



Research report

Social communication deficits: Specific associations with Social Anxiety Disorder

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ABSTRACT

Background: Social communication deficits are prevalent amongst children with anxiety disorders; however whether they are over-represented specifically among children with Social Anxiety Disorder has not been examined. This study set out to examine social communication deficits among children with Social Anxiety Disorder in comparison to children with other forms of anxiety disorder.

Methods: Parents of 404 children with a diagnosed anxiety disorder completed the Social Communication Questionnaire (SCQ; Rutter, M., Bailey, A., Lord, C., 2003. The Social Communication Questionnaire – Manual. Western Psychological Services, Los Angeles, CA). Children with a diagnosis of Social Anxiety Disorder ($n=262$) and anxious children without Social Anxiety Disorder ($n=142$) were compared on SCQ total and subscale scores and the frequency of participants scoring above clinical cut-offs.

Results: Children with Social Anxiety Disorder scored significantly higher than anxious children without Social Anxiety Disorder on the SCQ total ($t(352)=4.85$, $p<.001$, $d=.55$, $r=.27$), Reciprocal Social Interaction ($t(351)=4.73$, $p<.001$, $d=.55$, $r=.27$), communication ($t(344)=3.62$, $p<.001$, $d=.43$, $r=.21$) and repetitive, restrictive and stereotyped behaviors subscales ($t(353)=3.15$, $p=.002$, $d=.37$, $r=.18$). Furthermore, children with Social Anxiety Disorder were three times more likely to score above clinical cut-offs.

Limitations: The participants were a relatively affluent group of predominantly non-minority status. The social communication difficulties measure relied on parental report which could be influenced by extraneous factors.

Conclusions: Treatments for Social Anxiety Disorder may benefit from a specific focus on developing social communication skills. Future research using objective assessments of underlying social communication skills is required.

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1. Introduction

Anxiety disorders during childhood are common, serious, and are associated with poor life course consequences (e.g. Costello et al., 2004; Essau et al., 2000; Ezpeleta et al., 2001) and substantial health and social costs (Bodden et al., 2008). Social Anxiety Disorder, in particular, has a high prevalence (Costello et al., 2004) and is linked with serious long term consequences, including depression (Beesdo et al., 2007). Recent studies have demonstrated that children with Social Anxiety Disorder have poorer outcomes than children with other forms of anxiety from generic or transdiagnostic anxiety treatments (Compton et al., 2014; Ginsburg et al., 2011; Kerns et al., 2013). However, treatments which specifically target Social Anxiety Disorder appear to be associated with somewhat better outcomes (Doehrmann

et al., 2013; Mayo-Wilson et al., in preparation). These treatments are often more intensive, yet the content is typically broadly similar to the generic treatments; a key difference being increased opportunities for rehearsal of social skills (Beidel et al., 2000; Spence et al., 2000).

Early social communication difficulties have been implicated in the development of Social Anxiety Disorder. Specifically, it has been suggested that a lack of social skills may lead to negative reactions from others, which promote negative beliefs and avoidant behaviors in social situations (Rapee and Spence, 2004). Consistent with this hypothesis, children with autism spectrum disorder have elevated social anxiety symptoms compared to healthy peers (Kuu-sikko et al., 2008), which is accounted for by the degree of their social communication difficulties (Bellini, 2004). Also consistent with this hypothesis, compared to non-anxious children, children with Social Anxiety Disorder have been found to have lower self and peer ratings of social competence, as well as poorer social skills on behavioral assessments in the laboratory and in school (Beidel et al., 1999; Spence et al., 1999). However, evaluating social skills in situations where

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children are anxious introduces a confound, which makes it difficult to ascertain whether group differences reflect social communication skill deficits or a lack of social confidence. For example, Cartwright-Hatton et al. (2003) reported that children with higher levels of social anxiety only scored higher than others on observer ratings of how nervous they appeared, and not on other aspects of social skill, although the children gave more negative appraisals of their performance.

One approach to teasing apart social skills deficits and social anxiety is to consider the social communication difficulties that may underlie restricted social behaviors. Social communication deficits are a core trait of Autistic Spectrum Disorder, and include difficulties with communication of cognitive and emotional information through facial expression, gesture, and prosody and through implicit understanding of pragmatics and theory of mind (e.g. Tanguay et al., 1998). Of particular note is one study with a community population, in which children with high levels of social anxiety were rated by teachers as being less skilled in social tasks that involved insight into others' mental states, compared to their low-anxious peers (Banerjee and Henderson, 2001). Few studies have examined underlying social communication difficulties among children with Social Anxiety Disorder specifically, but a higher frequency of social communication difficulties has been found among groups of children with a range of anxiety disorders, compared to their non-anxious peers (van Steensel et al., 2013).

This study examines the degree to which social communication difficulties are specifically associated with Social Anxiety Disorder. In order to address the question of specificity, we compared social communication deficits among children meeting diagnostic criteria for Social Anxiety Disorder and children with other anxiety disorders. As anxiety disorders in children are commonly comorbid (e.g. Kendall et al., 2010), we accounted for this in our analyses, as well as other potential confounds, such as gender, age, ethnicity and any potential overlap in the assessment of social anxiety and social communication difficulties.

In summary, this study investigated the hypothesis that children with Social Anxiety Disorder will have significantly more social communication deficits, or ASD traits, than children with other forms of anxiety disorder.

2. Methods

2.1. Participants

Four-hundred and four clinically anxious children, aged 6–13 years, were assessed before commencing treatment. 64.9% ($n=262$) of the children met diagnostic criteria for current Social Anxiety Disorder (SOCANX), and 35.1% ($n=142$) met criteria for another anxiety disorder but not Social Anxiety Disorder (NONSOCANX). The two groups were well balanced on child age, gender, ethnicity and socio-economic status (see Table 1).

All participating children were recruited through referrals by local health and education service personnel to the Berkshire Child Anxiety Clinic at the University of Reading. Children were assessed by graduate psychologists using the Anxiety Disorders Interview Schedule for DSM-IV: Child and Parent version (ADIS-C/P (see below)) and were included on the basis of having an anxiety disorder as their principal diagnosis. The clinical service does not offer treatment to children with diagnosed autistic spectrum disorders (as alternative services are available), so referrals were accepted on the basis that an autistic spectrum disorder had not been identified.

2.2. Procedure

Ethical approval was granted from the University of Reading and Berkshire (NHS) Research Ethics Committees. All potential participants received information in writing and from discussions

with the research team, and provided written consent. Participating children and their primary caregiver completed initial diagnostic interviews and symptom questionnaires either in University clinic rooms or in satellite clinics in their locality.

2.3. Measures

2.3.1. Diagnoses

Children were assigned diagnoses on the basis of the Anxiety Disorders Interview Schedule for DSM IV for Children-Child and Parent Versions (ADIS-C/P; Silverman and Albano, 1996), a structured diagnostic interview with well-established psychometric properties (Silverman et al., 2001). When children met symptom criteria for a diagnosis (based on either child or parent report) they were assigned a clinical severity rating (CSR) from 0 (complete absence of psychopathology) to 8 (severe psychopathology). The higher CSR of the two was taken. As is conventional, only those who met symptom criteria with a CSR of 4 or more (moderate psychopathology) were considered to meet diagnostic criteria.

Assessors (psychology graduates) were trained on the administration and scoring of the ADIS-C/P through verbal instruction, listening to assessment audio-recordings and participating in diagnostic consensus discussions. The first 20 interviews conducted were then discussed with a consensus team, led by an experienced diagnostician (Consultant Clinical Psychologist). The assessor and the consensus team independently allocated diagnoses and CSRs. Following the administration of 20 child or 20 parent interviews, inter-rater reliability for each assessor was checked, and if assessors achieved reliability of at least .85 they were then required to discuss just one in six interviews with the consensus team (these ongoing checks were conducted to prevent inter-rater drift). Overall reliability for the team was excellent. Reliability for ADIS-C/P diagnosis was .98 (child report), .98 (mother report); and for CSRs .99 (child report), .99 (mother report).

2.3.2. Symptoms measures

The Spence Children's Anxiety Scale (SCAS-c/p; Nauta et al., 2003; Spence, 1998) was used to assess child and parent reported child anxiety symptoms. The child version requires children to rate how often they experience each of 38 anxiety symptoms, presented alongside six positive filler items on a 4-point scale from 0 (*never*) to 3 (*always*). Both versions have demonstrated good concurrent validity and internal consistency (Nauta et al., 2004; Spence, 1998). Internal consistency based on data from the current sample was good (Cronbach's alpha (α) = .92 for SCAS-C and .89 for SCAS-P).

The life-time version of the Social Communication Questionnaire (SCQ) is a 40 item parent-reported checklist of 'yes or no' questions from the Autism Diagnostic Interview-Revised (ADI-R). The SCQ has three subscales: Reciprocal Social Interaction (13 items), communication (8 items) and restricted and repetitive behaviors (RRBI; 6 items). The SCQ has demonstrated high reliability ranging from .84 to .93 (Rutter et al., 2003), with good internal consistency from the current sample (α = .86; subscale scores were lower for communication and RRBI likely due to the restricted variance from dichotomous responses to a low number of items; Social α = .85, communication α = .56, RRBI α = .42). Total scores of 15 or more indicate a likelihood of ASD (Rutter et al., 2003). The SCQ has been found to have high sensitivity and specificity when differentiating autism from other ASDs and no spectrum diagnoses (.90 and .86 respectively; Chandler et al., 2007) and performs better in this regard than other questionnaire measures of social communication (Charman et al., 2007).

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