Background Paper: Shy Children

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Shy Children

Being shy is a highly occurring trait. It is seen in our family members, friends, partners, peers, or even ourselves. A person may develop shyness from inheriting the trait, past experiences, or it just may be their natural disposition. There are many implications for developing shyness. Proven to begin in childhood, a child who is often referred to as "shy" is thought to suffer from *social phobia*. Even though 1% of adults are diagnosed with social phobia, experts have proven that social phobia begins in childhood. Early to middle adolescence is viewed as the most common age onset of for social phobia. The earlier the age of onset the, the less likely it is that they will recover in the future (Austin & Sciarra, 2010).

One component of shyness is social withdrawal. It stands out from other components of social withdrawal such as unsociability or social disinterest because it includes the desire for peer interaction (Austin & Sciarra 2010; Miller, Tserakhava, & Miller 2010). The child *wants* to interact with peers, but excludes themselves due to fear of rejection and feeling uncomfortable. Social apprehension in new or unfamiliar situations has to do with the way the parent responds to their child's temperament and can lead to their social success or failure. A parent's natural response to shyness is to overprotect, in turn causing the child to learn they cannot handle problems on their own. Although different in nature, overly controlling and overly protective parenting styles have been linked to poor social outcomes. Overprotective parenting is warm and encourages the child to depend on the parent. Overprotective parents use decision making techniques beyond a developmentally appropriate level. This inhibits their children from gaining their own set of coping strategies. It has been found that shy children with overprotective parents are less likely to be accepted by their peers and are lonelier. Overly controlling parents direct their child's shyness through more coercive techniques in an attempt to influence their child's

behavior. These techniques include behaviors such as love withdrawal, shaming, and placing guilt upon the child when they do not comply with their parent's request. There are a host of reasons that a parent may be overprotective with a shy child, but the high heritability of shyness suggests the parent has struggled with being shy and would like to protect their child from the stresses that come with a shy nature (Miller et al., 2010).

Gender is also important in the parenting, peer exclusion, and shyness relationship. A study shows that when boys are shy the father has been thought to be psychologically controlling and when girls are shy, both parents have been controlling (Miller et al., 2010). Fathers do not tolerate shyness in their sons so they are more directive than supportive in the presence of their son's shyness. This is a possible reason why it is typical for shy boys to experience greater loneliness. Mothers perceive their daughter's shyness to be typical behavior of a female; therefore they have a warm, supportive response. Of great importance, but still eluding researchers is how parents respond to shyness by gender in late childhood, even though it is evident in the early years (Miller et al., 2010).

Some children who have the most extreme cases of shyness that stem from the actions/non-action of their caregiver(s) may possibly have reactive attachment disorder (RAD). As explained in the DSM–IV (2000), reactive attachment disorder has two subtypes: inhibited/emotionally withdrawn and disinhibited/indiscriminating. In the inhibited subtype of RAD, the child has:

> emotional withdrawal, failure of social and emotional reciprocity, and lack of seeing or responding to comforting when distressed. Attachment behaviors such as seeking and accepting comfort, showing and responding to affection, relying

> on caregivers for help, and cooperating with caregivers are absent or markedly restricted. In addition, exploratory behavior is limited, owing to the absence of a preferred attachment figure (APA, 2000).

This shows that a caregiver's interaction with a child is very important and determines the level of success for the child in future social interactions and relationships.

Being shy is reported by individuals as not being a particularly inhibiting quality, but does cause a handful of problems in interpersonal relationships. This is first observed when children begin school. Already armed with apprehensions that stem from their parents reaction to their temperament, school-age children have a difficult time interacting with their peers. Peers avoid shy children as early as kindergarten. The passive actions, lack of eye contact, and avoidance of social interaction lead peers to believe shy children intentionally exhibit these traits and are unfriendly. Even though this occurs, it is only in westernized countries that assertiveness temperament and social intuitive is far more superior than shyness. Early childhood is when shyness is perceived as abnormal and therefore creating challenges for shy youth trying to fit in with their peers. Shy children in rural Chinese children have been thought to be leaders and socially competent. Shyness is also seen as normative in some American Indian communities; shy youth in those communities are free from stigma and their behavioral inhibition is not associated with adolescent social anxiety (Miller et al., 2010).

So, how can social anxiety/shyness be detected in a child? In a study by Biedel, Turner, and Morris (1999), fifty children with social anxiety reported their five most feared situations: (a) reading in front of the class, (b) musical or athletic performance, (c) joining in on a conversation, (d) speaking to adults, and (e) starting a conversation. Children who have a social

phobia also display physical symptoms when in a social distressing situation. These symptoms include but are not limited to: sweating, heart palpitations, flushes, chills, nausea, and shakiness (Austin & Sciarra, 2010).

Assessments can also be done to determine if a child has social anxiety. Social anxiety disorder can be diagnosed by most self-report and behavioral assessment scales used to diagnose clinical levels of anxiety. However, in doing this it is important to determine where the anxiety comes from that differentiates it from being social anxiety as opposed to a generalized anxiety disorder. Investigating the child's school history can help to identify anxiety that is reactive to environmental stimuli such as peer rejection or humiliating events in the presence of others and/or living in an high-crime neighborhood or abusive household. It is these considerations that help the identification of social anxiety successful (Austin & Sciarra, 2010).

Social anxiety can be treated in many different ways. In an individual/group treatment approach, children who have social phobia can attend cognitive-behavioral therapy programs where they learn social skills and talk about peer-generalization experiences. In addition, the family treatment approach can include educating the parents and other family members on the child's disorders and providing contingency management for the child so that they have a plan of action for interacting with the family. In the most extreme cases of social anxiety, children can be prescribed medicine to control the disorder although more studies are needed to determine the effectiveness of using anti-anxiety medications with this population of children (Austin & Sciarra, 2010).

It is important to identify and treat the symptoms of social anxiety in childhood in order to prevent further implications in the child's high school and adult years. The child may continue

to have poor social skills and underachieve in school and work settings. It is important for stakeholders in the child's life to actively promote strong social behaviors.

References

Austin, V. & Sciarra, D. (2010). *Children and adolescents with emotional and behavioral disorders.* Upper Saddle River, NJ: Pearson Education, Inc.

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders: DSM-IV-TR. Washington, DC: American Psychiatric Association.

Beidel, D. C., Turner, S. M., & Morris, T.L. (1999). Psychopathology of childhood social phobia. *Journal of the American Academy of Child & Adolescent Psychiatry*, 38(6), 643 -650.

Miller, S.R., Tserakhava, & Miller, C.J. (2010). My child is shy and has no friends: What does parenting have to do with it? *Journal of Youth and Adolescence*, 40, 442-452.