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Children with Generalized Anxiety Disorder Do Not Have Peer Problems, Just Fewer Friends

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Abstract

A common assumption is that all youth with anxiety disorders (AD) experience impaired peer relationships relative to healthy control children. Social impairments have been identified among youth with certain AD (e.g., social anxiety disorder; SAD), but less is known about the peer relationships of children with generalized anxiety disorder (GAD). We therefore compared the interpersonal functioning of youth with GAD, SAD, and controls (6 to 13 years). Despite having relatively fewer friends overall, children with GAD did not differ from controls in terms of the likelihood of having a best friend, participation in groups/clubs, and parent ratings of social competence. In comparison, youth with SAD were less socially competent, had fewer friends and difficulty making new friends compared to controls. Findings suggest that peer difficulties are not a universal feature of all childhood AD and highlight a need to better understand the social experiences and functioning of children with GAD.

Keywords

generalized anxiety disorder; peer relations; social competence; social anxiety disorder

Given the importance of social engagement for the development of appropriate interpersonal behavior and friendships, peer relations have a profound influence on children's social and emotional functioning [1–2]. Friendships help foster emotional security and support [3] and may protect against loneliness and depression [4]. As children mature, “best friendships” are formed [5], and intimacy and emotional disclosure with a best friend can increase feelings of support, enhance coping skills, and protect against negative treatment from other peers [6]. Thus, interpersonal effectiveness with peers can both foster children's well-being and buffer against negative outcomes.

Unfortunately, a proportion of children experience limited or impaired peer relationships, including few friendships overall, lack of a best friend, difficulty making or maintaining friendships, and peer rejection or neglect. Problems with peers also may limit opportunities for and involvement in social activities (e.g., clubs or sports teams, play dates, attending birthday parties) and lead to deficits in social skill. Further, social difficulties during early childhood may persist into later childhood, adolescence and adulthood in the absence of intervention efforts. For example, elementary school children identified as withdrawn by

peers tended to remain within this classification when reassessed three years later [7]. In addition, self-ratings of social (in)competence remained stable after a period of three years and were associated with increased feelings of loneliness and social dissatisfaction [8]. Similarly, being perceived negatively by peers during elementary school is more predictive of psychiatric difficulties than scholastic performance (e.g., grades, attendance) and teacher and self-ratings of behavior and adjustment up to 13 years later [9].

In considering individual risk, there appears to be a robust relationship between peer difficulties and anxiety in non-clinical samples of youth [10–13]. Anxiety and social withdrawal have been found to be risk factors for peer neglect and rejection [14], and peer rejection has in turn been associated with an increase in self-reported anxiety during the school year [15]. Anxious children have also been found to be less liked and more actively disliked by their peers than non-anxious children [13]. Social anxiety, in particular, is negatively associated with number of best friends, intimacy, companionship, and with support in close friendships for girls and with social incompetence and support for boys [12].

Although relatively less well-studied, difficulties in peer relationships have also been reported in clinical samples of children with anxiety disorders (AD; e.g., [16–19]). Some studies have examined peer-based differences in children with AD compared to other psychiatric diagnoses. Strauss and colleagues [18] reported that children meeting DSM-III criteria for various AD diagnoses were more neglected by peers than children with conduct disorder (CD) or normal controls. Although results were not examined based on specific AD, findings were replicated when anxious youth were compared to another, more heterogeneous clinical comparison group (including children with CD, attention-deficit/hyperactivity disorder, oppositional defiant disorder, and adjustment disorder, 19). Chansky and Kendall [16] found no significant group differences in social competence, social expectations, or friendships among children with DSM-III-R overanxious disorder (OAD), separation anxiety disorder, and avoidant disorder. However, when the data were collapsed across anxiety diagnoses, anxious children as a group had lower levels of self-perceived social competence, were more likely to expect to be disliked and rejected by unfamiliar peers, and had fewer friends than healthy controls. Although children with AD and controls were just as likely to have a best friend, the presence of a best friend was associated with a lower level of anxiety among controls only. Thus, in addition to basic differences in peer relationships, friendship may function differently for children with AD than for other children.

Although, collectively, data suggest that children with AD experience impaired social functioning, most research has examined children with DSM-III and DSM-III-R diagnoses, thereby limiting the potential generalizability to children with DSM-IV AD. Further, examination of children with AD, as a group, may misrepresent the peer relationships and difficulties of some anxious children. The vast majority of available evidence for peer problems among children with AD is limited to youth with obsessive compulsive disorder (OCD) or social anxiety disorder (SAD). Children with OCD reported being victimized by peers more than healthy controls and children with Type 2 diabetes [20], and greater severity of OCD symptoms was associated with higher rates of peer victimization [21]. Youth with OCD and their parents also reported impairment in peer relationships, including difficulty making friends and sleeping over at a friend's house [22].

Peer-related deficits have been consistently identified among youth with SAD as well. Beidel and colleagues [23] reported that 50% of children with SAD were not involved in any extracurricular activities and 75% had no or few friends. Similarly, adults with SAD (and their mothers) retrospectively reported fewer friends between the ages of 8–12 years than

controls [24]. Children with SAD have also been observed to spend less time interacting with peers, initiate fewer interactions, and receive fewer positive responses from peers than controls [25].

Surprisingly, the presence of peer difficulties in children with generalized anxiety disorder (GAD), the 2nd most common AD in childhood [26] has received little empirical attention. To our knowledge, only one study has examined peer variables in children with GAD. In this study, Verduin and Kendall [27] asked peers to rate the videotaped speeches of children with SAD, GAD, separation anxiety disorder, or no anxiety disorder (NAD) based on likeability and anxiety. In general, likeability was inversely related to anxiety and peers tended to like children with AD significantly less than the NAD group. When likeability ratings were examined for specific AD, only SAD was significantly associated with lower scores of peer liking. These data therefore raise the question as to whether children with GAD suffer from impairments in their peer relationships.

In considering the unique clinical features of GAD in childhood, findings from the study by Verduin and Kendall [27] are not entirely counter-intuitive. The core feature of GAD is excessive, uncontrollable worry that, in children, often includes worry about the future, past behavior, health, things going on in the world, and performance [28]. In addition, children with GAD often worry about and set exceedingly high standards for their competence in and the quality of peer relationships [29]. In our own extensive experiences working with anxious youth, children with GAD tend to be exceedingly conscientious and rule-abiding in their relationships with others, which may serve to facilitate rather than preclude close friendships. Alternatively, however, some of the unique clinical features of GAD may place strain on peer relationships. For example, excessive reassurance-seeking and preoccupation with performance, both core features of GAD, might annoy and/or eventually alienate other children. Thus, further empirical investigation of the peer relations in childhood GAD is warranted.

To summarize, a limited number of studies have examined peer relationships and difficulties in clinically anxious samples. Even when clinical samples are used, peer variables are rarely examined for specific AD, presumably based on the assumption that peer problems are common to all anxious youth. Unlike children with OCD and SAD, for which problems with peers are well documented, to our knowledge, only one study has examined peer variables among children with GAD, indicating similar likeability ratings as non-anxious children. The current study aimed to address this significant gap in the research by directly comparing the peer relationships of children with a primary diagnosis of GAD (without comorbid SAD), SAD (without comorbid GAD), and a healthy control (HC) group. Given that social impairment is a defining aspect of SAD, and that there are few empirical data to suggest impaired peer relations among youth with GAD, it was hypothesized that children with SAD would exhibit greater peer difficulties than children with GAD and controls, whereas the latter two groups would not differ in their peer relationships.

Method

Participants

The sample consisted of 54 children who met DSM-IV criteria for primary GAD ($n = 18$), SAD ($n = 18$), or no diagnosis (HC; $n = 18$). The three groups were matched on age, sex, and race/ethnicity. Children ranged in age from 6 to 13 years ($M_{GAD} = 9.06$, $M_{SAD} = 9.00$, and $M_{HC} = 9.56$ years) and were primarily of Caucasian ethnicity (GAD = 44.4%, SAD = 55.6%, and HC = 50%). Ten children with GAD (56.6%) and 4 children with SAD (22.2%) met criteria for at least one other disorder. Descriptive statistics for demographic and clinical characteristics are presented in Table 1.

Procedure

Anxious children were referred clinically or were participants of larger studies investigating anxiety at the Child and Adolescent Anxiety Program (CAAP) at the Children's National Medical Center in Washington, DC or the Anxiety Disorders Clinic (ADC) at the University of Central Florida in Orlando, Florida. The HC group consisted of children recruited through CAAP or ADC research protocols as healthy control participants (i.e., without psychiatric or chronic medical disorders). Exclusion criteria included comorbid SAD or GAD (in children diagnosed with primary GAD or SAD, respectively), selective mutism (due to the potential detrimental effects on peer relationships), autism spectrum disorders, bipolar diagnoses, psychosis, suicidal ideation, or mental retardation. All children and their parent(s) completed an in-person evaluation, during which all measures for the present study were collected. All participants provided written informed consent/assent detailing study procedures prior to enrollment.

Measures

Anxiety Disorders Interview Schedule for DSM-IV: Children and Parent Versions (ADIS-C/P, [30])—The ADIS – C/P is a semi-structured interview designed to assess DSM-IV AD and other DSM-IV psychiatric disorders. As part of the ADIS-C/P diagnostic interview, a Clinician Severity Rating (CSR) is assigned to each diagnosis, using a 9-point scale (0–8). A severity rating of 4 or higher was required for inclusion in the study. A licensed clinical psychologist, a postdoctoral fellow in clinical psychology, or a doctoral student in clinical psychology administered the ADIS-C/P to children and their parent(s). Interviews were conducted first with parents and then independently with children, by the same clinician. Diagnoses were assigned by interviewers based on information from both sources and discrepancies were addressed using procedures outlined by Silverman and Albano [30]. The ADIS-C/P has high inter-rater reliability for anxiety diagnoses [31]. The ADIS-C/P has high inter-rater reliability, particularly with regard to AD categories (i.e., ranging from .85 to 1.0; [32–33]) and is a widely used and accepted measure of psychopathology in children. Twenty percent of all interviews across both sites were scored by a second interviewer to determine interrater agreement. Interrater reliability for diagnoses of SAD ($k = 0.78$), and GAD ($k = 0.87$) was acceptable.

Interpersonal Relationships Module of the ADIS-P—Parent responses to five items of the Interpersonal Relationships Module of the ADIS-P were examined to evaluate children's interpersonal functioning. Items included in the analysis were “Would you say your child has more friends/fewer friends/same number as most kids?” (more friends, same number of friends, or fewer friends relative to same age peers); “Does your child have a best friend?” (yes or no); “Do you think your child has trouble making friends?” (yes or no); “Once your child has made friends, do you think he/she has trouble keeping them?” (yes or no); and, “Is your child in any club or group or does he/she play on any sports team?” (yes or no). The ADIS-P Interpersonal Relationships Module is sensitive to detecting differences in interpersonal functioning in children with SAD compared to anxious children without SAD [34].

Child Behavior Checklist-parent version (CBCL, [35])—Parent ratings of their children's behavioral and emotional functioning were assessed using the CBCL. The CBCL is a 117 item checklist that yields a total score, three competency scale scores (social, school, activities), two broadband dimensions (Internalizing, Externalizing), and eight narrow-band clinical domains. Only the *Social Competence* and *Social Problems Scales* were examined in the current study based on their specific relation to peer variables. Six items comprise the *Social Competence Scale* measuring the quality, quantity, and intensity of social activities, number of organizations involved in, activity level in organizations

relative to peers (i.e., less active, average, or more active), number of close friends, frequency of contact with friends, how well the child gets along with others relative to peers (i.e., worse, average, or better), and how well the child works/plays alone relative to peers (i.e., worse, average, or better). The *Social Problems Scale* consists of eleven items rated on a 3-point Likert scale ranging from 0 (not true) to 2 (often/always true) with higher scores reflecting greater social problems. Specific behaviors included on this scale include: dependent, lonely, does not get along with other kids, jealous, feels others are out to get him/her, accident-prone, gets teased, not liked by other kids, clumsy, prefers being with younger kids, and speech problems.

The CBCL is widely used and has acceptable psychometric properties. The Social Competence scale has excellent test-retest reliability ($r = .93$) and fair internal consistency ($\alpha = .68$; 35). The Social Problems scale has excellent test-retest reliability ($r = .90$) and good internal consistency ($\alpha = .82$; 35).

Results

Demographic and Clinical Characteristics

Initial analyses were conducted to assess for potential differences among groups on demographic and clinical characteristics (see Table 1 for descriptive statistics). A univariate analysis of variance (ANOVA) revealed nonsignificant differences among the groups on age ($F(2, 51) = .62, ns$). Regarding clinical severity CSR ratings, an independent samples t-test revealed a nonsignificant difference between the SAD ($M = 5.67$) and GAD ($M = 6.00$) groups ($t[34] = .90, ns$). Given the categorical nature of these variables, a series of chi square analyses were conducted to assess for differences among groups on a) sex, b) race/ethnicity, and c) secondary disorders. The three groups were not significantly different on sex ($X^2[2] = 1.97, ns$) or racial/ethnic distribution ($X^2[8] = 6.84, ns$), and the two clinical groups did not differ in the number of secondary disorders ($X^2[6] = 7.64, ns$).

Interpersonal Relationships

Given the categorical nature of these variables, to assess for group differences in specific areas of interpersonal functioning, a series of chi square analyses were conducted for parent report on items from the Interpersonal Relationships Module of the ADIS-P of their child's a) number of friends relative to peers, b) presence of a best friend, c) difficulty making friends, d) difficulty keeping friends, and e) involvement in a clubs/group activities. Percentages for the three groups are displayed in Table 2.

There were significant differences among the groups for number of friends relative to peers ($X^2[4] = 13.94, p < .01$) and difficulty making friendships ($X^2[2] = 23.91, p < .01$). Post hoc tests revealed that parents of children with GAD were more likely than parents of HC children to report that their child had fewer friends and were less likely to report that their child had the same amount or more friends relative to peers. Similarly, parents of children with SAD were more likely to report that their child had fewer friends and were less likely to report that their child had the same or more friends, relative to parents of HC peers. Children with GAD did not differ significantly from children with SAD on parent reported number of friends ($X^2[2] = 1.95, ns$).

With regard to initiating friendships, significantly more parents of children with SAD reported that their child had difficulty making friends compared to parents of HC children and children with GAD ($p < .002$). No significant differences emerged between the GAD and the HC groups for difficulty making friends ($X^2[1] = 2.12, ns$).

For all three groups, no significant differences were found for having a best friend ($X^2[2] = .98, ns$), difficulty keeping friends ($X^2[2] = 4.27, ns$) or participation in groups/clubs ($X^2[2] = .55, ns$).

Social Competence and Social Problems

A series of ANOVAs assessed for group differences on parent ratings of Social Competence and Social Problems based on CBCL scores. A significant F value was followed by least significant difference (LSD) tests to determine where differences occurred. The means and standard deviations for the three groups are reported in Table 3.

There was a significant main effect for group on CBCL Social Competence scores ($F[2, 51] = 5.55, p < .008$). Post hoc LSD tests revealed that children with SAD ($M = 42.81$) were rated as less socially competent than HC children ($M = 52.72, p < .003$). In contrast, the GAD group ($M = 47.56$) had Social Competence scores that fell between these two groups and was not significantly different from either ($ps > .05$). There were no significant group differences for Social Problems scores across the groups ($F[2, 51] = .96, ns$).

Discussion

Clinically anxious youth are often considered to be impaired in their peer relationships relative to healthy control (HC) children; yet evidence for this assumption is largely based on examination of children with various AD as one group. Given the unique clinical features of GAD, which may function to actually foster appropriate interpersonal behavior and friendships (e.g., high regard for competence and rule-abiding behaviors), together with findings indicating youth with GAD to be considered as likeable as non-anxious children [27], the current study sought to better understand the interpersonal functioning of children with GAD through comparison with anxious children for whom there is consistent evidence of social impairment (SAD), and HC youth. Overall findings from this study highlight a need to more closely examine the social functioning and peer relationships of clinically anxious youth based on specific diagnoses rather than broad categories of psychopathology.

Findings suggest the presence of both similarities and differences in the interpersonal relationships of the two anxious groups examined. Specifically, children with GAD and SAD were both judged to have fewer friends than HC children, and were just as likely to have a best friend. However, youth with SAD were viewed by parents as experiencing significant difficulty making new friends compared to both the GAD and HC groups. Youth with SAD were also rated as less socially competent than HC children. By comparison, youth with GAD did not differ from the latter group in terms of the quality of their peer interactions, the frequency of contact with friends (i.e., how many times per week they do things with friends outside of school), and the ability to make new friends. Interestingly, in contrast with aspects of social competence, there were no significant differences across the three groups on social problems, with all groups scoring in the nonclinical range on such problems as being dependent, lonely, jealous, clumsy, and exhibiting speech problems. Among youth with SAD, this difference may reflect the circuitous relationship between measures of social competence (e.g., friendship quality, frequency of contact with friends) and the social problems whereby less social engagement likely results in fewer opportunities for social problems to develop. However, anxious children, in general, have been described as neglected rather than rejected by peers (18, 23), suggesting that some of the specific problems measured (e.g., being teased, feeling others are out to get him/her) occur with less frequency than others (e.g., lonely). Overall, while both children with GAD and SAD may not have as many friends as their non-anxious peers, the basis for this difference appears to differ for these clinical groups (e.g., social competence).

In considering factors that may contribute to the fewer friendships of children with GAD, the possible influence of unique clinical features associated with this disorder need to be considered. Since friendships are often established based on the presence of self-other similarities [36], children with GAD may be more selective with regard to their peer affiliations, choosing to avoid friendships with 'adventurers' or 'risk-takers' who are not similarly concerned with rules and/or about possible injury. Along these same lines, the repertoire of social activities that youth with GAD are interested or willing to participate in may be more limited due to concerns about safety and performance. For youth who are particularly focused on their performance, schoolwork may be prioritized over social/extracurricular activities, in turn restricting opportunities for social interaction and friendship development. Although these possibilities remain speculative at present, findings indicating children with GAD have appropriate interpersonal behaviors and the ability to make new friends suggest important differences for a reduced number of friendships compared to youth with SAD. Future investigations of the specific types of friends these clinical groups tend to have (e.g., other anxious youth) may also help to explain group differences.

With respect to the interpersonal functioning of youth with SAD, numerous areas of difficulty are apparent. First, youth with SAD have fewer friends than HC peers, a finding well-documented in the literature for this population [23–24]. Notably, although children with SAD are as likely to have a best friend as non-anxious children, they have fewer close friendships. In contrast with our expectations, the majority of children with SAD (68%) were involved in an organized group or club. Although slightly lower, this overall rate of group participation did not differ from either the GAD or HC groups (72% and 78%, respectively). These findings may appear inconsistent with previous research reporting that only 50% of children and adolescents with SAD are involved in any extracurricular activities [23]; however, the discrepancy between these data may be representative of the age range examined. That is, during childhood, parents influence the degree to which their child participates in social activities (e.g., enrolling in extracurricular activities, and ensuring attendance to scheduled activities) and there are more opportunities for younger (as compared to older) children to be involved in group activities that also involve a parent (e.g., girl scouts) which likely contributes to their willingness to engage in activities. Similarly, parents of younger (as compared to older) children with social anxiety may be more apt to enroll their children in activities in an effort to address or alleviate their social difficulties.

In terms of specific areas of social competence, children with SAD have less contact with peers and have poorer quality interactions relative to HC children, consistent with school observations where SAD youth initiated fewer interactions, received fewer positive and more negative and "ignore" responses, and spent less time interacting with peers [25]. Furthermore, children with SAD have difficulty making friends. Some theorists [37–38] have interpreted such findings to indicate that rather than deficient social skills, symptoms of social anxiety prevent individuals with SAD from being effective in social settings. Empirically, however, data indicate that interventions targeting anxious arousal only do not positively impact social skills. For example, children treated with Social Effectiveness Therapy for Children (SET-C) which includes both in-vivo exposures and social skills training, evidenced significantly improved social skill at post-treatment, whereas children treated with fluoxetine alone displayed skills deficits at post-treatment similar to youth treated with a pill placebo [39–40]. Further, in considering the mediating role of social skills in the relationship between social anxiety and peer acceptance [41], these findings highlight the importance of social skills training to aid children with SAD in establishing the basic skills necessary to achieve developmentally appropriate interpersonal behavior and relationships.

Some limitations of this study should be noted. First, the sample was relatively small, which may have reduced our ability to detect significant differences among the groups. Second, the GAD and SAD groups do not represent “pure” samples, and secondary disorders (e.g., ADHD) may have impacted peer functioning. Alternatively, of course, pure samples would not be representative of the primary groups of interest as comorbidity is the rule rather than the exception among anxious youth. Third, although parents appear to be reliable reporters of their child's peer relations given their involvement in their child's social activities during this developmental stage [16], self-report data would provide valuable information regarding children's perception of the quality and quantity of their friendships. In addition, reports based on direct observation of children's behavior in social settings such as school was not used but may ultimately provide a more accurate reflection of true social functioning. Finally, since peer variables included in the current study do not represent all possible aspects of peer relations during childhood, additional empirical studies are needed to further examine the interpersonal functioning and behaviors of youth with different AD compared to HC youth. Thus, non-significant differences between the GAD and HC groups should not be interpreted to suggest overall equivalence in the social functioning of these two groups.

Summary

A common assumption is that impaired peer relationships is a universal feature of childhood AD. Past research has shown that children with SAD suffer from social impairments; however, few empirical studies have investigated the peer relationships of children with GAD. The aim of the current study was to compare the interpersonal functioning of youth with GAD, SAD, and HC children. Findings from this study illustrate that not all children with AD suffer from the same peer difficulties and impaired social functioning. When children with GAD were directly compared to children with SAD on measures of interpersonal functioning, important distinctions emerged. Whereas children with SAD are characterized by fewer close friends, difficulty making friends, less contact with peers and poorer quality peer interactions than their HC peers, children with GAD appear more similar than not to HC peers, with the exception of an overall reduced number of friends. The nature of this specific difference, nonetheless, remains unclear since youth with GAD appear to be as socially competent as HC youth. Future research based on direct observations of youth with GAD in social settings will guide accurate interpretation of this finding.

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Table 1

Demographic and clinical characteristics (N=54)

	Generalized Anxiety Disorder (GAD) n = 18	Social Anxiety Disorder (SAD) n = 18	Healthy Controls (HC) n = 18	
<i>Age (M/SD)</i>				<i>p</i> > .05
	9.06(1.8)	9.00(1.5)	9.56(1.7)	
<i>Sex (n/%)</i>				<i>p</i> > .05
Males	7(38.9)	6(33.3)	10(55.6)	
Females	11(61.1)	12(66.7)	8(44.4)	
<i>Race/Ethnicity (n/%)</i>				<i>p</i> > .05
Caucasian	8(44.4)	10(55.6)	9(50.0)	
Hispanic	2(11.1)	4(22.2)	3(16.7)	
African American	1(5.6)	1(5.6)	2(11.1)	
Asian/Pacific Islander	1(5.6)	2(11.1)	0(0.0)	
Other	6(33.3)	1(5.6)	4(22.2)	
<i>Clinical Severity CSR (M/SD)</i>				<i>p</i> > .05
	6.0(0.9)	5.7(1.3)		
<i>Secondary Disorder (n/%)</i>				<i>p</i> > .05
No Secondary Disorder	8 (44.4)	14 (77.8)		
Specific Phobia	2 (11.1)	2 (11.1)		
Separation Anxiety Disorder	2 (11.1)	2 (11.1)		
Major Depression	1 (5.6)	0 (0.0)		
Dysthymic Disorder	1 (5.6)	0 (0.0)		
ODD	1 (5.6)	0 (0.0)		
ADHD	3 (16.7)	0 (0.0)		

Table 2

Interpersonal Relationships Scores and Percentages on the ADIS-P

	Generalized Anxiety Disorder (GAD) n = 18	Social Anxiety Disorder (SAD) n = 18	Healthy Controls (HC) n = 18	F/ χ^2 value
<i>Number of Friends compared to Peers (n%)</i> *				13.94
More Friends	4(22.2) ^a	2(11.1) ^a	7(38.9) ^b	
Same Friends	8(44.4)	6(33.3)	11(61.1)	
Fewer Friends	6(33.3)	10(55.6)	0(0.0)	
<i>Best Friend (n%)</i>				.98
Yes	14(77.8)	16(88.9)	14(77.8)	
No	4(22.2)	2(11.1)	4(22.2)	
<i>Difficulty Making Friends (n%)</i> *				23.91
Yes	2(11.1) ^a	12(66.7) ^b	0(0.0) ^a	
No	16(88.9)	6(33.3)	18(100)	
<i>Difficulty Keeping Friends (n%)</i>				4.27
Yes	4(22.2)	3(16.7)	0(0.0)	
No	14(77.8)	15(83.3)	18(100)	
<i>Current Participation in Organization/Group Activity (n%)</i>				.55
Yes	13(72.2)	12(67.7)	14(77.8)	
No	5(27.8)	6(33.3)	4(22.2)	

^a Means sharing superscripts are not significantly different.

^b Means sharing superscripts are not significantly different.

* p value < .01

Table 3

Means and Standard Deviations for CBCL Social Scales

	Generalized Anxiety Disorder (GAD) n = 18	Social Anxiety Disorder (SAD) n = 18	Healthy Controls (HC) n = 18	F value
<i>CBCL Sub-Scale</i>				
Social Competence (M/SD)*	47.56(6.5) ^{ab}	42.81(9.6) ^a	52.72(10.2) ^b	5.55
Social Problems (M/SD)	56.11(7.6)	55.72(6.8)	53.28(5.4)	.96

^aMeans sharing superscripts are not significantly different.

^bMeans sharing superscripts are not significantly different.

* p value < .01