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Generic versus disorder specific cognitive behavior therapy for social anxiety disorder in youth: A randomized controlled trial using internet delivery

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ABSTRACT

The study examined whether the efficacy of cognitive behavioral treatment for Social Anxiety Disorder for children and adolescents is increased if intervention addresses specific cognitive and behavioral factors linked to the development and maintenance of SAD in young people, over and above the traditional generic CBT approach.

Participants were 125 youth, aged 8–17 years, with a primary diagnosis of SAD, who were randomly assigned to generic CBT (CBT-GEN), social anxiety specific CBT (CBT-SAD) or a wait list control (WLC). Intervention was delivered using a therapist-supported online program.

After 12-weeks, participants who received treatment (CBT-SAD or CBT-GEN) showed significantly greater reduction in social anxiety and post-event processing, and greater improvement in global functioning than the WLC but there was no significant difference between CBT-SAD and CBT-GEN on any outcome variable at 12-weeks or 6-month follow-up. Despite significant reductions in anxiety, the majority in both treatment conditions continued to meet diagnostic criteria for SAD at 6-month follow-up. Decreases in social anxiety were associated with decreases in post-event processing.

Future research should continue to investigate disorder-specific interventions for SAD in young people, drawing on evidence regarding causal or maintaining factors, in order to enhance treatment outcomes for this debilitating condition.

1. Introduction

Social Anxiety Disorder (SAD: previously Social Phobia) is one of the most common anxiety disorders experienced by young people, with lifetime prevalence rates estimated at 8.6% (Burstein et al., 2011; Lawrence et al., 2015). According to DSM-5 (American Psychiatric Association, 2013), the core defining features of SAD include fear or anxiety in social situations where the individual is exposed to possible scrutiny by others and a fear of acting in a way that will be negatively evaluated by others (either resulting from the individual's own behavior or from showing anxiety symptoms such as blushing, trembling or sweating). Young people with SAD fear situations such as school talks, sport and musical performances, as well as social interactions such as meeting new people, joining in conversations, asking for help in shops or at school, and going to parties or other gatherings (Beidel et al., 2007; Rao et al., 2007). Although the average age of onset is around 9.2 years (Burstein et al., 2011), children as young as three years of age have been found to experience SAD (Rapee, Kennedy, Ingram, Edwards, & Sweeney, 2010). Unfortunately, the disorder tends to persist if left untreated (Burstein et al., 2011), with onset prior to age 11 years of age increasing the risk of persistence into adulthood (Beesdo et al., 2007; Wittchen & Fehm, 2003).

The experience of SAD in young people is associated with numerous deleterious social, academic and psychological

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consequences, such as loneliness, depression, friendship problems, and school refusal (Beidel, Turner, & Morris, 1999). SAD in youth is comorbid with a significant number of mental health problems, particularly other anxiety disorders and depression, and with substance use in older adolescents (Beesdo-Baum et al., 2012; Burstein et al., 2011; Wittchen, Stein, & Kessler, 1999). Some longitudinal studies suggest that SAD actually precedes some mental health issues, being a risk factor for later substance abuse and depression (Beesdo et al., 2007; Black et al., 2015). Thus, early intervention is of utmost importance so that long-term adverse consequences can be averted.

The majority of studies examining the impact of cognitive behavioral therapy (CBT) in the treatment of anxiety disorders, including SAD, have involved a generic approach that targets underlying causal and maintaining problems that are common to a range of anxiety disorders. Therapy components typically include psycho-education about anxiety, coping strategies (e.g. relaxation; problem solving; identification and modification of maladaptive thoughts) and graded exposure to feared situations. These interventions are generally manualized and the same intervention content is used irrespective of the presenting anxiety problem (Barrett, Lowry-Webster, & Turner, 2000; Kendall & Hedtke, 2006; Rapee, Abbott, & Lyneham, 2006; Rapee, Spence, Cobham, & Wignall, 2000, p. 160; Silverman et al., 1999; Waters, Ford, Wharton, & Cobham, 2009).

Overall, there is a good deal of evidence to support the efficacy of a generic approach in treating anxiety disorders, with a recent meta-analysis indicating significant benefits (Bennett et al., 2013). However, recent studies suggest that outcomes following such interventions are weaker for youth with SAD than for other types of anxiety disorders. Children with SAD typically demonstrate a slower rate of change and are less likely to be free of a SAD diagnosis after treatment compared to youth with other anxiety disorders (Crawley, Beidas, Benjamin, Martin, & Kendall, 2008; Ginsburg et al., 2011; Hudson, Keers, et al., 2015; Hudson, Rapee, et al., 2015; Norton & Price, 2007). Indeed, in a collation of data from multiple sites, Hudson, Keers, et al. (2015) found that children with a primary diagnosis of SAD were nearly twice as likely as children with GAD to retain their primary diagnosis immediately after generic CBT and at 12-month follow-up. Similarly, Hudson, Keers, et al. (2015) and Hudson, Rapee, et al. (2015) in a study of 842 children with anxiety disorders found that only 22.3% and 30.7% of those with a primary diagnosis of SAD were free of this diagnosis after treatment and at follow-up respectively. In comparison, over 40% of children with other types of primary anxiety diagnosis were free of their primary diagnosis after treatment, which increased to around 56–57% by 3–12 month follow-up. The weaker treatment outcomes for children with SAD could not be explained by differences in age nor comorbid depression.

It is important to consider why children with SAD might respond less favourably to generic anxiety treatments compared to youth with other types of anxiety disorders. One possibility is that the generic approach does not focus sufficiently upon changing the cognitive and behavioral factors that are involved in the development and maintenance of SAD. A recent empirical review by (Spence & Rapee, 2016) noted that while SAD is associated with many of the risk factors linked to other types of anxiety disorder, such as parental over-control and over-protection (Ollendick, Benoit, & Grills-Taquechel, 2014) and adverse life events (Bögels & Brechman-Toussaint, 2006; McLaughlin et al., 2012), research also indicates that there are unique factors that are important in explaining the development and maintenance of SAD specifically. For example, Spence and Rapee (2016) reviewed evidence to show that young people with SAD are more likely to show deficits in social skills and to experience adverse social outcomes than non-anxious children or those with other types of anxiety disorder. They tend to have fewer friends, to be less well-liked by peers, and to be neglected, actively rejected and victimized by peers. Spence and Rapee (2016) expanded current adult theories of the maintenance of SAD (Clark & Wells, 1995; Rapee & Heimberg, 1997) to propose an evidence-based model of the development and maintenance of SAD during childhood and adolescence. This model proposed that a vicious cycle develops in which poor social skills tend to lead to adverse social outcomes that, in turn, result in anxious emotions, avoidance behaviors, and maladaptive beliefs and thoughts relating to one's social competence and social interactions. In response to adverse social experiences, young people come to believe that they are deficient, stupid, and unattractive, with little ability to control the outcomes of social situations. They come to regard other people as highly critical, with extremely high standards, and who observe their every action (an “audience” effect). Such maladaptive beliefs about the self and others are proposed to contribute to a range of cognitive biases and distortions before, during and after challenging social interactions, including biases in attention, expectations, interpretations, and evaluations. Increased vigilance to social situations, expectations that one will perform in a humiliating or embarrassing way, beliefs that others will appraise and respond negatively, and expectations that the outcome of social situations will be terrible, are all suggested to contribute to the further experience of anxiety. Furthermore, high levels of self-focused attention and consequential distraction away from the social task are likely to impair social performance. After social interactions, socially anxious individuals tend to interpret the response of others and the quality of their own performance as being worse than it actually is. They are also likely to engage in maladaptive post-event processing (PEP) which refers to the tendency to recall and ruminate about perceived negative aspects of previous social situations. Not surprisingly, feared social interactions are likely to be avoided where possible. Such avoidance, in combination with rejection and isolation by peers, may serve to reduce opportunities for further learning and practice of social skills. Thus, the cycle is perpetuated.

Generic CBT approaches for treating child and adolescent social anxiety assume that the psycho-education, cognitive restructuring, coping skills, and exposure components of treatment will be sufficient to address the factors that maintain SAD. We propose in the present paper that the treatment of SAD in youth is more likely to be effective if the intervention focuses more specifically upon the cognitive and behavioral factors that are implicated in its development and maintenance. We acknowledge that generic CBT programs for child anxiety include elements to increase awareness and modification of maladaptive cognitions before, during and after challenging social interactions, but they do not typically include information about self-focussed attention, with exercises to shift attention focus from the self to the social task, nor provide specific training in the reduction of post-event processing. Neither do they include systematic content to enhance social skills.

With children and adolescents, several studies have evaluated CBT interventions for SAD that included social skills training (Albano, Marten, Holt, Heimberg, & Barlow, 1995; Beidel, Turner, & Morris, 2000; Donovan, Cobham, Waters, & Occhipinti, 2015; Garcia-Lopez et al., 2006; Masia Warner, Fisher, Shrout, Rathor, & Klein, 2007; Olivares et al., 2002; Ost, Cederlund, & Reuterskiold, 2015; Spence, Donovan, & Brechman-Toussaint, 2000). A recent meta-analysis reported by Scaini, Belotti, Ogliari, and Battaglia (2016) noted that the effects of interventions that included social skills training tended to be more effective than those that did not. However, examination of effect sizes associated with the CBT interventions that included social skills training suggest that there is still considerable room for improvement and studies have not