

Self-report measures in the study of comorbidity in children and adolescents with social phobia: Research and clinical utility

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Received 7 May 2007; received in revised form 15 August 2007; accepted 15 August 2007

Abstract

We examined differences in self-reported anxiety and depression according to the number and pattern of *DSM-IV* comorbid diagnoses in 172 children and adolescents (mean age = 11.87, S.D. = 2.67; range = 7–17) with a primary diagnosis of social phobia. Three hypotheses were tested: (1) children with comorbid anxiety disorders would show significantly higher scores than children with social phobia-only on self-report measures, (2) self-report measures would significantly differentiate between children with social phobia and comorbid internalizing versus externalizing disorders, and (3) self-report measures would significantly differentiate children according to the type of anxiety comorbidities present. Multinomial logistic regressions showed that children with three anxiety disorders scored significantly higher than children with one and two diagnoses on two of three self-report measures used. Logistic regressions revealed that children's scores on measures did not differ according to the nature of the comorbid diagnoses (internalizing vs. externalizing). Finally, ROC curves showed that the MASC and the SPAI-C accurately classified children with additional diagnoses of SAD and GAD, respectively. The potential of self-report measures to further our understanding of childhood anxiety comorbidity and the clinical implications of their use to screen for comorbidity are discussed along with suggestions for further study.

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Keywords: Children; Anxiety; Comorbidity; Rating scales; Social phobia

Children rarely present to mental health or anxiety-specialty clinics with only one circumscribed anxiety diagnosis (see Curry, March, & Hervey, 2004). In an early study (Last, Strauss, & Francis, 1987) more than one third of an outpatient sample of 73 children diagnosed with separation anxiety disorder (SAD) had one or more additional anxiety disorders. A more recent investigation (Masi et al., 2004) corroborated these high

rates: 75% of 157 clinic-referred youths diagnosed with generalized anxiety disorder (GAD) also met criteria for at least one additional anxiety disorder, the most common being specific phobia (SP, 42%).

In addition, childhood anxiety disorders frequently co-occur with mood and disruptive disorders (e.g., Bernstein & Borchardt, 1991; Bird, Gould, & Staghezza, 1993; Fleitlich-Bilyk & Goodman, 2004; Masi, Favilla, Mucci, & Millepiedi, 2000). In one study (Anderson, Williams, McGee, & Silva, 1987) the comorbidity rate between anxiety and depressive disorders was 16.9% in a community sample of 792 children. Similarly, Ford, Goodman, and Meltzer (2003) found comorbidity rates of 27% and 17% for depressive

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and disruptive disorders, respectively, among children with an anxiety disorder diagnosis. Masi et al. (2004) also reported that among their clinic-referred children and adolescents diagnosed with GAD, 56% and 21% met criteria for an additional depressive and disruptive disorder, respectively.

Assessing children for anxiety disorders and comorbid patterns requires a multimethod, multitrait approach (Silverman & Kurtines, 1996). Categorical diagnoses are typically derived from structured or semi-structured clinical interviews, although these instruments are costly and time-consuming. On the other hand, rating scales provide valuable, inexpensive, and expedient information regarding a child's symptoms. Increasingly, the role of rating scales in diagnostic decision-making has been explored, in part guided by the incremental use of rating scales in clinical practice. Thus, studies looking at the diagnostic efficiency of rating scales, in general, and their utility in the study of comorbidity, in particular, have begun to accumulate. For example, some investigators have tried to examine the use of rating scales to predict the number or types (e.g., Dierker et al., 2001) of disorders present in particular samples, while others have examined whether scores on rating scales vary according to the diagnostic status of the child (e.g., Hofflich, Hughes, & Kendall, 2006). However, use of self-report measures to examine patterns of anxiety comorbidity in children has been very limited. Understanding how short, easy-to-use rating scales may add specific value to the process of clinical diagnosis can aid clinicians in identifying children at risk for presenting with multiple anxiety disorders and tailor psychological interventions appropriately.

Despite availability of anxiety-specific measures (e.g., Multidimensional Anxiety Scale for Children [MASC; March, Parker, Sullivan, Stallings, & Conners, 1997], Social Phobia and Anxiety Inventory for Children [SPAI-C; Beidel, Turner, & Morris, 1995]), very few studies have assessed their value in signaling patterns of psychiatric comorbidity in children and adolescents (Dierker et al., 2001; J.S. March, personal communication, September 2006; Rynn et al., 2006) with anxiety disorders. With respect to the MASC, this is somewhat surprising, considering the available literature supporting the psychometric strength of this measure (e.g., March et al., 1997; Ólason, Sighvatsson, & Smári, 2004; Rynn et al.) and its foundation in *Diagnostic and Statistical Manual of Mental Disorders* criteria (4th ed., *DSM-IV*; American Psychiatric Association, 1994).

Dierker et al. (2001) examined the performance of two self-report measures for anxiety (i.e., the Revised

Children's Manifest Anxiety Scale [RCMAS; Reynolds & Richmond, 1985] and the MASC) and a self-report measure of depression (i.e., the Center for Epidemiological Studies-Depression Scale [CES-D; Radloff, 1977]) at identifying youths with comorbid anxiety disorders. The MASC was related to a primary diagnosis of anxiety, although only among females with GAD. Receiver operating characteristic (ROC) curves showed that only the MASC had moderate ($0.70 < \text{AUC} < 0.90$) predictive power for anxiety comorbidity.

This study's finding that the MASC predicted anxious comorbidity is promising, although, as noted by the authors, only two types of comorbidity were examined (i.e., comorbid social phobia [SOP] and SP across both genders and comorbid SOP and GAD in females). Additionally, although this study did find that the MASC Total Score was successful at predicting anxiety comorbidity, it did not report on the relationship of the MASC subscales to anxiety disorders and/or patterns of comorbidity, an important question in light of the multidimensional nature of anxiety as assessed by the MASC.

Using the MASC, Hofflich et al. (2006) found that children with a principal diagnosis of GAD, SP, or SAD reported more frequent somatic complaints than children without an anxiety disorder diagnosis. However, no differences were found between the anxiety-disordered groups. Additionally, the authors found that anxious children with comorbid depression reported a higher frequency of somatic complaints than children with comorbid externalizing disorders and children with anxiety only. This is an important study, in that it found that the MASC Physical Symptoms subscale differentiated children with comorbid anxiety and depressive disorders from children with anxiety only, highlighting the utility of the MASC subscales in the study of comorbidity. However, this study did not examine differences according to the number of comorbid disorders or among those children with pure comorbid anxiety disorders. Furthermore, their findings were based on only one subscale of the MASC. Based on the rates of within-anxiety comorbidity in children, exploring this possibility remains an important endeavor.

Although the specific value of self-report measures such as the MASC has recently been explored, the value of disorder-specific measures (e.g., SPAI-C, CDI) has received much less attention. Determining potential value of these latter measures in the study of comorbidity may contribute important clinical and research knowledge into this phenomenon and, at the

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