbal encouragement to express depressive and anxiety symptoms. On the other hand, boys may learn that expressions of depression or anxiety are viewed as unmanly and are negatively consequated by others and, thus, learn not to discuss or admit to symptoms of anxiety and depression. Researchers have further hypothesized that differences in gender socialization are likely to be intensified during the adolescent years when both sexes are attempting to negotiate the developmental task of individuation and

independence (Kavanagh & Hops, 1994). Thus, it is likely that in the present study, adolescent females will score higher than males on measures of anxiety and depressive symptoms.

Although limited information exists regarding gender differences in relation to social anxiety symptoms, it is expected that adolescent females in the current investigation will score higher on self-reported social anxiety than males. This hypothesis is based on evidence suggesting that a gender difference favoring females exists for social anxiety symptoms in children (La Greca et al., 1988) and evidence suggesting that adolescent females, in comparison to males, have greater concerns regarding security in interpersonal relationships, are more status conscious, and are more concerned with issues of affiliation, all of which may lead to greater social anxiety among females (Benenson, 1990; Daniels-Biemess, 1989; also see Maccoby, 1990 for a review).

Method

Subjects

Four hundred twenty-eight (209 males, 219 females) 10th-grade students recruited from a public high school in a midsized Midwestern city participated in the study. Only those students with parental consent and who signed an assent form were eligible for participation (approximately 98% of all students recruited participated in the study). Participation was strictly voluntary and students were told they were completing questionnaires to help the investigator learn about teenagers' emotions and activities. Due to the racial and ethnic homogeneity of the city, the majority of the students were White but represented a wide range of socioeconomic levels. (The ethnic and socioeconomic composition of the subject sample mirrored that of the public school district in which 90% of the youth are White, 4.5% are African American, 2.3% are Asian, 1.9% are Hispanic, and 1% are Native American; and 23% come from low socioeconomic families).

Measures

Students completed the three paper-and-pencil self-report questionnaires described below.

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

The Social Anxiety Scale for Children-Revised (La Greca, 1991) consists of 18 items reflecting fears of negative evaluation and social avoidance and distress and 4 filler items. Students are asked to indicate along a 5-point continuum how true an item is for themselves. Separate versions of the scale exist for elementary school-aged children, adolescents, and parents. In the present study, the adolescent version of the scale, which contains more age-appropriate language, was used.

Factor analyses of the items have resulted in three factors: children's fears or concerns regarding negative evaluations from peers (Fear of Negative Evaluation, 8 items), social distress or discomfort specific to new situations or unfamiliar peers (Social Avoidance and Distress-New, 6 items), and general social inhibition (Social Avoidance and Distress-General, 4 items; La Greca, 1991). The internal consistency (alphas = .67 to .86) and temporal stability (r_s = .67-.70) have been adequately demonstrated (La Greca, 1989, 1991). In addition, La

Greca (1989) reports significant relationships between SASC scores and peer relations, teacher ratings of withdrawal, and self-reports of social competence providing evidence of the scales concurrent validity. La Greca (1991) recommends that subscale scores, rather than a total score, be used to score the SASCR due to the conceptual and empirical distinctions among the subscales.

Revised Children's Manifest Anxiety Scale (RCMAS)

The Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1978) is a 37-item questionnaire that assesses anxiety symptoms in children and adolescents aged 6 to 19. The RCMAS consists of 28 items that pertain to subjective, physiological, and motoric characteristics of anxiety and are summed to form a Total Anxiety score. Reynolds and Richmond (1985) report internal consistency coefficients ranging from .56 to .80 across 11 age groups for its three subscales and above .80 for the total score. In addition, its validity as a measure of chronic anxiety is supported by its .85 correlation with the Trait scale of the State-Trait Anxiety Inventory for Children (Reynolds & Richmond, 1985). The RCMAS was included in the present study as a measure of nonspecific anxiety symptoms and was selected because of its widespread use in previous research.

Children's Depression Inventory (CDI)

The Children's Depression Inventory (Kovacs & Beck, 1977) is a 27-item questionnaire that asks respondents to endorse statements about themselves reflecting cognitive and somatic symptoms of depression. This questionnaire was designed to be used with children and adolescents from 7 to 17 years of age. The CDI has been shown to have adequate internal consistency (alpha coefficients ranging from .71 to .94; Saylor, Finch, Spirito, & Bennett, 1984) and to differentiate between children independently diagnosed as depressed and nondepressed (Carlson & Cantwell, 1979). Although the CDI typically evidences a significant relationship with self-report anxiety symptoms (e.g., Finch et al., 1989; Hodges & Craighead, 1990), it was included in the present study because no measure of depressive symptoms has discriminant validity with anxiety symptoms in children and adolescents (Jolly & Dykman, 1994) and the CDI is the most frequent and commonly used depression measure among researchers and clinicians (Kazdin, 1981).

Procedure

All participating students completed the questionnaires as a group during one classroom period. Students were each given a packet containing the consent form and the three questionnaires. Instructions regarding the completion of the questionnaires were then provided, after which students were allowed to complete the forms at their own pace. Completion of these measures took approximately 20 minutes.

Results

Gender Mean Differences for Dependent Variables

Gender differences were examined by comparing means on the SASC-R, RCMAS, and CDI. As can be seen in Table 1, females scored significantly higher than males on the Social

Anxiety and Distress–New and on the Fear of Negative Evaluation subscales while there was no difference on the Social Anxiety and Distress–General subscale. Females also scored significantly higher than males on the CDI and the RCMAS.

Table 1. Gender Difference on Social Anxiety, General Anxiety, and Depression Measures

Measures	Male (<i>n</i> = 209)			Females (<i>n</i> = 219)			<i>t</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	Range	<i>M</i>	<i>SD</i>	Range		
SASC-R								
SAD-N	13.5	4.2	5–25	14.5	3.8	5–27	2.64	.009
SAD-G	10.6	4.1	5–22	10.1	3.6	5–21	1.46	NS
FNE	17.8	6.4	8–36	20.2	6.8	8–40	3.79	.001
RCMAS	7.1	5.1	0–24	9.6	5.2	0–23	5.00	.001
CDI	8.0	6.2	0–25	9.7	5.9	0–32	2.94	.003

Note: SASC-R = Social Anxiety Scale for Children–Revised, SAD-N = Social Avoidance and Distress–New, SAD-G = Social Avoidance and Distress–General. FNE = Fear of Negative Evaluation, RCMAS = Revised Children’s Manifest Anxiety Scale, CDI Children’s Depression Inventory.

Interrelationships among Social Anxiety, Anxiety, and Depressive Symptoms

To investigate the interrelationship among symptoms of social anxiety, anxiety, and depression and any gender differences with regard to these interrelationships, Pearson product moment correlation coefficients were computed for the total sample (see Table 2) and for males and females separately (see Table 3). Inspection of the correlation coefficients demonstrates significant relationships among the SASC-R, RCMAS, and CDI scores. Additionally, the pattern of correlations are similar for males and females; there were no significant differences between any of the correlation coefficients for males and females. It should be noted, however, that the relationship between symptoms of depression and unspecified anxiety for the total sample (i.e., $r = .11$) is stronger than that between depression and social anxiety (i.e., $r_s = .25, .35, .36$ for social anxiety and distress in new situations, social anxiety and distress in general, and fear of negative evaluation, respectively; $t = 30.87$ for $r_s .71$ vs $.36$). More specifically, the shared variance between symptoms of social anxiety and depression is only 16%, whereas the shared variance between symptoms of unspecified anxiety and depression is 50%. The difference in the strength of the correlations between CDI and RCMAS scores and CDI and SASC-R scores holds for both males and females (see Table 3).

Table 2. Correlations among Social Anxiety, Anxiety, and Depression Scores

	SASC-R			RCMAS
	SAD-N	SAD-G	FNE	
SAD-G	.59			
FNE	.60	.51		
RCMAS	.42	.42	.53	
CDI	.25	.35	.36	.71

Note: SASC-R = Social Anxiety Scale for Children–Revised, SAD-N = Social Avoidance and Distress–New, SAD-G = Social Avoidance and Distress–General, FNE = Fear of Negative Evaluation, RCMAS = Revised Children’s Manifest Anxiety Scale, CDI = Children’s Depression Inventory. All r s > .10 are significant at $p < .01$.

Table 3. Correlations among Social Anxiety, Anxiety, and Depression Scores for Males and Females

	SASC-R			
	SAD-N M/F	SAD-G M/F	FNE M/F	RCMAS M/F
SAD-G	.63/.58			
FNE	.58/.60	.54/.53		
RCMAS	.40/.42	.49/.40	.56/.48	
CDI	.28/.18	.41/.32	.41/.30	.67/.73

Note: M = males, F = females, SAD-N = Social Avoidance and Distress–New, SAD-G = Social Avoidance and Distress–General, FNE = Fear of Negative Evaluation, CDI = Children’s Depression Inventory. All r s > .15 are significant at $p < .01$.

The interrelationship among the CDI, RCMAS, and SASC-R was further examined by investigating the overlap in students identified as having extreme scores on each of these measures. Specifically, students having scores 1.5 standard deviations or more above the nonnative sample means on each instrument (i.e., 19 or above on the CDI, 22 or above on the RCMAS, and 62 or above on the SASC-R) were identified. (Note that since no normative data were available for the SASC-R, the cutoff score was based on 1.5 SDs of the mean for the population used in this study). These criteria resulted in 39 students (14 males and 25 females) identified as having extreme scores on the CDI, 35 (14 males and 21 females) on the SASC-R, and 4 (1 male and 3 females) on the RCMAS. Of more interest, however, is the number of students identified by both the CDI and either the RCMAS or the SASC-R. All four of the students who had extreme scores on the RCMAS also had extreme scores on the CDI. Thus, the overlap between the RCMAS and the CDI with regard to identifying students with extreme scores was 100%. The overlap between the CDI and the SASC-R, however, was only 17%. Specifically, only six (4 males and 2 females) of the students identified as having extreme scores on the SASC-R also had extreme scores on the CDI. There was also minimal overlap between the RCMAS and the SASC-R. Only one male student had extreme scores on both the SASC-R and the RCMAS.

Discussion

The results of the present study supported Clark and Watson’s (1991) tripartite theory of anxiety and depression. Specifically, as hypothesized, the relationship (as indexed by both

correlations and extreme score comparisons) between self-reported depression symptoms and unspecified anxiety symptoms was stronger than that between social anxiety symptoms and depression symptoms and between social anxiety symptoms and unspecified anxiety symptoms. These results suggest that the significant relationship between the CDI and the RCMAS found in the present study and in previous studies can be accounted for by their shared content, which primarily assesses general distress or negative affectivity. In contrast, the more moderate relationships found between self-reported social anxiety symptoms and both depression and unspecified anxiety symptoms suggest that the SASC-R assesses both general distress and symptoms specific to social anxiety.

The correlations between the SASC-R subscale scores and the RCMAS score are almost identical to those found by La Greca and her colleagues (1989) using elementary school-aged children. The relationship found between the SASC-R subscale scores and the CDI, however, are stronger (e.g., .25 vs .08, .35 vs .05, and .36 vs .17 for CDI and SAD-N, SAD-G, and FNE, respectively) than those reported by La Greca (1989). It is possible that this discrepancy is due to the age differences in the populations sampled. For example, it is possible that because of increased emphasis on, and importance of, peer relations in adolescence (e.g., Buhrmester & Furman, 1987; Duck, 1983), adolescent youth experiencing social anxiety may feel more despair concerning these symptoms than younger children. Nevertheless, the relationship between social anxiety and depression in children and adolescents should be investigated more thoroughly in future studies.

Consistent with previous studies, females in the present study reported more social anxiety, unspecified anxiety, and depressive symptoms than did males. With regard to social anxiety, La Greca (1989), La Greca and her colleagues (1988), and Hymel and Franke (1985) found that elementary school-aged girls reported more social anxiety than boys. This gender difference in social anxiety may be explained by the suggestion of previous researchers (e.g., Crombie, 1988; Maccoby, 1990) that social skills and interpersonal relationships are more important to girls than boys. If girls, in comparison to boys, are more interested in and preoccupied with interpersonal relationships, then it is understandable that they may experience more concerns regarding their performance in such relationships (i.e., social anxiety) than boys.

Our finding that females reported more depressive and anxiety symptoms is also supported by past research. For example, Lewinsohn and his colleagues (1993), using a non-clinical adolescent population and a clinical interview, found that females were more likely to be diagnosed with a depressive or anxiety disorder than were males. Kashani and his colleagues (1989) interviewed children and adolescents and found that anxiety disorders were more prevalent for girls than boys. With regard to self-report measures, Nelson and his colleagues (1987) found that female psychiatric inpatients reported higher CDI scores than their male counterparts and Saylor and his colleagues (1984) reported similar results for a sample of emotionally disturbed children being treated at an outpatient facility. Finally, Bernstein, Garfinkel, and Hoberman (1989) reported that female high school students received higher scores on the RCMAS than did males. Furthermore, such results are consistent with the social interactional perspective proposed by Kavanagh and Hops (1994).

Although the present results are limited in generalizability to the characteristics of the sample studied, our findings provide some nonnative data for the SASC-R for adolescents.

Furthermore, although the present results are based on self-report scores only, they provide evidence for Clark and Watson's tripartite theory of anxiety and depression. It is possible, however, that these results are specific to the measures used in the present study. Thus, it will be important to investigate the relationship among self-reported symptoms of depression and anxiety using other measures. In addition, it is possible that the results of the present study are limited to self-reported internalizing symptoms. Thus, to provide additional support for Clark and Watson's theory, it will be important for future research investigating the relationship between depression and anxiety to include other types of measures (e.g., structured diagnostic interviews, observational measures of behavioral symptoms, and reports by significant others). Finally, although the current results suggest that social anxiety, anxiety, and depression are experienced more frequently by females than males, there was significant overlap in the overall distribution of scores making it difficult to interpret the clinical significance or meaningfulness of the mean differences. Thus, it will be important for future research to examine the clinical significance of such gender differences and to interpret any such differences in a developmental framework to determine when such differences emerge and to provide an explanation for these differences.

References

- Abe, K., & Suzuki, T. (1986). Prevalence of some symptoms in adolescence and maturity: Social phobias, anxiety symptoms, episodic illusions and idea of reference. *Psychopathology*, 19, 200–205.
- Albano, A. M., Marten, P. A., Heimberg, R. G., & Barlow, D. H. (in press). Children and adolescents: Assessment and treatment. In R. G. Heimberg, M. R. Liebowitz, D. A. Hope, & F. Schneier (Eds.), *Social phobia: Diagnosis, assessment and treatment*. New York: Guilford.
- Beidel, D. C., & Turner, S. M. (1988). Comorbidity of test anxiety and other anxiety disorders in children. *Journal of Abnormal Child Psychology*, 16, 275–287.
- Bernstein, G. A., Garfinkel, B. D., & Hoberman, H. M. (1989). Self-reported anxiety in adolescents. *American Journal of Psychiatry*, 146, 384–386.
- Benenson, J. F. (1990). Gender differences in social networks. *Journal of Early Adolescence*, 10, 472–495.
- Bourdon, K. H., Boyd, J. H., Rae, D.S., Bums, B., Thompson, J. W., & Locke, B. Z. (1988). Gender differences in phobias: Results of the ECA community survey. *Journal of Anxiety Disorders*, 2, 227–241.
- Buhnnester, D. & Furman, W. (1987). The development of companionship and intimacy. *Child Development*, 58, 1101–1113.
- Buss, A. H. (1986). A theory of shyness. In W. H. Jones, J. M. Cheek, & S. R. Biggs (Eds.), *Shyness: Perspectives on research and treatment* (pp. 39–46). New York: Plenum.
- Carlson, G. A., & Cantwell, D. P. (1979). A survey of depressive symptoms in a child and adolescent psychiatric population. *Journal of the American Academy of Child Psychiatry*, 18, 587–599.
- Clark, L. A., & Watson, D. (1991). Tripartite model of anxiety and depression: Psychometric evidence and taxonomic implications. *Journal of Abnormal Psychology*, 100, 316–336.
- Crombie, G. (1988). Gender differences: Implications for social skills assessment and training. *Journal of Clinical Child Psychology*, 17, 116–120.
- Daniels-Beimess, T. (1989). Measuring peer status in boys and girls: A problem of apples and oranges? In B. H. Schneider, G. Attili, J. Nadel, & R. P. Weissberg (Eds.), *Social competence in developmental perspective* (pp. 107–120). Boston: Kluwer Academic Publishers.

- Duck, S. W. (1983). *Friends for life: The psychology of close relationships*. New York: SL Martin's Press.
- Elkind, D. (1980). Strategic interactions in early adolescence. In J. Adelson (Ed.), *Handbook of adolescent psychology* (pp. 432–444). New York: Wiley.
- Finch, A. J., Lipovsky, J. A., & Casat, C. D. (1989). Anxiety and depression in children and adolescents: Negative affectivity or separate constructs? In P. C. Kendall & D. Watson (Eds.), *Anxiety and depression: Distinctive and overlapping features* (pp. 171–202). New York: Academic Press, Inc.
- Garber, J., Weiss, B., & Shanley, N. (1993). Cognitions, depressive symptoms, and development in adolescents. *Journal of Abnormal Psychology*, 102, 47–57.
- Hetherington, E. M., Cox, M., & Cox, R. (1978). The aftermath of divorce. In J. H. Stevens, Jr. & M. Matthews (Eds.), *Mother-child, father-child relations*. Washington, DC: National Association for the education of young children.
- Hodges, K. (1990). Depression and anxiety in children: A comparison of self-report questionnaires to clinical interview. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 2, 376–381.
- Hodges, K., & Craighead, W. E. (1990). Relationship of the Children's Depression Inventory factors to diagnosed depression. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 2, 489–492.
- Huston, A. C. (1983). Sex-typing. In P. H. Mussen (Ed.-in-chief) & E. M. Hetherington (Ed.), *Handbook of child psychology* (4th edition, vol. 4, pp. 387–467). New York: Wiley.
- Hymel, S., & Franke, S. (1985). Assessing self-perceptions. In B. H. Schneider, K. H. Rubin, & J. E. Ledingham (Eds.), *Children's peer relations: Issues in assessment and intervention* (pp. 78–92). New York: Springer-Verlag.
- Jolly, J. B., & Dykran, R. A. (1994). Using self-report data to differentiate anxious and depressive symptoms in adolescents: Cognitive content specificity and global distress. *Cognitive Therapy and Research*, 18, 25–37.
- Kashani, J. H., Orvaschel, H., Rosenberg, T. K., & Reid, J. C. (1989). Psychopathology in a community sample of children and adolescents: A developmental perspective. *American Academy of Child and Adolescent Psychiatry*, 28, 701–706.
- Kavanagh, K., & Hops, H. (1994). Good girls? Bad boys? Gender and development as contexts for diagnosis and treatment. In T. H. Ollendick & R. I. Prinz (Eds.), *Advances in clinical child psychology* (vol. 16; pp. 45–79). New York: Plenum Press.
- Kazdin, A. E. (1981). Assessment techniques for childhood depression. *Journal of the American Academy of Child Psychiatry*, 20, 358–375.
- Kovacs, M., & Beck, A. T. (1977). An empirical-clinical approach toward a definition of childhood depression. In I. G. Schulterbrandt & A. Raskin (Eds.), *Depression in childhood: Diagnosis, treatment, and conceptual models* (pp. 1–25). New York: Raven Press.
- La Greca, A. M. (1989, February). *Social anxiety in children: Scale development and validation*. Paper presented at the first annual meeting of the Society for Research in Child and Adolescent Psychopathology, Miami, FL.
- La Greca, A. M. (1991, August). *The development of social anxiety in children*. Paper presented at the annual meeting of the American Psychological Association, San Francisco, CA.
- La Greca, A. M., Dandes, S. K., Wick, P., Shaw, K., & Stone, W. L. (1988). Development of the Social Anxiety Scale for Children: Reliability and concurrent validity. *Journal of Clinical Child Psychology*, 17, 84–91.

- Last, C. G., Strauss, C. C. & Francis, G. (1987). Comorbidity among childhood anxiety disorders. *Journal of Nervous and Mental Disease*, 175, 726–730.
- Lewinsohn, P. M., Hops, H., Roberts, R. E., Seeley, J. R., & Andrews, J. A. (1993). Adolescent psychopathology: I. Prevalence and incidence of depression and other DSM-ID-R Disorders in high school students. *Journal of Abnormal Psychology*, 102, 133–144.
- Maccoby, E. E. (1990). Gender and relationships: A developmental account. *American Psychologist*, 45, 513–520.
- Malcame, V. L. & Ingram, R. E. (1994). Cognition and negative affectivity. In T. H. Ollendick & R. I. Prinz (Eds.), *Advances in clinical child Psychology* (vol. 16; pp. 141–176). New York: Plenum Press.
- Nelson, W. M., III, Politano, P. M., Finch, A. J. Jr., Wendel, N., & Mayhall, C. (1987). Childhood Depression Inventory: Normative data and utility with emotionally disturbed children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 26, 43–48.
- Ollendick, T. H., & Yule, W. (1990). Depression in British and American children and its relation to anxiety and fear. *Journal of Consulting and Clinical Psychology*, 58, 126–129.
- Reynolds, 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.
- Reynolds, C. R., & Richmond, B. O. (1985). *Revised Children's Manifest Anxiety Scale (RCMAS)—manual*. Los Angeles, CA: Western Psychological Services.
- Saylor, C. F., Finch, A. J., Spirito, A., & Bennett, B. (1984). The Children's Depression Inventory: A systematic evaluation of psychometric properties. *Journal of Consulting and Clinical Psychology*, 52, 955–967.
- Somoza, E., Steer, R. A., Beck, A. T., & Clark, D. A. (1994). Differentiating major depression and panic disorders by self-report and clinical rating scales: ROC analysis and information theory. *Behavioral Research and Therapy*, 32, 771–782.
- Strauss, C. C., & Francis, G. (1989). Phobic disorders. In C. G. Last & M. Hersen (Eds.), *Handbook of child psychiatric diagnosis* (pp. 170–190). New York: John Wiley & Sons.
- Strauss, C. C., Last, C. G., Hersen, M., & Kazdin, A. E. (1988b). Association between anxiety and depression in children and adolescents. *Journal of Abnormal Child Psychology*, 16, 57–68.
- Tannenbaum, L. E., Forehand, R. L., & Thomas, A. M. (1992). Adolescent self-reported anxiety and depression: Separate constructs or a single entity. *Child Study Journal*, 22, 61–72.
- Watson, D., & Friend, R. (1969). Measurement of social-evaluative anxiety. *Journal of Consulting and Clinical Psychology*, 33, 448–457.