



CLINICAL FEATURES AFFECTING TREATMENT OUTCOME IN SOCIAL PHOBIA

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Summary—Characteristics of social phobics were examined to determine their effect on treatment acceptance, drop-out rate and amount of improvement at post-treatment. The rate of treatment non-acceptance was low and those who entered treatment differed from those who did not only on ratings of social phobia severity. The drop-out rate also was relatively low, and there were no differences between those who dropped out and those who completed treatment. When patients were divided on the specific versus generalized subtype dichotomy, a number of interesting findings emerged. Response to treatment was similar, but the specific subtype was significantly more improved at post-treatment than the generalized subtype. When compared on composite indexes of overall improvement and endstate functioning, there was no difference between the number of specific and generalized social phobics achieving significant or moderate improvement. However, a greater number of the specific subtype were judged to have high or moderate endstate status than the generalized subtype. A similar outcome was found when social phobics with comorbid disorders were compared with those who were non-comorbid. The results are discussed in terms of factors affecting outcome in social phobia treatment. Copyright © 1996 Elsevier Science Ltd

INTRODUCTION

A number of controlled treatment outcome studies demonstrating the efficacy of behavioral treatments for social phobia were published during the past decade. The results of these studies have been remarkably uniform. In a review of 13 outcome studies involving approximately 650 patients, Turner, Cooley-Quille and Beidel (1996) reported that although virtually all treatment comparisons show that treatment is superior to no treatment or placebo, there consistently is no significant difference among the various cognitive and cognitive-behavioral strategies. Similarly, across eight studies comparing cognitive-restructuring to exposure alone, only one found an additive effect for the cognitive component (Edelman & Chambless, 1995). The findings of meta-analytic studies are similar. Taylor (1996) reported no differences between cognitive and cognitive-behavioral treatments and Feske and Chambless (1995) found that exposure resulted in significantly superior improvement on social phobia measures when compared with controls or cognitive-behavioral treatment, but cognitive-behavioral treatment did not result in improvement that was significantly different from wait-list controls. The weight of the evidence suggests that current treatments are efficacious but there are little differences among the treatment variations, and exposure is likely to be the critical ingredient. Furthermore, treatment gains have been reported to last for as long as 2.5–5 yr (Heimberg, Salzman, Holt & Blendall, 1993; Turner, Beidel & Cooley, 1995; Wlazole, Schroeder-Hartwig, Hand, Kaiser & Munchau, 1990).

A major limitation in the treatment outcome literature is the virtual absence of data addressing important clinical issues such as characteristics of those who refuse treatment, those who drop-out of treatment, or those who do not improve with treatment. With the publication of DSM-III-R, two patterns of social phobia were recognized (specific or generalized) and available data suggest that the generalized subtype is the more severe (e.g. Herbert, Hope & Bellack, 1992; Turner, Beidel

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& Townsley, 1992a). Furthermore, emerging data suggest that the two subtypes might have different developmental features (e.g. Bruch & Heimberg, 1994; Stemberger, Turner, Beidel & Calhoun, 1995). To date, only one treatment study using behavioral or cognitive-behavioral treatments have examined the effects of treatment differentially on the subtypes (Brown, Heimberg & Juster, 1995). This study found that social phobics with either the non-generalized or generalized subtype improved equally with cognitive-behavioral group therapy, but the non-generalized subtype was significantly less impaired at post-treatment.

Finally, there has been little effort to determine if various clinical features are related to treatment response among social phobics. What few data are available suggest that Axis I or II comorbidity is not related to outcome (e.g. Brown *et al.*, 1995; Hofmann, Newman, Becker, Taylor & Roth, 1995; Turner, Beidel & Cooley, 1994a; Turner, Beidel & Jacob, 1994b). Even though the number of studies on comorbidity is small, and only one has examined directly treatment outcome and comorbidity in an unambiguous fashion, the results attest further to the robustness of current treatments for social phobia.

The current study examined a number of variables to determine their effects on treatment acceptance, treatment completion, efficacy of treatment and level of improvement. Data were from patients participating in the Turner *et al.* (1994b) study comparing flooding and atenolol in the treatment of social phobia.

METHOD

Subjects

Subjects were 84 patients who entered into a study of atenolol and flooding treatment of social phobia at the Western Psychiatric Institute and Clinic (WPIC) Anxiety Disorders Clinic (Turner *et al.*, 1994b). Patients were interviewed with the Initial Evaluation Form (Mezrich, Dow, Rich, Costello & Himmelhoch, 1981), a semi-structured general psychiatric interview schedule, and a consensus diagnosis was made by a senior clinician and staff psychiatrist. Those diagnosed with social phobia were referred to the WPIC Anxiety Disorders Clinic where they were re-interviewed with the Anxiety Disorders Interview Schedule—Revised (ADIS-R; DiNardo, Barlow, Cerny, Vermilyea, Vermilyea, Himadi & Wilson, 1986) to confirm the initial diagnosis. Twenty-five percent of the ADIS-R interviews were videotaped and independently rated by a second clinician who agreed with the diagnosis in all cases. Axis II disorders were determined with the use of the Structured Clinical Interview for DSM-III-R Axis II (SCID-II). Thirty-eight percent of the sample met criteria for a comorbid Axis I disorder and 24% met criteria for a comorbid Axis II disorder. Overall, 42.9% of the sample was comorbid for either an Axis I or II disorder. Patients also were classified as either the specific or generalized subtype by two independent raters who reviewed all semi-structured interview materials. The reliability coefficient for this classification was $\kappa = 0.97$.

The average age of participants was 36.2 yr ($SD = 8.7$; range = 21–60). Thirty-two were male, 52 were female, and all were white with the exception of one African-American and one Asian.

Patients completed a pre-treatment assessment including self-report inventories, independent evaluator ratings, and a behavioral assessment. For completers, this same protocol was administered at post-treatment. Further details of the assessment procedure can be found in Turner *et al.* (1994b). After completion of the assessment protocol, patients were randomly assigned to either flooding, atenolol, or pill placebo conditions. For some of the analyses that follow, the atenolol and pill placebo conditions were collapsed to examine differences between pharmacological and behavioral treatment. In such cases, the collapsed group is referred to as the 'pill' condition.

Measures

Self-report instruments. Subjects completed the Social Phobia and Anxiety Inventory (SPAI; Turner, Beidel, Dancu & Stanley, 1989), the Social Avoidance and Distress Scale (SADS; Watson & Friend, 1969), Fear of Negative Evaluation Scale (FNE; Watson & Friend, 1969), Fear Questionnaire (FQ; Marks & Mathews, 1979), and the Spielberger State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch & Lushene, 1970).

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