



Cognitive behavior therapy for generalized social anxiety disorder in adolescents: A randomized controlled trial

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ABSTRACT

Early identification and treatment of social anxiety disorder (SAD) is critical to prevent development of a chronic course of symptoms, persistent functional impairment, and progressive psychiatric comorbidity. A small but growing literature supports the effectiveness of cognitive behavior therapy (CBT) for anxiety disorders, including SAD, in adolescence. The present randomized controlled trial evaluated the efficacy of group vs. individual CBT for adolescents with generalized SAD in relation to an educational/supportive psychotherapy that did not contain specific CBT elements. All three treatments were associated with significant reductions in symptoms and functional impairment, and in improved social skills. No differences between treatments emerged on measures of symptoms, but the CBT conditions demonstrated greater gains on behavioral measures. The implications of the findings are discussed.

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Social anxiety disorder (SAD), also known as social phobia, is characterized by a marked and persistent fear and/or avoidance of social situations in which one fears being negatively evaluated by others or being subjected to embarrassment (American Psychiatric Association, 2000). SAD is divided into two subtypes: generalized and non-generalized. Individuals with generalized SAD experience anxiety across most social situations, whereas those with the non-generalized subtype fear a specific social or performance situation (Hofmann et al., 1999). SAD is widely believed to be among the most prevalent of psychiatric conditions, although most individuals with the disorder are never identified and do not obtain treatment (Chavira, Stein, Bailey, & Stein, 2004; Kessler et al., 1994). Without treatment, SAD tends to follow a chronic, unremitting course. Onset is typically in the early teens, with a mean onset of 15.5 years (Schneier, Johnson, Hornig, Liebowitz, & Weissman, 1992). Although the vast majority of research on SAD has focused on adults, the early onset, chronicity, high levels of comorbidity, and substantial distress and functional impairment

associated with the disorder highlight the critical importance of effective early assessment and intervention.

Although children and adolescents often report many types of worries and fears, most of these are transient and do not result in significant impairment in functioning (Muris, Merckelbach, Gadet, & Moulart, 2000). SAD, however, is associated with high levels of distress and significant functional impairment. Youths with SAD have few friends, limited extracurricular activities, and may have difficulty with school attendance and underachievement (Khalid-Khan, Santibanez, McMicken, & Rynn, 2007). Additionally, SAD in this population is highly correlated with school refusal, selective mutism, and increased comorbidity with depressive, anxiety, somatoform, and substance use disorders (Essau, Conradt, & Petermann, 1999; Last & Strauss, 1990). The social fear characteristic of SAD in youth can cause significant impairment in functioning, and can have long-term detrimental effects due to the disorder's chronic course. See Beidel, Ferrell, Alfano, & Yeganeh (2001), Kashdan and Herbert (2001) and Khalid-Khan et al. (2007) for comprehensive reviews of SAD in childhood and adolescence.

Currently, there is limited research on the psychological treatment of children and adolescents with SAD (Kashdan & Herbert, 2001; Khalid-Khan et al., 2007; Sweeney & Rapee, 2005). To date, most of the psychological interventions for social anxiety in children have been designed to target all anxiety disorders (e.g.,

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mixed anxiety populations). Most of these interventions are derived from cognitive-behavioral models designed for adults (Zaider & Heimberg, 2003), and have generally demonstrated positive results (Barrett, 1998; Barrett, Dadds, & Rapee, 1996; Kendall, 1994; Kendall et al., 1997; Rapee, 2000; Silverman et al., 1999). Relative to untreated controls, treated children are more likely no longer to meet criteria for their specific anxiety disorder following treatment, and to report fewer symptoms of anxiety and greater improvements in comorbid conditions. A notable limitation of this research, however, is that only a small number of studies have examined interventions specifically targeting SAD.

Two cognitive-behavioral treatment programs specifically targeting childhood or adolescent SAD have been developed: (1) cognitive-behavioral group therapy (CBGT) (Albano, Marten, Holt, Heimberg, & Barlow, 1995; Hayward et al., 2000; Spence, Donovan, & Brechman-Toussaint, 2000), and (2) social-effectiveness therapy (SET) (Beidel, Turner, & Morris, 2000b). In addition, “coping cat” child behavior therapy program (Flannery-Schroeder & Kendall, 2000; Kendall, 1990; Kendall, 1994) was designed to target anxiety disorders in general among children, but not SAD specifically. Each of these treatment approaches shares four critical intervention components: psychoeducation, exposure to feared situations, anxiety coping skills (e.g., relaxation techniques, cognitive restructuring, problem-solving), and homework assignments to facilitate consolidation of skills in real-world situations. The CBGT and SET programs are both modeled after established adult protocols and are typically conducted in a group format. The “coping cat” program is typically implemented in an individual format.

The research on these programs is quite promising. In an uncontrolled study of CBGT, Albano et al. (1995) piloted a 16-session multicomponent program for 5 adolescents with a primary diagnosis of SAD (Albano et al., 1995). This program was largely based on successful adult studies (Heimberg, Salzman, Holt, & Blendall, 1993). The program included skill building strategies (Christoff, Scott, Kelley, Baer, & Kelly, 1985), and parental involvement. At 3-months post-treatment, 4 of the 5 youths no longer met criteria for SAD, and at 1-year follow-up all participants were without an SAD diagnosis (Albano et al., 1995). Spence et al. (2000) compared the effectiveness of child-only CBGT ($n = 17$) to CBGT with a parental component ($n = 19$), both relative to a waitlist control (WLC) ($n = 14$). Children aged 7–14 years were randomly assigned to one of the three conditions. The treated children received 12 weeks of therapy with booster sessions at months 3 and 6 post-treatment. Significantly fewer children in both of the active treatment conditions met criteria for SAD at the end of the treatment relative to those in the WLC condition (87% remitted in CBGT with parental involvement, 58% in child-only CBGT, 7% in WLC), and gains were maintained at follow-up. Although no significant differences emerged between the two active treatments, the study was inadequately powered to detect such differences, and there appeared to be a trend favoring CBT with parental involvement. Hayward et al. (2000) compared CBGT ($n = 12$) to a WLC ($n = 23$) in a group of female adolescents. Relative to those in the control condition, treated adolescents had a 50% reduction in social phobia interference ratings; moreover, 45% of treated adolescents no longer met criteria for SAD at post-treatment, compared to 5% of the controls. Although promising in the short-term, at 1-year follow-up no significant differences were present between the treatment and control groups.

Social-effectiveness therapy for children (SET-C) has also demonstrated promising results. This program is delivered in 24 sessions over 12 weeks, with one treatment session per week focused on exposure and the second on social skills training. In an uncontrolled pilot study consisting of 16 children aged 8–12,

significant improvements in anxiety symptoms over time were observed (Beidel, Turner, & Morris, 1997). In a subsequent study, Beidel et al. (2000b) compared the effectiveness of SET-C in 50 SAD children to an active, non-SAD specific intervention consisting of test-taking and study skills training. Significant differences were revealed at post-treatment, with 67% of the SET-C children no longer meeting criteria for SAD compared to 5% of those in the control group. Six month follow-up assessments suggested further treatment gains, with 85% of the children in the SET-C group being diagnosis free. Gains were maintained at 5-year follow-up (Beidel, Turner, & Young, 2006).

More recent studies of SAD in youths have examined comparisons of treatment protocols, duration of treatment, and protocol applications to real-world settings. Olivares et al. (2002) and García-López et al. (2002) examined the effects of three different interventions for adolescent SAD in a school setting in Spain. Fifty-nine adolescents were randomized to receive Spanish language versions of SET, CBGT, therapy for adolescents with generalized social phobia (intervención en adolescentes con fobia social generalizada, IAFSG), or a no-treatment control group. IAFSG is a school-based CBT intervention consisting of 12 group sessions. Results showed that all three active treatments were superior to the control group in terms of reductions in social anxiety and improvements in social skills and self-esteem at post-treatment and at 1-year follow-up. Within-group analyses revealed that all three active interventions produced significant improvements from pre-treatment to post-treatment. Five year follow-up data demonstrated maintenance of effects in the three treatment conditions (García-López et al., 2006). Other school-based interventions have also demonstrated significant reductions in SAD (Fisher, Masia-Warner, & Klein, 2004; Masia-Warner et al., 2005; Masia-Warner, Fisher, Shrout, Rathor, & Klein, 2007). In another study, Gallagher, Rabian, & McCloskey (2004) randomly assigned 23 children with SAD to a 3-week CBT intervention or WLC. The brief intervention consisted of three 3-h weekly sessions. Results demonstrated positive effects of the program relative to WLC at post-treatment and 3-week follow-up.

The literature on the treatment of SAD in youths is limited but promising. A recent meta-analysis found large effects of CBT programs for childhood SAD, comparable in size to the effects of pharmacotherapy (Segool & Carlson, 2007). There are, however, several noteworthy limitations of the current literature. First, as noted above, most of the studies have not focused specifically on SAD, but rather on mixed groups of youths with various anxiety disorders. Moreover, of the studies that focused on SAD, the majority did not specifically target the more severe generalized subtype of the disorder. Second, most studies focused either exclusively on preadolescent children, or on samples that included both younger children as well as adolescents. There is a general consensus that adolescents with SAD present unique clinical challenges and may be more treatment resistant than younger children, suggesting the importance of a specific focus on adolescents (Kashdan & Herbert, 2001; Rao et al., 2007). Third, most of the studies to date have either been uncontrolled pilot investigations or have compared a single active treatment to a WLC. Such research designs, although representing valuable initial steps, only permit the most basic of conclusions about treatment effects. Fourth, there is a dearth of data on the use of individual treatment with SAD adolescents. Most existing studies have utilized group interventions, and those that have focused on individual treatment have generally focused on younger children. Given the typical onset of SAD in adolescence, as well as the unique challenges associated with the treatment of anxiety disorders at this developmental stage, interventions specifically targeting adolescents are needed. In terms of delivery format, due to

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